BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

ANDREAS PERRIGO, Claimant, vs. WALMART, Employer, and NEW HAMPSHIRE INSURANCE CO., Insurance Carrier, Defendants.	FILED JUN 15 2016 WORKERS COMPENSATION	File No. 5045163 ARBITRATION DECISION Head Note No.: 1804

STATEMENT OF THE CASE

Claimant, Andreas Perrigo, filed a petition in arbitration seeking workers' compensation benefits from Walmart, employer, and New Hampshire Insurance Company, insurance carrier, both as defendants, as a result of a stipulated injury sustained on November 26, 2012. This matter came on for hearing before Deputy Workers' Compensation Commissioner Erica J. Fitch, on October 29, 2015, in Des Moines, Iowa. The record in this case consists of claimant's exhibits 1 through 20, defendants' exhibits A through M, and the testimony of the claimant and Susan Johnson. The parties submitted post-hearing briefs, the matter being fully submitted on December 10, 2015.

ISSUES

The parties submitted the following issues for determination:

1. Whether claimant is entitled to temporary disability benefits from August 20, 2014 through March 12, 2015;

2. Whether the work injury of November 26, 2012 is a cause of permanent disability;

3. The extent of claimant's industrial disability;

4. Whether defendants are responsible for claimed medical expenses;

5. The extent of credit to defendants pursuant to Iowa Code section 85.38(2) for short term disability benefits paid; and

6. Specific taxation of costs.

The stipulations of the parties in the hearing report are incorporated by reference in this decision.

FINDINGS OF FACT

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

Claimant's testimony was clear and consistent as compared to the evidentiary record and his deposition testimony. Claimant was personable and his demeanor at the time of evidentiary hearing gave the undersigned no reason to doubt claimant's veracity. The undersigned observed claimant ambulate slowly, with the assistance of a cane. Claimant is found credible.

Claimant was 51 years of age at the time of hearing. He is married, with no minor dependents. Claimant currently resides in Ankeny, Iowa and has been a resident of the Des Moines metropolitan area for approximately 20 years. Claimant is a diabetic, with the condition well-controlled on medication. (Claimant's testimony; Exhibit M, page 3)

Claimant did not graduate high school, but attended night school and earned a high school diploma in approximately 1982 or 1984. In 1985 or 1986, claimant attended six to nine months of courses at Lincoln Technical Institute, studying auto mechanics. Claimant did not complete a degree program. In approximately 1995 and 1996, claimant attended nearly two years of courses at Gateway Electronic Institute. He pursued an associates' degree in computer technology, but fell one class shy of earning his degree at the time the school closed. Claimant testified he studied computer programming, yet noted the programming languages he studied are no longer in use. He did earn a diploma in architectural and engineering/AutoCAD drafting. In 2003, claimant took six to eight months of coursework at Des Moines Area Community College in pursuit of an associates' degree program in architectural mill working/cabinetmaking. Claimant did not earn a degree or certification. (Claimant's testimony; Ex. 19, p. 171; Ex. M, pp. 4-5)

Claimant's relevant medical history includes an upper back injury in 1986 or 1987, at which time claimant tore ligaments in his upper back while moving a refrigerator. (Claimant's testimony; Ex. M, p. 19) Claimant testified he did not require surgery, but spent six months "on the couch" recovering. (Ex. M, p. 19)

In June 2000, claimant sought medical care at Integra Health and was evaluated initially by Patricia Cox, ARNP. Ms. Cox noted complaints of low back pain for 48 hours, as well as a history of chronic low back pain which began 11 ½ years prior while moving a refrigerator. Claimant reported the week prior, he worked on his car and felt he strained his back. Claimant also reported sitting at work "hunched" over maps, which served as a daily strain on his back. Over the prior 48 hours, claimant reported suffering with low back pain and some numbness and tingling of the bilateral thigh and hamstring regions. Ms. Cox opined x-rays revealed no evidence of herniation and assessed low back pain with radiculopathy. She recommended conservative treatment, including ibuprofen 800 mg and Soma. (Ex. H, p. 1)

Claimant subsequently returned for follow up and was evaluated by Fred Marsh, M.D. Dr. Marsh reviewed claimant's x-rays and opined they might reveal some disc space changes at L5-S1, but no dramatic changes. He ordered an MRI. (Ex. H, p. 2) Claimant underwent the recommended lumbar spine MRI on June 22, 2000, which the radiologist read as revealing mild degenerative disc disease at L3-L4 and degenerative disc disease at L4-L5 and L5-S1. (Ex. H, pp. 3-4) Following MRI, a course of physical therapy was ordered. (Ex. H, p. 3) In follow up on July 13, 2000, George Kappos, M.D. opined claimant's MRI showed some disc bulging, but no herniations. He assessed degenerative disc disease of the lumbar spine and obesity. He advised claimant to lose weight in order to help his back symptoms. (Ex. H, p. 5)

On January 31, 2002, claimant was evaluated by Ms. Cox for a flare of low back pain over the past 72 hours after slipping on ice and twisting his back. No complaints of radiculopathy were noted. Claimant was advised to utilize conservative measures of heat, ice, stretching, massage, and use of Aleve. (Ex. H, p. 6) Dr. Kappos examined claimant on February 2, 2002, at which time claimant reported improvement in symptoms. Dr. Kappos released claimant to return to work and to continue to utilize conservative measures. (Ex. H, p. 7)

Claimant's work history prior to his employment with defendant-employer consisted of alternating stints performing security, drafting, and construction/handyman work. Claimant also served as a student aide while enrolled at Gateway Electronic Institute. Since August 2003, claimant has remained in the employ of defendant-employer. At the time of his hire, claimant earned approximately $7.00 per hour. (Claimant's testimony; Ex. 19, pp. 172-174)

Over the course of his employment with defendant-employer, claimant has held multiple job positions. At the time of his hire in August 2003, claimant worked as a stocker, which required the ability to continuously pick up, lift, carry and place items weighing up to 50 pounds; and the ability to frequently pick up, lift, carry and place items weighing over 50 pounds. (Ex. 15, pp. 138-139) In February 2004, claimant moved into a position as a tire lube express (TLE) service area associate, which required the ability to constantly pick up, lift, carry and place items weighing up to 50 pounds, while moving up and down a ladder or steps; and the ability to frequently pick up, lift, carry and place

items weighing over 50 pounds. (Ex. J, p. 2) In April 2004, claimant returned to a stocker position. (Ex. J, p. 4) In December 2004, claimant moved to the position of overnight TLE stocker, which required the ability to constantly lift, sort, carry, push, pull, and place items weighing up to 50 pounds without assistance, while moving over uneven surfaces and/or using ladders; and frequently lift over 50 pounds with team lifting. (Ex. J, p. 6)

At some point thereafter, claimant took a position as inventory control systems (ICS) team lead. This position was supervisory in nature and required claimant to manage inventory and unload trucks. Claimant supervised 12 employees, but did not perform scheduling. (Ex. M, p. 12)

On May 23, 2006, claimant suffered a work-related injury when he was struck in the back by a conveyor being pushed into a truck by other employees. (Claimant's testimony) On May 30, 2006, claimant presented to Dr. Kappos and reported suffering with left hip pain and back pain with radiation to the left leg. Dr. Kappos assessed a severe backache and left lumbar radiculopathy. He ordered a lumbar spine MRI and prescribed oxycodone. (Ex. H, pp. 8-9) Claimant underwent the recommended MRI on May 31, 2006, with the radiologist opining the results revealed degenerative changes, including disc bulges at L4-L5 and L5-S1. The radiologist also noted the results were difficult to interpret due to claimant's large body habitus. (Ex. G, p. 1; Ex. H, p. 10) As the MRI revealed several discs impacting nerves, claimant was referred for evaluation by a back specialist. (Ex. H, p. 11)

On June 17, 2006, claimant presented to Des Moines Orthopedic Surgeons for evaluation with David Hatfield, M.D. Claimant reported suffering with back pain with radiation down the left leg after being struck by a conveyor. Dr. Hatfield opined claimant's May 31, 2006 lumbar spine MRI revealed a broad-based L4-L5 disc protrusion, degenerative changes at L4-L5, broad-based L5-S1 disc extrusion, and lateral recess narrowing at both levels. He opined the MRI showed a component of foraminal narrowing affecting both the L4 and L5 levels, with lateral recess narrowing at L4-L5 and L5-S1. X-rays were taken, which Dr. Hatfield opined revealed degenerative changes at L4-L5. He recommended a course of conservative care, including work restrictions and a trial of epidural steroid injections. (Ex. A, pp. 7-9)

On June 23, 2006, Christian Ledet, M.D. performed an epidural steroid injection at left L5-S1. He performed a repeat epidural steroid injection at L5-S1 on August 14, 2016. (Ex. A, pp. 12-14) Claimant also participated in a course of physical therapy. (Ex. E, p. 5) On October 24, 2006, authorized physician Dr. McCaughey released claimant from care. He imposed permanent restrictions of a 50-pound occasional lift and avoidance of repetitive bending and twisting. Given these restrictions, Dr. McCaughey opined a change in job position from ICS to sales associate made sense. (Ex. 12, p. 129; Ex. E, p. 6)

Following a release from care, claimant returned to work at defendant-employer. His position was changed from ICS team lead to sales associate. Claimant initially worked as an electronic sales associate and then an automotive sales associate. Claimant testified his rate of pay decreased when he moved into a sales associate position. (Claimant's testimony; Ex. J, p. 7; Ex. M, pp. 12-16)

On November 28, 2007, claimant underwent an independent medical evaluation (IME) with John Prevo, D.O. Dr. Prevo opined claimant had achieved maximum medical improvement (MMI) as of the date of evaluation. He noted Dr. McCaughey had provided treatment and issued permanent restrictions. Dr. Prevo attributed the 50-pound lifting restriction to claimant's underlying degenerative disc disease. Dr. Prevo opined claimant sustained a two percent whole person impairment as a result of the work injury. (Ex. 12, p. 127) Following receipt of Dr. Prevo's IME report, defendants paid claimant ten weeks of permanent partial disability benefits, corresponding to Dr. Prevo's two percent whole person impairment rating. (Ex. 12, p. 125)

Over the intervening period, claimant continued to follow up with his physician for personal medical conditions, including weight loss efforts. In April 2008, claimant was issued a prescription for phentermine to assist with weight loss, which claimant utilized until September 2008. (Ex. H, pp. 17, 20-21) Claimant restarted use of phentermine in May 2012 after regaining approximately 50 of the 90 pounds he lost. (Ex. H, pp. 23-25) In January 2011, claimant was issued a prescription for Xenical to assist with weight loss. (Ex. H, p. 26)

In his continued employment with defendant-employer, claimant continued to change job positions. In August 2008, claimant moved into an overnight assembler position, which required claimant assemble bicycles, grills, and furniture. (Claimant's testimony; Ex. J, p. 9; Ex. M, pp. 12-16) In October 2009, claimant moved to the position of department manager of the lawn and garden department. This position required the physical ability to move, lift, carry, and place items weighing up to 50 pounds, as well as climb ladders. In this position, claimant managed 6 to 8 employees, but did not perform scheduling. (Ex. J, pp. 10, 12; Ex. M, pp. 12-16)

In June 2010, claimant became TLE Support Supervisor, which required the ability to move and place up to 50 pounds. (Ex. J, pp. 13, 15) In this role, claimant supervised technicians, the department manager, and the service manager. He dealt with customer complaints and scheduling, as well as ensured tasks were done properly and in accordance with legal guidelines. (Claimant's testimony; Ex. M, pp. 12-16) This position was ultimately eliminated, leading claimant to take a reduction in pay and return to an assembler position in June 2012. (Claimant's testimony; Ex. J, p. 20)

On August 19, 2012, claimant presented to Bondurant Family Practice and was evaluated by Brett Reiner, D.O. Claimant expressed complaints of an eight-day history of back pain and tingling of the back, as well as a "little bit" of left leg tingling. (Ex. 13,

p. 130) Dr. Reiner performed a Toradol injection and issued prescriptions for Skelaxin and Vicodin. (Ex. 13, p. 131)

Claimant testified between 2006 and 2012, he did not suffer from daily back pain. He admitted to suffering with symptoms an average of once or twice per month, which he treated with rest and on occasion, pain medication. Claimant testified he was capable of performing his daily duties, did not miss significant time as a result of his back, and did not receive any poor performance evaluations. (Claimant's testimony; Ex. M, p. 18)

On November 26, 2012, claimant suffered a stipulated work injury. On that date, claimant was directed to unload pallets of bikes, with each bike weighing from 20 to in excess of 40 pounds. The task lasted approximately 1 ½ hours and at the end of the process, claimant suffered with pain of his back and shooting pain down the left leg to the foot. Claimant did not recall a specific popping sensation while moving bicycles, but testified he began to suffer with pain after moving a few bicycles and this pain made it progressively harder for him to work. Claimant testified following the November 2012 work injury, his low back pain was much worse than he had experienced prior to the event and felt as if he were being stabbed in his tailbone region. He testified he also felt as if he had been cut from his left buttock to left foot. Claimant subsequently developed numbness of three toes of his left foot. (Claimant's testimony; Ex. M, pp. 16, 18)

That same date, claimant was referred for medical treatment at Iowa Methodist Occupational Health. Nicholas Bingham, M.D. evaluated claimant, who complained of back pain and tingling down the left leg to the foot after moving bicycles, a task claimant felt may have violated existing permanent restrictions against repetitive bending and twisting. Dr. Bingham assessed a lumbar strain on preexisting degenerative joint disease of the spine and recommended use of Vicodin and Naprosyn. Dr. Bingham also imposed work restrictions of no lifting more than ten pounds for over three to four hours per day; sitting, standing and walking as needed; and no kneeling, squatting, bending, stooping, twisting, or ladder climbing. (Ex. 1, p. 1; Ex. E, p. 7)

Claimant returned to Dr. Bingham on December 3, 2012 and expressed complaints of loss of motion and pain of the back, as well as paresthesias into the left leg. Dr. Bingham assessed an acute lumbar strain on preexisting degenerative joint disease. He continued claimant's medication and issued a referral to the pain clinic for evaluation for a possible epidural steroid injection. Dr. Bingham imposed work restrictions of a 15-pound lift; avoidance of repetitive bending and twisting; seated-only work; sitting, standing and walking as needed; no kneeling or squatting; and no pushing or pulling with over 5 pounds of force. (Ex. 1, p. 2; Ex. E, p. 8)

On December 14, 2012, claimant underwent a lumbar spine MRI. The radiologist opined the results revealed multilevel spondylosis, most prominent at the L5-S1 level

where there was likely impingement of the exiting L5 nerve root and traversing left S1 nerve root. (Ex. 2, pp. 9-10)

Claimant returned to Dr. Bingham on December 17, 2012. Dr. Bingham noted claimant's complaints were essentially unchanged, with pain radiating down the back of the thigh and lateral leg with numbness of the two small toes. Examination revealed pain and decreased motion of the back. Dr. Bingham opined claimant's MRI revealed multilevel spondylosis with a posterior disc protrusion at L4-L5 which compressed the left L5 nerve root and might also encroach the traversing S1 nerve root. Dr. Bingham assessed a lumbar strain with radiculopathy and recommended continued medications and activity restrictions. Imposed restrictions included a 15-pound maximum lift; sitting, standing, and walking as needed; no kneeling or squatting; and no pushing or pulling with over 15 pounds of force. Dr. Bingham also referred claimant for neurosurgical evaluation of nerve root impingement at L5. (Ex. 1, p. 3; Ex. E, p. 9) Claimant also began a course of physical therapy at the orders of Dr. Bingham. (Ex. 7, pp. 59-60)

At the referral of Dr. Bingham, on February 1, 2013, claimant presented to Iowa Ortho for evaluation by Cassim Igram, M.D. (Ex. 3, p. 11; Ex. E, p. 9) Claimant complained of persistent, worsening low back pain with radiation to the left leg and foot. Dr. Igram noted claimant was utilizing a cane and taking prescribed tramadol. (Ex. 3, p. 11) On examination, Dr. Igram noted claimant was morbidly obese with a body mass index (BMI) of 46. He also observed tenderness to palpation and noted claimant demonstrated difficulty rising to a standing position and ambulated slowly. Dr. Igram reviewed claimant's MRI and indicated it was limited by claimant's body habitus, yet opined the study revealed some degenerative changes without significant nerve root impingement. (Ex. 3, p. 13)

Dr. Igram assessed myofascial back pain, lumbar strain/sprain, low back pain, and morbid obesity. He opined surgery was unlikely to help claimant's symptomatology. He expressed uncertainty with respect to the prospect of relief with injections, but recommended a consultation with a physical medicine and rehabilitation specialist. (Ex. 3, p. 13) Dr. Igram imposed work restrictions of a 15-pound lift; avoidance of repetitive lifting, bending, and twisting; and the need to walk, sit, and stand as tolerated. (Ex. 3, p. 14)

On March 11, 2013, claimant returned to Dr. Bingham, who noted Dr. Igram opined claimant was not a surgical candidate. Claimant reported improvement in his leg pains, from constant to intermittent, but indicated he continued to utilize three tramadol per day and one naproxen. On examination, Dr. Bingham noted claimant ambulated with a quite antalgic gait and relied heavily on a cane. Dr. Bingham assessed a lumbar strain with radiculopathy. As claimant reported he was awaiting another opinion, Dr. Bingham recommended continuation of work restrictions and medications. (Ex. 1, p. 4)

Claimant returned to Dr. Bingham on March 25, 2013 and reported the sharp pain in his left lower extremity had largely subsided, but he continued to suffer with pain and stiffness of his back. Examination revealed an antalgic gait with claimant relying heavily on a cane, pain-limited range of motion, and some lumbar tenderness. Dr. Bingham assessed a lumbar strain with radiculopathy on preexisting degenerative joint disease of the lumbar spine. He recommended continued medications and work restrictions. (Ex. 1, p. 5; Ex. E, p. 10)

On April 8, 2013, claimant returned to Dr. Bingham and reported similar symptomatology, including generally constant back pain and intermittent numbness to the left foot. On examination, Dr. Bingham noted claimant ambulated with a grossly antalgic gait and relied heavily upon a cane. He also noted guarding of claimant's movements and range of motion limitations as a result of pain. Dr. Bingham continued conservative measures of medications and work restrictions. (Ex. 1, p. 6; Ex. E, p. 11)

Claimant returned to Dr. Bingham on April 22, 2013 and reported little change in his condition. Dr. Bingham noted claimant continued to use a cane with ambulation and on examination, demonstrated limited range of motion and a positive straight leg raise test. Dr. Bingham continued claimant's conservative treatment of medication and work restrictions. (Ex. 1, p. 7; Ex. E, p. 12)

On May 6, 2013, claimant presented to Dr. Bingham for evaluation. Dr. Bingham noted no change in claimant's condition, with claimant continuing to demonstrate a grossly antalgic gait and utilization of a cane. Dr. Bingham also noted range of motion of the back was limited by pain. Claimant also expressed radicular complaints and weakness. As claimant was scheduled for evaluation with another provider, Dr. Bingham released claimant from care, but maintained claimant's work restrictions. (Ex. 1, p. 8; Ex. E, p. 13)

At the arranging of defendants, on May 15, 2013, claimant presented to board certified orthopedic surgeon, Scott Neff, D.O. Dr. Neff noted claimant suffered an injury in 2006 when struck by a conveyor. Then on November 26, 2012, while moving boxes, claimant began having back pain with radiation down the left leg. Claimant reported subsequently developing numbness in the third, fourth and fifth toes of the left foot. Claimant complained of low back pain with pain down the left buttock and leg, with numbness of the third through fifth toes. Claimant attributed 70 percent of his pain complaints to his back and 30 percent to his leg. (Ex. I, pp. 1-2)

Dr. Neff performed a review of medical records pertaining to the 2006 and 2012 injuries. (Ex. I, p. 3-4) He ordered x-rays, which he opined revealed degenerative disc disease at multiple levels without evidence of spondylolisthesis; significant spurring anteriorly at T11-T12; and degenerative lumbar scoliosis. (Ex. I, p. 4) Dr. Neff also performed a physical examination, during which he noted tenderness to palpation at L5 and the upper left buttock, and a straight leg raise test positive for back pain. He noted claimant utilized a cane with ambulation. (Ex. I, p. 4)

Following records review, interview and examination, Dr. Neff opined claimant demonstrated multilevel degenerative disc disease which was contributed to by genetics, aging and morbid obesity. Dr. Neff opined he did not find any evidence of damage or harm to the physical structure of claimant's spine as a result of the work injury. He opined claimant presented with symptoms similar to those he experienced in 2006, but noted improvement in claimant's neurologic examination over the 2006 examination of Dr. Hatfield, in that claimant demonstrated intact reflexes. (Ex. I, p. 5)

Dr. Neff opined claimant did not suffer a "compensable injury." He indicated the MRI findings did not demonstrate a true disc herniation and opined the observed disc bulges were degenerative in nature and not the result of a work injury. (Ex. I, p. 5) Dr. Neff opined claimant did not demonstrate true radicular symptoms on examination, as ankle jerk reflexes were equal and symmetrical, and straight leg raise testing was negative for radicular pain. (Ex. I, p. 6) Dr. Neff opined claimant demonstrated significant multilevel degenerative disc disease, contributed to by "comorbid circumstances, aging, and morbid obesity." He opined claimant's work injury was "minimal and within the range of normal activities of life." Consequently, Dr. Neff indicated he could not opine that "the proximate cause" of claimant's continued symptoms was work-related. (Ex. I, p. 5) Dr. Neff opined:

> The most recent alleged injury was not really, in my opinion, an injury; but made the preexisting degenerative disc disease of the lumbar spine more symptomatic for a period of time.

(Ex. I, p. 6)

Dr. Neff opined claimant required medical treatment of all of his personal conditions. (Ex. I, p. 6) He indicated he did not anticipate claimant would "recover" from his conditions and opined the degenerative disc and degenerative facet disease would continue to worsen. Dr. Neff also indicated claimant might suffer from non-injury related cluneal nerve entrapment. (Ex. I, p. 5) Dr. Neff opined claimant should be restricted in his activities as a result of degenerative disc disease and morbid obesity; however, he opined claimant could continue to work as a bike assembler. (Ex. I, p. 6) In summary, Dr. Neff opined:

> In my opinion, based on the history as obtained by this examiner and from the extensive records I reviewed, his degenerative disk disease and the potential spinal stenosis has not been caused, contributed to, or aggravated by the alleged work injuries as described. Consequently, future treatment would be directly the result of personal circumstance, degenerative disk disease, and habitus, and not the result of work injury.
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> . . . .

> Again, these treatment recommendations will be the result of his degenerative disk disease, facet arthritis, and overall wear and tear changes.

(Ex. I, p. 7)

While on light duty for defendant-employer, claimant initially performed "zoning," which is pulling stocked merchandise to the front of shelves throughout the store. (Ex. 14, p. 137; Ex. M, p. 16) Claimant then worked as a TLE greeter/service writer, writing up the vehicles which came in for service. (Claimant's testimony)

On June 11, 2013, claimant presented to personal physician, Ricardo Bendezu, M.D. Claimant informed Dr. Bendezu that his authorized physician had opined his complaints were no longer work related. Claimant expressed interest in a second opinion with respect to his back pain. He informed Dr. Bendezu his symptoms had persisted since an event moving bicycles in November 2012. Claimant described constant low back pain at a level 8 on a 10-point scale, occasional left buttock and leg pain, and some numbness of the third through fifth toes. (Ex. 4, p. 14a) Dr. Bendezu assessed low back pain and limb pain. He opined the back pain was likely secondary to degenerative disc disease, with claimant reporting a work injury in November 2012. He prescribed Tramadol and recommended claimant lose weight; he also advised claimant to discuss a second opinion with his attorney. (Ex. 4, p. 16)

At the arranging of claimant's attorney, on August 7, 2013, claimant presented for independent medical evaluation (IME) with Jacqueline Stoken, D.O. Dr. Stoken issued a report containing her findings and opinions dated October 7, 2013. Dr. Stoken reviewed medical records pertaining to claimant's 2006 and 2012 work injuries. (Ex. 8, pp. 61-64) She noted a history of a back injury on May 23, 2006, when claimant was struck by a conveyor. Dr. Stoken indicated an MRI showed a pinched nerve and degenerative disc disease. Following a course of conservative care, claimant was ultimately released with permanent restrictions. (Ex. 8, p. 61)

Dr. Stoken noted claimant then suffered a work injury on November 26, 2012 while unloading bikes. (Ex. 8, p. 62) Claimant complained of low back pain, ranging in severity from a level 5 to level 10 on a 10-point scale and averaging a level 8. Claimant reported receiving moderate relief with Tramadol and mild relief with physical therapy. Dr. Stoken also performed a physical examination. (Ex. 8, p. 65)

Following records review, history and examination, Dr. Stoken assessed status post work injury on May 23, 2006 with an acute low back strain with disc bulges at L4-L5 and L5-S1 impinging the left L5 and S1 nerve roots; status post work injury on November 26, 2012 with a herniated disc of the lumbar spine, left lower extremity radiculopathy, and right sacroiliac joint dysfunction; and chronic low back pain. She opined these diagnoses were producing claimant's low back and leg symptoms. Dr. Stoken opined claimant's diagnoses were causally related to the work injury on

November 26, 2012, in that the work activities claimant was performing were a material factor in producing the conditions. She further opined claimant's work activities were "aggravating, accelerating" of the preexisting condition and likely were the cause of his right sacroiliac joint dysfunction. (Ex. 8, p. 66)

Dr. Stoken opined claimant achieved MMI as of February 1, 2013. She opined claimant fell within DRE Lumbar Category III, warranting a permanent impairment rating of 13 percent whole person due to the lumbar injury with herniated disc and left lower extremity radiculopathy. (Ex. 8, p. 66) Dr. Stoken indicated reasonable future care could include pain management, but also noted claimant might benefit from lumbar surgery to relieve pressure on the nerves. (Ex. 8, p. 67)

In her narrative report, Dr. Stoken recommended permanent restrictions of avoidance of repetitive bending, lifting, and twisting; and avoidance of lifting more than 20 pounds frequently. (Ex. 8, p. 67) She also authored a more detailed work restriction worksheet which reiterated restrictions of: waist to floor lifting of 10 pounds constantly, 20 pounds frequently, and 40 pounds rarely; waist to crown lifting of 5 pounds constantly, 10 pounds frequently, and 30 pounds rarely; bilateral carrying of 10 pounds constantly, 20 pounds frequently, and 40 pounds rarely; avoidance of repetitive bending, lifting, twisting, and use of the upper extremities; occasional bending, stooping, reaching above shoulder height, twisting, turning, and pushing or pulling up to 40 pounds; sitting or standing up to 4 hours and walking up to 8 hours; and the need to alternate between standing and sitting. (Ex. 5, p. 49; Ex. 8, p. 68)

Defendants' former counsel authored a letter to Dr. Bingham dated December 5, 2013. Counsel provided Dr. Neff's IME for review and inquired if Dr. Bingham agreed with opinions expressed by Dr. Neff. On December 10, 2013, Dr. Bingham completed and signed the enclosed letter, thereby setting forth his opinions. Dr. Bingham agreed there was no evidence of damage or harm to the physical structures of claimant's back as a result of the work injury. (Ex. E, p. 14) He further agreed there was no evidence of disc herniation on claimant's MRIs. Dr. Bingham opined claimant demonstrated significant degenerative disc disease and degenerative facet disease at multiple levels and the conditions would likely progress continually over time. He opined the imposed restrictions of a 50-pound weight limit and avoidance of forward flexion and lifting with arms extended were imposed as a result of the degenerative disc disease and claimant's morbid obesity. (Ex. E, p. 15)

Dr. Bingham agreed with Dr. Neff's characterization of the work injury as minimal in nature and within the range of normal activities of life. Consequently, he agreed it was not possible to opine "that the proximate cause" of claimant's ongoing symptoms was work-related. (Ex. E, p. 15) Dr. Bingham further opined claimant's degenerative disc disease and potential spinal stenosis was not caused, contributed to, or aggravated by the work injury. As a result of this opinion, Dr. Bingham indicated future treatment would be a result of claimant's personal condition and not the work injury; specifically, any treatment recommendation for epidural steroid injections or facet rhizotomy would

be a result of the degenerative disc disease, facet arthritis, and overall wear and tear. (Ex. E, p. 16)

On December 13, 2013, Dr. Bendezu completed a work status report for defendant-employer. He identified claimant's diagnoses as chronic low back pain. Dr. Bendezu noted claimant's pain limited his sitting and standing duration, as well as affected bending, lifting, standing, and sitting. He adopted the restrictions set forth by Dr. Stoken on October 7, 2013. (Ex. 5, p. 48)

On December 17, 2013, claimant requested accommodation from defendant-employer in the form of a stool or chair to use in his duties. (Ex. 5, p. 50) On January 2, 2014, defendant-employer denied claimant's request for a stool on the grounds that an assembler's duties required lifting 50 pounds and no reasonable accommodation could be made which allowed claimant to meet this essential function of the position. Therefore, defendant-employer offered claimant reassignment into another position. Claimant was advised he could look for available positions and defendant-employer would similarly search to identify a position within claimant's abilities. (Ex. 16, p. 140) Defendant-employer later identified available positions as a people greeter, maintenance associate, and TLE greeter. Claimant was further advised he had been approved to use a one-step ladder to sit on and roll while working on lower shelves. (Ex. 16, p. 143)

On January 20, 2014, claimant returned to Dr. Bendezu for evaluation. Claimant reported suffering with constant low back pain and some left leg pain, especially with walking. Dr. Bendezu noted a history of low back pain secondary to degenerative disc disease and the occurrence of a work injury. Claimant reported he was assigned permanent restrictions by a physiatrist in October 2013. Claimant also reported experiencing some relief with injections, but the eventual return of pain. He expressed interest in a more permanent solution. (Ex. 4, p. 23) Dr. Bendezu ordered a lumbar spine MRI and referred claimant for a neurosurgical consultation. (Ex. 4, p. 25) Dr. Bendezu also completed a Department of Transportation (DOT) certification for claimant to obtain a temporary handicap placard. (Ex. 5, pp. 51-52)

On January 27, 2014, claimant underwent a lumbar spine MRI. The radiologist read the results as revealing slight progression of moderate lumbar spondylosis compared to the December 14, 2012 study and persistent mild to moderate degenerative spinal stenosis at L4-L5 with disc bulging, facet arthropathy and disc space margin spur formation. The radiologist recommended clinical correlation for possible left L5 radiculopathy. The radiologist also noted the left neural foramen was compromised and could result in irritation of the exiting left L4 nerve root. Additionally, the radiologist noted left-sided neural foraminal stenosis at L5-S1 due to disc protrusion, vertebral endplate spur formation and facet arthritis, which could also potentially result in left L5 radiculopathy. (Ex. 8, pp. 78-79)

On February 13, 2014, claimant underwent evaluation at the physical medicine and rehabilitation department of Dr. Bendezu's practice. It was recommended claimant utilize Voltaren topical gel and Tramadol, participate in aqua therapy, and undergo neurosurgical consultation. (Ex. B, pp. 7-10)

As a result of this referral, on March 10, 2014, claimant presented for neurosurgical consultation with Esmiralda Henderson, M.D. Claimant and Dr. Henderson discussed surgical options. Dr. Henderson informed claimant the goal of surgery would be to alleviate leg pain, as the surgery would not provide relief of back pain. Claimant expressed a desire to attempt additional conservative care prior to undergoing surgery. Accordingly, Dr. Henderson referred claimant for pain management evaluation. (Ex. C, p. 1)

On April 4, 2014, claimant presented to Pain Specialists of Iowa for evaluation by Dana Simon, M.D. Dr. Simon reviewed claimant's MRI and assessed lumbar degenerative disc disease and sciatica of the left and right sides. He recommended a transforaminal epidural injection. (Ex. 9a, p. 80) On April 10, 2014, Dr. Simon performed an L4, L5 transforaminal selective nerve root block/epidural steroid injection. (Ex. 9a, p. 82; Ex. F, pp. 1-4)

Claimant returned to Dr. Simon on May 28, 2014 and reported complete relief of pain for one day and a lessened level of pain for four days post-injection. He complained of low back pain, increasing left leg pain, and numbness of the lateral three toes of the left foot. Dr. Simon noted claimant's back pain had begun eight years prior when struck by a conveyor and then in November 2012, claimant suffered a "[s]evere pain exacerbation" while loading bikes. Dr. Simon opined claimant's MRI revealed significant changes and likely left L5 radiculopathy. He assessed left-sided sciatica, right-sided sciatica, lumbar degenerative disc disease, and degeneration of a lumbar/lumbosacral disc. (Ex. 9a, p. 84) He performed transforaminal steroid injections. (Ex. 9a, p. 87) Dr. Simon recommended aqua therapy, a weight control evaluation and a left L4, L5 selective nerve root block/epidural steroid injection, as well as a possible injection at the S1 level. (Ex. 9a, p. 84)

On June 19, 2014, claimant returned to Dr. Simon for evaluation. Dr. Simon opined claimant's MRI findings were consistent with both left L4 and L5 nerve root irritation and clinical symptoms of radiculopathy in the left lower extremity. He performed a left L4, L5 selective nerve root block/lumbar transforaminal epidural steroid injection. If claimant's symptoms did not improve, Dr. Simon recommended neurosurgical evaluation with Dr. Henderson. (Ex. 9a, pp. 88-90)

Claimant returned to Dr. Henderson for evaluation on July 14, 2014. Dr. Henderson noted she previously evaluated claimant on March 10, 2014, at which time she offered an L4-L5, L5-S1 transforaminal lumbar interbody fusion to treat left leg radicular pain. Claimant elected to pursue further conservative care and pain management, but returned to again discuss surgical options. Claimant reported no real

change in his symptoms, notably pain in the left low back with radiation down the left leg into the foot, as well as numbness of the small three toes. (Ex. 10, p. 100)

Dr. Henderson opined claimant's MRI of January 27, 2014 revealed degenerative spinal stenosis at L4-L5 and L5-S1 with disc bulges and annular tears causing bilateral foraminal/lateral recess stenosis, worst on the left side at the L5-S1 level. Dr. Henderson assessed low back pain with left leg radiculopathy, likely arising from the left L5 level or possibly from the left L4 level. (Ex. 10, p. 103) Dr. Henderson indicated the goal of surgical intervention would be to help with claimant's leg pain, but there was no guarantee the surgery would actually result in improvement. She cautioned claimant's constant numbness might be a sign of permanent nerve damage, which surgery would not improve. Claimant consented to surgery. (Ex. 10, p. 103)

On August 20, 2014, Dr. Henderson performed surgery, consisting of an L4-L5 and L5-S1 anterior interbody discectomy and fusion with placement of two intervertebral cages and anterior fixation at L4-L5 and L5-S1. Dr. Henderson noted a postoperative diagnosis of L4-L5 and L5-S1 bilateral foraminal stenosis with bilateral nerve root neurogenic claudication and mechanical radiculopathy. (Ex. 10, p. 104) Postoperative care included removal from work, physical therapy, and use of a brace. (Ex. 10, p. 107; Ex. C, p. 6)

Claimant returned to Dr. Henderson on November 18, 2014 and noted significant improvement in leg pain. X-rays taken that date revealed stable and appropriately-placed hardware. Dr. Henderson assessed left leg radiculopathy, partially improved. She ordered a lumbar spine MRI. In the event the MRI showed compression, she recommended return evaluation to determine a treatment plan. In the event no compression was shown, Dr. Henderson opined claimant's pain was likely neuropathic and permanent in nature. She recommended continued activity restriction. (Ex. 10, pp. 107-108)

Claimant subsequently underwent a lumbar spine MRI, which the radiologist read as revealing interval anterior spinal fusion at L4-L5 and L5-S1 levels, as well as spondylosis. (Ex. D, p. 1)

Claimant returned to Dr. Bendezu on November 25, 2014 in follow up of chronic low back pain which Dr. Bendezu related to an injury. Dr. Bendezu noted that post-surgery, claimant continued to suffer with low back pain, but his leg pain had improved. Dr. Bendezu informed claimant his pain might be chronic for the remainder of his life and that if his symptoms did not improve, claimant may want to consider applying for disability benefits. Dr. Bendezu advised claimant to wean from hydrocodone onto Tramadol. (Ex. 4, pp. 34-36) Dr. Bendezu subsequently completed paperwork for defendant-employer with respect to claimant's application for disability benefits. Dr. Bendezu opined claimant was totally disabled at that time and a specialist would determine when claimant was able to return to work. (Ex. 5, p. 53)

On December 12, 2014, claimant returned to Dr. Bendezu for evaluation. Dr. Bendezu noted claimant suffered with chronic low back pain and left leg pain secondary to an injury at work. (Ex. 4, p. 37) Dr. Bendezu renewed claimant's DOT certification for a handicap parking placard. (Ex. 5, p. 55) Dr. Bendezu also completed paperwork regarding claimant's work restrictions; he noted he based his opinions on claimant's subjective reports of what tasks he was capable of performing. (Ex. 4, p. 39) Denoted restrictions included no bending, pulling, climbing, or twisting; a 15-pound maximum lift; standing of 30 minutes per hour; and use of a chair. (Ex. 5, p. 54) Dr. Bendezu noted the restrictions would likely be permanent unless claimant received relief with pain clinic treatment. (Ex. 4, p. 40)

Claimant returned to Dr. Simon on February 3, 2015. Dr. Simon noted claimant underwent anterior spinal fusion at L4-L5, L5-S1 in August 2014. Following surgery, claimant reported resolution of leg pain, but continued persistent low back pain. He reviewed claimant's post-surgical MRI and assessed bilateral sciatica, primarily on the left, and lumbar degenerative disc disease with pain and spasms. Dr. Simon recommended conservative care including weight control evaluation, aqua therapy, and bilateral sacroiliac joint injections. (Ex. 9a, pp. 93-94) On February 18, 2015, Dr. Simon performed bilateral sacroiliac joint injections for a noted diagnosis of sacroilitis and left-sided sciatica. (Ex. 9a, pp. 96-99)

Claimant testified he returned to work at defendant-employer in March 2015. He testified he returned to work as a part-time people greeter. Claimant testified he was not permitted to return to work as a TLE greeter, the position he occupied prior to surgery, due to changes in his work restrictions. (Claimant's testimony; Ex. M, p. 17)

On April 3, 2015, claimant returned to Dr. Bendezu with complaints of continued low back pain and occasional left leg pain, as well as a feeling of needles in the bilateral legs. Dr. Bendezu prescribed Tramadol and Voltaren topical gel. Dr. Bendezu also completed paperwork for defendants regarding claimant's restrictions. (Ex. 4, pp. 45-47) He identified restrictions of an inability to sit or stand for long periods; no bending, climbing, ladder use, or twisting; a 10-pound maximum lift, push, or pull; walking of 15 minutes per hour; standing or sitting for up to 4 hours per day; the need for a chair with lumbar support; and a maximum work day of 4 hours. (Ex. 5, p. 56; Ex. G, p. 7)

Due to his limitation to four-hour workdays, claimant subsequently requested he be scheduled between 7:00 a.m. and 12:00 p.m. or 1:00 p.m. and 6:00 p.m. (Ex. 16, pp. 144-146)

Claimant's counsel authored a letter to Dr. Bendezu dated April 14, 2015, in follow up of an April 10, 2015 telephone conference. Counsel restated what he understood to be Dr. Bendezu's opinions as expressed in that conference; Dr. Bendezu signed the letter on April 20, 2015, expressing agreement with the statements therein. Dr. Bendezu indicated no follow up evaluation of claimant was currently scheduled, but

he anticipated a need to evaluate claimant intermittently in the future. He indicated he may renew claimant's prescription for Tramadol, but anticipated referring claimant to other providers for low back treatment which was interventional in nature. (Ex. 6, pp. 57-58)

Dr. Bendezu indicated he was aware of the 2006 injury in addition to the November 2012 injury. Dr. Bendezu opined both incidents were contributing factors in producing claimant's current level of symptomatology. He opined the 2006 work injury resulted in a baseline level of low back symptoms which claimant was able to treat without surgical intervention. He opined on November 26, 2012, claimant experienced a permanent exacerbation of that underlying condition and the exacerbation led to surgical treatment by Dr. Henderson. He further opined claimant was capable of working within restrictions as imposed. (Ex. 6, pp. 57-58)

On June 2, 2015, defendants' counsel authored a letter to Dr. Bingham and provided medical records for his review. Dr. Bingham thereafter opined he stood by his opinions as expressed on December 10, 2013. Dr. Bingham opined claimant suffered an acute exacerbation of an underlying degenerative condition as a result of the work injury of November 2012. He indicated he was unable to state whether or not claimant returned to his baseline, preinjury level because he did not have personal knowledge of claimant's prior condition. However, Dr. Bingham opined he saw no evidence to suggest the exacerbation was "anything but temporary." He elaborated to opine he did not believe the work injury led to any permanent aggravation or acceleration of the progress of claimant's preexisting degenerative disc disease of the lumbar spine. (Ex. E, p. 18) Dr. Bingham further opined he did not believe claimant's need for lumbar fusion was related to the work injury of November 2012. (Ex. E, p. 19)

On June 8, 2015, claimant returned to Dr. Stoken for supplemental IME. Dr. Stoken issued a report of her findings and opinions dated June 22, 2015. Dr. Stoken performed a medical records review, interviewed claimant, and performed a physical examination. (Ex. 11, pp. 110-116) Claimant complained of decreased left leg pain post-surgery, but continued constant back pain and numbness of three toes of the left foot. Claimant described his back pain as an average level 8, with variation from a level 5 to a level 9 on a 10-point scale. (Ex. 11, p. 115) He continued to utilize Tramadol three to four times daily and relied upon a cane with ambulation. (Ex. 11, pp. 110, 115)

Following records review, interview, and examination, Dr. Stoken assessed status post work injury on November 26, 2012, with a herniated disc of the lumbar spine, left lower extremity radiculopathy and right sacroiliac joint dysfunction, which had been treated with L4-L5 and L5-S1 anterior interbody discectomy and fusion; as well as chronic low back pain with left lower extremity radiculopathy. (Ex. 11, p. 116) Dr. Stoken causally related claimant's diagnoses to the work injury of November 26, 2012. She opined claimant sustained a combined 27 percent whole person impairment as a result of the surgical procedure and reduced range of motion. Dr. Stoken

recommended permanent work restrictions of avoidance of repetitive bending, lifting, and twisting; and avoidance of lifting more than 10 pounds on a frequent basis. She indicated reasonable future care would include pain management, specifically periodic evaluation, medications, and potentially injections. (Ex. 11, p. 117)

At the time of evidentiary hearing, claimant continued to work for defendant-employer as a people greeter. Claimant's work hours vary from 8 to 24 hours per week, with the majority of his time spent seated. As of the date of hearing, claimant earned $12.45 per hour. As a full time employee with defendant-employer, claimant received employer-provided benefits, including paid vacation, stock purchasing options, a 401k, life insurance and the option to purchase group-rate health insurance. As claimant is now a part time employee, claimant testified in the upcoming year he will lose his health insurance. (Claimant's testimony)

Susan Johnson, personnel coordinator for defendant-employer, testified at evidentiary hearing. Ms. Johnson testified the position of people greeter is a regular job within defendant-employer and if claimant were not performing the duties, another employee would do so. She explained claimant's responsibilities included greeting customers on entrance, checking receipts, and thanking customers on exit. During summer months, claimant works as a greeter in the lawn and garden department; during cooler months, he works at the front of the store. Ms. Johnson testified claimant is allowed a chair and is limited to 4-hour shifts. She acknowledged as a part-time employee, claimant accrues less vacation and will lose his ability to purchase health insurance at the group rate, as he does not average 30 hours of work per week. (Ms. Johnson's testimony)

Ms. Johnson's testimony was clear and consistent with the evidentiary record. Her demeanor at the time of hearing gave the undersigned no reason to doubt her veracity. Ms. Johnson is found credible.

Claimant testified he continues to experience daily low back pain. Sometimes the pain is minimal, but other times, the pain is excruciating. Pain worsens with prolonged walking or standing, movement and lifting, and sitting in upright chairs. Claimant also testified he continues to suffer with leg pain from time-to-time. Although he continues to use a cane, claimant will develop leg pain when he is required to walk across defendant-employer's store. Claimant testified he also continues to experience numbness of three toes of his left foot. Claimant's conditions impact his activities of daily living, self-care, recreation, and ability to sleep. Claimant relies upon his wife to transport him, as he believes he is unable to drive safely. (Claimant's testimony)

Claimant applied for Social Security Disability benefits in January 2015, but was denied. The matter is currently on appeal. (Claimant's testimony)

CONCLUSIONS OF LAW

The first issue for determination is whether claimant is entitled to temporary disability benefits from August 20, 2014 through March 12, 2015.

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).

When an injured worker has been unable to work during a period of recuperation from an injury that did not produce permanent disability, the worker is entitled to temporary total disability benefits during the time the worker is disabled by the injury. Those benefits are payable until the employee has returned to work, or is medically capable of returning to work substantially similar to the work performed at the time of injury. Section 85.33(1).

Healing period compensation describes temporary workers' compensation weekly benefits that precede an allowance of permanent partial disability benefits. Ellingson v. Fleetguard, Inc., 599 N.W.2d 440 (Iowa 1999). Section 85.34(1) provides that healing period benefits are payable to an injured worker who has suffered permanent partial disability until the first to occur of three events. These are: (1) the worker has returned to work; (2) the worker medically is capable of returning to

substantially similar employment; or (3) the worker has achieved maximum medical recovery. Maximum medical recovery is achieved when healing is complete and the extent of permanent disability can be determined. Armstrong Tire & Rubber Co. v. Kubli, Iowa App., 312 N.W.2d 60 (Iowa 1981). Neither maintenance medical care nor an employee's continuing to have pain or other symptoms necessarily prolongs the healing period.

Claimant argues he is entitled to temporary total disability/healing period benefits for the period of August 20, 2014 through March 12, 2015, with the period corresponding to claimant's fusion surgery and subsequent rehabilitation prior to returning to work. Defendants argue claimant's work injury of November 26, 2012 was a temporary aggravation which resolved and accordingly, did not give rise to the fusion surgery on August 20, 2014. Therefore, the undersigned must determine if claimant's ongoing complaints, which gave rise to the fusion procedure, are causally related to the stipulated work injury of November 26, 2012.

It is undisputed that claimant suffered with back symptomatology prior to the stipulated work injury of November 26, 2012. Claimant initially suffered with an injury in 1986 or 1987, which resulted in torn ligaments per claimant's testimony. The medical records reveal claimant suffered with a flare of low back pain with some numbness and tingling of the bilateral thighs in June 2000. At that time, claimant expressed the belief he strained his back working on a car. Claimant underwent a lumbar spine MRI which revealed degenerative disc disease. Claimant was treated conservatively and advised to lose weight. The next medical record referencing low back pain occurred in January 2002, after claimant reported he slipped on ice and twisted his back. He again was treated conservatively and was released to work within a few days.

In August 2003, claimant began work at defendant-employer and proceeded to fill multiple positions which required movement of products weighing up to 50 pounds and often required movement of items weighing over 50 pounds. While in the position of ICS team lead, claimant suffered a work related injury on May 23, 2006, when struck by a conveyor. Claimant again underwent an MRI of the lumbar spine which the radiologist opined revealed degenerative changes, including disc bulges at L4-L5 and L5-S1. Dr. Hatfield opined the MRI revealed a broad-based disc bulge and degenerative changes at L4-L5, broad-based L5-S1 disc extrusion, lateral recess narrowing at both levels, and foraminal narrowing affecting L4 and L5.

Claimant received conservative treatment, including epidural steroid injections, and was released by Dr. McCaughey on October 24, 2006 with permanent restrictions of a 50-pound occasional lift and avoidance of repetitive bending and twisting. Given these restrictions, Dr. McCaughey opined a change in claimant's job position was appropriate. Claimant subsequently underwent an IME with Dr. Prevo, who related the restrictions to claimant's underlying degenerative disc disease and opined claimant sustained a permanent impairment of 2 percent whole person as a result of the work injury.

Thereafter, claimant returned to work at defendant-employer. He moved from a position as ICS team lead to sales associate, first in electronics and then in the automotive department. In 2008, claimant moved into a position as an assembler. In 2009, claimant became department manager over lawn and garden, which required maneuvering of items weighing up to 50 pounds. In 2010, claimant moved into the position of TLE support supervisor, also requiring the ability to move up to 50 pounds. In 2012, claimant returned to an assembler position.

Following the May 2006 work injury, claimant returned to work full time for defendant-employer in multiple positions requiring a physical ability to maneuver up to 50 pounds. There is no evidence claimant did not satisfactorily complete these duties and it is reasonably assumed claimant excelled in his employment given his elevation into managerial positions. There is no evidence claimant missed significant work or required ongoing medical care for his back during this time. The evidentiary record contains only one medical record precipitated by back complaints, in August 2012. At that time, claimant visited his personal physician on one occasion, with complaints of an 8-day period of back pain and tingling, as well as slight left leg tingling. He received an injection of Toradol and prescriptions for Skelaxin and Vicodin. Thereafter, claimant continued to work at defendant-employer, without numerous absences attributable to back complaints.

Claimant credibly testified between 2006 and 2012, he did not suffer from daily back pain, but admitted to suffering with pain an average of once or twice per month. During painful episodes, claimant treated with rest and occasionally, use of pain medication. Claimant testified his symptoms did not cause him to miss work on a frequent basis and he remained capable of performing his work duties.

On November 26, 2012, claimant suffered a stipulated work injury while moving bicycles. Following the work injury, claimant testified the nature of his pain worsened and he felt as if he had been stabbed in his tailbone region and cut from his left buttock to his left foot. Claimant also developed numbness in three digits of his left foot. Defendants admitted the occurrence of a work injury on this date, yet argue claimant's injury was temporary in nature and resolved to a baseline condition. Claimant argues his complaints have persisted since the alleged work injury and his continued complaints and need for treatment are causally related to the November 26, 2012 work injury.

Following the November 26, 2012 work injury, claimant underwent a repeat lumbar spine MRI on December 14, 2012. The radiologist read the results as revealing multilevel spondylosis, most prominent at L5-S1 where there was likely impingement of the exiting L5 nerve root and traversing left S1 nerve root. Dr. Bingham opined it revealed multilevel spondylosis with a posterior disc extrusion at L4-L5 which compressed the left L5 nerve root and might encroach the traversing S1 nerve root. Dr. Igram, opined the MRI showed degenerative changes without significant nerve root impingement. Dr. Neff, on May 15, 2013, opined the MRI revealed no herniations and

disc bulges which were degenerative in nature. Dr. Stoken opined the MRI revealed a herniated disc of the lumbar spine.

From the work injury until evaluation with Dr. Neff in May 2013, claimant received regular evaluations from Dr. Bingham. During that time, claimant consistently complained of back and leg symptoms. By March 2013, claimant's medical notes reveal claimant ambulated with an antalgic gait and relied upon a cane. This symptom and reliance upon a cane has remained consistent since March 2013.

Claimant relies upon the opinions of Drs. Stoken and Bendezu with respect to the existence of a causal connection between his continued complaints and the work injury of November 2012. Dr. Stoken, by reports of October 7, 2013 and June 22, 2015, opined claimant's work activities on November 26, 2012 were a material factor in producing claimant's conditions. Dr. Stoken further opined the work activities on that date aggravated/accelerated claimant's preexisting back condition. Dr. Bendezu opined claimant's 2006 work injury resulted in a baseline level of low back symptoms and the November 26, 2012 injury resulted in a permanent exacerbation of claimant's underlying condition and ultimately required surgical intervention.

Defendants rely upon the opinions of Drs. Neff and Bingham. Dr. Neff opined there was no evidence of damage or harm to the physical structure of claimant's spine as a result of the work injury and further opined claimant demonstrated significant degenerative disc disease. Dr. Neff described claimant's work injury as minimal and within the range of normal activities of life. He therefore indicated he could not opine that "the proximate cause" of claimant's continued symptoms was work related. He opined the work injury simply made the preexisting degenerative condition more symptomatic for a period and further opined the degenerative disc disease was not caused, contributed to, or aggravated by the work injury.

Dr. Bingham expressed agreement with these opinions. Subsequently, Dr. Bingham opined claimant suffered an acute exacerbation of an underlying degenerative condition. However, he indicated he was unable to state whether claimant returned to a baseline level following the work injury, as he lacked personal knowledge of the pre-November 2012 condition. Dr. Bingham opined there was no evidence to suggest the exacerbation was anything more than temporary and further expressed belief claimant did not suffer a permanent aggravation or acceleration of the progress of his degenerative disc disease.

The undersigned provides greatest weight to the opinions of Dr. Bendezu. Dr. Bendezu provided treatment of claimant's ongoing complaints after defendants ceased providing care based upon the opinion of Dr. Neff. Following a course of care lasting nearly two years, Dr. Bendezu opined claimant suffered with a baseline preexisting condition of his back which was permanently exacerbated by the work injury of November 26, 2012 and led to surgical intervention.

Dr. Bendezu's opinion is buttressed by the opinion of Dr. Stoken, the testimony of the claimant, the content of claimant's medical records, and claimant's employment history with defendant-employer. Dr. Stoken opined the work injury of November 26, 2012 was a material factor in producing claimant's ongoing symptomatology and aggravated/accelerated claimant's preexisting condition. Claimant credibly testified he suffered with back complaints prior to the November 26, 2012 injury; however, he testified the nature and severity of those symptoms changed following the work injury and persisted since that date. Claimant's testimony is consistent with his medical records which reveal one medical visit between late 2006 and November 2012 wherein claimant specifically sought treatment of back complaints. This visit took place on August 19, 2012 and consisted of one solitary visit. During this period of late 2006 to November 2012, claimant continued to work full time for defendant-employer in positions which required lifting and maneuvering of items weighing up to 50 pounds.

Following the work injury, claimant never returned to any of his preinjury positions due to physical limitations. The medical records do not reveal significant improvement or resolution of claimant's symptoms at any time. In fact, the post-injury records reveal consistent back and lower extremity pain, as well as numbness of digits of the left foot. Claimant's medical records from pre-November 2012 do not indicate claimant suffered with constant low back pain, consistent left leg pain, or contain any reference to left foot numbness. Since March 2013, claimant has ambulated with assistance of a cane; he was not required to rely on such a device prior to the November 2012 work injury.

Dr. Neff opined claimant did not suffer a "compensable" injury, a statement which better reflects a legal determination than a medical opinion. Dr. Neff opined claimant did not suffer any structural harm to his back as a result of the November 26, 2012 work injury. He described claimant's work injury as minimal and within the range of normal activities of life. Consequently, Dr. Neff opined his could not state that "the proximate cause" of claimant's continued symptoms was work related. He also opined claimant's work injury simply caused claimant's preexisting condition to become more symptomatic for a period of time.

I find Dr. Neff's opinions to be entitled to little weight. Claimant need not prove that *the* proximate cause of his symptoms was work related, but that the work injury was *a* proximate cause of the disability (i.e. the work injury was a substantial factor in bringing about the disability). Additionally, Dr. Neff opined the work injury caused a temporary period of increased symptomatology; however, review of the medical records does not reveal a period prior to Dr. Neff's evaluation during which claimant's symptoms resolved or lessened significantly.

Treating physician, Dr. Bingham, expressed general agreement with Dr. Neff's opinions. He opined the work injury did not lead to any permanent aggravation or acceleration of the progress of claimant's preexisting degenerative disc disease. However, Dr. Bingham also indicated he was unable to opine whether claimant's

condition post-November 2012 injury returned to a baseline, preinjury level. He explained he did not believe he could issue such an opinion as he lacked personal knowledge of claimant's preinjury position. Therefore, he opined claimant suffered an acute exacerbation of a preexisting condition and he saw no evidence to suggest the injury was anything more than temporary in nature. As Dr. Bingham's opinion did not definitively address the issue of whether or not claimant's injury returned to baseline following a period of increased symptomatology, I find his opinion somewhat equivocal and entitled to negligible weight on this particular issue.

I find the opinions of Drs. Bendezu and Stoken are entitled to the greatest weight on the issue of whether or not the work injury is causally related to claimant's continued, ongoing complaints. These opinions support a determination that claimant's post-November 26, 2012 conditions never resolved to preinjury levels and thus, the work injury resulted in a permanent aggravation of the preexisting condition. The medical opinions are also consistent with claimant's credible testimony and the medical evidence which demonstrates a sharp dichotomy between claimant's preinjury and post-injury conditions. Prior to the work injury, claimant was capable of working full time for defendant-employer in a position which required lifting up to 50 pounds, missed little work, did not require consistent medical attention, and was capable of ambulating without an assistive device. Post-injury, claimant has remained under stringent work restrictions which limit him to less than full-time employment and precluded performance of his preinjury positions, required regular medical evaluation and treatment, and rendered claimant reliant upon an assistive device.

It is therefore determined claimant has proven, by a preponderance of the evidence that his ongoing low back and left lower extremity symptoms are causally related to the work injury of November 26, 2012. It is specifically determined that the work injury permanently worsened and lighted up claimant's preexisting degenerative condition of the lumbar spine, resulting in persistent symptomatology of the low back and left lower extremity. As claimant's ongoing medical conditions and need for treatment are causally related to the work injury of November 26, 2012, claimant is entitled to temporary total disability/healing period benefits pursuant to Iowa Code section 85.33(1) or section 85.34(1), if either should prove applicable, from August 20, 2014 through March 12, 2015.

The next issue for determination is whether the work injury of November 26, 2012 is a cause of permanent disability. As set forth *supra*, the undersigned finds the work injury of November 26, 2012 resulted in a permanent worsening and lighting up of claimant's preexisting degenerative condition of the lumbar spine, resulting in persistent symptomatology of the low back and left lower extremity. It is undisputed claimant's continued symptomatology resulted in a spinal fusion and imposition of permanent work restrictions. Therefore, the work injury is found to be a cause of permanent disability.

The next issue for determination is the extent of claimant's industrial disability.

Under the Iowa Workers' Compensation Act, permanent partial disability is compensated either for a loss or loss of use of a scheduled member under Iowa Code section 85.34(2)(a)-(t) or for loss of earning capacity under section 85.34(2)(u). The parties have stipulated claimant's disability shall be evaluated industrially.

Since claimant has an impairment to the body as a whole, an industrial disability has been sustained. Industrial disability was defined in Diederich v. Tri-City R. Co., 219 Iowa 587, 258 N.W. 899 (1935) as follows: "It is therefore plain that the legislature intended the term 'disability' to mean 'industrial disability' or loss of earning capacity and not a mere 'functional disability' to be computed in the terms of percentages of the total physical and mental ability of a normal man."

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

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

Total disability does not mean a state of absolute helplessness. Permanent total disability occurs where the injury wholly disables the employee from performing work that the employee's experience, training, education, intelligence and physical capacities would otherwise permit the employee to perform. See McSpadden v. Big Ben Coal Co., 288 N.W.2d 181 (Iowa 1980); Diederich v. Tri-City R. Co., 219 Iowa 587, 258 N.W. 899 (1935).

A finding that claimant could perform some work despite claimant's physical and educational limitations does not foreclose a finding of permanent total disability, however. See Chamberlin v. Ralston Purina, File No. 661698 (App. October 29, 1987); Eastman v. Westway Trading Corp., II Iowa Industrial Commissioner Report 134 (App. 1982).

At the time of evidentiary hearing, claimant was 51 years old and resided in Ankeny, Iowa. Claimant obtained a high school diploma and subsequently pursued multiple semesters of post-secondary education in auto mechanics, computer programming, AutoCAD, and architectural mill working. Claimant does not possess a post-secondary degree; however, his education has shown him to be an intelligent individual who is capable of accepting instruction and learning requisite knowledge and skill to be utilized in a workplace.

Claimant's work history consists generally of security, drafting, construction, and his work for defendant-employer. Claimant was hired at defendant-employer in August 2003 and remained an employee at the time of evidentiary hearing. During his employment with defendant-employer, claimant has held a number of jobs, including supervisory positions. The vast majority of these pre-November 2012 positions have required the ability to lift and maneuver items weighing up to 50 pounds.

As a result of the work injury of November 26, 2012, claimant sustained a permanent worsening of a preexisting condition of his lumbar spine. Claimant required extensive treatment of his low back and left leg conditions, including medications, physical therapy, injections, and ultimately an L4-L5 and L5-S1 anterior interbody discectomy and fusion with placement of two intervertebral cages and anterior fixation at L4-L5 and L5-S1. Despite surgical intervention, claimant has been left with continued low back pain and numbness of digits of the left foot, as well as intermittent left leg pain. As a result, claimant ambulates slowly and utilizes a cane.

Only one physician has offered an opinion with respect to the extent of claimant's permanent impairment following the fusion surgery, Dr. Stoken. Dr. Stoken opined claimant sustained a combined 27 percent whole person impairment as a result of the surgical procedure and reduced range of motion. She also recommended permanent work restrictions of avoidance of repetitive bending, lifting, and twisting; and avoidance of lifting more than 10 pounds on a frequent basis.

Following the fusion surgery, Dr. Bendezu imposed permanent restrictions of no bending, climbing, ladder use, or twisting; a 10-pound maximum lift, push, or pull; walking of 15 minutes per hour; standing or sitting for up to 4 hours per day; the need for a chair with lumbar support; and a maximum work day of 4 hours. He also noted claimant was unable to sit or stand for long periods. As Dr. Bendezu provided claimant continued treatment and thus had the opportunity to evaluate claimant on multiple occasions, the undersigned believes Dr. Bendezu is in the best position to address claimant's functional abilities.

Furthermore, the parties have utilized Dr. Bendezu's permanent restrictions in efforts to locate a job placement for claimant. As a result of Dr. Bendezu's restrictions, defendant-employer placed claimant in a position of part-time people greeter. He was not permitted to return to any of his preinjury or pre-fusion job positions. The position of people greeter is a legitimate position within defendant-employer; however, claimant is also limited to a maximum work day of 4 hours. The undersigned finds it quite telling that an employer as large as defendant-employer has only been able to place claimant in one job position. Additionally, although claimant has been placed in this position, defendant-employer does not consistently provide claimant with a regular number of work shifts per week. Rather, claimant's work hours vary from 8 to 24 hours per week.

Defendant-employer is a large, sophisticated company and has impressively sought to retain claimant as an employee. In doing so, defendant-employer has

provided a significant number of accommodations, including limiting claimant's work shift and providing a chair to utilize. However, the position claimant occupies is not one which is prevalent throughout the labor market and as demonstrated by claimant's varying hours, is not a consistent source of income. While claimant is an intelligent man who has demonstrated the ability to learn multiple skills and supervise other employees, the undersigned finds his restrictions are so limiting that he is not likely to obtain and retain employment within the general labor market.

Upon consideration of the above and all other relevant factors of industrial disability, it is determined claimant is currently permanently and totally disabled as a result of the injury of November 26, 2012. Such an award entitles claimant to permanent total disability benefits, commencing November 27, 2012, the day after claimant sustained the work-related injury, and continuing during the period claimant remains permanently and totally disabled. The parties stipulated at the time of the work injury, claimant's gross weekly earnings were $490.78, and claimant was married and entitled to 2 exemptions. The proper rate of compensation is therefore, $342.72. As the work injury of November 26, 2012 is found to have resulted in permanent total disability, claimant is not entitled to overlapping temporary total disability/healing period benefits.

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

The employer shall furnish reasonable surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance, and hospital services and supplies for all conditions compensable under the workers' compensation law. The employer shall also allow reasonable and necessary transportation expenses incurred for those services. The employer has the right to choose the provider of care, except where the employer has denied liability for the injury. Section 85.27. Holbert v. Townsend Engineering Co., Thirty-second Biennial Report of the Industrial Commissioner 78 (Review-Reopening October 16, 1975).

When dealing with unauthorized care, to be entitled to payment, claimant must establish the care was rendered on a compensable claim. That being established, claimant must establish that the care provided on the compensable claim was both reasonable and the outcome more beneficial than the care offered by the defendants. Bell Bros. Heating and Air Conditioning v. Gwinn, 779 N.W.2d 193, 206 (Iowa 2010).

After receipt of Dr. Neff's opinions, defendants declined to offer claimant additional medical treatment. Claimant thereafter incurred expenses in treatment of his continued back and left leg symptomatology, as detailed in the itemized request for medical expenses attached to the hearing report. The care received by claimant was rendered in respect to compensable conditions, was reasonable, and was beneficial in allowing claimant to manage his pain and decrease his lower extremity symptoms. It is determined these costs are the responsibility of defendants.

The next issue for determination is the extent of credit to defendants pursuant to Iowa Code section 85.38(2) for short term disability benefits paid. The parties agree claimant received short term disability benefits and the plan documents allow defendants a credit as claimed. Defendants did not provide a precise amount of such benefits paid; however, claimant stipulates a credit is due for short term disability received. Therefore, it is determined defendants are entitled to a credit in the amount of short term disability benefits paid.

The final issue for determination is a specific taxation of costs pursuant to Iowa Code section 86.40 and rule 876 IAC 4.33. Claimant requests taxation of the costs of: filing fee ($100.00); service fees ($12.22); Dr. Bendezu's report ($125.00); claimant's deposition transcript ($137.75); and Dr. Stoken's report arising from the June 8, 2015 evaluation ($1,200.00). The costs of filing fee, service fees, Dr. Bendezu's report, and claimant's deposition transcript are not disputed by defendants. These are allowable costs and are accordingly, taxed to defendants.

Defendants do contest taxation of any portion of Dr. Stoken's June 8, 2015 IME. Dr. Stoken charged $3,200.00 in connection with her second evaluation of claimant. Claimant requested taxation of $1,200.00 of this cost as a practitioner's report, the portion of the fee charged by Dr. Stoken for written report preparation. Dr. Stoken's itemized invoice reveals she spent 3 hours on written report preparation and charged $400.00 per hour, for a total fee of $1,200.00. Claimant requests taxation of this portion of her IME fee as a practitioner's report pursuant to rule 4.33. Defendants argue Dr. Stoken's July 2015 evaluation is a second IME and the cost of which should not be borne by defendants, as defendants paid the cost of Dr. Stoken's original IME.

Claimant is not permitted to receive reimbursement for the full cost of Dr. Stoken's July 2015 IME as a practitioner's report under rule 4.33. Rather, the Iowa Supreme Court has ruled only the portion of the IME expense incurred in preparation of the written report can be taxed. Des Moines Area Regional Transit Authority v. Young, 867 N.W.2d 839 (Iowa 2015). Dr. Stoken's bill itemization identified what portion of the IME fee was attributable solely to report preparation, with the figure representing the $1,200.00 amount requested by claimant. While $1,200.00 likely falls at the upper range of a taxable report preparation fee, the undersigned does not find the fee unreasonable. Accordingly, defendants are taxed with the cost of Dr. Stoken's report preparation fee in the amount of $1,200.00 pursuant to rule 4.33.

ORDER

THEREFORE, IT IS ORDERED:

Defendants shall pay unto claimant permanent total disability benefits at the weekly rate of three hundred forty-two and 72/100 dollars ($342.72), commencing November 27, 2012 and continuing during the period claimant remains permanently and totally disabled.

Defendants are found responsible for claimant's prior medical expenses submitted by claimant at the hearing as set forth in the decision.

Defendants shall pay accrued weekly benefits in a lump sum.

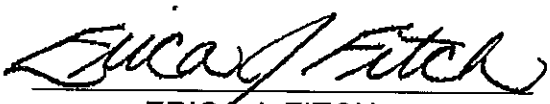
Defendants shall pay interest on unpaid weekly benefits awarded herein as set forth in Iowa Code section 85.30.

Defendants shall receive credit for benefits paid, including short term disability benefits.

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

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

Signed and filed this 15th day of June, 2016.



ERICA J. FITCH
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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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.