BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

ROBERTO BAUTISTA, Claimant, vs. IOWA PREMIUM BEEF, Employer, and AMERICAN ZURICH INSURANCE CO., Insurance Carrier, Defendants.	File No. 1643891.01 ARBITRATION DECISION Head Note Nos: 1108, 1800, 1803.1

STATEMENT OF THE CASE

Claimant, Roberto Bautista, has filed a petition for arbitration seeking Workers' Compensation benefits against Iowa Premium Beef, employer, and American Zurich Insurance Company, both as defendants.

In accordance with agency scheduling procedures and pursuant to the Order of the Commissioner in the matter of the Coronavirus/COVID-19 Impact on Hearings, the hearing was held on December 18, 2020, via Court Call. The case was considered fully submitted on January 16, 2021, upon the simultaneous filing of briefs.

The record consists of Joint Exhibits 1-10, Claimant's Exhibits 1-8 and Defendants' Exhibits A-G, along with testimony of the claimant and Arnulfo Garcia.

ISSUES

1. The nature and extent of claimant's permanent disability;
2. Whether claimant was underpaid PPD to date;
3. Whether claimant's injury is limited to the right shoulder or extends into the body as a whole;
4. Whether claimant injured his back and/or neck;
5. Whether he sustained a sequela injury to his left shoulder due to overuse;
6. Whether he can claim a bilateral loss under 85.34(2)(v);
7. Whether claimant's wages are less today than at the time of his injury and thus entitled to an industrial disability analysis;

8. Whether claimant is entitled to reimbursement of an IME under Iowa Code section 85.39 (Cl. 8, p. 64);
9. And costs.

STIPULATIONS

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

The parties agree claimant sustained an injury which arose out of and in the course of his employment on December 28, 2017. This injury was the cause of temporary disability and permanent disability. The parties agree the claimant is entitled to both temporary and permanent benefits but disagree as to the extent and nature of permanent disability.

The parties agree the claimant sustained a right shoulder injury and that the commencement date for permanent partial disability benefits, if any are awarded, is March 21, 2019.

At the time of the injury, the claimant's gross earnings were $1096.00 a week. The claimant was married and entitled to five exemptions. The parties agree that the weekly benefit rate based on the foregoing numbers is $716.22.

Defendants waive all affirmative defenses. Defendants further agreed to reimburse claimant for the cost of the independent medical examination itemized in Exhibit 8, page 64. Prior to the hearing the claimant was paid 52 weeks of permanent partial disability benefits at the rate of $668.55 per week. The defendants acknowledge that this is an underpayment due to a miscalculation of rate based upon the number of exemptions to which defendants erroneously believed claimant was entitled. A supplemental check for the other payment has been issued at the time of the hearing but not yet received by the claimant. The claimant also seeks reimbursement for the 85.39 examination which the defendants have agreed to pay but the payment has not yet been forthcoming.

FINDINGS OF FACT

Claimant was a 55-year-old person at the time of the hearing. He is a married person and at the time of his injury, had the responsibility for one minor child and two elderly adults.[1]

[1] The original benefit rate was incorrectly calculated based on the one minor child but has since been corrected. Defendants have agreed to pay the underpayment of PPD due to the incorrect benefit rate calculation.

Claimant ceased his education around the seventh grade. He immigrated to the United States in 1992. He is unable to speak or write English with proficiency. He is able to understand simple instructions in English while on the job and can respond appropriately in English, but he is not able to converse well. He is not fluent. He has limited computer skills.

His past work history includes agricultural work and meat packing work for JBS. (See e.g. CE 2, p. 31) The agricultural work involved heavy lifting of thirty to fifty pounds, carrying buckets and sacks of fruits and vegetables, work over the head such as placing the sacks and buckets into trucks, picking fruit off trees. He testified that he did not believe he could perform these jobs since his work-related injury of December 28, 2017. At JBS he worked with large sections of meat and would, at times, have to handle heavy weights and do work over his shoulder.

Prior to working for defendant employer, claimant had no issues with his shoulder, neck or back. He underwent a pre-employment physical wherein he was deemed able to work without limitations.

Claimant began working for defendant employer on May 14, 2015. His various jobs included deboning chops, dumping the pallets, knife room sharpener, meat reconditioner and working in the supply room. (CE 6:42) The chops weighed 60-70 pounds. He testified he would not be able to lift the chops or do that type of work today. Claimant was moved into the trainer position, the position he held at the time of the injury. As a trainer, claimant was required to lift and turn heavy pieces of meat to display proper technique for the employees he was training.

On December 28, 2017, claimant was walking to retrieve his supplies. The floor was slippery. He fell backwards, striking his right shoulder, neck and shoulder blade. He felt pain immediately in the right shoulder. After the fall, he reported the fall to his superiors and he was taken to the nursing room. He was referred to Jerry Wille, M.D., and was seen on the same day.

Dr. Wille's records note claimant was suffering severe pain in his upper right arm and elbow without radiation. (JE 1:1) At this time, claimant made no mention of any neck pain. He was focused and concerned about the right shoulder. Dr. Wille prescribed pain medications and referred claimant for an orthopedic consult. (JE 1:2) Claimant was moved to a light-duty position in the supply area of the plant.

On January 4, 2018, claimant was seen by Christopher Vincent, M.D., who suspected a long head biceps tendon rupture and possible rotator cuff tendon tear. (JE 2:4) The MRI confirmed claimant had a long head biceps tendon rupture with Popeye deformity as well as a supraspinatus tendon tear with a type II anterolateral downsloping acromion and subacromial impingement. (JE 2:6; JE 7:111) Dr. Vincent advised claimant to undergo surgical repair which took place on February 8, 2018. (JE 2:8-10).

There was no mention of neck pain in the medical records and claimant testified he was focused on his shoulder injury and recovery. However, he testified that during the second visit when he and Dr. Vincent discussed the MRI, claimant reported that he had pain in his right neck and between the shoulder blades. This is not recorded.

Claimant was returned to the supply room position but with restrictions of not to use the right arm. (JE 2:15) Physical therapy was ordered. Claimant returned to Dr. Vincent's office on February 22, 2018, for stitch removal (JE 2:13) and then in follow-up on March 22, 2018. (JE 2:17) There was no mention of neck pain in these visits. During the March 22, 2018, visit, Dr. Vincent was concerned that claimant was not performing activities and exercises on his own and that his range of motion was poor. (JE 2:17)

One of claimant's work tasks was sorting gloves. He would need to reach across a table to sort the good gloves from the bad. He testified that this reach aggravated pain in his shoulder. After the March 22, 2018, visit, restrictions of no lifting, pushing or pulling of more than three pounds were continued along with no reaching or overhead work. (JE 2:18) Claimant was instructed to continue with therapy. He returned to Dr. Vincent on May 3, 2018, who ordered an EMG due to numbness in the forearm and significant atrophy and weakness in the biceps and brachialis. (JE 2:21) The EMG demonstrated normal innervation of the biceps brachii without evidence of musculocutaneous nerve injury, but there was evidence of carpal tunnel and cubital tunnel syndrome which Dr. Vincent did not find to be connected to the shoulder injury. (JE 2:23; JE 4:51) Claimant was released to a 10-pound lifting restriction, no work above the shoulder level and to increase his weight restrictions by 2.5 pounds per week. (JE 2:24)

Around June 2018, claimant was moved from the gloves job to the meat reconditioner position. That job required him to lift meat off the floor, wash it, trim it, spray it and then return it to the work table. The weights varied from one to twenty pounds. He used a hook to lift the meat and worked with his left arm primarily because it was stronger. As time went on, pain in his left shoulder began to develop, "little by little," he testified. Claimant continued to have nerve injury symptoms which concerned Dr. Vincent. (JE 2:26) Dr. Vincent referred claimant to a colleague with more experience in nerve damage cases. (JE 2:26) Claimant's restrictions were modified again to no lifting greater than 10 pounds on the right side and no more than 20 pounds bilaterally. (JE 2:27)

On July 3, 2018, claimant was seen for PT. His left ROM was measured as normal. (JE 5:53)

On July 27, 2018, claimant consulted with Kurt A. Smith, D.O. Dr. Smith recommended repeat EMG. (JE 6:67) The new EMG on August 9, 2018, showed right musculocutaneous neuropathy and right median neuropathy; localizing to the level of the wrist. (JE 6:71) Dr. Smith prescribed Tramadol and gabapentin, continued work restrictions, and sent claimant back to physical therapy. (JE 6:74) On September 20,

2018, claimant continued to complain of pain and right arm weakness. (JE 6:76) Dr. Smith discontinued gabapentin, started Lyrica, and continued claimant on work restrictions imposed by Dr. Vincent as well as physical therapy. (JE 6:77) The physical therapist contacted Dr. Smith indicating that claimant was having difficulty with pain in the right shoulder during active range of motion and that it would be helpful to have a home electrical stimulator. (JE 6:80) On October 22, 2018, Dr. Smith wrote a prescription for the home muscle stimulator. (JE 6:80-81)

On September 6, 2018, claimant returned to Dr. Vincent with the same symptoms and little improvement. (JE 2:29) He complained of a new onset of gastrointestinal issues and was trying to wean himself off of pain medications. (JE 2:29) There was no mention of neck or left shoulder issues. His left shoulder range of motion was measured and was within normal limits. (JE 2:30)

On November 1, 2018, claimant was seen by Dr. Smith for the right upper arm pain. The Lyrica was causing daytime dizziness. (JE 6:82) Dr. Smith advised claimant to continue with occupational therapy and neurorehabilitation. (JE 6:83)

On November 8, 2018, claimant returned for follow-up with Dr. Vincent following his appointment with Dr. Smith for the nerve pain. Claimant maintained he was not improving. (JE 2:33) Symptoms recorded were solely in the right shoulder and right upper extremity. There was no mention of left shoulder or neck. (JE 2:33) Right shoulder range of motion was reduced, but left shoulder range of motion was full. (JE 2:34) Dr. Vincent believed that claimant continued to have pain associated with a nerve injury and recommended an MR arthrogram. (JE 2:35) Claimant's work restrictions were no lifting more than 20 pounds. (JE 2:36)

On December 6, 2018, claimant returned to Dr. Vincent with ongoing issues in the right shoulder. The MRI showed excellent integrity of his supraspinatus tendon repair and no evidence of re-tear. (JE 2:38) Dr. Vincent believed claimant's ongoing dysfunction was related to nerve dysfunction and offered an injection. (JE 2:38) Claimant declined.

Karen Speicher, the occupational therapist working on claimant's nerve injury, left a voicemail message for Dr. Smith. (JE 6:87) The therapist wanted permission to advance patient to gentle strengthening and work conditioning. Id. Claimant was a lot less sensitive now to movement but did not have full range of motion. (JE 6:87) Dr. Smith signed off on this on the same date.

On December 20, 2018, claimant saw Dr. Smith in follow-up. (JE 6:88-89) His symptoms were unchanged. Dr. Smith discontinued the prescription for Lyrica as claimant had stopped taking it. Claimant was advised to continue with ibuprofen as needed.

On February 8, 2019, claimant followed up with Dr. Smith reporting right arm pain occurring intermittently. The pain symptoms were aggravated by lifting and movement and relieved by rest. (JE 6:92)

Claimant underwent an FCE on February 18, 2019. (JE 8) The overall classification was mixed due to the claimant demonstrating conflicting consistency reports. The pain questionnaires were low for subjective pain reports and behaviors, but there were some signs of cogwheeling/breakaway pain during the strength test but not during the lifting evaluation. There were no overt pain behaviors during the evaluation. Claimant failed only two of the seven validity criteria. (JE 8:16) Based on the results, claimant was placed in the medium demand vocation which allowed for:

Bilateral floor to waist lifting at 23 pounds occasionally.

Right unilateral lifting at 2.5 pounds occasionally.

Left unilateral lifting at 30 pounds occasionally.

Standing and sitting with no functional limitations.

(JE 8:113) The therapist also believed claimant could not safely lift over his shoulder, that his lifting capacity was inconsistent with the demands of his job, and he had diminished functional use of the upper extremities in work above chest level. (JE 8:113, 117)

On March 21, 2019, he returned to Dr. Smith who reviewed the FCE, noted discrepancy between his lifting abilities during the FCE, which was 2.5 pounds, versus the 20 pounds claimant was lifting in therapy. (JE 6:96) Dr. Smith determined claimant was at MMI and adopted the work restrictions set forth by Dr. Vincent of no lifting greater than 20 pounds and no lifting above his shoulder. Id.

On March 28, 2019, claimant brought complaints of burning pain down the right arm. (JE 2:40) Again, however, claimant's left shoulder ROM examination was normal. Id. Dr. Vincent felt claimant had reached MMI regarding the rotator cuff reconstruction and biceps tenodesis. However, Dr. Vincent did find a mass on the distal arm that needed follow-up. (JE 2:42) Claimant was referred to a vascular surgeon for evaluation of the mass. As for the right shoulder issue, Dr. Vincent offered an injection and permanent work restrictions of 20 pounds on the right and avoidance of work above the level of the shoulder. (JE 2:42)

Claimant maintained that he reported the left shoulder pain to Dr. Vincent during this March 2019 appointment and then also to the nurse, Tammy, at work in April 2019. (Ex 4:38) He reported that his left arm was hurting due to overuse on the left because of the injury to the right. Id.

On April 19, 2019, Dr. Vincent opined that there was no further treatment he could offer claimant from an orthopedic standpoint. (JE 2:46) Injections were a

possibility to provide intermittent relief. (JE 2:46) As it related to claimant's ability to return to work, Dr. Vincent noted claimant's work restrictions of no lifting greater than 20 pounds on the right and no over the shoulder work on either side. (JE 2:46) He assigned an 11 percent upper extremity impairment rating on the left. (JE 2:46)

On April 19, 2019, Dr. Smith authored an opinion letter placing claimant at MMI and adopting the work restrictions of Dr. Vincent. (JE 6:98) He further assessed a 6 percent upper extremity rating or 4 percent whole body impairment. (JE 6:98)

Claimant testified that his pain worsened in the left shoulder from May 2018 and into 2019. He said that it was the result of using the left arm to lift the meat, although during testimony he said that he used both arms to lift the meat twice before modifying his testimony to a single arm usage.

On May 23, 2019, claimant was evaluated at the UIHC with an interpreter for issues related to his right arm. There was normal arterial flow in the right brachial and it was recommended that claimant resume normal activity as much as possible including usage of the right arm. (JE 9:129)

Claimant was not authorized to receive care for his left shoulder and sought care on his own with David Huante, M.D. at Franklin Family Practice on June 11, 2019. (JE 10) Per the history, claimant explained to Dr. Huante the poor outcome from the surgery and the lasting pain and range of motion limitations in the right shoulder. (JE 10:130) Claimant also reported that he experienced pain in the left para-cervical, left posterior shoulder and medial scapular muscles, as well as the lower thoracic and para-lumbar muscle right after the fall; however, only the right-sided issues had been addressed in physical therapy. (JE 10:130) During this June 2019 visit, Claimant expressed continued pain in the right upper extremity with limitation in function and strength as well as para-cervical, left posterior shoulder and left sided para-spinal back pain. (JE 10:130) Claimant also relayed that his work with a knife required him to rotate at the waist and neck in a repetitive manner causing pain in the neck as well as the left posterior shoulder and left para-lumbar muscle region. (JE 10:131) He also compensates for the limitation in the right upper extremity function and strength by putting more demand on his left upper extremity which aggravates the left shoulder and lower back muscles. (JE 10:131)

During the examination, Dr. Huante found that claimant had a slightly raised left upper shoulder compared to his right and that his muscle bulk was comparable throughout. (JE 10:131) He exhibited significant limitation in range of motion of the cervical spine with rotating of the head to the right limited to 45 degrees instead of the normal 90 degrees. Rotation on the left was no greater than 60 degrees. (JE 10:131) He could flex 80 percent and extend 70 percent of the normal range. (JE 10:131) His posterior para-cervical muscles were taut and mildly tender to palpation on the right and moderately tender on the left. (JE 10:131) He had an abnormal left posterior shoulder region with a very tender and taut trapezius muscle segment along with three different

trigger points. (JE 10:131) There was also tenderness at the base of the left paracervical region corresponding to the cervical component of the trapezius muscle. (JE 10:131) His rhomboids major and minor muscles were also moderately tender on palpation with at least four respective trigger points. (JE 10:132) Left upper extremity crossover from left to right revealed at least a 50 percent limitation in range of motion due to pain, stiffness and tautness of the rhomboid muscles. (JE 10:132) The para-spinal muscles from T11 down to L4 were also taut and tender with range of motion in the lumbar spine limited by at least 25 percent with full flexion and rotation to the right and left limited by at least 40 percent due to pain and stiffness. (JE 10:132) Both upper extremities had reduced reflexes at the elbow and at the wrist, greater on the right than the left. (JE 10:132) He also had decreased muscle mass involving the right biceps and an abnormal contraction configuration on the right compared to the left. (JE 10:132)

Dr. Huante's assessment was chronic myofascial pain syndrome involving the trunk and para-spinal musculature. (JE 10:132) His recommendation was dedicated, localized physical therapy, stretching and other modalities such as trigger point injections to improve function, range of motion, and flexibility of the affected musculature; however, pain is often a permanent condition. (JE 10:132)

Claimant was seen by Dr. Vincent on October 1, 2019, for left shoulder pain. (JE 6:104) In the history section, the onset of pain was December 28, 2017. (JE 6:104) The pain was piercing and sharp, at a 6 out of 10 level, and relieved by rest. (JE 6:104) Claimant believed it was the result of overuse of the left shoulder. (JE 6:104) As his symptoms were consistent with rotator cuff tear, an MRI was recommended and an injection was administered to provide temporary relief. (JE 6:105-106)

On October 4, 2019, Dr. Vincent authored a second opinion letter in response to the medical records from Dr. Huante. (JE 6:108) Dr. Vincent felt that the history claimant gave to Dr. Huante and the one given to Dr. Vincent were different.

> I compared his subjective reporting to Dr. Huante in June of 2019, to the sworn testimony he gave in July 2019, and compared both of these with the interview I had with him on October 1, 2019. There is [*sic*] significant inconsistencies seen in all 3 of these interviews with regard to the timeline of which his left shoulder pain began, as well as the job duties he was performing when these symptoms began. He reported to me that his pain started in the left shoulder 5-6 months prior to my evaluation, which would be in April of 2019. He reports that he was having to do repetitive lifting of meat at his plant, and he was compensating for his inability to perform duties with the right by overusing his left. This was the reason he reported to me was the cause of his shoulder pain. He did not have any specific injury or specific day in which his pain started. However, he reported to Dr. Huante that he developed pain in the left shoulder once he returned to full duty. He reported to Dr. Huante that he had been returned to full, unrestricted duty and that he was required to debone and

> process beef with no restrictions. This is inconsistent and inaccurate in comparison with the job description I have of him and what he reported to me. I also reviewed the sworn testimony he gave July of 2019, during which he reported that his symptoms began in March 2018, when he was working in light duty as a glove selection [*sic*] for other employees.

(JE 6:108)

Dr. Vincent opined that claimant's left shoulder problems would have developed, more likely than not, in absence of his employment due to the type of light duty work claimant had been performing since he returned to work including the glove duty as well as the meat reconditioning position. (JE 6:109) The work claimant was performing was low force, light weight and below shoulder height. (JE 6:109) His radiographs demonstrate a type 3 acromion which significantly predisposes patients who develop rotator cuff tendinopathy and tendonitis as well as rotator cuff tearing. (JE 6:109)

Claimant did not undergo the MRI.

Currently, claimant is working full time in a job that meets his restrictions on both sides. However, he is still in pain in both shoulders, right biceps, right side of his neck and between his shoulder blades. He takes an average of 6-8 Tylenol per day.

At the time of the December 28, 2017 injury, claimant's earnings were $21.50 per hour. At the time of the alleged injury date of April 12, 2019, claimant was earning $23.00 per hour. (CE 6:43) Claimant testified that his hourly wage was reduced to $16.60 when he was at MMI and released to return to work. He now earns $21.50 per hour for one job and $19.50 per hour for another job. He received $35,804.60 in permanent partial disability payments. (Ex 5:40)

Claimant underwent an IME with Sunil Bansal, M.D., on October 21, 2019. (CE 1) His right shoulder exhibited reduced range of motion and strength deficits along with tenderness to palpation. (CE 1:12) He had sensory discrimination loss over the thumb and reduced reflexes in the bilateral upper extremities. (CE 1:14) He exhibited tenderness to palpation over the cervical paraspinal musculature, greater on the right than the left. (CE 1:13) There was tenderness to palpation over the thoracic back, with no guarding or spasms and full range of motion. (CE 1:13) He was also tender to palpation in the left shoulder, greatest at the acromioclavicular joint into the subacromial bursa. (CE 1:13) He exhibited reduced range of motion on the left as well. CE 1:13)

Dr. Bansal explained in his opinion letter that the mechanism of forceful direct impact to the shoulder, coupled with a clinical presentation of immediate right shoulder pain was consistent with acute rotator cuff and biceps tear. (Ex. 1:15) The left shoulder pathology was the result of overuse and overcompensation from the right shoulder pathology. (Ex. 1:15) Dr. Bansal pointed to the development of left shoulder pain occurring a few months after the right shoulder injury and progressed and worsened as claimant began using a hook at work with the left arm. (Ex 1:15) In similar situations, it

is common to have contralateral arm rotator cuff pathology, as there will be excessive abduction and shoulder rotational forces, aggravating impingement. Also, when he was holding the meat with his left arm, between the waist and chest level, there was further aggravation of impingement. (Ex 1:15) Finally, he developed chronic myofascial pain syndrome, typified by the presence of persistent trigger points, caused by muscle overload or trauma. (Ex 1:16) Dr. Bansal assessed a 23 percent impairment for the right shoulder/upper extremity, a 5 percent impairment for the neck, a 3 percent impairment to the left shoulder, and permanent restrictions of bilateral lifting only 23 pounds occasionally from floor to waist, 2.5 pounds unilaterally with his right arm, 30 pounds unilaterally with the left arm, no work over shoulder level on each side and only occasional reaching with either arm. (Ex 1)

On March 9, 2020, Dr. Vincent issued another opinion letter responding to the opinion letter of Dr. Bansal.

> I would like to address the causation opinions from Dr. Bansal regarding Roberto's left shoulder and cervical spine. In regards specifically to causation, I disagree with Dr. Bansal's underlying rationale. Dr. Bansal states, "In these situations, it is common to have contralateral arm rotator cuff pathology, as there will be excessive abduction and shoulder rotation forces aggravating the impingement. Also, when he was holding the meat with his left arm, it was between waist and chest level, further aggravating impingement." This is fundamentally wrong. It has been shown in multiple studies, and I can affirm with my own experience that it is very rare for patients to develop contralateral symptoms specifically related to overuse. In Mr. Bautista's situation, he was on quite stringent restrictions. There would be no explanation for him to develop these symptoms as a result of "overuse." Dr. Bansal states that "In these situations, it is common to have contralateral arm rotator cuff pathology, as there will be excess abduction and shoulder rotation forces aggravating impingement." This is incorrect. Dr. Bansal does not have an accurate understanding of rotator cuff pathology, its pathogenesis, and what causes it. It is further demonstrated by his report of work within waist and chest level aggravating rotator cuff impingement. This is also fundamentally inaccurate and the studies he quoted in his IME report are outdated. While there are certain positions that increase contact forces on the rotator cuff, which has been shown by biomechanical studies, one cannot use these studies to conclude that the light duty work Mr. Bautista was doing for Premium Beef would cause these symptoms. Quite the contrary. Mr. Bautista has worked for years, doing higher demand activities without any problems with his rotator cuff. These symptoms developed in the left shoulder, most likely because of the anatomic development of his left shoulder. He has a type 2-3 acromion, which places him at high risk for these problems. The stringent restrictions he was on could not be causally related to his symptoms. I

> believe his symptoms on the left more likely than not would have developed even in the absence of his. [*sic*] The light duty he was [*sic*] after his right sided surgery could not be attributed to the development of a rotator cuff tear or even rotator cuff tendinitis. In addition, the light duty he was performing throght [*sic*} this time frame, at which time he reported to me that his symptoms began, would not causally be related to the diagnosis of rotator cuff tendinitis or rotator cuff tear. He was lifting very light meats. It is low repetitive motions that were at the waist and below level picking up objects off the floor, trimming them slightly, and washing them. This is all very low force. These are similar forces that he would exert preparing meals at home, performing simple hygiene, such as showering, and would have developed in the absence of his employment.

(Ex. A:1)

Dr. Bansal responded to the March 9, 2020, report of Dr. Vincent stating that Dr. Vincent's opinions were "typical of a call to authority fallacy. Essentially, he finds the entirety of the opinions in my IME report to be fundamentally flawed and the medical literature to be outdated, yet he provides no supportive or refuting literature himself." (CE 1:20) He further asserts that Dr. Vincent mischaracterized the causation analysis. Dr. Bansal stated that claimant's cervical spine pathology was the result of the trauma itself as claimant hit the area of his neck and back on the ground. (CE 1:20) Dr. Bansal also stated that claimant's pathology was to his right rotator cuff and that the surgical excision was to an anatomic part proximal to the glenohumeral joint as is the rotator cuff itself. (CE 1:22)

Dr. Vincent replied to Dr. Bansal's report stating that Dr. Vincent was familiar with the work duties of employees of defendants and that the types of duties claimant performed while recovering were extremely light. (DE A:5) He further opined that it was rare to see patients develop overuse syndrome absent increased demand on the non-injured shoulder. (DE A:5)

On November 10, 2020, Dr. Bansal issued a final opinion stating that Dr. Vincent constructs multiple straw man fallacies. (Ex 1:24) Dr. Bansal moves away from the glove job as an inciting factor (despite previously identifying that as an aggravating cause in his initial report), and focuses on the work claimant was performing with the hook. (Ex 1:25) Mr. Bautista's testimony regarding the beginning of his left shoulder pain varied. At some points, Mr. Bautista stated that his glove work, which involved reaching, was when his pain started. Other times, it was when he started working with the hook. Thus, Dr. Bansal's exhortation to rely upon Mr. Bautista's statement that his left shoulder symptoms were initiated months after right shoulder surgery is on shaky ground. As for the neck, Dr. Bansal points to the examination of Dr. Huante as supportive of the finding the neck pathology was connected to the work injury, but disregards Dr. Smith's repeated contemporaneous examinations of no neck pain and full range of motion. (Ex. 1:25)

Dr. Bansal accuses Dr. Vincent of straw man arguments, but straw man arguments are those that intentionally misrepresent a position. I do not find that Dr. Vincent's opinions are those that intentionally misrepresent Dr. Bansal's. Dr. Bansal's initial opinions did not adequately explain how an acute injury to the neck would have resulted in no symptoms until June 2019. Even when claimant went to speak with Tammy, the office nurse, he brought up only the left shoulder and not the neck. Dr. Bansal's opinions do not adequately explain how he initially attributed the left shoulder injury to claimant's light duty work with the gloves that was "further aggravated" when claimant was moved into the hook position, a position that claimant himself called an "easy job" during his discussion with Tammy. (CE 4:38) Based on claimant's varying reports of the start of the pain, the remoteness of the pain to the actual date of injury, and the contemporaneous medical reports showing normal left shoulder and normal neck prior to the June 2018, medical visit, Dr. Vincent's opinions are deemed more reliable than that of Dr. Bansal.

CONCLUSIONS OF LAW

Claimant alleges he has sustained a direct compensable workers' compensation injury to his right shoulder and sequelae injury to his left shoulder, neck, and back. Defendants concede that claimant sustained a right shoulder injury which arose out of and in the course of his employment, but that all the benefits owed to claimant have been satisfied.

The party who would suffer loss if an issue were not established has the burden of proving that issue by a preponderance of the evidence. Iowa R. App. P. 6.904(3).

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

The claimant has the burden of proving by a preponderance of the evidence that the injury is a proximate cause of the disability on which the claim is based. A cause is proximate if it is a substantial factor in bringing about the result; it need not be the only cause. A preponderance of the evidence exists when the causal connection is probable rather than merely possible. George A. Hormel & Co. v. Jordan, 569 N.W.2d 148 (Iowa

1997); Frye v. Smith-Doyle Contractors, 569 N.W.2d 154 (Iowa App. 1997); Sanchez v. Blue Bird Midwest, 554 N.W.2d 283 (Iowa App. 1996).

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

There are competing expert opinions in this matter. It is unrefuted that claimant had no problems prior to his right shoulder injury. It is not disputed that claimant has pain, discomfort and limitations in the left shoulder and the neck. Rather, the dispute is whether those symptoms are related to the work injury.

Dr. Huante, the medical doctor that claimant saw after being denied care from defendants, gave no causation opinion. The two primary causation opinions come from Dr. Vincent, an orthopedic specialist, and Dr. Bansal, a public health specialist.

Dr. Vincent's opinions are more convincing. Dr. Vincent noted the inconsistencies in the opinions that claimant gave regarding the type of work he did. Claimant testified during hearing that he used both arms—left and right—to pick up meat. The work was not repetitive and it was low force although it did require reaching. Claimant's underlying condition was predisposed to tears, and Dr. Vincent, who is an orthopedic specialist, wrote that Dr. Bansal's science was fundamentally incorrect.

Additionally, claimant's neck pain and left shoulder pain were not noted during physical therapy or during the 2018 visits with Dr. Smith where claimant's left shoulder and neck were examined and found to be within normal limits and pain free range of motion. Claimant's report of neck pain and left shoulder pain did not arise until around April 2019.

Thus, the greater weight of the evidence supports a finding that claimant's injury arising out of the December 28, 2017, was solely to the right shoulder.

The second issue is whether the shoulder injury extends into the whole body. Claimant argues that the defendants have conceded that the injury extends to the whole body in that treatment included a distal clavicle excision which is located in the trunk of the body. In other cases before the agency, the distal clavicle has been found to be a shoulder injury rather than a whole body injury while another decision determined the

distal clavicle to be proximal to the shoulder, extending beyond the shoulder. Cox v. Bridgestone Americas, Inc., File No. 19003499.01 (March 3, 2021) (finding the distal clavicle is closely entwined with the glenohumeral joint both in location and function), Garcia Rubalcava v. Siouxpreme Egg Products, Inc., File No. 5066865 (June 23, 2020) (determining that the statute is ambiguous as to the definition of shoulder and thus should be construed in favor of the injured worker).

While I find the dicta in Garcia Rubalcava persuasive, Dr. Bansal indicated that the surgical excision was to an anatomic part proximal to the glenohumeral joint, but that the rotator cuff is proximal as well. The rotator cuff has been determined to be part of the shoulder in previous Commissioner holdings. Chavez v. MS Technology, LLC., File No. 5066270 (App. September 30, 2020) and Deng v. Farmland Foods, Inc., File No. 5061883 (App. September 29, 2020). Both appellate cases were filed following the Garcia Rubalcava decision. Thus, following Deng and Chavez, I find that the distal clavicle is closely intertwined with the glenohumeral joint both in location and function, as stated by Dr. Bansal and depicted in the diagram in his decision. The claimant's injury is limited to his right upper extremity.

Since this case involves disability to a scheduled member under the 5th edition AMA guidelines control;

> [W]hen determining functional disability and not loss of earning capacity, the extent of loss or percentage of permanent impairment shall be determined solely by utilizing the guides to the evaluation of permanent impairment, published by the American medical association, as adopted by the workers' compensation commissioner by rule pursuant to chapter 17A. Lay testimony or agency expertise shall not be utilized in determining loss or percentage of permanent impairment pursuant to paragraphs 'a' through 'u', or paragraph 'v' when determining functional disability and not loss of earning capacity.

Iowa Code § 85.34(2)(x) (2019).

There are differing opinions as to the extent of the functional disability. Dr. Vincent assessed a 13 percent impairment rating while Dr. Bansal assessed a 23 percent impairment rating for the right upper extremity. The difference rests in the distal clavicle excision. Dr. Bansal, per the 5th AMA guidelines, added a percentage for the distal clavicle excision whereas Dr. Vincent opted not to. Given that the AMA guidelines are to control, the distal clavicle excision should count. Defendants point out in the brief that the correct addition for the distal clavicle excision is 3 percent rather than 10 percent as adopted by Dr. Bansal. Thus, the appropriate functional disability is 16 percent.

The parties agree that the commencement of PPD benefits is March 21, 2019. Defendants stipulated at hearing that the underpayment of PPD would be paid. The remaining issues are moot but for the costs.

Claimant also requests an assessment of costs. 876 IAC 4.33 allows for the assessment costs at the discretion of the deputy. Given that claimant has prevailed in this matter, the assessment of costs against defendant employer and insurer are appropriate.

ORDER

THEREFORE, it is ordered:

That defendants' employer and insurer are to pay unto claimant forty (40) (250 x16 percent) weeks of permanent partial disability benefits at the rate of seven hundred sixteen and 22/100 dollars ($716.22) per week from March 21, 2019.

That defendants are to pay the underpayment of weekly benefits.

That defendants are to pay the 85.39 examination.

That defendants' employer and insurer shall pay accrued weekly benefits in a lump sum.

That defendants' employer and insurer shall pay interest on unpaid weekly benefits awarded herein as set forth in Iowa Code section 85.30.

That defendants' employer and insurer shall pay the costs of this matter pursuant to rule 876 IAC 4.33 except for the examination performed by Dr. Bansal.

Signed and filed this 15th day of June, 2021.

JENNIFER S. GERRISH-LAMPE
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served, as follows:

James Byrne (via WCES)

Peter John Thill (via WCES)

Right to Appeal: This decision shall become final unless you or another interested party appeals within 20 days from the date above, pursuant to rule 876-4.27 (17A, 86) of the Iowa Administrative Code. The notice of appeal must be filed via Workers' Compensation Electronic System (WCES) unless the filing party has been granted permission by the Division of Workers' Compensation to file documents in paper form. If such permission has been granted, the notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 150 Des Moines Street, Des Moines, Iowa 50309-1836. The notice of appeal must be received by the Division of Workers' Compensation within 20 days from the date of the decision. The appeal period will be extended to the next business day if the last day to appeal falls on a weekend or legal holiday.