BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

LISA HAALAND,	FILED	
Claimant,	JAN 02 2019	File No. 5062844
vs.	WORKERS COMPENSATION	ARBITRATION
TRINITY HEALTH CORPORATION d/b/a MERCY MEDICAL CENTER – NORTH IOWA,		DECISION
Employer, Self-Insured, Defendant.		Head Note No.: 1100

STATEMENT OF THE CASE

Claimant, Lisa Haaland, filed a petition in arbitration seeking workers' compensation benefits from Trinity Health Corporation d/b/a Mercy Medical Center-North Iowa, self-insured employer, as defendant, as a result of an alleged injury sustained on April 11, 2016. This matter came on for hearing before Deputy Workers' Compensation Commissioner Erica J. Fitch, in Des Moines, Iowa. The record in this case consists of Joint Exhibits 1 through 13, Claimant's Exhibits 1 through 18, Defendant's Exhibits A through G, and the testimony of the claimant and Patricia Hill.

ISSUES

The parties submitted the following issues for determination:

1. Whether claimant sustained an injury on April 11, 2016 which arose out of and in the course of her employment;

2. Whether the alleged injury is a cause of temporary disability;

3. Whether claimant is entitled to temporary disability benefits from April 11, 2016 through May 8, 2017;

4. Whether the alleged injury is a cause of permanent disability;

5. Extent of industrial disability;

6. The extent of defendant's credit for sick pay and short term disability benefits;

7. Whether claimant is entitled to reimbursement of an independent medical examination under Iowa Code section 85.39;

8. Whether defendant is responsible for claimed medical expenses and medical mileage;

9. Whether claimant is entitled to penalty benefits under Iowa Code section 86.13 and, if so, how much; and

10. Specific taxation of costs.

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

FINDINGS OF FACT

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

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

Claimant was 48 years of age at the time of hearing. She resides in Mason City, Iowa. Claimant graduated high school in 1987. She subsequently obtained a travel industry diploma and an associate's degree in information technology. In connection with her work at Shopko, claimant earned a certified pharmacy technician certificate. (Claimant's testimony)

Claimant's work history prior to her hire at defendant consists generally of childcare provider, customer service, cashiering, assembler, and pharmacy technician. (Claimant's testimony; CE8, pages 30-40) She began as a part-time cashier in the pharmacy of a Shopko store and worked in this capacity during 2010 and 2011. She earned $7.75 or $8.00 per hour. Claimant then earned her pharmacy technician certification and began work at Shopko as a full time pharmacy tech. She remained in this position into 2015. During her time as a pharmacy tech at Shopko, claimant earned

$9.00 per hour and her highest annual earnings were $17,715.31. (Claimant's testimony; CE8, pp. 39-40; DED, pp. 1-6)

On May 29, 2014, claimant presented to her personal care provider, Shumalia Masood, M.D. with complaints of right shoulder pain with radiation to the right ear. Claimant reported the symptoms began six weeks prior, without known injury. Dr. Masood assessed right shoulder pain and limited range of motion; she ordered x-rays and a course of physical therapy. Dr. Masood also assessed depression and prescribed Wellbutrin. (JE2, pp. 1-2) Per Dr. Masood's order, claimant underwent x-rays of the right shoulder that same date. The radiologist opined the films demonstrated calcific density, most likely reflecting calcific tendinitis. (JE1, p. 1)

On September 8, 2015, claimant was involved in a front-impact motor vehicle accident at a speed of approximately 20 miles per hour. Claimant was transported to the emergency room, where she reported striking her head. Claimant complained of moderate head pain, as well as pain in her chest, abdomen, and right-sided neck. (JE1, p. 2) She underwent CTs of the chest, head, cervical spine, and abdomen/pelvis. The cervical spine and chest CTs revealed no acute, traumatic findings. The head CT revealed minimal soft tissue swelling. (JE1, pp. 5-7) Following examination and a series of labs, claimant was diagnosed with a head contusion. (JE1, pp. 7-8) She received a fentanyl injection and prescription for Norco. Claimant was removed from work for three days and advised to follow up with her personal care provider. (JE1, pp. 5, 9)

Claimant applied for employment with defendant in December 2015. Claimant underwent a post-offer employment physical on December 4, 2015. The results of the functional testing revealed claimant's body index score corresponded with the sedentary-light physical demand category of work. The provider cleared claimant to perform the essential functions of the pharmacy tech position. (JE4, pp. 1-2) The job description for the pharmacy tech position noted physical demands of: shoulder to overhead lifting of 1 pound frequently; essential reaching at shoulder level or above; and frequent static flexion and rotation of the neck. (CE7, pp. 34-35) She began work as a pharmacy tech on December 14, 2015. Claimant's position was full time, with a base rate of pay of $13.27 per hour. (CE8, pp. 39-40; DEB, p. 1)

Claimant's supervisor, Patricia Hill, testified at evidentiary hearing. Ms. Hill testified the pharmacy tech position is a sedentary to light physical demand job. She estimated the majority of lifting involved weights of three pounds or less. She testified a pharmacy tech is constantly moving her neck during the day, responding to pharmacists, answering phone calls, and pulling medications. Ms. Hill testified pharmacy techs perform medicine pulls which are staggered throughout the day. Each pull takes approximately 30 minutes and is performed about 3 times per shift. During such pulls, techs retrieve medications from bins located from slightly above floor level to overhead. Ms. Hill testified a wheeled stool was available for use and techs were permitted to remove bins and place them at a lower level to work. Additional pharmacy

tech duties included filling the medication machines and IV creation. (Ms. Hill's testimony)

Ms. Hill testified claimant was slow in performance of her duties, even beyond the initial learning period. Ms. Hill testified claimant put forth effort and appeared to try to the best of her abilities, but failed to meet an expected pace and seemed uncomfortable. Claimant's eyesight contributed to her pace, as claimant moved items close to her face to read. Her eyesight also led to errors and difficulties in the IV room. (Ms. Hill's testimony)

In mid-March 2016, defendant disciplined claimant with a written warning for attendance issues. Claimant's absences were noted as unacceptable, with claimant accumulating 19 attendance points since January 2016 for absences and tardiness. (DEC, p. 1) At 30 attendance points within a 12-month period, defendant recommends termination. (Ms. Hill's testimony)

At the time of this warning, Ms. Hill testified she and claimant spoke about claimant's duties. Ms. Hill testified claimant relayed difficulty with IV room tasks. At this point, Ms. Hill testified she began to look into more suitable positions for claimant within defendant. She introduced claimant to the manager of defendant's retail pharmacy, as opposed to the hospital side. Claimant expressed interest, but declined to transfer as the only available position was part-time. (Ms. Hill's testimony)

Ms. Hill's testimony was clear, professional, and consistent with the evidentiary record. Her demeanor was excellent and gave the undersigned no reason to doubt her veracity. Ms. Hill is found credible.

Claimant testified she last worked at defendant on April 11, 2016. At that time, she began to feel ill and sought medical care. (Claimant's testimony) Claimant did not return to work at defendant following mid-April 2016. She was paid sick time and short term disability benefits. (DEF, pp. 2-13)

On April 15, 2016, claimant presented to Christopher Morse, D.O. with complaints of headaches and associated neck spasms. Dr. Morse assessed tension headaches and segmental and somatic dysfunction of the head region. Dr. Morse performed osteopathic treatment and removed claimant from work until April 19, 2016. (JE5, pp. 1-2)

Claimant also sought care with Dr. Masood. Dr. Masood excused claimant from work on April 19, 2016, to return on April 20, 2016. (JE2, p. 3) On April 22, 2016, Dr. Masood excused claimant from work until April 24, 2016. (JE2, p. 4)

Per an order from Dr. Masood, claimant underwent a brain MRI on April 26, 2016. The radiologist opined the results revealed a white matter pattern of findings nonspecific for claimant's age. Differential diagnoses were noted as including demyelinating disorders; dysmyelinating disorders; small vessel disease; Lyme disease;

and migraine headaches. (JE1, p. 10) Following receipt of the MRI, Dr. Masood authored a letter to claimant that same date. Thereby, Dr. Masood informed claimant the brain MRI revealed she may possible have a migraine disorder versus some inflammation of the blood vessels in the brain. As Topamax had been trialed, Dr. Masood recommended neurosurgical evaluation and treatment. (JE2, p. 5)

On May 5, 2016, claimant presented to neurologist, Thomas Pfiffner, M.D. Claimant complained of headaches, dizziness, nausea, numbness, tingling, and neck pain. (JE6, p. 2) Dr. Pfiffner performed a physical and neurological examination. He assessed cervicogenic migraine headaches and paravertebral muscular spasm; he opined claimant likely suffered a whiplash injury in the September 2015 motor vehicle accident. Dr. Pfiffner prescribed medication and ordered physical therapy for headaches. (JE6, pp. 3-4) He removed claimant from work. (JE6, pp. 7-8)

On May 16, 2016, claimant returned to Dr. Pfiffner for evaluation of headache complaints. Claimant reported continued neck pain radiating into the suboccipital and temporal regions. Dr. Pfiffner performed an examination and assessed cervicogenic migraine/headaches. He recommended medication and a course of physical therapy. (JE2, pp. 6-7; JE6, pp. 13-15)

Claimant returned to Dr. Pfiffner on June 2, 2016. She complained of constant, daily headaches, with pain also going down the left side of her neck into the left shoulder. Due to the recent development of left shoulder pain, Dr. Pfiffner reviewed claimant's prior right shoulder x-ray and opined it appeared to show hydroxyapatite deposition disease in the rotator cuff tendon. He questioned if the same were present in claimant's left shoulder. (JE2, p. 8; JE6, p. 17) Dr. Pfiffner noted diagnoses of cervicogenic migraine, left shoulder pain, and hydroxyapatite deposition disease of the shoulders. He ordered left shoulder x-rays and an orthopedic referral for the left shoulder, as well as a second opinion at the Mayo Clinic relative to headache complaints. Dr. Pfiffner indicated he saw no reason claimant could not work from a neurological standpoint, but kept claimant off work pending orthopedic evaluation. (JE2, p. 9; JE6, p. 19) At Dr. Pfiffner's direction, claimant underwent left shoulder x-rays on June 2, 2016. The radiologist opined the x-rays revealed mild degenerative arthritic changes of the left glenohumeral joint and amorphous calcification, likely sequela of chronic calcific tendinitis. (JE1, p. 11; JE6, p. 20)

Pursuant to Dr. Pfiffner's order, on June 3, 2016, claimant presented for orthopedic evaluation of left shoulder pain with Chad Boyer, PA. Claimant reported involvement in a motor vehicle accident where she struck her head and face. Claimant reported she had been experiencing headaches and associated numbness of her face and left arm. Mr. Boyer noted a referral had been made to Mayo Clinic. Claimant also reported bilateral shoulder pain, left much worse than right, with symptoms extending down the arm into the hand. (JE2, p. 11; JE6, p. 21)

Mr. Boyer reviewed claimant's left shoulder x-rays and opined they revealed calcific tendinitis of the rotator cuff insertion on the greater tuberosity of the shoulder;

inferior osteophyte at the humeral head; and mild-to-moderate degenerative change at the acromioclavicular joint. He performed a physical examination. (JE2, p. 12; JE6, p. 23) Mr. Boyer assessed left shoulder pain, with a suspicion of impingement or bursitis with acromioclavicular arthritis. He performed a subacromial cortisone injection. (JE2, p. 13; JE6, pp. 23-24)

Pursuant to Dr. Pfiffner's recommendation, claimant presented to the Mayo Clinic Neurology department on June 15, 2016. Aaron Bubolz, D.O. examined claimant. Claimant reported a chief complaint of headaches, beginning approximately two months prior, as well as left-sided neck and shoulder pain. (JE8, pp. 6-7) Following examination, Dr. Bubolz issued diagnoses including headaches, with history and examination suggestive of chronic migraine without aura. Dr. Bubolz opined claimant's neck pain might play a role, but was insufficient to establish a diagnosis of cervicogenic headaches per se, given her past history and the length of time between the whiplash injury and onset of headaches. Dr. Bubolz also noted an assessment of possible subclinical left occipital neuralgia. He prescribed medication for symptomatic and prophylactic use. (JE8, p. 13)

On July 11, 2016, claimant returned to Mr. Boyer with complaints of left shoulder pain. Claimant reported one to two days of symptomatic relief following the cortisone injection. Mr. Boyer ordered a left shoulder MRI and follow up with a shoulder surgeon. (JE2, pp. 18-19; JE6, pp. 28, 30)

Claimant underwent a left shoulder MRI on July 18, 2016. The radiologist opined it revealed advanced glenohumeral and moderate acromioclavicular degenerative change; severe thickening of the supraspinatus and infraspinatus tendons consistent with tendinopathy; and associated calcific deposits. (JE1, p. 12; JE6, p. 31)

On July 26, 2016, claimant presented to Richard Rattay, M.D. Claimant reported she had not worked since April 2016 due to development of significant headaches. Claimant indicated she was participating in physical therapy for head and neck complaints in March 2016 and around that time, she also developed left shoulder pain. Claimant reported her left shoulder had bothered her off and on since 2013, specifically when she worked at Shopko. (JE1, p. 13; JE6, p. 32)

Dr. Rattay reviewed claimant's left shoulder x-rays and opined they revealed moderate glenohumeral osteoarthritis with inferior osteophyte at the humeral head; calcific tendinitis or tendinosis of the supraspinatus insertion at the humeral head; moderate acromioclavicular joint arthrosis; type II-III acromion; and minimal high riding of the humerus at the glenoid. He opined claimant's left shoulder MRI revealed advanced glenohumeral osteoarthritis; moderate acromioclavicular joint arthrosis; severe thickening of the supraspinatus and infraspinatus consistent with tendinopathy; and calcific deposits at the supraspinatus. (JE1, p. 14; JE6, p. 34) Dr. Rattay performed a physical examination. (JE1, p. 14; JE6, pp. 33-34)

Thereafter, Dr. Rattay assessed impingement syndrome of the left shoulder and neck pain. Dr. Rattay noted claimant had been treated for left-sided neck pain and left-sided headaches, but was not responding well to treatment. He noted claimant developed left shoulder pain around the same time and remained symptomatic with partial relief of symptoms following corticosteroid injection. Dr. Rattay expressed belief the majority of claimant's symptoms were most likely coming from the shoulder, but noted the potential of cervical radiculopathy. As a result, Dr. Rattay performed a diagnostic and therapeutic injection of the glenohumeral joint and ordered a cervical spine MRI. (JE1, pp. 14-15; JE6, pp. 34-35)

Pursuant to Dr. Rattay's order, claimant underwent cervical spine x-rays and MRI on August 2, 2016. X-ray revealed minimal degenerative changes of the cervical spine with mild loss of normal cervical lordosis. (JE1, p. 16; JE6, p. 38) The radiologist opined the MRI revealed right paracentral disc protrusion at C5-C6, contacting the cord but without stenosis; tiny, likely insignificant, left paracentral C6-C7 protrusion; and enlarged sella with suspected empty sella turnica or arachnoid cyst. (JE1, p. 17; JE6, p. 36)

On August 11, 2016, claimant returned to Dr. Rattay. Following MRI review, Dr. Rattay assessed neck pain and left shoulder impingement syndrome. Dr. Rattay expressed belief the majority of claimant's symptoms arose from the shoulder and noted claimant had demonstrated early osteoarthritis at the glenohumeral joint, impingement pathology, and acromioclavicular joint pain. He discussed surgical options with claimant relative to the left shoulder. Prior to proceeding, Dr. Rattay referred claimant for cervical spine treatment in a pain clinic, in hopes of better determining whether claimant's neck played a role in claimant's symptomatology. (JE6, p. 40) Dr. Rattay imposed activity restrictions. (JE6, pp. 45, 47)

Over time, claimant began to believe her complaints were related to her work activities at defendant. (Claimant's testimony) On August 15, 2016, claimant reported her conditions to defendant as allegedly work-related. (CE2, p. 25)

At Dr. Rattay's referral, on August 16, 2016, claimant presented to pain management physician, Ronald Kloc, D.O. Claimant complained of headaches and pain of her left neck and arm. (JE2, p. 22; JE6, p. 42) Dr. Kloc examined claimant. (JE2, p. 23; JE6, pp. 43-44) He reviewed claimant's cervical spine MRI and opined it revealed modestly prominent disc bulge at C5-C6 paramedian right; smaller disc bulge at C6-C7 paramedian left; and hypertrophic facet at C7-T1. (JE2, p. 23; JE6, p. 44) Dr. Kloc assessed cervical spondylosis without myelopathy and cervical disc displacement. Dr. Kloc identified two possible causes of claimant's symptoms. He opined the bulge at C6-C7 caused a bit of mild stenosis. He also opined the hypertrophic facet at C7-T1 was the more likely cause of headache symptoms. (JE2, p. 23; JE6, p. 44) Dr. Kloc advised claimant to return for medial branch blocks at C7 and T1. (JE2, p. 24; JE6, p. 44)

On September 26, 2016, Dr. Kloc performed left-sided C7-T1 medial branch blocks. (JE6, p. 51; JE10, p. 1)

On October 11, 2016, claimant returned to Dr. Rattay for evaluation. As claimant had recently reported her conditions as alleged work-related injuries, a case manager was present. Claimant complained of pain of her neck, shoulder, and head, all on the left side. She denied improvement following the injection by Dr. Kloc. (JE6, p. 54) Dr. Rattay performed an examination and assessed impingement syndrome of the left shoulder. Dr. Rattay expressed belief claimant had maximized conservative care measures. Surgical options were discussed and Dr. Rattay advised arthroscopy provided a 50 percent chance of improving symptoms, with improvement represented as 50 percent better than current symptoms. Dr. Rattay stressed claimant did not need to proceed with surgery at this time; claimant expressed desire to proceed. (JE6, pp. 55-56) Dr. Rattay opined claimant's left shoulder problem was not work-related. He opined claimant presented with significant pathology of the shoulder; however, on imaging, the pathology appeared longstanding. He also commented claimant did not recall any specific injury at work. (JE6, p. 54)

Claimant's short term disability benefits expired in mid-October 2016. In total, she collected short term disability benefits from April 17, 2016 through October 15, 2016. The gross sum of benefits was $7,553.56; claimant's net benefit was $5,531.91. (DEF, pp. 1-13) Ms. Hill testified such benefits are provided and paid by defendant for non-occupational injuries only. (Ms. Hill's testimony)

Claimant returned to Dr. Kloc on October 18, 2016. She denied any good relief with medial branch blocks. Dr. Kloc advised claimant to proceed with shoulder surgery in hopes of relieving neck and arm symptoms prior to undergoing further injections. (JE6, pp. 58-59) However, claimant subsequently underwent two epidural steroid injections at C6-C7 on December 8, 2016 and January 11, 2017. (JE6, pp. 69, 71; JE10, pp. 3, 5)

On November 17, 2016, claimant received notice of termination from defendant. Jackie Luccht advised claimant her organizational leave expired in October 2016 and defendant was unable to accommodate claimant's existing work restrictions. As a result, claimant's employment was terminated. (CE4, p. 28)

At the referral of defendant, on December 22, 2016, claimant presented for independent medical examination (IME) with board certified occupational medicine physician, Charles Mooney, M.D. (DEA, p. 10) Claimant relayed complaints of neck pain, headaches, and left shoulder symptoms. (DEA, p. 1) She complained of nearly constant daily headaches; ongoing neck pain, left greater than right, with occasional radiation to the shoulder and intermittent numbness of her face and hands; and left shoulder pain. (DEA, p. 4) Dr. Mooney examined claimant. (DEA, pp. 5-6) He reviewed and summarized provided medical records. (DEA, pp. 1-3) One such record reviewed was a job analysis authored by a therapist; Dr. Mooney noted no evidence of risk factors for shoulder or cervical spine pathology. (DEA, pp. 3-4)

Following interview, records review, and examination, Dr. Mooney issued diagnoses relative to claimant's cervical spine, bilateral shoulders, and headaches. With respect to claimant's neck, Dr. Mooney assessed MRI evidence of degenerative facet and disc disease of the cervical spine, without evidence of specific radiculopathy or myelopathy, and without response to usual treatments. With respect to the shoulders, Dr. Mooney assessed evidence of calcific tendinosis of the left and right shoulders associated with glenoid osteoarthropathy. Finally, with respect to the headaches, Dr. Mooney assessed chronic headache complaints with a history of migraine and symptoms most consistent with migraine. (DEA, p. 6)

Dr. Mooney addressed the question of potential causal relationship between claimant's conditions and her work activities at defendant. Dr. Mooney opined claimant's cervical spine condition was unrelated to her activities at defendant during her brief period of employment. He opined the job analysis did not demonstrate evidence of occupational risk factors for a direct causal factor or as a material aggravator for claimant's diagnosis and existing complaints. Dr. Mooney also noted claimant's history of cervical injury in September 2015 and whiplash syndrome, which he opined could be considered a risk factor for her current neck complaints, although also inconsistent with claimant's headache pattern. (DEA, p. 6) Dr. Mooney opined claimant's headache condition was long-standing and related to migraine symptoms. Dr. Mooney opined claimant's bilateral shoulder calcific tendinosis and advanced glenohumeral arthropathy were also unrelated to claimant's work activities. He opined there was no evidence of causal or aggravating factors in claimant's job duties. (DEA, p. 7)

Dr. Mooney recommended claimant continue treatment at Mayo Clinic for her headache condition. He similarly recommended continued orthopedic evaluation of her shoulder condition. Dr. Mooney opined claimant had failed reasonable interventions with respect to her neck. Dr. Mooney opined claimant was capable of returning to work "at whatever level" she desired. However, he admitted claimant would experience difficulty with repeated overhead lifting with the left shoulder. In response to inquiry as to estimation of claimant's dates of maximum medical improvement and permanent disability, Dr. Mooney opined these factors were not applicable due to lack of causal connection to claimant's work activities. (DEA, p. 7)

Claimant underwent left shoulder surgery with Dr. Rattay on January 23, 2017. The procedure consisted of left shoulder arthroscopic subacromial decompression; distal clavicle resection; labral, biceps, and glenohumeral wear and tear debridement; and partial rotator cuff tear debridement. (JE1, pp. 18-19)

Claimant was unhappy with the care rendered to her by Dr. Masood. As a result, she established care with Stephen Holmes, M.D. and Tara Eisenlohr, ARNP. Care included prescription medication and referrals to appropriate specialists. (JE9, p. 1; JE11)

On March 16, 2017, claimant presented to neurosurgeon Sandeep Bhangoo, M.D. for evaluation. Claimant complained of pain on the left side of her head, extending down into the neck and shoulder; similar symptoms were described as present occasionally on the right side as well. (JE12, p. 1) Dr. Bhangoo performed an examination and reviewed the MRIs of claimant's cervical spine and brain. Dr. Bhangoo opined he lacked surgical options. He and claimant discussed her frustration with her lack of progress, despite seeing multiple specialists. In order to rule out a potential diagnosis of pseudotumor, Dr. Bhangoo referred claimant for an ophthalmology examination to search for papilledema. (JE12, p. 2)

On April 3, 2017, claimant presented to Michael Korthals, D.O., at Dr. Bhangoo's direction. Dr. Korthals performed an ophthalmologic examination and found no signs of papilledema. (JE13, p. 7) Following receipt of Dr. Korthals' report denoting no papilledema, Dr. Bhangoo authored a letter to Ms. Eisenlohr. Dr. Bhangoo opined the pseudotumor diagnosis was unlikely and he lacked other care options. (JE12, p. 5)

Following left shoulder surgery, claimant followed up periodically with Dr. Rattay. At an appointment April 18, 2017, claimant reported improvement in shoulder pain, but denied improvement in headaches or neck pain. Dr. Rattay ordered six additional weeks of physical therapy, followed by a home exercise program. He imposed temporary work restrictions and released claimant to full duty without restrictions effective May 30, 2017. No further follow up was scheduled, with claimant advised to return as needed. (JE6, pp. 89-90)

On May 3, 2017, claimant underwent clinical assessment with psychologist, Dan Courtney. (JE3)

On May 8, 2017, claimant presented to Rajinder Verma, M.D. for neurology consult related to chronic headaches and neck pain. (JE6, p. 91) Following examination, Dr. Verma assessed: chronic daily headaches, mostly tension-type with a component of cervicogenic headaches; symptoms suggestive of obstructive sleep apnea in the context of obesity; and chronic musculoskeletal neck pain related to musculoligamentous strain without clinical evidence of cervical radiculopathy or myelopathy. He ordered a series of labs and a sleep study; he also prescribed medication. (JE6, pp. 95-96)

At the arranging of claimant's counsel, on August 4, 2017, claimant presented to board certified occupational medicine physician, Sunil Bansal, M.D. for IME. Dr. Bansal issued a report containing his findings and opinions on September 29, 2017. (CE1, pp. 1, 24) Dr. Bansal reviewed claimant's medical records and authored a summary. (CE1, pp. 1-13) He performed a physical examination. (CE1, pp. 16-18)

Dr. Bansal also interviewed claimant. Claimant reported sustaining progressive injuries to her head, neck, and left shoulder. She indicated she initially stayed home from work because she felt unwell; she then began to develop headaches and aching neck pain around the same timeframe. She also began to experience issues with left

hand strength and subsequently, left shoulder pain. (CE1, p. 13) Claimant described a number of current complaints, including: severe headaches; inability to fully turn her head to the left; constant neck pain; occasional sharp shooting pains in the neck; frequent to occasional left shoulder pain; decreased range of motion of the left shoulder; and the inability to lift above shoulder level with the left arm. (CE1, pp. 15-16)

Claimant described her job duties for Dr. Bansal. He noted claimant's duties involved stretching and reaching to retrieve medications from overhead bins. Claimant reported she "constantly" pulled medications and filled orders; once orders were filled, she delivered medications throughout the hospital. Claimant estimated lifting over shoulder level for a "good portion" of her shift, but spent a greater portion looking down to fill orders. (CE1, p. 16)

Claimant disclosed a prior history of migraines in her 20s, as well as a motor vehicle accident in September 2015. Claimant reported she experienced neck pain following the motor vehicle accident, but reported the symptom resolved. Dr. Bansal noted claimant had also seen a physician for chronic headaches. (CE1, p. 13)

Following interview, records review, and examination, Dr. Bansal offered opinions with respect to any causal relationship between claimant's conditions and her work activities. Dr. Bansal opined he was unable to causally relate claimant's neurologic symptoms to her work activities. (CE1, p. 20) However, he opined claimant sustained work-related cumulative injuries to her left shoulder and neck. (CE1, p. 23) He opined claimant's cumulative job duties were highly pathognomonic for the shoulder pathology demonstrated by claimant, specifically shoulder impingement. Dr. Bansal highlighted the significant amount of over shoulder level lifting, in particular. (CE1, pp. 22-23) With respect to claimant's neck condition, Dr. Bansal opined claimant's cumulative work activities were a significant contributing factor for aggravation of cervical spondylosis, with the development of C5-C6 and C6-C7 disc protrusions. Dr. Bansal reasoned claimant's duties involved considerable over shoulder level work, requiring constant extension of the neck, as well as constant flexion of the neck while filling orders. (CE1, p. 20) Dr. Bansal acknowledged claimant experienced neck pain following the September 2015 motor vehicle accident. He noted claimant was cleared in the emergency department and passed a rigorous preemployment physical. Dr. Bansal also noted claimant reported her symptoms resolved and did not involve the current complaint of left-sided radicular arm pain which was consistent with left-sided C6-C7 disc protrusion. (CE1, pp. 21-22)

Dr. Bansal opined claimant had achieved maximum medical improvement (MMI) for her neck and left shoulder conditions. He assigned dates of May 8, 2017 to the neck condition and April 18, 2017 to the left shoulder condition. (CE1, p. 18) Dr. Bansal also offered opinions with respect to the extent of claimant's permanent impairment as a result of her claimed injuries. Dr. Bansal opined claimant sustained no ratable impairment for her neurologic symptoms. For the left shoulder rotator cuff tear and impingement syndrome, status post arthroscopy, Dr. Bansal opined a combined impairment of 15 percent upper extremity or 9 percent whole person based upon

decrements in range of motion and surgical intervention. Dr. Bansal opined claimant's left-sided C6-C7 disc protrusion with radicular complaints, spasms, and loss of range of motion warranted a DRE Cervical Category II rating, corresponding to an impairment of 8 percent whole person. (CE1, p. 19)

Dr. Bansal recommended permanent restrictions of: maximum lift of 30 pounds occasionally or 15 pounds frequently; no overhead lifting or reaching; and avoidance of repeated neck motion or prolonged posturally flexed positions. (CE1, p. 23) He opined claimant was unable to meet the physical demand level of her former position. (CE1, p. 24) In terms of future treatment, Dr. Bansal recommended maintenance care potentially including medications, injections, physical therapy, TENS unit, or pain management specialist evaluation. (CE1, p. 23)

Claimant applied for services from Iowa Vocational Rehabilitation Services. Claimant was informed services were immediately available to her as she had been placed in the significantly disabled category of worker. (CE3, p. 27) From June to September 2017, claimant worked for Iowa Vocational Rehabilitation as an office assistant. She worked part time, 20 hours per week, and earned $7.25 per hour. (CE8, pp. 39-40) In September 2017, claimant obtained employment with the Mason City School District as a teacher's assistant. She worked part-time, 20 hours per week, and earned $12.15 per hour. (CE8, pp. 39-40)

CONCLUSIONS OF LAW

The first issue for determination is whether claimant sustained an injury on April 11, 2016 which arose out of and in the course of her employment.

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 alleged injury actually occurred and that it both arose out of and in the course of the employment. Quaker Oats Co. v. Ciha, 552 N.W.2d 143 (Iowa 1996); Miedema v. Dial Corp., 551 N.W.2d 309 (Iowa 1996). The words "arising out of" referred to the cause or source of the injury. The words "in the course of" refer to the time, place, and circumstances of the injury. 2800 Corp. v. Fernandez, 528 N.W.2d 124 (Iowa 1995). An injury arises out of the employment when a causal relationship exists between the injury and the employment. Miedema, 551 N.W.2d 309. The injury must be a rational consequence of a hazard connected with the employment and not merely incidental to the employment. Koehler 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.

A personal injury contemplated by the workers' compensation law means an injury, the impairment of health or a disease resulting from an injury which comes about, not through the natural building up and tearing down of the human body, but because of trauma. The injury must be something that acts extraneously to the natural processes of nature and thereby impairs the health, interrupts or otherwise destroys or damages a part or all of the body. Although many injuries have a traumatic onset, there is no requirement for a special incident or an unusual occurrence. Injuries which result from cumulative trauma are compensable. Increased disability from a prior injury, even if brought about by further work, does not constitute a new injury, however. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); Ellingson v. Fleetguard, Inc., 599 N.W.2d 440 (Iowa 1999); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995); McKeever Custom Cabinets v. Smith, 379 N.W.2d 368 (Iowa 1985). An occupational disease covered by chapter 85A is specifically excluded from the definition of personal injury. Iowa Code section 85.61(4)(b); Iowa Code section 85A.8; Iowa Code section 85A.14.

When the injury develops gradually over time, the cumulative injury rule applies. The date of injury for cumulative injury purposes is the date on which the disability manifests. Manifestation is best characterized as that date on which both the fact of injury and the causal relationship of the injury to the claimant's employment would be plainly apparent to a reasonable person. The date of manifestation inherently is a fact based determination. The fact-finder is entitled to substantial latitude in making this determination and may consider a variety of factors, none of which is necessarily dispositive in establishing a manifestation date. Among others, the factors may include missing work when the condition prevents performing the job, or receiving significant medical care for the condition. For time limitation purposes, the discovery rule then becomes pertinent so the statute of limitations does not begin to run until the employee, as a reasonable person, knows or should know, that the cumulative injury condition is serious enough to have a permanent, adverse impact on his or her employment. Herrera v. IBP, Inc., 633 N.W.2d 284 (Iowa 2001); Oscar Mayer Foods Corp. v. Tasler, 483 N.W.2d 824 (Iowa 1992); McKeever Custom Cabinets v. Smith, 379 N.W.2d 368 (Iowa 1985).

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

The question of causal connection is essentially within the domain of expert testimony. The expert medical evidence must be considered with all other evidence introduced bearing on the causal connection between the injury and the disability. Supportive lay testimony may be used to buttress the expert testimony and, therefore, is also relevant and material to the causation question. The weight to be given to an

expert opinion is determined by the finder of fact and may be affected by the accuracy of the facts the expert relied upon as well as other surrounding circumstances. The expert opinion may be accepted or rejected, in whole or in part. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); IBP, Inc. v. Harpole, 621 N.W.2d 410 (Iowa 2001); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995). Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417 (Iowa 1994). Unrebutted expert medical testimony cannot be summarily rejected. Poula v. Siouxland Wall & Ceiling, Inc., 516 N.W.2d 910 (Iowa App. 1994).

Claimant has brought claims regarding alleged neurological injury, as well as injuries to her neck and left shoulder. Each of claimant's claimed injurious conditions will be addressed individually.

Claimant alleges neurological injury, including chronic headaches. She was examined by a number of physicians and specialists, including neurologists and neurosurgeons. None of the treating physicians offered specific opinions with respect to any causal relationship between claimant's work activities and neurological complaints. However, both parties' IME physicians offered opinions on causal connection. Dr. Mooney opined claimant's neurological complaints, specifically chronic headaches, were longstanding and related to migraine symptoms. He specifically opined claimant's neurological complaints were not work-related. Claimant's own IME physician, Dr. Bansal, opined he was unable to relate claimant's neurological symptoms to her work activities.

As no physician has related claimant's neurological symptoms to her work activities and two physicians have specifically opined no such causal relationship exists, claimant's claim for neurological injury must fail. Claimant has failed to carry her burden of proving, by a preponderance of the evidence, that she sustained a neurological injury arising out of and in the course of her employment with defendant.

Claimant alleges she also sustained a neck injury as a result of her job duties. Claimant's cervical complaints were the subject of significant work up and evaluations with multiple physicians. None of the treating physicians offered opinions with respect to causal connection between claimant's cervical condition and her work activities. Both parties' IME physicians did offer specific opinions with respect to causation. Dr. Mooney opined claimant presented with degenerative facet and disc disease without evidence of specific radiculopathy or myelopathy. He opined the condition was not work-related, citing a lack of risk factors for injury or aggravation of a condition. Dr. Bansal opined claimant's cervical condition was work-related and opined claimant's cumulative work activities were a significant contributing factor for aggravation of cervical spondylosis with development of C5-C6 and C6-C7 disc protrusions. He specifically highlighted claimant's performance of considerable over shoulder level work requiring constant extension of the neck, as well as filling orders which required constant flexion of the neck. Dr. Bansal also opined claimant's current complaints of radicular arm pain were consistent with left-sided C6-C7 disc protrusion.

Following review of the entirety of the evidentiary record with respect to claimant's neck condition, I award greater weight to the opinion of Dr. Mooney on the question of causation. Dr. Bansal's opinion that claimant experiences radicular arm pain is inconsistent with the weight of the medical evidence, notably the opinion of specialist, Dr. Verma. Dr. Verma specifically found no clinical evidence of cervical radiculopathy, as did Dr. Mooney. I am also unconvinced Dr. Bansal possessed an accurate understanding of claimant's job duties prior to the alleged work injury. Dr. Bansal specifically referenced considerable over shoulder level work requiring constant extension, as well as constant flexion while filling orders. This conclusion appears largely based on claimant's own descriptions of her work duties and her use of words which do not align with occupational categories. Ms. Hill's clear and credible testimony regarding claimant's work functions does not align with Dr. Bansal's apparent understanding of claimant's duties. Dr. Mooney's opinion, relying in part upon a job analysis, does comport with Ms. Hill's testimony.

As I award greater weight to the opinion of Dr. Mooney with respect to the question of causation of claimant's neck condition, I find claimant has failed to prove by a preponderance of the evidence that her cervical condition is causally related to her work duties at defendant.

Finally, claimant alleges injury to her left shoulder. Claimant received significant evaluation and treatment of her left shoulder condition, including surgery with Dr. Rattay. Dr. Rattay opined claimant's left shoulder condition was not work-related. He opined claimant's pathology appeared longstanding. Dr. Mooney opined claimant's shoulder condition was unrelated to her work duties, as her duties lacked risk factors for such injury. Dr. Bansal opined claimant's cumulative job duties, specifically the significant amount of over shoulder level reaching, were highly pathognomic for claimant's shoulder condition.

Following review of the entirety of the record, I award greatest weight to the opinions of Dr. Rattay, as buttressed by Dr. Mooney, with respect to causal relationship between claimant's left shoulder condition and work duties at defendant. Dr. Rattay acted as claimant's treating surgeon. He possessed the opportunity to examine and interact with claimant regarding her shoulder complaints over a prolonged period of time. He possesses expertise in shoulder surgery and observed claimant's shoulder intraoperatively. Dr. Rattay opined claimant's condition was not work related, as did Dr. Mooney. Dr. Bansal's opinion that claimant's condition is work related relies upon performance of a significant amount of over shoulder level work. As identified *supra*, I find Dr. Bansal lacked an accurate understanding of claimant's job duties at defendant.

As I award greatest weight to the opinions of Drs. Rattay and Mooney on the question of causation of claimant's left shoulder condition, claimant's claim of shoulder injury must fail. I find claimant has failed to prove, by a preponderance of the evidence, that her left shoulder injury is causally related to her work duties at defendant.

Claimant has failed to prove a causal relationship between her work duties at defendant and her neurological, neck, and left shoulder conditions. As such, consideration of the following issues is unnecessary: causation as to temporary disability; entitlement to temporary disability benefits; causation as to permanent disability; extent of any industrial disability; the extent of defendant's credit for sick pay and short term disability benefits; whether defendant is responsible for claimed medical expenses and medical mileage; and whether claimant is entitled to penalty benefits under Iowa Code section 86.13 and, if so, how much.

The next issue for determination is whether claimant is entitled to reimbursement of an IME under Iowa Code section 85.39.

Section 85.39 permits an employee to be reimbursed for subsequent examination by a physician of the employee's choice where an employer-retained physician has previously evaluated "permanent disability" and the employee believes that the initial evaluation is too low. The section also permits reimbursement for reasonably necessary transportation expenses incurred and for any wage loss occasioned by the employee attending the subsequent examination.

Defendant is responsible only for reasonable fees associated with claimant's IME. Claimant has the burden of proving the reasonableness of the expenses incurred for the examination. See Schintgen v. Economy Fire & Casualty Co., File No. 855298 (App. April 26, 1991). Claimant need not ultimately prove the injury arose out of and in the course of employment to qualify for reimbursement under section 85.39. See Dodd v. Fleetguard, Inc., 759 N.W.2d 133, 140 (Iowa App. 2008).

If the evaluation by the physician retained by the employer includes a permanent disability rating and "the employee believes this evaluation to be too low," the employee may obtain a subsequent examination by a physician of the employee's choice and be reimbursed by the employer for the reasonable fee of the examination, plus transportation expenses. Des Moines Area Reg'l Transit Auth. v. Young, 867 N.W.2d 839, 843 (Iowa 2015).

Claimant seeks an order of reimbursement for Dr. Bansal's IME in the amount of $2,988.00. (CE15, p. 51) However, at the time of Dr. Bansal's IME, no employer-retained physician had opined as to the extent of claimant's permanent disability. Dr. Mooney offered opinions on causation, but did not offer opinions on the extent of permanent disability. As such, claimant's right to a reimbursable section 85.39 IME was not triggered. Accordingly, claimant is not entitled to reimbursement of Dr. Bansal's IME.

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 fee ($6.74); and Dr. Bansal's report ($2,414.00). As claimant failed to prevail on any element of her claim, costs are properly borne by claimant.

ORDER

THEREFORE, IT IS ORDERED:

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

Claimant shall take nothing from these proceedings.

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

Costs are taxed to claimant pursuant to 876 IAC 4.33.

Signed and filed this 2nd day of January, 2019.

ERICA J. FITCH
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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EJF/srs

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