BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

NICHOLAS D. LORENZEN, Claimant, vs. FIRST STUDENT, Employer, and NEW HAMPSHIRE INSURANCE COMPANY, Insurance Carrier, Defendants.	FILED APR 03 2018 WORKERS COMPENSATION	File No. 5057885 ARBITRATION DECISION Head Note Nos.: 1802, 1803, 2502

STATEMENT OF THE CASE

Nicholas Lorenzen, claimant, filed a petition in arbitration seeking workers' compensation benefits against First Student, employer, and New Hampshire Insurance Company for an accepted work injury.

This case was heard on January 17, 2018, in Council Bluffs, Iowa. The case was considered fully submitted on February 9, 2018, upon the simultaneous of filing of briefs.

The record consists of Joint Exhibits 1-12, Claimant's Exhibits 1-4, Defendants' Exhibits B-L. Exhibit A was offered but claimant objected to its admission based on timeliness. A ruling on the admission is incorporated herein.

ISSUES

Whether Exhibit A, a late-served report from a medical expert, should be admitted;

Whether the injury is a cause of temporary disability and, if so, the extent;

Whether the injury is a cause of permanent disability and, if so,;

The appropriate commencement date of permanent disability benefits;

The extent of claimant's industrial disability;

Whether claimant is entitled to an independent medical evaluation (IME) under Iowa Code section 85.39;

Whether claimant is entitled to an assessment of 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 on December 13, 2013, which arose out of and in the course of his employment. They further agree that the injury was the cause of some temporary disability during a period of recovery and that it was the cause of a permanent disability that is industrial in nature.

At the time of the injury, the claimant's gross earnings were $359.00 per week. He was married and entitled to 4 exemptions. Based on the foregoing numbers the weekly benefit rate is $259.27.

Prior to the hearing the claimant was paid 50 weeks of permanent partial disability benefits at the rate of $259.27. The parties agree the defendants are entitled to reimbursement or credit of that amount against any award of permanent partial disability benefits.

Findings of Fact

Claimant was a 44-year-old person at the time of the hearing. He has a high school education, graduating in the top 25 percent of his class. He has no behavioral or learning disabilities. His past work history includes cleaning and maintenance, general labor, route sales, shipping and receiving clerk, security guard, self-employed truck driver, Council Bluffs school district truck driver, and his work for the defendant employer as a school bus driver. He reported to vocational rehabilitation services that his highest wage ever was $15,000.00-$16,000.00 per year. (CE 2:6)

He began working for the defendant employer in April 2009 as a bus driver. He worked approximately 4 hours per day, 2 in the morning and 2 in the afternoon with his summers off. At the same time, he was working for the Council Bluffs Community School District operating a local delivery van approximately 20 hours per week. The bus driving position required some light physical duty such as inspections and cleaning. He was required to take a DOT physical each year to be eligible to drive the bus. The DOT physical requires the ability to climb in and out of the bus, pull a 100 pound bag down

the aisle and out the back of the bus and be able to jump in and out of the emergency exit at the back of the bus.

Claimant testified that prior to the day of his injury he had no problems with his left shoulder. He denied any chronic pain or inability to perform his job duties as a result of any physical ailment.

On December 13, 2013, claimant was working the afternoon route. His hands were in a push/pull position as he was attempting to navigate a left turn. He felt a pop and excruciating pain. He was able to finish his route and then called his injury into the dispatcher.

He was sent to Mercy Hospital at Council Bluffs. An x-ray was conducted as well as the examination. He was sent home with pain medications and ordered to follow up with occupational health. (JE 2) His initial course of treatment was physical therapy through which claimant did not find relief. A December MRI revealed rotator cuff and labrum tears along with degenerative joint disease. (JE 3:6) Ultimately, claimant underwent surgical repair of his right shoulder on February 14, 2014, performed by Charles Rosipal, M.D.

Prior to the surgery, claimant was returned to work. Initially, he wanted to work all 4 hours consecutively instead of 2 hours in the morning and 2 hours in the afternoon which were his regular work hours prior to the injury. He lived 40 miles away from work and was unable to go to a second job because of his shoulder injury. He could not afford to drive home and back and therefore was hoping he could work the consecutive hours and not be forced to sit around for 5 hours between shifts. (JE 3:13)

He contacted Rosipal's office on February 5, 2014 indicating that he had taken himself off of work because his other arm and shoulder was beginning to hurt. He blamed this on overuse and compensation. (JE 4:14) He believed that his work restrictions limited him to sitting at a table for two hours in the morning and two hours in the afternoon. (JE 4:14) The following day, claimant called again indicating that the employer was completely disregarding the work restrictions. The employer had reached out to Dr. Rosipal's office and acknowledged "their error in placing him on bus for light duty." (JE 4:15) It was agreed that claimant would be sitting at a table for four hours in a row to accommodate some of the hardship placed on the claimant due to the distance between home and the employer. In the end claimant felt that it would be better for him financially if he remained off of work due to the cost of fuel. (JE 4:15)

Following surgery, claimant participated in extensive physical therapy, attending over 50 visits. On July 1, 2014, claimant was returned to work to drive a bus, delivery or commercial vehicle. He was not to lift anything greater than 30 pounds at waist level and no lifting greater than 10 pounds of chest height or above. (JE 4:22) On July 29, 2014, claimant was returned to full duty work with no restrictions. (JE 4:23) During the July 29, 2014, visit, claimant reported improvement in his shoulder, however there was constant tingling in the left fourth and fifth digits of his hand. Dr. Rosipal recommended

an EMG testing for cubital tunnel syndrome. He believed that the cubital tunnel syndrome was related to or aggravated by claimant's injury or surgery. (JE 4:23)

Claimant underwent the EMG on August 11, 2014 which revealed no abnormal results. (JE 6)

Claimant returned to full duty but complained of continual pain in the shoulder, reduced range of motion, and biceps pain. Claimant testified that he failed a DOT physical. After this failure, he returned to Dr. Rosipal and another MRI was ordered which revealed a possible new high-grade partial thickness tear of the posterior fibers, consistent with biceps tenotomy, and mild rotator cuff tendinitis. (JE 3:8, 4:24) Dr. Rosipal consulted with another doctor in his office and together they concluded that the MRI results did not show any high-grade component and no repeat surgery was warranted. (JE 4:27) Dr. Rosipal recommended claimant proceed with a functional capacity evaluation. (JE 4:27)

Instead of the functional capacity evaluation, claimant sought out Thomas M. Atteberry, M.D., for a second opinion on September 26, 2014. (JE 7:44) Dr. Atteberry did not believe claimant should go forward with the functional capacity evaluation but instead recommended more physical therapy to address claimant's stiffness and poor motion. (JE 7:44) Dr. Atteberry was unsure whether there was a recurrent tear or simply increased signal noise due to the healing process. (JE 7:45)

On October 23, 2014, in response to an inquiry from counsel for the defendants, Dr. Rosipal authored an opinion letter that future physical therapy would not be of benefit to the claimant and instead he should undertake a functional capacity evaluation to define safe and permanent restrictions. (JE 4: 31)

The claimant returned to Dr. Atteberry for follow-up care on December 2, 2014, wherein Dr. Atteberry suggested a second surgery. (JE 7:49) Instead of surgery, claimant underwent a functional capacity evaluation on December 11, 2014. (JE 8:63) Due to inconsistencies through anatomical and performance principles, the evaluation was deemed invalid. The evaluator agreed that the claimant suffered from discomfort and deficits from the injuries but that the claimant's responses were out of proportion to actual injury. (JE 8:63)

The functional capacity evaluator opined that the claimant's physical conditions were such that he would be unable to safely meet the requirements for reaching, lifting and carrying of a bus driver position. (JE 8:63) Claimant exhibited reduced range of motion in the left shoulder as well as reduced grip strength on the left. (JE 8:64) As for work restrictions, the evaluator recommended the following:

MATERIAL HANDLING ACTIVITES

	Occasional/ 1-33%	**Frequent/ 34-66%**	**Constant 67-100%**
Lifting- Floor to waist	25	_____	_____

Floor to shoulder	25	0	
9 inches to waist	50		
9 inches to shoulder	40	25 (chest level)	
9 inches to overhead	20		
Carrying-			
Box	25	50 feet	
Sled Push	170lbs	50 feet	
Sled Pull	185lbs	50 feet	

Comments: Mr. Lorenzen was able to lift from ground level. He demonstrated a loose grip on the left side. Right upper extremity performed majority of the lift. Push/pull task completed using a weighted sled device.

NON MATERIAL HANDLING ACTIVITIES

	Occasional/ 1-33%	**Frequent/ 34-66%**	**Constant 67-100%**
Stairs	Safe		
Sitting	Frequent		
Standing	Frequent		
Bending (back)	Occasional		
Reaching-forward	Occasional		
Reaching-overhead	Occasional		
Kneeling	Safe		
Walking	Frequent		
Balancing	No loss-of-balance episodes		
Peg Board	Below average coordination (L)		
Driving Simul.	Guarded. Arm tucked into body		

Comments: Mr. Lorenzen was able to navigate 2 flights of stairs with minimal use of 1 rail. He was able to demonstrate a normal step pattern on the stairs. He was able to safely transfer into kneeling position without external support. He required assistance from the wall to transfer to standing. Overhead reach to 73 inches on the left and 87 on the right.

(JE 8:66)

Despite the invalid results, Dr. Rosipal spoke with the therapist who confirmed that the restrictions set forth in the claimant's functional capacity examination were consistent with what the claimant would be able to tolerate. Therefore, Dr. Rosipal adopted those functional capacity evaluations and determined that claimant was left with a permanent partial impairment of the left upper extremity of 12 percent or 7 percent of the whole person. (JE 4:32) Claimant was to return to work with restrictions as outlined in the functional capacity evaluation. (JE 4:32)

On March 23, 2015, claimant began to see Kirk S. Hutton M.D., for a third opinion of his left shoulder. (JE 10:70) Dr. Hutton found claimant to be over reactive and theatrical with his reactions to any testing and did not believe that the claimant gave full effort during the testing. (JE 10:70) Dr. Hutton recorded the following in his examination:

> Cervical spine range of motion is slightly decreased. He has negative Spurling's bilaterally. There is slight tenderness to palpation anteriorly over the left shoulder. Range of motion of the left shoulder consists of active forward flexion to 80° and passive to 145°, although when he realizes that I am bringing the arm up that high, he guards and will not let it go beyond about 100°. External rotation of the left shoulder is to 40° with significant guarding and 50° on the right. Internal rotation is only to the greater trochanter. Again, his range of motion is very inconsistent and will change if he is distracted. Rotator cuff strength is 4/5 throughout, and again, there is questionable effort. He has positive Neer's, Hawkins, Whipple's and pain with Speeds maneuver. Cross-arm adduction causes deep anterior shoulder pain. Belly press maneuver causes slight pain. He has mild weakness with a bear hug maneuver.

(JE 10:70)

Dr. Hutton read the second MRI as showing tendinopathy with abnormality of the upper subscapularis, an anchor near the rotator interval tissue near the biceps groove as well as a significant intrasubstance tearing of the midportion of the supraspinatus that represented a high-grade partial tear involving probably 80 percent of the tendon. (JE 10:71) Dr. Hutton concluded that the patient's symptoms were coming from the high grade partial thickness tear of the supraspinatus but he was not convinced that the injury was actually caused by turning the steering wheel on a bus. He believed that the only injury was to the biceps tendon treated by Dr. Rosipal and that the work injury had resolved. (JE 10: 71) Dr. Hutton did not believe claimant was a good candidate for surgery given his poor conditioning and obesity. (JE 10:71)

Dr. Hutton expanded on his opinions in a checklist letter written by the defendants. In that letter, he agreed that actions taken by the claimant to turn left would not place stress upon a left shoulder but his right. (JE 10:72) Further, he believed that the December 13, 2013 injury impacted his biceps tendon and that was treated satisfactorily by Dr. Rosipal. (JE 10:72) Dr. Hutton provided no cause for the supraspinatus tear but ruled out the bus driving incident. (JE 10:75) After reviewing the records, he also concluded that the second surgery performed by Dr. Atteberry in the summer of 2015 was not reasonable, necessary or related to the work injury of December 13, 2013. (JE 10:75)

Claimant returned to Dr. Atteberry in May 2015 seeking more help for his ongoing left shoulder problems. Dr. Atteberry agreed to perform a surgery but warned the claimant that the surgery would be very difficult and he could not provide any surety regarding the outcome because of claimant's weight, previously failed rotator cuff repair, and the length of time the long head of his biceps tendon had been torn. (JE 7:49) The

surgery took place on June 15, 2015. The surgery revealed no recurrent tear. Dr. Atteberry performed a debridement of the existing scar tissue after which claimant began a course of physical therapy and recovery. (JE 9)

On August 4, 2015, claimant returned to Dr. Atteberry reporting that the therapy was somewhat helpful and that the shoulder may be "a little better." Claimant reported left knee pain that had been ongoing for many years. (JE 7:52) Dr. Atteberry injected the claimant with Synvisc and determined that claimant's progress with his shoulder was likely all he would achieve. (JE 7:52) Claimant underwent a second knee injection on August 14, 2015 and a third on August 21, 2015. From the medical records, it appears that these injections were not helpful.

On October 30, 2015 claimant returned for follow-up on his left shoulder. He stated that the second surgery did not improve his left shoulder condition and he was beginning to have pain in his neck. (JE 7:56) Dr. Atteberry recommended claimant seek out a pain management specialist as there were no other surgical solutions that Dr. Atteberry could offer. Claimant began care with Alan Eckhoff, M.D., on December 10, 2015. (JE 11:78) In the initial intake interview, claimant reported short-term memory loss, left-sided partial paralysis, left shoulder pain, left-sided neck pain, pain radiating down into his left arm and into his fourth and fifth digits, numbness and tingling in fingers, muscle cramps in the biceps, weakness of the right arm, right shoulder pain, and headaches. (JE 11:78) A CT was conducted of the cervical spine which showed essentially a negative exam. He exhibited limited range of motion on the left and mild weakness. Id. Based on the imaging, it was recommended claimant undergo a left shoulder intra-articular steroid injection. (JE 11:82) This was administered on January 26, 2016. The injection helped to reduce the pain by approximately 50 percent for 5 weeks. (JE 11:86) Deep tissue massage was ordered and another injection was administered on March 25, 2016. (JE 11:90)

On April 21, 2016, he reported to Dr. Eckhoff's office with reports of back pain. He also reported that the second injection provided no relief. (JE 11:93) Physical therapy was recommended along with medications. (JE 11:93)

Claimant returned to Dr. Atteberry on August 26, 2016. It was noted the claimant underwent nerve conduction studies that morning which showed no obvious abnormalities, no evidence of supra-scapular nerve injury or any mild empathic changes of and no evidence of cervical radiculopathy or peripheral nerve compression. (JE 7:60) Dr. Atteberry found claimant at maximum medical improvement (MMI) and proceeded to issue an impairment rating.

On October 20, 2015, counsel for the claimant asked Dr. Atteberry for an opinion regarding causation and permanency. Dr. Atteberry did not respond other than to write that claimant needed a new EMG. (JE 7:58) He did issue an impairment rating September 13, 2016.

He wrote as follows:

> With regards to the questions cited in your letter, the reason for his surgery of June 25, 2015, was continued shoulder pain and weakness. He had a new MRI following his original surgery, which was questionable for a possible recurrent tear. The patient had failed conservative treatment. Since his original work injury was the reason for his initial surgery with Dr. Rosipal and patient failed to improve postoperatively, I would definitely feel that the work injury of December 13, 2013 was ultimately the reason that he required the second surgery on June 15, 2015. Given that Nick was not found to have a recurrent tear and simply underwent debridement of scar tissue, I would have expected him to be off work only to the point where his function improved enough to return to at least light duty. Normally, this would be in the neighborhood of four to six weeks. However, Nick's function failed to return to normal in his left arm and he is continuing to have significant disability. I would declare his date of maximum medical improvement to be August 26, 2016. Based on his strength and range of motion deficits as well as continued discomfort in the arm, I would declare his permanent partial impairment to be 28% of his left upper extremity, which is equal to 17% of the whole person. This is based on the Guides to the Evaluation of Permanent Impairment, 5th Edition using Charts and Tables of Chapter 16.
>
> With regards to permanent work restriction, I think detailed restrictions are going to be very difficult to define due to the fact that Nick has not been able to complete a functional capacity evaluation. It is certainly possible that he will require continued pain management for the discomfort in his left shoulder.

(JE 7:61)

Claimant underwent an independent medical examination with Sunil Bansal, M.D., on August 21, 2017. (CE 4) Claimant described his current condition as constant aching left shoulder pain as well as sharp shooting pains throughout his biceps. (CE 4:11) He had popping and clicking in his shoulder, constant numbness and tingling of the shoulder radiating into the arm and down to his fourth and fifth fingers. He reported cramping of his left biceps, with the majority of his pain throughout the top of his arm. He claimed difficulty with his right shoulder as a result of overcompensating for his left side. He described the inability to lift with his left hand and arm, frequently dropping objects from his left hand, and unable to lift anything over shoulder level with his left arm. (CE 4:11) Dr. Bansal diagnosed claimant with a left shoulder partial thickness rotator cuff and labral tear. He agreed that claimant reached MMI on August 26, 2016. (CE 4:13) Dr. Bansal concluded that the claimant tore his labrum and rotator cuff while making a wide circular motion with the left arm. As a result of the loss of range of motion, pain, and discomfort, Dr. Bansal assigned a 16 percent impairment of the body as a whole. (See CE 4:15) Dr. Bansal recommended a restriction of no lifting greater than 5 pounds occasionally with the left arm along with no lifting over shoulder level with the left arm and no frequent reaching with the left arm. (CE 4:15)

It should be noted that Dr. Bansal recorded the following regarding the second surgery of claimant.

> [Lorenzen] returned to the second surgeon on his own, and proceeded with a second left shoulder surgery. He is unsure of the exact procedure, but anchors were placed and further repair was performed. Afterward he was informed he had severe tearing of his biceps, which was not able to be repaired. The tear was cleaned up, but his biceps was not able to be reattached.

(CE 4:11)

Dr. Bansal charged $2,539.00 for the independent medical examination and report. (CE 4:16)

On November 28, 2017, Dr. Rosipal authored an opinion letter at the request of the defendants. (JE 4:35) Dr. Rosipal examined the claimant, who reported continual pain and weakness. His active forward flexion was 100°, further passive motion was up to 130°, abduction in the scapular plane was 90°, cross body abduction was 20°, external rotation with the elbow at the side was 45°, internal rotation with the arm abducted to 90° was 40°, extension of the shoulder was 30°. (JE 4:36) He had a 4+ out of five strength in the provocative rotator cuff testing and abduction in the scapular plane as well as in forward flexion. He also had five out of five strength in internal and external rotation with the elbow at the side. Id. Dr. Rosipal continued to maintain the claimant's left shoulder injury was caused by his work and his work duties at the defendant employer. (JE 4:36) He further opined that the claimant sustained a permanent impairment as a result of the December 14, 2013 work injury and that claimant was left with a permanent partial impairment of the left upper extremity of 15 percent based upon the range of motion, strength and dysfunction, which converts to 9 percent of the whole person. Dr. Rosipal did not believe the claimant needed further medical treatment, determined the claimant was at MMI, and maintained the functional capacity restrictions were appropriate. He went on to write as follows,

> I did review the previous permanent partial impairment ratings provided by both Dr. Atteberry and Dr. Bansal and feel that they are absurdly high. As an example, shoulder that has undergone a replacement of the ball and socket maxs [*sic*] out at 25 percent of the affected extremity. Mr. Lorenzen in no way, shape or form had a replacement surgery performed. His range of motion is adequate, albeit optimal, and he continues to have pain. The range of motion documented by Dr. Bansal has either miraculously tripled in all planes or he concomitantly, he had a frozen shoulder at the time of his examination which also seemed unlikely.

(JE 4:36-37)

In a December 7, 2017 checklist letter, Dr. Hutton opined that the June 15, 2015 operation was not reasonable, necessary or related to the December 13, 2013 injury. (JE 10:76) He agreed with Dr. Rosipal's rating of 12 percent to the upper extremity and recommended lifting restrictions of 25 pounds or less, below shoulder level and within 18 inches of the body. (JE 10:76)

In a November 30, 2017 checklist letter, Dr. Eckhoff opined that he could not determine to a reasonable degree of medical certainty whether the treatment he provided to claimant was related to the December 13, 2013 injury. (JE 11:94)

On February 24, 2015, claimant met with Iowa Vocational Rehabilitation Services for assistance with long term job placement. (CE 1:3) In the intake paperwork, claimant reported chronic lower back pain, permanent restrictions from rotator cuff surgery, degenerative disk disease, history of stroke, obesity, and Type II diabetes. When asked how his injury had affected his ability to work, claimant replied that he was unable to return to his job as a school bus driver due to the shoulder injury and would not be able to lift, stand, sit, bend or any other repetitive motion for work. Claimant reported that his diabetes was uncontrolled and sugar spikes needed to be addressed by sitting down and remaining seated until the spike was regulated. He indicated that he had to have assistance from his wife dressing, bathing and moving about the house. At the time of the March 16, 2016 appointment, claimant reported using a cane for stability. (CE 1:3)

During another visit with claimant's counselor at the vocational rehabilitation services, claimant reported that his functional capacity evaluation was incomplete because "they didn't want to state JC was unable to work." (CE 1:4) There are notations that claimant applied for jobs in security at Walmart, Aldi's grocery, freight line sales, Farmers Insurance and Nebraska Furniture Mart with no callbacks. (CE 1:5)

On September 14, 2015, claimant had another appointment with the Iowa Vocational Rehabilitation Services, but this time in Des Moines. (CE 1:6) Claimant had moved to be closer to family due to his financial circumstances. During this interview, claimant described an ordinary day in which he would rise at 5:30 a.m. to help get the kids off to school, attend any appointments necessary to maintain their welfare status, and ready for his family's return in the evening. (CE 1:6)

He was using a cane with his right hand because of left-sided weakness from the stroke earlier in the year. Claimant was also suffering some short-term memory loss which he wondered if was related to the stroke but the counselor suggested might be because of his continuous stress level since the injury. From a medical standpoint, claimant had steroid injections in both left knee and back without improvement.

Currently, he suffers from chronic headaches, usually one per week that is severe enough to require him to lie down for a few hours with the lights off. He may also have had some hearing loss or tinnitus. (See CE 1:6)

He has applied for Social Security Disability but was initially denied. The application was based on claimant's left shoulder, the stroke, degenerative back

disease, and allergies. (DE G:18) He seemed to imply that because of his left shoulder injury, he was not able to lift any weight or perform repetitive desk duties such as typing, writing or using the phone. (DE G:18) He explained that he was unable to prepare his own meals, do household chores, or work. (DE G:19) This application was denied. On December 22, 2015, claimant re-applied and this time asserted additional mental health components to his claim and cited new limitations such as the inability to lift more than 2 pounds, the inability to stand for more than 1 minute, the inability to sit for more than 30 minutes, and the inability to pay attention for more than 2 seconds. (DE G, 28, 33, 35) The latter two were proven to be inaccurate at the hearing. Claimant sat for nearly two hours without complaint during cross-examination.

Claimant was found to be disabled by the Social Security Administration on April 4, 2016. (CE 1:1) The date of disability was determined to be April 11, 2014.

Claimant is, at times, either inconsistent or unreliable in his historical narration. The information he gave to Dr. Bansal about his second surgery was not accurate. The second surgery revealed no tear. However, Dr. Bansal recorded that claimant had severe tearing of his biceps, hardware was used to repair some part of the tear, but overall the biceps was not able to be reattached. Claimant told the vocational rehabilitation counselor that his FCE was "incomplete" because the evaluator did not want to state that the claimant was unable to work. In fact, the FCE was invalid and ruled so because of claimant's inconsistent responses during his testing. Further, despite the invalid test, the evaluator vouched for the claimant's disability to Dr. Rosipal and Dr. Rosipal adopted the restrictions set forth by the evaluator.

Claimant testified at hearing that his second surgery was both helpful and not helpful.

Because of these varying accounts, claimant's in-hearing testimony is given low weight.

CONCLUSIONS OF LAW

Defendants proferred Exhibit A which was a new report from Dr. Atteberry. Claimant objected on the basis that the report was late.

Dr. Atteberry is not an expert witness. Claimant first sought out Dr. Atteberry in September 2015 for a second opinion regarding whether a second surgery was an option for claimant's ongoing shoulder pains. Dr. Atteberry agreed that it was, although he made no promises as to the outcome. The surgery took place in the summer of 2016.

The hearing assignment order governs the deadlines pertaining to exhibits. Specifically, the hearing order requires parties to exchange exhibit lists and witnesses at least 30 days prior to hearing. The report was on January 5, 2018, and served on January 15, 2018. The hearing took place on January 17, 2018.

When a party violates agency rules or the hearing assignment order in failing to timely exchange proposed exhibits, the exhibits will be excluded only if the objecting party shows that receipt of the evidence would be unfairly prejudicial. Division of Workers' Compensation rule 876 IAC 4.19(3)(e).

Defendants assert that there is no prejudice to the claimant given that Dr. Atteberry is not an expert, but rather a treating physician. Further, medical records from treating physicians are often allowed more lenience. However, the January 5, 2018, report of Dr. Atteberry is not part of the care he provided to the claimant in 2015 and 2016, but rather an opinion on claimant's post-surgical subjective complaints and his maximum recuperation. These opinions could have been obtained prior to the deadlines as they were not related or influenced by late-disclosed opinions of the claimant or claimant's experts. Given that deadlines had passed, claimant would not be able to address the statements of the expert. This is prejudicial. Further, the opinions of Dr. Atteberry expressed in Defendant's Exhibit A are no different than opinions of others already in the record. Weighing the fairness to be afforded to both parties and the prejudicial nature of the allowance of the untimely exhibit, it is found that Exhibit A is excluded.

Claimant seeks a finding that he is entitled to additional healing period benefits following the surgery of Dr. Atteberry on June 25, 2015, until August 26, 2016.

Section 85.34(1) provides that healing period benefits are payable to an injured worker who has suffered permanent partial disability until (1) the worker has returned to work; (2) the worker is medically capable of returning to substantially similar employment; or (3) the worker has achieved maximum medical recovery. The healing period can be considered the period during which there is a reasonable expectation of improvement of the disabling condition. See Armstrong Tire & Rubber Co. v. Kubli, Iowa App. 312 N.W.2d 60 (1981). Healing period benefits can be interrupted or intermittent. Teel v. McCord, 394 N.W.2d 405 (Iowa 1986).

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 is seeking a second healing period from the second surgery until his release. The parties agree that the medical care of Dr. Atteberry was unauthorized; however, unauthorized care can be the responsibility of the defendants if, among other factors, the care was reasonable and beneficial to the claimant. Bell Bros. Heating and Air Conditioning v. Gwinn, 779 N.W.2d 193 (Iowa 2010). In his brief, claimant states that the "best evidence in this case is the testimony of Lorenzen who unequivocally testified that the care and treatment provided by Dr. Atteberry after the second surgery improved his condition." (Claimant's Post Hearing Brief, p. 6) Claimant's testimony was not unequivocal. On cross-examination, he conceded that the second surgery did not improve his condition. That testimony is supported by the contemporaneous medical notes of Dr. Atteberry. On October 30, 2015, Dr. Atteberry documented that the claimant had not improved since the time of surgery. Further, the actual surgery itself

was unnecessary. Both Dr. Rosipal and Dr. Hutton believed a second surgery was unnecessary and this was proven to be true when Dr. Atteberry operated. There was no tear as the radiologist and Dr. Atteberry feared. Instead, claimant's shoulder was healing from the first surgery and Dr. Atteberry provided only a debridement of existing scar tissue.

The medical care of Dr. Atteberry was unauthorized and further, claimant testified that the second surgery provided no relief consistent with previous statements made to his medical providers. Therefore, it is determined that the second surgery was not reasonable and necessary in addition to being unauthorized and therefore, claimant is not entitled to healing period benefits following the second surgery.

The parties agree claimant did sustain a work injury on December 13, 2013, but disagree as to the extent.

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).

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.

There is no dispute among the experts that the claimant sustained a permanent disability. Drs. Rosipal, Hutton, Atteberry, and Bansal all agree that the claimant sustained an injury arising out of the December 13, 2013 incident. The dispute is over the extent.

In reviewing the medical records, Dr. Rosipal was the most careful, and in retrospect, the most accurate medical provider. For instance, when the second MRI was obtained, he reviewed it with another specialist, essentially seeking out a second opinion. He correctly concluded that the increased signal in the MRI was not the evidence of a tear, but merely signs from the healing from the first surgery. When he received the invalid FCE results, Dr. Rosipal took the time to call the evaluator and obtain further information which led Dr. Rosipal to adopt the FCE results despite their invalidity.

It is because of his careful and accurate diagnosis and treatment in addition to his educational and work background that Dr. Rosipal's opinion is adopted herein. It should be noted that Dr. Rosipal's opinions and restrictions are largely supported by the opinions of Dr. Hutton.

However, before moving forward, I will address the opinions of Dr. Bansal and Dr. Atteberry. Dr. Atteberry concluded claimant sustained a 17 percent industrial disability due to range of motion and strength deficits in addition to pain. Dr. Bansal issued a 16 percent industrial rating.

Dr. Bansal's opinions are not reliable in this case due to the inaccurate information he received regarding the second surgery. Claimant told Dr. Bansal that the second surgery revealed a tear that could not be repaired. Dr. Bansal either was not provided the medical record of the second surgery or chose to believe claimant's account of the second surgery over the medical record. Nonetheless, the expert opinion is given lower weight when it is based on faulty information.

Dr. Atteberry, like Dr. Rosipal, was a treating orthopaedic surgeon. He cared for the claimant from the fall of 2015 into 2016. Dr. Atteberry went forward with a second surgery that two other orthopaedic specialists felt was unwarranted. The second surgery proved the two orthopaedic specialists correct. The second surgery revealed no tear. This is not to say that Dr. Atteberry is not a careful doctor or an expert in his field;

however in rendering a decision, the undersigned must make a determination as to what weight to afford the opinions in the case.

Based on the whole of Dr. Rosipal's care and treatment, it is his opinions that appear to be the most careful and reasoned. Dr. Rosipal actually examined claimant once more in 2017 before rendering a final opinion.

Dr. Rosipal's opinions are that claimant sustained a 9 percent impairment of the whole body. Dr. Rosipal adopted the restrictions of no lifting greater than 25 pounds from floor to shoulder, 50 pounds from 9 inches to the waist, 40 pounds from 9 inches to the shoulder, 20 pounds from 9 inches to overhead; 25 pounds carrying; 170 pounds pushing and 185 pounds pulling. (JE 8:66)

Claimant has only a high school diploma, but he was a good student. Further, he has past experience working in retail, cleaning, stocking, sales, security guard, and machine operator. While he has visited several times with Iowa Vocational Rehabilitation Services, claimant has not shown motivation to return to work. Some of his reluctance to seek new employment may be due to his non-work related health problems such as his April 2014 stroke and newly developed back and knee problems.

Based on the foregoing, it is determined that claimant has sustained a 25 percent industrial loss as a result of the injury to his left shoulder.

The commencement date of permanent partial disability benefits is either when the claimant returned to work or substantially similar work or the date of MMI. Claimant returned to full duty work without restrictions on July 29, 2014. Claimant eventually failed a DOT physical and as a result was not able to return to his full duty work. Further, the FCE restrictions would place him outside that position. It is not clear from the record when claimant left his employment with defendant employer. The greater weight of the evidence supports a finding that claimant returned to full duty work without restrictions on July 29, 2014, thus entitling to him to permanent benefits beginning on that date.

Claimant is seeking reimbursement of an IME as well as costs. Dr. Bansal's report is an IME and cannot be recovered under 4.33. See Des Moines Area Regional Transit Authority v. Young, 867 N.W.2d 839, 847 (Iowa 2015). Under 85.39, as interpreted by the Supreme Court in Des Moines Area Regional Transit Authority v. Young, only the examination portion of the fee can be recoverable. Dr. Bansal did not provide a breakdown of his costs. The claimant did not testify as to the length of the examination. Dr. Bansal's report is 15 pages and there were substantial medical records. Therefore, two-thirds of the bill is apportioned to the examination and one-third to the report.

Defendants argue claimant is not entitled to any reimbursement of deposition transcript costs however, claimant's bill of taxable costs includes only the filing fee and therefore defendants' argument is moot. Claimant is entitled to the entirety of his costs identified in Exhibit 4 pursuant to 876 IAC 4.33.

ORDER

THEREFORE, it is ordered:

That defendants are to pay unto claimant one hundred twenty-five (125) weeks of permanent partial disability benefits at the rate of two hundred fifty-nine and 27/100 dollars ($259.27) per week from July 29, 2014.

That defendants shall pay accrued weekly benefits in a lump sum.

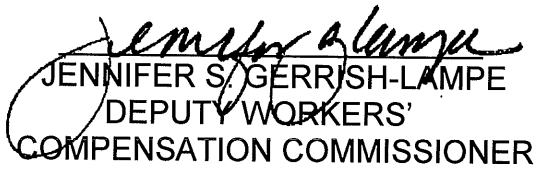
That defendants shall pay interest on unpaid weekly benefits awarded herein as set forth in Iowa Code section 85.30.

That defendants are to be given credit for benefits previously paid.

That defendants shall pay the costs of this matter pursuant to rule 876 IAC 4.33.

That defendants shall pay two-thirds of the bill of Dr. Bansal pursuant to Iowa Code § 85.39.

Signed and filed this 3rd day of April, 2018.



JENNIFER S. GERRISH-LAMPE
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

Copies to:

Jacob John Peters
Attorney at Law
PO Box 1078
Council Bluffs, IA 51502-1078
jakep@peterslawfirm.com

Andrew T. Tice
Attorney at Law
100 Court Ave., Ste. 600
Des Moines, IA 50309-2346
atice@ahlerslaw.com

JGL/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.