BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

MICHAEL B. QUAIL,

Claimant,

vs.

SIMONSEN IRON WORKS,

Employer,

and

SENTRY INSURANCE,

Insurance Carrier,
Defendants.

FILED

SEP 15 2017

WORKERS COMPENSATION

File No. 5055412

ARBITRATION DECISION

Head Note No.: 1402.40

Claimant Michael Quail filed a petition in arbitration on December 24, 2015, against the defendant, Simonsen Iron Works ("Simonsen"), and its insurer, the defendant, Sentry Insurance ("Sentry"), alleging he sustained an injury to his right elbow, arm, shoulder, neck, and body as a whole while working for Simonsen on October 5, 2015.

An arbitration hearing was held on March 3, 2017, at the Division of Workers' Compensation in Des Moines, Iowa. Attorney Ernest Wilcke appeared on behalf of Quail. Quail appeared and testified. Attorney Michael Roling appeared on behalf of Simonsen and Sentry. Exhibits 1 through 17, and A through K were admitted. The record was left open through May 15, 2017, for the receipt of Exhibits 18 and L and post-hearing briefs, which were received into the record. At that time the record was closed.

Before the hearing the parties prepared a hearing report listing stipulations and issues to be decided. Simonsen and Sentry waived all affirmative defenses.

STIPULATIONS

1. An employer-employee relationship existed between Simonsen and Quail at the time of the alleged injury.

2. Quail sustained an injury on October 5, 2015, which arose out of and in the course of his employment with Simonsen.

3. Although entitlement to temporary benefits cannot be stipulated, Quail was off work from October 5, 2015 through October 19, 2015.

4. At the time of the alleged injury Quail's gross earnings were $440.00 per week, he was married and entitled to two exemptions, and the parties believe the weekly rate is $304.81.

5. Although disputed, the medical providers would testify as to the reasonableness of their fees and/or treatment set forth in the listed expenses and the defendants are not offering contrary evidence.

6. Simonsen and Sentry agreed to pay the cost of Quail's independent medical examination and associated transportation expenses.

7. Although a causal connection of the expenses to a work injury cannot be stipulated, the listed expenses are at least casually connected to the medical condition(s) upon which the claim of injury is based.

ISSUES

1. What is the nature of the injury?

2. Is the alleged injury a cause of temporary disability during a period of recovery?

3. Is Quail entitled to temporary benefits from October 5, 2015 through October 19, 2015?

4. Is the alleged injury a cause of permanent disability?

5. If the alleged injury is a cause of permanent disability, what is the commencement date for permanent partial disability benefits?

6. Is Quail entitled to recover the medical expenses set forth in Exhibit 13?

7. Should penalty benefits be awarded to Quail?

8. Should costs be assessed to either party?

FINDINGS OF FACT

Quail is single and lives in Spencer, Iowa. (Exhibit J, pages 4-5) Quail is right-hand dominant. (Exs. 1, p. 1; B, p. 2; D, p. 4; J, p. 10; Tr., p. 23) At the time of the hearing he was fifty-one. (Transcript, pp. 7, 12)

Quail attended school through the age of seventeen, and left in the tenth grade to work for his father, a construction contractor. (Tr., p. 7; Ex. J, pp. 6-7) While he was attending high school Quail fractured several bones in his foot as a result of a motorcycle accident. (Tr., p. 10; Ex. J, pp. 6-7) Quail could not attend school due to his injuries for a period of months and he ultimately decided not to return to school. (Tr., p. 11; Ex. J, pp. 6-7)

After dropping out of high school Quail worked for his father as a construction laborer from 1984 through 1990. (Tr., pp. 12-13; Ex. J, p. 9) Quail worked with a crew constructing homes and buildings, where he installed roofing, drywall, and insulation. (Tr., pp. 8-10, 13; Ex. J, pp. 9-10) When Quail's father retired in 1990, his brother took over the business. (Tr., p. 13; Ex. J, p. 11) Quail worked for his brother for approximately four years. (Tr., p. 14)

For most of his career Quail has worked in construction. Quail worked as a foreman in roofing and construction off and on for many years. (Tr., pp. 14-21; Ex. J, pp. 11-15, 24) He also worked as a delivery driver for two employers. (Tr., pp. 14-16, 21; Ex. J, pp. 15, 26-27)

Quail left construction for a period of time and he worked as a school custodian for eight years with the Spencer Community School District. (Tr., p. 24; Ex. J, pp. 28, 30) Quail returned to construction for a period of time until he accepted a position working on a motorcycle assembly line for one year, and then he returned to construction. (Tr., pp. 25-27, 29; Ex. J, pp. 30-32)

Quail sustained several injuries while working construction. He injured his knee and underwent arthroscopic surgery, he underwent carpal tunnel surgery and received workers' compensation benefits, and he fractured his right arm and received workers' compensation benefits. (Tr., pp. 15, 19, 22-23; Ex. J, pp. 15, 20)

Simonsen hired Quail in April 2015, for a driver and labor position. (Ex. B, p. 1) At the time of his hiring Quail completed a medical inquiry form which asked, "[h]ave you had any injuries on the job? If yes, please describe: date of injury, employer, body part affected, cause, amount of lost time, any permanent disability (%), was workers comp. claim filed?" (Ex. B, p. 1) Quail checked "no" with respect to the question and he did not provide any additional comments. (Ex. B, p. 1) Quail testified he responded "no" because he "could do the work. I didn't have any problems with any of my other surgeries, and I needed to – I needed the job." (Tr., p. 31) During cross-examination Quail acknowledged he knew his answer was incorrect at the time he gave it. (Tr., p. 78)

On the medical inquiry form Quail reported he wore a brace for right tennis elbow "yrs ago," but denied ever having problems with hand numbness or tingling, carpal tunnel syndrome, or tendonitis. (Ex. B, p. 2) Quail testified when Simonsen hired him he did not have any restrictions or limitations with his neck, arm, shoulder, or hand, and he was not treating with a physician at that time. (Tr., p. 35)

On September 28, 2015, Quail attended an appointment with Christopher Rierson, D.O., an orthopedic surgeon, complaining of right elbow pain. (Ex. 1, p. 1) Quail completed a history form noting he had been experiencing continuous, moderate right elbow pain for approximately one to two weeks, which had worsened during the last week and which was worse with use. (Ex. C, p. 1) Dr. Rierson documented Quail reported he had been having trouble with his elbow for "some time" and he had arthroscopic elbow surgery "some time ago" to remove bony spurs. (Ex. 1, p. 1) Dr.

Rierson noted Quail reported he was having trouble with full extension, flexion, and weakness, and he had not noticed a loss of motion in his elbow until recently. (Ex. 1, p. 1) Dr. Rierson documented, "I presume that the issue with [his elbow] is mostly degenerative changes as well as the bony formations that are preventing his range of motion." (Ex. 1, p. 1) Dr. Rierson ordered imaging and referred Quail to his partner, Phillip Deffer, Jr., M.D., also an orthopedic surgeon. (Ex. 1, p. 1)

Dr. Rierson did not document Quail's right elbow pain was work-related. Quail relayed he did not report his right arm pain to Simonsen because "if it was a pulled muscle, I didn't feel like it was a workman's comp issue, so I was going to get it taken care of myself." (Tr., pp. 79-80)

Quail testified on October 5, 2015, he ratchet-strapped large parts on a flatbed and hauled the parts to Milford for painting. (Tr., pp. 35-36) Workers in Milford unloaded the parts, and loaded new parts for Quail to return to Simonson. (Tr., p. 37) Quail testified one of the individuals who was loading the parts

> brought them up over the trailer and instead of slowly letting them down, he pretty much dropped them. And the one leg stand come [*sic*] flying off at me, so I put my left hand up so it wouldn't hit me in the head or the body, and took my right hand and shoved sideways so it wouldn't come down on me. And the part hit the ground and I kind of fell down too.

(Tr., p. 38) Quail reported when the part came toward him, he shoved with his right hand, and he experienced "a big pop in my elbow. And right away I started getting swelling in my neck and my hand started burning. My arm was numb and burning feeling, and I got things strapped back down so I could get back to the warehouse as quick as I could," about a twelve mile drive. (Tr., pp. 38-39)

Quail testified prior to the incident he was not having any difficulties with his shoulder or elbow. (Tr., p. 40) Quail reported he, "never really had any problems" with his elbow before October 5, 2015, and it did not limit his ability to work prior to the incident. (Tr., p. 46)

Gregory Besaw, the production manager for Simonsen, testified in his deposition before the October 5, 2015 incident Quail came into work with a sling and reported he had "elbow problems," from "an accident that happened prior to working there from, you know, swinging a hammer, just working hard with your body over the years." (Ex. 11, p. 8) Besaw relayed Simonsen prided himself on his workmanship and he continued to work even though he was using a sling. (Ex. 11, p. 9) Besaw denied that Quail reported a work injury to him in September 2015. (Ex. 11, p. 10)

Cindy Hinton, the office manager for Simonsen testified in her deposition prior to October 5, 2015, she observed Quail walking around holding his arm, "and then a week after that he had it in a sling. And I asked him, you know, what the problem was because he was really moaning about it. And he said it was too many years of slinging a hammer in construction." (Ex. 12, pp. 3-4)

Quail reported the October 5, 2015, work injury to Simonsen. Simonsen arranged an appointment for Quail with Bruce Feldmann, M.D., a family medicine physician, that day. (Tr., pp. 41-42) Dr. Feldmann noted Quail relayed as he was handling material it started to fall toward him, "and he forcefully resisted it and it pushed his arm backwards, abducted and rotated" causing pain in his trapezius and neck. (Ex. 2, p. 1) Dr. Feldmann assessed Quail with "[a] right trapezius, posterior trapezius shoulder strain." (Ex. 2, p. 3) Dr. Feldmann restricted Quail from working that day, ordered him to use ice, prescribed Lortab and Nabumetone, imposed a ten pound lifting restriction and ordered he should avoid lifting over shoulder height, forceful pushing, and pulling. (Ex. 2, pp. 4-5)

Quail has a history of prior workers' compensation actions and injuries. In January 2017, Marc Hines, M.D., a neurologist, performed an independent medical examination for Quail, which included an examination and review of his medical records. (Ex. 10, p. 1) Dr. Hines noted Quail fractured or displaced his second metatarsal head and received a permanent impairment rating of twenty percent loss of function to the left foot, and sixteen percent to the right leg based on ankylosing of the tarsal metatarsal joints in 1984. (Ex. 10, p. 1) Quail also mentioned problems with his back and knee in December 1984. (Ex. 10, p. 1)

Dr. Hines documented Quail first reported bilateral hand and wrist pain, and numbness and tingling in his right hand in September 1989. (Ex. 10, p. 1) Quail was diagnosed with bilateral carpal tunnel syndrome and received bilateral carpal tunnel surgeries. (Ex. 10, p. 1)

Quail also received a permanent impairment rating for a work-related injury to his knee in 1996. (Ex. 10, p. 2) In 2000, during a medical vocational rehabilitation examination with Rick Wilkerson, D.O., an orthopedic surgeon, Quail complained of right foot and low back pain. (Ex. 10, p. 2) Dr. Wilkinson assessed Quail with right foot tarsal metatarsal traumatic arthritis that was chronic with progressive symptoms and mechanical low back pain, and recommended restrictions of no standing over eight hours, or lifting over forty pounds repetitively. (Ex. 10, p. 2)

In August 2005, Quail attended an appointment with Dr. Deffer, Dr. Wilkinson's partner, and reported he sustained a right elbow injury while working for Smith Construction in October 2004. (Ex. 10, pp. 2-3) In his summary, Dr. Hines noted Dr. Deffer documented Quail relayed he felt a pop in his elbow while pushing a heavy window, and he experienced increasing and pain and swelling over the next few days. (Ex. 10, p. 3) Quail received a computerized tomography scan which revealed multiple osteocartilaginous loose bodies in the anterior and posterior aspect of the elbow. (Ex. 10, p. 3) Dr. Deffer diagnosed Quail with right elbow osteoarthritis with loose bodies, and performed a right elbow arthroscopy, retrieval of loose bodies, and arthroscopic debridement on January 13, 2006. (Ex. A, p. 1) After surgery Quail received physical therapy. (Ex. 10, p. 3) Dr. Hines noted upon discharge, Dr. Deffer found Quail's flexion was excellent, he had good pronation and supination, and he "lacked about 10-degrees short of full extension." (Ex. 10, p. 3)

On October 9, 2015, Quail attended a follow up appointment with Dr. Feldmann, reporting his neck and shoulder had improved fifty percent. (Ex. 2, p. 6) Dr. Feldmann imposed a twenty pound lifting restriction with the right arm, and imposed restrictions of minimizing work above shoulder height, forceful pushing, pulling, and squeezing. (Ex. 2, p. 9)

On October 12, 2015, Dr. Deffer examined Quail and ordered a computerized tomography scan. (Ex. 3, p. 1) The reviewing radiologist listed an impression of "severe diffuse degenerative changes with joint space narrowing and prominent marginal osteophyte formation" of the right elbow, with "multiple intra-articular loose bodies." (Ex. 4, p. 1) Dr. Deffer restricted Quail from working October 12, 2015 through October 19, 2015. (Ex. C, p. 5)

Simonsen documented Quail did not attend work or call to report he was going to be absent on October 19, 2015, October 20, 2015, October 21, 2015, and October 22, 2015. (Ex. H) Due to Quail's failure to attend work, Simonsen terminated his employment on October 22, 2015. (Exs. H, p. 3; 12, p. 11) Quail presented Exhibits 15A through 15G, which are photographs of calls he made from his cellular telephone October 5 through 8, 2015, to his supervisors at Simonsen. Quail testified he did not make any calls to Simonsen October 19 through 22, 2015. (Tr., p. 88) Hinton testified Simonsen did not receive any documentation restricting Quail from working after October 19, 2015, until the time of his discharge. (Ex. 12, pp. 11-12)

At hearing Quail testified he returned to work on October 19, 2015. (Tr., p. 54) Quail noted that Simonsen asked him to drive a forklift, and operate scissor lift, which he could not do. (Tr., p. 55) Quail testified he did not return to work on October 20 through 21, 2015, and reported he was under a doctor's care and had received an excuse not to go to work. (Tr., p. 56)

On October 22, 2015, Quail returned to Dr. Feldmann reporting pain when unscrewing bolts on a lift at work. (Ex. 2, p. 11) Quail reported he was experiencing a burning sensation down into his neck, arm, hand, and thumb. (Ex. 2, p. 13) Dr. Feldmann listed an impression of shoulder and neck pain with radicular symptoms, ordered Quail not to use his right arm outside of his sling, and referred him to orthopedics. (Ex. 2, p. 14)

During a follow-up appointment on October 26, 2015, Dr. Deffer noted he had reviewed Quail's imaging, which revealed "huge osteophytes off the front and back of the elbow" and he listed an impression of elbow osteoarthritis with severe osteophyte loose body formation. (Ex. 3, p. 2) Dr. Deffer discussed surgical options with Quail, prescribed Flexeril, and restricted Quail from working October 19, 2015 through November 19, 2015. (Ex. 3, pp. 2-3)

On December 21, 2015, Quail underwent right shoulder and cervical spine magnetic resonance imaging. (Ex. 4, pp. 3-4) With respect to the shoulder imaging, the reviewing radiologist listed an impression of "[a]bnormal signal within the anterior labrum suspicious for poorly defined anterior labral tear" and no evidence of a rotator

cuff tear with respect to the right shoulder. (Ex. 4, p. 3) With respect to the cervical imaging, the reviewing radiologist listed an impression of:

> 1. Degenerative changes which are most advanced at C5-C6 and C6-C7.
>
> 2. Posterior disc pathology at C5-C6 and C6-C7, causing central canal stenosis with flattening of the cervical spinal cord at both of these levels but no abnormal cord signal to suggest impingement.
>
> 3. Neuroforaminal stenosis bilaterally at C4-C5, C5-C6 and C6-C7 as detailed above.
>
> 4. Acute facet degenerative changes bilaterally in the mid cervical spine as detailed above.

(Ex. 4, p. 5)

Douglas Martin, M.D., an occupational medicine physician, conducted an independent medical examination of Quail for Simonsen and Sentry. (Ex. D) Dr. Martin examined Quail and reviewed his medical records. (Ex. D) On December 16, 2015, Dr. Martin issued a letter opining,

> his right elbow is a preexisting problem and, although he certainly may have had an increase in the amount of pain after this work related incident, I do not think that is representative of an injury acceleration or an exacerbation, but, rather, an increase in the amount of pain during an event process that can be related more to the previous advanced degenerative issues of the elbow going forward. Thus, I do not believe that his right elbow should have any relationship to his workers [*sic*] compensation claim.
>
> Regarding any issues with respect to his right shoulder and his neck area, I do believe that his causal correlation to the work related event that has been described to me. The mechanism of injury was recreated today and I certainly can understand, in the position that he was in, how this could have created a rotator cuff injury or perhaps a cervical disk injury.
>
> Obviously, the advanced diagnostic imaging studies are going to help ferret this out even more.

(Ex. D, pp. 6-7) Dr. Martin recommended restrictions of no use of the right upper extremity. (Ex. D, p. 7)

Dr. Martin received and reviewed Quail's cervical and shoulder magnetic resonance imaging and issued a second letter on December 23, 2015, opining:

> [h]is right shoulder MRI scan shows that his rotator cuff is intact. There is a signal in the anterior labrum that is suspicious for a poorly defined labral tear. However, this is something that would not be acute.
>
> The gentleman's MRI scan imaging of his cervical spine is quite remarkable. This shows advanced degenerative changes for his age at multiple levels. But, most concerning is the fact that, at the C5/6 level, there is disk space narrowing, moderate diffuse disk protrusion left posterolaterally, and there is end plate and uncovertebral osteophytosis which is leading to a degree of central canal stenosis and rather significant foraminal stenosis. At the C6/7 level, there are similar findings. These are probably the 2 levels that are creating the concern with respect to his upper extremity radicular picture.
>
> I have made the suggestion that this gentleman needs to see a Neurosurgical Specialist for his cervical spine. I do not think that he needs to see an Orthopedic Specialist for his shoulder. Of course, he already has an Orthopedic doctor that he sees to take care of his elbow situation with regards to his degeneration and loose body osteophytosis.
>
> The findings on the MRI scan are degenerative in their nature and not related to any type of work related injury. The situation, therefore, is such that any Neurosurgical intervention that will be required for his cervical spine would be dealt without outside of the workers' compensation benefit system.

(Ex. D, p. 1) After receiving Dr. Martin's opinion, on January 12, 2016, counsel for Simonsen and Sentry sent Quail's counsel a letter, notifying him Dr. Martin had opined Quail's elbow, cervical spine, and right shoulder conditions are not related to any type of work injury he sustained at Simonsen, and further treatment was being denied. (Ex. L)

On February 24, 2016, Quail returned to Dr. Deffer complaining of right elbow, shoulder, and neck pain. (Ex. 3, p. 4) Dr. Deffer reviewed Quail's magnetic resonance imaging, noting it revealed multilevel cervical stenosis with neural foraminal impingement encroachment, and he listed an impression of cervical stenosis, right shoulder labral tear, and right elbow osteoarthritis with osteophyte formation and loss of motion. (Ex. 3, p. 4) Dr. Deffer noted he believed Quail would benefit from an elbow arthrotomy and excision of osteophytes, and recommended Quail see a neurosurgeon. (Ex. 3, p. 4)

Quail attended an appointment with Hank Klopper, M.D., a neurosurgeon, on March 15, 2016. (Ex. 5, p. 1) Dr. Klopper documented Quail reported he started experiencing neck pain on October 5, 2015, when he was pushing a heavy load at work and he felt a pop in his right elbow and pain in his upper arm and neck, a tightness in his right forearm, and numbness and tingling in his right upper extremity, specifically in his hand. (Ex. 5, p. 1) Dr. Klopper reviewed Quail's imaging, assessed him with neck pain, noted Quail's main problems appeared to be in his elbow, and issued a

prescription for physical therapy to treat his neck pain, noting, "[h]e does not have any radicular symptoms at present," and planned to see how Quail responded following elbow surgery. (Ex. 5, pp. 4-5)

On April 7, 2016, Quail attended an appointment with J. David Watts, M.D., an orthopedic surgeon, complaining of right elbow pain. (Ex. 7, p. 1) Dr. Watts noted Quail started a new job the previous fall where he was engaged in "a lot of repetitive motions with this elbow" and "on October 5th he was on a trailer when a part started rolling back and he pushed this and heard a pop." (Ex. 7, p. 1) Dr. Watts assessed Quail with right elbow degenerative changes and discussed an outer bridge procedure with Quail, and referred him to Scott McPherson, M.D., also an orthopedic surgeon. (Ex. 8, p. 1)

On April 13, 2016, Quail attended an appointment with Brett Bastian, PA-C, who works with Dr. McPherson. (Ex. 8, p. 1) Bastian documented Quail reported on October 5, 2015, he was waiting for a trailer to be loaded and a leg stand dropped two feet, "[h]e tried to catch this to prevent it from falling when he felt a pop in his right elbow." (Ex. 8, p. 1) Bastian examined Quail, reviewed his imaging, and listed an impression of advanced degenerative arthritis of the right elbow with limited arc of motion and increasing pain. (Ex. 8, p. 2) Bastian recommended a right elbow open arthrotomy using a triceps split posterior approach removing the anterior and posterior spurs and performing a capsule release, and a right ulnar nerve transposition and extended carpal tunnel release, which he discussed with Dr. McPherson. (Ex. 8, pp. 2-3)

On May 31, 2016, Quail underwent a right extended carpal tunnel release with flexor tenosynovectomy, right ulnar nerve submuscular transposition, and a right elbow arthrotomy with extensive contracture release, and loose body and spur removal. (Ex. 9, p. 1) Following surgery Quail was placed in a hinged elbow brace for sleeping. (Ex. 9, p. 3)

Counsel for Simonsen and Sentry sent a form letter to Dr. Rierson on October 20, 2016, regarding his care and treatment of Quail, which he signed without providing any written comments. (Ex. E) Dr. Rierson agreed that when he examined Quail on September 28, 2015, he recommended surgical intervention for Quail's right elbow condition prior to his reported right arm injury in October 2015, and he referred Quail to Dr. Deffer for his right elbow condition, "which was not related to the his work, but instead was a degenerative and/or arthritic condition not covered under workers' compensation at the time of the referral." (Ex. E, p. 2) Dr. Rierson noted he agreed with Dr. Martin's opinion that the method of injury reported to Quail's right elbow "is not likely to have caused a large osteophyte to break off of Mr. Quail's elbow, but it more likely than not caused pain to his preexisting degenerative and arthritic condition in his right elbow." (Ex. E, p. 2)

Counsel for Simonsen and Sentry also sent a letter to Dr. Deffer on December 19, 2016, regarding his care and treatment of Quail, which he signed without providing any written comments. (Ex. F) Dr. Deffer agreed

1. You previously treated Mr. Quail approximately ten years ago for his elbow condition that included multiple surgeries on the right elbow.

2. You are aware that Mr. Quail saw Dr. Rierson on 9/28/15. Dr. Rierson noted a reduced range of motion, swelling, tenderness and positive Tinel's sign in the right elbow.

3. X-rays from 9/28/15 showed significant degenerative and arthritic changes in Mr. Quail's right elbow.

4. Dr. Rierson recommended surgical intervention for the right elbow condition on 9/28/15.

5. Subsequent to the alleged 10/05/15 injury, Mr. Quail had a CT scan which did not show any acute injury.

6. It is your opinion to a reasonable degree of medical certainty that Mr. Quail may have experienced an increase in pain as a result of the alleged 10/05/15 injury but that did not change the need for surgery which existed prior to the 10/05/15 injury, and therefore would not have been a significant and material aggravation of his preexisting condition.

(Ex. F, pp. 1-2)

Dr. Hines performed an independent medical examination of Quail on January 13, 2017. (Ex. 10, p. 1) Dr. Hines reviewed Quail's medical records and examined him. (Ex. 10, p. 1) Dr. Hines noted Quail's position with Simonsen required him to strap down multiple straps that had to be cranked down extremely tight, and to engage in repetitive wrist and hand motions, and "[i]t therefore, seems completely conceivable that the patient would develop a right carpal tunnel syndrome even though he had a background of difficulty with carpal tunnel bilaterally and an ulnar neuropathy on the right along with the lateral epicondylitis." (Ex. 10, p. 13) Dr. Hines concluded:

> [a]n injury in the right elbow with multiple loose bodies that had previously been managed to the point of minimal deficit until this Fall, [*sic*] which included a fall onto the elbow. Ulnar neuropathy on the right, as well as, median neuropathy on the right and the median and ulnar neuropathy may have more than one etiology. Certainly with regard to the median, there is every reason to believe that this may be a representation of the repetitive work of the ulnar also, but he also did fall on the elbow, so this may be partly contributory to that difficulty. These would be the etiologies along with the diagnoses, which I believe are related to the incident on October 5, 2015.

(Ex. 10, pp. 13-14)

Using the AMA Guides Dr. Hines did not assign a permanent impairment rating to Quail's right shoulder or cervical spine. (Ex. 10, p. 14) With respect to Quail's right upper extremity, Dr. Hines opined:

> [i]n order to get an overall sense of the impairment, I have first used Tables 16-31 through 34 to get a sense of what the impairments might be for ulnar and median neuropathy of an entrapment type if we were to simply use the loss of grip strength as a measure. In that regard, his Jamar dynamometry demonstrates that he has more than a 50% loss in grip strength in his dominant hand, compared to the nondominant hand. Using Table 16-34, this would be roughly equivalent to a 20% upper extremity impairment. Returning though to specific impairments for the specific nerves themselves, the abnormalities in the arm are cumulative in terms of trying to maintain the arm in stationary position and have sufficient strength to perform a number of ordinary daily maneuvers. So that grip strength, may, in fact, represent one of the better ways of measuring the motor dysfunction. The patient's bedside exam shows a slight weakness in intrinsic hand muscles and opponents pollicis but this is an inadequate measure because when we are looking at movements such as grip or opposition of the thumb, we will be using a number o [*sic*] muscles from the elbow down to stabilize the forearm, wrist and then to perform the finger and thumb movements. The maximum sensory deficit for median is 39% but I did not detect a sensory deficit. The maximum motor deficit is 10%. This is modified by Table 16-11, Page 484 where the patient would fall under the descriptor #4, complete active range of motion against gravity with some resistance. The motor deficit, therefore, for the median, would be 2.5%. With regard to the ulnar, the patient has sensory deficits, but also the grip strength and some weakness. Using Table 16-15, page 492, as we did for the median, the ulnar never below the forearm can have a 35% motor deficit maximum and 7% sensory deficit maximum. The sensory deficit is substantial as it is in his hand on the ulnar side. He has both lost sensibility and has recurrent pain. Therefore, he would fall under Category 3 for this giving him the 60% of the 7, would be 4.2% for sensory impairment. With regard to the motor impairment, as stated, this will be 35% maximum from the Table 16-15, Page 492, but is modified by Table 16-11, Page 484. We, again find that he falls under category 4, complete active range of motion against gravity with some resistance, but has together with the median loss, substantial grip strength and has some mild loss of intrinsic muscle strength at the bedside. He would, therefore, fall under a 25% of the maximum 35%. This would give an 8.75% impairment. Adding the impairments thus discussed, the patient would have a 15.45% impairment. This is slightly underrating what the grip strength impairment alone would give, but this would be rounded down to 15% upper extremity impairment. There is separable impairment, however, for the range of motion deficits in his elbow. Again, utilizing *The Fifth Edition Guides to the Evaluation of Permanent Medical Impairment*, particularly Tables 16-32, 16-33 and 16-34 on Pages 471 and 472, the

> patient has a 6% upper extremity impairment for loss of flexion and 2% upper extremity impairment for loss of extension. Noting that all of these impairments are upper extremity impairments, I have used an additive notation and have come up with 23% upper extremity impairment for this patient.

(Ex. 10, pp. 14-15) With respect to restrictions, Dr. Hines noted Quail would have difficulty lifting over ten pounds with his right arm, he is unable to climb ladders or manipulate things in high places, and he should avoid repetitive hand activity twisting, turning, and using jackhammers. (Ex. 10, p. 15)

Dr. Deffer issued an opinion letter to Quail's attorney on February 2, 2017. (Ex. 3, p. 5) Dr. Deffer reported he treated Quail in 2005 for an elbow injury he sustained with Smith's Construction in October 2004. (Ex. 3, p. 5) Dr. Deffer noted at that time Quail had a "dramatic loss of motion and had evidence of osteophyte formation," and underwent an arthroscopy and removal of loose bodies and osteophytes. (Ex. 3, p. 5) Dr. Deffer documented Quail regained his motion and he was released from care in February 2006, with full flexion and ten degrees short of full extension with full pronation and supination. (Ex. 3, p. 5)

Dr. Deffer relayed Quail returned to him on October 12, 2015, with significant osteoarthritis of the right elbow with bone spur formation and loose bodies. (Ex. 3, p. 5) Dr. Deffer reported, "[i]t is reasonable to assume that the patient would develop ongoing degenerative changes as a result of his work activities," exacerbating his preexisting condition. (Ex. 3, p. 5) Dr. Deffer documented he had not seen Quail since February 2016, and he was uncertain whether he had returned to his preinjury condition, which was important to determining whether he sustained a temporary aggravation of a preexisting condition or a permanent aggravation. (Ex. 3, p. 5)

Simonsen and Sentry sent a copy of Dr. Hines's independent medical examination report to Dr. Martin. (Ex. D, p. 10) After reviewing the report, Dr. Martin issued an opinion on February 2, 2017, criticizing Dr. Hines's opinion, noting "insofar as he uses grip strength and other strength determinants for impairment rating. The AMA Guides, Fifth Edition, is very clear that strength can not be used as a methodology for impairment rating when there is pain, lack of motion or absence of body parts – which obviously, we have here because of the gentleman's previous problems." (Ex. D, p. 11) Dr. Martin further opined he disagreed with Dr. Hines that Quail's right carpal tunnel, ulnar neuropathy, and lateral epicondylitis conditions are related to the work incident or his job duties, noting:

> I think the medical record clearly shows preexisting issues with regards to this gentleman's right elbow, as well as right carpal tunnel syndrome. As I explained to you on the telephone, I would have extreme difficulty in trying to differentiate out a true lateral epicondylar problem, as opposed to generalized elbow pain secondary to this gentleman's limitations of motion and his advanced degenerative changes. I would respectfully point out that the term "lateral epicondylitis" is technically incorrect, in that it implies

> an inflammatory condition. We now know, from a variety of studies, that tennis elbow is, instead, an angiofibrotic dysplastic abnormality and does not have a relationship to an inflammatory condition.

(Ex. D, p. 11) Dr. Martin opined Quail's carpal tunnel, ulnar neuropathy, and lateral epicondylitis are preexisting conditions. (Ex. D, p. 12)

Quail testified that since his work injury he has numbness in his little finger, pain in his elbow, his elbow snaps and pops when he rotates his hands, his hand falls asleep two or three times per night while he is sleeping, he had a knot in the back of his neck and when he looks up in the air he experiences a pulling sensation in his arm. (Tr., pp. 67, 71) Quail reported he cannot lift a fork with his right hand up to his mouth, he has difficulty buttoning shirts, he has difficulty writing, and he drops things. (Tr., pp. 67, 69-70) Quail relayed that driving more than an hour causes his neck to become tight. (Tr., pp. 68-69) Quail continues to take Flexeril. (Tr., p. 68)

Quail has performed manual labor for most of his life. (Tr., p. 76) Quail reported he has been unable to find work given his ten pound lifting restriction. (Tr., p. 76)

CONCLUSIONS OF LAW

I. Credibility

Simonsen and Sentry aver Quail is not a credible witness. When assessing witness credibility, the trier of fact "may consider whether the testimony is reasonable and consistent with other evidence, whether a witness has made inconsistent statements, the witness's appearance, conduct, memory and knowledge of the facts, and the witness's interest in the [matter]." State v. Frake, 450 N.W.2d 817, 819 (Iowa 1990). Quail has an obvious interest in this case given he is seeking workers' compensation benefits. During the hearing I did not observe Quail engage in any furtive movements. His eye contact and rate of speech were appropriate.

Quail is a poor historian. During his testimony Quail was confused about the dates he returned to work. Quail reported he returned to work on October 19, 2015, and alleges Simonsen terminated him while he was restricted from working. (Tr., p. 54) The record supports Quail called Simonsen October 5, 2015 through October 8, 2015. (Exs. 15A-15G) The record does not support he returned to work on October 19, 2015. Quail admitted he did not make any calls to Simonsen October 19, 2015 through October 22, 2015. (Tr., p. 88) Hinton testified Simonsen did not receive any documentation restricting Quail from working after October 19, 2015, through the time of his discharge. (Ex. 12, pp. 11-12)

In addition, Quail testified, "I never really had any problems with [my elbow]" before his October 5, 2015 work injury, and it did not limit his ability to work prior to his work injury. (Tr., p. 46) This testimony is inconsistent with sworn testimony from Besaw and Hinton, both employees of Simonson. Besaw and Hinton both testified that prior to Quail's October 5, 2015 work injury, they observed him wearing a sling on his right arm and he reported his right arm problems were due to swinging a hammer for many years.

(Exs. 11, p. 9; 12, pp. 3-4) Quail's testimony is also inconsistent with his medical records. Quail attended an appointment with Dr. Rierson, an orthopedic surgeon, complaining of right elbow pain on September 28, 2015, before the October 5, 2015 incident. (Ex. 1, p. 1)

Quail was also dishonest when he completed a medical history form at the time of his hiring with Simonsen. The medical inquiry from asked, "[h]ave you had any injuries on the job? If yes, please describe: date of injury, employer, body part affected, cause, amount of lost time, any permanent disability (%), was workers comp. claim filed?" (Ex. B, p. 1) Quail checked "no" with respect to the question and he did not provide any additional comments. (Ex. B, p. 1) Quail testified he responded "no" because he "could do the work. I didn't have any problems with any of my other surgeries, and I needed to – I needed the job." (Tr., p. 31)

On the medical inquiry form Quail reported he wore a brace for right tennis elbow "yrs ago," but denied ever having problems with hand numbness or tingling, carpal tunnel syndrome, or tendonitis. (Ex. B, p. 2) This is also untrue. When questioned about his statements, Quail testified when Simonsen hired him he did not have any restrictions or limitations with his neck, arm, shoulder, or hand, and he was not treating with a physician at that time. (Tr., p. 35)

Quail received workers' compensation benefits for multiple work injuries prior to his employment with Simonsen, including his right upper extremity. During cross-examination Quail acknowledged that he knew his answer was incorrect at the time he gave it. (Tr., p. 78) I do not find Quail's testimony regarding his right elbow condition before October 5, 2015, reasonable and consistent with other evidence I believe. Based on the false statements, I do not find Quail to be a credible witness. I do not believe Quail's testimony that he was not having problems with his right elbow before the October 5, 2015 incident.

II. Nature of the Injury

Quail alleges he sustained permanent injuries to his shoulder, cervical spine, and right upper extremity as a result of the October 5, 2015 work injury. Simonsen and Sentry deny Quail's assertions, and contend Quail sustained no permanent impairment to his shoulder and cervical spine as a result of the October 5, 2015 work injury, and his right upper extremity problems are preexisting and not causally related to the October 5, 2015 work injury.

To receive workers' compensation benefits, an injured employee must prove, by a preponderance of the evidence, the employee's injuries arose out of and in the course of the employee's employment with the employer. 2800 Corp. v. Fernandez, 528 N.W.2d 124, 128 (Iowa 1995). An injury arises out of employment when a causal relationship exists between the employment and the injury. Quaker Oats v. Ciha, 552 N.W.2d 143, 151 (Iowa 1996). The injury must be a rational consequence of a hazard connected with the employment, and not merely incidental to the employment. Koehler

Elec. v. Willis, 608 N.W.2d 1, 3 (Iowa 2000). The Iowa Supreme Court has held, an injury occurs "in the course of employment" when:

> it is within the period of employment at a place where the employee reasonably may be in performing his duties, and while he is fulfilling those duties or engaged in doing something incidental thereto. An injury in the course of employment embraces all injuries received while employed in furthering the employer's business and injuries received on the employer's premises, provided that the employee's presence must ordinarily be required at the place of the injury, or, if not so required, employee's departure from the usual place of employment must not amount to an abandonment of employment or be an act wholly foreign to his usual work. An employee does not cease to be in the course of his employment merely because he is not actually engaged in doing some specifically prescribed task, if, in the course of his employment, he does some act which he deems necessary for the benefit or interest of the employer.

Farmers Elevator Co. v. Manning, 286 N.W.2d 174, 177 (Iowa 1979).

The claimant bears the burden of proving the claimant's work-related injury is a proximate cause of the claimant's disability and need for medical care. Ayers v. D & N Fence Co., Inc., 731 N.W.2d 11, 17 (Iowa 2007); George A. Hormel & Co. v. Jordan, 569 N.W.2d 148, 153 (Iowa 1997). "In order for a cause to be proximate, it must be a 'substantial factor.'" Ayers, 731 N.W.2d at 17. A probability of causation must exist, a mere possibility of causation is insufficient. Frye v. Smith-Doyle Contractors, 569 N.W.2d 154, 156 (Iowa Ct. App. 1997). The cause does not need to be the only cause, [i]t only needs to be one cause." Armstrong Tire & Rubber Co. v. Kubli, 312 N.W.2d 60, 64 (Iowa 1981).

The question of medical causation is "essentially within the domain of expert testimony." Cedar Rapids Cmty. Sch. Dist. v. Pease, 807 N.W.2d 839, 844-45 (Iowa 2011). The deputy commissioner, as the trier of fact, must "weigh the evidence and measure the credibility of witnesses." Id. The trier of fact may accept or reject expert testimony, even if uncontroverted, in whole or in part. Frye, 569 N.W.2d at 156. When considering the weight of an expert opinion, the fact-finder may consider whether the examination occurred shortly after the claimant was injured, the compensation arrangement, the nature and extent of the examination, the expert's education, experience, training, and practice, and "all other factors which bear upon the weight and value" of the opinion. Rockwell Graphic Sys., Inc. v. Prince, 366 N.W.2d 187, 192 (Iowa 1985).

It is well-established in workers' compensation that "if a claimant has a preexisting condition or disability, aggravated, accelerated, worsened, or 'lighted up' by an injury which arose out of and in the course of employment resulting in a disability found to exist," the claimant is entitled to compensation. Iowa Dep't of Transp. v. Van Cannon, 459 N.W.2d 900, 904 (Iowa 1990). The Iowa Supreme Court has held,

> a disease which under any rational work is likely to progress so as to finally disable an employee does not become a "personal injury" under our Workmen's Compensation Act merely because it reaches a point of disablement while work for an employer is being pursued. It is only when there is a direct causal connection between exertion of the employment and the injury that a compensation award can be made. The question is whether the diseased condition was the cause, or whether the employment was a proximate contributing cause.

Musselman v. Cent. Tel. Co., 261 Iowa 352, 359-60, 154 N.W.2d 128, 132 (1967).

Quail sustained a work injury on October 5, 2015, and he received medical treatment the day of the injury from Dr. Feldmann. (Ex. 2, p. 1) Dr. Feldmann assessed Quail with a right trapezius, posterior trapezius strain, imposed a ten pound lifting restriction and restrictions of avoiding lifting over shoulder height, forceful pushing, and pulling, and he restricted Quail from working that day. (Ex. 2, pp. 4-5) Dr. Feldmann treated Quail for his neck and shoulder complaints on October 9, 2015, and October 22, 2015. (Ex. 2, pp. 6-14) Dr. Feldmann did not treat Quail for any right elbow complaints.

A. Cervical Spine and Right Shoulder

Quail alleges the October 5, 2015 work injury caused permanent impairments to his cervical spine and right shoulder. Four physicians have provided opinions regarding Quail's work injuries, Dr. Rierson, a treating orthopedic surgeon, Dr. Deffer, a treating orthopedic surgeon, Dr. Martin, an occupational medicine physician who examined Quail for purposes of conducting an independent medical examination only, and Dr. Hines, a neurosurgeon who examined Quail for purposes of conducting an independent medical examination only.

Dr. Martin initially opined,

> [r]egarding any issues with respect to his right shoulder and his neck area, I do believe that has causal correlation to the work related event that has been described to me. The mechanism of injury was recreated today and I certainly can understand, in the position that he was in, how this could have created a rotator cuff injury or perhaps a cervical disk injury.

(Ex. D, p. 6) After reviewing magnetic resonance imaging of Quail's cervical spine and right shoulder, Dr. Martin found the imaging did not support Quail had sustained any acute injuries, and opined Quail's cervical spine and right shoulder conditions were not caused by the work injury. (Ex. D, p. 1) Drs. Hines, Rierson, and Deffer did not offer contrary opinions. None of the examining physicians have opined Quail sustained a permanent to his cervical spine or right shoulder as a result of the October 5, 2015, work injury. Quail has not met his burden of proof that he sustained temporary or permanent impairments to his cervical spine and right shoulder as a result of the work injury.

B. Right Elbow Condition

Quail alleges he sustained a permanent impairment to his right elbow as a result of the October 5, 2015 work injury. Drs. Rierson, Deffer, Martin, and Hines provided opinions regarding the alleged injury to Quail's right elbow. All four physicians agree Quail has a right elbow condition, but disagree regarding causation.

Dr. Martin opined Quail's right elbow condition is a preexisting problem, and while he may have had an increase in pain after the incident on October 5, 2015, he does not "think that is representative of an injury acceleration or an exacerbation, but, rather, an increase in the amount of pain during an event process that can be related more to previous advanced degenerative issues of the elbow going forward." (Ex. D, p. 6)

Dr. Hines disagreed with Dr. Martin, opining Quail's multiple loose bodies in the elbow, and ulnar and median neuropathy conditions present in Quail's right elbow are causally related to the October 5, 2015 incident. (Ex. 10, pp. 13-14) Dr. Hines acknowledged while the right ulnar neuropathy and median neuropathy at the right elbow may have more than one etiology, Quail's repetitive work and the fall on the elbow "may be partly contributory to that difficulty," and Quail had managed his right elbow condition with multiple loose bodies "to the point of minimal deficit" until the October 5, 2015 work injury, which included a fall onto the elbow. (Ex. 10, pp. 13-14) Dr. Hines' opinion is equivocal, I do not find it convincing.

Dr. Rierson, a treating orthopedic surgeon, opined Quail's x-rays from September 28, 2015 showed significant degenerative and arthritic changes in his right elbow, he referred Quail to Dr. Deffer, recommended Quail undergo surgical intervention for his right elbow condition, noted the elbow condition was not related to his work, "but instead was a degenerative and/or arthritic condition not covered under workers' compensation at the time of the referral," and he agreed with Dr. Martin that the method of injury "is not likely to have caused a large osteophyte to break off of Mr. Quail's elbow, but it more likely than not caused pain to his preexisting degenerative and arthritic condition in his right elbow." (Ex. E, pp. 1-2) Dr. Rierson agreed he could not state whether the October 5, 2015, work injury was the cause for his need for surgical intervention because he had not examined him after September 28, 2015. (Ex. E, p. 2)

Dr. Deffer, a treating orthopedic surgeon, also opined Quail's x-rays from September 28, 2015 showed significant degenerative and arthritic changes in his right elbow, Dr. Rierson had recommended surgical intervention that date, a computerized tomography scan following the October 5, 2015 injury did not show an acute injury, and while Quail may have experienced an increase in pain as a result of the October 5, 2015 injury, "that did not change the need for surgery which existed prior to the 10/05/15 injury, and therefore would not have been a significant and material aggravation of his preexisting condition." (Ex. F, pp. 1-2)

In response to an inquiry from Quail's counsel in February 2017, Dr. Deffer noted, "[i]t is reasonable to assume that the patient would develop ongoing

degenerative changes as a result of his work activities," exacerbating his preexisting condition. (Ex. 3, p. 5) Dr. Deffer documented he had not seen Quail since February 2016, and he was uncertain whether he had returned to his preinjury condition, which is important to determining whether he sustained a temporary aggravation of a preexisting condition or a permanent aggravation. (Ex. 3, p. 5) Dr. Deffer modified his earlier opinion, noting he could not determine whether Quail had sustained a temporary aggravation of a preexisting condition or a permanent aggravation of a preexisting condition. (Ex. 3, p. 5)

I find the opinion of Drs. Rierson and Martin most persuasive. Dr. Hines acknowledged while the right ulnar neuropathy and median neuropathy at the right elbow may have more than one etiology, "[c]ertainly with regard to the median," Quail's repetitive work and the fall on the elbow "may be partly contributory to that difficulty," and Quail had managed his right elbow condition with multiple loose bodies "to the point of minimal deficit" until the October 5, 2015 work injury, which included a fall onto the elbow. (Ex. 10, pp. 13-14) Dr. Hines discussed Dr. Rierson's medical records from the September 28, 2015 visit, but he did not discuss Dr. Rierson's recommendation of surgery before the October 5, 2015 work injury. (Ex. 10, pp. 3-4) Dr. Hines' opinion does not discuss or counter Dr. Deffer's finding that the computerized tomography scan following the October 5, 2015, work injury revealed no acute injury.

Simonsen did not select Dr. Rierson or Dr. Deffer to treat Quail. Quail selected Drs. Rierson and Deffer. Dr. Deffer first treated Quail for a right elbow work injury in 2005. (Ex. 10, pp. 2-3) Quail experienced a pop in his right elbow while pushing a heavy window, with associated pain and swelling. (Ex. 10, pp. 2-3) Dr. Deffer diagnosed Quail with right elbow osteoarthritis with loose bodies, and performed a right elbow arthroscopy, retrieval of loose bodies, and arthroscopic debridement in 2006. (Ex. A, p. 1) When he was released from care Quail's flexion was excellent, but he "lacked about 10-degrees short of full extension." (Ex. 10, p. 3)

Quail did not receive medical treatment for his right elbow condition for several years after he was released by Dr. Deffer. On September 28, 2015, Quail attended an appointment with Dr. Rierson, Dr. Deffer's practice partner, complaining of right elbow pain and discomfort. Following an examination, Dr. Rierson recommended Quail undergo surgery for his right elbow condition before the October 5, 2015, work injury. Dr. Deffer noted the computerized tomography scan following the October 5, 2015, work injury did not show an acute injury, did not change the need for surgery, and the work injury did not cause "a significant and material aggravation" of Quail's preexisting condition. (Ex. F, pp. 1-2) Dr. Deffer later modified his opinion, noting that he had not examined Quail in some time, and he could not determine whether Quail had sustained a temporary aggravation of a preexisting condition or a permanent aggravation of a preexisting condition. (Ex. 3, p. 5)

The record does not support Quail's preexisting right elbow condition was aggravated, accelerated, worsened, or lighted up by the October 5, 2015, incident. Quail has not met his burden of proof that he sustained a temporary or permanent impairment to his right elbow caused by the October 5, 2015 work injury. Given these

findings, Quail is not entitled to an award of penalty benefits, or to recover the costs of the medical expenses set forth in Exhibit 13.

III. Costs

Quail seeks to recover the $100.00 filing fee for the petition, the $155.00 cost of Quail's deposition, $65.51 for medical records, and the $209.52 cost of Dr. Deffer's report. Rule 876 IAC 4.33(6), provides

> [c]osts taxed by the workers' compensation commissioner or a deputy commissioner shall be (1) attendance of a certified shorthand reporter or presence of mechanical means at hearings and evidential depositions, (2) transcription costs when appropriate, (3) costs of service of the original notice and subpoenas, (4) witness fees and expenses as provided by Iowa Code sections 622.69 and 622.72, (5) the costs of doctors' and practitioners' deposition testimony, provided that said costs do not exceed the amounts provided by Iowa Code sections 622.69 and 622.72, (6) the reasonable costs of obtaining no more than two doctors' or practitioners' reports, (7) filing fees when appropriate, (8) costs of persons reviewing health service disputes.

The rule does not expressly allow for the recovery of costs for medical records. Given I found Quail failed to meet his burden of proof in this case, I find the parties should pay their own costs.

ORDER

IT IS THEREFORE ORDERED, THAT:

Claimant shall take nothing additional in this proceeding.

Defendants shall file subsequent reports of injury as required by this agency pursuant to rules 876 IAC 3.1(2) and 876 IAC 11.7.

Signed and filed this 15th day of September, 2017.

HEATHER L. PALMER
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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HLP/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.