BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

WILLIAM PECKHAM, Claimant, vs. ROGER ROBERTS d/b/a ROBERTS CONSTRUCTION, Employer, and AUTO-OWNERS INSURANCE GROUP, Insurance Carrier, Defendants.	:	File No 5056939 ARBITRATION DECISION Head Note Nos.: 1803, 3000, 3002

FILED
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WORKERS COMPENSATION

STATEMENT OF THE CASE

This is a proceeding in arbitration. The contested case was initiated when claimant, Bill Peckham, filed his original notice and petition with the Iowa Division of Workers' Compensation. The petition was filed on July 11, 2016. Claimant alleged he sustained a work-related injury on July 6, 2013. (Original notice and petition)

For purposes of workers' compensation, Roger Roberts d/b/a Roberts Construction, is insured by Auto Owners Insurance Group. Defendants filed their answer on July 15, 2016. The defendants admitted the occurrence of the work injury. A First Report of Injury was filed on July 12, 2013.

The hearing administrator scheduled the case for hearing on September 7, 2017. The hearing took place in Des Moines, Iowa at 150 Des Moines Street. The undersigned appointed Ms. Brittney Sposeto, as the certified shorthand reporter. She is the official custodian of the records and notes.

Claimant testified on his own behalf. Defendants elected not to call any witnesses at the hearing. Joint Exhibits 1 through 7 were admitted. Claimant offered Exhibits 1 through 3. They were admitted. Defendants offered Exhibits A through L. They were also admitted. The parties also submitted post-hearing briefs on October 13, 2017. The case was deemed fully submitted on that date.

STIPULATIONS

The parties completed the designated hearing report. The various stipulations are:

1. There was the existence of an employer-employee relationship at the time of the alleged injury;

2. Claimant sustained an injury on July 6, 2013 which arose out of and in the course of his employment;

3. The alleged injury is a cause of both temporary and permanent disability;

4. Healing period benefits are no longer an issue;

5. The parties agree any weekly benefit rate should be paid at $361.52 per week;

6. Defendants waive any affirmative defenses they may have had available to them;

7. Prior to the hearing, defendants paid claimant 68 weeks of permanent partial disability benefits at the correct rate of $361.52 per week; and

8. The parties agree claimant has paid the costs listed in his attachment.

ISSUES

The issues presented are:

1. The nature and extent of claimant's permanent partial disability; and

2. The commencement date for the payment of permanent partial disability benefits.

FINDINGS OF FACT

This deputy, after listening to the testimony of claimant at hearing, and after judging the credibility of claimant, plus after reading the evidence, and the post-hearing briefs, makes the following findings of fact and conclusions of law:

The party who would suffer loss if an issue were not established has the burden of proving the issue by a preponderance of the evidence. Iowa Rule of Appellate Procedure 6.14(6).

Claimant is single with one minor child. He resides in Creston, Iowa which is located in Union County. It is a small town of approximately 7,600 individuals. Claimant

grew up on a farm in Macksburg, Iowa. He graduated from high school in 1990. He attended less than one semester of college at Southwestern Community College. From 1995 through 1999 claimant served in the United States Navy. He served in both Bosnia and Bahrain. Claimant worked as a mechanic in the Navy. Claimant is a one pack per day smoker of tobacco products. He has been encouraged to stop smoking.

In 2013 claimant was hired by Mr. Roberts from Afton, Iowa to work as a carpenter for Roger Roberts Construction Company. On the date of the work injury, claimant was standing on a 25 foot ladder when the left foot of the ladder sunk into the ground and began tipping. Claimant fell 25 feet to concrete. He landed on his feet, then his knees, hands, elbows, and finally his face.

The Iowa EMS report is detailed in Exhibit B, pages 5 through 8. C.A. Kleckner, an EMS, authored the report. In the narrative, the provider wrote in relevant part:

> Pt stated the ladder had fallen and he fell to the concrete feet first. Pt stated he landed on his feet, then fell forward onto his hands, then struck his face. Pt denies any head/neck/back pain. Pt's fiance denies pt lost consciousness. Pt c/o left foot and right ankle pain. Pt has a deformed/swollen left foot and swollen right ankle, pulses intact both feet. Pt has an abrasion left knee, a deep approximately 1 cm lac on left elbow, a superficial approximately 0.5cm lac on his forehead, and an abrasion on the bridge of his nose.

(Exhibit B, page 6)

Claimant was transported to Greater Regional Medical Center in Creston. (Ex. C, pp. 9-10) David Steele, M.D., diagnosed claimant with the following conditions:

1. Fall.
2. Right comminuted talus fracture.
3. Right comminuted calcaneus fracture.
4. Disruption of tibiotalar joint.
5. Left medial talus fracture.
6. Fourth and fifth left metatarsophalangeal joint dislocations.
7. Angulated fracture of left third metatarsal neck.

(Ex. C, p. 10)

Because of the nature of the injuries, claimant was transported to Iowa Methodist Medical Center. (Joint Ex. 1, pp. 1 through 10) Jon C. Gehrke, M.D., commenced treatment of claimant. On July 10, 2013, Dr. Gehrke performed an open reduction and internal fixation of the right talus. (Jt. Ex. 1, p. 5) Claimant was placed in a well-padded posterior splint. (Jt. Ex. 1, p. 6) On July 31, 2013, Dr. Gehrke performed an open reduction and internal fixation of the metatarsophalangeal joint number 4 and 5 on the left foot. The two toes were pinned from the toe tip into each respective metatarsal. (Jt. Ex. 1, p. 8) On January 7, 2014, claimant underwent right knee arthroscopy with meniscus debridement. (Transcript, p. 43) On January 13, 2014, Dr. Gehrke released claimant to "Sit Down" work only – No standing or walking. (Jt. Ex. 3, p. 56)

Not only was care authorized with Dr. Gehrke, but defendants also authorized care with Daniel C. Miller, D.O., at Occupational Medicine Plus, P.C. in Clive, Iowa. (Jt. Ex. 2) The initial evaluation occurred on July 17, 2013. (Jt. Ex. 2, p. 11) Claimant complained of the following issues, which are partially listed:

> The R knee has not been treated to date.
>
> Claimant reported, "I smacked my forehead off the concrete."
>
> Pt c/o "knot" on the forhead [*sic*] – healed but still bothers him
>
> Again he states he thinks his nose is possibly broken.
>
> L elbow – pt states there is "a hole there that is infected and pus is coming out of it".
>
> Abrasions on L knee are "pretty much healed".
>
> R knee – pt states it "swells and goes down from the torn ligament". Again, this has not yet been treated and Lori states she plans to address this with Dr. Gehrke at the appt scheduled for this Friday.
>
> Ins req a once over of all complaints minus the B ankles and feet (as previously stated, he is treating with Gehrke for this.)

(Jt. Ex. 2, p. 11)

There was a follow up appointment on July 29, 2013. (Jt. Ex. 2, p. 15) Claimant discussed the "knot" on his forehead. He indicated there was only occasional moisture in the area and he was still bothered by the spot. (Jt. Ex. 2, p. 15) Claimant's nose was not really bothering him. (Jt. Ex. 2, p. 15) He did acknowledge he had a previous nasal fracture. (Jt. Ex. 2, p. 11) Claimant reported fluid on the left elbow but there was no pus draining from the wound. (Jt. Ex. 2, p. 15) The abrasions on the left knee were healed. (Jt. Ex. 2, p. 15) Dr. Miller treated claimant for traumatic bursitis of the left elbow. (Jt. Ex. 2, p. 24) Claimant reported experiencing migraine headaches but

Dr. Miller did not determine the cause of those headaches. (Jt. Ex. 2, p. 24) The physician surmised the headaches were related to the use of Vicodin. (Jt. Ex. 2, p. 24) Imitrex 25 mg was prescribed for migraine headaches not otherwise specified, (NOS). (Jt. Ex. 2, p. 31)

On September 16, 2013, claimant visited Bryan L. Folkers, D.O., a plastic surgeon. Dr. Folkers evaluated claimant's nasal fracture. A CT maxillofacial scan of the facial bones was taken. Dr. Folkers reviewed the scan. It showed multiple fractures and bone fragments involving the nasal bones. Dr. Folkers opined the following about the two fractures:

> They appear to be chronic and more of a distant past than a recent traumatic injury to this area. There are two smaller fragments in the anterior portion of the nasal bone that are less sclerotic and these are probably more acute in nature when I reviewed this; they do not seem to be displaced. The nasal septum is deviated to the left. No other fractures are noted. No septal hematoma is noted.

Dr. Folkers conducted a physical examination of the nasal area. He found:

> There is no edema, swelling, or periorbital edema or ecchymosis. A nasal speculum was used to visualize the internal nasal vault and it shows turbinate hypertrophy bilaterally. It shows septal deviation to the patient's left. He does have good air flow bilaterally with occlusion, as well as extraction test to open the internal nasal valve angle and shows increased air flow. There is no growth deformity on examination of the nasal bones. He exhibits no tenderness over this area. He also has a scar over his glabella area as a result of the injury and this has a little bit of scar tissue in the subcutaneous fatty area. I instructed him on scar massage in this area. On facial exam he has poor dentition. He has good occlusion. No trismus noted. No maxillary tenderness. No mandibular tenderness. PERRLA. EOMFL. No neurosensory deficit bilaterally. Infraorbital feel within normal limits.
>
> ASSESSMENT 1. Nasal fracture and septal deviation as noted above.
>
> PLAN Due to his asymptomatic nature and the chronic history of nasal fracture I do not believe this needs to be surgically corrected at this time. He does have septal deviation on the left that may cause him some obstructed air flow in the future. I do not believe this is a cause from the recent traumatic event. I instructed him not to blow his nose for a period of time and use nasal saline spray, as well as a Breathe Right strip. He will follow up with me on a p.r.n. basis.

(Ex. E, pp. 22-23)

On May 19, 2014, Dr. Gehrke ordered a functional capacity evaluation (FCE). (Jt. Ex. 3, p. 60) A baseline FCE was conducted on June 10, 2014 at Accelerated Rehabilitation Centers. Mr. Mitch Thole, P.T., DPT, conducted the examination. The physical therapist opined claimant was employable within the confines of his physical capabilities and tolerances. (Jt. Ex. 5, p. 78)

Dr. Gehrke declared claimant to be at maximum medical improvement on June 27, 2014. The orthopedic surgeon opined the following with respect to claimant's ability to return to work:

> 1. I believe the patient can go back to a sedentary type capacity, maybe even using machinery but not on his feet for extended periods of time. He would be able to climb up into machinery in my opinion so he may sit down and use the machinery.
>
> 2. The patient does have retained hardware on the right ankle and may benefit at some point down the road from hardware removal if indicated.

(Jt. Ex. 3, pp. 61-62)

Dr. Gehrke provided a permanent impairment rating in his report of August 18, 2014. The surgeon calculated the rating as follows:

> With regard to his right knee, the patient sustained a medial meniscus tear requiring a partial medial meniscectomy resulting in a whole-person impairment rating of 1%, and a lower extremity impairment rating of 2%.
>
> With regard to his right ankle, the patient sustained a talus fracture requiring surgical intervention and now has significant degenerative changes of his ankle and subtalar joint. According to AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, chapter 17, paged [*sic*] table 17-31, this patient has a subtalar joint interval of 1mm resulting in a whole-person impairment rating of 6%, a lower extremity impairment rating of 15%, and a foot impairment rating of 21%.
>
> In addition, his right ankle is affected as well, secondary to this talus fracture. According to Chapter 17, page 544, table 17-31, this patient has a joint interval of his right ankle of 3mm resulting in a 2% whole-person impairment rating and a 5% lower extremity impairment rating.
>
> With regard to his left ankle, the patient sustained a talus fracture with mild resulting degenerative changes. According to chapter 17, page 544, table 17-31, the patient has a cartilage interval of 4mm, resulting in a 2%

> whole-person impairment rating and a 5% lower extremity impairment rating.
>
> All of the above ratings are additive. Right lower extremity and left lower extremity.

(Jt. Ex. 3, pp. 63-64)

On October 8, 2015, Dr. Gehrke performed a right talus hardware removal and debridement of talar dome. (Jt. Ex. 1, p. 9) According to the operative report, the screws were removed without difficulty. There was some drilling into the bone in order to increase blood supply into the area. (Jt. Ex. 1, p. 9)

Claimant testified the screw removal did not really help him. (Tr., p. 50) He stated he is able to walk approximately two blocks. (Tr., p. 50)

Claimant applied for Social Security Disability benefits. As a result, he was sent to Raymond Tibe, Psy.D., for psychological testing and a mental status examination. (Ex. 2, pp. 32-34). The testing occurred on March 29, 2017. Claimant came with his mother who had permission to be included in part of the interview. The clinical psychologist offered the following diagnostic impressions based upon the Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. by the American Psychiatric Association (2005):

Ax I	Cognitive disorder NOS (294.9) Adjustment disorder with depression – chronic (309.00) History of possible ADHD History of combat with some possible symptomotology [*sic*] of PTSD
Ax II	Deferred
Ax III	History of head trauma with memory loss and increased emotionality, chronic pain
Ax IV	History of lack of energy and vitality, dreams and overwhelming thoughts of trauma
Ax V	GAF of 50 -55

> Regarding work related activities, I can see where the mix of the client's physical and emotional issues would make prolonged attention, concentration and pace difficult. I think the client's ability relate to people would be flawed at times by his emotionality. I think the client's ability to process incoming information is probably limited to concrete and direct

> issues. I can see where he could have difficulty with the more abstract and sophisticated. Regarding judgment, I think the client's ability is currently intact for direct and concrete issues. Again, I can see where the more sophisticated and abstract may be taxing at times.

(Ex. 2, p. 34)

On November 20, 2015, claimant presented to the Madison County Memorial Hospital for a consultation with Benjamin Robert Beecher, M.D. Claimant's chief complaint was pain in the lateral right hip. (Jt. Ex. 7, p. 90) Claimant reported he had been diagnosed with bursitis in 2003. Then he discussed his work injury in 2013. Claimant indicated the pain about the lateral aspect of his hip area was more pronounced since his work injury. Claimant complained of pain that started in the area of the buttock and radiated all down the left leg, with numbness and tingling. (Jt. Ex. 7, p. 90)

Dr. Beecher ordered x-rays of the left hip. There were no hip fractures. (Jt. Ex. 7, p. 91) There was the presence of a small cyst at the head/neck junction. (Jt. Ex. 7, p. 91)

Dr. Beecher provided the subsequent assessment for claimant:

> **ASSESSMENT/PLAN:** 44-year-old male with left leg pain. He also has radicular type symptoms including radiating pain, numbness and tingling as well as some tenderness over his trochanteric bursa. Concern that this is mostly coming from his back. We will obtain an MRI of his lumbar spine to evaluate for disc herniation or nerve compression. He will follow up after the MRI. If he does have evidence of this we will get him into a back doctor. I discussed with him the mild trochanteric bursitis he has maybe related to his back itself or maybe secondary. He will follow up after lumbar MRI.

(Jt. Ex. 7, p. 91)

On December 11, 2015, claimant underwent magnetic resonance imaging (MRI). Mitchell R. Erickson, M.D., interpreted the results as:

> Impression:
>
> 1. Broad-based left paracentral disc herniation with mild caudal extent at L5-S1. Findings may affect the left S1 nerve joint.
>
> 2. Asymmetric right high-grade neural foraminal stenosis at L5-S1.

(Jt. Ex. 7, p. 92)

On January 11, 2016, claimant visited Broadlawns Medical Center at the Winterset, Iowa location. (Jt. Ex. 6, p. 85) Matthew C. Biggerstaff, D.O., assessed claimant's lumbar pain, lower extremities, hips and left leg conditions. The physician interpreted the results of the MRI as showing a broad-based disc herniation at L5-S1 affecting the left S1 nerve root. Dr. Biggerstaff also noted there was right-sided foraminal stenosis. (Jt. Ex. 6, p. 85) The left low back pain was chronic in nature and had existed since July of 2014. Claimant reported numbness or tingling with weakness. He stated walking aggravated his pain. (Jt. Ex. 6, p. 86)

Dr. Biggerstaff diagnosed claimant with the following conditions:

1. Herniated lumbar disc without myelopathy –

2. Degeneration of lumbar or lumbosacral intervertebral disc –

3. Lumbar spinal stenosis –

(Jt. Ex. 6, p. 87)

On January 18, 2016, claimant underwent a lumbar epidural steroid injection. (Jt. Ex. 7, p. 93) The injection was performed by Dr. Biggerstaff, at the Madison County Memorial Hospital. (Jt. Ex. 7, p. 93) The patient tolerated the procedure well and was discharged home without complications. (Jt. Ex. 7, p. 93)

Claimant returned to Broadlawns Medical Center on February 29, 2016. He had 80 percent pain relief after his first epidural steroid injection. The pain relief lasted approximately 4 weeks. Claimant desired another injection. (Jt. Ex. 6, p. 88)

Dr. Biggerstaff performed a second lumbar epidural steroid injection on March 7, 2016. Claimant tolerated the procedure well. (Jt. Ex. 7, p.94)

Pursuant to Iowa Code section 85.39, claimant exercised his right to an independent medical examination. Sunil Bansal, M.D., M.P.H., examined claimant on April 7, 2017. (Ex. 1, p. 1) Dr. Bansal causally related the following conditions to claimant's work injury:

<u>HEAD:</u>
Persistent post concussive syndrome.
Migraines
Memory Loss (short and long term memory)
Concentration impairment
Dizziness/vertigo

<u>NOSE:</u>
Nasal fracture and septal deviation.

RIGHT SHOULDER/LEFT SHOULDER:
Examination and symptomatology characteristic of left and rotator cuff pathology. Unfortunately, an MRI has not been performed to adequately elucidate his pathology.

LEFT ELBOW:
Left elbow contusion – resolved.

BACK:
L5-S1 disc herniation.

LEFT HIP:
Aggravation of left hip bursitis.

RIGHT KNEE:
Impaction fracture involving the anterior periphery of the medial tibial plateau. Complex tear of the body and posterior horn of the medial meniscus.

Status post right knee arthroscopy with meniscus debridement.

RIGHT ANKLE/FOOT:
Comminuted right intra-articular talar body fracture, right talar body shoulder fracture with no significant displacement, minimally displaced right calcaneus fracture with talar body fracture.

Status post closed reduction of right talar fracture/dislocation.

Status post open reduction and internal fixation of the right talus.

Status post right talus hardware removal and debridement of the talar dome.

Avascular necrosis of the talar head with post traumatic osteoarthritis of the ankle after open reduction and internal fixation of the talus fracture.

LEFT ANKLE/FOOT:
Nondisplaced medial talus fracture.
Subluxation of left toes four and five at the metatarsophalangeal joints.

Status post open reduction and internal fixation of the fourth and fifth metatarsophalangeal joints, left foot.

(Ex. 1, pp. 23-24)

Dr. Bansal provided a permanent impairment rating for the following:

Right ankle and foot of 3% whole person or 7% lower extremity;

Left ankle and foot of 9% whole person or 23% lower extremity;

Right knee of 1% whole person or 2% lower extremity;

Total of 13% whole person or 32% of the lower extremity.

(Ex. 1, pp. 28-29)

Then Dr. Bansal rated claimant's shoulders at five percent to the whole person or nine percent to the upper extremity. The nose was given two percent to the whole person. Dr. Bansal rated the back as five percent to the whole person. Finally, the evaluating physician rated claimant as having a ten percent permanent impairment to the whole person. (Ex. 1, pp. 27-28)

Pursuant to a request from defendants, Joshua D. Kimmelman, D.O., examined claimant on June 29, 2017 in the offices of Iowa Ortho. (Ex. A, p. 1) Claimant voiced the subsequent complaints to Dr. Kimmelman:

> He complains of pain and numbness across his back and into his LEFT leg. He reports he thought it was his hip but later found out that he had a herniated disk in his back. He actually saw Dr. Ben Beecher for hip pain in January 2016, who felt that his problems were coming from his back, not from his hip, and referred him for a magnetic resonance imaging showing a herniated disk at the L5-S1 on the LEFT side, [*sic*] He had epidural steroid injections for that but reports it continues to be symptomatic. He complains of pain in his RIGHT knee, which he feels is getting worse recently and in his ankles, RIGHT more so than LEFT. He complains of shoulder pain but when asked if he felt this was the result of the accident, he reports he was hard working his whole life and that he has aches and pains and does not particularly attribute his current symptoms of his elbows, wrists or shoulders to his fall. He reports that he does get headaches and that he has a sister who has migraine headaches and that since this episode this fall he has gotten migraine headaches, and he understands the seriousness. It is noted in the record that he did not complain of headaches until October 7, 2013, when he reported daily migraines to Dr. Miller. He reports that his recollection is that he got his first headache either in the hospital or shortly after he got out of the hospital and cannot account for why there was no previous record of headaches. He also complained of bilateral shoulder pain, as I review the records, for the first time on October 28, 2013, and he agrees that this is probably accurate, but believes that his headaches started prior to

> October 2013. He, in the emergency room records and on the tertiary triage trauma team, a primary tertiary trauma team exam on discharge no loss of consciousness and according to the record did not report head trauma while he was hospitalized at this hospital. He report [*sic*] that he can only walk two blocks at this time because he will get pain in his knee as well as pain in his RIGHT ankle as well as the LEFT leg.

(Ex. A, p. 2)

Dr. Kimmelman noted claimant could not sit still. His arms would flap around, his head moved and claimant moved his back all over while he was sitting in a chair. (Ex. A, p. 2) Dr. Kimmelman described the movements as extrapyramidal or uncontrolled motions. The evaluating physician did not relate the uncontrolled movements to the work injury. (Ex. A, p. 4) Likewise, Dr. Kimmelman did not relate any migraine headaches to the work injury. The basis for Dr. Kimmelman's opinion was the headaches did not appear until October of 2013. The headaches developed more than three and one-half months after the occurrence of the work injury. (Ex. A, pp. 3-4) Dr. Kimmelman found no documentation to substantiate claimant had a brain injury with bleeding. (Ex. A, p. 4) He ruled out a causally connected brain injury. Dr. Kimmelman stated he did not have the expertise to evaluate whether claimant had memory loss. (Ex. A, p. 4)

With respect to the back and the left hip, Dr. Kimmelman opined claimant had a herniated disk as demonstrated on magnetic resonance imaging. However, the original complaint was a left hip injury.

The evaluating physician did find permanent impairment ratings for the right knee and the right intra-articular ankle injury with avascular necrosis and the left ankle did demonstrate posttraumatic changes but well-preserved joint spaces. (Ex. A, p. 4) Dr. Kimmelman rated claimant as having a 2 percent permanent impairment for a right leg partial menisectomy, and a 48 percent permanent impairment for right leg foot and ankle injury. The total impairment equates to 49 percent permanent impairment to the right leg. (Ex. A, p. 4)

Dr. Kimmelman opined claimant is restricted by his right ankle. The evaluator deemed claimant to be a candidate for a tibiotalar fusion. Such a procedure would place the ankle in a neutral position. Dr. Kimmelman believed the neutral position would improve claimant's function and comfort level. (Ex. A, p. 4)

RATIONALE AND CONCLUSIONS OF LAW

The claimant has the burden of proving by a preponderance of the evidence that the alleged injury actually occurred and that it both arose out of and in the course of the employment. Quaker Oats Co. v. Ciha, 552 N.W.2d 143 (Iowa 1996); Miedema v. Dial Corp., 551 N.W.2d 309 (Iowa 1996). The words "arising out of" referred to the cause or

source of the injury. The words "in the course of" refer to the time, place, and circumstances of the injury. 2800 Corp. v. Fernandez, 528 N.W.2d 124 (Iowa 1995). An injury arises out of the employment when a causal relationship exists between the injury and the employment. Miedema, 551 N.W.2d 309. The injury must be a rational consequence of a hazard connected with the employment and not merely incidental to the employment. Koehler Electric v. Wills, 608 N.W.2d 1 (Iowa 2000); Miedema, 551 N.W.2d 309. An injury occurs "in the course of" employment when it happens within a period of employment at a place where the employee reasonably may be when performing employment duties and while the employee is fulfilling those duties or doing an activity incidental to them. Ciha, 552 N.W.2d 143.

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

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

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

occupational disease covered by chapter 85A is specifically excluded from the definition of personal injury. Iowa Code section 85.61(4) (b); Iowa Code section 85A.8; Iowa Code section 85A.14.

While a claimant is not entitled to compensation for the results of a preexisting injury or disease, its mere existence at the time of a subsequent injury is not a defense. Rose v. John Deere Ottumwa Works, 247 Iowa 900, 908, 76 N.W.2d 756, 760-61 (1956). It the claimant had a preexisting condition or disability that is materially, aggravated, accelerated, worsened or lighted up so that it results in disability, claimant is entitled to recover. Nicks v. Davenport Produce Co., 254 Iowa 130, 135, 115 N.W.2d 812, 815 (1962); Yeager v. Firestone Tire & Rubber Co., 253 Iowa 369, 375, 112 N.W.2d 299, 302 (1961).

When an expert's opinion is based upon an incomplete history it is not necessarily binding on the commissioner or the court. It is then to be weighed, together with other facts and circumstances, the ultimate conclusion being for the finder of the fact. Musselman v. Central Telephone Company, 154 N.W.2d 128, 133 (Iowa 1967); Bodish v. Fischer, Inc., 257 Iowa 521, 522, 133 N.W.2d 867 (1965).

The weight to be given an expert opinion may be affected by the accuracy of the facts the expert relied upon as well as other surrounding circumstances. St. Luke's Hospital v. Gray, 604 N.W.2d 646 (Iowa 2000).

Expert testimony may be buttressed by supportive lay testimony. Bradshaw v. Iowa Methodist Hospital, 251 Iowa 375, 380; 101 N.W.2d 167, 170 (1960).

The commissioner as trier of fact has the duty to determine the credibility of the witnesses and to weigh the evidence. Together with the other disclosed facts and circumstances, and then to accept or reject the opinion. Dunlavey v. Economy Fire and Casualty Co., 526 N.W.2d 845 (Iowa 1995).

Under the Iowa Workers' Compensation Act permanent partial disability is categorized as either to a scheduled member or to the body as a whole. See section 85.34(2). Section 85.34(2)(a)-(t) sets forth specific scheduled injuries and compensation payable for those injuries. The extent of scheduled member disability benefits to which an injured worker is entitled is determined by using the functional method. Functional disability is "limited to the loss of the physiological capacity of the body or body part." Mortimer v. Fruehauf Corp., 502 N.W.2d 12, 15 (Iowa 1993); Sherman v. Pella Corp., 576 N.W.2d 312 (Iowa 1998). Compensation for scheduled injuries is not related to earning capacity. The fact-finder must consider both medical and lay evidence relating to the extent of the functional loss in determining permanent disability resulting from an injury to a scheduled member. Terwilliger v. Snap-On Tools Corp., 529 N.W.2d 267, 272-273 (Iowa 1995); Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417, 420 (Iowa 1994).

Benefits for permanent partial disability of two members caused by a single accident is a scheduled benefit under section 85.34(2)(s); the degree of disability must be computed on a functional basis with a maximum benefit entitlement of 500 weeks. Simbro v. DeLong's Sportswear, 332 N.W.2d 886 (Iowa 1983).

At the time of the work injury, the first responders noted claimant complained of no head or back injuries. He did not lose consciousness on the date of the work injury. There is absolutely no medical evidence in the entire record to support claimant's claim; he suffered a brain bleed. It is true claimant complained of headaches, dizziness, and memory loss, but those symptoms appeared many months after the work injury occurred. Even though, Dr. Tibe, the licensed clinical psychologist, diagnosed claimant with a cognitive disorder, the disorder was not otherwise specified. Claimant had PTSD but it was related to having served in combat. Claimant had a history of possible ADHD. He had chronic depression. All of Dr. Tibe's opinions were based on the assumption, claimant had a head injury. He did not. Claimant takes nothing in the form of permanency benefits for an alleged head injury.

Dr. Bansal found permanency to the nose. However, the x-rays showed the fractures were more likely than not related to old injuries. Claimant even admitted he sustained a fractured nose when he was a child. Claimant did not sustain a permanent condition to his nose as a result of his work injury. Claimant takes nothing in the form of permanency benefits for an alleged nose injury.

Claimant was not able to prove he had a causal connection between the work accident and the back, shoulders and left hip. Records of the complaints did not appear until months or years after the accident occurred. Again the first responders indicated claimant made no back complaints to them at the time of work injury. Claimant did not seek treatment for his back until the latter part of 2015 and the early part of 2016. The back and hip complaints were just too far removed in time from the work injury to have been causally connected. Additionally, claimant had pre-existing bursitis of the hip. As far as the shoulders were concerned, claimant never really treated for shoulder difficulties. At best, he had muscular strain. Claimant takes nothing in the form of permanency benefits for alleged injuries to his back, shoulders, and left hip.

It is the determination of the undersigned deputy workers' compensation commissioner; claimant has successfully established he sustained injuries to his right foot/ankle, his right knee and his left foot/ankle. Three experts have provided impairment ratings for the lower extremities.

Dr. Gehrke, the authorized treating surgeon, opined claimant could perform work in the sedentary category of labor. The surgeon believed claimant would be capable of climbing into machinery in order to operate the equipment. Dr. Gehrke rated claimant as having a 1 percent whole person impairment for the right knee, an 8 percent whole person impairment for the right foot/ankle and 2 percent whole person impairment for the left foot/ankle. The combined rating totals 11 percent to the body as a whole.

Dr. Bansal, the independent medical examiner, rated claimant as having a permanent impairment rating of 3 percent to the body as a whole for the right ankle/foot, left ankle/foot of 9 percent to the whole person and 1 percent to the body as a whole for the right knee. The combined rating equals 13 percent to the body as a whole.

Finally, there is the rating from Dr. Kimmelman. He rated the right ankle/foot and knee as 49 percent to the right lower extremity or 20 percent to the body as a whole. He did not rate the left ankle/foot. Dr. Kimmelman recommended a fusion of the right ankle. He noted claimant is restricted because of the right foot and ankle.

It is the determination of this deputy; Dr. Kimmelman's opinion carries the most weight with the undersigned. His report was detailed but easy to comprehend. Dr. Kimmelman has practiced in the field of orthopedics for numerous years. He has a stellar reputation. He is the one expert who recommended additional treatment for claimant's right ankle/foot. Claimant has sustained a permanent partial disability to the right leg in the amount of 20 percent to the body as a whole. Because he sustained simultaneous injuries to the leg, the injury is calculated on the basis of 500 weeks. However, this is a case that is figured by the functional method and is not an industrial disability case.

The final issue is the matter of costs. Iowa Code section 86.40 states:

> **Costs.** All costs incurred in the hearing before the commissioner shall be taxed in the discretion of the commissioner.

Iowa Administrative Code Rule 876—4.33(86) states:

> **Costs.** Costs 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. Costs of service of notice and subpoenas shall be paid initially to the serving person or agency by the party utilizing the service. Expenses and fees of witnesses or of obtaining doctors' or practitioners' reports initially shall be paid to the witnesses, doctors or practitioners by the party on whose behalf the witness is called or by whom the report is requested. Witness fees shall be paid in accordance with Iowa Code section 622.74. Proof of payment of any cost shall be filed with the workers' compensation commissioner before it is

> taxed. The party initially paying the expense shall be reimbursed by the party taxed with the cost. If the expense is unpaid, it shall be paid by the party taxed with the cost. Costs are to be assessed at the discretion of the deputy commissioner or workers' compensation commissioner hearing the case unless otherwise required by the rules of civil procedure governing discovery. This rule is intended to implement Iowa Code section 86.40.

Iowa Administrative Code rule 876—4.17 includes as a practitioner, "persons engaged in physical or vocational rehabilitation or evaluation for rehabilitation." A report or evaluation from a vocational rehabilitation expert constitutes a practitioner report under our administrative rules. Bohr v. Donaldson Company, File No. 5028959 (Arb. November 23, 2010); Muller v. Crouse Transportation, File No. 5026809 (Arb. December 8, 2010). The entire reasonable costs of doctors' and practitioners' reports may be taxed as costs pursuant to 876 IAC 4.33. Caven v. John Deere Dubuque Works, File Nos. 5023051, 5023052 (App. July 21, 2009).

Claimant is requesting certain costs as detailed in claimant's attachment to the hearing report.

The following costs are taxed to defendants:

$100.00 filing fee

$ 12.93 service fee

ORDER

THEREFORE, IT IS ORDERED:

Defendants shall pay unto claimant, one hundred (100) weeks of permanent partial disability benefits at the stipulated weekly benefit rate of three hundred sixty-one and 52/100 dollars ($361.52) and commencing from June 28, 2014.

All past due benefits shall be paid in a lump sum together with interest as follows:

> Defendants shall pay accrued weekly benefits in a lump sum together with interest at the rate of ten (10) percent for all weekly benefits payable and not paid when due which accrued before July 1, 2017, and all interest on past due weekly compensation benefits accruing on or after July 1, 2017, shall be payable at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two (2) percent. See: Gamble v. AG Leader Technology, File No. 5054686 (App. Apr. 24, 2018).

Defendants shall take credit for all benefits previously paid to claimant.

Defendants shall pay the costs as detailed in the decision.

Defendants shall file all reports as required by law.

Signed and filed this 31st day of May, 2018.

MICHELLE A. MCGOVERN
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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