BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

KARENJEANNE DUNBAR, Claimant, vs. MENARD, INC., Employer, and XL INSURANCE, Insurance Carrier, Defendants.	:	File Nos. 20008907.02 1657325.02 ARBITRATION DECISION Headnotes: 1402.40, 1803, 1803.1, 2907

Claimant KarenJeanne Dunbar filed a petition in arbitration seeking workers' compensation benefits from defendants Menard Inc., employer, and XL Insurance., insurer. The hearing occurred before the undersigned on August 12, 2021, via CourtCall video conference.

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

The evidentiary record consists of: Joint Exhibits 1 through 8; Claimant's Exhibits 1 through 7; and Defendants' Exhibits A through B. Claimant testified on her own behalf. The evidentiary record was closed on August 12, 2021, and the case was considered fully submitted upon receipt of the parties' briefs on September 27, 2021.

ISSUES

The parties submitted the following disputed issues for resolution:

1. Whether claimant's injury was limited to her shoulder or extended into her body as a whole.

2. Whether claimant is entitled to any additional permanent partial disability (PPD) benefits.

3. Whether claimant is entitled to reimbursement for an independent medical examination (IME) and costs.

FINDINGS OF FACT

Claimant sustained stipulated work-related injuries on September 21, 2018 (File No. 1657325.02) and October 5, 2018 (File No. 20008907.02). On September 21, 2018, claimant was lifting a wooden pallet when she felt a pull in her shoulder. (Hearing Transcript, pp. 31-32) Though she reported the injury, she required no medical treatment and was able to return to her job without issue. (Tr., pp. 32-33)

Then, on October 5, 2018, claimant was lifting a box containing artificial Christmas trees overhead when she felt what she believed to be a tear in the same shoulder. (Tr., p. 33) She felt a burning sensation from the top of her shoulder down into her chest and arm. (Tr., p. 34) She reported the injury to defendant-employer and was taken to a chiropractor hours later after completing a drug screening. (Tr., p. 35) The chiropractor gave claimant a sling to wear and assigned work restrictions. (Tr., pp. 36-37)

Though both claimant and her chiropractor requested that claimant be seen by a medical doctor, defendants continued to send claimant to the chiropractor for several more visits. (Tr., pp. 37-38; Joint Exhibit 1) It was not until October 19, 2018 that claimant was authorized to be evaluated at a medical clinic. (Tr., p. 38; JE 2, pp. 14-16) Claimant was seen in urgent care and occupational health, at which time an MRI was ordered. (JE 2, p. 18) When the MRI revealed tearing, claimant was referred to orthopedics for further evaluation. (JE 2, p. 21; Tr., p. 45)

Defendants then authorized care with Matthew Bollier, M.D., an orthopedist at the University of Iowa Hospitals and Clinics. Claimant was not evaluated by Dr. Bollier until December 10, 2018, more than two months after her injuries. (JE 4, p. 25) Dr. Bollier recommended surgery to address claimant's "rotator cuff tear, biceps tendon as well as the AC joint, which is a pain generator on exam." (JE 4, p. 28) He opined that claimant's work injury "was a significant factor in current shoulder findings." (JE 4, p. 28)

Claimant underwent surgery, which consisted of right shoulder arthroscopy with rotator cuff repair, capsular release, extensive debridement, arthroscopic biceps tenodesis, subacromial decompression, and distal clavicle excision. (JE 4, p. 30) Unfortunately, the surgery was unsuccessful in alleviating claimant's pain symptoms. (Tr., p. 46)

Claimant underwent several months of physical therapy after Dr. Bollier's surgery, but she continued to experience pain. (See Tr., p. 48) Dr. Bollier's office also recommended injections and an at-home TENS unit in the summer of 2019, neither of which had been authorized by defendants by the time claimant followed up with Dr. Bollier on September 20, 2019. (JE 3, pp. 44-50)

At the September 20, 2019 appointment, due to claimant's persistent and ongoing pain that had not been mitigated by treatment, Dr. Bollier placed claimant at maximum medical improvement (MMI), referred claimant for a functional capacity evaluation (FCE) to determine permanent restrictions, and assigned a five percent upper extremity impairment rating for deficits in claimant's shoulder range of motion. (JE 4, p. 52)

Claimant received no additional treatment until a telehealth visit with Dr. Bollier on May 8, 2020. (JE 4, p. 56) She reported pain that was "unchanged" since she last saw Dr. Bollier in September of 2019. (JE 4, p. 56) Dr. Bollier recommended an additional MRI. (JE 4, p. 57)

The MRI revealed an "intact" rotator cuff, but there was some confusion about whether claimant's shoulder contained a "mass" that needed to be aspirated. (JE 4, p. 59; Tr., p. 60) Regardless, claimant had relocated to Florida by this time and decided to forgo any additional surgery. (Tr., pp. 60-61) Other than a one-time appointment with an orthopedist in Florida, claimant had not pursued any additional treatment for her shoulder at the time of the hearing. (Tr., p. 65; JE 7)

Claimant was evaluated for purposes of an IME on March 6, 2020 by Stanley Mathew, M.D. Dr. Mathew agreed with Dr. Bollier's recommendations for an at-home TENS unit and injection therapy and also recommended pain management including physical therapy and medication management. (Claimant's Ex. 2, p. 45) He assigned permanent restrictions but was not asked to give his opinions regarding a permanent partial impairment rating. (See JE 2, pp. 39-40, 45)

Claimant had a subsequent IME with Mark Taylor, M.D., in the summer of 2021. Dr. Taylor assigned a 19 percent right upper extremity impairment based on range of motion deficits in claimant's shoulder and claimant's distal clavicle excision. (Cl. Ex. 1, p. 24) Like Dr. Bollier and Dr. Mathew, Dr. Taylor also recommended permanent restrictions. (Cl. Ex. 1, p. 24)

Dr. Bollier responded to Dr. Taylor's IME in a letter to defendants' counsel. He maintained his five percent upper extremity rating for range of motion deficits and declined to assign impairment for the distal clavicle resection "as this is a chronic degenerative condition and AC joint arthroplasty was not caused by the work injury." (Defendants' Ex. A, p. 1)

In a follow-up letter dated August 9, 2021, Dr. Taylor agreed with Dr. Bollier that claimant "more than likely had AC joint abnormalities on an x-ray even prior to her work injury." (Cl. Ex. 1, p. 31) However, he noted that "[e]ven if there were pre-existing radiographic abnormalities associated with the AC joint, she was asymptomatic until the injury." (Cl. Ex. 1, pp. 31-32) As such, it was Dr. Taylor's opinion that the injury was a "lighting up" of her condition. (Cl. Ex. 1, p. 31)

I find Dr. Taylor's opinion regarding claimant's distal clavicle resection to be most persuasive. While claimant may have had a chronic degenerative condition, Dr. Taylor

is correct that claimant was asymptomatic before her stipulated work injuries and only became symptomatic after. Ultimately claimant would not have required a distal clavicle resection at the time she did but for her work-related injuries. Thus, I find that claimant's distal clavicle resection was related to her work injuries, and I adopt Dr. Taylor's impairment rating.

Claimant's permanent disability is thus based on her distal clavicle resection and range of motion deficits in her shoulder. (Cl. Ex. 1, p. 23) I find this permanent disability was caused by the October 5, 2018 date of injury in File No. 20008907.02; it was not until this date that claimant was unable to work and required medical treatment.

As it specifically relates to claimant's distal clavicle resection, Dr. Taylor's report explains that "[t]he clavicle, or collarbone, originates at the sternum . . . and extends over to or near the shoulder joint where the AC, or acromioclavicular, joint is found." (Cl. Ex. 1, p. 26) Per Dr. Bollier's operative report, the portion of the clavicle that was resected in claimant was on the side of the AC joint—not the sternum. (JE 4, p. 33) ("We resected the distal clavicle so that there was adequate space between the end of the clavicle and the acromion.") When looking at the illustration contained in Dr. Taylor's report, the acromion and AC joint sit just "above" the glenohumeral joint. (Cl. Ex. 1, p. 26) Thus, I find that the portion of claimant's clavicle that was surgically resected was interconnected in location to claimant's glenohumeral joint.

As explained by Dr. Taylor, "In an individual experiencing difficulty related to impingement and other abnormalities associated with the joint, a subacromial decompression is sometimes completed" and might include various procedures to "allow for increased space in the subacromial area and helps to minimize the chances of friction and thus pain." (Cl. Ex. 1, p. 27) Dr. Taylor noted that claimant underwent several of these procedures. (Cl. Ex. 1, p. 27) Thus, I find claimant's distal clavicle resection was performed to improve function of the glenohumeral joint.

CONCLUSIONS OF LAW

The first question that must be decided is whether claimant's injury is limited to her "shoulder" under Iowa Code section 85.34(2)(n) (post-July 1, 2017) or extends into her body as a whole under section 85.34(2)(v).

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

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).

As noted above, claimant underwent surgery consisting of shoulder arthroscopy with rotator cuff repair, capsular release, extensive debridement, arthroscopic biceps tenodesis, subacromial decompression, and distal clavicle excision. I found all of these procedures to be related to claimant's work injuries, including claimant's distal clavicle excision. While claimant may have had some underlying degeneration, she was asymptomatic prior to the incidents at work. Thus, I conclude claimant carried her burden to prove that the entirety of her surgery was caused by claimant's stipulated work-related injuries.

The Commissioner in Deng v.Farmland Foods, File No. 5061883 (App. Sept. 29, 2020) and Chavez v. MS Technology, LLC, File No. 5066270 (App. Sept. 30, 2020) already addressed several of the conditions treated during claimant's surgery. In Deng, the Commissioner concluded the muscles that make up the rotator cuff are included within the definition of "shoulder" under section 85.34(n) and therefore should be compensated as a scheduled member under that section. In Chavez, the Commissioner likewise determined any disability resulting from a subacromial decompression should be compensated as a shoulder. Thus, following the Commissioner's decisions in both Deng and Chavez, I find any disability resulting from claimant's rotator cuff tear and repair and subacromial decompression should be compensated as a shoulder under section 85.34(n).

This leaves claimant's distal clavicle excision for consideration. Claimant notes that her clavicle is also part of her torso and extends to the middle of the chest. She asserts that permanently altering a bone that extends into the sternum likewise permanently alters the torso, which is part of the whole body.

However, as explained above, the only portion of claimant's clavicle that was affected was the portion that is closely interconnected in location to claimant's glenohumeral joint. In other words, the portion of claimant's clavicle that was surgically altered was situated away from claimant's torso and chest. Furthermore, as discussed above, the excision was performed not because claimant had an injury to her clavicle, but instead to treat claimant's shoulder pain and function by creating additional space in the subacromial area to minimize the chances of impingement and resulting pain.

In Deng and Chavez, the Commissioner's rationale turned largely on whether the particular muscle, bone or joint at issue was closely connected and/or intertwined both in function and location to the glenohumeral joint. In Deng, for example, which focused on the claimant's rotator cuff muscles, the Commissioner reasoned as follows:

> Given the entwinement of the glenohumeral joint and the muscles that make up the rotator cuff, including the infraspinatus, and the importance of the rotator cuff to the function of the joint, I find the muscles that make up the rotator cuff are included within the definition of 'shoulder' under section 85.34(2)(n).

In Chavez, the Commissioner offered similar reasoning with respect to the claimant's labrum injury and subacromial decompression:

> Unlike other cases wherein the Supreme Court found the injured body parts in question to be clearly distinct from their corresponding scheduled members, I find the labrum is closely interconnected both in location and function to the glenohumeral joint. In fact, like the rotator cuff, the labrum is not only extremely close in proximity to the glenohumeral joint (if not wholly contained within the joint space), but it is crucial to the proper functioning of the joint.

With respect to the claimant's subacromial decompression, the Commissioner noted the "acromion is closely entwined with the glenohumeral joint both in location and function" and the "subacromial decompression impacted two anatomical parts that are essential to the functioning of the glenohumeral joint; in fact, the procedure was actually performed to improve the function of the joint."

Thus, applying the Commissioner's rationale in Deng and Chavez to the present case, I conclude any permanent disability resulting from claimant's distal clavicle excision should be compensated as a shoulder under section 85.34(2)(n). Like in those cases, the procedure in this case was performed to improve the function of the glenohumeral joint, and the portion of the clavicle that was surgically altered was in close proximity to the joint. Importantly, this was the same conclusion reached by the Commissioner in a recent appeal decision: Welch v. Seneca Tank, File No. 1647781.01 (App. Oct. 20, 2021)

As noted by the Commissioner in Welch, "the scenario presented in this case is different than if claimant had suffered a broken collarbone and the clavicle itself was injured. Here, the clavicle was not injured but was instead altered to improve the functionality of the glenohumeral joint and shoulder (as it is commonly known)."

Claimant also asserts her injury extends beyond the shoulder based on persistent pain in her trapezius. However, no physician assigned any permanent impairment for this alleged pain. Again, the only impairment ratings in the record are for range of motion deficits in claimant's shoulder and for her distal clavicle excision. Thus,

I find claimant failed to carry her burden to prove that her injury extends beyond the shoulder due to this pain complaint.

As a result, I conclude claimant failed to prove that any of her injuries or conditions are compensable as unscheduled, whole body injuries under section 85.34(2)(v). Instead, claimant is entitled to compensation for her scheduled member shoulder under section 85.34(2)(n). Claimant's argument regarding her entitlement to industrial disability benefits under section 85.34(2)(v) is therefore moot.

As discussed above, I found Dr. Taylor's impairment rating to be most persuasive because it included impairment for claimant's distal clavicle excision. Thus, I conclude claimant sustained a 19 percent right upper extremity impairment. See Deng, File No. 5061883 (App. Sept 29, 2020) (finding upper extremity rating—not whole person rating—should be applied to 400-week schedule).

Permanent partial disability compensation for the shoulder shall be paid based on a maximum of 400 weeks. Iowa Code § 85.34(2)(n). Having adopted Dr. Taylor's 19 percent upper extremity impairment rating, I conclude claimant carried her burden to prove she is entitled to 76 weeks of PPD benefits.

In addition to her claim for additional PPD benefits, claimant also seeks reimbursement for her IME and various costs. In her post-hearing brief, claimant clarified that she is seeking reimbursement of her IME with Dr. Taylor (not Dr. Mathew) pursuant to Iowa Code section 85.39. The reimbursement provisions of this section were triggered by Dr. Bollier's impairment rating on September 20, 2019. Claimant did not obtain her IME with Dr. Taylor until June of 2021, subsequent to Dr. Bollier's evaluation of permanent impairment. Thus, I conclude claimant is entitled to full reimbursement of Dr. Taylor's IME in the amount of $2,770.50. (See Cl. Ex. 6, p. 63)

Claimant additionally seeks reimbursement for her filing fees, service fees, Dr. Mathew's evaluation and report and fees for medical records. Assessment of costs is a discretionary function of this agency. Iowa Code § 86.40. Costs are to be assessed at the discretion of the deputy commissioner or workers' compensation commissioner hearing the case. 876 IAC 4.33.

Defendants in their post-hearing brief assert claimant is not entitled to reimbursement for Dr. Mathew's IME under section 85.39, and I agree, but consistent with the Iowa Supreme Court's holding in Des Moines Area Regional Transit Authority v. Young, 867 N.W.2d 839 (Iowa 2015), the cost of Dr. Mathew's report may be taxed as a cost. In this case, however, I did not rely on Dr. Mathew's report. He did not offer an impairment rating, and because I found claimant's injury to be limited to a scheduled member, his opinions on claimant's permanent restrictions were largely irrelevant. Thus, I decline to assess Dr. Mathew's report as a cost.

I likewise decline to tax the charge for obtaining medical records as a cost; there is no provision in rule 876-4.33 that allows for such reimbursement.

I conclude defendants are only responsible for reimbursement of claimant's filing fees and service fees. 876 IAC 4.33 (3), (7).

ORDER

THEREFORE, IT IS ORDERED:

File No. 1657325.02:

Claimant shall take nothing further as it pertains to permanent partial disability benefits.

File No. 20008907.02:

Defendants shall pay claimant 76 weeks of permanent partial disability benefits commencing as stipulated on September 21, 2019, at the stipulated rate of two hundred seventy-eight and 58/100 dollars ($278.58) per week.

Defendants shall pay accrued weekly benefits in a lump sum together with interest 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 percent.

Both Files:

Defendants shall reimburse claimant in the amount of two thousand, two hundred seventy and 50/100 dollars ($2,770.50) for Dr. Taylor's IME.

Pursuant to rule 876 IAC 4.33, defendants shall reimburse claimant's costs in the amount of two hundred six and 90/100 dollars ($206.90).

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

Signed and filed this 2nd day of December, 2021.

STEPHANIE J. COPLEY
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served as follows:

Andrew Giller (via WCES)

Kent Smith (via WCES)

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