BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

MICHAEL VONSPRECKEN, Claimant, vs. BBU, INC., Employer, and ACE AMERICAN INSURANCE COMPANY, Insurance Carrier, Defendants.	FILED DEC 31 2018 WORKERS COMPENSATION File No. 5057238 A R B I T R A T I O N D E C I S I O N Head Note Nos.: 1108, 1402, 1802, 1803, 3000, 3002, 3800

STATEMENT OF THE CASE

This is a proceeding in arbitration. The contested case was initiated when claimant, Michael Vonsprecken, filed his original notice and petition with the Iowa Division of Workers' Compensation. The petition was filed on March 29, 2017. Claimant alleged he sustained a work-related cumulative injury that manifested on February 8, 2016. (Original notice and petition)

For purposes of workers' compensation, BBU, INC., is insured by ACE American Insurance Company. Defendants filed their answer on April 5, 2017. The defendants denied the occurrence of the work injury. A First Report of Injury was filed on September 20, 2016.

The hearing administrator scheduled the case for hearing on January 24, 2018. The hearing took place at the Iowa Works Center in Davenport, Iowa. The undersigned appointed Ms. Lucinda Winslow-Haidsiak, as the certified shorthand reporter. She is the official custodian of the records and notes.

Claimant testified on his own behalf. Defendants called Mr. Carl Nelson to testify at the hearing. Joint Exhibits 1 through 4 were admitted. Claimant offered exhibits marked 1 through 11. Defendants offered exhibits A through M. All exhibits were admitted as part of the record. The parties also submitted post-hearing briefs on March 19, 2018. 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. If permanency is awarded, the permanency would be calculated by the industrial method;

3. If permanency is awarded, the parties agree the commencement date is December 5, 2016;

4. Defendants have waived their right to any affirmative defenses;

5. If weekly benefits are owed to claimant, defendants shall take a credit for the net short-term disability benefits in the amount of $4,931.36; and

6. The parties agree claimant has paid certain costs prior to the hearing.

ISSUES

The issues presented are:

1. Whether claimant sustained an injury on February 8, 2016 which arose out of and in the course of his employment;

2. Whether the alleged injury is a cause of temporary and/or permanent disability;

3. If permanency is found, there is the issue as to the extent of permanency;

4. The issue of rate is in dispute; claimant believes the weekly benefit rate is $938.73, and defendants believe the weekly benefit rate is $778.61;

5. Claimant is requesting the payment of medical bills pursuant to Iowa Code section 85.27; and

6. Claimant is requesting the payment of an independent medical examination pursuant to Iowa Code section 85.39.

FINDINGS OF FACT

This deputy, after listening to the testimony of claimant and Mr. Carl Nelson, after judging the credibility of the witnesses, 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 59 years old and single. He graduated from high school in 1978. He also attended a couple of years of college. On April 30, 1988, claimant joined the precursor of BBU, Inc. He held the job title of route sales representative. He was a member of the Teamsters Union and the union steward until January 6, 2018. Claimant retired from his employment effective January 26, 2018. (Exhibit M, page 105)

For numerous years, claimant worked as a bulk route delivery driver. He drove a two-and-a half-ton straight truck. Claimant delivered private-label bread to Hy-Vee Stores. The duties included rolling dollies filled with bread off of his truck and into the back rooms of the stores. Then claimant rolled the empty dollies from the stores back into his truck. (Transcript page 10)

In the spring of 2013, claimant's duties changed. He was no longer a bulk route driver. He became a regular truck route driver. His job duties changed and he began to handle trays, and individual products as well as stocking shelves. (Tr., pp. 13-14) Claimant had to inspect his truck before he drove it. When he arrived at a specific location, he opened the back of his truck and began to unload the products. He stacked the trays inside the truck and then placed the trays on a dolly that was located on the ground. (Tr., p. 14) Claimant estimated a tray of bread weighed 15 pounds. (Tr., p. 15) Once the dolly was loaded, claimant rolled the dolly into the store and out to the floor to stock the shelves with the various products. Claimant placed the empty trays back onto the dolly. It was his custom to lift 2 to 3 empty trays together back onto the dolly before pushing the empty dolly out to the truck to secure more products. (Tr. p. 16)

Claimant testified his new job duties involved more bending, more twisting, kneeling, and crouching. (Tr., p. 18) The Route Sales Representative job description from BBU, Inc., is detailed in Exhibit A, pages 1 through 8. It is incorporated by reference as though fully set out herein.

RELEVANT TREATMENT RECORDS PRIOR TO FEBRUARY 8, 2016

On October 22, 2007, claimant visited his personal physician, Wade Lenz, M.D. Among other matters, claimant complained of ongoing arthritis in his knees and back. (Ex. L, pp. 65-66) Dr. Lenz recorded in his clinical notes for the same date:

> He has some mild arthritis in his knees, hips, and ankles. He gets by reasonably well on some Tylenol, occasionally Ibuprofen. Mood is good. He has no neurological history. ROS is otherwise unremarkable.

(Ex. L, p. 66)

Claimant returned to Dr. Lenz on November 13, 2008. Again, claimant complained of arthritis in the knee and back. Claimant reported he took over-the-

counter Tylenol P.M. (Ex. L, p. 67) Claimant reported intermittent back pain. (Ex. L, p. 68) Dr. Lenz found claimant's gait to be normal and his joints were good. (Ex. L, p. 68)

Claimant had another yearly physical on October 11, 2010. Claimant reported he was taking Glucosamine and Chondroitin for the arthritis in his knee and back. (Ex. L, p. 69) Dr. Lenz noted:

> Unable to really palpate the tenderness in his right lower extremity. His back is fairly good. He has a little bit of tenderness in mid to lower lumbar spine on palpation. Negative straight leg. Reflexes are normal. Good distal pulses. Mood and affect are appropriate. Gait is normal.

(Ex. L., p. 70)

On October 13, 2011, Dr. Lenz had a one-year follow-up of claimant's condition. (Ex. L, p. 71) Claimant was taking Flexeril on an as-needed basis. He was also taking Glucosamine and Chondroitin for the arthritis in his knee and back.

Claimant had his next physical on October 17, 2012. He was taking the same medications for his knee and back as he had taken in 2011. (Ex. L, p. 74) The legs showed no swelling. (Ex. L, p. 75) Claimant returned to the doctor on October 31, 2012. (Ex. L, p. 77) Claimant complained of muscle cramping and considerable pain in his right knee and leg. (Ex. L, p. 77) Claimant indicated the pain was worse when he was driving. (Ex. L, p. 78) Claimant reported he was much more active, as he had to deliver bread into the stores. (Ex. L, p. 78) Dr. Lenz noted tenderness around the right knee with the probability that the tenderness was due to osteoarthritis. With respect to the osteoarthritis, Dr. Lenz developed the following plan:

> Physical today. Patient has some underlying osteoarthritis for which he takes glucosamine. For additional pain relief will give tramadol 50 mg three times a day. As he continues to lose weight maybe some of the arthritis pain will improve. . .

(Ex. L, p. 78)

The next examination with Dr. Lenz occurred on December 4, 2013. Claimant was taking Flexeril, Tramadol, Glucosamine and Chondroitin. (Ex. L, p. 79) Claimant still complained of arthritis in his knee and back. (Ex. L, p. 80) Neither leg had swelling. (Ex. L, p. 81) Dr. Lenz stated in his clinical notes: "Knees are fairly good except tender along the joint lines." (Ex. L, p. 85) Dr. Lenz found claimant did not have much arthritic change in the hands. Most of the arthritis was in the knees and back. (Ex. L, p. 85) Dr. Lenz urged claimant to use Flexeril as sparingly as possible. (Ex. L, p. 85)

Claimant returned to the physician on March 5, 2015. Claimant was taking the same medications as prior to this visit. Claimant had continued complaints of arthritis in his knee and back. (Ex. L, p. 87) He had restless leg syndrome. (Ex. L, p. 88)

On December 9, 2015, claimant had another physical examination. He reported having surgery for right carpal tunnel syndrome. (Ex. L, p. 90) Claimant acknowledged he still had arthritic problems with his knee and back. (Ex. L, p. 90) Dr. Lenz renewed claimant's prescriptions for Tramadol and Flexeril. (Ex. L, p. 92)

RELEVANT MEDICAL TREATMENT FOLLOWING FEBRUARY 8, 2016

On February 10, 2016, claimant visited Dr. Lenz. Claimant reported pain in his right leg mainly in the area of the calf. (Joint Exhibit 1, page 1) He indicated the calf pain started over the weekend and then increased in intensity over the next several days. Claimant described the pain as "Seems to go through the whole leg at times." (Jt. Ex. 1, p. 1) Claimant informed his physician the knee always hurt but became worse with activities. (Jt. Ex. 1, p. 1) Claimant said he had not experienced any injuries that would account for the pain. (Jt. Ex. 1, p. 1) Claimant described the pain as a "spasm but it is more like a tightening and a cramp and an ache." (Jt. Ex. 1, p. 1) Dr. Lenz placed in his clinical notes his impressions and plan for claimant as follows:

> IMPRESSION AND PLAN: Patient with leg pain. He has some evidence of peripheral vascular disease, is this claudication, we will obtain ultrasound of the lower extremity vascular studies to rule out claudications causing his pain. We will also obtain lumbar series with obliques to see if there is any type of referral pain in his leg. He is on aspirin at this point. Continue to rest the leg since activity and being on his legs seems to aggravate it at this point. For pain control he can take the Tramadol up to six a day and that with the Tylenol.

(Jt. Ex. 1, p. 2)

On the same day, x-rays of the lumbar spine were taken. Casey A. Veach, M.D. read the x-rays. Dr. Veach opined there was a mild degenerative change at L4-L5 with disk height loss. The sacrum was unremarkable. (Jt. Ex. 1, p. 3)

On February 26, 2018, claimant returned to see Dr. Lenz. The physician found claimant to be tender at the origin of the fibula. (Jt. Ex. 1, p. 5) Dr. Lenz did not elicit any numbness or tingling or decreased sensation in the leg during the physical examination of the leg. (Jt. Ex. 1, p. 6) Strength in the leg was found to be normal. (Jt. Ex. 1, p. 6) Dr. Lenz diagnosed claimant with neuralgia of the leg. Gabapentin was prescribed. (Jt. Ex. 1, p. 6)

Dr. Lenz referred claimant to Oliver Ancheta, M.D. for a consultation regarding claimant's right leg symptoms. (Jt. Ex. 1, p. 7) Dr. Ancheta's initial impressions were as follows:

> IMPRESSION: Fifty-six year-old right handed white male with approximately one month history of right leg pain, primarily along the lateral aspect with findings on neurological examination of absent right

> ankle jerk and decreased sensation along the lateral aspect of the right foot and four lateral toes with underlying history of low back pain is suggestive of right L5-S1 radiculopathy, etiology to be determined.
>
> PLAN AND RECOMMENDATIONS: I discussed at some length with the patient the possible nature of his symptoms and the indication to obtain further diagnostic tests with a lumbar spine MRI. He understood and agreed to proceed, therefore, an appointment will be scheduled for this. We will call the patient when the result of this test becomes available and initiate a follow-up visit at that time.

(Jt. Ex. 1, p. 8)

Claimant underwent magnetic resonance imaging (MRI) on March 7, 2016. Craig P. Tillman, M.D., interpreted the results of the testing. Dr. Tillman opined:

> IMPRESSION:
>
> 1. Moderate degenerative disk disease changes are seen especially at L2-L3 and at the L4-L5 level. Mild spinal canal stenosis caused by degenerative changes in the facet joints and bulging of the disk is seen at the L4-L5 and at the L2-L3 level.
>
> 2. Lateral bulging of the disk does produce some mild spinal canal stenosis on the right side at the L3-L4 and L4-L5 levels.

(Jt. Ex. 1., p. 10)

After the results of the MRI were revealed, claimant met again with Dr. Ancheta. The appointment occurred on March 9, 2016. Dr. Ancheta diagnosed claimant with:

> A - -Low back pain with right leg pain likely due to lumbar radiculopathy, likely due to the above mentioned lumbar MRI findings.
>
> P - - I discussed with the patient the result of his lumbar spine MRI and treatment options. He is interested to pursue further evaluation with a spine surgeon to see if he would benefit from any surgical intervention. He would like to go to the Quad Cities, therefore, we will schedule him an appointment with Dr. Dolphin. He will continue gabapentin as directed by Dr. Lenz, his PCP. We will see him back on an as needed basis. The patient expressed understanding and agreement with the plan.

(Jt. Ex. 1, p. 11)

On March 31, 2016, claimant met with Michael Dolphin, D.O., an orthopedic surgeon in Davenport, Iowa. (Jt. Ex. 2, p. 1) Claimant provided the following medical history to Dr. Dolphin:

History of Present Illness:

Michael is a 56-year-old male who presents for consultation from Dr. Ancheta. He complains of low back pain that radiates into his right buttock, lateral thigh and lateral shin. He describes the pain as a dull, sharp pain that is constant in nature. Patient rates his pain at 6/10 now and can reach 8-9/10 at its worst. The onset was gradual without injury about two months ago and has continued to worsen. He states that he believes this is from repetitive lifting from work. The patient's symptoms are aggravated by going down stairs, going up stairs, standing and walking. The patient's symptoms are relieved by rest. He states he has noticed intermittent left leg pain that has occurred over the last couple of days. He denies any numbness and tingling of the lower extremities. Denies bowel and bladder incontinence. Patient denies physical therapy for his lumbar spine and lumbar epidural steroid injections. Patient denies back surgery. Patient takes tramadol and gabapentin 300 mg TID which is helpful. He presents today with a disc from Medical Associates dated 3/7/16.

(Jt. Ex. 2, p. 1)

Dr. Dolphin conducted a comprehensive physical examination of claimant. The orthopedic surgeon also discussed the results of the imaging with claimant. Dr. Dolphin diagnosed claimant with:

Impression:

1. Low back pain
2. Other intervertebral disc degeneration, lumbar region
3. Radiculopathy, lumbar region

(Jt. Ex. 2, p. 3)

Dr. Dolphin recommended a trial epidural steroid injection at the midline of L4-L5. The doctor wanted claimant to return for a follow-up appointment within 2 weeks. (Jt. Ex. 2, p. 3) Claimant returned to see Dr. Dolphin on April 27, 2016. Claimant reported some relief after his lumbar injection. He rated his pain at 3-4/10. Claimant described the pain as a dull, sharp pain when he walked or stood. (Jt. Ex. 2, p. 4) Dr. Dolphin recommended aggressive function rehabilitation for four weeks. (Jt. Ex. 2, p. 5) Since there was no light duty available for claimant, Dr. Dolphin kept claimant off work. (Jt. Ex. 2, p. 5) On May 25, 2016, claimant stated the epidural steroid injection had completely worn off after just 4 weeks. (Jt. Ex. 2, p. 6) Claimant and Dr. Dolphin discussed the risks and benefits of proceeding with surgery. (Jt. Ex. 2, p. 7)

On September 21, 2016, Dr. Dolphin performed a right transpedicular approach for lumbar disk herniation between L3 and L4. (Jt. Ex. 2, p. 8) Subsequent to the surgery, claimant was transferred to the recovery room in stable condition. (Jt. Ex. 2, p. 8)

On September 30, 2016, claimant returned to the office of Dr. Dolphin. Claimant informed the surgeon he had 75 percent relief but some low back pain. (Jt. Ex. 2, p. 10) Dr. Dolphin discovered the incision was healing nicely. There was no hint of infection. (Jt. Ex. 2, p. 11) Dr. Dolphin set up the following treatment plan for claimant:

> **Plan:**
>
> At this point, Michael may lift 20 lbs and increase 5lbs [sic] every week after. He will also start into physical therapy for core strengthening and lower extremity stretching 2-3 times per week for the next 4-6 weeks. We provided him with a script for this at today's visit. We will continue him off work. We will see him back in 4 weeks for follow up. He is in agreement and has no further questions.

(Jt. Ex. 2, p. 11)

Claimant returned to see Dr. Dolphin on October 28, 2016 for follow up care. Claimant reported 70 percent relief with 100 percent improvement of the leg pain. Claimant rated his pain at 2-3/10. He denied any radicular complaints, numbness, and tingling of the lower extremities. (Jt. Ex. 2, p. 12) Claimant wanted to continue with physical therapy. He was not ready to return to work due to the heavy lifting involved. As a consequence, Dr. Dolphin recommended a work hardening program. (Jt. Ex. 2, p. 13)

On November 18, 2016, claimant again saw Dr. Dolphin. Claimant stated his leg pain was 100 percent improved. His back was 75 to 80 percent improved, although he had some low back pain with spasms. Claimant denied any radicular complaints, numbness or tingling of his lower extremities. Claimant desired to continue with work hardening. (Ex. J, p. 59)

Claimant's final physical therapy session occurred on December 2, 2016. (Ex. I, p. 56) Dr. Dolphin released claimant to return to work effective December 5, 2016. (Ex. J, p. 60)

Claimant returned to work in December of 2016. He still worked as a route sales representative and performed the same duties expected of all drivers in the same position. Claimant testified he performed some of his duties in a slightly different manner so as to take pressure off of his back and leg. Claimant did not miss work other than his normal scheduled vacation time.

On January 11, 2017, claimant returned to Dr. Lenz's office. (Ex. L, p. 100) Claimant did not complain of any muscle aches or restless legs. (Ex. L, p. 102) He was

no longer taking Glucosamine and Chondroitin. (Ex. L, p. 101) Claimant had a normal gait and stance. (Ex. L, p. 103)

Claimant testified his condition became continuously worse with time. (Tr., p. 23) The last day claimant worked was January 6, 2018. He testified his decision to retire in January of 2018 was based on his inability to perform physically the duties of his job. (Tr., p. 29) At the time of his retirement, claimant was earning more money than on the date of his alleged work injury. Pursuant to the union contract, claimant is entitled to his pension. Claimant believes it will be approximately $2,000.00 per month.

Mr. Carl Nelson testified for defendants. He is the territory sales manager at BBU, Inc. Mr. Nelson testified claimant worked under the job description that is marked Exhibit A. During direct examination by Mr. Thill, Mr. Nelson testified as follows:

> Q. Can you describe for the Deputy the quality of the work as a route sales representative of Mr. Vonsprecken?
>
> A. Yeah. He was a - - what I would say, better-than-average RSR. He knew what he had to do, and very few issues. Took care of his customers. They all had his cell phone number, and they usually called him. There were things I didn't even know about that he took care of, and that's fine. But we talked at least once a week, and if he had any concerns, that's when he discussed them with me, so.

(Tr., p. 65)

Mr. Nelson testified claimant had talked about retiring for a number of years. Claimant purchased a recreational vehicle and he and his girlfriend were going to travel around the country. (Tr., p. 69)

RELEVANT OPINIONS FROM MEDICAL EXPERTS

Defendants retained Brian Braaksma, M.D., to render an independent medical examination and to provide an opinion regarding the cause of claimant's back and leg pain. Dr. Braaksma issued his initial report on July 22, 2016. The evaluating doctor was asked to answer some specific question to a reasonable degree of medical certainty. The following are the questions and answers Dr. Braaksma provided in his report:

1. *Is the diagnosis rendered by the treating physician properly stated and supported by objective findings? Please explain.*

   Patient's current diagnosis of right lower extremity radiculopathy I feel is currently unsupported by the patient's physical exam findings and the objective evidence on imaging. He certainly may have a component of right L3 radiculopathy, however, I feel he may have a significant component of right intraarticular hip pathology, primarily degenerative disk

disease causing pain radiating to the right thigh and lateral aspect of the knee. Furthermore, he has tenderness to palpation over the fibular head and may have peroneal nerve entrapment at that level causing similar symptoms of the right lower extremity. I believe that further evaluation with AP and lateral x-rays of the right hip, as well as an EMG of the right lower extremity would help support or refute the current treating physician's diagnosis of right lower extremity radiculopathy.

2. *Regarding the causation, is the claimant's condition causally related to employment? Specifically:*

(a) Is the occurrence or incidence complained of a near manifestation of appearance of symptoms of a definitely preexisting, deteriorating condition?

I currently do not believe that the patient's current conditions are related to any work-related injury or accident. However, I believe that he does require further evaluation for definitive diagnosis.

(b) Did traumatic work exposure directly cause the condition?

No.

(c) Did work exposure aggravating [sic], accelerate, and participate, i.e., permanently aggravating a preexisting condition beyond its originary progression?

Again, I believe that further evaluation is necessary. However, regardless, I do not believe that his work activities or work exposures would have aggravating [sic], accelerated, or precipitated any preexisting condition beyond the originary progression.

(d) Was an appreciable period of workplace exposure the sole cause of the claimant's condition, or at least a material contributive factor in the conditions, onset, or progression?

Further workup is necessary to determine the underlying cause of the patient's current conditions, and therefore I will defer from answering that question definitively.

3. *Treatment has all to date been necessary and appropriate as related to the work injury?*

I believe that all of the treatment he has received has been appropriate and necessary, however incomplete.

4. *Is further treatment needed for the diagnosis related to the injury? If yes, please render your treatment recommendations in detail.*

   I believe that an evaluation of his right hip is necessary with AP and lateral x-rays of the right hip, as well as AP pelvis for evaluation of intraarticular hip arthritis. Furthermore, an intraarticular hip injection with local anesthetic and corticosteroid could be beneficial as a diagnostic and therapeutic measure to further elucidate the cause of his symptoms. Finally, an EMG of the right lower extremity could be beneficial to exclude a peripheral nerve entrapment of the peroneal nerve at the fibular head, as well as a peripheral neuropathy as opposed to lumbar radiculopathy.

5. *What medications, if any, are appropriate?*

   Gabapentin 300 mg t.i.d. until definitive diagnosis is achieved would be appropriate.

6. *Workability: Does the examinee require work restrictions? If so, please specify the restrictions and the duration for which they need to be in place?*

   Light-duty work restrictions with a 25-pound lifting restriction, to avoid excessive lumbar bending, twisting, and heavy lifting until a definitive diagnosis is made would be appropriate.

7. *Is the claimant able to work and perform duties of an occupation? If not, please indicate the date they [sic] should be expected to return to work.*

   Patient can currently work with light-duty restrictions.

8. *Finally, has the claimant reached maximum medical improvement? If not, please indicate the date that the claimant will achieve maximal medical improvement.*

9. I do not believe he is at maximal medical improvement. I do not believe a definitive diagnosis has been made or at least other potential diagnoses have not been excluded. MMI would not be achieved until a definitive diagnosis is achieved and definitive treatment of that diagnosis has been performed.

   Again, conclusions and recommendations are made within a reasonable degree of medical and surgical certainty. If there are any further questions or if further medication information becomes available to me, I would be happy to reevaluate and render further opinions.

(Jt. Ex. 4, pp. 3-5)

Dr. Braaksma issued a second opinion on December 12, 2016. This opinion was generated after claimant had had his spinal surgery. Dr. Braaksma added the following opinions:

1. In my original evaluation of the patient I had recommended an evaluation of the right hip with radiographs as well as EMG of the right lower extremity prior to the spinal surgery to help define a diagnosis. Surgery was subsequently performed by Dr. Dolphin and per medical records provided to me from Dr. Dolphin's office, the patient is symptomatically improved. Therefore, I do not believe further workup to include x-rays of the hip or EMB of the right lower extremity are medically necessary at this time.

2. I do not believe that Mr. Vonsprecken's reported work duties materially aggravated a preexisting lumbar spine condition subsequently resulting in the surgery performed by Dr. Dolphin. Again, I do not believe that these work duties materially aggravated any preexisting condition, nor do I believe that they accelerated or precipitated any preexisting condition beyond its surgical progression.

(Ex. H, p. 50)

David H. Segal, M.D., conducted an independent medical examination pursuant to Iowa Code section 85.39 per the request of claimant's counsel. The actual examination occurred on April 28, 2017. The actual report was dated, May 19, 2017. At the time of the exam, claimant indicated his pain level was a 5 out of 10 on an analog scale. Claimant indicated his pain averaged 4-5/10. Claimant told Dr. Segal the pain was better since claimant had undergone surgery but the pain was increasing since he had returned to work. (Ex. 1, p. 7) During the examination, claimant explained he had aching, cramping seldomly, dull, sometimes dull sharp pain, on occasion he experienced shooting pain, he had occasional spasms, stiffness, and his right buttock felt as if it was bruised. (Ex. 1, p. 7)

Dr. Segal opined claimant had a cumulative work injury as the result of lifting, bending and twisting. (Ex. 1, p. 7) The symptoms were aggravated by:

> **Aggravated by:** Sitting, (sometimes relieves initially, aggravates if too long), Any prolonged activity or position, Ascending stairs, Descending stairs, Going up or down ramps, Extension, Flexion, Side bending, Changing position, Daily activities, Getting up from a seated position, Lifting, Lying down (at first horrible, then eases up), Pulling, Pushing, Reaching overhead, Rolling over in bed (sometimes), Sitting, Sneezing, Standing (if longer than 10 minutes), Twisting, Walking (if longer than 10 minutes)

(Ex. 1, p. 7)

The following is a summary of Dr. Segal's opinion about the cause of claimant's back pain:

BRIEF SUMMARY

> I had the opportunity to take a very detailed work history of Mr. VonSprecken and correlate the onset of back pain to specific work activities and the job switch with Mr. VonSprecken had in April/May 2013. At that time, his job duties were changed to a much more physical job with considerably more lifting, bending, twisting and stocking shelves. This was the causative factor of his low back pain and leg pain that led to the surgery and his continued low back pain. In that new job, the combination of needing to move dollies weighing 500 pounds each, and worse, the hundreds of times per day that he needed to lift and twist (sometimes 100+ times per hour) was definitely a major contributing factor, if not the major contributing factor to his development of low back and leg pain. This type of activity is clearly not a normal or typical type of work activity. This type of work causes significant strains and stresses that a normal lumbar spine would not be exposed to in most occupations. This correlates to the onset of his low back pain, which led to the development of his leg pain and need for surgery and the continued low back pain today.

(Ex. 1, p. 10)

Dr. Segal opined the work was a substantial factor in bringing about the injury. He opined the injury resulted in a permanent impairment. (Ex. 1, p. 10) Dr. Segal provided the following diagnoses related to the work injury:

1) Right L3 radiculopathy. The onset was casually related to the cumulative work injury as outlined above. The right leg symptoms are from nerve impingement from the disc herniation in the L3-L4 neural foramen on the right. His response to the surgery proves that the disc herniation was the anatomical cause of the right leg pain. Disc herniations can happen spontaneously sometimes with bends, twists, or lifts. Because there was no such event that Mr. VonSprecken can identify out of work, the causal factor in the herniation is the repeated lifting, bending, and twisting that started with his job in April/May 2013. The fact that the leg stiffness started insidiously with that job activity of April/May 2013, and as early as December 2013 became significant, is evidence that the L3 radiculopathy represents a cumulative work injury from the activities at his job with the new duties that he started in April of May of 2013.

2) Mechanical low back pain. The onset was causally related to the cumulative work injury as outlined above. The low back pain is likely

multifactorial. On imaging, he does have facet arthropathy at those levels as well as degenerative disc changes. His low back pain started shortly after he began his new duties in April or May of 2013. Shortly after starting the new duties, he tried a back brace because of the back pain, but it was too restrictive, and he could not wear it. Sometimes it even hurt him more. His low back continues to hurt independent of the relief that he has in his right leg from the surgery. Though not quite as bad as the leg pain was, the mechanical low back pain averages 5-6/10, and he feels it is getting steadily worse. The low back pain continues till today and is aggravated with work activities. The onset of the low back pain coincides with the start of the new work activities in April/May 2013, which is strong evidence that the mechanical low back pain is causally related to the work duties of the job that he started April or May 2013.

3) Right sacroiliac joint arthropathy. Mr. VonSprecken has tenderness along his right SI joint and has four positive provocative SI joint tests on exam. He also has tenderness nearby in the right sciatic notch related to the residual radiculopathy. The area of pain and tenderness at the right SI joint coincides with the start of the new work activities in April/May 2013. The cumulative work injury starting April/May 2013 is the causal factor of the current SI joint arthropathy and pain.

4) Spinal instability at L2-L3. AS [sic] noted above, the images reveal spinal instability at L2-L3. This instability is a major contributing factor to the mechanical low back pain syndrome, along with its facet arthropathy and SI joint arthropathy. This instability was likely caused by the cumulative work injury of April/May 2013. And it did become symptomatic and become permanently aggravated due to the injury of April/May 2013. This instability makes the chance of needing a lumbar fusion in the future much greater.

(Ex. 1, p. 11)

Dr. Segal opined it was likely claimant had degenerative changes prior to 2013 in his spine. (Ex. 1, p. 11) However, according to Dr. Segal, the changes were asymptomatic, and claimant did not seek significant medical treatment for any symptoms. (Ex. 1, p. 11)

Dr. Segal did assign a permanent impairment rating according to the AMA Guides to the Evaluation of Permanent Impairment, 5th Ed. The evaluating doctor calculated the impairment rating as follows:

...Currently, the best way to evaluate permanent impairment for Mr. VonSprecken would be to look at the *AMA Guides,* Fifth Edition, page 384, Table 15-3 "Criteria for Rating Impairment Due to Lumbar Spine

> Injury." He would fit into Lumbar Category III, 10%-13% impairment of whole person. That category is described as "significant signs of radiculopathy, such as dermatomal pain and/or in a dermatomal distribution, sensory loss, loss of relevant reflex(es), loss of muscle strength, or history of herniated disc at the level and on the side that would be expected from objective clinical findings, associated with radiculopathy, or individuals who had surgery for radiculopathy but are now asymptomatic." Given that, I would put Mr. Vonsprecken at 12% impairment of whole person for the continued limitations that he has. Additionally, this does not take into account the mechanical low back pain syndrome and SI joint pain that he has and that continues. I would give him an additional 2% for that, and that is validated in the Pain Chapter of this book. Mechanical pain syndromes that are not accounted for do get an additional 2% impairment of whole person. Therefore he would be 14% impairment of the whole person based on the cumulative work injury that started April/May 2013.
>
> *What permanent restrictions, if any, would you recommend?* As far as permanent restrictions, Mr. VonSprecken is working. What he describes to me is that he is struggling through the day but is getting by, and at this point he physically is able to continue working. As far as restrictions, I would say he would need to rest as needed, up to 10 minutes every hour, depending on the day and how much pain he is in. If it were possible to limit bending or adjust his work environment to decrease the amount of bending (which he does try to do on his own with the way he stacks the carts), if that could be maximized, that would help him as well. He should not lift more than 25 pounds at once either from the ground to waist or waist over his head, and he does his best to self-limit that at this time. Those should be the permanent restrictions at this time.

(Ex. 1, p. 12)

Dr. Segal ended his report with some concluding comments. He explained why he differed with the opinions of Dr. Braaksma. Dr. Segal also opined he detected no symptom magnification exhibited by claimant. (Ex.1, p. 13) The following are those concluding comments:

CONCLUDING COMMENTS

> I would like to comment on the IME that is contained in the records. With all due respect to Dr. Braaksma, his IME does not discuss why he feels that the patient's current conditions are not related to any work activity or incident. There was no one day of actual injury that Mr. VonSprecken can remember either at home or at work. In his IME, there is no accounting for the hundreds of times a day, 100+ times per hour, that Mr. VonSprecken has to bend and lift up to 25 pounds at a time. This is a very unusual work

> situation. This work situation causes tremendous strains and tensions and stressors on the low back and on the discs, particularly in the lumbar spine. Comparing that activity to another job which does not require such tremendous strains on a constant basis would indicate the work activities beginning April/May 2013 as the main causal factor of the back pain, leg pain, the need for surgery and the need for continued treatment. The onset of his low back and then right leg pain when Mr. VonSprecken stated that job in April/May 2013 makes it probable with a high degree of medical certainty that those specific activities were the substantial factors causing the current low back pain as well as the right radicular pain. In fact, the converse does not make sense. It does not make sense to say that that type of abnormal activity was not a substantial cause of the development of the radiculopathy. Although in other people radiculopathies can occur without accident, when there is a repetitive and cumulative injury or tremendous stressor with a temporal relationship to development of low back pain and leg pain, then the very likely and very probable cause of that pain is the stressor or work injury (in this case a cumulative work injury) from the highly unusual and abnormal work activity, which causes tremendous stressors on the low back. This was not really adequately addressed in the IME of Dr. Braaksma, and it is not the case where there must be a single incident causing the pain. Cumulative work injuries are accepted and established as a cause of work injury and low back injury; and in Mr. VonSprecken's case, it is very clear that he has a cumulative work injury causing both the need he had for surgery, and the development of low back pain, the radicular pain, and the current pain he is having.

(Ex. 1, p. 12)

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).

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).

The greater weight of the evidence shows claimant suffers from a pre-existing degenerative condition. The onset of the degenerative condition commenced in 2007. (Ex. L, pp. 65-66) As a result, claimant has failed to prove his alleged work injury arose out of and in the course of his employment.

Dr. Lenz diagnosed claimant with arthritis in his knees, hips, ankles and back. The diagnosis occurred in October of 2007. (Ex. L, pp. 65-66) Claimant testified he developed pain in his right leg after his job duties changed in 2013. However, the medical records establish claimant was encountering symptoms to his back, right leg, and knee due to his degenerative condition before his job duties had changed in 2013.

In 2008, claimant had the same arthritic back and knee. His back pain was intermittent. (Ex, L, pp. 67-68) Claimant had mid-to-low back and right leg symptoms in 2010 when he saw Dr. Lenz. Flexeril was prescribed for muscle cramping. (Ex. L, pp. 69-70) In October of 2012, claimant was still taking Glucosamine and Chondroitin for arthritis in the back and knee. Dr. Lenz continued to prescribe Flexeril for claimant. (Ex. L, p. 74) On October 31, 2012, Dr. Lenz found tenderness around the right knee. (Ex. L, p. 78) Dr. Lenz prescribed Tramadol for pain relief. (Ex. L, p. 78)

Dr. Dolphin performed the back surgery on September 21, 2016. The treating surgeon could not causally relate claimant's work duties to the lumbar disc bulge that needed repair. The basis for Dr. Dolphin's opinions is that such disc bulges develop over time with or without work activities. (Jt. Ex. 3, p. 2)

Dr. Braaksma also opined on two occasions that claimant's work duties did not cause or materially aggravate claimant's pre-existing degenerative condition.

Only Dr. Segal related claimant's condition to his work duties. However, not as much weight is accorded to the opinions of Dr. Segal as to the other two physicians. Dr. Segal has some credibility issues of his own. Dr. Segal entered into a Settlement Agreement with the Board of Medicine on December 16, 2016. It is true Dr. Segal is

allowed to engage in medical consultations, perform medical record reviews, and conduct independent medical examinations; he is no longer able to perform neurosurgery. Dr. Segal suffers from a personal condition that prevents him from performing surgery. There were other factors involved in the settlement agreement which indicated to this deputy; Dr. Segal had some credibility issues. For that reason, his expert opinion is not considered of the same caliber as the opinions of Dr. Braaksma, and especially Dr. Dolphin, the treating surgeon. Dr. Dolphin had numerous opportunities to observe claimant, listen to his patient's medical history and observe claimant during the course of the surgical procedure.

For all of the foregoing reasons, it is the determination of the undersigned; claimant did not establish by a preponderance of the evidence that he sustained an injury on February 8, 2016 that arose out of and in the course of his employment. As a consequence, claimant takes nothing from these proceedings.

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).

ORDER

THEREFORE, IT IS ORDERED:

Claimant takes nothing from these proceedings.

Each party shall pay his/its/their own costs.

Defendants shall file all reports as required by law.

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

Michelle A. McGovern

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DEPUTY WORKERS'
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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.