BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

LYLE D. HANKS,

Claimant,

vs.

SMITHCO MANUFACTURING, INC.,

Employer,

and

SFM MUTUAL INSURANCE CO.,

Insurance Carrier,
Defendants.

File No. 5054781

ARBITRATION

DECISION

Head Note Nos.: 1803; 2501; 2701

STATEMENT OF THE CASE

This is a proceeding in arbitration. The contested case was initiated when claimant, Lyle D. Hanks, filed his original notice and petition with the Iowa Division of Workers' Compensation. The petition was filed on November 9, 2015. Claimant alleged he sustained a work-related injury on March 30, 2015. (Original notice and petition.)

For purposes of workers' compensation, Smithco Manufacturing, Inc., defendant, is insured by SFM Mutual Insurance Company, defendant. A first report of injury was filed on May 22, 2015. Defendants filed their answer on December 4, 2015. They admitted the occurrence of the work injury.

The hearing administrator scheduled the case for hearing on October 13, 2016. The hearing took place in Sioux City, Iowa, at the Iowa Workforce Development Building. The undersigned appointed Ms. Jami L. Johnson 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. The parties offered exhibits. Claimant offered exhibits marked 1 through 7. Defendants offered exhibits marked A and B. Defendants objected to pages 10 and 11 of Exhibit 7. Nevertheless, all proffered exhibits were admitted as evidence in the case.

Post-hearing briefs were filed on December 30, 2016. 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 March 30, 2015 which arose out of and in the course of his employment;

3. Temporary benefits are no longer an issue;

4. The parties agree if permanency is found, the permanency is an industrial disability;

5. The parties agree, if a permanent work injury is determined, claimant reached maximum medical improvement on May 20, 2015;

6. The parties agree, the weekly benefit rate is $504.57;

7. Prior to the date of the hearing, defendants paid claimant 30 weeks of permanent partial disability benefits at the rate of $556.10 per week; and

8. The parties agree certain costs that are detailed were paid by claimant.

ISSUES

The issues presented are:

1. To what extent is claimant's permanent partial disability?

2. For which costs are defendants liable?

FINDINGS OF FACT

This deputy, after listening to the testimony of claimant at hearing, after judging his credibility, and 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 61 years old and right hand dominant. He is married with two adult children. Claimant has a high school diploma but no other formal education. He resides in Hinton, Iowa. The town has fewer than 1,000 residents and is located in

Plymouth County. In order to find and maintain employment, claimant must commute to a larger town.

Claimant detailed his work history in his answer to defendants' interrogatory 3. (Exhibit B, page 18) He held positions at Jolly Time Popcorn in Sioux City, Iowa; Wells Blue Bunny Dairy in Le Mars, Iowa; K.D. Feeds in Sioux City, Iowa; and Staples Retail Store in Orange City, Iowa.

Claimant commenced his employment with Smithco Manufacturing, Inc., in 2012. The company is located in Le Mars, Iowa. Management hired claimant to work as a press brake operator. At the time of the work injury, claimant was earning $16.40 per hour.

There is no dispute; claimant sustained an injury to his right shoulder on March 30, 2015 while he was working on a computer based press brake. Claimant was lifting a 70-pound knife into the press when he felt his right shoulder snap. Claimant reported the injury to his supervisor. On the day of the work injury, claimant presented to Clinic Le Mars. (Exhibit 3) Steven J. Meis, M.D., attended to claimant. The physician diagnosed claimant with bicipital tendonitis of the right shoulder and with a torn bicipital tendon. (Exhibit 3, page 2) Dr. Meis prescribed physical therapy, 220 mg of Naproxen, and ice therapy. (Ex. 3, p. 2)

A referral to an orthopedic surgeon was made. Claimant consulted with Jay T. Strittholt, M.D., on April 6, 2015. Dr. Strittholt found some slight asymmetry in the biceps muscle as compared to the opposite side. There was marked weakness, marked impingement, and a possible rotator cuff tear. (Ex. 1, p. 5)

On April 7, 2015, claimant underwent MRI testing of the right shoulder. The results showed:

1. Large complete rotator cuff tear involving supraspinatus, subscapularis, with retraction to the level of the humeral head. High riding humeral head with prominent narrowing of the subacromial space.

2. Biceps pulley tear with dislocation long head of the biceps tendon. Superior labral degenerative appearing tear.

3. Prominent AC joint arthropathy. Os acromiale.

(Ex. 1, p. 12)

On May 5, 2015, Dr. Strittholt performed the following surgical procedures:

1. Labral debridement;

2. Biceps stump debridement;

3. Subacromial decompression;

4. Rotator cuff repair.

(Ex. 1, p. 17)

In his operative report, Dr. Strittholt explained why he did not repair the right bicep tendon. He wrote:

> A small incision was made directly over the biceps tendon sheath in an attempt to retrieve the more distal biceps. The patient did not have the usual contour for a full rupture of the biceps. The thought was that perhaps this has scarred in to the bicipital groove. Perhaps it could be retrieved and then a formal tenodesis could be performed. However, no tendon could be identified.

(Ex. 1, p. 17)

Subsequent, to the date of the surgery, claimant commenced physical therapy. The surgeon placed claimant on one-handed duty. Claimant reported pain even when he was not using his right arm. (Ex. 1, p. 24) Claimant described his pain as "throbbing." He testified the pain felt as if he was striking his thumb.

In September of 2015, claimant reported he was not making much progress. He described soreness in his shoulder, especially in the early morning. (Ex. 1, p. 28) Dr. Strittholt ordered additional MRI testing. (Ex. 1, p. 28) Dr. Strittholt interpreted the results as:

> IMPRESSION:
>
> 1) Status post rotator cuff repair. Repair of the prior tear anteriorly at the insertion. There is a partial undersurface or articular surface tear supraspinatus 1.8 cm proximal to the insertion with thinning of the remaining tendon at this level. This is new compared to the prior.
>
> 2) Biceps labral anchor and intra-articular portion long head biceps tendon obscured by post surgical change.
>
> 3) Minimal effusion. Some fluid seen in the subacromial/subdeltoid bursa.

(Ex. 1, pp. 29-30)

Dr. Strittholt opined the new changes that were seen on the September 2015 MRI were not related to the original work injury on March 30, 2015. (Ex. 1, p. 32) Dr. Strittholt also opined the changes were not related to claimant's work in any way. (Ex. 1, p. 32) Claimant reached maximum medical improvement on November 10, 2015 per

the opinion of Dr. Strittholt. (Ex. 3, p. 7) On the same date, Dr. Strittholt imposed permanent work restrictions. Claimant was restricted from lifting more than 10 pounds on a frequent basis with his right arm; he was precluded from pushing or pulling with the right arm; and claimant was not to reach above his shoulder with his right arm. (Ex. 1, p. 34)

Defendants requested an independent file review from Douglas W. Martin, M.D., a Fellow in the American College of Occupational & Environmental Medicine. Dr. Martin is a well-known expert in the field of workers' compensation. Dr. Martin did not examine claimant but only reviewed certain medical records. Dr. Martin expressed an opinion concerning the findings discovered by the September 2015 MRI testing. He wrote in his report of October 19, 2015:

> In response to the questions that you have posed in your letter of October 2, 2015, I respond as follows:
>
> (1) 'Are the new changes reported on the postsurgical September 10, 2015 right shoulder MRI related to the original injury dated March 3, 2015?'
>
> *Answer:* No. The more distal signal on the new MRI scan imaging study was not found on the original scan imaging study. It is noted that the original injury was March 30, 2015 and the MRI scan imaging study that was done in April shows a retracted cuff tear, which the postsurgical MRI scan imaging study has shown repair and anatomical positioning.
>
> (2) 'If the answer to Question #1 is no, can you please explain what could anatomically cause the new changes?'
>
> *Answer:* From an anatomic perspective, there are multiple possibilities, with respect to this new, more proximal based partial thinning. One can be intrinsic compressive forces on the tendon itself. Secondly, could be the presence of an os acromiale, as there is some relationship between that and shoulder tendinopathy, impingement and eventual rotator cuff pathology.
>
> It is, often times, pointed out that rotator cuff disease is usually multifactorial, due to a combination of external compression, age-related degeneration, possibilities of trauma, and intrinsic degeneration. It is, obviously, probably more likely than not that trauma is not related here, because one would expect him to have not had any significant activities, with regards to his right shoulder from the time of his original surgery to the time of the second MRI scan imaging study. Therefore, it is probably more an issue of the

> nontraumatic factors that are in play here, with respect to this new finding.
>
> . . . .
>
> (4) 'If Mr. Hanks' current status is not related to the March 3, [sic] 2015 right shoulder injury, please respond to the following:
>
> A. Has Mr. Hanks reached maximum medical improvement status for the March 30, 2015 work related injury?'
>
> (i) If no, treatment recommendations?
>
> (ii) If yes, what is the impairment rating?
>
> *Answer:* It is likely that Mr. Hanks has, indeed, reached maximum medical improvement, with regards to the March 30, 2015 work injury.

(Ex. 5, pp. 2-3)

At the time, Dr. Martin declined to provide a permanent impairment rating for claimant's right shoulder. The evaluating physician had not taken a medical history from claimant and there was no physical examination. (Ex. 5, p. 3)

On November 13, 2015, Dr. Strittholt rated claimant's right shoulder as having a functional impairment of 10 percent to the right upper extremity. (Ex. 1, p. 36) According to the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, Table 16-3 at page 439, a 10 percent permanent impairment to the right upper extremity equates to a rating of 6 percent to the body as a whole.

On February 19, 2016, claimant exercised his right to an independent medical examination pursuant to Iowa Code section 85.39. Claimant presented to Sunil Bansal, M.D., M.P.H., a board certified physician in occupational medicine. Dr. Bansal found tenderness to palpation with the greatest tenderness at the acromioclavicular joint and proximal biceps. Surgical scarring was also found. (Ex. 7, p. 6) Dr. Bansal diagnosed claimant with:

> Right rotator cuff tear and biceps tear.
> Status post right shoulder labral debridement, biceps stump debridement, subacromial decompression, and rotator cuff repair.

(Ex. 7, p. 7)

Dr. Bansal indicated: "Mr. Hanks had a large and complete rotator cuff tear. He has a significant amount of loss of range of motion and weakness." (Ex. 7, p. 8) Dr. Bansal rated claimant as having an 8 percent whole person impairment based upon Figures 16-40 through 16-46 of the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition.

The restrictions Dr. Bansal imposed were more onerous than the restrictions imposed by Dr. Strittholt. Dr. Bansal's restrictions were no lifting greater than 10 pounds rarely, or 5 pounds occasionally with the right arm. Additionally, claimant was prevented from lifting above his shoulder level with his right arm. (Ex. 7, p. 8)

With respect to the findings of the September 2015 MRI, Dr. Bansal's opinions differed vastly from the opinions held by Dr. Strittholt and Dr. Martin. Dr. Bansal opined:

> **7. Do you feel that the postoperative changes indicated in the September MRI are a sequela of the original injury? If so, why? Why does your opinion differ from the other medical providers?**
>
> Actually, Dr. Strittholt's opinion was that the supraspinatus tendon did not have a re-tear, but rather was thinned. It [sic] not unusual to have thinning of the remaining tendon after a very large tear is repaired. It is similar to having a laceration of the skin that is quite wide and retracted. To pull it together, it will cause the area close to the repair to be stretched out and thinned.

(Ex. 7, pp. 8-9)

After defense counsel received a copy of Dr. Bansal's report, copies were sent to Dr. Strittholt and Dr. Martin for their review and comment. It is not surprising the two doctors retained by defendants differed considerably with the opinions held by Dr. Bansal.

Dr. Strittholt issued a response on June 2, 2016. The orthopedic surgeon opined:

> Rotator cuff pathology is a degenerative process. Injury could have caused tear, but tendon already abnormal. Tendon tissue is minimally Elastic is [sic] does not thin as it is stretched substantially.

(Ex. 1, p. 37)

Dr. Martin responded on June 2, 2016 to the opinions of Dr. Bansal. In his report, Dr. Martin replied in relevant portion:

> (1) 'Does your opinion that the proximal based partial thinning revealed on the September 10, 2015 MRI is not related to the original March of 2015 date of injury remain the same?'
>
> *Answer:* Yes.
>
> (2) 'Comments?'

Answer: I think that I have gone over this in a fair degree of detail within my October 19, 2015 report. It is important to understand that, on the MRI scan imaging study that was done postsurgically, the area of new thinning is 1.8 centimeters proximal to the area of repair. In other words, in the interim portion of the rotator cuff tendon, between where the actual repair was done and where the new area of thinning is, reflects a thickness that is actually normal. Obviously, if one is going to make an argument, as Dr. Bansal has attempted to do, the supraspinatus tendon has a transmission of forces throughout it that is relatively consistent and equal. You would see, if that argument were to be correct, that the thinning would be constitutionally consistent with regards to the entire duration of the supraspinatus tendon.

Unfortunately, Dr. Bansal, apparently, does not understand this. I, therefore, am in agreement with Dr. Strittholt, in this regard. The area of partial tearing or partial thinning that is on the new MRI scan imaging study is more than likely due to the reasons that I have pointed out in my previous report – that being an intrinsic compressive force in that area of the tendon itself or another possibility could be the presence of an os acromiale, as there is some relationship between that and shoulder tendinopathy, with regards to additional impingement.

I think that the Radiologist himself, in looking at the report, has been rather straightforward in this regard – in that it is a 'new finding.'

(Ex. 5, pp. 6-7)

Per the request of claimant's counsel, another opinion was sought from Dr. Bansal. His last report was issued on October 12, 2016. He voiced a strong opinion in direct contravention to Dr. Martin's opinion about the findings resulting from the September 2015 MRI. Specifically, Dr. Bansal argued:

I have reviewed Dr. Martin's reply to my IME, and I respectfully disagree with his analysis. The essence of his argument is that the new thinning and tearing seen in the September 2015 MRI of the supraspinatus tendon cannot possibly be related to the tearing incurred by the March 30, 2015 injury because the 'new' tearing is proximal to the original tear, and there is no evidence of continuation from the original tear to the new tear. This argument is inaccurate on both counts.

On the latter point, there were clearly continuation signs as the MRI states there was thinning of the entire tendon, including from the original site of tearing to the new site. This is a very important point from a biomechanical standpoint, and explains why there was tearing proximal to the original site. This is actually an expected finding, and has to do with

the distribution of tensile stress of the supraspinatus tendon. The new tearing is expected to occur proximally.

Stress distribution in the supraspinatus tendon with partial-thickness tears: an analysis using two-dimensional finite element model.

Sano H, Wakabayashi, I, Itoi E. J Shoulder Elbow Surg. 2006 Jan-Feb; 15(1):100-5.

(Ex. 7, pp. 10-11)

At his arbitration hearing, claimant testified, he is unable to perform any tasks over his head. He is unable to shampoo his hair. He must hold a cup of coffee close to his body. He testified he has problems gripping with his right hand. He no longer cuts his own steak. He is able to lift a gallon jug of milk. He does not hunt with a shot gun now. He is able to fish but casting his rod is difficult. Claimant is unable to start his lawn mower. He is unable to change a light bulb if it requires him to reach over his head. If claimant needs to paint at home, he uses his left arm.

With respect to his employment at Smithco Manufacturing, Inc., claimant returned to work. He has not driven a forklift truck since his shoulder surgery. He has worked in the tool cage since May of 2015. He pulls parts for other people to use. Often he must ask co-employees for assistance. Claimant testified he wants to work at the company for as long as possible. He has no plans to retire. This is the highest paying job he has ever held.

RATIONALE AND CONCLUSIONS OF LAW

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, 76 N.W.2d 756 (1956). If 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, 115 N.W.2d 812 (1962); Yeager v. Firestone Tire & Rubber Co., 253 Iowa 369, 112 N.W.2d 299 (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).

The parties stipulated claimant sustained a permanent injury to the body as a whole. As a result, he is entitled to have his disability calculated by the industrial method.

Since claimant has an impairment to the body as a whole, an industrial disability has been sustained. Industrial disability was defined in Diederich v. Tri-City R. Co., 219 Iowa 587, 258 N.W. 899 (1935) as follows: "It is therefore plain that the legislature intended the term 'disability' to mean 'industrial disability' or loss of earning capacity and not a mere 'functional disability' to be computed in the terms of percentages of the total physical and mental ability of a normal man."

Functional impairment is an element to be considered in determining industrial disability which is the reduction of earning capacity, but consideration must also be given to the injured employee's age, education, qualifications, experience, motivation, loss of earnings, severity and situs of the injury, work restrictions, inability to engage in employment for which the employee is fitted and the employer's offer of work or failure to so offer. McSpadden v. Big Ben Coal Co., 288 N.W.2d 181 (Iowa 1980); Olson v. Goodyear Service Stores, 255 Iowa 1112, 125 N.W.2d 251 (1963); Barton v. Nevada Poultry Co., 253 Iowa 285, 110 N.W.2d 660 (1961).

Compensation for permanent partial disability shall begin at the termination of the healing period. Compensation shall be paid in relation to 500 weeks as the disability bears to the body as a whole. Section 85.34.

The first sub-issue to address is whether all of the findings discovered on the September 2015 MRI were related to the initial work injury. There is a difference of opinion among the medical experts whether the findings on the September 2015 MRI were related to claimant's work injury on March 30, 2015.

The authorized, treating surgeon, Dr. Strittholt, was adamant. The new findings were not related to the March 30, 2015 date of injury. Additionally, the surgeon opined, the findings were not the result of any medical treatment provided because of the March 30, 2015 work injury. The new findings were not "a sequelae from the original injury." (Claimant's Post Hearing Brief, page 8)

Dr. Martin, was asked for his opinion regarding the same findings. Dr. Martin opined the new changes were not related to the original work injury. The evaluating

physician offered several hypotheses to explain the anatomical changes seen in September 2015. Dr. Martin explained in a simplified manner that:

> It is, often times, pointed out that rotator cuff disease is usually multifactorial, due to a combination of external compression, age-related degeneration, possibilities of trauma, and intrinsic degeneration. It is, obviously, probably more likely than not that trauma is not related here, because one would expect him to have not had any significant activities, with regards to his right shoulder from the time of his original surgery to the time of the second MRI scan imaging study. Therefore, it is probably more an issue of the nontraumatic factors that are in play here, with respect to this new finding.

(Ex. 5, p. 3)

Only Dr. Bansal held a contrary opinion. He speculated the supraspinatus tendon did not re-tear. It was thinned. Dr. Bansal wrote:

> It [sic] not unusual to have thinning of the remaining tendon after a very large tear is repaired. It is similar to have a laceration of the skin that is quite wide and retracted. To pull it together, it will cause the area close to the repair to be stretched out and thinned.

(Ex. 7, pp. 9)

Dr. Bansal's opinion was then distributed to both Dr. Strittholt and to Dr. Martin. The two experts provided written responses. The undersigned found Dr. Martin's explanation at exhibit 5, page 7, to be the most convincing opinion to explain why the findings in September 2015 were not related to the original work injury. Dr. Martin discussed persuasively:

> It is important to understand that, on the MRI scan imaging study that was done postsurgically, the area of new thinning is 1.8 centimeters proximal to the area of repair. In other words, in the interim portion of the rotator cuff tendon, between where the actual repair was done and where the new area of thinning is, reflects a thickness that is actually normal.

(Ex. 5, p. 7)

It is the determination of this deputy; the anatomical changes that were noted by the September 2015 MRI testing were not the result of the original work injury. Additionally, those new findings were not the result of any medical treatment claimant received for the original work injury.

With respect to claimant's permanent right shoulder injury, Dr. Strittholt rated claimant as having a 6 percent permanent impairment to the body as a whole. Dr. Bansal rated claimant as having an 8 percent impairment to the body as a whole. Dr.

Martin did not provide a permanent impairment rating. Both Dr. Strittholt and Dr. Bansal imposed permanent work restrictions that involve severe weight restrictions with the right upper extremity. Dr. Bansal's restrictions were more onerous than the restrictions imposed by Dr. Strittholt. Claimant is not to be reaching above his right shoulder. He has been following the restrictions imposed by Dr. Strittholt.

Claimant returned to Smithco Manufacturing, Inc., in May 2015. He is in another position which has lighter duties than the duties of a brake press operator. Management is accommodating claimant in the workplace. Claimant is unable to return to the brake press operator position.

Claimant is 61 years old. He is considered an older worker. He only has a high school diploma. Retraining is very unlikely in the event claimant should lose his present job. Claimant appears to be of average intelligence. He has an excellent work record. After reviewing claimant's job history, it is doubtful he would be able to return to the manufacturing jobs he previously held. He probably could return to some work in the retail industry. No doubt, his wages would be considerably less than what he is currently earning. Claimant has sustained a loss of earning capacity.

Therefore, after reviewing all of the factors involving industrial disability; it is the determination of the undersigned deputy workers' compensation commissioner; claimant has an industrial disability in the amount of 55 percent. Defendants shall pay unto claimant 275 weeks of permanent partial disability benefits commencing from the stipulated date of May 20, 2015, and payable at the rate of $504.57 per week.

In arbitration proceedings, interest accrues on unpaid permanent disability benefits from the onset of permanent disability. Farmers Elevator Co., Kingsley v. Manning, 286 N.W.2d 174 (Iowa 1979); Benson v. Good Samaritan Ctr., File No. 765734 (Ruling on Rehearing, October 18, 1989).

The final issue is costs to litigate.

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).

The following costs are assessed to defendants:

Filing fee $100.00

ORDER

THEREFORE, IT IS ORDERED:

Defendants shall pay unto claimant two hundred seventy-five (275) weeks of permanent partial disability benefits at the stipulated weekly benefit rate of five hundred four and 57/100 dollars ($504.57) and payable from May 20. 2015.

Accrued benefits shall be paid in a lump sum, together with interest, as provided by law.

Costs are assessed to defendants as detailed in the body of this decision.

Defendants shall file all reports as required by law

Signed and filed this 7th day, February, 2017.

Michelle A. McGovern

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.