BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

RICK HUGHES, Claimant, vs. IMT MUTUAL HOLDING COMPANY, Employer, and CINCINNATI INSURANCE CO., Insurance Carrier, Defendants.	File No. 22003564.01 ARBITRATION DECISION Headnotes: 1402; 1402.40; 1800; 1803; 2500; 2501; 2700; 2701; 4000

STATEMENT OF THE CASE

The claimant, Rick Hughes, filed a petition for arbitration seeking workers' compensation benefits from employer IMT Mutual Holding Company ("IMT"), and their insurer, Cincinnati Insurance Company. Dillon Besser appeared on behalf of the claimant. Christine Westberg Dorn appeared on behalf of the defendants. Also present was Morgan Bohnenkamp, an IMT employee.

The matter came on for hearing on April 20, 2023, before Deputy Workers' Compensation Commissioner Andrew M. Phillips. Pursuant to an order of the Iowa Workers' Compensation Commissioner, the hearing occurred electronically via Zoom. The hearing proceeded without significant difficulty.

The record in this case consists of Joint Exhibits 1-5, Claimant's Exhibits 1-9, and Defendants' Exhibits A-D. All of the exhibits were received into evidence without objection.

The claimant testified on his own behalf.

Darcy Kriens was appointed the official reporter and custodian of the notes of the proceeding. The evidentiary record closed at the end of the hearing, and the matter was fully submitted after the parties submitted post-hearing briefing on June 1, 2023.

STIPULATIONS

Through the hearing report, as reviewed at the commencement of the hearing, the parties stipulated and/or established the following:

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

2. That the claimant sustained an injury, which arose out of, and in the course of employment on March 4, 2020.

3. That, at the time of the alleged injury, the claimant earned two thousand two hundred fourteen and 03/100 dollars ($2,214.03) per week, that the claimant was married, and entitled to three exemptions. Accordingly, the parties stipulated that the weekly rate of compensation is one thousand three hundred fifty-two and 22/100 dollars ($1,352.22).

4. That, with regard to disputed medical expenses:

    a. The fees or prices charged by the providers are fair and reasonable.
    b. The treatment was reasonable and necessary.
    c. Although the causal connection of the expenses to a work injury cannot be stipulated, the listed expenses are at least causally connected to the medical condition(s) upon which the claim of injury is based.

Entitlement to temporary disability and/or healing period benefits was no longer in dispute. Credits against any award are no longer in dispute as the defendants paid no weekly benefits to date. The defendants waived their affirmative defenses.

The parties are now bound by their stipulations.

ISSUES

The parties submitted the following issues for determination:

1. Whether the alleged injury is a cause of temporary disability during a period of recovery.

2. Whether the alleged injury is a cause of permanent disability.

3. Whether the injury is a scheduled member disability or a disability compensated pursuant to Iowa Code section 85.34(2)(v), if it is a cause of permanent disability.

4. The proper commencement date for permanent partial disability benefits, should any be awarded.

5. Whether the claimant is entitled to payment of certain medical expenses as itemized in Claimant's Exhibit 8.

6. With regard to the disputed medical expenses:

a. Whether the listed expenses were causally connected to the work injury.
b. Whether the requested expenses were authorized by the defendants.

7. Whether the claimant is entitled to alternate care pursuant to Iowa Code section 85.27.

8. Whether the claimant is entitled to penalty benefits pursuant to Iowa Code section 86.13.

9. Whether the claimant is entitled to a specific taxation of costs, and the amount of those costs.

FINDINGS OF FACT

The undersigned, having considered all of the evidence and testimony in the record, finds:

Rick Hughes, the claimant, was 65 years old at the time of the hearing. (Testimony). He resides in Walford, Iowa, with his wife. (Testimony). He graduated from Spirit Lake High School in 1976, and went on to attend the University of Northern Iowa. (Testimony).

While in college, Mr. Hughes worked for a yard work business that he started in high school. (Testimony). He would put docks into lakes, and perform light construction work. (Testimony). Eventually, he left this business upon graduation from college. (Testimony).

Mr. Hughes testified that he has a long family history with IMT, insofar as his father worked for IMT for 38 years. (Testimony). Mr. Hughes took a semester off from college to work for IMT. (Testimony). He worked on catastrophic claims following a devastating hailstorm. (Testimony). He then returned to the University of Northern Iowa and earned his degree in marketing. (Testimony).

Following his graduation from the University of Northern Iowa, Mr. Hughes took a job with IMT as a claims trainee. (Testimony). He handled telephone claims and did mostly “redundant paperwork” for about two months. (Testimony). He then moved into a claims adjuster role following an increase in storm claims in the spring of 1982. (Testimony). After he finished adjusting storm claims, he was sent to the Cedar Rapids area as a claims adjuster. (Testimony). He worked as a claims adjuster in the Cedar Rapids area until 1984. (Testimony).

In 1984, Mr. Hughes began work as a branch manager for Norwest Insurance Agency in Waterloo, Iowa. (Testimony). He was involved in new business sales, maintenance of a book of business, and supervision of three other employees. (Testimony). While employed by Norwest Insurance Agency, he obtained commercial and personal lines insurance licenses in Iowa and Illinois. (Testimony). He continued to maintain those licenses as of the time of the hearing. (Testimony). He also earned a chartered property casualty underwriting (“CPCU”) designation in 1992. (Testimony).

Mr. Hughes returned to IMT in the claims adjuster role in 1985. (Testimony). He stayed in that position until 1987 when he became involved in field marketing. (Testimony). That position is now called a territory manager. (Testimony). At the time of the hearing, Mr. Hughes worked as a senior territory manager for IMT. (Testimony). He was promoted to this role in the mid-1990's. (Testimony). As a senior territory manager, Mr. Hughes is responsible for production and loss ratios for commercial and personal lines insurance policies underwritten by IMT in a certain territory. (Testimony). He oversees about 60 agencies with 80 to 85 separate locations across the eastern half of Iowa. (Testimony). He performs some commercial underwriting. (Testimony). He also visits up to four agents or agencies per day during four days of the week. (Testimony). He spends one day of the week performing clerical work at his home office. (Testimony). In order to reach these agencies, Mr. Hughes drove a company vehicle. (Testimony).

In March of 2020, Mr. Hughes drove a 2019 Toyota Camry LE, which was a four-door vehicle. (Testimony). He had been driving the vehicle for about one year at the time of his injury. (Testimony). He noted that he is 6-foot 2-inches tall, and described the Camry as "a hard car to get comfortable in." (Testimony). He described a trim piece on the seat as "pretty pronounced," and noted that where he sat in the seat "was kind of recessed." (Testimony). He testified further that he had to move the seat as far back from the steering wheel as possible in order to obtain enough leg space in order to "really feel comfortable in the car, which consequently put a fair amount of pressure on [his] right leg that operated the accelerator." (Testimony).

Over time in early March of 2020, Mr. Hughes began feeling a lot of pressure in the back of his leg. (Testimony). The pain and pressure progressively worsened, and he began to experience redness. (Testimony). He complained about pain to one of the agents he visited in Davenport, Iowa. (Testimony). The agent is an EMT and suggested that the claimant should be checked out due to concerns about a deep venous thrombosis ("DVT"). (Testimony). After meeting with the agent, Mr. Hughes returned to Cedar Rapids and went to an urgent care. (Testimony).

On March 11, 2020, Mr. Hughes reported to the urgent care at MercyCare South where Liv Kelley-Sellnau, A.R.N.P., examined him. (Joint Exhibit 1:1-2). He indicated that he had constant aching pain in his right leg that started five to seven days earlier. (JE 1:1). He also exhibited swelling. (JE 1:1). Mr. Hughes expressed concern to Ms. Kelley-Sellnau that he may have a clot. (JE 1:2). She told the claimant to go to the emergency room if he was concerned about a clot. (JE 1:2).

Accordingly, Mr. Hughes transited to the emergency department at St. Luke's Hospital for further evaluation of his right leg swelling, tightness, and pain. (JE 2:3-11). Mr. Hughes told the provider that he never experienced anything like this in the past. (JE 2:4). He expressed concern that he may have a clot as he drove over 150 miles per day for his work. (JE 2:4). He noted taking aspirin, but elaborated that it was not helping to ease his pain. (JE 2:4). Upon examination, Mr. Hughes was found to have elevated blood pressure, along with tenderness, erythema, and warmth to the right lower shin. (JE 2:6). He also exhibited swelling in the right lower extremity. (JE 2:6). An ultrasound was ordered, which showed a nonocclusive thrombus in the right mid

femoral vein, an occlusive thrombus in the posterior tibial and peroneal veins of the right upper calf. (JE 2:7, 11). The providers recommended outpatient therapy using oral anticoagulant medications, and prescribed Mr. Hughes with Eliquis. (JE 2:7). They also told him to follow-up with his primary care physician. (JE 2:7).

Mr. Hughes was told to keep his leg elevated as much as possible. (Testimony).

On March 12, 2020, Mr. Hughes e-mailed his supervisor and told him about his medical situation. (Testimony). He also mentioned that he would "be laid up," and suggested that his blood clot may have arisen due to vehicle operation. (Testimony).

On March 13, 2020, IMT closed their home office due to the COVID-19 pandemic. (Testimony). They also told people like Mr. Hughes to stay off of the road. (Testimony). Since the pandemic altered people's work schedules and work setting, Mr. Hughes did not need to take any time off of work due to his DVT. (Testimony). He was able to work remotely from his home office, and keep his leg elevated pursuant to the directives of his doctors. (Testimony).

Mr. Hughes returned to the emergency room at St. Luke's Hospital on March 14, 2020, complaining of a headache, and worsening pain and swelling in his right lower extremity. (JE 2:12-17). He took Eliquis as prescribed, and began having "one of the worst headaches he has ever had." (JE 2:12). Another ultrasound was performed, which showed no significant changes compared to the March 11, 2020, ultrasound. (JE 2:14). A CT of the claimant's head was normal. (JE 2:14-15). The doctor attributed continued swelling to "poor compliance with elevation," and recommended that the claimant take Excedrin or Tylenol with caffeine to alleviate his headache symptoms. (JE 2:16). The doctor concluded that the headache was "likely a side effect of the Eliquis, which will hopefully improve when his dosing decreases." (JE 2:16).

On March 17, 2020, Bradley Beer, M.D., evaluated the claimant at MercyCare Blairs Ferry. (JE 3:22-33). Mr. Hughes continued to have slight pain, swelling, and redness in his right leg, but noted that it had significantly improved. (JE 3:23). Dr. Beer noted that Mr. Hughes had a right lower extremity DVT involving the femoral popliteal and lower veins. (JE 3:24). Dr. Beer ordered genetic testing to evaluate the potential cause of the blood clot. (JE 3:29). The testing returned positive for a heterozygous genetic mutation which, according to Dr. Beer, likely played a role in the formation of the blood clot. (JE 3:29). Dr. Beer anticipated that the claimant would require anticoagulants for three months, at which time an ultrasound would be repeated. (JE 3:24). If the issue resolved at that time, then anticoagulants would be discontinued. (JE 3:24).

On May 28, 2020, Mr. Hughes reported to the cardiovascular lab at CRS Ultrasound. (JE 2:18-21). Another ultrasound was conducted of the claimant's right leg. (JE 2:18-19). The ultrasound showed interval improvement of the occlusive and nonocclusive thrombus in the claimant's right lower extremity. (JE 2:19).

Randal Wojciehoski, D.P.M., D.O., performed an IME on the claimant on July 27, 2020, in Iowa City, Iowa. (Defendants' Exhibit B:9-13). Dr. Wojciehoski was board certified in internal medicine and emergency medicine. (DE B:17). He reviewed the

claimant's medical history, including Mr. Hughes' description of pressure behind his right knee while driving. (DE B:9). Dr. Wojciehoski opined that Mr. Hughes was basically recovered from his DVT since the clot had been diminishing. (DE B:10). The right lower extremity was 1 cm larger than the left lower extremity. (DE B:11).

Based upon his findings, the doctor opined that Mr. Hughes' work contributed 50 percent to his DVT, while his genetic condition contributed 50 percent as a "material contributory causative factor," to his DVT. (DE B:12). Dr. Wojciehoski recommended that Mr. Hughes complete a six-month course of anticoagulants, including Eliquis, and repeat ultrasound examination to address the "integrity and dissolution of the clot." (DE B:12). The doctor opined that Mr. Hughes would achieve maximum medical improvement ("MMI") on September 12, 2020, which was six months following the beginning of treatment for the DVT. (DE B:12). Finally, Dr. Wojciehoski concluded that Mr. Hughes had a 0 percent permanent partial impairment as a result of the work injury. (DE B:12-13).

By the fall of 2020, Mr. Hughes still had tightness in his leg, pressure behind his kneecap, and pain in his lower calf. (Testimony).

On September 16, 2020, the claimant had another ultrasound to his right leg, as ordered by Dr. Beer. (JE 3:34-35). The ultrasound showed "[s]table distribution of thrombus within the right distal femoral vein, above and below-knee popliteal vein and peroneal vein." (JE 3:35). The radiologist noted "slight improvement" in the overall amount of the clot since the previous ultrasound. (JE 3:35).

Dr. Beer examined Mr. Hughes again on October 14, 2020, for a follow-up of hypertension, hyperlipidemia, and DVT. (JE 3:36-42). Dr. Beer noted a diagnosis of DVT of the right leg secondary to prolonged driving. (JE 3:36, 39). The doctor noted the results of the September ultrasound. (JE 3:38). The plan for treating the claimant's DVT was to continue treatment with anticoagulants with a follow-up in three months. (JE 3:40).

Mr. Hughes had a follow-up ultrasound on his right leg on January 18, 2021. (JE 5:53-54). The ultrasound showed mild improvement of the below knee popliteal vein thrombus with "mild recanalization." (JE 5:54). The ultrasound showed an "[o]therwise stable DVT…" (JE 5:54). Dr. Beer reviewed the results and noted the improvement and that the clot appeared to be "opening up." (JE 5:53). Dr. Beer recommended three additional months of anticoagulants before another ultrasound to re-evaluate the claimant's condition. (JE 5:53).

The claimant had another ultrasound on April 27, 2021. (JE 5:55-56). The ultrasound showed decreased DVT in the claimant's right leg with "persistent nonocclusive thrombus in the right popliteal vein below the knee." (JE 5:56). Dr. Beer reviewed the results and noted the persistent thrombus. (JE 5:55). He also noted that the size of the thrombus had decreased since the prior ultrasound. (JE 5:55). Dr. Beer recommended that Mr. Hughes continue taking anticoagulants, and have another ultrasound in three months to re-evaluate his condition. (JE 5:55).

On May 9, 2021, Dr. Beer provided Mr. Hughes with another refill of Eliquis. (JE 3:43).

A repeat ultrasound was performed on August 17, 2021. (JE 3:44-45). The ultrasound showed interval worsening of the DVT in the posterior tibial and peroneal veins of the right calf. (JE 3:45). It also showed nonocclusive DVT in the posterior tibial and peroneal veins of the right calf. (JE 3:45). An occlusive DVT was also seen in the right popliteal vein below the knee. (JE 3:45). The findings were compared to an April 27, 2021, ultrasound. (JE 3:44). Glenn Hammer, M.D. noted that the findings of the ultrasound were concerning because Mr. Hughes took anticoagulants, yet the DVT worsened. (JE 3:45). Dr. Beer reviewed the results of the ultrasound and concurred that a clot appeared to be forming again in the popliteal vein below the right knee. (JE 5:61). Dr. Beer recommended three additional months of anticoagulants, followed by another ultrasound. (JE 5:61). Dr. Beer contemplated a referral to hematology to determine if the claimant may benefit from alternative treatments. (JE 5:61).

On August 27, 2021, Dr. Beer saw Mr. Hughes again. (JE 3:45-47). Due to the claimant's persistent and slightly worsening DVT in the right leg, Dr. Beer recommended a referral to hematology and oncology. (JE 3:47). This referral would help to determine whether additional testing or alternative therapy could help resolve Mr. Hughes' DVT. (JE 3:47). Dr. Beer also wanted to determine why the clot went from nonocclusive to occlusive despite the fact that the claimant took anticoagulants. (JE 3:47).

Dr. Wojciehoski wrote a supplemental report dated September 8, 2021. (DE B:14-16). As part of preparing this report, the doctor examined additional medical records, but did not re-examine Mr. Hughes. (DE B:14). He did not change his opinion, and continued to maintain that the DVT was 50 percent caused by the claimant's work and 50 percent caused by the claimant's genetic predisposition to clotting. (DE B:15). The doctor recommended that Mr. Hughes have ongoing medical treatment. (DE B:15). Dr. Wojciehoski further opined that Mr. Hughes' condition had yet to plateau, and that "despite the fact that he is anticoagulated, he does continue to develop worsened thrombosis distally in the leg." (DE B:15). Accordingly, the doctor recommended continued treatment. (DE B:15).

Jasmine Nabi, M.D. of Oncology Associates at Mercy examined Mr. Hughes on September 16, 2021. (JE 5:63-65). Dr. Nabi recounted the claimant's diagnoses, and treatment to date. (JE 5:63). She noted that Mr. Hughes told her that the seat of his IMT provided vehicle hit or applied pressure to the posterior of his right thigh. (JE 6:63). Dr. Nabi opined that Mr. Hughes had DVT in his right lower extremity that was associated with prolonged driving and sedentary work. (JE 5:65). She noted that his company vehicle "may be exacerbating the situation" insofar as the seat pressured his right thigh. (JE 5:65). She recommended that Mr. Hughes remain on anticoagulants as long as he was working in a sedentary occupation. (JE 5:65). She also recommended that Mr. Hughes change his work vehicle noting the potential exacerbation of his poor circulation, and that he have a colonoscopy. (JE 5:65).

In 2021, as the pandemic eased, IMT allowed employees to begin making field calls to their agencies again. (DE C:26). Around this time, Mr. Hughes "eased into"

making field calls to agents. (Testimony; DE C:26). He continued to have symptoms from his clot and DVT in his leg, but he also began to notice "early fatigue," which he described as "fatigue that you wouldn't normally experience for the movement that you're going through." (Testimony). He provided an example of walking for one mile. (Testimony). If he performed that exercise, his left leg would be fine, but his right leg would fatigue rapidly. (Testimony).

Mr. Hughes had another ultrasound of his right leg on February 7, 2022, in order to evaluate his DVT. (JE 5:67). The ultrasound showed occlusive thrombosis of the right popliteal vein below the knee. (JE 5:67). There also was nonocclusive thrombosis of the popliteal vein above the knee. (JE 5:67). The radiologist observed that the nonocclusive thrombosis of the peroneal and posterior tibial veins had resolved. (JE 5:67).

Dr. Nabi visited with Mr. Hughes again on March 18, 2022. (JE 5:68-70). Mr. Hughes noted feeling "well" overall, and told Dr. Nabi that he had a new vehicle which was more comfortable. (JE 5:68). He also told her that he planned to retire in 2023. (JE 5:68). Dr. Nabi reiterated her previous diagnoses. (JE 5:69). She recommended that Mr. Hughes remain on anticoagulants while he worked in a sedentary job in which he drove 150 miles or more per day; however, once he retired, Mr. Hughes could transition to daily aspirin. (JE 5:70). She also recommended that ultrasound follow-ups be discontinued, and allowed Mr. Hughes to return to her clinic on an as-needed basis. (JE 5:70).

On March 28, 2022, Dr. Nabi issued a letter in which she opined that the blood clot was "likely caused" by prolonged driving for work. (JE 5:71). She recommended that Mr. Hughes decrease his time driving in order to decrease the risk of recurrent blood clots. (JE 5:71).

On June 29, 2022, Dr. Beer provided the claimant with a refill of his anticoagulant prescriptions. (JE 3:48-49).

Dr. Nabi wrote a letter, dated November 7, 2022. (CE 3:17-18). Dr. Nabi opened her letter by outlining her board certification in internal medicine, medical oncology, and hematology. (CE 3:17). Dr. Nabi reiterated her opinion that it was, more likely than not, Mr. Hughes' work activities were a "direct causal factor" of his right leg DVT. (CE 3:17). Specifically, Dr. Nabi pointed to the driving distances and company vehicle as work activities that worsened or caused his DVT. (CE 3:17). Dr. Nabi further noted that the claimant's genetic condition did not alter her opinions. (CE 3:17). She continued by opining that Mr. Hughes achieved MMI on March 18, 2022. (CE 3:17). Dr. Nabi indicated that Mr. Hughes was at an increased risk of suffering future blood clots, and thus that his work injury caused a permanent injury. (CE 3:17).

At the arrangement of his attorney, Mr. Hughes had an independent medical examination with John Kuhnlein, D.O., M.P.H., F.A.C.P.M., F.A.C.O.E.M., on November 11, 2022. (Testimony; CE 1:1). He noted that, between an interview and the examination itself, Dr. Kuhnlein met with him for one and a half to two hours. (Testimony). Dr. Kuhnlein is board certified in occupational medicine and is a certified

independent medical examiner. (CE 2:12). He also is a past clinical instructor in occupational and environmental medicine at the University of Iowa. (CE 2:12).

Dr. Kuhnlein issued a report outlining the findings of his IME on November 28, 2022. (CE 1:1-10). He began his report by recounting Mr. Hughes' job responsibilities, and material handling requirements, including driving a car on average of 150 miles per day. (CE 1:1). Mr. Hughes told Dr. Kuhnlein that the high front lip of the seat in his IMT issued Toyota Camry put pressure on the rear of his right leg while he drove. (CE 1:2). Dr. Kuhnlein then reviewed the applicable medical records. (CE 1:3-6). Dr. Kuhnlein found Mr. Hughes to have range of motion of 0 degrees to 135 degrees in his right leg. (CE 1:8). Dr. Kuhnlein's examination of the claimant's right knee was unremarkable. (CE 1:8). After reviewing the claimant's treatment to date, and examining the claimant, he diagnosed Mr. Hughes with DVT of the right leg, along with heterozygous prothrombin/factor II gene mutation. (CE 1:8).

Dr. Kuhnlein found that it was more likely than not that Mr. Hughes' work for IMT was a substantial factor in the development of his right leg DVT. (CE 1:8). Namely, Dr. Kuhnlein pointed to the pressure points created by the seat of the IMT provided Toyota Camry on the back of the claimant's right leg, along with Mr. Hughes sitting for prolonged periods of time. (CE 1:8). Dr. Kuhnlein discussed the gene mutation possessed by Mr. Hughes. (CE 1:8). He opined that this genetic predisposition or mutation increased risk for blood clots by two to four times the normal risk. (CE 1:8). Dr. Kuhnlein aptly noted that Mr. Hughes was exposed to a workplace stressor that caused his DVT, and that his genetic predisposition made it more likely that a DVT would occur. (CE 1:8).

The doctor placed Mr. Hughes at MMI as of March 18, 2022, which is the claimant's last visit with Dr. Nabi. (CE 1:9). Dr. Kuhnlein then used the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, in order to provide a permanent impairment rating. (CE 1:9). Dr. Kuhnlein opined that the use of anticoagulants and their continued use, along with the continued presence of a DVT in the right leg was "consistent with the fact that there have been permanent changes in the vascular system, and his vascular system has not returned to its preinjury state without clots." (CE 1:9). Dr. Kuhnlein opined that the claimant had two differently sized calves due to vascular changes and not due to muscular atrophy. (CE 1:9). This contradicts physical measurements taken of the claimant's calves. (CE 1:8-9). Dr. Kuhnlein used Chapter 9 of the Guides, as he found Table 17-6 and 17-38 to be inappropriate based upon the claimant's condition. (CE 1:9). Dr. Kuhnlein notes that Chapter 9 of the Guides pertains to individuals with "acquired blood clotting defects…" (CE 1:9). Dr. Kuhnlein opined that Mr. Hughes should continue taking anticoagulants so he is not at an increased risk of pulmonary emboli cardiac complications or stroke. (CE 1:9). Based upon this, Dr. Kuhnlein opined that Mr. Hughes was assigned to "class II," and assigned him a 16 percent whole person impairment. (CE 1:9).

Dr. Kuhnlein recommended that Mr. Hughes have a repeat ultrasound in order to determine whether the claimant needed to continue taking anticoagulants. (CE 1:8). He recommended that Mr. Hughes be allowed to sit, stand, or walk, on an as tolerated basis, "with the ability to change positions for comfort." (CE 1:9). He allowed Mr.

Hughes to occasionally crawl, kneel, stoop, or squat. (CE 1:9). He also allowed Mr. Hughes to travel for work provided he could take breaks to stretch from time to time. (CE 1:10).

On February 10, 2023, defendants' counsel wrote a letter to David Lawrence, M.D., F.A.C.S., seeking a records review and his opinions in regard to a number of questions. (DE A:4-5). Dr. Lawrence is board certified in vascular surgery. (DE A:6).

In a letter dated March 22, 2023, Dr. Lawrence responded to the questions posed by defendants' counsel. (DE A:1-3). Dr. Lawrence opined that the claimant's genetic clotting disorder placed him at a greater baseline risk than the general population, and that it was "likely that the sedentary aspects" of the claimant's work activities contributed to his developing a DVT in his right leg. (DE A:1). Dr. Lawrence found the partially occlusive DVT in the right leg to be chronic, and that this represented a "permanent change" to the deep venous system. (DE A:1). In spite of this, Dr. Lawrence did not speculate or opine as to the "long term clinical significance" of any change. (DE A:1). Dr. Lawrence found that the claimant did not sustain a permanent impairment. (DE A:2). He cited to Dr. Nabi's opinion that Mr. Hughes may not need to continue long-term anticoagulants after he retires. (DE A:2). Dr. Lawrence agreed that Mr. Hughes may be at greater risk for developing future DVTs, but noted that this could be due to chronic DVT, his genetic factors, or his lifestyle choices. (DE A:2). Dr. Lawrence did not provide any firm opinion on the date claimant reached MMI. (DE A:2).

Dr. Lawrence recommended that Mr. Hughes take five-minute breaks after driving for 30 minutes. (DE A:2). He also recommended that Mr. Hughes wear medical grade compression hose on longer drives for business and pleasure. (DE A:2). Dr. Lawrence indicated that he would treat a "provoked" DVT for three to six months, and a DVT secondary to a clotting disorder on a potentially lifelong basis. (DE A:2). Dr. Lawrence deferred to hematology for any long-term pharmacologic management, while recommending that the claimant wear compression hose. (DE A:2). Despite the foregoing, Dr. Lawrence concluded that, due to the claimant being "minimally symptomatic," ongoing or permanent anticoagulation therapy was "not-consistent with a simple provoked (work-related) DVT." (DE A:2).

Since returning to the road, Mr. Hughes has altered his schedule in order to accommodate his lingering DVT issues. (Testimony). He also drove a Subaru Forester, instead of the previously provided Toyota Camry. (DE C:24). He no longer schedules long driving days back-to-back. (Testimony). He also stops every so often in order to stretch his leg. (Testimony). These changes have had no impact on how he does his job. (Testimony).

At the time of the hearing, Mr. Hughes experienced fatigue in his leg when he sat in a vehicle for a long period of time. (Testimony). He also still described pain in the middle of his lower right calf. (Testimony). He experienced pressure behind his right kneecap. (Testimony). He altered the amount of daily activity that he performed depending on how his leg feels. (Testimony). He still is able to bicycle and remain physically active, but he has had to alter these exercises due to his physical condition. (Testimony). Mr. Hughes enjoyed hunting for waterfowl and pheasant. (DE C:29).

Mr. Hughes continued to take Eliquis. (Testimony). He testified that it was his understanding that he could "switch to an aspirin regimen" once he retires and is no longer on the road as much. (Testimony). He also testified that he wears compression socks when he knows he is going to be on his feet. (Testimony). He noted that he would likely continue to wear compression socks after his retirement. (Testimony).

Mr. Hughes enjoys working out, riding his bicycle, and fishing. (Testimony). Since his injury, he has altered his workouts to accommodate his right leg fatigue. (Testimony).

Mr. Hughes testified that he loved his job with IMT. (Testimony). He enjoys the corporate culture, and family connection that he has to IMT. (Testimony). He plans on retiring in 2024. (Testimony). Due to his seniority, he noted he would begin training a replacement for his position in the summer of 2023, in anticipation for his retirement. (Testimony).

IMT has certain pay bands under which employees are paid. (Testimony). Mr. Hughes was at the top of his pay band, but still received salary increases year-over-year. (Testimony). He also received certain bonuses since his injury. (Testimony).

Mr. Hughes is proficient in using a computer. (Testimony). He uses IMT proprietary programs, Microsoft Word, and Microsoft Outlook. (Testimony). He also has learned to use Zoom. (Testimony). He is proficient in using a cell phone. (Testimony).

Mr. Hughes testified that he never experienced a blood clot in the past, nor had he ever had a DVT. (Testimony). Through blood work, it was discovered that Mr. Hughes had a specific gene mutation which caused him to be at a "somewhat higher risk of blood clot." (Testimony). He was not aware of this condition prior to experiencing the clot and DVT in March of 2020. (Testimony).

Mr. Hughes used his personal health insurance to pay for some of his medical care. (Testimony). He also paid a thirty-five and 00/100 dollars ($35.00) copay per prescription fill of Eliquis. (Testimony). Following an examination by Dr. Wojciehowski, the workers' compensation carrier began to pay for some of his medical bills, but they did not cover his out-of-pocket payments. (Testimony).

CONCLUSIONS OF LAW

The party who would suffer loss if an issue were not established has the burden of proving that issue by a preponderance of the evidence. Iowa Rule of Appellate Procedure 6.904(3).

Causation

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 medical causation is "essentially within the domain of expert testimony." Cedar Rapids Cmty. Sch. Dist. v. Pease, 807 N.W.2d 839, 844-45 (Iowa 2011). The commissioner, as the trier of fact, must "weigh the evidence and measure the credibility of witnesses." Id. The trier of fact may accept or reject expert testimony, even if uncontroverted, in whole or in part. Frye, 569 N.W.2d at 156. When considering the weight of an expert opinion, the fact-finder may consider whether the examination occurred shortly after the claimant was injured, the compensation arrangement, the nature and extent of the examination, the expert's education, experience, training, and practice, and "all other factors which bear upon the weight and value" of the opinion. Rockwell Graphic Sys., Inc. v. Prince, 366 N.W.2d 187, 192 (Iowa 1985). Unrebutted expert medical testimony cannot be summarily rejected. Poula v. Siouxland Wall & Ceiling, Inc., 516 N.W.2d 910 (Iowa App. 1994). Supportive lay testimony may be used to buttress expert testimony, and therefore is also relevant and material to the causation question.

Iowa employers take an employee subject to any active or dormant health problems, and must exercise care to avoid injury to both the weak and infirm and the strong and healthy. Hanson v. Dickinson, 188 Iowa 728, 176 N.W. 823 (1920). While a claimant must show that the injury proximately caused the medical condition sought to be compensable, it is well established that a cause is "proximate" when it is a substantial factor, or even the primary or most substantial cause to be compensable under the Iowa workers' compensation system. Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417 (Iowa 1994); Blacksmith v. All-American, Inc., 290 N.W.2d 348 (Iowa 1980).

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

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

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

The first disputed issue noted in the hearing report is whether or not the work injury was a cause of temporary disability. No doctor ever opined that the claimant should be off work due to his injury. Additionally, at the time that the claimant was injured, his company required him to begin working from home, due to the COVID-19 pandemic. There is insufficient evidence in the record to conclude that the claimant's work injury was a cause of temporary disability.

I turn next to the issue of whether the claimant's DVT was a cause of permanent disability. The claimant sought treatment with several doctors. The defendants also had a records review conducted, and had the claimant attend an IME with a physician of their choosing. The claimant also attended an IME with a physician of his choosing. There are differences in opinions of the various physicians.

Mr. Hughes was initially diagnosed with a DVT in March of 2020. An initial ultrasound showed a nonocclusive thrombus in the right mid femoral vein, and occlusive thrombi in the posterior tibial and peroneal veins of the right upper calf. He was prescribed anticoagulants, namely Eliquis. He was monitored via ultrasound every few months. By late May of 2020, the clots in Mr. Hughes' lower extremity showed interval improvement of the occlusive and nonocclusive thrombus. During the course of his treatment, Mr. Hughes was found to have some genetic predisposition to clotting.

The DVT showed continued improvement through the fall of 2020. By January 18, 2021, a follow-up ultrasound showed mild improvement and mild recanalization in the popliteal vein. Dr. Beer, the claimant's primary physician, opined that the clot appeared to be "opening up." The DVT issues remained stable until August of 2021. During a follow-up ultrasound on August 17, 2021, it was noted the DVT in the posterior tibial and peroneal veins worsened since the previous ultrasound. Specifically, an occlusive DVT was seen in the right popliteal vein below the knee. Dr. Beer and the examining radiologist agreed that a clot was forming again below the right knee in the popliteal vein.

Mr. Hughes was referred to hematology and/or oncology for continued follow-up of his DVT issues. He began to see Dr. Nabi, who recommended that he remain on anticoagulants as long as he was working in a sedentary position. She also recommended that he change his work vehicle due to the role it played in causing his injury. A follow-up ultrasound in February of 2022, continued to show occlusive thrombosis of the right popliteal vein below the knee, along with nonocclusive thrombosis of the right popliteal vein above the knee. Finally, the radiologist noted that the nonocclusive thrombosis in the peroneal and posterior tibial veins had resolved. Following this ultrasound, Dr. Nabi continued to recommend Mr. Hughes remain on anticoagulants so long as he was in a sedentary job wherein he drove considerable distances. As she treated Mr. Hughes in 2022, Dr. Nabi recommended that he reduce his driving time. She also continued to prescribe him with anticoagulants until discharging him to return on an as-needed basis. Dr. Beer continued to prescribe Mr. Hughes with anticoagulants, and Mr. Hughes testified that he was due for an annual follow-up visit with Dr. Beer to obtain a refill of his anticoagulant medications.

I found Mr. Hughes to be an exceptionally credible witness. Mr. Hughes testified that he becomes easily fatigued in his right leg. The fatigue comes on when he sits in a vehicle for some time, and also when he exercises or walks. Mr. Hughes described himself as someone who exercised on a regular basis, including using a rowing machine and bicycling. Since his DVT, he has had to modify the length and technique of these exercises. Mr. Hughes testified that he still had pain in the middle of his right calf.

After being diagnosed with DVT, and treating for several months with anticoagulants, the defendants sent Mr. Hughes to see Dr. Wojciehoski for an IME. Dr. Wojciehoski is a doctor of podiatric medicine and a doctor of osteopathic medicine. He saw Mr. Hughes on July 27, 2020. The doctor found Mr. Hughes' right lower extremity to be 1 cm larger than his left lower extremity. Dr. Wojciehoski opined that Mr. Hughes should complete a six-month course of anticoagulants with repeat ultrasound examinations to determine the progress of the DVT. Without additional explanation, Dr. Wojciehoski declared that Mr. Hughes would achieve MMI on September 12, 2020, as it was six months after he began treatment. Interestingly, Dr. Wojciehoski attributed 50 percent of the claimant's ongoing issues to his work and 50 percent to his genetic condition. Finally, Dr. Wojciehoski concluded that Mr. Hughes had a 0 percent permanent partial impairment as a result of his work injury.

Dr. Wojciehoski issued a supplemental report on September 8, 2021, following a records review that he conducted. Based upon this review, the doctor did not alter his position that the claimant's right leg issues were 50 percent attributable to his genetic condition and 50 percent attributable to his riding in an IMT issued Toyota Camry. Dr. Wojciehoski recommended ongoing medical treatment and commented on the claimant's worsening thrombosis in his right leg. He concluded at that time that Mr. Hughes had yet to plateau.

Dr. Nabi, who is board certified in internal medicine, medical oncology, and hematology, provided her opinions on Mr. Hughes' condition on November 7, 2022. She opined that it was more likely than not that the claimant's work activities were a "direct causal factor" of the DVT, and that driving considerable distances worsened his DVT. She placed Mr. Hughes at MMI as of March 18, 2022, and opined that he was at risk for suffering future blood clots. She also opined that the claimant suffered a permanent injury; however, she made no mention of the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, nor did she elucidate any more opinions as to the claimant's ongoing condition.

At the arrangement of claimant's counsel, Dr. Kuhnlein examined Mr. Hughes for an IME on November 11, 2022. Dr. Kuhnlein issued a report regarding the same on November 28, 2022. Dr. Kuhnlein is board certified in occupational medicine and is a certified independent medical examiner. Dr. Kuhnlein examined the claimant and opined that the claimant had a DVT of the right leg, along with heterozygous prothrombin/factor II gene mutation. Dr. Kuhnlein went on to opine that it was more likely than not that Mr. Hughes' work was a substantial factor in the development of the DVT in his right leg. Dr. Kuhnlein noted that Mr. Hughes had a genetic predisposition that increased his risk for blood clots by two to four times the normal risk. He noted that

the workplace stressor, namely the seat of the Toyota Camry, caused the DVT, and that the genetic predisposition simply made it more likely that a DVT would occur. Upon physical examination, Dr. Kuhnlein found the claimant had the same circumference for both his right and left thigh and right and left calf.

Dr. Kuhnlein opined that the claimant sustained a permanent disability due to his DVT. Dr. Kuhnlein noted in his report, "Mr. Hughes did not have this thrombosis before the work injury and does now, so the impairment would be greater than 0 [percent], as the thrombosis represents a loss or loss of use of the vascular system in his right leg." (CE 1:9). Dr. Kuhnlein then outlined why Table 17-6 and 17-38 of the Guides were not appropriate to evaluate the permanent impairment to the claimant's right lower extremity, as Table 17-6 was "related to leg muscle atrophy," and Table 17-38 discussed "peripheral vascular disease rather than occlusive vascular disease…" (CE 1:9).

The doctor felt that Chapter 9 of the Guides was "the most accurate means for assessing impairment…" in this case. (CE 1:9). Dr. Kuhnlein referenced page 203 of the Guides and specifically how it relates to persons with "acquired blood clotting defects." (CE 1:9). Since Mr. Hughes continued to have signs of the DVT on objective testing but could perform his daily activities with "continuous treatment" in the form of anticoagulants, Dr. Kuhnlein placed Mr. Hughes in "class II," and assigned him a 16 percent whole person impairment rating.

The final opinion with regard to permanent impairment comes from Dr. Lawrence, who is board certified in vascular surgery. Dr. Lawrence performed a records review on behalf of the defendants. Of note, he never examined, or spoke with, Mr. Hughes in arriving at his opinions. Nevertheless, Dr. Lawrence agreed that the claimant's work activities contributed to his development of a DVT. He also found the partially occlusive DVT to be chronic and noted that this represented a "permanent change" to the claimant's deep venous system. Despite this note, Dr. Lawrence concluded that Mr. Hughes did not suffer a permanent impairment due to his DVT. He also noted that Mr. Hughes may not require the long-term use of anticoagulants. Dr. Lawrence did not provide any firm date as to his opinion on when the claimant achieved MMI.

Interestingly, despite his opinions that the claimant did not have a permanent impairment, Dr. Lawrence recommended that Mr. Hughes take five minute breaks after driving for 30 minutes. He also recommended that Mr. Hughes wear medical grade compression hose on longer drives. Dr. Lawrence then provided his treatment course for a "provoked" DVT at about three to six months, while noting that a DVT secondary to a clotting disorder may require lifelong treatment. This contradicts his opinion that, because the claimant was "minimally symptomatic," ongoing or permanent anticoagulant therapy was "not-consistent with a simple provoked (work-related) DVT." It also contradicts his statement that he would defer to a hematologist for long-term pharmacologic management.

On the one hand, are the opinions of Dr. Lawrence following his records review, and Dr. Wojciehoski following his IME and records review. On the other are those of Dr. Nabi and Dr. Kuhnlein following their treatment and IME, respectively.

Dr. Wojciehoski issued his initial report very close to the time of the injury. He indicated that Mr. Hughes would achieved MMI in six months, without taking into consideration potential developments or worsening of his condition. While he issued a supplemental report, it seems as though he prejudged Mr. Hughes' condition. I find his report to be the least credible.

Dr. Lawrence is a vascular surgeon. His report was convincing until he contradicted himself by opining as to whether Mr. Hughes should still be on anticoagulants and then stating that he would defer to a hematologist for pharmacologic management. He also indicated that a DVT secondary to a clotting disorder (such as that suffered by Mr. Hughes) may require lifelong treatment, while arguing that Mr. Hughes did not require such treatment as he was "minimally symptomatic." Dr. Lawrence also never examined, met with, or talked to, Mr. Hughes. I find his report to lack credibility, as well.

Dr. Nabi, who treated the claimant, and is a board certified hematologist, opined that Mr. Hughes' DVT caused a permanent injury. She opined further that Mr. Hughes was at an increased risk of suffering future blood clots. She placed Mr. Hughes at MMI effective March 18, 2022. While Dr. Nabi opined that the claimant suffered a permanent injury, she did not provide any additional analysis as to how she arrived at this position based upon the Guides. While I find the opinions of Dr. Nabi to be more reliable, as she was a treating physician, and has the expertise to opine on the claimant's ongoing DVT, I cannot find the claimant to have sustained a permanent disability by a preponderance of the evidence based solely on her opinions.

Finally, the claimant urges the adoption of the opinions of Dr. Kuhnlein. Dr. Kuhnlein is board certified in occupational medicine. He examined the claimant for purposes of an IME, and met with him for one and a half to two hours. Dr. Kuhnlein noted that the seat of the Toyota Camry created pressure points in the back of Mr. Hughes' right leg. When combined with sitting for prolonged periods of time and the claimant's genetic predisposition to clotting issues, the result was a DVT. Dr. Kuhnlein opined that the continued presence of a DVT in the right leg was "consistent with the fact that there have been permanent changes in the vascular system," and that Mr. Hughes' vascular system had "not returned to its preinjury state without clots." If I ended my analysis here, it would be easy to declare that the DVT caused a permanent disability to Mr. Hughes.

However, there are significant limitations to Dr. Kuhnlein's report. First, Dr. Kuhnlein mentions that some of his evaluation and opinion is based upon a size differential in the claimant's calves. However, his report shows no differential in size between the left calf and right calf.

Second, where Dr. Kuhnlein finds his justification for providing a rating of permanent impairment is problematic. Chapter 17 of the Guides provides various methods for determining permanent impairment to the lower extremities. Dr. Kuhnlein begins his evaluation of permanent impairment by dismissing impairment rating criteria provided in Table 17-6, on page 530 of the Guides. Table 17-6 provides criteria for "Impairment Due to Unilateral Leg Muscle Atrophy." 17.2d, which immediately precedes

Table 17-6 discusses unilateral muscle atrophy as a basis for permanent impairment. No doctor has ever diagnosed Mr. Hughes with muscle atrophy. There is no evidence of differences in circumference in the claimant's calves as of Dr. Kuhnlein's evaluation, which 17.2d provides as a criteria for evaluating muscle atrophy. I agree with Dr. Kuhnlein that this would be an inappropriate section of the Guides to use to evaluate or determine that the claimant suffered a permanent impairment.

Dr. Kuhnlein then discusses rating criteria as found in Table 17-38 of the Guides. As noted in 17.2n, which is titled "Vascular Disorders," "[t]able 17-38 classifies and provides criteria for impairments due to peripheral vascular disease of the lower extremity." Interestingly, the Guides provides an example of a proper rating for "[i]mpairment [c]aused by [v]ascular [d]isease [d]ue to a [d]eep [v]enous [t]hrombosis (DVT)." The Guides gives the example of an individual who suffered a closed, but displaced tibial fracture who then suffers a DVT during their postoperative course of treatment. See Guides, page 554. Dr. Kuhnlein dismisses this section of the Guides because it "discusses peripheral vascular disease rather than occlusive vascular disease…" (CE 1:9). Peripheral vascular disease is "a slow and progressive circulation disorder," which restricts blood flow to areas such as the legs. See Peripheral Vascular Disease, online: https://www.hopkinsmedicine.org/health/conditions-and-diseases/peripheral-vascular-disease#:~:text=What%20is%20peripheral%20vascular%20disease,%2C%20veins%2C%20or%20lymphatic%20vessels, (last visited June 7, 2023). Therefore, I agree with Dr. Kuhnlein that this would likely not be an appropriate section with which to evaluate permanent disability due to DVT.

Dr. Kuhnlein settles on Chapter 9 as the section most apt to determine whether the claimant sustained a permanent disability, and the extent thereof. Chapter 9 "provides criteria for evaluating permanent impairment of the hematopoietic system…" which includes the bone marrow, lymph nodes, spleen, and "a complex family of proteins critical for blood clotting and immune defenses." See Guides, page 191. Dr. Kuhnlein cites to page 203 of the Guides in noting that "[i]mpairment of the whole person with acquired blood clotting defects is estimated at 0% to 10%." See Guides, page 203. This statement is located under Section 9.5, titled "Hemorrhagic and Platelet Disorders." Id. This refers to coagulation disorders and platelet disease. Id. The Guides note that, "[a]cquired blood-clotting defects are usually secondary to severe underlying conditions, such as chronic liver disease." Id. This section appears to refer more to conditions where excessive bleeding is an issue. Dr. Kuhnlein uses this section to place Mr. Hughes into a "Class II"

For reasons unknown to the undersigned, Dr. Kuhnlein makes no mention of Section 9.6 of the Guides. This section is titled "Thrombotic Disorders," and begins with an introductory paragraph that states, "[t]hrombotic disorders involve arteries, veins, or both. Thrombosis may be either primary due to inherited disorder or secondary due to acquired conditions. While each risk factor may contribute to thrombosis, combined factors may lead to a greater risk." Id. at 206. Section 9.6a then refers to known inherited thrombotic disorders, such as "defective protein due to mutation associated with venous thrombosis." Id. Section 9.6b refers to "[a]cquired thrombotic conditions

associated with venous thrombosis," to include "immobility." Id. A thrombotic disorder is noted to result from "systematic complications following thrombosis and anticoagulation regimen." Id. Impairment rating due to thrombotic disorders is "evaluated according to the affected body system." Id. What this means, is that the impairment rating for a thrombotic disorder is "based upon the degree of injury to the end organ…" Id. at 207. This would mean that Mr. Hughes' impairment would be evaluated as a permanent disability to his lower extremity, had this section been utilized. The Guides allow for a whole person impairment rating should there be involvement of several organ systems. Id. The Guides then provides a helpful example of a woman who had a family history of multiple clotting issues, and had taken anticoagulants. Id. She also had five separate DVTs and two pulmonary embolisms. Id. The Guides provides a sample impairment rating based upon her underlying issues along with a lower extremity condition. Id.

The record does not indicate that the claimant suffers from a hemorrhagic disorder. "Hemorrhage is the medical term for bleeding…" and commonly refers to excessive bleeding. See MedlinePlus, online: https://medlineplus.gov/ency/article/000045.htm (last visited June 7, 2023). The record also does not indicate, nor is there any explanation that would indicate that Mr. Hughes suffers from a platelet disorder. Mr. Hughes has a genetic mutation known as prothrombin gene mutation, or Factor II mutation. Furthermore, there is no evidence that Mr. Hughes' blood clotting defect is acquired, as indicated by Dr. Kuhnlein. Acquired in the context of this section means something caused by another factor and not something that is congenital. See Guides at 203. In this regard, Mr. Hughes does not have an acquired clotting issue. Mr. Hughes has a genetic condition that makes it more likely for him to experience a clot such as a DVT. The Guides indicates that "[a]cquired blood-clotting defects are usually secondary to severe underlying conditions, such as chronic liver disease." Id.

The claimant did not prove, by a preponderance of the evidence, that his work injury was a cause of permanent impairment. Dr. Kuhnlein's opinions regarding permanent impairment are not detailed enough to indicate why his chosen section of the Guides is the appropriate evaluation of permanent disability. The undersigned is not a medical expert, and therefore cannot substitute his own expertise to displace that of a medical doctor. Because of the foregoing, the claimant failed to meet his burden.

Payment of Medical Expenses

The claimant requests payment for certain medical expenses incurred in Claimant's Exhibit 8.

The employer shall furnish reasonable surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance, and hospital services and supplies for all conditions compensable under the workers' compensation law. The employer shall also allow reasonable and necessary transportation expenses incurred for those services. The employer has the right to choose the provider of care, except where the employer has denied liability for the injury. Iowa Code 85.27. Holbert v.

Townsend Engineering Co., Thirty-second Biennial Report of the Industrial Commissioner 78 (Review-Reopening, October 1975).

Pursuant to Iowa Code 85.27, claimant is entitled to payment of reasonable medical expenses incurred for treatment of a work injury. Claimant is entitled to an order of reimbursement if he/she has paid those expenses. Otherwise, claimant is entitled only to an order directing the responsible defendants to make such payments directly to the provider. See Krohn v. State, 420 N.W.2d 463 (Iowa 1988).

In cases where the employer's medical plan covers the medical expenses, claimant is entitled to an order of reimbursement only if he has paid treatment costs; otherwise, the defendants are ordered to make payments directly to the provider. See Krohn, 420 N.W.2d at 463. Where medical payments are made from a plan to which the employer did not contribute, the claimant is entitled to a direct payment. Midwest Ambulance Service v. Ruud, 754 N.W.2d 860, 867-68 (Iowa 2008) ("We therefore hold that the commissioner did not err in ordering direct payment to the claimant for past medical expenses paid through insurance coverage obtained by the claimant independent of any employer contribution."). See also Carl A. Nelson & Co. v. Sloan, 873 N.W.2d 552 (Iowa App. 2015)(Table) 2015 WL 7574232 15-0323.

The employee has the burden of proof to show medical charges are reasonable and necessary, and must produce evidence to that effect. Poindexter v. Grant's Carpet Service, I Iowa Industrial Commissioner Decisions, No. 1, at 195 (1984); McClellan v. Iowa S. Util., 91-92, IAWC, 266-272 (App. 1992).

The employee has the burden of proof in showing that treatment is related to the injury. Auxier v. Woodward State Hospital School, 266 N.W.2d 139 (Iowa 1978), Watson v. Hanes Border Company , No. 1 Industrial Comm'r report 356, 358 (1980) (claimant failed to prove medical charges were related to the injury where medical records contained nothing related to that injury) See also Bass v. Veith Construction Corp., File No 5044438 (App. May 27, 2016)(Claimant failed to prove causal connection between injury and claimed medical expenses); Becirevic v. Trinity Health, File No. 5063498 (Arb. December 28, 2018) (Claimant failed to recover on unsupported medical bills).

Nothing in Iowa Code section 85.27 prohibits an injured employee from selecting his or her own medical care at his or her own expense following an injury. Bell Bros. Heating and Air Conditioning v. Gwinn, 779 N.W.2d 193, 205 (Iowa 2010). In order to recover the reasonable expenses of the care, the employee must still prove by a preponderance of the evidence that unauthorized care was reasonable and beneficial. Id. The Court in Bell Bros. concluded that unauthorized medical care is beneficial if it provides a "more favorable medical outcome than would likely have been achieved by the care authorized by the employer." Id.

The defendants in this case dispute that the listed expenses were causally connected to the work injury, and whether the requested expenses were authorized by the defendants. The claimant seeks reimbursement for three thousand six hundred eighty-seven and 23/100 dollars ($3,687.23) in out-of-pocket expenses and an order that the defendants reimburse the employer's group health insurance plan fourteen

thousand seven hundred twenty-three and 91/100 dollars ($14,723.91) for related medical care.

The workers' compensation insurer agreed to only pay for 50 percent of treatment based upon the opinions of Dr. Wojciehoski. Unfortunately for the insurer, based upon the facts of this case, there is absolutely no basis in Iowa law for their actions. The mere existence of a pre-existing medical condition 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). It is well established in workers' compensation that "if a claimant had a preexisting condition or disability, aggravated, accelerated, worsened, or 'lighted up' by an injury which arose out of and in the course of employment resulting in a disability found to exist," the claimant is entitled to compensation. Iowa Dep't of Transp. v. Van Cannon, 459 N.W.2d 900, 904 (Iowa 1990). The Iowa Supreme Court has held,

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

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

Susan Olson, a Senior Workers' Compensation Claim Specialist for Cincinnati Insurance wrote to Mr. Hughes on August 27, 2020, that "it is anticipated that we will reimburse BCBS [the claimant's personal health insurer] for 50% of the bills they have paid related to this claim, as well as the future ultrasound and final bills related to your Eliquis prescription." The insurer seems to imply by their letter that they would only provide for treatment for Mr. Hughes' DVT until he reached MMI on Dr. Wojciehoski's speculated date of September 12, 2020. The insurer indicated that they reimbursed the claimant's insurer for "50% of what Blue Cross/Blue Shield paid for medical benefits directly related to the work injury (DVT)…" on October 29, 2020. (CE 6:32). Ms. Olson indicated the insurer would also "reimburse 50% of … charges" for recent medical visits related to the work injury. (CE 6:32). By February 22, 2021, the insurer indicated that they would reimburse the claimant's personal health insurer for medical care related to the DVT, provided Dr. Wojciehoski agreed that they were related to the DVT. (CE 6:33). On September 29, 2021, Ms. Olson told Mr. Hughes that they received the report from Dr. Wojciehoski indicating that Mr. Hughes' condition had not resolved. (CE 6:34). She requested an update as to the claimant's ongoing ultrasounds and care in this e-mail. (CE 6:34).

The defendants argue that Mr. Hughes was told to submit medical billing to the insurer for reimbursement, including his out-of-pocket expenses for Eliquis. The language used by Ms. Olson in her e-mails contradicts this assertion. The defendants also dispute causal connection of the treatment indicated and authorization. These are

odd defenses considering the defendant-insurer constructively abandoned the claimant's care. While Ms. Olson would "check-in" with the claimant periodically, the insurer never once exercised their obligation under Iowa law to provide for reasonable medical care. Effectively, the insurer placed the obligation to pay for medical care on the personal health insurer to provide care, and simply agreed to pay for 50 percent of the billing.

While I found Dr. Nabi and Dr. Kuhnlein's opinions as they relate to permanent impairment to be inadequate based upon Iowa law, I do find them illustrative as they relate to the claimant's medical care. Additionally, the parties previously stipulated that the claimant's injury arose out of, and in the course of his employment with IMT. Therefore, it would be reasonable for the defendants to fulfill their obligations under Iowa Code section 85.27, and other applicable Iowa laws. The defendants shall reimburse the claimant's personal health insurer for one hundred percent (100%) of any outstanding medical billing related to his work injury as noted in Claimant's Exhibit 8. The defendants shall also reimburse the claimant one hundred percent (100%) of his out-of-pocket expenses incurred due to his DVT, including out of pocket expenses for his Eliquis prescription as provided in Claimant's Exhibit 8.

Alternate Medical Care

The claimant indicated that they are seeking an order for alternate medical care pursuant to Iowa Code section 85.27. The claimant indicates that this includes continued prescriptions for Eliquis as recommended by Dr. Nabi.

Iowa Code 85.27(4) provides, in relevant part:

> For purposes of this section, the employer is obliged to furnish reasonable services and supplies to treat an injured employee, and has the right to choose the care…. The treatment must be offered promptly and be reasonably suited to treat the injury without undue inconvenience to the employee. If the employee has reason to be dissatisfied with the care offered, the employee should communicate the basis of such dissatisfaction to the employer, in writing if requested, following which the employer and the employee may agree to alternate care reasonably suited to treat the injury. If the employer and employee cannot agree on such alternate care, the commissioner may, upon application and reasonable proofs of the necessity therefor, allow and order other care.

Iowa Code 85.27(4).

The employer has the right to choose the provider of care, except where the employer has denied liability for the injury. Iowa Code 85.27. Holbert v. Townsend Engineering Co., Thirty-second Biennial Report of the Industrial Commissioner 78 (Review-Reopening, October 16, 1975). An employer's right to select the provider of medical treatment to an injured worker does not include the right to determine how an injured worker should be diagnosed, evaluated, treated, or other matters of professional medical judgment. Assmann v. Blue Star Foods, File No. 866389 (Declaratory Ruling, May 19, 1988). Reasonable care includes care necessary to diagnose the condition

and defendants are not entitled to interfere with the medical judgment of its own treating physician. Pote v. Mickow Corp., File No. 694639 (Review-Reopening Decision, June 17, 1986).

By challenging the employer's choice of treatment - and seeking alternate care – claimant assumes the burden of proving the authorized care is unreasonable. See e.g. Iowa R. App. P. 14(f)(5); Bell Bros. Heating and Air Conditioning v. Gwinn, 779 N.W.2d 193, 209 (Iowa 2010); Long v. Roberts Dairy Co., 528 N.W.2d 122 (Iowa 1995). Determining what care is reasonable under the statute is a question of fact. Long v. Roberts Dairy Co., 528 N.W.2d 122 (Iowa 1995).

An application for alternate medical care is not automatically sustained because claimant is dissatisfied with the care he has been receiving. Mere dissatisfaction with the medical care is not ample grounds for granting an application for alternate medical care. Rather, the claimant must show that the care was not offered promptly, was not reasonably suited to treat the injury, or that care was unduly inconvenient for the claimant. Id. Because "the employer's obligation under the statute turns on the question of reasonable necessity, not desirability," and injured employee's dissatisfaction with employer-provided care, standing alone, is not enough to find such care unreasonable. Id. Reasonable care includes care necessary to diagnose the condition, and defendants are not entitled to interfere with the medical judgement of its own treating physician. Pote v. Mickow Corp., File No. 694639 (Review-Reopening Decision, June 17, 1986).

The defendants never authorized medical care. They constructively denied the claimant's medical care despite their clear knowledge that he sought treatment. They could have exercised their statutory right and directed care at any time between the incident date and the date of the hearing. They failed to do so. Accordingly, the defendant sought out care on his own, and achieved a more favorable outcome. Dr. Nabi, one of the claimant's treating physicians opined that Mr. Hughes should remain on anticoagulants while he worked in a sedentary job in which he drove 150 miles or more per day. She continued by noting that, once Mr. Hughes retired, he could transition to a daily aspirin regimen. Dr. Kuhnlein also recommended additional treatment, to include an additional ultrasound.

The defendants would seemingly point to the opinions of Dr. Wojciehoski and Dr. Lawrence. As with his opinions on permanent disability, I give no weight to the opinion of Dr. Wojciehoski in this matter. Dr. Lawrence noted in his opinions that he would defer to a hematologist for long-term pharmacologic management. In this case, the most credible hematologist is Dr. Nabi. Therefore, reasonable care would be the defendants providing the claimant with continued care via follow-up visits with Dr. Beer as needed, as well as supplying the claimant with his continued prescription for Eliquis.

Penalty

Iowa Code section 86.13(4) provides the basis for awarding penalties against an employer, and states:

(a) If a denial, a delay in payment, or a termination of benefits occurs without reasonable or probable cause or excuse known to the employer or insurance carrier at the time of the denial, delay in payment, or termination of benefits, the workers' compensation commissioner shall award benefits in addition to those benefits payable under this chapter, or chapter 85, 85A, or 85B, up to fifty present of the amount of benefits that were denied, delayed, or terminated without reasonable or probable cause or excuse.

(b) The workers' compensation commissioner shall award benefits under this subsection if the commissioner finds both of the following facts:

(1) The employee has demonstrated a denial, delay in payment, or termination of benefits.

(2) The employer has failed to provide a reasonable or probable cause or excuse for the denial, delay in payment, or termination of benefits.

(c) In order to be considered a reasonable or probable cause or excuse under paragraph "b", an excuse shall satisfy all of the following criteria:

(1) The excuse was preceded by a reasonable investigation and evaluation by the employer or insurance carrier into whether benefits were owed to the employee.

(2) The results of the reasonable investigation and evaluation were the actual basis upon which the employer or insurance carrier contemporaneously relied to deny, delay payment of, or terminate benefits.

(3) The employer or insurance carrier contemporaneously conveyed the basis for the denial, delay in payment, or termination of benefits to the employee at the time of the denial, delay, or termination of benefits.

If weekly compensation benefits are not fully paid when due, Iowa Code 86.13 requires that additional benefits be awarded unless the employer shows reasonable cause or excuse for the delay or denial. Robbennolt v. Snap-On Tools Corp., 555 N.W.2d 229 (Iowa 1996). Delay attributable to the time required to perform a reasonable investigation is not unreasonable. Kiesecker v. Webster City Custom Meats, Inc., 528 N.W.2d 109 (Iowa 1995).

It is also not unreasonable to deny a claim when a good faith issue of law or fact makes the employer's liability fairly debatable. An issue of law is fairly debatable if viable arguments exist in favor of each party. Covia v. Robinson, 507 N.W.2d 411 (Iowa 1993). An issue of fact is fairly debatable if substantial evidence exists which would support a finding favorable to the employer. Gilbert v. USF Holland, Inc., 637 N.W.2d 194 (Iowa 2001). An employer's bare assertion that a claim is fairly debatable

is insufficient to avoid imposition of a penalty. The employer must assert facts upon which the commissioner could reasonably find that the claim was "fairly debatable." Meyers v. Holiday Express Corp., 557 N.W.2d 502 (Iowa 1996).

If an employer fails to show reasonable cause or excuse for the delay or denial, the commissioner shall impose a penalty in an amount up to 50-percent of the amount unreasonably delayed or denied. Christensen v. Snap-On Tools Corp., 554 N.W.2d 254 (Iowa 1996). The factors to be considered in determining the amount of the penalty include: the length of the delay, the number of delays, the information available to the employer, and the employer's past record of penalties. Robbennolt, 555 N.W.2d at 238.

For purposes of determining whether an employer has delayed in making payments, payments are considered "made" either (a) when the check addressed to a claimant is mailed, or (b) when the check is delivered personally to the claimant by the employer or its workers' compensation insurer. Robbennolt, 555 N.W.2d at 235-236; Kiesecker, 528 N.W.2d at 112).

Penalty is not imposed for delayed interest payments. Schadendorf v. Snap-On Tools Corp., 757 N.W.2d 330, 338 (Iowa 2008); Davidson v. Bruce, 594 N.W.2d 833, 840 (Iowa 1999).

The claimant requests that I impose a penalty on the defendants for their failure to pay weekly benefits. The defendants argue that Iowa law does not allow for the imposition of penalty benefits for a failure to pay medical benefit. This is confirmed by the Iowa Supreme Court in Klein v. Furnas Elec. Co., 384 N.W.2d 370, 375 (Iowa 1986), in which the court indicated that Section 86.13 was applicable by its express terms to weekly compensation payments. While the statute has changed since 1986, the language still indicates that it applies to compensation payments, which differ from medical payments.

I previously determined that the claimant failed to prove by a preponderance of the evidence that they were entitled to temporary or permanent disability benefits. Had the claimant proven entitlement to said benefits, there was a strong case to be made for awarding penalty benefits in this matter. The actions of the insurer in attempting to apportion their liability in this case between the claimant's pre-existing genetic condition and the work injury, in clear contravention of Iowa law, were quite concerning. The insurer would do well to examine their practices to prevent incurring penalties in future decisions. However, based upon this case and the law, I am unable to award penalty benefits to Mr. Hughes.

Costs

Claimant seeks the award of costs as outlined in Claimant's Exhibit 9. Costs are to be assessed at the discretion of the deputy commissioner hearing the case. See 876 Iowa Administrative Code 4.33; Iowa Code section 86.40. 876 Iowa Administrative Code 4.33(6) provides:

> [c]osts taxed by the workers' compensation commissioner or a deputy commissioner shall be (1) attendance of a certified shorthand reporter or

> presence of mechanical means at hearings and evidential depositions, (2) transcription costs when appropriate, (3) costs of service of the original notice and subpoenas, (4) witness fees and expenses as provided by Iowa Code sections 622.69 and 622.72, (5) the costs of doctors' and practitioners' deposition testimony, provided that said costs do not exceed the amounts provided by Iowa Code sections 622.69 and 622.72, (6) the reasonable costs of obtaining no more than two doctors' or practitioners' reports, (7) filing fees when appropriate, including convenience fees incurred by using the WCES payment gateway, and (8) costs of persons reviewing health service disputes.

Pursuant to the holding in Des Moines Area Regional Transit Authority v. Young, 867 N.W.2d 839 (Iowa 2015), only the report of an IME physician, and not the examination itself, can be taxed as a cost according to 876 IAC 4.33(6). The Iowa Supreme Court reasoned, "a physician's report becomes a cost incurred in a hearing because it is used as evidence in lieu of the doctor's testimony," while "[t]he underlying medical expenses associated with the examination do not become costs of a report needed for a hearing, just as they do not become costs of the testimony or deposition." Id. (noting additionally that "[i]n the context of the assessment of costs, the expenses of the underlying medical treatment and examination are not part of the costs of the report or deposition"). The commissioner has found this rationale applicable to expenses incurred by vocational experts. See Kirkendall v. Cargill Meat Solutions Corp., File No. 5055494 (App. Dec., December 17, 2018); Voshell v. Compass Group, USA, Inc., File No. 5056857 (App. Dec., September 27, 2019).

The claimant requests a taxation of one hundred fifty and 00/100 dollars ($150.00) for their phone consultation with Dr. Nabi. Dr. Nabi's invoice simply states that it is for "[l]egal [c]onsulting" and notes a Meeting on October 24. It does not indicate what portion of this is related to drafting a report. Therefore, this is not a taxable cost pursuant to 876 Iowa Administrative Code 4.33(6), or Young.

The claimant also requests a taxation of one hundred three and 00/100 dollars ($103.00) for the filing fee. In my discretion, I award the claimant the filing fee of one hundred three and 00/100 dollars ($103.00).

ORDER

THEREFORE, IT IS ORDERED:

That the claimant shall take nothing regarding temporary and/or permanent disability.

That the defendants shall reimburse medical expenses as noted.

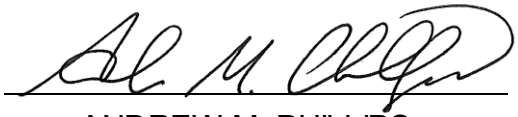
That the defendants shall provide alternate medical care as ordered.

That the defendants shall reimburse the claimant one hundred three and 00/100 dollars ($103.00) for costs.

That the defendants shall pay accrued weekly benefits in a lump sum together with interest. All interest on past due weekly compensation benefits shall be payable at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two percent. See Gamble v. AG Leader Technology, File No. 5054686 (App. Apr. 24, 2018).

That the defendant shall file subsequent reports of injury (SROI) as required by this agency pursuant to 876 Iowa Administrative Code 3.1(2) and 876 Iowa Administrative Code 11.7.

Signed and filed this __15th__ day of August, 2023.



ANDREW M. PHILLIPS
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served, as follows:

Dillon Besser (via WCES)

Christine Westberg Dorn (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.