BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

JENNA ANDERSON f/k/a JENNA SHUMATE,	:	
Claimant,	FILED	File No. 5044400
vs.	AUG 12 2015	ARBITRATION
POLARIS INDUSTRIES, INC.,	WORKERS COMPENSATION	DECISION
Employer, Self-Insured, Defendant.	:	Head Note Nos.: 1402.40; 1803; 1803.1 3000; 4000

STATEMENT OF THE CASE

Claimant, Jenna Anderson, filed a petition in arbitration seeking workers' compensation benefits from Polaris Industries, Inc., self-insured employer, as defendant, as a result of a stipulated injury sustained on June 1, 2011 and/or August 3, 2011. This matter came on for hearing before Deputy Workers' Compensation Commissioner, Erica J. Fitch, on July 22, 2014, in Des Moines, Iowa. The record in this case consists of claimant's exhibits 1 through 11, defendant's exhibits A through P, and the testimony of the claimant. The parties submitted post-hearing briefs, the matter being fully submitted on August 21, 2014.

ISSUES

The parties submitted the following issues for determination:

1. The proper manifestation date for claimant's stipulated cumulative injury, June 1, 2011 or August 3, 2011;

2. Whether the work injury is a cause of permanent disability;

3. The extent of claimant's permanent disability;

4. Whether the alleged disability is a scheduled member disability or an industrial disability;

5. The proper rate of compensation;

6. Whether claimant is entitled to payment of various medical expenses;

7. Whether claimant is entitled to reimbursement for an independent medical evaluation pursuant to Iowa Code section 85.39;

8. Whether claimant is entitled to penalty benefits under Iowa Code section 86.13 and, if so, how much; and

9. Specific taxation of costs.

The stipulations of the parties in the hearing report are incorporated by reference in this decision.

FINDINGS OF FACT

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

Claimant's testimony was consistent as compared to the evidentiary record and her deposition testimony. Her demeanor at the time of evidentiary hearing gave the undersigned no reason to doubt claimant's veracity. Claimant is found credible.

Claimant was 28 years of age at the time of hearing. She resides in Spirit Lake, Iowa. Claimant graduated high school in 2005; during her high school career, claimant was an honor student, earning A and B grades. In 2010, claimant earned an associate's degree in photojournalism. Claimant is right-hand dominant. (Claimant's testimony; Exhibit L, page 3; Ex. P, Deposition Transcript p. 7) Her work history consists of part-time work during high school as a dishwasher, cook, and restaurant busser. Following high school, claimant worked as a housekeeper, cook, cashier, fast food shift lead, dishwasher, busser, assistant manager at a tobacco store, day care worker, and sandwich maker. (Ex. L, pp. 4-5)

In August 2010, claimant applied for work at defendant. (Ex. I, pp. 1-3) Defendant manufactures equipment such as all-terrain vehicles, Bobcats, snowmobiles, four-wheelers, and motorcycles. Claimant began work on September 15, 2010 as an assembly line worker; she earned $12.18 per hour. At the time of her hire, claimant denied any physical disabilities. (Claimant's testimony; Ex. J, pp. 1-5)

In June 2011, claimant began suffering with right elbow and wrist difficulties. Specifically, claimant developed shocking pain at elbow and radiating down the arm, sharp and stabbing pains, and numbness and tingling. Claimant spoke with her supervisor regarding her symptoms and was advised to rest over the upcoming 4th of July holiday. When her symptoms did not improve over break claimant completed an incident report. Claimant testified a nurse back-dated the date of injury to June 1, 2011. Claimant was directed to the in-house physical therapist, but after achieving no relief, she asked to see a doctor. (Claimant's testimony; Ex. P, Depo. Tr. pp. 15-17)

Defendant referred claimant for care with Jeffrey Goerss, M.D. The first appointment took place on August 3, 2011. At that time, claimant complained of pain

from her right elbow to her hand. Dr. Goerss assessed medial epicondylar pain with tendonitis and possible overuse syndrome. Dr. Goerss prescribed an NSAID and a course of physical therapy. He also provided work restrictions limiting claimant to one-handed duty. (Ex. 1, p. 1) Claimant continued to follow-up with Dr. Goerss in August and September 2011; during this time, Dr. Goerss recommended continued conservative treatment. (Ex. 1, p. 1) After completion of the course of physical therapy, Dr. Goerss released claimant to return to normal duties on September 22, 2011. (Ex. 1, pp. 1-2)

Due to continued complaints, company nurse Penny Ashland, RN, arranged for claimant to return to Dr. Goerss on October 17, 2011. At that time, Dr. Goerss noted claimant complained of some minor epicondylar pain, with the majority of complaints arising from the base of her right thumb. He assessed de Quervain's tendonitis and performed an injection at the base of the thumb. Dr. Goerss ordered claimant to wear a splint and restricted her to light duty for two weeks. (Ex. 1, p. 2) When claimant returned to Dr. Goerss on October 31, 2011, Dr. Goerss referred claimant to Philip Deffer Jr., M.D., due to complaints of prolonged wrist and hand pain. (Ex. 1, p. 3)

Claimant presented to Dr. Deffer on November 9, 2011. Dr. Deffer noted claimant reported experiencing global right arm pain, including the medial elbow, volar wrist, and thumb. X-rays of the right wrist were found to be normal. Dr. Deffer assessed subjective complaints of right upper extremity pain and recommended continued conservative care. He specifically added a course of work hardening, designed to allow claimant to return to work. (Ex. C, p. 1)

Claimant continued to complain of numbness and tingling of the right hand and fingers. On December 15, 2011, Ms. Ashland provided claimant ice packs to use while at work. (Ex. 9, p. 19; Ex. H, p. 1)

On December 20, 2011, claimant returned to Dr. Deffer. Following evaluation, Dr. Deffer assessed right upper extremity pain with ulnar neuritis. He removed claimant from the work hardening program pending electrodiagnostic studies of the right upper extremity. (Ex. 3, p. 1) Marvin Hurd, M.D. performed electrodiagnostic studies on December 29, 2011. He opined the nerve conduction studies were normal and EMG results revealed no abnormalities. (Ex. E, pp. 1-2) Dr. Deffer reviewed the electrodiagnostic studies on January 9, 2012. He opined the studies were normal and recommended continued conservative care and work restrictions. (Ex. C, p. 2)

Claimant returned to Dr. Deffer on February 21, 2012. Dr. Deffer noted complaints of global arm pain from the mid-humerus down the arm, primarily located about the right elbow and radiating down the arm. Dr. Deffer indicated it was necessary to keep claimant "protected at work." (Ex. 3, p. 2)

Claimant testified during the course of her care with Dr. Deffer, she would occasionally develop pain in her right shoulder and neck. Claimant testified she informed her physical therapist, who indicated the shoulder was likely tight due to disuse of the right arm and provided claimant with exercises to loosen the tightness of

the shoulder. Claimant admitted she never informed her physicians of any shoulder complaints. (Claimant's testimony; Ex. P, Depo. Tr. pp. 28-29)

On April 3, 2012, claimant returned to Dr. Deffer, who noted claimant suffered from global arm pain which seemed to change from time to time. Dr. Deffer indicated this change in symptoms appeared to frustrate claimant's physical therapist due to an inability to focus on a specific pain type. Dr. Deffer again indicated claimant's past x-ray and nerve studies were normal, so he ordered a right hand and wrist MRI. Pending MRI, Dr. Deffer recommended continued light duty. (Ex. 3, p. 3)

Following right hand and wrist MRI, claimant returned to Dr. Deffer on April 17, 2012. Dr. Deffer opined claimant had normal x-rays, nerve studies, and the MRI of wrist and hand were normal. He assessed right hand and wrist pain. Dr. Deffer opined he had nothing to offer claimant by way of additional treatment, placed claimant at maximum medical improvement (MMI) as of April 17, 2012, and released claimant from care. Dr. Deffer recommended transitioning claimant into full duty work, with the caveat claimant should modify her duties as warranted by pain. Due to a lack of demonstrable pathology, Dr. Deffer opined claimant sustained no ratable permanent impairment. (Ex. C, pp. 3-5)

Following her release by Dr. Deffer, claimant continued to present to Ms. Ashland with complaints of right elbow, forearm, thumb, wrist, and upper arm pain, numbness of the forearm, and tingling of the wrist and fingers. On July 20, 2012, claimant reported tingling of the right arm from her fingers to her shoulder. Ms. Ashland provided ice and Biofreeze for claimant's use. (Ex. 9, p. 18)

Due to continued complaints, defendant referred claimant to R. Blake Curd, M.D., on September 12, 2012. Claimant reported originally feeling pain from her right elbow down her arm to the wrist, but indicated the pain at the time of evaluation existed from the shoulder down. (Ex. 4, p. 3) Dr. Curd described the pain as numbness and tingling beginning around the medial elbow and then radiating down along the ulnar aspect of the forearm and burning and aching with occasional throbbing. He performed an ultrasound evaluation of the right ulnar nerve and observed what appeared to be dilation of the ulnar nerve posterior to the medial epicondyle. Dr. Curd assessed ulnar neuritis and recommended conservative care of use of a Heelbo pad and medication. He also imposed work restrictions. (Ex. 4, pp. 6-8)

After evaluation of claimant on October 12, 2012, Dr. Curd noted no dramatic improvement in symptoms and added a course of physical therapy to claimant's treatment regimen. (Ex. 4, pp. 10-11)

When claimant returned to Dr. Curd on November 26, 2012, she reported improvement in pain symptoms. While her pain previously was a level 8 on a 10-point scale, that level had since declined to a level 4 and could reach as low as a level 2. Accordingly, Dr. Curd recommended continued conservative measures. (Ex. 4, pp. 12-13)

Claimant returned to full duty work in January 2013. She returned to Dr. Curd and reported she was able to complete her duties, but was sore at the conclusion of a work day. Dr. Curd ordered continued use of Neurontin and released claimant without restrictions. (Ex. 4, p. 15; Ex. D, pp. 1-3)

On March 6, 2013, claimant returned to Dr. Curd, at which time Dr. Curd noted claimant was not tolerating her work environment. He noted claimant was capable of performing quality control, but developed pain from the elbow into the ring and small fingers with heavier activities. He opined claimant appeared to demonstrate some evidence of ulnar neuritis and possible mild ulnar nerve palsy. Dr. Curd reissued work restrictions and recommended repeat electrodiagnostic studies. (Ex. 4, pp. 16-17)

K.C. Chang, M.D. performed the ordered studies on March 20, 2013. He opined the results demonstrated a normal nerve conduction study and EMG, without electrical evidence of peripheral neuropathy. (Ex. 5, pp. 1-2) Thereafter, claimant presented to Dr. Curd, who reviewed the studies and opined the EMG results were completely normal with no evidence of peripheral compressive neuropathy. He ordered continued conservative management and work restrictions. (Ex. 4, pp. 19-20)

On April 24, 2013, claimant returned to Dr. Curd. At that time, Dr. Curd noted claimant complained of persistent symptoms despite maximized conservative treatment. He noted complaints of numbness and tingling in the ulnar nerve distribution with numbness, tingling, and aching radiating into the ring and small fingers. He opined claimant demonstrated clinical evidence of ulnar neuritis with inflammation of the ulnar nerve at the elbow. Dr. Curd opined claimant's right elbow pain was due to claimant's work activities and had not improved to pre-injury status. Dr. Curd indicated he had no additional conservative measures to offer and recommended right-sided ulnar nerve decompression. In the interim, Dr. Curd continued claimant's work restrictions of no repetitive flexion and extension across the elbow, no lifting over ten pounds with the right arm, and the requirement to work with the elbow pad on her right arm. (Ex. 4, pp. 21-23; Ex. 6, p. 1)

At defendant's referral, on June 18, 2013, claimant presented to physical medicine and rehabilitation physician, Jerry Blow, M.D., for independent medical evaluation (IME). Dr. Blow issued a report of his opinions dated June 19, 2013. Claimant identified the worst pain in medial elbow, with a dull pain throughout the entire arm, thumb, and wrist. (Ex. A, p. 12) He noted claimant had been off work since May without improvement in symptoms. (Ex. A, p. 11) Dr. Blow also noted claimant smoked one pack of cigarettes per day and had not recently attempted to quit. (Ex. A, p. 10)

Following records review, interview, and examination, Dr. Blow assessed forearm tendinitis and medial epicondylitis. He opined claimant's pain in the right elbow and wrist was consistent with medical epicondylitis. Dr. Blow noted claimant had a history of some symptoms associated with ulnar neuritis, but no EMG documentation of ulnar neuropathy. Dr. Blow opined claimant developed medial epicondylitis and forearm tendinitis as a result of work activities at defendant. He further opined the condition was temporary in nature, commencing on June 1, 2011 and had reached MMI as of his

evaluation on June 18, 2013. Dr. Blow opined claimant's current complaints were unrelated to work activities, as claimant had been off work since May 7, 2013 without any relief of symptoms. On this basis, Dr. Blow opined claimant's work injury was not a contributing factor to claimant's current pain complaints and need for treatment. (Ex. A, pp. 13-14)

Dr. Blow also opined claimant's treatments of physical therapy, anti-inflammatories, iontophoresis, ultrasound, work restrictions, and evaluations with Drs. Goerss, Deffer, and Curd, were medically appropriate treatment for the diagnoses of medial epicondylitis and forearm tendinitis. He reasoned at the time of these treatments, claimant's pain complaints coincided with changes in work activities and warranted medical treatment. However, alternation of work duties had not since made a difference in claimant's complaints. Although with treatment claimant would experience some improvement in symptoms, the symptoms would again worsen when claimant returned to work activities. (Ex. A, pp. 13-14)

Dr. Blow opined claimant had received extensive medical care, without long lasting relief. He opined no additional medical treatment was required and specifically opined surgery would not be medically appropriate given claimant's negative EMG studies and the lack of improvement in symptoms since being entirely off work. Dr. Blow elaborated to state surgery was not medically necessary, reasonable, or causally related to claimant's work activities as she had no EMG evidence of ulnar neuropathy and being off work had not resulted in a significant change in symptoms. (Ex. A, p. 14)

With regard to the extent of claimant's permanent impairment, if any, Dr. Blow highlighted a lack of EMG evidence of ulnar neuropathy, good range of motion of the elbow, only slight reduction in range of motion of the wrist, and good strength in the right upper extremity. He opined claimant did not sustain ratable permanent impairment. Dr. Blow further opined no permanent restrictions were warranted. (Ex. A, pp. 14-15)

On June 27, 2013, defendant's third party administrator authored a letter to claimant indicating her indemnity benefits would be terminated on July 26, 2013. The letter attributed the termination of benefits to Dr. Blow's opinion claimant reached MMI as of June 18, 2013. (Ex. O, p. 1)

Ms. Ashland telephoned claimant on June 28, 2013. At that time, Ms. Ashland advised claimant her assembly line was on layoff, but claimant would be expected to return to work with the rest of the line on July 1, 2013. Ms. Ashland advised claimant she would be expected to rotate through the jobs on which she had been trained. (Ex. 9, p. 16)

On July 11, 2013, Ms. Ashland spoke with claimant on the production floor. Claimant complained of pain from her right elbow to wrist. Ms. Ashland provided claimant an ice pack, with time to ice the elbow in the medical office. At that time, claimant complained of progressive worsening of symptoms since returning to work.

Ms. Ashland advised claimant defendant would follow physician-imposed restrictions and there currently were no restrictions imposed. (Ex. 9, p. 16)

Claimant returned to the medical office on July 12, 2013 and informed Ms. Ashland her complaints were improved, but requested an ice pack. (Ex. 9, p. 16)

On July 16, 2013, claimant presented to Ms. Ashland with complaints of right elbow pain. Claimant informed Ms. Ashland she had been advised the prior day that no further care had been authorized. Ms. Ashland advised claimant to contact defendant's third party administrator regarding a referral for care. (Ex. 9, p. 17)

Claimant was terminated on July 23, 2013 due to "check back fails." As a result of an excessive number of check back fails, claimant had been put into disciplinary action and ultimately terminated. (Ex. K, p. 1) Claimant explained check back work essentially involves inspecting coworkers' work product. A check back fail is received if the inspector misses an error. Claimant testified she was terminated because her arm prevented her from doing her work, indicating she received her final check back fail while waiting to see the nurse. (Ex. P, Depo. Tr. pp. 19-21) Claimant earned $15.56 at time of her termination. (Ex. J, p. 15)

Following her termination by defendant, claimant secured a position as a hotel lobby clerk. She ultimately quit this employment as she was directed to present to work despite being sick. Claimant then secured work as kitchen help at an assisted living facility. She quit this employment to return to work at Subway as a sandwich artist. Claimant continued to work at Subway at the time of evidentiary hearing. She earns $8.75 per hour and works 30 to 35 hours per week. (Claimant's testimony; Ex. P, Depo. Tr. pp. 46-50)

Claimant's served answers to defendant's interrogatories on August 2, 2013. At that time, claimant complained of shooting pain from the right elbow to the right hand, and numbness and tingling of the fingers. She attributed these complaints to repetitive work duties. (Ex. L, pp. 1, 6)

At the arranging of claimant's attorney, claimant presented for IME with board certified neurologist and pain management physician Marc Hines, M.D., on March 7, 2014. Following records review, interview, and examination, Dr. Hines issued a report of his opinions signed March 14, 2014. (Ex. 7, p. 11) Dr. Hines noted claimant had been a 1 pack per day smoker since the age of 16. Dr. Hines indicated claimant presented with episodic symptoms of pain radiating from her elbow up into her arm, even as high as her shoulder. He located the majority of recurrent symptoms in the elbow joint over the medial epicondyle with intermittent numbness down the ulnar aspect into the ring and small fingers. Dr. Hines opined these clinical findings suggested both medial epicondylitis and ulnar neuropathy, despite negative EMG studies. (Ex. 7, pp. 4-5)

Dr. Hines assessed evidence of medial epicondylar pain and dysfunction, leading him to concur with other examiners who opined claimant presented with some element

of medial epicondylitis. However, Dr. Hines opined the proximal and distal radiation of pain appeared more consistent with an ulnar neuritis, despite negative EMG findings. (Ex. 7, p. 5) He opined EMG findings to be only one piece of the clinical picture for ulnar neuropathy. Accordingly, Dr. Hines assessed medial epicondylitis with secondary ulnar neuropathy due to "continued swelling with a long term difficulty from overuse." Dr. Hines opined the condition resulted from "recurrent overuse" and would not resolve completely with rest, as the condition had become chronic in nature. In addition to claimant's right upper extremity condition, Dr. Hines also opined claimant presented with depression. Dr. Hines opined claimant became depressed as a result of her inability to function around her arm problems, problems which chronically disrupted her sleep and interfered with daily activities. (Ex. 7, p. 6)

With regard to the existence and extent of claimant's permanent impairment, if any, Dr. Hines opined a combined impairment of 19 percent whole person. Dr. Hines opined claimant sustained a 10 percent whole person impairment as a result of the medial epicondylitis. From the ulnar neuropathy, Dr. Hines found a permanent impairment of 10 percent right upper extremity or 6 percent whole person due to motor deficits. Finally, Dr. Hines found claimant had sustained a 5 percent whole person impairment as a result of her depression, but also opined the condition was treatable. When combined, Dr. Hines' opinions totaled 19 percent whole person permanent impairment. (Ex. 7, p. 6)

Dr. Hines did not impose any permanent restrictions, as he found claimant's decreased grip strength would not impact her ability to safely perform her current job. He recommended claimant return to Dr. Curd for ulnar decompression surgery, with inspection of the medial epicondyle. Additionally, Dr. Hines recommended claimant begin use of an antidepressant and use of a soporific gel over the medial epicondyle. (Ex. 7, p. 7)

On April 9, 2014, claimant returned to Dr. Curd with continued complaints of pain and soreness around the medial elbow. Dr. Curd opined claimant continued to demonstrate clinical signs and symptoms of flexor pronator tendinosis and ulnar neuritis. He recommended a repeat nerve study to evaluate for deterioration of ulnar nerve function. (Ex. 4, p. 24)

Claimant testified Dr. Hines advised her to speak with a physician regarding her depression, a condition which claimant relates to pain issues. Claimant testified she spoke with Dr. Curd, but Dr. Curd advised her to consult with her family physician. Claimant testified she did so and her personal physician prescribed an antidepressant. Once she began taking the antidepressant, claimant indicated she began to feel like herself again, is happier, and no longer feels worthless or cries. (Claimant's testimony)

On May 5, 2014, defendant's counsel and Dr. Goerss engaged in a discussion, following which defendant's counsel authored a letter purporting to express the opinions expressed by Dr. Goerss during said discussion. Dr. Goerss signed the letter on May 9, 2014, agreeing to the opinions and conclusions stated. By this letter, Dr. Goerss opined claimant's injury was limited to her right forearm and he did not anticipate claimant

would suffer any permanent injury or condition as a result of her work at defendant. (Ex. B, p. 1)

At the arranging of claimant's attorney, on May 27, 2014, claimant reported to vocational consultant, Barbara Laughlin, for an employability assessment. Ms. Laughlin reviewed claimant's employment history and designated the work as falling primarily into unskilled or semi-skilled work in the light or medium physical demand categories. (Ex. 8, pp. 5-8) Ms. Laughlin also performed a computerized transferable skills analysis. In doing so, she utilized the "significant decrease in grip strength" noted by Dr. Hines and reduced handling to only an occasional basis. Ms. Laughlin also noted climbing and working at heights had been "reduced" in her analysis, but is unclear if her definition of "reduced" eliminates those tasks entirely or limits the tasks to the same level as the handling exertion. (Ex. 8, p. 10)

In any event, under the first scenario of occasional handling, Ms. Laughlin opined claimant lost access to 93.8 percent of directly transferable occupations, 80.5 percent of generally transferable occupations, and 98.3 percent of unskilled occupations. Should one limit handling to a frequent level, as opposed to occasional, Ms. Laughlin found claimant demonstrated a 6.3 percent loss of directly transferable occupations, 3.2 percent of generally transferable occupations, and 18.9 percent of unskilled occupations. (Ex. 8, pp. 10-11) Following her analysis, Ms. Laughlin opined claimant's work for defendant in production assembly required frequent handling and claimant was unable to tolerate such a level of exertion without pain. (Ex. 8, p. 11) Ms. Laughlin also found claimant sustained a 47 percent wage loss comparing her wage at Subway, $8.25, with her wages at defendant. (Ex. 8, pp. 8, 12)

Claimant provided deposition testimony on June 24, 2014. At that time, claimant testified she had visited her personal physician approximately two months prior to deposition for complaints of depression related to her right arm and limitations upon her activities. Her personal physician prescribed citalopram. Claimant testified she believes the medication helps and she feels happier. (Ex. P, Depo. Tr. pp. 31-32, 35) Claimant also testified she does not believe she has a permanent mental injury. (Ex. P, Depo. Tr. p. 36) Despite improvement in her mental health condition, claimant testified her arm has worsened since she left defendant's employ. Claimant testified her arm symptoms worsen with activity, including work and activities of daily living. (Ex. P, Depo. Tr. pp. 39-40, 57-58) To treat these complaints, claimant uses tramadol prescribed by Dr. Curd. (Ex. P, Depo. Tr. p. 61)

Ms. Ashland also provided deposition testimony on June 24, 2014. Ms. Ashland testified she has served as company nurse for defendant since 2003. (Ex. 9, p. 4) She described claimant's former job duties as a general assembly operator, tasked with putting parts together and assembling the parts on machines. (Ex. 9, p. 5) Ms. Ashland testified as a result of the stipulated work injury, claimant was diagnosed with epicondylitis, an inflammation of the epicondyles of the elbow. (Ex. 9, p. 7) She was not aware of claimant having any medical problems with her arm or shoulder prior to the stipulated work injury. (Ex. 9, p. 5) Following the work injury, Ms. Ashland testified claimant continued to have complaints and difficulty related to her elbow and forearm up

until the time of her termination. On a couple occasions, claimant came to see Ms. Ashland in tears. When claimant presented to Ms. Ashland, Ms. Ashland provided ice and medications. (Ex. 9, pp. 7-8, 10)

Ms. Ashland's testimony was clear and consistent with the testimony of other witnesses. Her testimony was also consistent with the medical records in evidence. The undersigned was presented with no reason to doubt Ms. Ashland's testimony. Ms. Ashland is found credible.

Bradley Jones, human resources manager for defendant, provided deposition testimony on June 24, 2014. While employed at defendant, Mr. Jones testified claimant worked as an assembler. Assembler duties vary based on station and could require direct assembly of components to a product or subassembly of products that were later mounted to the machine. (Ex. 10, pp. 3-4) Mr. Jones testified he was unaware of any restrictions to claimant's arm or shoulder prior to the work injury. (Ex. 10, pp. 4-5) Mr. Jones testified claimant was subject to disciplinary action due to quality fails and ultimately terminated for that reason. (Ex. 10, pp. 8, 12) He indicated defendant has a grievance procedure in place for workers to contest disciplinary warnings received; employees may comment on the written warning itself and/or consult with human resources. Mr. Jones testified claimant never spoke with him directly regarding any warning and never wrote comments on the corrective action forms. (Ex. 10, pp. 12-13)

Mr. Jones' testimony was clear and consistent with the testimony of other witnesses. His testimony was also consistent with the personnel records in evidence. The undersigned was presented with no reason to doubt Mr. Jones' testimony. Mr. Jones is found credible.

James Jenson provided deposition testimony on June 24, 2014. Mr. Jenson serves as supervisor of an assembly line at defendant. In this role, Mr. Jenson supervised claimant for about three months while she was assigned to an auditor position. At that time, claimant was tasked with auditing different aspects of a unit to ensure quality. Mr. Jenson testified he felt claimant was attempting to perform her job. He also testified claimant appeared to be in some pain, including crying at times; claimant also told Mr. Jenson she was in pain. (Ex. 11, pp. 3-5, 7)

Mr. Jenson's testimony was clear and consistent with the testimony of other witnesses. The undersigned was presented with no reason to doubt Mr. Jenson's testimony. Mr. Jenson is found credible.

At evidentiary hearing, claimant testified she desires to undergo surgery as recommended by Dr. Curd and Dr. Hines. Claimant relates her need for surgery to her work activities, as she did not suffer with such symptoms prior to the stipulated work injury and has not sustained any intervening injuries since the stipulated work injury. Claimant testified her right arm condition impacts her daily and recreational activities. She continues to use tramadol and an antidepressant.

CONCLUSIONS OF LAW

The first issue for determination is the proper manifestation date for claimant's stipulated cumulative injury, June 1, 2011 or August 3, 2011.

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 6.14(6).

When the injury develops gradually over time, the cumulative injury rule applies. The date of injury for cumulative injury purposes is the date on which the disability manifests. Manifestation is best characterized as that date on which both the fact of injury and the causal relationship of the injury to the claimant's employment would be plainly apparent to a reasonable person. The date of manifestation inherently is a fact based determination. The fact-finder is entitled to substantial latitude in making this determination and may consider a variety of factors, none of which is necessarily dispositive in establishing a manifestation date. Among others, the factors may include missing work when the condition prevents performing the job, or receiving significant medical care for the condition. For time limitation purposes, the discovery rule then becomes pertinent so the statute of limitations does not begin to run until the employee, as a reasonable person, knows or should know, that the cumulative injury condition is serious enough to have a permanent, adverse impact on his or her employment. Herrera v. IBP, Inc., 633 N.W.2d 284 (Iowa 2001); Oscar Mayer Foods Corp. v. Tasler, 483 N.W.2d 824 (Iowa 1992); McKeever Custom Cabinets v. Smith, 379 N.W.2d 368 (Iowa 1985).

The parties stipulate claimant sustained a cumulative work-related injury to her right upper extremity. However, the parties did not stipulate to an injury date. The June 1, 2011 date represents the date defendant's nurse assigned to claimant's injury. The August 3, 2011 date represents the first medical appointment with Dr. Goerss. The undersigned must determine which date properly reflects the manifestation date for claimant's stipulated cumulative injury.

Claimant began suffering with right elbow and wrist difficulties during the month of June 2011. Claimant approached her supervisor with the complaints and was advised to rest over the upcoming Independence Day holiday. Claimant did so, but her symptoms did not abate. She thereafter completed an incident report and was initially directed for care with defendant's in-house physical therapist. When this too failed to provide relief, defendant referred claimant to Dr. Goerss for care. At the initial evaluation on August 3, 2011, Dr. Goerss imposed work restrictions.

It is determined claimant's cumulative injury manifested on August 3, 2011 for several reasons. There is no evidence claimant suffered with symptoms on June 1, 2011. Claimant's testimony indicating she developed symptoms and was advised to rest over the upcoming July 4th holiday supports a finding symptoms developed later in the month of June. There is no indication claimant's ability to work was impeded on

June 1, 2011; however, as of the restrictions imposed on August 3, 2011, claimant's work duties were directly affected. It was at this time when claimant became aware she would be unable to perform her job duties as a result of the condition. For these reasons, it is determined claimant's injury manifested on August 3, 2011.

The next issue for determination is whether the work injury is a cause of permanent disability.

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

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

Claimant has complained of injuries to her right arm and shoulder, as well as depression. Claimant's claim regarding the right upper extremity will be addressed first. Defendant stipulated claimant sustained an injury to her right arm, specifically the right elbow and wrist. Defendant provided treatment thereof. The point of contention with respect to claimant's right arm is not the existence of the original injury, but whether the condition resolved or ongoing complaints remain causally related to the stipulated injury. More specifically, claimant alleges her ongoing complaints remain related to the work injury and she is entitled to the surgical intervention recommended by Dr. Curd.

On April 24, 2013, Dr. Curd opined claimant continued to suffer with right arm symptoms causally related to her work duties at defendant. He further opined claimant's condition had not improved to her pre-injury status. Due to a lack of further conservative treatment options and despite normal EMG findings, Dr. Curd recommended right-sided ulnar nerve decompression.

Following Dr. Curd's opinion of April 24, 2013, defendant referred claimant for IME with Dr. Blow. Dr. Blow noted continued symptoms and assessed forearm

tendinitis and medial epicondylitis which he causally related to claimant's work activities at defendant. However, Dr. Blow opined claimant's conditions were temporary in nature, commencing in June 2011 and having reached MMI as of the time of his evaluation on June 18, 2013. Due to the fact claimant had been off work since May 7, 2013 without improvement in her symptoms, Dr. Blow opined claimant's work injury was not a contributing factor to her ongoing symptoms or need for treatment. Dr. Blow opined no additional medical treatment was required and specifically opined surgery was not medically appropriate given normal EMG studies and lack of improvement in symptoms while removed from the work environment.

On March 7, 2014, claimant presented to Dr. Hines for her IME. Dr. Hines opined claimant's clinical findings suggested both medial epicondylitis and ulnar neuropathy, despite negative EMG studies. Dr. Hines opined EMG findings represent only one piece of a clinical picture for ulnar neuropathy. Accordingly, Dr. Hines assessed medial epicondylitis with secondary ulnar neuropathy due to continued swelling with a long term difficulty from overuse. Dr. Hines attributed the condition to overuse and opined the condition would not resolve with rest alone, as the condition had become chronic. Dr. Hines recommended further treatment, specifically including a return to Dr. Curd for ulnar decompression surgery.

Upon review of the entirety of the evidentiary record and paying particular attention to the causation opinions of Drs. Curd, Blow, and Hines, the undersigned finds claimant has met her burden of proving her ongoing right upper extremity symptoms are causally related to the stipulated work-related injury. Claimant's authorized, treating physician, Dr. Curd related claimant's symptoms to the work injury and recommended surgical intervention. Of the three causation opinions in evidence, only Dr. Curd had the opportunity to examine claimant on more than one occasion and is similarly, the only opining physician to provide treatment to claimant.

Dr. Blow opined the treatment provided by Dr. Curd had been medically appropriate, yet disagreed with Dr. Curd's surgical recommendation given negative EMG findings and lack of improvement when claimant was off work for over one month. Dr. Blow opined claimant's condition was temporary and had resolved; however, there is no evidence claimant suffered with any symptoms prior to the stipulated work injury. Similarly, there is no evidence claimant's complaints ceased at any time following the work-related injury; rather, the evidence demonstrates claimant has continuously complained of symptoms.

While Dr. Blow's concern regarding the negative EMG findings is understandable, there is also no evidence claimant is malingering or exaggerating her symptoms such as would draw a lack of objective findings into question. Furthermore, Dr. Curd was aware of the negative EMG findings, yet still opined claimant required surgery for the work-related condition. Dr. Curd's opinions receive support from the IME opinion of Dr. Hines, who explained EMG findings to be only one piece of a clinical picture for diagnosis of ulnar neuropathy. Dr. Blow further questioned Dr. Curd's surgical recommendation due to claimant's lack of improvement following removal from

work. Dr. Hines also addressed this critique by opining such symptoms would not resolve with rest alone due to the chronic nature of the condition.

Given the above, it is determined the opinions of Dr. Curd are entitled to the greatest weight. Dr. Curd was in the best position to assess claimant's condition given multiple visits and presiding over a course of conservative treatment. Dr. Curd's opinions are supported by the IME opinion of Dr. Hines. The IME opinion of Dr. Blow is inadequate to counter the weight of these contrary opinions. Therefore, it is determined claimant has proven her work-related injury of August 3, 2011 has continued to cause right upper extremity symptoms. Accordingly, claimant is entitled to further medical treatment for these complaints. The record lacks a contemporaneous medical record which indicates whether or not Dr. Curd continues to recommend surgical intervention. Therefore, the undersigned will not order defendant to pay for the surgery as originally recommended by Dr. Curd. Rather, claimant is entitled to return to Dr. Curd for evaluation and development of a treatment plan which may include surgical intervention, should Dr. Curd continue to recommend such care.

Claimant also argues she sustained an injury to her right shoulder, as claimant's pain can extend to the shoulder. Claimant has complained of pain radiating from her elbow into the remainder of her right arm, as high as her shoulder. However, no physician has opined claimant suffers with any pathology of the right shoulder, nor opined claimant sustained permanent impairment to the right shoulder as a result of the work injury. The unrebutted opinion of Dr. Goerss opines claimant's right arm condition was limited to the right forearm. Due to lack of supportive medical evidence, it is determined claimant failed to prove the stipulated work injury is a cause of permanent disability to her right shoulder.

Finally, claimant alleges she sustained depression as a result of the work-related injury. Claimant testified she developed depressive symptoms due to right arm pain and limitations. Dr. Hines specifically opined claimant developed depression as a result of the impact of the right arm condition upon claimant's ability to function. At the direction of Dr. Curd, claimant spoke with her family physician regarding her depression and was prescribed an antidepressant. The evidentiary record lacks any opinions to rebut the opinion of Dr. Hines. Therefore, it is determined the stipulated work injury led claimant to develop depression.

Although claimant developed depression and required treatment thereof as a result of the stipulated work injury, the record does not support a finding the condition caused permanent impairment. At the time of his evaluation on March 7, 2014, Dr. Hines opined claimant had sustained a permanent impairment of five percent whole person as a result of her depression. However, this opinion came before claimant received any treatment of her condition. Even Dr. Hines indicated while claimant demonstrated permanent impairment at the time of evaluation, he also opined the condition was treatable. Claimant subsequently procured treatment of her depression, treatment which has proven beneficial in resolving her symptoms. Claimant herself testified that with use of the antidepressant prescribed by her personal physician, she began to feel like herself again, is happier, no longer feels worthless, and no longer

suffers crying fits. Subsequent to receipt of treatment, claimant testified she does not believe she suffers with any permanent mental injury.

Dr. Hines' permanent impairment opinion is the only opinion in evidence which supports a finding claimant's depression caused permanent disability. His opinion was rendered with the caveat claimant's condition was treatable. Subsequent to receipt of such treatment, claimant testified she improved and did not believe she sustained permanent mental injury. Therefore, while claimant continues to remain on an antidepressant, there is no evidence her depression has resulted in permanent impairment. Despite finding claimant's depression is not currently a cause of permanent impairment, the condition is causally related to the stipulated work injury and defendant is thus responsible for ongoing medical care to treat the condition.

The next issue for determination is the extent of claimant's permanent disability. The next issue for determination is whether the alleged disability is a scheduled member disability or an industrial disability. These issues will be considered together. The parties contemplated claimant's need for further right upper extremity surgery, yet stipulated the matter of permanency is ripe for determination. Accordingly, the undersigned will determine the extent of claimant's permanent disability as it existed at the time of evidentiary hearing.

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

By this decision, the undersigned determined the stipulated work injury was a cause of permanent disability to claimant's right upper extremity. The undersigned found claimant failed to prove the injury extended into claimant's shoulder. While I found claimant developed depression as a result of the work injury, I also found that condition did not result in permanent impairment. Therefore, claimant's permanent disability is limited to the scheduled member right upper extremity.

Dr. Deffer initially released claimant from care on April 17, 2011 and opined she sustained no ratable impairment due to lack of demonstrable pathology. However, this opinion is entitled to little weight, as defendant subsequently selected a new authorized physician to treat claimant's ongoing complaints. This new authorized physician, Dr. Curd, provided care until April 24, 2013; at which time he opined claimant should

undergo surgical intervention. Dr. Curd has never opined on the extent of permanent impairment, as he continues to recommend further care, including a recommendation for repeat nerve studies as recently as April 9, 2014.

On June 18, 2013, Dr. Blow opined claimant sustained a temporary condition and due to negative EMG findings, good range of motion of the elbow, slight reduction in range of motion of the wrist, and good strength of the right upper extremity, claimant sustained no ratable impairment nor required permanent restrictions. Dr. Blow, however, opined claimant's ongoing symptoms were not work-related. Therefore, his opinion claimant sustained no ratable impairment offers little probative assistance in determining claimant's current permanent impairment.

Dr. Hines examined claimant on March 7, 2014. At that time, he opined claimant sustained permanent impairment as a result of her right arm condition. Specifically, Dr. Hines opined claimant sustained a permanent impairment of 10 percent right upper extremity or 6 percent whole person for ulnar neuritis. For the medial epicondylitis, Dr. Hines opined claimant sustained a 10 percent whole person impairment. By the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, table 16-3, a 10 percent whole person impairment equates to either a 16 or 17 percent upper extremity impairment. Dr. Hines also opined no permanent restrictions were required as claimant's decreased grip strength would not impact claimant's ability to safely perform her current employment. This caveat, however, indicates claimant may require permanent restrictions should she enter a line of work requiring gripping activities.

On May 9, 2014, Dr. Goerss signed a letter opining he did not anticipate claimant would suffer any permanent injury as a result of her right upper extremity condition. However, his opinion is entitled to little weight, as there is no evidence he examined claimant or reviewed medical records after he referred her to Dr. Deffer on October 31, 2011. After the referral to Dr. Deffer, claimant received conservative treatment for an extended period, the majority of which at defendant's authorization. Therefore, Dr. Goerss' opinion is entitled to very little weight.

On May 27, 2014, Ms. Laughlin issued an analysis of claimant's employability. As this is a scheduled member case, the question of claimant's employability and earning capacity is not relevant. Therefore, Ms. Laughlin's report is provided no weight.

Claimant testified she has sustained no relief of arm symptoms since she left defendant's employ and symptoms worsen with activity. She continues to use tramadol for pain, as prescribed by Dr. Curd.

The undersigned discounted the opinions of Drs. Deffer, Blow and Goerss on the extent of claimant's permanent impairment, if any. The only remaining physician to opine on the extent of permanent impairment is Dr. Hines. Dr. Hines issued his opinion following examination of claimant and while defendant urges the undersigned to find Dr. Hines' report not credible on the basis of a federal court case from a different jurisdiction, the undersigned declines to do so. The concerns raised in that separate

case and addressed by Dr. Hines at deposition indicate an isolated incident and not a course of behavior which would draw Dr. Hines' credibility into question in every case.

Therefore, the undersigned adopts Dr. Hines' opinion on the extent of claimant's right upper extremity impairment. Dr. Hines issued permanent impairment ratings of 10 percent right upper extremity for ulnar neuropathy and the equivalent of 16 or 17 percent right upper extremity for medial epicondylitis. When combined, these ratings total 24 or 25 percent right upper extremity. It is therefore determined claimant is entitled to 61.25 weeks of permanent partial disability benefits (24.5 percent x 250 weeks = 61.25 weeks). These benefits shall commence on the stipulated date of June 29, 2013.

The next issue for determination is the proper rate of compensation.

If the employee is paid on a daily or hourly basis or by output, weekly earnings are computed by dividing by 13 the earnings over the 13-week period immediately preceding the injury. Any week that does not fairly reflect the employee's customary earnings is excluded, however. Section 85.36(6).

By post-hearing brief, claimant refers the undersigned to Exhibit J, a daily summary of claimant's hours and wages, and simply states "[u]tilizing the representative weeks prior to each injury date, the claimant's rate should be either $499.17 (DOI 6/1/11) or $507.20 (DOI 8/3/11), depending on the date of injury." (Claimant's post-hearing brief, p. 8)

By post-hearing brief, defendant specified which weeks were used as representative for each date of injury. Defendant also provided a detailed computation as to claimant's gross average weekly wage for each date of injury. For the alleged June 1, 2011 date of injury, defendant computed a gross average weekly wage of $499.17. Utilizing this gross average weekly wage and the parties' stipulation claimant was single and entitled to 1 exemption, defendant asserts a weekly rate of $319.50 for the June 1, 2011 date of injury. For the alleged August 3, 2011 date of injury, defendant computed a gross average weekly wage of $507.20. Utilizing this gross average weekly wage and the parties' stipulation claimant was single and entitled to 1 exemption, defendant asserts a weekly rate of $326.78 for the August 3, 2011 date of injury.

Due to defendant's specificity in the analysis of representative weeks and computation of gross average weekly wage, the undersigned adopts defendant's calculation of rate. Based upon Exhibit J and absent any delineation as to how claimant arrived at her proposed weekly rate, the undersigned is simply unable to find any support for claimant's proposed rates. As the undersigned has determined claimant's injury manifested on August 3, 2011 and adopted defendant's computation of rate, it is found claimant's proper rate of compensation is $326.78.

The next issue for determination is whether claimant is entitled to payment of various medical expenses.

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. Section 85.27. Holbert v. Townsend Engineering Co., Thirty-second Biennial Report of the Industrial Commissioner 78 (Review-Reopening October 16, 1975).

When dealing with unauthorized care, to be entitled to payment, claimant must establish the care was rendered on a compensable claim. That being established, claimant must establish that the care provided on the compensable claim was both reasonable and the outcome more beneficial than the care offered by the defendant. Bell Bros. Heating v. Gwinn, 779 N.W.2d 193, 206 (Iowa 2010).

Claimant seeks payment of medical expenses and medical mileage in the amount of $280.48. This total includes: $80.00 office visit with Dr. Curd on April 9, 2014; mileage incident to Dr. Curd's evaluation in the amount of $133.20; and $67.28 for an office visit with claimant's personal physician on May 2, 2014 to procure a prescription to treat her depression. By this decision, the undersigned found claimant's ongoing right arm symptoms treated by Dr. Curd on April 9, 2014 and depression treated by her personal physician on May 2, 2014 were compensable claims. At the time of the evaluations, defendant had not offered claimant care for either condition. By this visit, claimant pursued ongoing care with Dr. Curd, care which the undersigned ordered continued by this decision. Claimant also secured relief of her depression symptoms through the prescription ordered by her personal physician. Therefore, it is determined defendant is responsible for the medical expenses claimed by claimant.

The next issue for determination is whether claimant is entitled to reimbursement for an independent medical evaluation pursuant to Iowa Code section 85.39.

Section 85.39 permits an employee to be reimbursed for subsequent examination by a physician of the employee's choice where an employer-retained physician has previously evaluated "permanent disability" and the employee believes that the initial evaluation is too low. The section also permits reimbursement for reasonably necessary transportation expenses incurred and for any wage loss occasioned by the employee attending the subsequent examination.

Defendants are responsible only for reasonable fees associated with claimant's independent medical examination. Claimant has the burden of proving the reasonableness of the expenses incurred for the examination. See Schintgen v. Economy Fire & Casualty Co., File No. 855298 (App. April 26, 1991). Claimant need not ultimately prove the injury arose out of and in the course of employment to qualify for reimbursement under section 85.39. See Dodd v. Fleetguard, Inc., 759 N.W.2d 133, 140 (Iowa App. 2008).

Claimant seeks reimbursement for Dr. Hines' IME in the amount of $2,050.00, as well as attendant medical mileage in the amount of $227.13. Dr. Hines' evaluation took place on March 7, 2014. Prior to Dr. Hines' evaluation, Dr. Deffer released claimant from care and opined claimant sustained no ratable impairment on April 17, 2012. Furthermore, defendant arranged for its own IME of claimant by Dr. Blow on June 18, 2013. At that time, Dr. Blow also opined claimant did not sustain ratable permanent impairment. Either of these opinions would trigger claimant's right to a section 85.39 evaluation. There is no evidence Dr. Hines' IME fee was unreasonable, nor that it was unreasonable for claimant to utilize Dr. Hines to perform an IME. Therefore, claimant is entitled to reimbursement of Dr. Hines' IME in the amount of $2,050.00, as well as payment of medical mileage in the amount of $227.13.

The next issue for determination is whether claimant is entitled to penalty benefits under Iowa Code section 86.13 and, if so, how much.

If weekly compensation benefits are not fully paid when due, section 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 Meats, Inc., 528 N.W.2d 109 (Iowa 1995).

It also is 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 the 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.

Iowa Code 86.13, as amended effective July 1, 2009, states:

> 4. 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 percent 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 prove 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.

Claimant argues defendant behaved unreasonably in terminating claimant's benefits and failing to pay permanent disability benefits following receipt of Dr. Blow's opinions arising from the June 18, 2013 IME. On the basis of Dr. Blow's opinion, defendant ceased payment of temporary benefits pursuant to a 30-day notice sent June 27, 2013. After the 30-day period elapsed on July 26, 2013, defendant paid no additional indemnity benefits. The undersigned found claimant entitled to 61.25 weeks of permanent disability benefits by this decision. As these benefits have not been paid, claimant has established a delay, denial, or termination of benefits as required by section 86.13(4)(b)(1).

The burden therefore shifts to defendant to prove a reasonable or probable cause or excuse pursuant to section 86.13(4)(b)(2). In order to establish this reasonable or probable cause or excuse, defendant must satisfy the requirements of section 86.13(4)(c). First, defendant must prove the excuse was preceded by a reasonable investigation. In this case, defendant paid benefits while investigating the compensability of the claim, specifically, while seeking the opinions of Dr. Blow. Second, the results of the investigation must be the basis of the denial, delay, or

termination of benefits. In this case, defendant relied upon the opinions of Dr. Blow in terminating and denying further benefits, as evidenced by the 30-day notice's reference to and inclusion of Dr. Blow's report. Finally, defendant must prove the basis of the action was contemporaneously conveyed to claimant. In this case, Dr. Blow issued his report on June 19, 2013. Defendant's third-party administrator authored a letter conveying the termination and denial on June 27, 2013. Defendant did not terminate claimant's benefits until July 26, 2013. Defendant therefore contemporaneously conveyed the basis of the denial and termination. Defendant has established a reasonable or probable cause or excuse pursuant to section 86.13(4).

The crux of claimant's argument lies in the premise defendant acted unreasonably in securing the opinion of Dr. Blow and relying thereon. Claimant believes it was unwarranted for defendant to ignore the opinion of treating physician Dr. Curd and secure the opinion of Dr. Blow and thereafter, rely upon an opinion claimant believes is contrary to the evidence. Claimant ultimately prevailed in proving her right upper extremity condition persisted, contrary to the opinion of Dr. Blow. The fact claimant ultimately prevailed does not mean defendant was unreasonable in relying upon the opinion of Dr. Blow. Furthermore, while I rejected the opinion of Dr. Blow in favor of that of Dr. Curd, I did not do so upon the basis of an obvious and apparent mistake or fallacy in Dr. Blow's report. Therefore, there is no basis to determine defendant's reliance upon the report of Dr. Blow was unreasonable to a degree which would render defendant subject to penalty benefits. Claimant is not entitled to penalty benefits.

The final issue for determination is a specific taxation of costs pursuant to Iowa Code section 86.40 and rule 876 IAC 4.33. Claimant requests taxation of the costs of: $100.00 filing fee; $24.19 in copies of medical records; $973.00 for Ms. Laughlin's vocational report; and $103.85 for a copy of claimant's deposition transcript. These are allowable costs and are taxed to defendant. Claimant also requests taxation of mileage incurred in conjunction with Ms. Laughlin's vocational evaluation in the amount of $333.35. The undersigned finds no basis to tax the cost of mileage associated with claimant procuring a vocational evaluation to defendant. Therefore, defendant is taxed with costs in the amount of $1,201.04.

ORDER

THEREFORE, IT IS ORDERED:

Defendant shall pay unto claimant sixty-one point two five (61.25) weeks of permanent partial disability benefits commencing June 29, 2013 at the weekly rate of three hundred twenty-six and 78/100 dollars ($326.78).

Defendant shall pay claimant's prior medical expenses submitted by claimant at the hearing as set forth in the decision.

Defendant shall reimburse claimant for Dr. Hines' independent medical evaluation and attendant medical mileage as set forth in the decision.

Defendant shall pay accrued weekly benefits in a lump sum.

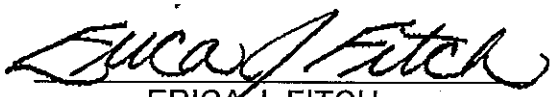
Defendant shall pay interest on unpaid weekly benefits awarded herein as set forth in Iowa Code section 85.30.

Defendant shall receive credit for benefits paid.

Defendant shall file subsequent reports of injury as required by this agency pursuant to rule 876 IAC 3.1(2).

Costs are taxed to defendant pursuant to rule 876 IAC 4.33 in the amount of one thousand two hundred one and 04/100 dollars ($1,201.04).

Signed and filed this 12th day of August, 2015.



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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.