BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

FILED
APR 12 2016
WORKERS' COMPENSATION

TERRI BOMER,	File Nos. 5047508, 5047509
Claimant,	ARBITRATION
vs.	DECISION
GLENWOOD RESOURCE CENTER,	
STATE OF IOWA,	
Self-Insured, Employer, Defendant.	Head Note Nos. 1108, 1801, 2701

STATEMENT OF THE CASE

Claimant, Terri Bomer, filed petitions in arbitration seeking workers' compensation benefits from Glenwood Resource Center, State of Iowa, self-insured employer, as defendant, as a result of stipulated injuries sustained on January 18, 2013 and January 16, 2014. This matter came on for hearing before Deputy Workers' Compensation Commissioner, Erica J. Fitch, on June 25, 2015, in Des Moines, Iowa. The record in this case consists of claimant's exhibits 1 through 18, defendant's exhibits A through P, and the testimony of the claimant and Heath Sayers. The parties submitted post-hearing briefs, the matter being fully submitted on July 17, 2015.

ISSUES

In File No. 5047508 (Date of Injury: January 18, 2013):

The parties submitted the following issues for determination:

1. Whether claimant's ongoing low back and left knee complaints are causally related to the stipulated work injury of January 18, 2013;

2. Whether claimant is entitled to a running award of temporary total disability benefits from June 26, 2015;

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

4. The extent of claimant's permanent disability, including whether claimant sustained a scheduled member or industrial disability;

5. The commencement date for permanent partial disability benefits;

6. Whether claimant is entitled to an award of alternate care pursuant to Iowa Code section 85.27;

7. Whether defendant is responsible for medical expenses listed in Exhibit 14;

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

9. Whether defendant is entitled to a credit for prior sums paid pursuant to a Compromise Settlement agreement entered into with respect to an alleged September 2006 injury; and

10. Specific taxation of costs.

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

In File No. 5047509 (Date of Injury: January 16, 2014):

1. Whether claimant's ongoing low back and left knee complaints are causally related to the stipulated work injury of January 16, 2014;

2. Whether claimant is entitled to a running award of temporary total disability benefits from June 26, 2015;

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

4. The extent of claimant's permanent disability, including whether claimant sustained a scheduled member or industrial disability;

5. The commencement date for permanent partial disability benefits;

6. Whether claimant is entitled to an award of alternate care pursuant to Iowa Code section 85.27;

7. Whether defendant is responsible for medical expenses listed in Exhibit 14;

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

9. Whether defendant is entitled to a credit for prior sums paid pursuant to a Compromise Settlement agreement entered into with respect to an alleged September 2006 injury; and

10. 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. During evidentiary hearing, claimant alternated periodically between sitting and standing. While standing, claimant rubbed her low back, but was able to transition between seated and standing positions without obvious difficulty. Claimant's demeanor at the time of evidentiary hearing gave the undersigned no reason to doubt claimant's veracity. Claimant is found credible.

Claimant was 48 years of age at the time of hearing. Claimant graduated high school in 1985. Following high school, claimant completed a certified medical assistant program in approximately 1990 or 1991. In 2005, claimant earned certifications as a nursing assistant and medication aide. (Claimant's testimony; Exhibit 16, page 105)

Claimant's work history consists of cook, dishwasher, telemarketer, certified medical assistant, order picker/puller, bartender, production worker, construction, and certified nursing assistant. Her wages in these positions typically fell in the range of $8.00 to $10.00 per hour. (Ex. 16, p. 104) In late 2005, claimant began work at Glenwood Resource Center as a resident treatment worker; she remained employed in this position at the time of evidentiary hearing. (Claimant's testimony; Ex. 16, p. 104) Claimant's duties involve assisting adult males afflicted with mental illness, a physical handicap, or a mental handicap, with daily activities. (Claimant's testimony) The job description for the position of resident treatment worker requires an employee be able to walk at a normal pace, push and maneuver adult wheelchairs, be on one's feet for eight hour shifts, lift at least 50 pounds, and frequently bend, stoop, and twist. (Ex. 17, p. 106) Claimant earns approximately $21.00 per hour for her work as a resident treatment worker. (Ex. 16, p. 104)

Claimant's relevant medical history reveals claimant suffered a left knee injury at the age of 14 after jumping over a fence. The injury ultimately required three subsequent surgeries in 1983, 1984, and 1986. Claimant testified her knee condition never returned to its pre-injury state, and she continued to suffer with occasional swelling. (Claimant's testimony; Ex. O, p. 73)

Claimant testified she suffered numerous work-related injuries in the course of her duties as a resident treatment worker at Glenwood Resource Center. Injuries included a head injury, concussion, hematomas, bites, and having dirt or gravel thrown in her eyes. (Claimant's testimony)

On September 25, 2006, claimant suffered an alleged left knee injury while at work at Glenwood Resource Center when a door was slammed upon her left knee. (Ex. O, p. 74) Multiple medical providers opined claimant suffered from significant preexisting arthritis of the left knee prior to the alleged work injury. (Ex. G, pp. 36, 39, 42) Michael McGuire, M.D. ultimately performed left total knee replacement in 2007. Following treatment, Dr. McGuire released claimant to return to work without restrictions in November 2007 and subsequently opined claimant sustained a 37 percent lower extremity impairment as a result of the total knee replacement. (Ex. G, p. 40) Claimant and defendant entered into a compromise settlement agreement approved by this agency on April 3, 2008. Documentation attached to the settlement denotes claimant was paid 118 weeks of permanent disability benefits with respect to the left knee. (Ex. G, pp. 32-35)

Claimant's subsequent medical history reveals she was evaluated at Medical Partners of Glenwood Grape Community Hospital on July 17, 2008 and August 24, 2008 after incidents where claimant twisted her left knee at work. On each occasion, orthopedic evaluation was suggested. Claimant was also treated with either Vicodin or Motrin. (Ex. A, pp. 1-4) On February 18, 2009, claimant was seen by Arthur West, M.D. of Concentra. Claimant reported she injured her left knee when shoved by a resident. Dr. West assessed a left knee strain and prescribed physical therapy and Lorcet. (Ex. B, pp. 5-6)

On July 7, 2009, claimant returned to Dr. West and reported sustaining a back injury on July 6, 2009 when she was attacked by a resident. Dr. West noted complaints in the right thoracic and lumbar regions. Dr. West assessed back pain, ordered a course of physical therapy, and prescribed ibuprofen 800 milligrams (mg) and Skelaxin. (Ex. B, pp. 7-8) Claimant returned to Dr. West in follow up on July 14, 2009. Claimant reported no continued pain; Dr. West released claimant from care, to perform a home exercise program. (Ex. B, p. 9)

Claimant returned to Dr. West on December 27, 2010 and reported she sustained injuries to her left leg and back while dealing with a resident. Dr. West assessed a sprain of the medial collateral ligament (MCL) of the left knee and a lumbar strain. He removed claimant from work, ordered a course of physical therapy, and prescribed ibuprofen 800 mg and Cyclobenzaprine. (Ex. B, pp. 10-11) A colleague of Dr. West, Dennis O'Leary, M.D., saw claimant in follow up on January 3, 2011. Claimant reported no continued pain. Dr. O'Leary released claimant to regular activities, with claimant to perform a home exercise program. (Ex. B, p. 12)

On January 18, 2013, claimant sustained a work injury at Glenwood Resource Center when a resident grabbed her at the neck and threw claimant to the ground. Claimant twisted her left knee upon landing and suffered with immediate pain of her back. She immediately reported the incident and requested medical treatment. (Claimant's testimony; Ex. O, p. 74)

Defendant arranged for claimant to return to Dr. West for evaluation on January 22, 2013. Claimant complained of back pain and left knee pain. Following examination, Dr. West assessed a contusion of the lumbar region and knee pain. He initiated a course of conservative care, including medications and physical therapy. Dr. West allowed claimant to continue with regular activities, without restrictions. (Ex. 2, p. 5)

Claimant continued to follow up periodically with Dr. West. (Ex. 2, p. 6) Due to persistent symptoms, on February 5, 2013, Dr. West ordered a lumbar spine MRI. (Ex. 2, p. 7) The lumbar spine MRI was performed on February 12, 2013. (Ex. 3, p. 15)

Following MRI, claimant returned to Dr. West on February 13, 2013. Dr. West reviewed claimant's MRI, noting it revealed an L3-L4 broad-based left neural foraminal/far lateral disc protrusion obliterating the left lateral recess and displacing the nerve roots into the central canal. Dr. West prescribed a Medrol Dosepak and valium. He recommended continued physical therapy and imposed work restrictions of no lifting greater than 30 pounds and no bending greater than 6 times per hour. (Ex. 2, pp. 8-9)

Claimant returned to Dr. West on February 20, 2013 and reported slight improvement in symptoms. Dr. West prescribed Mobic and continued physical therapy. He maintained claimant's existing work restrictions. (Ex. 2, p. 10)

On February 26, 2013, claimant returned to Dr. West with complaints of worsening symptoms. Dr. West removed claimant from work for two days, with claimant then working under restrictions of no lifting greater than 10 pounds, no prolonged standing or walking, no bending greater than 4 times per hour, and no pushing or pulling with over 15 pounds of force. Dr. West recommended continued medication use, with the addition of Ultracet. He also recommended continued physical therapy and an evaluation by an orthopedic surgeon. (Ex. 2, pp. 11-12)

On March 13, 2013, claimant presented to Nebraska Spine Center for evaluation by orthopedic surgeon, J.B. Gill, M.D. Dr. Gill ordered x-rays, which he opined revealed spondylosis of the lumbar spine. He also reviewed claimant's MRI and opined it revealed a herniated disc at L3-L4 on the left, compressing the L4 nerve root, and a component of far lateral protrusion. (Ex. 4, p. 19) Dr. Gill recommended a left L3-L4 transforaminal epidural steroid injection (TESI). Pending the TESI, Dr. Gill continued claimant's work restrictions. (Ex. 4, pp. 20, 23)

On March 21, 2013, John Massey, M.D. of Nebraska Spine Center performed a lumbar TESI. (Ex. 4, p. 24) Claimant testified she received approximately three days of relief following the TESI. The TESI did not eliminate her pain; it simply reduced her symptoms to a level that made it easier for her to function. (Claimant's testimony)

Claimant returned to Dr. Gill on April 9, 2013 and reported approximately 40 percent improvement following TESI, but continued back and left leg pain. (Ex. 4, p. 26) As claimant's symptoms primarily arose from her back, Dr. Gill expressed belief a

repeat injection would not likely be beneficial. He prescribed indomethacin and released claimant to return to work full duty, without restrictions. (Ex. 4, pp. 29-30)

On April 30, 2013, claimant returned to Dr. Gill with complaints of continued left-sided low back pain. Claimant denied any leg pain at the time of evaluation. Dr. Gill noted claimant reported no relief with indomethacin, little relief with TESI, and no improvement with physical therapy. Dr. Gill also noted claimant had returned to work and was assaulted on April 11, 2013, leading to treatment for concussive symptoms. (Ex. 4, p. 31) Dr. Gill opined claimant did not require surgical intervention. However, he opined claimant had failed conservative treatment and issued a referral for ongoing conservative measures. Dr. Gill allowed claimant to continue working without restrictions. (Ex. 4, p. 34)

At the referral of Dr. Gill, on July 29, 2013, claimant presented to physiatrist, James Devney, D.O. Claimant complained of low back pain and left lower extremity pain following a work injury on January 18, 2013. (Ex. 5, p. 35) Claimant underwent standing lumbar x-rays which were reviewed by Dr. Devney; he also reviewed claimant's MRI of February 2013. (Ex. 5, p. 37) Following examination, Dr. Devney counseled claimant regarding the importance of tobacco cessation. He prescribed Lodine XL and Lidoderm patches and advised claimant to continue full duty work. (Ex. 5, p. 38)

On August 8, 2013, claimant returned to Dr. Devney with continued complaints of low back pain. Dr. Devney performed a left L3-L4 and L4-L5 TESI. (Ex. 5, p. 39)

Claimant followed up with Dr. Devney on August 21, 2013 and reported 40 percent improvement in symptoms post-TESI on August 8, 2013. Dr. Devney noted claimant's left knee pain had improved, but claimant continued to complain of persistent low back and hip pain. (Ex. 5, p. 40) Dr. Devney refilled claimant's Lodine and recommended a follow up lumbar epidural injection. (Ex. 5, p. 42) Dr. Devney performed the recommended left L4-L5 and L5-S1 TESI on September 3, 2013. (Ex. 5, p. 43)

On September 17, 2013, claimant presented to Dr. Devney and reported 40 percent improvement in symptoms following the TESI of September 3, 2013. Dr. Devney noted claimant's hip pain had largely resolved. However, he opined the TESI offered no particular benefit to claimant's chronic low back pain. Dr. Devney opined claimant's MRI demonstrated multilevel degenerative pathology involving the discs and facet joints. He recommended a diagnostic bilateral L4-L5 and L5-S1 facet joint nerve block in order to determine if claimant was a candidate for radiofrequency rhizotomy. (Ex. 5, p. 46)

On September 19, 2013, Dr. Devney performed bilateral L4-L5 and L5-S1 facet joint nerve blocks. He noted an immediate 100 percent improvement in claimant's lumbar pain. (Ex. 5, p. 47) Accordingly, on October 11, 2013, Dr. Devney proceeded with bilateral L4-L5 and L5-S1 facet joint radiofrequency neurotomy. (Ex. 5, p. 48)

Claimant testified the rhizotomy did not eliminate her pain, but made pain levels more tolerable for approximately one week. (Claimant's testimony)

Claimant returned to Dr. Devney in follow up on October 22, 2013. Dr. Devney noted claimant complained of increased low back pain and left buttock pain following the L4-L5 and L5-S1 facet joint rhizotomy. (Ex. 5, p. 50) Dr. Devney prescribed Gralise and Naprelan. He removed claimant from work for the remainder of the week, to return to work thereafter on a maximum eight-hour work day. (Ex. 5, p. 52)

On November 6, 2013, claimant presented to the emergency room at Methodist Jennie Edmundson Hospital and was evaluated by Kimberly Dierks, PA-C. Claimant complained of bilateral lumbar pain with radiation to the right lower extremity with an onset of January 2013. Claimant received a prescription for hydrocodone and was advised to follow up with Dr. Devney. (Ex. 1, p. 1; Ex. C, pp. 13-14) Claimant testified she presented to the hospital at the referral of her supervisor due to continued pain complaints. (Claimant's testimony)

On November 12, 2013, claimant returned to Dr. Devney, who noted claimant denied significant improvement. Dr. Devney noted he found it difficult to ascertain if claimant's pain had responded following the rhizotomy, as she had made several requests for hydrocodone. He opined claimant's neurological examination was normal, but claimant showed signs of symptom magnification by way of positive Waddell's signs. (Ex. 5, pp. 53, 55) Dr. Devney opined:

> With all things considered, and after having undergone extensive conservative care, it would seem reasonable to place [claimant] at maximal medical improvement as of today's date.

(Ex. 5, p. 55)

Dr. Devney recommended a functional capacity evaluation (FCE) to assess the validity of claimant's complaints and to identify any limitations. Dr. Devney released claimant from care and recommended she use over the counter analgesics as needed, as opioid analgesics were not warranted. (Ex. 5, p. 55)

Following release by Dr. Devney, claimant resumed full duty work as a resident treatment worker at Glenwood Resource Center. Claimant testified she continued to suffer with pain of her left low back, into the left buttock and down her legs, as well as swelling and aching of her left knee. During this time, claimant had difficulty managing her pain levels. (Claimant's testimony)

On December 16, 2013, claimant presented for FCE with Mark Blankespoor, PT. Mr. Blankespoor opined claimant demonstrated maximum, consistent effort and performance throughout the examination. He opined the results of the FCE to be valid in determining claimant's level of functioning. (Ex. 6, p. 58) Mr. Blankespoor opined claimant demonstrated the ability to function in the medium physical demand category;

specifically with the ability to lift up to 60 pounds rarely and 50 pounds occasionally with the front carry task. (Ex. 6, p. 59) Claimant also demonstrated some limitation in crouching and step ladder use, to an occasional basis only. (Ex. 6, p. 60) Mr. Blankespoor reviewed the job description for a resident treatment worker and opined claimant demonstrated no significant limitations with respect to the physical demands required. Mr. Blankespoor expressed belief claimant's abilities matched the physical demands outlined in the job description. He opined the results of the FCE indicated claimant could safely perform all the essential functions of her position. (Ex. 6, p. 59)

On January 16, 2014, claimant sustained an injury at Glenwood Resource Center when a resident shoved her, leading her to strike her back against a shower wall and twist her left knee on a slippery wet floor. Claimant reported the incident and requested medical treatment. (Claimant's testimony; Ex. O, p. 75)

On January 19, 2014, claimant was evaluated at the emergency room of Methodist Jennie Edmundson Hospital by Anne Harmon Paulmeyer, PA-C. Claimant complained of left knee pain following a recent injury, as well as back pain. Claimant received prescriptions for hydrocodone and Cyclobenzaprine. (Ex. 1, p. 3; Ex. C, p. 17)

On January 21, 2014, claimant returned to Dr. West for evaluation. Claimant informed Dr. West she sustained an injury to her back and left knee. Following examination, Dr. West assessed lumbar pain and knee pain. He removed claimant from work and recommended continued use of her prescribed medications. Dr. West expressed belief claimant's knee would benefit from a steroid injection and accordingly, referred claimant for evaluation by an orthopedic knee specialist. Dr. West also recommended claimant follow up with Dr. Devney with respect to her back. (Ex. 2, pp. 13-14)

Despite the referral from Dr. West, Dr. Devney declined to see claimant due to concern over potential medication-seeking behavior. (Claimant's testimony)

Dr. Devney authored a letter to defendant's third party administrator dated February 4, 2014. By the letter, Dr. Devney confirmed claimant achieved maximum medical improvement (MMI) for her back complaints as of November 12, 2013. Dr. Devney indicated he did not anticipate claimant would require further treatment for her back with the exception of continued performance of a home exercise program. In accordance with the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, Dr. Devney opined claimant fell within DRE Lumbar Category II, warranting a permanent impairment of 5 percent whole person. Dr. Devney further expressed agreement with the permanent restrictions set forth in claimant's FCE report. (Ex. 5, pp. 56-57)

Defendant paid claimant 25 weeks of permanent partial disability benefits, in accordance with Dr. Devney's 5 percent whole person rating. (Ex. K, p. 52)

In accordance with Dr. West's referral, defendant arranged for claimant to be evaluated by Huy Trihn, M.D. of Miller Orthopedic Specialists on February 6, 2014. Claimant complained of low back pain and increased pain and swelling of the left knee. Claimant reported a history of two work related injuries and reported she suffered with chronic low back pain since the first injury, but the left knee swelling associated with the first injury had previously resolved. (Ex. 7, p. 65) Following examination, Dr. Trihn assessed a left knee strain with synovitis and probable loosening of the femoral component, as well as chronic low back pain. Dr. Trihn performed an aspiration of the left knee and recommended claimant use ice and an Ace wrap on the knee. He imposed restrictions of no lifting over 10 pounds; no bending, squatting, or kneeling; and minimal use of stairs. Dr. Trihn opined the work injury of January 16, 2014 did not cause any significant or permanent aggravation to the low back or left knee. He also opined the synovitis was most likely secondary to loosening of the femoral component and possibly, wear of the patella. (Ex. 7, pp. 66-67)

On February 20, 2014, claimant returned to Dr. Trihn in follow up. Claimant complained of a sore low back and reported her left knee had developed swelling shortly after the last evaluation. Following examination, Dr. Trihn assessed a mild left knee strain from the January 16, 2014 work injury, synovitis of the left knee most likely secondary to preexisting loosening of the femoral component, and preexisting chronic low back pain. Dr. Trihn opined the January 16, 2014 injury did not cause permanent aggravation or result in disability. He placed claimant at MMI and released claimant to full duty work. Dr. Trihn suggested claimant follow up with her primary surgeon with respect to her left knee condition. (Ex. 7, p. 68; Ex. M, p. 58)

Following Dr. Trihn's February 20, 2014 report, defendant denied claimant required further medical treatment or sustained any additional permanent disability as a result of the January 16, 2014 injury. (Ex. M, p. 55)

After Dr. Trihn released claimant, she returned to work at Glenwood Resource Center as a full duty resident treatment worker. Despite returning to full duty, claimant testified she continued to suffer with pain while working. (Claimant's testimony; Ex. O, p. 76) Claimant testified she began misusing opiates and benzodiazepines. Claimant testified her abuse of medications led to work performance problems at Glenwood Resource Center. Due to these problems, Glenwood Resource Center required her to participate in a substance abuse evaluation. (Claimant's testimony)

On April 28, 2014, claimant participated in a substance abuse evaluation at Inroads Counseling (Inroads). Claimant informed the therapist she was on FMLA leave while addressing her substance abuse issues. She reported previously falling asleep at work due to abuse of benzodiazepines. (Ex. D, p. 20) Claimant also disclosed use of opiate pain medications, including her own prescribed hydrocodone and Oxycontin prescribed to her daughter. (Ex. D, p. 22) She expressed desire to undergo treatment of her dependency issues. The evaluating therapist recommended claimant participate in an intensive outpatient program. (Ex. D, p. 26)

Claimant received a work directive from Glenwood Resource Center dated May 12, 2014. In order to maintain her employment, claimant was expected to abide by her treatment plan at Inroads, provide periodic updates to her employer, and secure a full duty release prior to returning to employment. (Ex. G, pp. 53-54)

In May 2014, claimant began her course of treatment at Inroads. While undergoing treatment, claimant utilized FMLA leave. Claimant testified she received treatment for anxiety, depression, and sedative dependence. (Ex. O, pp. 78-79) She admitted to suffering with depression in some form since her 20s; she intermittently used medication in treatment of her depression. Claimant was also diagnosed with anxiety in her 20s; she has battled anxiety consistently since her diagnosis. Claimant testified her use of Xanax became problematic in 2014, when she began using greater than her prescribed dosage. (Claimant's testimony; Ex. O, p. 79) Claimant testified during this period she also used hydrocodone and Oxycontin. (Claimant's testimony; Ex. O, p. 80)

Upon successful completion of a treatment program, claimant was ultimately released from treatment with a full duty work release on August 8, 2014. (Ex. D, p. 27) Claimant testified she has not used Xanax or any other benzodiazepine since completing her treatment at Inroads. (Ex. O, pp. 79-80)

At the arranging of claimant's counsel, on August 4, 2014, claimant presented for independent medical evaluation (IME) with board certified occupational and environmental medicine physician, Robin Sassman, M.D. Dr. Sassman issued a report of her findings and opinions dated September 15, 2014. Claimant complained of constant achy low back pain which radiated to the left hip and left knee pain, described as "swollen and achy." Claimant reported receiving a prescription for hydrocodone for these complaints from her personal physician, Dr. Robert Kent. (Ex. 11, p. 84)

Dr. Sassman reviewed claimant's medical records dating to April 2012. (Ex. 11, 81-84) She also ordered x-rays of claimant's left knee and performed a physical examination. (Ex. 11, pp. 85-86, 91) Following records review, history, and examination, Dr. Sassman assessed low back pain with radiculopathy and left knee pain. (Ex. 11, p. 86)

Dr. Sassman opined the initial injury of January 18, 2013 was directly and causally related to claimant's low back symptoms. She also opined the January 16, 2014 injury aggravated the underlying low back symptoms. In support of her opinion, Dr. Sassman noted claimant's denial of low back symptoms prior to the work injuries and lack of evidence she sought care for low back symptoms prior to the work injuries. Dr. Sassman also opined claimant's reported mechanisms of injury were consistent with causing low back symptoms. (Ex. 11, pp. 86-87)

With respect to claimant's left knee, Dr. Sassman opined claimant did well post-replacement in 2007. She noted claimant reported noticing left knee pain after the initial injury on January 18, 2013, but claimant did not receive a true evaluation of the left

knee until after the January 16, 2014 work injury when she complained of worsening pain. Given that claimant did well following replacement in 2007, until 2013, Dr. Sassman opined the two work injuries aggravated the underlying replacement and problems of the left knee. Dr. Sassman explained on both occasions claimant suffered a traumatic twisting injury, a mechanism of injury consistent with possibly aggravating the replacement. (Ex. 11, p. 87)

With respect to additional treatment, Dr. Sassman recommended claimant undergo a repeat lumbar spine MRI and evaluation by a spine surgeon. In the event claimant was deemed non-surgical, Dr. Sassman recommended evaluation by a pain management specialist for treatment of pain symptoms of the back. Dr. Sassman also recommended evaluation by an orthopedist specializing in knee replacements. Dr. Sassman expressed belief claimant had not achieved MMI, pending her treatment recommendations. However, if such treatment was not completed, Dr. Sassman assigned an MMI date of August 4, 2014, corresponding to her evaluation of claimant. (Ex. 11, p. 87)

Dr. Sassman also provided provisional impairment ratings of claimant's back and left knee conditions. Dr. Sassman opined claimant fell within DRE Lumbar Category II, warranting a permanent impairment of 5 percent whole person. She also opined that based on claimant's history, it appeared the range of motion of claimant's knee had "changed since the injuries in question," thus warranting a permanent impairment of 10 percent left lower extremity. When converted and combined, Dr. Sassman found a total impairment of 9 percent whole person. (Ex. 11, p. 88)

Dr. Sassman recommended permanent restrictions of: lifting, pushing, pulling, and carrying of 30 pounds rarely floor-to-waist, 50 pounds rarely waist-to-shoulder, and 30 pounds rarely above shoulder level; occasional sitting, standing, and walking, with the need to change positions; rare stooping, bending, or use of stairs; no crawling, kneeling, walking on uneven surfaces, or use of ladders; and no use of vibratory or power tools. (Ex. 11, p. 88)

On October 16, 2014, claimant's attorney contacted defendant's attorney and requested authorization of the care recommendations made by Dr. Sassman. Defendant denied authorization of the requested care. (Ex. 15, p. 101) After defendant denied further treatment, claimant sought care with her personal physician, Dr. Robert Kent. (Claimant's testimony)

At the referral of Dr. Kent, on February 18, 2015, claimant presented for left knee evaluation with Craig Hansen, M.D. of OrthoWest. Claimant complained of some pain of the knee, swelling of the knee, and some difficulty traversing stairs. (Ex. 8, p. 69) Claimant underwent x-rays of the left knee which revealed well-maintained alignment without obvious loosening. Dr. Hansen assessed left knee pain status post knee replacement and MCL sprain. He prescribed an MCL brace and advised claimant to wear the brace during daytime hours for six weeks. Dr. Hansen advised claimant to return for follow up in six weeks' time. (Ex. 8, p. 71)

At the referral of Dr. Kent, on March 10, 2015, claimant presented for evaluation by Guy Music, M.D. of Midwest Neurosurgery & Spine Specialists. Dr. Music noted claimant suffered with a work related injury in 2013, with persistent low back pain since that time. Dr. Music noted claimant received treatment in 2013, returned to work, and reinjured her back in 2014. He noted defendant attempted to return claimant to Dr. Devney, who refused to see claimant due to medication abuse issues. Defendant then referred claimant to Dr. Trihn, who, Dr. Music noted, addressed claimant's left knee complaints, but not the back complaints. Since that time, claimant reported suffering with daily left low back pain, with radiation to the left buttock and leg to the knee. Dr. Music reviewed claimant's MRI and opined it revealed a large left broad-based disc protrusion causing severe left lateral recess stenosis and foraminal stenosis. He assessed a left L3-L4 disc herniation causing left-sided low back pain and left lower extremity radicular symptoms. (Ex. 9, p. 73) Dr. Music opined it appeared claimant would benefit from a left L3-L4 microlumbar discectomy, but he required a new MRI of the lumbar spine prior to making any treatment recommendations. (Ex. 9, p. 74)

On March 19, 2015, claimant underwent the lumbar spine MRI ordered by Dr. Music. The radiologist opined it revealed a left L3-L4 disc protrusion with moderate-severe foraminal stenosis. (Ex. 10, p. 78) On March 24, 2015, Dr. Music telephoned claimant to advise her the MRI showed a persistent large left lateral L3-L4 disc herniation. Claimant indicated she was ready and willing to proceed with scheduling surgery. (Ex. 9, p. 75)

Defendant forwarded a copy of Dr. Sassman's IME to Dr. Devney for review and comment. Following review, Dr. Devney authored a statement dated April 23, 2015. Dr. Devney indicated he last treated claimant in 2013. Following an extensive course of conservative treatment, Dr. Devney indicated he placed claimant at MMI on November 12, 2013. Dr. Devney opined as a result of a permanent exacerbation of a preexisting lumbar spine spondylosis, claimant sustained a permanent impairment of 5 percent whole person. Dr. Devney opined he agreed with the restrictions set forth in claimant's FCE, which allowed work within the medium physical demand category, with lifting up to 60 pounds rarely and 50 pounds occasionally. (Ex. E, p. 28)

In review of Dr. Sassman's IME, Dr. Devney learned claimant sustained a second injury in January 2014. Dr. Devney noted disagreement between Drs. Trihn and Sassman with respect to claimant's knee condition, but offered no opinion on the knee, as he had not personally treated claimant's left knee. With respect to claimant's back complaints, Dr. Devney expressed belief evaluation by another spine specialist was unwarranted. He noted review of claimant's February 2013 MRI showed multilevel disc desiccation with varying degrees of disc collapse, and by Dr. Sassman's examination, claimant remained neurologically intact and continued to smoke. Dr. Devney explained professional literature "denotes poor postoperative functional outcomes in smokers requiring multilevel discectomy/fusion," and accordingly, opined claimant was an inappropriate surgical candidate. (Ex. E, p. 28) Also with respect to claimant's back, Dr. Devney opined claimant's functional impairment remained at 5 percent whole

person, and he observed no reason to change claimant's assigned permanent work restrictions. (Ex. E, p. 29)

On April 29, 2015, claimant's counsel conducted a conference with Dr. Music. On May 19, 2015, Dr. Music completed a check-the-box form authored by claimant's counsel purporting to set forth Dr. Music's opinions. Dr. Music acknowledged review of claimant's Concentra medical records dated July 14, 2009 through January 13, 2011 and Dr. Sassman's IME of September 15, 2014. Dr. Music agreed the work injuries of January 18, 2013 and January 16, 2014 caused and/or materially and substantially aggravated claimant's back and resulted in the need for a left L3-L4 microlumbar discectomy. (Ex. 9, pp. 76-77)

Defendant provided Dr. Trihn with a copy of Dr. Sassman's IME for review. On June 11, 2015, Dr. Trihn issued responses to a check-the-box form authored by defendant's attorney. Dr. Trihn agreed claimant did not require additional medical treatment for her left knee or back as "an exclusive result" of the January 16, 2014 injury. He also agreed it was impossible to state whether the 10 percent lower extremity rating assigned by Dr. Sassman was related to claimant's preexisting knee condition or to the work injuries of January 2013 and January 2014, as there was no evidence Dr. Sassman conducted a left knee examination prior to January 18, 2013 or reviewed medical records authored prior to January 18, 2013 with respect to the left knee. (Ex. F, p. 30)

At evidentiary hearing, claimant testified she continues to suffer with pain of her low back, radiating to the left hip and leg, as well as aching and swelling of the left knee. Claimant testified her knee condition also affects her gait. She continues to use hydrocodone and baclofen as prescribed by Dr. Kent, with whom she has a signed pain contract. Claimant testified she takes hydrocodone approximately every four hours. Claimant testified the medications do not provide complete relief from her pain; however, they do decrease the pain so as to make it easier for her to function throughout the day. Without these medications, claimant testified she would be unable to tolerate full time work. (Claimant's testimony)

Claimant testified defendant has not provided her additional medical treatment, and she desires continued treatment with Drs. Music and Hansen. Claimant testified she was scheduled to undergo surgery with Dr. Music on June 26, 2015, the day following arbitration hearing. She explained the surgery is designed to repair the bulged disc present at L3-L4. Claimant testified she has been advised she will be off work for 12 weeks following surgery and then will return to work on light duty. Claimant testified she has not returned to Dr. Hansen; however, claimant explained she is satisfied with his care and intends to return once she has healed from back surgery. (Claimant's testimony)

Claimant has not sought work outside of Glenwood Resource Center, nor does she intend to do so. Claimant expressed intention to remain an employee of Glenwood Resource Center until her retirement. (Claimant's testimony)

Heath Sayers, treatment program manager at Glenwood Resource Center, testified at evidentiary hearing. From 2008 to May 2015, Mr. Sayers served as a resident treatment supervisor, tasked with overseeing resident needs and various administrative duties. During a portion of his time in this role, Mr. Sayers supervised claimant directly, most recently from March 2013 to May 2015. Following her FCE in December 2013, Mr. Sayers testified claimant was able to fulfill her duties as a resident treatment worker within the restrictions set forth in her FCE. The subsequent January 2014 work injury resulted in no additional permanent work restrictions; Mr. Sayers testified claimant returned to her normal position as a resident treatment worker. Following both injuries, Mr. Sayers testified claimant returned to work in her pre-injury position and performed her duties in a satisfactory manner. Additionally, claimant continued to work approximately 10 hours of voluntary overtime per two-week pay period; Mr. Sayers testified night supervisors specifically request claimant perform overtime for them. (Mr. Sayer's testimony)

Mr. Sayer's testimony was clear and consistent with the remainder of the evidentiary record. His demeanor at the time of hearing gave the undersigned no reason to doubt his veracity. Mr. Sayers is found credible.

CONCLUSIONS OF LAW

In File No. 5047508 (Date of Injury: January 18, 2013):

The first issue for determination is whether claimant's ongoing low back and left knee complaints are causally related to the stipulated work injury of January 18, 2013.

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 R. App. P. 6.14(6).

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 suffered a stipulated work-related injury on January 18, 2013. As a result of the injury, claimant was referred for care with Dr. West. Dr. West assessed a contusion of the lumbar region and knee pain. Dr. West initiated a course of conservative treatment which included a lumbar spine MRI on February 12, 2013. By the radiologist's report, the MRI revealed an L3-L4 broad-based left neural foraminal/far lateral disc protrusion obliterating the left lateral recess and displacing the nerve roots into the central canal. Following MRI, Dr. West continued claimant's conservative care and ultimately referred claimant for orthopedic evaluation.

Claimant's care was then assumed by Dr. Gill, who opined claimant's MRI revealed a herniated disc at L3-L4 on the left, compressing the L4 nerve root, and a component of far lateral protrusion. Dr. Gill recommended work restrictions and a TESI. Dr. Gill ultimately opined claimant was not a surgical candidate, but had failed conservative measures, thus warranting referral to a physiatrist.

At this juncture, claimant's care was assumed by physiatrist, Dr. Devney. Dr. Devney began a course of conservative treatment which ultimately included a left L3-L4 and L4-L5 TESI, a left L4-L5 and L5-S1 TESI, bilateral L4-L5 and L5-S1 facet joint nerve blocks, and bilateral L4-L5 and L5-S1 facet joint radiofrequency rhizotomy. In November 2013, Dr. Devney became concerned with respect to what he believed was claimant's drug-seeking behavior and signs of symptom magnification. He placed claimant at MMI on November 12, 2013 and ordered an FCE to assess the validity of claimant's complaints and to identify any limitations. Claimant underwent a valid FCE on December 16, 2013, which indicated claimant was capable of functioning at the medium physical demand level, with the ability to lift up to 60 pounds rarely and 50 pounds occasionally. Following review, Dr. Devney expressed agreement with the FCE restrictions and opined claimant sustained a 5 percent whole person impairment as a result of her back condition. Dr. Devney subsequently opined claimant was an inappropriate surgical candidate.

Claimant resumed full duty work at Glenwood Resource Center. However, claimant credibly testified she continued to suffer with pain of her left low back, into the left buttock and down her legs, as well as swelling and aching of her left knee.

Unfortunately, shortly after her release by Dr. Devney, claimant suffered a second injury to her back and left knee, on January 16, 2014. In this instance, claimant was shoved backwards into a shower wall, striking her back and twisting her left knee on the wet floor. Claimant was directed for care with Dr. West, who assessed lumbar pain and knee pain. He initiated a conservative treatment plan and issued referrals to an orthopedic knee specialist and to Dr. Devney for claimant's back. Due to his prior concerns regarding drug-seeking behavior, Dr. Devney declined to see claimant.

Following Dr. Devney's refusal, defendant arranged for claimant to be seen by Dr. Trihn on February 6, 2014. Dr. Trihn assessed a left knee strain with synovitis and probable loosening of the femoral component, as well as chronic low back pain. Dr. Trihn aspirated the left knee and imposed work restrictions. However, he opined the work injury of January 16, 2014 did not cause any significant or permanent aggravation to the low back or left knee. Despite continued symptoms of the back and left knee, Dr. Trihn placed claimant at MMI at their next appointment, February 20, 2014. He opined the January 16, 2014 injury did not cause a permanent aggravation of claimant's condition or result in permanency or a need for work restrictions. Dr. Trihn subsequently opined claimant did not require additional treatment of her back or left knee as an exclusive result of the January 16, 2014 injury.

Claimant again returned to work at Glenwood Resource Center, but continued to suffer with pain while working. Claimant soon developed dependency issues with respect to misuse of prescribed Xanax, as well as misuse of narcotic hydrocodone and Oxycontin. Claimant willingly participated in and successfully completed an outpatient treatment program and was released to full duty work on August 8, 2014.

Contemporaneous with her completion of the substance abuse program, claimant underwent IME with Dr. Sassman. At that time, claimant complained of constant low back pain which radiated to the left hip, and left knee pain. Dr. Sassman opined claimant's low back symptoms were directly and causally related to the initial work injury of January 18, 2013. She further opined the subsequent injury of January 16, 2014 aggravated the underlying symptoms. Dr. Sassman highlighted the lack of treatment of prior low back symptoms and consistent mechanisms of injury. As claimant did well following knee replacement in 2007, until 2013 following the first injury, Dr. Sassman opined the two work injuries aggravated the underlying replacement and pathology of the left knee. Dr. Sassman opined claimant had not achieved MMI for either condition and recommended further evaluation.

Claimant requested defendant authorize additional medical evaluation in accordance with Dr. Sassman's recommendations, but was denied. Claimant then sought care through her personal physician, Dr. Kent. Dr. Kent issued referrals to Dr. Hansen for the left knee and Dr. Music for the low back. Dr. Hansen evaluated claimant on February 18, 2015 and assessed left knee pain status post knee replacement and MCL sprain. He prescribed an MCL brace and advised claimant to follow up. At the time of evidentiary hearing, claimant had yet to return to Dr. Hansen, as she was undergoing treatment of her low back condition with Dr. Music.

Dr. Music evaluated claimant on March 10, 2015 and opined claimant suffered with persistent low back pain since the injury in 2013, and was reinjured in 2014. Dr. Music reviewed claimant's February 2013 MRI and opined it revealed a large left broad-based disc protrusion causing severe left lateral recess stenosis and foraminal stenosis. He assessed a left L3-L4 disc herniation causing left-sided low back pain and left lower extremity radicular symptoms. Dr. Music opined it appeared claimant would benefit from a left L3-L4 microlumbar discectomy, but he desired a new MRI. Claimant

underwent a repeat lumbar spine MRI, which Dr. Music opined showed a persistent large left lateral L3-L4 disc herniation. Dr. Music subsequently opined the work injuries of January 2013 and January 2014 caused and/or materially and substantially aggravated claimant's back and resulted in the need for a left L3-L4 microlumbar discectomy. Claimant testified this procedure was scheduled for the day after evidentiary hearing in this matter.

No physician retained by defendant has evaluated claimant since Dr. Trihn released claimant on February 20, 2014. Dr. Trihn opined the subsequent work injury of January 16, 2014 did not cause a permanent aggravation of claimant's back and knee conditions. This opinion does not address the potential for claimant's January 18, 2013 injury to have caused lasting, ongoing problems with respect to the back and left knee.

Dr. Devney placed claimant at MMI for her back complaints on November 12, 2013, but did so in large part due to what he perceived as drug-seeking behavior and signs of symptom magnification. It is well within Dr. Devney's discretion to determine which patients he is willing to see; however, the remainder of the evidence in the record demonstrates claimant continued to express complaints of back pain at the time of her release by Dr. Devney. Furthermore, Dr. Devney's concerns regarding symptom magnification were counteracted by claimant's valid FCE which demonstrated residual functional limitations. Claimant credibly testified she continued to suffer with poorly managed pain complaints and developed a dependency issue for which she voluntarily and successfully participated in treatment.

After claimant participated in substance abuse treatment, she was provided with no further care of her ongoing complaints by defendant. No repeat evaluation of complaints was offered. Defendant continued to deny evaluation even after Dr. Sassman's IME which revealed continued complaints of the back and left knee, as well as recommendation for further evaluation. Dr. Sassman opined claimant's back condition was directly and causally related to claimant's injury of January 18, 2013, with the subsequent injury of January 16, 2014 aggravating her symptoms. Dr. Sassman also opined claimant did well post-replacement in 2007 until the first work injury in January 2013. She opined the two work injuries aggravated the underlying replacement. Both of Dr. Sassman's causation opinions support a determination claimant suffered injuries to her back and left knee on January 18, 2013, with those symptoms aggravated by the subsequent injury on January 16, 2014.

Dr. Sassman's opinion is supported by the opinion of Dr. Music. Dr. Music evaluated claimant in 2015, subsequent to both work injuries. He thereafter opined the work injuries of January 18, 2013 and January 16, 2014 caused and/or materially and substantially aggravated claimant's back and resulted in a need for left L3-L4 microlumbar discectomy.

Defendant attempts to counter the opinions of Dr. Sassman by having Drs. Devney and Trihn review and comment on Dr. Sassman's IME. Dr. Trihn opined claimant did not require additional medical treatment for her left knee or back as an

exclusive result of the second injury on January 16, 2014; however, his opinions do not address the potential need for additional treatment as a result of the original injury of January 18, 2013. Dr. Devney expressed belief further evaluation by a spine specialist was unwarranted, as claimant was not a surgical candidate. The fact Dr. Devney does not believe claimant is a surgical candidate is not binding upon other medical providers, most notably upon a neurosurgeon such as Dr. Music. Dr. Devney is a physiatrist who has not evaluated claimant since 2013 and learned of claimant's subsequent injury via Dr. Sassman's IME report. Furthermore, Dr. Devney's opinion does not equate to an opinion claimant does not continue to suffer with back symptoms as a result of the original work injury of January 18, 2013.

Claimant's credible testimony supports the causation opinions expressed by Dr. Sassman and Dr. Music. Claimant testified she has suffered with back and left knee symptoms consistently since the January 18, 2013 injury. Claimant consistently relayed such complaints to her medical providers, but her back care was terminated by Dr. Devney in November 2013, and she never received appropriate evaluation of her knee complaints. She subsequently suffered an intervening injury in January 2014; however, there is little evidence in the record which would support a determination the January 2014 injury was significant enough so as to cause further structural damage. Rather, the evidence supports claimant suffered injuries to her back and left knee on January 18, 2013, as supported by MRI evidence of an L3-L4 disc herniation in February 2013. The herniation visible on the February 2013 MRI is the same condition for which claimant plans to undergo surgery with Dr. Music.

Given the above, it is determined claimant has proven by a preponderance of the evidence that her continued back and left knee complaints are causally related to the work injury of January 18, 2013.

The next issue for determination is whether claimant is entitled to an award of alternate care pursuant to Iowa Code section 85.27.

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 1975).

Iowa Code section 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.

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 the care was unduly inconvenient for the claimant. 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, 123 (Iowa 1995).

Defendant declined to offer claimant additional treatment of her back and left knee complaints after Dr. Trihn's release in February 2014. The denial persisted despite request by claimant for additional care. By this decision, the undersigned determined claimant has proven her current complaints are causally related to the work injury of January 18, 2013. Defendant provided no care for the January 18, 2013 injury specifically since November 2013 and no care for any of claimant's complaints since February 2014. It is determined defendant failed to provide prompt care, reasonably suited to treatment of claimant's ongoing complaints. Claimant's request for an award of alternate care is therefore, granted. Claimant is free to pursue medical treatment with Drs. Music and Hansen, as requested.

The next issue for determination is whether claimant is entitled to a running award of temporary total disability benefits from June 26, 2015.

When an injured worker has been unable to work during a period of recuperation from an injury that did not produce permanent disability, the worker is entitled to temporary total disability benefits during the time the worker is disabled by the injury. Those benefits are payable until the employee has returned to work, or is medically capable of returning to work substantially similar to the work performed at the time of injury. Section 85.33(1).

Healing period compensation describes temporary workers' compensation weekly benefits that precede an allowance of permanent partial disability benefits. Ellingson v. Fleetguard, Inc., 599 N.W.2d 440 (Iowa 1999). Section 85.34(1) provides that healing period benefits are payable to an injured worker who has suffered permanent partial disability until the first to occur of three events. These are: (1) the worker has returned to work; (2) the worker medically is capable of returning to substantially similar employment; or (3) the worker has achieved maximum medical

recovery. Maximum medical recovery is achieved when healing is complete and the extent of permanent disability can be determined. Armstrong Tire & Rubber Co. v. Kubli, Iowa App., 312 N.W.2d 60 (Iowa 1981). Neither maintenance medical care nor an employee's continuing to have pain or other symptoms necessarily prolongs the healing period.

By this decision, the undersigned found claimant has proven a causal connection between her ongoing low back and left knee complaints and the work injury of January 18, 2013. I further awarded claimant's request for alternate care in the form of designation of Drs. Hansen and Music as authorized providers. At the time of evidentiary hearing, claimant remained in an active period of treatment with Dr. Music, as well as continued observation by Dr. Hansen. Accordingly, it is determined claimant's healing period with respect to her conditions has not concluded. However, as of the date of evidentiary hearing, claimant had not missed work and thus, an award of healing period benefits is not proper by this decision.

As the undersigned has determined claimant remains in a period of healing with respect to her back and left knee conditions arising from the work injury of January 18, 2013, the issues of causation of permanent disability, extent of permanent disability, commencement date for permanent disability benefits, and defendant's entitlement to credit against any permanency award will not be addressed at this time.

The next issue for determination is whether defendant is responsible for medical expenses listed in Exhibit 14.

Claimant requests the undersigned find defendant responsible for medical expenses associated with the following medical appointments: February 18, 2015 and April 1, 2015 appointments at OrthoWest (Dr. Hansen's practice) and a March 10, 2015 appointment at Midwest Neurosurgery & Spine Specialists (Dr. Music's practice).

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 defendants. Bell Bros. Heating v. Gwinn, 779 N.W.2d 193, 206 (Iowa 2010).

By this decision, the undersigned determined claimant's ongoing back complaints treated by Dr. Music and ongoing left knee complaints treated by Dr. Hansen are causally related to the work injury of January 18, 2013. Therefore, the care offered by both Drs. Music and Hansen has been rendered on compensable injuries. The undersigned further finds at the time claimant sought additional care with Drs. Music and Hansen; defendant had denied authorization of any additional evaluation and/or treatment of her work related conditions. However, as of the date of evidentiary hearing, claimant remained early in her course of treatment with both Drs. Music and Hansen. It is simply too early to determine if the courses of care with these physicians will prove beneficial. While one could assume *any* care of ongoing conditions would be

superior to the utter absence of care, it is claimant who bears the burden of proving the care received was beneficial. It is simply too early in the course of treatment to prove this factor at this juncture; therefore, it is determined claimant's entitlement to an order finding defendant responsible for the medical expenses listed in Exhibit 14 is not ripe for determination.

The next issue for determination is whether claimant is entitled to reimbursement of 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).

Dr. Devney issued an opinion with respect to the extent of claimant's permanent disability on February 4, 2014. He also adopted claimant's permanent restrictions as set forth in her FCE, with the FCE necessarily factoring in claimant's back and left knee abilities. Therefore, at the time of Dr. Sassman's IME on August 4, 2014, an employer-retained physician had previously evaluated claimant's permanent disability. Dr. Sassman charged $2,361.50 for the IME. (Ex. 13, p. 96) There has been no allegation the charged fee was unreasonable. Therefore, it is determined claimant is entitled to reimbursement for Dr. Sassman's IME in the amount of $2,361.50.

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 an $875.00 conference between claimant's counsel and Dr. Music on April 29, 2015, completed in connection with securing Dr. Music's opinions on causation (Ex. 18, pp. 107-108) and $22.30 for copies of Dr. Hansen's medical records. (Ex. 18, pp. 109-110) The costs of securing a doctor's report and copying fees are allowable costs and are taxed to defendant.

In File No. 5047509 (Date of Injury: January 16, 2014):

The first issue for determination is whether claimant's ongoing low back and left knee complaints are causally related to the stipulated work injury of January 16, 2014.

By this decision, *supra*, the undersigned determined claimant's ongoing back and left knee complaints are causally related to the original injury of January 18, 2013. The undersigned found the work injury of January 16, 2014 resulted in increased symptoms, but did not result in additional structural damage. Accordingly, it is found the work injury of January 16, 2014 resulted in a temporary aggravation, which resolved to the prior level of disability caused by the work injury of January 18, 2013.

As I have determined the work injury of January 16, 2014 resulted in a temporary aggravation only, claimant is not entitled to an award of alternate care, temporary disability benefits, permanent disability benefits, or payment of medical expenses in File No. 5047509.

The undersigned awarded claimant reimbursement of Dr. Sassman's IME and found defendant responsible for case costs in File No. 5047508; therefore, an additional award in File No. 5047509 is improper.

ORDER

THEREFORE, IT IS ORDERED:

In File No. 5047508 (Date of Injury: January 18, 2013):

Claimant has proven her ongoing back and left knee complaints are causally related to the work injury of January 18, 2013.

Claimant's request for alternate care in the form of ongoing treatment with Dr. Hansen and Dr. Music is granted.

Defendant shall reimburse claimant for Dr. Sassman's independent medical evaluation.

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

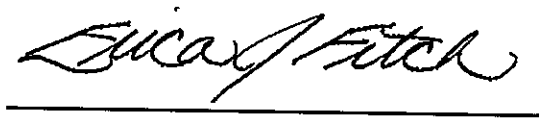
Costs are taxed to defendant pursuant to 876 IAC 4.33 as set forth in the decision.

In File No. 5047509 (Date of Injury: January 16, 2014):

Claimant shall take nothing from these proceedings.

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

Signed and filed this 12th day of April, 2016.



ERICA J. FITCH
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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EJF/sam

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.