BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

FILED
JUN 18 2018
WORKERS' COMPENSATION

GREGORY STRONG, Claimant, vs. WESTERN IOWA TECH COMMUNITY COLLEGE, Employer, IMPACC, Insurance Carrier, Defendants.	File Nos. 5040800, 5056575 ARBITRATION DECISION Head Note Nos. 1108, 1803

STATEMENT OF THE CASE

Gregory Strong filed two petitions for arbitration seeking workers' compensation benefits from, the employer, Western Iowa Tech Community College, and IMPACC, the insurance carrier.

The matter came on for hearing on June 6, 2017, before Deputy Workers' Compensation Commissioner Joseph L. Walsh in Sioux City, Iowa. The record in the case consists of joint exhibits 1 through 22; claimant's exhibits 1 through 16; defense exhibits A through J; as well the sworn testimony of claimant. Because treatment continued just prior to hearing, the hearing record was held open to allow defendants to submit rebuttal reports. (Transcript, page 170) Following the hearing, claimant submitted additional exhibits 17 through 19. These additional exhibits were received without objection. Carolyn Plueger was appointed court reporter. The parties argued this case and the matter was fully submitted on August 14, 2017.

ISSUES AND STIPULATIONS

Claimant has filed two separate petitions.

File No. 5040800:

The defendants stipulate claimant suffered an injury which arose out of and in the course of employment on November 13, 2009. The defendants admit that this injury is a cause of both temporary and permanent disability. The claimant is not seeking any

type of temporary disability benefits. Claimant does seek additional permanent partial disability benefits. The defendants dispute claimant's entitlement to any further benefits, and in fact, contend claimant has not reached maximum medical improvement. Therefore, permanency cannot be assessed. The elements which comprise the rate of compensation have been stipulated for this date of injury. Affirmative defenses have been waived. There is no claim for medical benefits. Claimant seeks reimbursement for the independent medical evaluations (IME). The defendants dispute the claimant is entitled to the IME expenses sought. The hearing report contains a stipulation regarding the benefits paid. The defendants seek a credit as described in the report. Costs are disputed.

File No. 5056575:

The defendants stipulate claimant suffered an injury which arose out of and in the course of employment on February 12, 2012. The defendants admit that this injury is a cause of both temporary and permanent disability. The claimant is not seeking any type of temporary disability benefits. Claimant does seek additional permanent partial disability benefits. The defendants dispute claimant's entitlement to any further benefits, and in fact, contend claimant has not reached maximum medical improvement. Therefore, permanency cannot be assessed. The elements which comprise the rate of compensation have been stipulated for this date of injury. Affirmative defenses have been waived. There is no claim for medical benefits. Claimant seeks reimbursement for the independent medical evaluations (IME). The defendants dispute the claimant is entitled to the IME expenses sought. The hearing report contains a stipulation regarding the benefits paid. The defendants seek a credit as described in the report. Costs are disputed.

FINDINGS OF FACT

Gregory Strong was 57 years old as of the date of hearing. He was born in Sioux City, Iowa, in 1960. He was raised and educated in South Sioux City, Nebraska. He graduated from high school in 1978 and went on to attain a degree in applied science from South Dakota in 1982. While he was self-employed, he attended Wayne State College on a part-time basis, eventually obtaining a teaching certificate in 1988.

Mr. Strong testified live and under oath at hearing. I find his testimony highly credible and believable. His testimony is consistent with his previous sworn testimony in discovery, as well as the medical documentation in the record. His testimony was straightforward and there was nothing about his demeanor which caused me any concern as to whether he was truthful.

Mr. Strong has a varied and interesting work history, mostly in education. After graduating from South Dakota, he ran his own business repairing and installing heating and air conditioning units until 1987. After attaining his teaching certificate from Wayne State, he held two other teaching/administration positions for educational institutions before becoming employed at Western Iowa Tech Community College (hereafter

"WITCC"). During that time, he also coached various sports. He applied for and was hired as a division chair in instruction beginning in the fall semester of 1999. (Claimant's Exhibit 3, page 7)

Prior to his first work injury in this case, Mr. Strong was generally healthy. He did have a sports-related injury involving his left knee which led to surgeries in 1981, 1982 and 1999. He testified his knee healed well after the 1999 surgery. (Transcript, page 40) Prior to this injury, he was physically active, coaching and playing sports, hunting and fishing, up until his work injury in December 2009. Mr. Strong was also diagnosed with anxiety and sleep apnea in December 2007. He had never experienced any impairments in his right shoulder or low back prior to 2009.

On November 13, 2009, Mr. Strong was in a life-altering automobile accident which arose out of and in the course of his employment. On that date, he traveled with several co-workers to a conference. He was in the front passenger seat. Upon returning, an automobile collided into the right passenger door, where Mr. Strong was sitting. (Cl. Ex. 16, p. 112) Mr. Strong was assisted out of the van through the driver's side. He was taken to the closest hospital, St. Anthony's in Carroll, Iowa. Emergency treatment was provided, including a Toradol injection, and he was released. His main concern at the hospital was his right shoulder. He returned home with his fellow employees after he was released. Since then, the claimant has undergone a long, arduous treatment regimen. The medical file is complex and voluminous.

After a short time, his low back became his main source of pain. He was authorized to receive chiropractic care. (Joint Ex. 4, p. 31) He finally saw his first physician outside of the emergency room, Douglas Martin, M.D., on December 28, 2009. Dr. Martin documented Mr. Strong's primary complaints as his right shoulder and low back. He recommended conservative care, including physical therapy. Mr. Strong followed up with Dr. Martin on January 5, 2010. At that time, Dr. Martin noted some improvement from physical therapy; however, he also described anxiety attacks. He referred claimant to a psychologist, Clayton Toddy, Psy.D. The referral was initially denied.

In February 2010, claimant underwent an MRI and then was referred to Wade Jensen, M.D., an orthopedic surgeon. Dr. Jensen diagnosed right shoulder subacromial impingement. (Jt. Ex. 6, p. 56) He continued Mr. Strong on physical therapy and performed a right shoulder injection on March 29, 2010. (Jt. Ex. 6, p. 59) Both Dr. Martin and Dr. Jensen documented claimant's development of panic attacks. Dr. Martin suggested the likely diagnosis of post-traumatic stress disorder and again recommended referral to a mental health specialist. (Jt. Ex. 5, p. 48) In March 2010, claimant was evaluated by Dr. Toddy who diagnosed post-traumatic stress disorder (PTSD) with intermittent panic attacks. (Jt. Ex. 10, p. 267) Only six visits were authorized at this time. He received treatment from Dr. Toddy until approximately April 2010. (Jt. Ex. 10, p. 269)

Mr. Strong's significant shoulder and low back symptoms continued throughout 2010. In July 2010, claimant was referred to Wade Lukken, M.D., for pain management treatment for his low back. Dr. Lukken diagnosed "left sacroiliitis" and began injections, as well as a prescription for Cymbalta. (Jt. Ex. 9, p. 145)

In October 2010, Dr. Jensen performed surgery on the right shoulder described as "shoulder debridement, biceps tenotomy, subacromial decompression and distal clavicle excision." (Jt. Ex. 6, p. 65) He continued care with Dr. Jensen thereafter, and received an additional injection in December 2010. His complaints, however, did not subside and in April 2011, another MRI was performed. The MRI showed a "recurrence of scar tissue formation that is causing an increase in pain." (Jt. Ex. 6, p. 82) During this time, Dr. Jensen also recommended a radiofrequency ablation (RFA), which had previously been recommended by Dr. Lukken (and denied), for claimant's low back. (Jt. Ex. 6, p. 82) Dr. Lukken had performed some facet injections for the low back which provided modest relief. After the shoulder MRI, two more shoulder injections were provided with no real relief. Conservative care continued for a time. In December 2011, claimant was evaluated by Dean K. Wampler, M.D. (Jt. Ex. 12) Dr. Wampler did not agree with a second shoulder surgery but recommended that claimant proceed with the RFA. (Jt. Ex. 12, p. 330)

Mr. Strong sought mental health treatment from a family medicine practitioner and Sergeant Bluff Family Medicine Center in early January 2012. (Jt. Ex. 13) Michael Jurgens, M.D., placed him on some medications for PTSD and asked him to follow up. (Jt. Ex. 13, p. 331)

Dr. Jensen performed a second surgery on January 24, 2012, described as "AC joint resection and revision subacromial decompression." (Jt. Ex. 6, p. 88) He again, had postoperative treatment including work restrictions, medications and physical therapy. (Jt. Ex. 6, p. 90; Jt. Ex. 7, p. 118)

On February 13, 2012, Mr. Strong suffered a new and distinct injury which arose out of and in the course of his employment. After completing a physical therapy session, he returned to his office at WITCC campus. His right arm was immobilized in a sling. As he was walking down a flight of stairs, he had a sharp, shooting pain in his low back which caused him to fall down. (Tr., p. 75) He was unable to get up and called campus security for assistance. (Tr., p. 78) Mr. Strong did have a history of falling from the low back pain prior to this, which is fairly well-documented in the medical file.

On February 15, 2012, Dr. Lukken performed the RFA. (Jt. Ex. 9, p. 156) Claimant testified that the RFA worked very well and improved his low back symptoms. He testified that the pain relief helped him to stop falling. (Tr., p. 85) On February 20, 2012, Mr. Strong returned to Dr. Jensen. The fall at work is documented. X-rays were taken and claimant was prescribed Percocet and TENS unit for the new pain. (Jt. Ex. 6, p. 62)

On February 20, 2012, Mr. Strong sought treatment with his family clinic for his left knee pain. The treatment note adequately documents the injury and noted the new damage to claimant's left knee. (Jt. Ex. 13, p. 133) He was referred back to CNOS and saw Dr. Jensen for the left knee on March 9, 2012. Dr. Jensen ordered an MRI, which showed a large posterior lateral meniscal tear and chronic degenerative changes. (Jt. Ex. 6, p. 96) Dr. Jensen recommended conservative treatment in hopes of returning the knee back to claimant's pre-injury "asymptomatic" state. (Jt. Ex. 6, p. 97) Management of the medications had fallen upon Dr. Lukken at this point who placed Mr. Strong on hydrocodone. (Jt. Ex. 9, p. 160) An injection was attempted for the knee, but was not terribly effective. Mr. Strong also continued to receive physical therapy for his right shoulder, back and left knee. (Jt. Ex. 8, pp. 132-37)

In April 2012, Mr. Strong returned to Dr. Toddy for cognitive behavioral psychotherapy. (Jt. Ex. 10, p. 270) He has essentially continued with this treatment since that date. The last treatment note in the records is June 15, 2016. (Jt. Ex. 10, p. 321) The working diagnoses from Dr. Toddy have been as follows: (1) posttraumatic stress disorder, (2) major depressive disorder and (3) panic disorder.

In June 2012, Dr. Jensen recommended a total knee replacement. "Given that his symptoms all came after a fall from work, I do believe he needs to proceed with ultimate treatment of this problem." (Jt. Ex. 6, p. 100) On July 16, 2012, Dr. Jensen placed claimant at maximum medical improvement for his right shoulder and low back. (Jt. Ex. 6, p. 101) A few days later he provided a 9 percent whole body impairment rating for the combination of the two injuries. (Jt. Ex. 6, p. 103)

A left knee total arthroplasty was performed on September 20, 2012. (Jt. Ex. 6, p. 104) Dr. Lukken continued to prescribe his medications during this timeframe; he stayed on narcotic pain medications for the right shoulder and left knee. (Jt. Ex. 9, p. 164)

In January 2013, Mr. Strong reported weakness in the left knee. Dr. Jensen limited his hours of work to four per day with a gradual increase in hours. (Jt. Ex. 6, p. 108) In March 2013, Dr. Lukken adjusted Mr. Strong's medications again, suggesting he should wean off oxycontin. (Jt. Ex. 9, p. 177) Mr. Strong had developed nausea and gastrointestinal problems related to the narcotics. He was sent to a specialist in April and May 2013, who provided treatment. (Jt. Ex. 14, p. 345) In May, 2013, Mr. Strong underwent a functional capacity evaluation. The results were invalid. (Jt. Ex. 22, p. 479) On June 13, 2013, Dr. Jensen placed Mr. Strong at maximum medical improvement for his left knee and rated his functional disability at 37 percent of the left lower extremity. (Jt. Ex. 6, p. 115)

There was some discussion between the physicians during this time as to whether claimant had developed complex regional pain syndrome (CRPS). A lumbar sympathetic block was performed in July 2013, which failed (and ruled out CRPS). (Jt. Ex. 9, p. 190)

In August 2013, Mr. Strong was evaluated by Todd Sekundiak, M.D., an orthopedic surgeon specializing in knee replacement revision surgeries. Dr. Sekundiak proposed a surgical option for an additional revision surgery on the left knee. (Jt. Ex. 16, p. 356) Dr. Jensen then referred claimant to Daniel Nelson, M.D., at CNOS. (Jt. Ex. 6, p. 117) Dr. Nelson documented Mr. Strong's significant complaints at that time, which included a burning pain in his knee, particularly when going downstairs, or an incline or uneven surfaces. (Jt. Ex. 15, p. 349) Dr. Nelson, however, initially recommended the use of a brace and did not seem to recommend the surgery suggested by Dr. Sekundiak. Dr. Nelson referred claimant back to Dr. Sekundiak. During the same timeframe, Dr. Lukken treated claimant's worsening back symptoms and discussed the possibility of a spinal cord stimulator. (Jt. Ex. 9, p. 185) Ultimately, however, he recommended to wait to see what further treatment, if any, claimant would get on his left knee. (Jt. Ex. 9, p. 187) Ongoing treatment consequently continued into 2014.

In March 2014, a second RFA was performed due to recurrent low back symptoms. (Jt. Ex. 9, p. 194) This provided good relief again. Throughout 2014, Dr. Lukken continued to provide pain management treatment including significant use of pain narcotics. (Jt. Ex. 9, pp. 192-213) Claimant was unable to reduce his use of the medications due to pain. (Jt. Ex. 9, p. 198) Mr. Strong returned to Dr. Sekundiak in June 2014, who diagnosed "failed total knee arthroplasty" and noted chronic severe left knee pain and instability. (Jt. Ex. 16, p. 361) Mr. Strong decided to proceed with revision surgery, which was finally performed on March 19, 2015. (Jt. Ex. 16, p. 375) Thereafter, he underwent a relatively normal course of postoperative knee treatment. (Jt. Ex. 16, pp. 377-80) The surgery produced some success, but Mr. Strong continued to experience pain and swelling, particularly with activity.

In 2016, Mr. Strong continued with both pain management treatment as well as follow-up care for his left knee. He routinely saw Dr. Lukken and Dr. Sekundiak. In May 2016, Dr. Sekundiak discussed the possibility of yet another revision surgery. (Jt. Ex. 16, p. 401) Another RFA, or alternatively, a spinal cord stimulator, was also discussed with Dr. Lukken around the same time. (Jt. Ex. 9, p. 251) By September 2016, Dr. Lukken was using complex regional pain syndrome as a working diagnosis (in addition to several others). (Jt. Ex. 9, p. 262) On November 22, 2016, in a letter to claimant's counsel, Dr. Lukken recommended the spinal cord stimulator as the best course of treatment. (Jt. Ex. 9, p. 263) Defendants asked for claimant to return to Dr. Sekundiak, which he did in January 2017. Dr. Sekundiak discussed all potential options with the claimant and he was instructed to discuss these matters with his family and "work-comp" and then make a decision to proceed with surgery or the spinal cord stimulator. (Jt. Ex. 16, p. 404) Dr. Sekundiak provided permanent impairment and restrictions in the event that further treatment was not undertaken. (Jt. Ex. 16, p. 409)

On May 31, 2017, Mr. Strong underwent placement of a trial dorsal ganglion root stimulator. (Jt. Ex. 19, p. 447) This was adjusted on June 7, 2017, following the hearing. (Cl. Ex. 17) Mr. Strong ultimately decided not to proceed with the permanent spinal stimulator because the results were "variable." (Cl. Ex. 19)

There are numerous expert medical opinions in the file as well. Philip Ascheman, Ph.D., was retained by defendants to provide opinions about claimant's mental health claims. (Def. Ex. A) He opined claimant suffered from posttraumatic stress disorder with panic attacks. He declined to diagnose agoraphobia. (Def. Ex. A, p. 6) He also declined to diagnose depression. Dr. Ascheman placed claimant at maximum medical improvement for this condition, noting that he had not been in psychotherapy since June 2016, and was stable with medications alone. (Def. Ex. A, p. 7) He did not place any restrictions on Mr. Strong.

Claimant retained Sunil Bansal, M.D. (Cl. Ex. 11) Dr. Bansal prepared a lengthy report which summarized all of the medical records in the case, which are voluminous. Dr. Bansal examined claimant as well and provided the following impairment ratings. For his right shoulder, Dr. Bansal opined claimant suffered an 11 percent whole body rating with significant lifting restrictions of 10 pounds occasional and 5 pounds frequently, as well as no lifting or frequent reaching above the shoulder or away from the body on the right. (Cl. Ex. 11, pp. 76-77) For his low back, he assigned a 5 percent whole body rating, and restrictions of no lifting over 40 pounds occasionally or 20 pounds frequently. (Cl. Ex. 11, pp. 77-78) He rated the left knee at 50 percent of the left lower extremity (20 percent body as a whole) and assigned restrictions of no frequent kneeling, squatting, climbing or twisting; stand/walk as tolerated; and avoid uneven terrain. (Cl. Ex. 11, p. 82-83) He related all of these conditions and impairments to claimant's November 2009, work injury. (Cl. Ex. 11, p. 79)

Claimant also submitted an expert report from Kunal Patra, M.D. (Cl. Ex. 13) Dr. Patra thoroughly reviewed the medical file and evaluated Mr. Strong. When asked to state the diagnoses, Dr. Patra provided three full, single-spaced pages of explanations. (Cl. E. 13, pp. 95-98) I interpret this lengthy explanation to include the following diagnoses (which were underlined in the report): (1) posttraumatic stress disorder; (2) panic disorder with agoraphobia, (3) and major depressive disorder, single episode. (Cl. Ex. 13, pp. 96-98) Dr. Patra conceded that the depressive symptoms were really subsumed in the PTSD diagnosis. (Cl. Ex. 13, p. 98) I interpret this opinion to be that his condition is permanent and that he reached maximum medical improvement. (Cl. Ex. 13, p. 99) Dr. Patra provided various impairment ratings for his different conditions as well (5 percent under three separate categories), although it is somewhat unclear to me what his total rating is. (Cl. Ex. 13, p. 99) Dr. Ascheman and Dr. Patra exchanged rebuttal reports critical of the others' opinions, as well.

CONCLUSIONS OF LAW

The first question is whether the February 12, 2012, injury is an independent injury, or whether it is more appropriately evaluated as a sequela of the original November 13, 2009, injury.

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).

When an injury occurs in the course of employment, the employer is liable for all of the consequences that "naturally and proximately flow from the accident." Iowa Workers' Compensation Law and Practice, Lawyer and Higgs, section 4-4. The Supreme Court has stated the following. "If the employee suffers a compensable injury and thereafter suffers further disability which is the proximate result of the original injury, such further disability is compensable." Oldham v. Scofield & Welch, 222 Iowa 764, 767, 266 N.W. 480, 481 (1936). The Oldham Court opined that a claimant must present sufficient evidence that the disability was naturally and proximately related to the original work injury.

In this case, the parties stipulated the claimant suffered an injury which arose out of and in the course of his employment on November 13, 2009. They also stipulated that he suffered an injury which arose out of and in the course of his employment on February 12, 2012. The second injury was also a direct result of the first injury. The question is, for purposes of assessing the benefits owed, whether benefits should be assessed against the first injury date as a sequela or the second injury date as a new injury. The defendants chose to pay benefits under two separate injuries, while the claimant argues it is really one injury with a sequela.

The medical evidence in this claim establishes definitively that the second incident was both a sequela of the first injury and a new, distinct compensable injury. The claimant had a documented history of falling as a result of his sharp low back pain. The claimant credibly described the fall which occurred down the stairs as a classic sequela-type injury. His treating physician, Dr. Lukken provided a classic expert opinion regarding sequela. (Jt. Ex. 9, p. 240) There is also no doubt that the claimant's second injury was, in fact, an independent injury which arose out of and in the course of employment. I conclude that legally, the claims may be evaluated under either theory.

I find that claimant has met his burden of proof that the second injury is a sequela of the first and the disability is most appropriately evaluated, under the facts and circumstances presented at hearing, as such.

The next issue is the extent of claimant's permanent partial disability.

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

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

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

Although claimant is close to a normal retirement age, proximity to retirement cannot be considered in assessing the extent of industrial disability. Second Injury Fund v. Nelson, 544 N.W. 2d 258 (Iowa 1995). However, this agency does consider voluntary retirement or withdrawal from the work force unrelated to the injury. Copeland v. Boones Book and Bible Store, File No. 1059319, (App. November 6, 1997). Loss of earning capacity due to voluntary choice or lack of motivation is not compensable. Id.

Having reviewed all of the evidence presented by the parties, and considering the appropriate factors of industrial disability, I find that the claimant has suffered a 60 percent loss of earning capacity as a result of his November 13, 2009, work injury.

The claimant was 57 years old at the time of hearing. He is college educated and he is obviously very bright, accomplished and highly-employable. The defendants point out that his earnings have continued to go up significantly after his injury. He has been employed with WITCC since 1999 and his employment is stable. WITCC is obviously an excellent employer. Mr. Strong serves as the Department Chair for Career & Technical Education. This is a high-level and prestigious position. Mr. Strong has a number of valuable skills which would make him highly employable in the competitive job market as well.

The claimant's impairments suffered as a result of his work injury, however, are quite severe. Regarding his low back, claimant suffers from the following diagnoses which were caused or materially aggravated by his automobile accident: (1) lumbar facet syndrome, (2) lumbar spondylosis, and (3) lumbar radiculopathy. (Jt. Ex. 9, p. 262) He has undergone continuous pain management treatment since 2009 for these conditions. While three radiofrequency ablations have kept the symptoms related to these conditions in check, there is no doubt that these conditions, and their corresponding symptoms would severely impact claimant's ability to earn wages in the competitive job market. Regarding his shoulder, claimant underwent subacromial decompression and AC joint resection in 2011 as a direct result of the accident. He has permanent impairment and limitations in his shoulder associated with this injury and resulting surgery. This impairment may be the least disabling of his conditions, he still experiences ongoing pain and symptoms associated with it. Regarding his left knee, claimant has suffered a 50 percent functional disability with a working diagnosis of CRPS, or at minimum chronic pain. He has undergone two total knee replacements yet continues to experience significant difficulties with ambulation. He has undergone a protracted and continuous course of treatment since the 2012, sequela.

The claimant has been treated for chronic pain with a substantial and continuous regimen of narcotic pain medications which has caused ancillary health problems.

His work restrictions are best described by Dr. Sekundiak just prior to hearing as "sedentary activities only." (Jt. Ex. 16, p. 409) The restrictions suggested by Dr. Bansal are much more specific, however, they essentially arrive at the same location. Mr. Strong is substantially limited in his functional activities as a result of his work-related accident.

On top of all of this, claimant has posttraumatic stress disorder and panic disorder as a result of his work injury. There is a debate between the parties as to whether the panic disorder includes an element of agoraphobia. I find this debate to be technical and ultimately of little value to the determination of claimant's overall disability. Dr. Ascheman suggests that the appropriate elements are not present to make such a diagnosis. There is no question Mr. Strong suffers from posttraumatic stress disorder and panic attacks. After significant treatment with medications and four years of psychotherapy, the conditions appear relatively controlled although he still suffers miserable symptoms of depression, anxiety, panic and sleep disturbance, which impact his ability to function. His GAF score at the time of his last visit was 60. His conditions are deemed to be permanent. These conditions undoubtedly affect claimant's employability in the competitive job market in a variety of ways.

Mr. Strong is highly-motivated. While he is appropriately employed in what is essentially a sedentary position, he was previously not limited to such. His job universe has been dramatically and significantly limited as a result of his work injury. His ability to maintain his employment while undergoing continuous treatment for these conditions since 2009, is a tribute to both his own dedication, as well as the good faith efforts of his employer. As I found, the claimant is highly credible. I believe his testimony regarding

his ongoing symptoms, inabilities and difficulties with his life since his injury. If this claim were to be assessed for actual damages, outside of the statutory limitations set by Chapter 85, I suspect his pain and suffering, emotional distress and other common law damages would be much higher. Within the confines of the workers' compensation system, I find that the claimant has suffered a 60 percent loss of access to the competitive employment market.

The parties also dispute the correct commencement date for permanency. The commencement and credit issues are complicated by the fact that this has been processed as two separate injuries. The issue of when permanency benefits commence is now settled.

Pursuant to Iowa Code section 85.34(1) (2015), permanency commences on the date the injured worker "returned to work." Evenson v. Winnebago Industries, 881 N.W.2d 360, 372 (Iowa 2016); see also Iowa Code section 85.34(2) (2015).

In this case, I found that all of the claimant's permanency is attributable to his first injury on November 13, 2009. Based upon the evidence, I find that Mr. Strong initially returned to work from his injury on December 6, 2010. (Jt. Ex. 6, p. 70) The defendants, however, are entitled to a credit for all of the weeks of permanency paid for both claims.

The final issues involve the IME expenses and costs.

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).

Iowa Code section 86.40 states:

> **Costs.** All costs incurred in the hearing before the commissioner shall be taxed in the discretion of the commissioner.

Iowa Administrative Code Rule 876—4.33(86) states:

> **Costs.** Costs taxed by the workers' compensation commissioner or a deputy commissioner shall be (1) attendance of a certified shorthand reporter or presence of mechanical means at hearings and evidential depositions, (2) transcription costs when appropriate, (3) costs of service of the original notice and subpoenas, (4) witness fees and expenses as provided by Iowa Code sections 622.69 and 622.72, (5) the costs of doctors' and practitioners' deposition testimony, provided that said costs do not exceed the amounts provided by Iowa Code sections 622.69 and 622.72, (6) the reasonable costs of obtaining no more than two doctors' or practitioners' reports, (7) filing fees when appropriate, (8) costs of persons reviewing health service disputes. Costs of service of notice and subpoenas shall be paid initially to the serving person or agency by the party utilizing the service. Expenses and fees of witnesses or of obtaining doctors' or practitioners' reports initially shall be paid to the witnesses, doctors or practitioners by the party on whose behalf the witness is called or by whom the report is requested. Witness fees shall be paid in accordance with Iowa Code section 622.74. Proof of payment of any cost shall be filed with the workers' compensation commissioner before it is taxed. The party initially paying the expense shall be reimbursed by the party taxed with the cost. If the expense is unpaid, it shall be paid by the party taxed with the cost. Costs are to be assessed at the discretion of the deputy commissioner or workers' compensation commissioner hearing the case unless otherwise required by the rules of civil procedure governing discovery. This rule is intended to implement Iowa Code section 86.40.

Iowa Administrative Code rule 876—4.17 includes as a practitioner, "persons engaged in physical or vocational rehabilitation or evaluation for rehabilitation." A report or evaluation from a vocational rehabilitation expert constitutes a practitioner report under our administrative rules. Bohr v. Donaldson Company, File No. 5028959 (Arb. November 23, 2010); Muller v. Crouse Transportation, File No. 5026809 (Arb. December 8, 2010) The entire reasonable costs of doctors' and practitioners' reports may be taxed as costs pursuant to 876 IAC 4.33. Caven v. John Deere Dubuque Works, File Nos. 5023051, 5023052 (App. July 21, 2009).

I agree with the defendants that the claimant is only entitled to one IME. The defendants contend that the IME costs are unreasonable. I disagree. With this voluminous record, I do not find Dr. Bansal's IME expense to be unreasonable. The defendants are required to reimburse the IME expenses set forth in Claimant's Exhibit 11, page 85, plus mileage in the amount of $85.32. Defendants are also responsible for the report (only) of Dr. Patra, in the amount of $2,600.00 as set forth in Claimant's Exhibit 13, page 109. In addition, claimant is entitled to additional expenses in the amount of $579.89 as set forth in the attachment to the hearing report. It is noted that defendants contend claimant should pay the cost of his own deposition transcript. I disagree. The transcript was used as an exhibit at hearing. I deem this to be a proper,

allowable and reasonable expense under Section 86.40.

ORDER

THEREFORE IT IS ORDERED

Defendants shall pay the claimant three hundred and fifty (300) weeks of permanent partial disability benefits at the rate of seven-hundred eighty-five and 86/100 ($785.86) per week commencing December 6, 2010.

Defendants shall pay accrued weekly benefits in a lump sum.

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

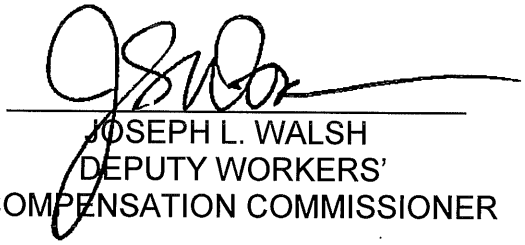
Defendants shall be given credit for the weeks previously paid on both claims.

Defendants shall reimburse the claimant for Dr. Bansal's IME in the amount of four thousand four hundred ninety and no/100 dollars ($4,490.00) as set forth in Claimant's Exhibit 11, page 85, plus medical mileage in the amount of eighty-five and 32/100 dollars ($85.32).

Defendants shall pay the reasonable costs of this action in the amount of three thousand one hundred seventy-nine and 89/100 dollars ($3,179.89).

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

Signed and filed this 18th day of June, 2018.



JOSEPH L. WALSH
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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JLW/kjw

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.