BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

KELLY THOMPSON, Claimant, vs. CURRIES MFG., Employer, and TRAVELERS INDEMNITY CO. OF CT., Insurance Carrier, Defendants.	File Nos. 5061992, 5064256 ARBITRATION DECISION Headnotes: 1402.40, 1403.10, 1702, 1803, 1803.1, 2206, 2501, 2502

FILED
APR 30 2019
WORKERS' COMPENSATION

Claimant Kelly Thompson filed a petition in arbitration on April 23, 2018, File Number 5061992, against the defendants, Curries Manufacturing ("Curries") and Travelers Indemnity Company of Connecticut ("Travelers"), alleging he sustained injuries to his shoulders and neck while working for Curries on January 27, 2017. Thompson filed a second petition on June 26, 2018, File Number 5064256, against Curries and Travelers, alleging he sustained injuries to his bilateral arms and hands while working for Curries on November 27, 2012. Curries and Travelers filed an answer in File Number 5061992, on May 25, 2018, admitting Thompson sustained a work injury, but denying Thompson sustained a permanent injury. Curries and Travelers filed an answer in File Number 5064256, admitting Thompson sustained an injury to his bilateral hands and arms on November 1, 2013, but denying Thompson sustained a permanent disability. Thompson moved to consolidate both files, and the motion was granted.

An arbitration hearing was held on February 22, 2019, at the Division of Workers' Compensation, in Des Moines, Iowa. Attorney Martin Ozga represented Thompson. Thompson appeared and testified. Attorney James Ballard represented Curries and Travelers. Marcia Medley and Amy Schmitt attended the hearing on behalf of Curries and Travelers, but did not testify. Joint Exhibits ("JE")1 through 23, Exhibits 1 through 7 and A through D, were admitted into the record. The record was held open through March 8, 2019, for the receipt of post-hearing briefs. The briefs were received and the record was closed.

Before the hearing the parties prepared a hearing report for each file, listing stipulations and issues to be decided. Curries and Travelers waived all affirmative defenses for both files.

FILE NUMBER 5061992

STIPULATIONS

1. An employer-employee relationship existed between Curries and Thompson at the time of the alleged injury.

2. Thompson sustained an injury on January 27, 2017, which arose out of and in the course of his employment with Curries.

3. Temporary benefits are no longer in dispute.

4. If the injury is found to be the cause of permanent disability, the disability is an industrial disability.

5. The commencement date for permanent partial disability benefits, if any are awarded, is January 28, 2017.

6. At the time of the alleged injury, Thompson's gross earnings were $1,187.04 per week, he was married and entitled to three exemptions, and the parties believe the weekly rate is $749.18.

7. Prior to the hearing Thompson was paid no weeks of permanent partial disability benefits for File Number 5061992.

8. Curries and Travelers paid Thompson seventy-three weeks of permanent partial disability benefits for File Number 5064256, and if Thompson receives an award of permanent partial disability benefits for File Number 5061992, Curries and Thompson are entitled to a credit for permanent partial disability benefits paid to Thompson for File Number 5064256 under Iowa Code section 85.34(7).

9. Costs have been paid.

ISSUES

1. Is the alleged injury a cause of temporary disability during a period of recovery?

2. Is the alleged injury a cause of permanent disability?

3. If the alleged injury is a cause of permanent disability what is the extent of disability?

4. Is Thompson entitled to payment of medical expenses?

5. Is Thompson entitled to recover the cost of an independent medical examination?

6. Is Thompson entitled to payment of medical expenses?

7. Should costs be assessed against either party?

FILE NUMBER 5064256

STIPULATIONS

1. An employer-employee relationship existed between Curries and Thompson at the time of the alleged injury.

2. Thompson sustained an injury on November 1, 2013, which arose out of and in the course of his employment with Curries.

3. The alleged injury is a cause of temporary disability during a period of recovery.

4. Temporary benefits are no longer in dispute.

5. The alleged injury is a cause of permanent disability.

6. If the injury is found to be the cause of permanent disability, the disability is a scheduled member disability to Thompson's right and left arms.

7. If the injury is found to be the cause of permanent disability, the disability is an industrial disability to Thompson's right shoulder.

8. The commencement date for permanent partial disability benefits, if any are awarded, is April 7, 2016.

9. At the time of the alleged injury, Thompson's gross earnings were $1,068.56 per week, he was married and entitled to four exemptions, and the parties believe the weekly rate is $689.21.

10. Prior to the hearing Thompson was paid seventy-three weeks of compensation at the rate of $734.96 per week.

11. Costs have been paid.

ISSUES

1. What is the nature of the injury?

2. What is the extent of disability?

3. Is Thompson entitled to recover the cost of an independent medical examination?

4. Is Thompson entitled to interest on twenty-five weeks of benefits?

5. Should costs be assessed against either party?

FINDINGS OF FACT

Kelly Thompson is married and lives in Mason City, Iowa. (Exhibit 3, page 5). At the time of the hearing Thompson was fifty-two. (Transcript, p. 9) Thompson is right-hand dominant. (Ex. 3, p. 18) In 1985 Thompson graduated from high school. (Tr., p. 9; Ex. 3, p. 6) Thompson did not attend any schooling after high school. (Tr., p. 9; Ex. 3, p. 6)

Curries hired Thompson in August 1985. (Tr., pp. 9-10) Curries manufactures hollow metal frames and doors. (Tr., p. 9) Thompson was first assigned to spot welding, and later moved into roll forming, where the product is bent on a line. (Tr., p. 10) Within roll forming Thompson works on the Dahlstrom line, which punches the hardware in one unit. (Tr., p. 10) Thompson has worked on the Dahlstrom line for the past eighteen to twenty years. (Tr., p. 10; Ex. 3, p. 7)

There are two Dahlstrom lines at Curries Thompson operates that are fifty yards long each. (Tr., pp. 11, 13) The process begins with a 10,000 pound steel coil that is 11/164 wide. (Tr., p. 11) The line rolls the coil down to a straightener into a pre-punched area where the hardware is punched, and the line moves the product into a pit and into a mill that forms the stop and the wings on the rail, and then moves the product to rehit dies that punch the locks, hinges, and miters. (Tr., p. 11) The product then moves to another mill that forms the face and goes through an end cut-off die that cuts off the product into pieces. (Tr., p. 11) Thompson is responsible for making sure the line is running and stacking the rail after it comes out on the conveyor. (Tr., p. 11)

Thompson uses hand shears to cut the steel at the beginning and end of the coil and when there is a defective piece in the steel. (Tr., p. 12) Defective steel is put into a junk tub and when a pile accumulates, Thompson removes the pile, weighing between seventy and eighty pounds from the junk tub. (Tr., pp. 12-13) Thompson also removes steel pieces at the end of the line and places the pieces in four stacks for each line. (Tr., p. 13) Thompson uses a scissor lift on a table where he stacks the steel, but when the line is full he has to off-stack or off-load product weighing fifteen pounds and push it six to seven feet onto an automated line. (Tr., pp. 13-14)

Thompson's job description, Exhibit C, provides that he does not have to lift over ten pounds. (Tr., p. 14) Thompson disagreed and reported he has to off-load footers that are ten feet by six feet and weigh between twenty-five and thirty pounds onto a cart. (Tr., p. 14)

In 2012, Thompson started experiencing numbness and tingling in his hands and elbows. (Tr., p. 14) Thompson reported he spoke with a person in human resources at Curries about the problems and the human resources person provided him with arm bands to wear and sleeves at night. (Tr., p. 14) Thompson performed his regular job on the Dahlstrom line. (Tr., p. 16) Thompson reported he continued to have problems with his hands and arms, including tingling sensations, loss of grip, numbness, and a feeling that his upper extremities were falling asleep. (Tr., p. 15)

On November 1, 2013, Thompson was caught up with his work, so Curries moved him to feed a drywall roll former where he had to feed the machine with product by pulling stacks with 150 pieces up onto the conveyors. (Tr., p. 16) While pulling a stack Thompson strained his right shoulder and reported his work injury to Curries. (Tr., p. 16)

On December 2, 2013, Thompson attended an appointment with Howard Kim, M.D. with Healthworks Occupational Health, complaining of right shoulder pain, bilateral elbow pain for several years, and bilateral hand numbness and pain. (JE 1, p. 1) Thompson reported he had right shoulder problems fifteen years earlier following a work injury, which resolved, until he reinjured his right shoulder three weeks ago while feeding a roll form onto a conveyor. (JE 1, p. 1) Thompson relayed he had right shoulder pain and difficulty reaching above the shoulder with his right arm. (JE 1, p. 1) Thompson further reported the numbness and pain in his hands interfered with his sleep, causing him to wake up. (JE 1, p. 1) Thompson also stated he was having difficulty straightening his right arm at the elbow fully when compared with his left arm, and reported he had been using bilateral elbow bands. (JE 1, p. 1) Dr. Kim ordered a right shoulder x-ray, electromyography studies of Thompson's bilateral upper extremities, dispensed bilateral wrist splints, ordered physical therapy and occupational therapy, prescribed Relafen, and imposed work restrictions of sedentary activity with pushing and pulling up to ten pounds, to avoid forceful and firm gripping with the hands bilaterally, and to avoid above shoulder level activity. (JE 1, p. 2)

On December 10, 2013, Thompson underwent electromyography with Sant Hayreh, M.D. (JE 2, p. 13) Dr. Hayreh noted the findings were compatible with bilateral carpal tunnel syndrome, mild on the right side, and moderate on the left side, and mild right ulnar neuropathy at the elbow. (JE 2, p. 13)

Thompson returned to Dr. Kim on December 13, 2013, complaining of continuing numbness, pain, and tingling in both hands, right shoulder discomfort, and right elbow pain on the medial side. (JE 1, p. 3) Dr. Kim noted electromyography revealed bilateral carpal tunnel syndrome and mild right ulnar neuropathy at the elbow. (JE 1, p. 3) Dr. Kim assessed Thompson with right shoulder pain, mild right ulnar neuropathy, and bilateral carpal tunnel syndrome, referred Thompson for an orthopedic consultation, and continued his occupational and physical therapy and Relafen. (JE 1, p. 3)

Thompson continued to remain symptomatic and Dr. Kim ordered right shoulder magnetic resonance imaging during an appointment on December 30, 2013. (JE 1, p. 4)

On January 8, 2014, Thompson attended an appointment with Rene Recinos, M.D., a hand surgeon. (JE 3, p. 15) Dr. Recinos documented Thompson performed remodeling side jobs, and while recently siding his hand was so weak he could not wield a hammer. (JE 3, p. 15) Dr. Recinos listed an impression of bilateral carpal tunnel syndrome and right cubital tunnel syndrome. (JE 3, p. 16) Dr. Recinos imposed restrictions of limiting repetitive motion and from using vibrating power tools, and ordered Thompson to use splints while sleeping only. (JE 3, p. 17) Thompson denied performing a lot of side jobs and testified he was performing jobs around his house and helping a friend. (Tr., pp. 45-46)

On March 26, 2014, Thompson underwent a right diagnostic arthroscopy with subacromial decompression and mini open rotator cuff repair with Timothy Gibbons, M.D., an orthopedic surgeon. (JE 4, p. 18) Following surgery, Dr. Gibbons diagnosed Thompson with a right shoulder rotator cuff tear. (JE 4, p. 18) Thompson was off work for nine weeks and returned to his work on the Dahlstrom line. (Tr., p. 19)

On February 28, 2015, Dr. Gibbons performed a right endoscopic carpal tunnel release and right cubital decompression on Thompson. (JE 5, p. 21) Following surgery, Dr. Gibbons diagnosed Thompson with right carpal tunnel syndrome and right cubital tunnel syndrome. (JE 5, p. 21)

On March 25, 2015, Dr. Gibbons performed a left endoscopic carpal tunnel release and left cubital tunnel release on Thompson. (JE 6, p. 23) Following surgery, Dr. Gibbons diagnosed Thompson with left carpal tunnel syndrome and left cubital tunnel syndrome. (JE 6, p. 23)

Thompson attended an appointment with Dr. Gibbons on May 19, 2015. (JE 7, p. 25) Dr. Gibbons examined Thompson, noted Thompson reported he was "doing great" and released him to full duties as tolerated. (JE 7, pp. 25-26) Using the Guides to the Evaluation of Permanent Impairment (AMA Press, 5th Ed. 2001) ("AMA Guides"), Dr. Gibbons opined Thompson had sustained a zero percent permanent impairment, and noted Thompson had been released without restrictions. (JE 7, p. 27)

Thompson returned to Dr. Gibbons on August 6, 2015, complaining of bilateral hand tingling, and reporting his fingertips were problematic. (JE 7, p. 29) Dr. Gibbons referred Thompson to a neurologist. (JE 7, p. 30)

On October 2, 2015, Thompson attended an appointment with Anu Baweja, M.D., a neurologist. (JE 12, p. 56) Dr. Baweja examined Thompson and assessed him with bilateral hand numbness, pain in both wrists, and pain in both elbows. (JE 12, pp. 50-51) Thompson reported he had bilateral hand numbness, worse on the right and worse with activities involving gripping and grabbing fine instruments and tools. (JE 12,

p. 52) Thompson further relayed he had trouble twisting bottle caps, dropping things, wrist achiness, and problems with driving, texting, and typing, which require him to shake or alternate his hands constantly. (JE 2, p. 52) Thompson noted that his hands were not waking him up at night anymore, but he had wrist achiness that tended to radiate up to his elbow. (JE 12, p. 52) Dr. Baweja recommended electromyography. (JE 12, p. 53)

On October 19, 2015, Thompson returned to Dr. Baweja. (JE 12, p. 56) Dr. Baweja documented the electromyography was abnormal and showed evidence of "very mild median neuropathy at or distal to the bilateral wrists, as seen in carpal tunnel syndrome, possibly residual after carpal tunnel release surgery." (JE 12, p. 56) Dr. Baweja further noted there was no evidence of cubital tunnel syndrome on either elbow, and dispensed elbow pads given Thompson's symptoms suggested ulnar neuritis. (JE 12, p. 56) Dr. Baweja assessed Thompson with bilateral carpal tunnel syndrome that may be residual or recurrent, but mild in nature, and pain in both elbows, worse on the left, and prescribed gabapentin. (JE 12, pp. 56-57)

On December 1, 2015, Thompson attended an appointment with Dr. Gibbons, complaining of constant tingling in his hands, mainly in the distal median nerve distribution, and "tweaks in his elbow where the ulnar nerve, when he cranks something, seems to sublux." (JE 7, p. 31) Dr. Gibbons recommended a right ulnar nerve transposition and a right open carpal tunnel release. (JE 7, p. 31)

Dr. Gibbons performed a right ulnar nerve transposition intramuscular and a right open carpal tunnel release on Thompson on January 6, 2016. (JE 8, p. 33) On March 23, 2016, Dr. Gibbons performed a left ulnar nerve transposition intramuscular and a left open carpal tunnel release on Thompson. (JE 9, p. 35)

On April 5, 2016, Thompson attended a follow-up appointment with Dr. Gibbons. (JE 10, p. 37) Dr. Gibbons released Thompson to return to work and prescribed Norco. (JE 10, p. 38)

During an appointment with Dr. Gibbons on May 17, 2016, Thompson reported he was still having pain, especially in his elbows, and he did not believe his grip strength was coming back. (JE 10, p. 39) Dr. Gibbons documented Thompson requested Dr. Gibbons release him to his regular duties even though that would cause him some pain with gripping because his regular assignment was better than the alternative assignment at Curries. (JE 10, p. 39) Dr. Gibbons released Thompson to full duty without restrictions and found Thompson had reached maximum medical improvement. (JE 10, p. 40)

On June 28, 2016, Thompson returned to Dr. Gibbons reporting he had returned to regular duty and he did not believe he had made any progress throughout his treatment, noting his hands still go numb and he has pain in his elbows. (JE 10, p. 41) Dr. Gibbons ordered nerve conduction velocity testing and released Thompson to return to his normal duties. (JE 10, p. 42)

On January 27, 2017, the Dahlstrom line was full, so Thompson had to off-load the product to the side of the conveyor instead of using the scissor lift. (Tr., p. 24) Thompson off-loaded the product into a stationary cart approximately two feet off the ground. (Tr., p. 24) When the cart was full Thompson had to push the cart six feet before it would grab onto the automated rollers that would pull it down the rest of the way. (Tr., p. 24) Thompson relayed the cart weighed between 400 and 500 pounds and contained approximately 270 pieces of material. (Tr., p. 24) As he was pushing the cart down the line the cart stalled in a dip in the conveyor, which required Thompson to push it over the hump. (Tr., p. 24) Thompson pushed the cart and it went about three feet before it stalled and he kept trying to push it. (Tr., p. 24)

Thompson's coworker, Dave Cobb, came over to assist Thompson and helped him push the cart the rest of the way. (Tr., p. 24) When Thompson and Cobb pushed the cart Thompson noticed he had pain in his right and left shoulder, with the left being worse than the right. (Tr., p. 25) Thompson testified when he and Cobb pushed the cart Thompson had his hands stretched out in front of his and his knees were hitting the rollers. (Tr., p. 25) Thompson reported he did not immediately have problems with his neck and he thought his problems were in his shoulders. (Tr., p. 25) Thompson testified he had not had any problems with his neck or left shoulder before the January 27, 2017 work injury. (Ex. 3, p. 31)

Rajinder Verma, M.D., a neurologist, conducted electromyography on Thompson on March 9, 2017. (JE 10, p. 43) Dr. Verma noted the study was normal for both upper extremities. (JE 10, p. 43)

Thompson returned to Dr. Gibbons on March 23, 2017, reporting he was performing his normal duties, but still experiencing tingling in his hands and a sense of weakness in his grip, noting vibratory tools particularly irritate his condition, and he is aware of elbow pain. (JE 10, p. 45) Dr. Gibbons examined Thompson and noted, "[h]e has incredible grip strength. I did not formally test it, as I know he would easily be within normal limits," noted his sensation was intact to light touch, and nerve conduction studies showed distinct improvement in both the median and ulnar nerves compared to the studies in 2013. (JE 10, p. 45) Dr. Gibbons listed an impression of bilateral cubital tunnel and bilateral carpal tunnel syndrome, and noted Thompson may benefit from a neurology consultation and noted he could get a second opinion. (JE 10, p. 45)

On March 27, 2017, Thompson attended an appointment with John Swisher, D.O., a family medicine provider, for a preventative visit. (JE 13, p. 58) Dr. Swisher documented Thompson had been experiencing constant numbness in his bilateral hands and elbows for one year. (JE 13, p. 62) Dr. Swisher did not note Thompson had any problems with his neck or shoulders.

On June 6, 2017, Thompson attended an appointment with Samuel Hunt, M.D., with Healthworks Occupational Health, and complaining of a persistent achy discomfort that has become progressively worse since he injured himself at work. (JE 1, p. 5) Dr.

Hunt assessed Thompson with bilateral shoulder bursitis, and prescribed a prednisone burst. (JE 1, pp. 6-7)

During an appointment with Dr. Kim on June 20, 2017, Dr. Kim ordered shoulder x-rays, recommended physical therapy for his shoulders, and prescribed Voltaren. (JE 1, pp. 9-10)

On July 19, 2017, Thompson underwent magnetic resonance imaging of his left shoulder. (JE 17, p. 99) The reviewing radiologist listed an impression of:

> 1. Diffuse articular surface partial tearing of the supraspinatus and infraspinatus tendons but without full thickness component. Intrasubstance laminar extension is identified extending along the myotendinous junction of the infraspinatus.
>
> 2. Diffuse bursal surface fraying.
>
> 3. Trace subacrominal/subdeltoid bursal fluid with mild hypertrophic change at the AC joint.
>
> 4. Intact long head of the biceps tendon.
>
> 5. Degenerative signal change within the superior glenoid labrum but without frank labral detachment. However there is a small accompanying paralabral cyst.

(JE 17, pp. 99-100) Thompson also underwent right shoulder magnetic resonance imaging, and the reviewing radiologist listed an impression of:

> 1. Status post supraspinatus and infraspinatus rotator cuff tendon repair with retained screws within the humeral head. No full-thickness defect is seen. Postsurgical changes are noted within the repaired tendons. Mild articular surface fraying.
>
> 2. Intact glenoid labrum and long head of biceps tendon.
>
> 3. Trace subacrominal/subdeltoid bursal fluid. Mild degenerative change of the AC joint.

(JE 18, p. 101)

Thompson returned to Dr. Kim on July 5, 2017, complaining of bilateral shoulder pain and neck pain. (JE 1, p. 11) Dr. Kim discontinued Thompson's physical therapy because the therapy was causing increased neck pain and not helping his shoulder pain. (JE 1, p. 11) Dr. Kim assessed Thompson with bilateral shoulder pain and neck pain, recommended he undergo x-rays and cervical magnetic resonance imaging, and referred him to orthopedics. (JE 1, p. 11)

Thompson underwent cervical spine magnetic resonance imaging on July 7, 2017. (JE 16, p. 97) The reviewing radiologist listed an impression of:

> 1. Moderate to fairly prominent broad-based disc osteophyte complex C6-7 with at least moderate LEFT foraminal stenosis and early right-sided involvement as well.
>
> 2. Fairly mild broad-based disc bulge C5-6 versus disc osteophyte complex.
>
> 3. C4-5 mild broad-based disc bulge.
>
> 4. C3-4 mild broad-based disc bulge with bilateral foraminal stenosis to a degree from uncinated process hypertrophy.
>
> 5. C6-7 degenerative disc disease and spondylosis.
>
> 6. Flattened cervical lordotic curvature.

(JE 16, p. 98) During an appointment on July 14, 2017, Dr. Kim noted the magnetic resonance imaging showed disc bulges at C6 and C7, and referred Thompson to orthopedics. (JE 1, p. 12)

On August 1, 2017, Thompson returned to Dr. Gibbons reporting he did not have the grip strength he was accustomed to having, he was experiencing tingling in his hand, and he had undergone a cervical workup that showed he had bulging discs. (JE 10, p. 47) Dr. Gibbons examined Thompson, found he had a powerful grip on both sides, grossly he had no deficiencies, and his elbows had full extension, flexion, and supination. (JE 10, p. 47) Dr. Gibbons released Thompson to regular duty without restrictions and found he had reached maximum medical improvement. (JE 10, p. 48)

On August 30, 2017, Thompson attended an appointment with Steven Aviles, M.D., an orthopedic surgeon with Iowa Ortho, complaining of bilateral shoulder pain that is aching and sharp with an onset of January 27, 2017, and numbness, tingling, and weakness in the arms he attributed to cubital tunnel surgery. (JE 19, p. 103) Dr. Aviles documented Thompson's pain started after he lifted a steel frame, and he had burning in his shoulders at work. (JE 19, p. 103) Dr. Aviles documented his examination showed minor inconsistencies in the bilateral shoulders. (JE 19, p. 103) Dr. Aviles documented on examination of the bilateral shoulders Thompson had external rotation of 90 degrees, abduction of 90 degrees, internal rotation of 90 degrees, and flexion of 180 degrees, with painful passive range of motion, and crepitus in the right only. (JE 19, p. 104) Dr. Aviles opined magnetic resonance imaging from July 19, 2017, and examination of the right shoulder showed mild arthritis with anchors, with intact biceps and rotator cuff with no bursitis or evidence of impingement, and magnetic resonance imaging from July 19, 2017, and examination of the left shoulder showed mild tendinopathy and intact superior labrum and biceps. (JE 19, p. 105) Dr. Aviles noted:

> [h]is magnetic resonance imagings show no evidence of any significant disease. His rotator cuff repair is stout and strong and he shows no evidence of biceps pathology on the RIGHT side. There is no bone spurring. With regards to the LEFT side, he has some mild bruising of the rotator cuff but no evidence of tearing. The biceps is unremarkable as well, there is a small bone spur. He exhibits more biceps pathology on the LEFT side. The RIGHT side looks very healthy and I do not think there are any other treatment options I can provide. He has already failed physical therapy. I will try an intra-articular corticosteroid injection under fluoroscopic guidance for the LEFT shoulder. I will see him back afterwards. The only restriction I am providing is avoidance of overhead activity.

(JE 19, p. 105)

Thompson also attended an appointment with Trevor Schmitz, M.D., an orthopedic surgeon with Iowa Ortho, on August 30, 2017, regarding his neck pain with an onset of January 27, 2017. (JE 20, pp. 113, 116) Thompson reported severe bilateral posterior neck and bilateral shoulder pain radiating into his hands that has been getting progressively worse, which he described as aching, dull, sharp, stabbing, and tingling. (JE 20, pp. 113, 116) Dr. Schmitz noted the pain developed when Thompson was pushing stacks of steel frames and is aggravated by flexion, hyperextension, lifting, and pushing, and relieved by rest. (JE 20, pp. 113, 116) On examination, Dr. Schmitz noted Thompson had painless functional range of motion at the shoulders, elbows, wrists, and digits, but pain with rotator cuff testing. (JE 20, pp. 113, 117) Dr. Schmitz further noted upper extremity neurological testing showed "[u]pper extremity motor strength is 5/5 at the shoulders, elbows, wrists, and digits bilaterally. Give way weakness with bilateral wrist muscle testing. Sensation intact to touch bilaterally C5 through T1. Deep tendon reflexes 2+ at the biceps, brachioradialis, and triceps. No pathologic reflexes. Spurling's sign is negative. Lhermitte's sign is negative." (JE 20, pp. 114, 117)

Dr. Schmitz reviewed Thompson's magnetic resonance imaging, and ordered an x-ray. (JE 20, pp. 114, 118) Dr. Schmitz opined Thompson likely had a hemangioma lipoma at T1, severe disc degeneration at C6-C7, no obvious evidence of central foraminal stenosis at C2-C3, a broad-based disc bulge at C3-C4 with bilateral foraminal stenosis, a broad-based disc bulge at C4-C5 with mild left and no right-sided foraminal stenosis, a broad-based disc bulge at C5-C6 with no significant central foraminal stenosis, and moderate left-sided foraminal stenosis at C6-C7 with questionable right-sided foraminal stenosis, and no evidence of pathology at C7-T1. (JE 10, pp. 114, 118) Dr. Schmitz also reviewed Thompson's right shoulder magnetic resonance imaging, which showed no full thickness defect, partial tearing of the supraspinatus and infraspinatus tendons, hypertrophy of the AC joints, degenerative signal changes in the superior glenoid labrum with no frank labral detachment, and a paralabral cyst. (JE 10, pp. 114, 118) Dr. Schmitz reviewed Thompson's electromyography of his bilateral upper extremities from March 9, 2017, and found the examination was normal. (JE 10,

pp. 114, 118) Dr. Schmitz opined findings on examination were consistent with a shoulder source for his pain, noted he did not have a good explanation for the numbness and tingling, but he did think a significant portion of Thompson's pain was stemming from his shoulders, and he did not see an obvious finding on cervical spine magnetic resonance imaging that could explain Thompson's symptoms, and he documented he had discussed his findings with Dr. Aviles. (JE 20, pp. 114, 118) Dr. Schmitz released Thompson to return to work without restrictions. (JE 20, p. 119)

On September 14, 2017, J. Wesley Rayburn, M.D., a pain specialist with Iowa Ortho, performed a left shoulder injection on Thompson. (JE 21, p. 120) Thompson testified the injection did not help him. (Tr., p. 28; Ex. 3, p. 41)

On October 2, 2017, Thompson returned to Dr. Aviles, reporting daily symptoms in his shoulders aggravated by reaching up. (JE 19, p. 107) Dr. Aviles noted Thompson had some mild tendinopathy on the left and "[h]is exam does suggest some evidence of biceps problems but the corticosteroid injection intra-articularly did not give him any lasting relief" and he had failed physical therapy. (JE 19, p. 107) Dr. Aviles found he did not have anything to offer Thompson, opined he had reached maximum medical improvement, and released him with no restrictions finding he had minimal disease on magnetic resonance imaging. (JE 19, pp. 108-11)

Thompson testified after Dr. Aviles released him Travelers informed him he was not going to receive any additional care and he could receive care with his own physician. (Tr., pp. 29, 52) On November 21, 2017, Thompson attended an appointment with Dr. Swisher, his personal physician, complaining of worsening neck pain with stiffness and numbness from the elbow to his fingers with tingling in his arms that is aggravated by looking down with an onset of six months ago, and bilateral shoulder pain that is constant and stable with an onset date of January 27, 2017, he described as aching, burning and sharp, with shoulder popping, that interferes with his sleep. (JE 13, p. 66; Tr., pp. 29-30) Dr. Swisher assessed Thompson with bulging of a cervical intervertebral disc, partial left rotator cuff tear, right shoulder impingement syndrome, bilateral upper extremity neuropathy, left shoulder bursitis, and history of right rotator cuff repair, administered bilateral shoulder injections, and referred Thompson to Ronald Kloc, D.O., for pain management. (JE 13, pp. 69-75)

Thompson attended an appointment with Dr. Kloc for pain management on November 28, 2017. (JE 22, p. 123) Dr. Kloc listed an impression of a disc bulge at C6-C7, and bilateral arm radiculopathy, and recommended Thompson undergo cervical epidural steroid injections. (JE 22, p. 124) Thompson reported relief after three cervical epidural injections, and rated his pain a one to two out of ten. (JE 22, pp. 125-28)

At the request of Thompson, Curries and Travelers scheduled a second opinion evaluation for Thompson with Benjamin Paulson, M.D., an orthopedic surgeon specializing in hand and upper extremity surgery with Iowa Ortho. (JE 23, p. 130) During the December 1, 2017 appointment, Dr. Paulson assessed Thompson with right and left carpal tunnel and cubital tunnel syndrome and released him to return to work

without restrictions. (JE 23, pp. 130-32) Dr. Paulson noted Dr. Gibbons had placed Thompson at maximum medical improvement and issued a zero percent impairment rating for his right and left upper extremities on August 1, 2017. (JE 23, p. 133) Using the AMA Guides and range of motion testing on examination, Dr. Paulson opined:

> [u]sing Table 16-28 on page 467 and Figure 16-31 on page 469 he has normal range of motion of her [*sic*] wrist, so gets no impairment due to loss of range of motion of the wrist. With his elbow, he is getting 70 degrees of supination and 75 degrees of pronation with each side. Using Figure 16-37 on page 474 having 75 degrees of pronation on each side would be a 0.5% impairment and having 70 degrees of supination would be a 0% impairment. He also does not have full range of motion with extension and flexion of his elbows. On the right, he is getting 25-130 and by using Figure 16-34 on page 472, 25 degrees from full extension would be a 2.5% impairment and flexion to 130 would be an additional 1. Combining the 0.5% with the 2.5% with the 1% on the right totals a 4% impairment of the right due to loss of range of motion. With the left, he is getting 15-120 and by again using Figure 16-34 on page 474-572 having 15 degrees of full extension would be a 1.5% impairment, and flexion to 120 would be a 2% impairment. Combing the 1.5 with 2 with 0.5 again totals a 4% impairment of the left upper extremity due to loss of range of motion. I do not see any documentation of the patient having decreased range of motion of his elbow before, so I cannot say if this was present before his surgeries.
>
> The patient does have some decreased grip strength, but by using section 16.8 on page 507 I would not give him any impairment due to decreased grip strength due to the fact that he has no significant motor loss or injury that would cause a decreased grip strength and in addition it is not appropriate to give strength impairment when there is some decreased range of motion.
>
> With the patient's continued numbness and tingling this is somewhat a judgment call on what to give him an impairment rating. Under the section of carpal tunnel syndrome on page 495 Column 1 with a normal nerve conduction study he would fall under category 3 for a normal nerve study, which would be a 0% impairment for carpal tunnel syndrome. The patient though did have 2 carpal tunnel releases on each side and does still report he has significant numbness and tingling and is having trouble with 2-point sensation. This does not quite fit with the nerve conduction study. Of course, nerve conduction studies are not always 100% accurate, but in general, they do give objectionable data. I certainly feel it is reasonable with the patient's 2 surgeries and having some symptoms to estimate an impairment of 1% of both the right and the left for residual carpal tunnel syndrome seems appropriate. Likewise, with cubital tunnel syndrome the ulnar nerve has a maximum of 7% for sensory

> deficit or pain by using Table 16-15 on page 492. Again the patient has normal findings on a nerve conduction study but also by using Table 16-10 section A on page 482 he does report significant pain and loss of sensation in the ulnar nerve distribution. Again the nerve conduction study is objectionable data, but it is not always 100% correct. Though in general it does give a reasonable finding, I doubt it is significantly off. The most I would anticipate would be a 10% sensory deficit of the ulnar nerve, and multiplying 10% by 7% would give 0.7% for impairment for both the right and the left upper extremities due to residual cubital tunnel syndrome. This would round to a 1%.
>
> Therefore, I think it is reasonable to give the patient a 4% impairment of both the right and left upper extremities due to loss of range of motion, 1% for residual carpal tunnel syndrome, and 1% for residual cubital tunnel syndrome. This combines for a total of 6% impairment of the right upper extremity and a 6% impairment of the left upper extremity.

(JE 23, pp. 133-34)

Thompson returned to Dr. Swisher on January 3, 2018, and reported his pain had been relieved by injections. (JE 13, p. 76)

On February 14, 2018, Dr. Gibbons issued an impairment rating to Travelers, noting in December 2017, he assigned Thompson an eight percent permanent impairment rating, and he had reviewed Thompson's chart and his opinion had not changed. (JE 11, p. 49) Dr. Gibbons noted he had been asked to review Dr. Paulson's impairment rating from December 1, 2017, and noted:

> I disagree with Dr. Paulson' rating. He used the criteria for range of motion at the elbows for 4% of his impairment rating. At the time of my examination of this patient, I did not detect any restriction in range of motion in either upper extremity. Dr. Paulson also gives the patient a 1% impairment rating for carpal tunnel syndrome and cubital tunnel syndrome 1%, for combined total of 6%, but Dr. Paulson admitted that he had no objective evidence for assigning these 1% values based on the *American Medical Association Guide to Evaluation of Permanent Impairment*, Fifth Edition. His 1% assignment at each diagnosis was purely subjective. Therefore, I disagree completely with Dr. Paulson's 6% impairment rating and I am confident in [*sic*] my 0% impairment rating more accurately reflects the patient's condition using the *American Medical Association Guide to Evaluation of Permanent Impairment*, Fifth Edition.

(JE 11, p. 49)

During an appointment with Thompson on February 27, 2018, Dr. Kloc listed an impression of brachial neuritis and cervical disc displacement, and prescribed Lyrica for

pain management. (JE 22, p. 129) Thompson testified that after he saw Dr. Kloc on February 27, 2018, he has not received any additional treatment for his neck or shoulders. (Tr., p. 32)

On March 7, 2018, Dr. Aviles issued an opinion letter in response to a request from Travelers, as follows:

> I am in receipt of Dr. Swisher's notes dated November 21, 2017. I have reviewed these notes in detail. According to your letter, dated February 28, 2018, Dr. Swisher has related at least some element of his subjective complaints to a work-related injury. I respectfully disagree with Dr. Swisher on this matter. His evaluation and his records do not change how I feel about Mr. Thompson's complaints on October 2, 2017. I placed him at maximum medical improvement. I returned him back to work without restrictions. I do not see any need to change. My opinion has not changed regarding Mr. Thompson's shoulders. Dr. Swisher's notes do not change how I feel on this matter.

(JE 19, p. 112)

Thompson continued to treat with Dr. Swisher, his primary care provider. (JE 13, pp. 79-94) During an appointment on April 2, 2018, Dr. Swisher documented Thompson reported no problems with back pain, neck pain, joint swelling, and muscle swelling. (JE 13, p. 85) Dr. Swisher noted on neurological examination Thompson had intact sensation to light touch, a moderate group, and 4/5 external rotation of the shoulders, and he reported feeling tingling. (JE 13, pp. 85-86)

John Kuhnlein, D.O., an occupational medicine physician, conducted an independent medical examination for Thompson on December 28, 2018, and issued his report on January 8, 2019. (Ex. 1) Dr. Kuhnlein reviewed Thompson's medical records and examined him. (Ex. 1, pp. 1-13) With respect to the November 27, 2017 injury date, Dr. Kuhnlein diagnosed Thompson with bilateral carpal and cubital tunnel syndromes with residual dysfunction and a right shoulder rotator cuff tear with arthroscopic subacromial decompression and mini-open rotator cuff repair. (Ex. 1, p. 14) With respect to the January 27, 2017 injury date, Dr. Kuhnlein diagnosed Thompson with degenerative disc disease of the cervical spine with resolved radiculopathy and chronic myofascial cervical spine pain, resolved right shoulder impingement syndrome with mild acromioclavicular joint osteoarthritis, and left shoulder impingement syndrome with mild acromioclavicular joint osteoarthritis and diffuse articular partial rotator cuff tear. (Ex. 1, p. 14)

Dr. Kuhnlein opined Thompson's bilateral carpal and cubital tunnel syndromes were related to his work for Curries on a cumulative basis. (Ex. 1, p. 14) With respect to the January 27, 2017 injury date, Dr. Kuhnlein opined the specific incident where Thompson was pushing a 400 to 500 pound cart that settled on the rollers so it could not move "lit up" the impingement syndrome in both of his shoulders, noting the right

shoulder impingement syndrome resolved with Dr. Swisher's injection, and that Thompson has ongoing left shoulder pain. (Ex. 1, p. 15) Dr. Kuhnlein further opined the work injury lit up degenerative disc disease in the cervical spine, noting Thompson originally had a radiculopathy that had resolved to cervical myofascial pain. (Ex. 1, p. 15)

Dr. Kuhnlein recommended a formal consultation with Dr. Paulson for further bilateral and carpal tunnel syndrome treatment, intermittent epidural injections to address Thompson's neck pain, stretching exercises for his neck, and ice when necessary. (Ex. 1, p. 15) Given Thompson responded to the right shoulder injection performed by Dr. Swisher, Dr. Kuhnlein recommended a referral to James Nepola, M.D., at the University of Iowa Hospitals and Clinics for his left shoulder condition. (Ex. 1, p. 15) Dr. Kuhnlein recommended Thompson wear elbow pads at night. (Ex. 1, p. 15)

Dr. Kuhnlein found Thompson had reached maximum medical improvement for his carpal and cubital tunnel syndrome conditions on or about March 23, 2017, and for the initial shoulder injury on or about September 26, 2014. (Ex. 1, p. 16) Dr. Kuhnlein further opined if Thompson declined further treatment, Thompson reached maximum medical improvement for his right shoulder on or about November 21, 2017, when Dr. Swisher injected it, and for the left shoulder on November 21, 2017. (Ex. 1, p. 16) With respect to his neck condition, Dr. Kuhnlein opined Thompson had reached maximum medical improvement on February 27, 2018, his last visit with Dr. Kloc. (Ex. 1, p. 16)

Using the AMA Guides, Dr. Kuhnlein opined:

> [w]ith respect to the right carpal tunnel syndrome, and turning to page 495, Mr. Thompson also has abnormal two-point discrimination, with positive clinical findings in the context of negative nerve conduction studies. For impairment rating purposes, he would not fit neatly into the category as outlined on page 495. Empirically, the rating should be more than zero as it would be for the right carpal tunnel syndrome because Mr. Thompson sustained a loss or loss of use of the right median nerve, as he has ongoing symptoms, as well as objective findings on examination. During the two surgical procedures performed by Dr. Gibbons, the transverse carpal ligament was excised in both cases, and so there was a physical change in the right carpal tunnel as a result of Dr. Gibbons' treatment, so the rating would not be zero. In this case, I believe the rating would be 3% right upper extremity impairment.
>
> With respect to the right cubital tunnel syndrome, Mr. Thompson has abnormal two-point discrimination in the ulnar nerve distribution, with positive clinical findings suggesting ongoing ulnar nerve entrapment. Turning to Table 16-15, Page 492, an initial 7% right upper extremity impairment would be assigned. This value must be modified by a factor from Table 16-10, Page 482. Given the examination, I would use a 50%

modifier. When these values are multiplied together (7% x50%) and rounded according to the instructions on page 20, this is a 4% right upper extremity impairment. It makes sense that this would not be a 0% impairment rating. In Dr. Gibbons' second surgery, he noted significant subcutaneous scarring of the ulnar nerve and noted that subluxation could be demonstrated preoperatively. The records indicate that Mr. Thompson had ongoing problems with the ulnar nerve distribution after this procedure. As impairment is defined as the loss of use of a body part and given the physical difficulties experienced by Mr. Thompson, it makes sense that the rating would be greater than zero.

Using the Combined Values Chart on page 604, when these values are combined (4% x3%) this is a 7% right upper extremity impairment.

With respect to the left carpal tunnel syndrome, and turning to page 495, Mr. Thompson has abnormal two-point discrimination, with positive clinical findings in the context of negative nerve conduction studies. For impairment rating purposes, he would not fit neatly into the category as outlined on page 495. Empirically, the rating should be more than zero because Mr. Thompson sustained a loss or loss of use of the left median nerve, as he has ongoing symptoms, as well as objective findings on examination. During the two surgical procedures performed by Dr. Gibbons, the transverse carpal ligament was excised in both cases, and so there was a physical change in the left carpal tunnel as a result of Dr. Gibbons' treatment, so the rating would not be zero. In this case, I believe the rating would be 3% left upper extremity impairment.

With respect to the left cubital tunnel syndrome, Mr. Thompson has abnormal two-point discrimination in the ulnar nerve distribution, with positive clinical findings suggesting ongoing ulnar nerve entrapment. Turning to Table 16-15, Page 492, an initial 7% right upper extremity impairment would be assigned. This value must be modified by a factor from Table 16-10, Page 482. Given the examination, I would again use a 50% modifier. When these values are multiplied together (7% x50%) and rounded according to the instructions on page 20, this is a 4% left upper extremity impairment. It makes sense that this would not be a 0% impairment rating. In Dr. Gibbons's second surgery, he noted significant subcutaneous scarring of the ulnar nerve and noted that subluxation could be demonstrated preoperatively. The records indicate that Mr. Thompson had ongoing problems with the ulnar nerve distribution after this procedure. As impairment is defined as the loss or loss of use of a body part and given the physical difficulties experienced by Mr. Thompson, it makes sense that the rating would be greater than zero. I believe this 4% upper extremity impairment is appropriate.

Using the Combined Values Chart on page 604, when these values are combined (4% x3%) this is a 7% left upper extremity impairment.

In the case of the right shoulder, the left shoulder cannot be used as a control at this time because Mr. Thompson has injured the left shoulder as well. Turning to Figures 16-40, 16-43 and 16-46, there is a total of 7% right upper extremity impairment for deficits in range of motion. Turning to Table 16-15, page 492, the sensory deficit is in the right axillary nerve distribution. This would be an initial 5% right upper extremity impairment. However, this value must be modified by the value from Table 16-10, page 482. I would use the 25% modifier. When these values are multiplied (5% x25%) and rounded according to the instructions on page 20, this is a 1% right upper extremity impairment for the sensory deficit.

Turning to the Combined Values Chart on page 604, when these values are combined (7% x1%) this is 8% right upper extremity impairment. I would attribute all of the right shoulder impairment to the November 27, 2012 injury, as there was no further loss or loss of use of the right shoulder as a result of the January 27, 2017 injury, as those symptoms resolved with Dr. Swisher's injection.

Using the Combined Values Chart on page 604, when these values are combined (8% x7% x7%) this is a 20% right upper extremity impairment. Turning to Table 16-3, page 439, this would convert to a 12% whole person impairment for the November 27, 2012, injury.

With respect to the January 27, 2017, injury, there would be no impairment for the right shoulder.

In the case of the left shoulder, the right shoulder cannot be used as a control because Mr. Thompson injured the right shoulder as well, so all impairment ratings will be based solely on measurements of the left shoulder. Turning to Figures 16-40, 16-43 and 16-46, there is a total of 10% left upper extremity impairment for deficits in range of motion. Turning to Table 16-3, page 439, this would convert to a 6% whole person impairment. This impairment would be attributed to the January 27, 2017, injury.

With respect to the cervical spine, the DRE method is indicated according to pages 379-380. Turning to Table 15-5, page 392, I would place Mr. Thompson into DRE Cervical Category II and assign 5% whole person impairment.

> Turning to the Combined Values Chart on page 604, when these values are combined (6% x5%) this is a 11% whole person impairment for the January 27, 2017, injury.
>
> In summary, Mr. Thompson sustained a 12% whole person impairment for the November 27, 2012 injury, and an 11% whole person impairment for the January 27, 2017, injury. With further evaluation and treatment of the left shoulder, I would expect this impairment to decrease.

(Ex. 1, pp. 16-18)

With respect to the first injury date, Dr. Kuhnlein recommended material handling restrictions of lifting forty pounds occasionally from floor to waist, forty pounds occasionally from waist to shoulder, and twenty pounds occasionally over the shoulder. (Ex. 1, p. 18) Dr. Kuhnlein recommended nonmaterial handling restrictions of crawling occasionally, and no use of ladders or at heights because of an inability to maintain a three-point safety stance because of the bilateral entrapment neuropathies, but he did not restrict Thompson from climbing stairs, recommended Thompson change hand positions while driving, and use hand or power tools occasionally. (Ex. 1, pp. 18-19)

With respect to the second injury date, Dr. Kuhnlein recommended the same material handling restrictions for the left shoulder and neck and additional restrictions of occasional crawling, gripping and grasping occasionally at or above shoulder height, and noted Thompson could work on ladders or at heights as long as he could maintain a three-point safety stance and could keep work below shoulder height. (Ex. 1, p. 19)

In response to a request from counsel for Curries and Travelers, Dr. Schmitz issued an opinion letter on January 16, 2019, as follows:

> I previously evaluated Mr. Thompson on August 30, 2017. He was stating to me that he had an injury date of January 27, 2017, and was endorsing some numbness and tingling from the elbows down into the hands as well as primarily shoulder pain. I should note that on examination he had a negative arm adduction sign. He had a negative Spurling's sign. Both of these are specific tests for cervical radiculopathy. In addition, he had an EMG which is another test that would identify cervical radiculopathy on March 9, 2017, which was read as normal. He did have cervical spine imaging including an MRI on July 7, 2017, which essentially demonstrated disc bulging and degeneration with no acute findings. Given all of this objective evidence for a lack of cervical radiculopathy on examination, negative EMG, and cervical spine imaging that was consistent with primary degenerative changes I could not state with any reasonable degree of medical certainty the work incident resulted in a material aggravation of his cervical condition; thus, justifying the assigning of any permanent impairment. Dr. Kuhnlein assigned him a 5% whole person

> impairment, and I would state that I do not think he warrants any permanent impairment with regards to this injury.

(Ex. A, p. 1)

Pursuant to a request for counsel for Curries and Travelers, Dr. Aviles issued an opinion letter on January 23, 2019, as follows:

> I am in receipt of your inquiries dated January 11, 2019. I also am in receipt of Dr. Kuhnlein's independent medical examination. It does not change my opinion and how I feel about Mr. Thompson's shoulder. Last time I had seen him was on October 2, 2017. He had full range of motion and excellent strength at the time. According to the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition she [*sic*] deserves a 0% permanent partial impairment rating. I feel very comfortable saying that he can go back to work without restrictions and that he does not require any further treatment.

(Ex. B, p. 2)

Thompson testified that after the third and fourth surgeries on his bilateral arms he continued to have symptoms in his bilateral arms that have not resolved. (Tr., p. 22) Thompson relayed he continues to have tingling in his fingertips and whole hand, and tremors that shoot down his arms on a daily basis. (Tr., pp. 23, 34) Thompson reported his symptoms are worse with lifting. (Tr., p. 23) Thompson testified he is able to perform his job on the Dahlstrom line, but he has problems with his hands going numb when he grabs and stacks the rail, and he has numbness and pain in his elbows when stacking rail on a double-layered cart, with the pain being worse at the end of the day. (Tr., p. 23) Thompson relayed his pain is better over the weekend. (Tr., p. 23)

Thompson testified he also has problems with burning and sharp pains in his left shoulder anytime he reaches up to shoulder level or carries objects. (Tr., p. 32) Thompson reported when he stacks product he tries to keep his left elbow close to his body and he uses his right arm to stack up product above his shoulder. (Tr., p. 33) Thompson testified his right shoulder is better, but his left shoulder condition has become worse since February 27, 2018, the last day he saw Dr. Kloc. (Tr., p. 33)

Thompson reported his left shoulder impacts his ability to carry things outside of work, and the problems with his hands and elbows make mowing and raking his yard, and using his snow blower difficult. (Tr., pp. 35-37) Thompson relayed vibration from a weed eater and leaf blower at home, and Sawzall at work cause problems for his hands and arms. (Tr., p. 36) Thompson has difficulty throwing a ball and he reported he cannot play catch anymore. (Tr., p. 36)

At the time of the hearing Thompson was still working on the Dahlstrom line. (Tr., p. 32) Thompson testified he is able to perform his job on the Dahlstrom line

despite his problems. (Tr., p. 23, 34-35) Thompson used to work with others on the Dahlstrom line, but he has worked alone for ten to twelve years on the Dahlstrom line. (Tr., p. 42) Thompson reported he continues to use hand shears to cut steel that he stacks into a tub that weighs up to seventy to eighty pounds that he carries four to five times per day approximately ten feet. (Tr., p. 43) Thompson regularly lifts ten to twenty-five pounds throughout the course of his day and often above his head by himself. (Tr., p. 44)

Thompson testified his job on the Dahlstrom line is the highest paying production job at Curries, a level seven job. (Tr., p. 35) Thompson reported he has looked for other work at Curries, but the available jobs would require him to shear more, use his hands, grab, flip, and use his shoulders, which he cannot do. (Tr., p. 34) Thompson noted he used to back up the coil lines, but he no longer does that because the job requires the worker to grab and flip rail in the flat and put it on the line. (Tr., p. 34) During cross-examination Thompson admitted there are other positions within the plant including maintenance work that pay higher rates than Thompson is paid. (Tr., p. 40) Thompson applied for a maintenance foreman job several years ago, but he has not applied since 2017. (Tr., p. 40) Curries also has office jobs, but Thompson reported he does not have the skills to work in the office, or to work as a supervisor or plant manager. (Tr., p. 41)

Thompson denied performing remodeling jobs outside of work. (Tr., p. 45) Thompson reported that in 2013 he helped a friend with some side work, including plumbing and plastering, but he never did a lot of construction work. (Tr., p. 45) Thompson testified he stopped helping his friend after he had surgery on his hands because it hurt to perform the work. (Tr., p. 57)

Thompson testified he has not missed time from work. (Tr., p. 54) Thompson has not received any treatment since February 27, 2018, and he is not taking any medication other than over-the-counter ibuprofen. (Tr., pp. 32, 54, 56) Thompson does not have any permanent restrictions, and he reported he does not have any restrictions because he did not want to lose his job. (Tr., p. 56)

CONCLUSIONS OF LAW

I. Applicable Law

These cases involve several issues, including extent of disability, preexisting disability with the same employer, recovery of the cost of an independent medical examination, and interest under Iowa Code sections 85.30, 85.34, 85.39, and 535.3. In March 2017, the legislature enacted changes (hereinafter "Act") relating to workers' compensation in Iowa. 2017 Iowa Acts chapter 23 (amending Iowa Code sections 85.16, 85.18, 85.23, 85.26, 85.33, 85.34, 85.39, 85.45, 85.70, 85.71, 86.26, 86.39, 86.42, and 535.3). Under 2017 Iowa Acts chapter 23 section 24, the changes to Iowa Code sections 85.34 and 85.39 apply to injuries occurring on or after the effective date of the Act. These cases involve injuries occurring before July 1, 2017, therefore, the

provisions of the new statute involving extent of disability and preexisting disability with the same employer under Iowa Code section 85.34, and recovery of the cost of an independent medical examination under Iowa Code section 85.39 do not apply to this case. The calculation of interest is governed by Sanchez v. Tyson, File No. 5052008 (Ruling on Defendant's Motion to Enlarge, Reconsider, or Amend Appeal Decision Re: Interest Rate Issue), which holds interest for all weekly benefits payable and not paid when due which accrued before July 1, 2017, is payable at the rate of ten percent; all interest on past due weekly compensation benefits accruing on or after July 1, 2017, is payable at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two percent.

II. Nature of the Injuries

Thompson contends he sustained permanent injuries to his right shoulder and bilateral hands and arms while working for Curries on November 1, 2013, and permanent injuries to his left shoulder and neck while working for Curries on January 27, 2017. Curries admits Thompson sustained injuries while working for Curries on November 1, 2013 and January 27, 2017, but denies Thompson sustained a permanent impairment as a result of the work injuries.

To receive workers' compensation benefits, an injured employee must prove, by a preponderance of the evidence, the employee's injuries arose out of and in the course of the employee's employment with the employer. 2800 Corp. v. Fernandez, 528 N.W.2d 124, 128 (Iowa 1995). An injury arises out of employment when a causal relationship exists between the employment and the injury. Quaker Oats v. Ciha, 552 N.W.2d 143, 151 (Iowa 1996). The injury must be a rational consequence of a hazard connected with the employment, and not merely incidental to the employment. Koehler Elec. v. Willis, 608 N.W.2d 1, 3 (Iowa 2000). The Iowa Supreme Court has held, an injury occurs "in the course of employment" when:

> it is within the period of employment at a place where the employee reasonably may be in performing his duties, and while he is fulfilling those duties or engaged in doing something incidental thereto. An injury in the course of employment embraces all injuries received while employed in furthering the employer's business and injuries received on the employer's premises, provided that the employee's presence must ordinarily be required at the place of the injury, or, if not so required, employee's departure from the usual place of employment must not amount to an abandonment of employment or be an act wholly foreign to his usual work. An employee does not cease to be in the course of his employment merely because he is not actually engaged in doing some specifically prescribed task, if, in the course of his employment, he does some act which he deems necessary for the benefit or interest of his employer.

Farmers Elevator Co., Kingsley v. Manning, 286 N.W.2d 174, 177 (Iowa 1979) (quoting Bushing v. Iowa Ry. & Light Co., 208 Iowa 1010, 1018, 226 N.W. 719, 723 (1929)).

The claimant bears the burden of proving the claimant's work-related injury is a proximate cause of the claimant's disability and need for medical care. Ayers v. D & N Fence Co., Inc., 731 N.W.2d 11, 17 (Iowa 2007); George A. Hormel & Co. v. Jordan, 569 N.W.2d 148, 153 (Iowa 1997). "In order for a cause to be proximate, it must be a 'substantial factor.'" Ayers, 731 N.W.2d at 17. A probability of causation must exist, a mere possibility of causation is insufficient. Frye v. Smith-Doyle Contractors, 569 N.W.2d 154, 156 (Iowa Ct. App. 1997). The cause does not need to be the only cause, "[i]t only needs to be one cause." Armstrong Tire & Rubber Co. v. Kubli, 312 N.W.2d 60, 64 (Iowa 1981).

The question of medical causation is "essentially within the domain of expert testimony." Cedar Rapids Cmty. Sch. Dist. v. Pease, 807 N.W.2d 839, 844-45 (Iowa 2011). The deputy commissioner, as the trier of fact, must "weigh the evidence and measure the credibility of witnesses." Id. The trier of fact may accept or reject expert testimony, even if uncontroverted, in whole or in part. Frye, 569 N.W.2d at 156. When considering the weight of an expert opinion, the fact-finder may consider whether the examination occurred shortly after the claimant was injured, the compensation arrangement, the nature and extent of the examination, the expert's education, experience, training, and practice, and "all other factors which bear upon the weight and value" of the opinion. Rockwell Graphic Sys., Inc. v. Prince, 366 N.W.2d 187, 192 (Iowa 1985).

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

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

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

A. November 1, 2013 Work Injury

Thompson alleges he sustained permanent impairments to his right shoulder and bilateral hands and arms caused by the November 1, 2013 work injury. Curries and Travelers deny Thompson has sustained a permanent impairment.

Dr. Gibbons performed a right diagnostic arthroscopy with subacromial decompression and mini open rotator cuff repair on Thompson, and diagnosed him with a right rotator cuff tear. (JE 4, p. 18) Dr. Gibbons apparently offered an impairment rating of ten percent to the upper extremity following surgery. (Ex. D, p. 4) His opinion was not produced at hearing. Dr. Kuhnlein is an occupational medicine physician who performed an independent medical examination for Thompson. Dr. Kuhnlein opined Thompson had sustained no impairment to his right shoulder for the January 27, 2017, injury, but found he sustained an eight percent permanent impairment to the right shoulder as a result of the November 1, 2013 work injury. Dr. Kuhnlein's opinion concerning the November 1, 2013 work injury is unrebutted. Thompson has established he sustained a permanent impairment to his right shoulder caused by the November 1, 2013 work injury.

Three physicians provided ratings for Thompson's bilateral upper extremities, Dr. Gibbons, a treating orthopedic surgeon who performed multiple surgeries on Thompson, Dr. Paulson, an orthopedic surgeon specializing in hand and upper extremity surgery who provided a second opinion, and Dr. Kuhnlein, an occupational medicine physician who examined Thompson for purposes of an independent medical examination. I find the opinion of Dr. Paulson, as supported by Dr. Kuhnlein, to be the most persuasive. Dr. Paulson has superior education and experience, specializing in hand and upper extremity surgery.

Dr. Gibbons first performed a right carpal tunnel and a cubital tunnel release on February 28, 2015 and a left carpal tunnel and a cubital tunnel release on March 25, 2015. (JE 5, p. 21; JE 6, p. 23) Less than two months after the left upper extremity surgery, Dr. Gibbons released Thompson to full duty without restrictions and opined he had sustained a zero percent permanent impairment under the AMA Guides. (JE 7, pp. 25-27)

Thompson continued to complain of symptoms in his bilateral upper extremities after the two surgeries. He was referred to Dr. Baweja, a neurologist, who confirmed Thompson's electromyography studies were abnormal, and Dr. Gibbons performed a right ulnar nerve transposition and a right open carpal tunnel release on January 6, 2016, and a left ulnar nerve transposition and a left open carpal tunnel release on March 23, 2016. (JE 9, pp. 33-35) Thompson continued to complain of symptoms in his bilateral upper extremities. On May 17, 2016, again less than two months after the fourth surgery, Dr. Gibbons released Thompson to full duty without restrictions and found he had reached maximum medical improvement. (JE 10, pp. 39-40) Thompson continued to complain of symptoms after additional electromyography was deemed

normal. Dr. Gibbons released Thompson to regular duty without restrictions and opined he was at maximum medical improvement on August 1, 2016. (JE 10, pp. 47-48)

Dr. Gibbons opined Thompson had "incredible grip strength," but also noted, "I did not formally test it, as I know he would easily be within normal limits." (JE 10, p. 45) This is contrary to the objective finding of Dr. Paulson. (JE 23, pp. 133-34) While Dr. Gibbons challenged Dr. Paulson's impairment rating and stated he was confident in his zero percent impairment rating, the exhibits produced at hearing do not support Dr. Gibbons provided an impairment rating following the third and fourth surgeries. (JE 11, p. 49)

Thompson testified he has continued to have problems with his bilateral upper extremities following his upper extremity surgeries. While testifying at hearing concerning his ongoing problems I was able to observe Thompson. He engaged in direct eye contact, his rate of speech was appropriate, and he did not engage in any furtive movements. I found his testimony concerning his ongoing problems with his bilateral upper extremities, as supported by his medical records credible. The evidence presented at hearing supports Thompson sustained permanent impairments to his bilateral upper extremities and right shoulder caused by the November 1, 2013 work injury.

B. <u>January 27, 2017 Work Injury</u>

Thompson alleges he sustained permanent injuries to his left shoulder and neck while working for Curries on January 27, 2017. Curries and Travelers contend Thompson has not sustained a permanent impairment to his neck or left shoulder caused by the work injury. Three physicians have given permanent impairment ratings for the January 27, 2017 work injury, Dr. Aviles, an orthopedic surgeon retained by Curries and Travelers, Dr. Schmitz, an orthopedic surgeon retained by Curries and Travelers, and Dr. Kuhnlein, an occupational medicine physician retained by Thompson to conduct an independent medical examination for Thompson. I find the opinion of Dr. Kuhnlein, the physician who most recently examined Thompson, to be the most persuasive.

On August 30, 2017, Curries and Travelers sent Thompson to Iowa Ortho to be examined by Drs. Aviles and Schmitz, both orthopedic surgeons. Dr. Aviles opined his examination of Thompson showed mild tendinopathy and intact superior labrum and biceps, and magnetic resonance imaging showed no evidence of any significant disease. (JE 19, p. 105) Dr. Aviles recommended an injection for the left shoulder, which was performed by Dr. Rayburn. (JE 19, p. 105; JE 21, 120) The injection did not provide any relief. Thompson returned to Dr. Aviles complaining of left shoulder symptoms, aggravated by lifting up, and Dr. Aviles found he did not have anything to offer Thompson, and released him without restrictions. (JE 19, pp. 107-11)

Dr. Schmitz found on examination Thompson had painless functional range of motion at the shoulders, elbows, wrists, and digits, but pain with rotator cuff testing. (JE

20, pp. 113, 117) Dr. Schmitz reviewed Thompson's cervical and shoulder magnetic resonance imaging and electromyography testing. Dr. Schmitz opined Thompson likely had a hemangioma lipoma at T1, severe disc degeneration at C6-C7, no obvious evidence of central foraminal stenosis at C2-C3, a broad-based disc bulge at C3-C4 with bilateral foraminal stenosis, a broad-based disc bulge at C4-C5 with mild left and no right-sided foraminal stenosis, a broad-based disc bulge at C5-C6 with no significant central foraminal stenosis, and moderate left-sided foraminal stenosis at C6-C7 with questionable right-sided foraminal stenosis, and no evidence of pathology at C7-T1. (JE 10, pp. 114, 118) Dr. Schmitz opined his findings on examination were consistent with a shoulder source for Thompson's pain, noting he did not have a good explanation for the numbness and tingling Thompson was reporting, but also noting he thought "a significant portion of his pain is stemming from the shoulders" and released Thompson to return to work without restriction. (JE 20, p. 118)

Dr. Kuhnlein diagnosed Thompson with degenerative disc disease of the cervical spine with resolved radiculopathy and chronic myofascial cervical spine pain, and left shoulder impingement syndrome with mild acromioclavicular joint osteoarthritis and diffuse articular partial rotator cuff tear. (Ex. 1, p. 14) Dr. Kuhnlein found the work injury "lit up" Thompson's impingement syndrome in both shoulders, but the right shoulder impingement syndrome resolved with an injection performed by Dr. Swisher, and "lit up" Thompson's degenerative disc disease, noting the radiculopathy had resolved to cervical myofascial pain. (Ex. 1, p. 15)

Dr. Kuhnlein's examination does not show normal range of motion for the shoulder. Dr. Kuhnlein documented on examination Thompson's flexion of the right shoulder was 140 degrees and the left shoulder was 120 degrees, extension of the right shoulder was seventy degrees and the left shoulder was fifty degrees, abduction of the right shoulder was 120 degrees and the left shoulder was 90 degrees, adduction of the right shoulder was thirty degrees and the left shoulder was twenty degrees, internal rotation of the right shoulder was 80 degrees and the left shoulder was 80 degrees, external rotation of the right shoulder was 85 degrees and the left shoulder was 50 degrees. (JE 19, p. 104) This is compared to Dr. Aviles's findings Thompson's bilateral shoulders had external rotation of 90 degrees, abduction of 90 degrees, internal rotation of 90 degrees, and flexion of 180 degrees, with painful passive range of motion, and crepitus in the right only. (JE 19, p. 104)

Drs. Aviles and Schmitz did not examine Thompson after 2017. In January 2019, Curries and Travelers sent Drs. Aviles and Schmitz a copy of Dr. Kuhnlein's independent medical examination and requested their opinions. Dr. Aviles and he opined at the time of his examination Thompson had full range of motion and excellent strength of his left shoulder, and using the AMA Guides, assigned Thompson a zero percent permanent partial impairment rating, and opined he did not need work restrictions or further treatment. (Ex. B, p. 2)

Dr. Schmitz opined during his examination in 2017 he performed specific tests on Thompson for radiculopathy, which were negative, electromyography was normal, and

his cervical magnetic resonance imaging demonstrated disc bulging and degeneration with no acute findings. (Ex. A, p. 1) Based on this information Dr. Schmitz opined, "I could not state with any reasonable degree of medical certainty the work incident resulted in a material aggravation of his cervical condition," and he did not believe Thompson had sustained a permanent impairment to his cervical spine caused by the work injury. (Ex. A, p. 1)

Dr. Kuhnlein did not opine Thompson had ongoing radiculopathy, noting the radiculopathy had resolved to cervical myofascial pain, and that the work injury "served to 'light up' the degenerative disc disease." (Ex. 1, p. 15) As noted by Dr. Kuhnlein, before the January 27, 2017, work injury, Thompson had not complained of any discomfort or problems with his cervical spine. As discussed above, during the hearing I observed Thompson testify concerning his work injuries, his lack of symptoms before his work injuries, and his ongoing problems. Thompson engaged in direct eye contact, his rate of speech was appropriate, and he did not engage in any furtive movements. Based on Thompson's testimony, Dr. Kuhnlein's opinion, and Thompson's medical records, I find Thompson has established he sustained permanent impairments to his left shoulder and cervical spine caused by the January 27, 2017 work injury.

III. Extent of Disability

Permanent partial disabilities are divided into scheduled and unscheduled losses. Iowa Code § 85.34(2). If the claimant's injury is listed in the specific losses found in Iowa Code section 85.34(2)(a)-(t), the injury is a scheduled injury and is compensated by the number of weeks provided for the injury in the statute. Second Injury Fund v. Bergeson, 526 N.W.2d 543, 547 (Iowa 1995). "The compensation allowed for a scheduled injury 'is definitely fixed according to the loss of use of the particular member.'" Id. (quoting Graves v. Eagle Iron Works, 331 N.W.2d 116, 118 (Iowa 1983)). If the claimant's injury is not listed in the specific losses in the statute, compensation is paid in relation to 500 weeks as the disability bears to the body as a whole. Id.; Iowa Code § 85.34(2)(u). "Functional disability is used to determine a specific scheduled disability; industrial disability is used to determine an unscheduled injury." Bergeson, 526 N.W.2d at 547.

"Industrial disability is determined by an evaluation of the employee's earning capacity." Cedar Rapids Cmty. Sch. Dist. v. Pease, 807 N.W.2d 839, 852 (Iowa 2011). In considering the employee's earning capacity, the deputy commissioner evaluates several factors, including "consideration of not only the claimant's functional disability, but also [his] age, education, qualifications, experience, and ability to engage in similar employment." Swiss Colony, Inc. v. Deutmeyer, 789 N.W.2d 129, 137-38 (Iowa 2010). The inquiry focuses on the injured employee's "ability to be gainfully employed." Id. at 138.

The determination of the extent of disability is a mixed issue of law and fact. Neal v. Annett Holdings, Inc., 814 N.W.2d 512, 525 (Iowa 2012). Compensation for permanent partial disability shall begin at the termination of the healing period. Iowa

Code § 85.34(2). Compensation shall be paid in relation to 500 weeks as the disability bears to the body as a whole. Id. § 85.34(2)(u).

A. November 1, 2013 Work Injury

The evidence at hearing supports Thompson sustained permanent impairments to his right shoulder and bilateral upper extremities caused by the November 1, 2013 work injury. Because the injury to the shoulder is an industrial disability, the injuries are compensated industrially.

At the time of the hearing Thompson was fifty-two. (Ex. 3, p. 18) Thompson graduated from high school in 1985 and he has received no additional formal schooling. (Tr., p. 9; Ex. 3, p. 6) Curries hired Thompson in August 1985. (Tr., pp. 9-10) Thompson continued to work for Curries at the time of the hearing. He has performed the same job for Curries for the past eighteen to twenty years. (Tr., p. 10; Ex. 3, p. 7) He is not looking for other employment.

Following the November 1, 2013 work injury, and after each of the five surgeries performed by Dr. Gibbons, Thompson eventually returned to his job at Curries without restrictions. At the time of the hearing Thompson was performing his normal job without restrictions. While Thompson has returned to his normal job at Curries, he continues to struggle with tingling in his fingertips and whole hands, tremors that shoot down his arms on a daily basis, problems with numbness in his hands, and pain in his elbows at work. (Tr., pp. 22-23) As discussed above, I found Thompson's testimony concerning his ongoing symptoms credible. Considering all of the factors of industrial disability, I find Thompson has sustained a twenty percent industrial disability caused by the November 1, 2013 work injury. Thompson is awarded 100 weeks of permanent partial disability benefits at the stipulated weekly rate of $689.21, commencing on the stipulated commencement date of April 7, 2016.

B. January 27, 2017 Work Injury

The January 27, 2017, work injury is the second injury with the same employer. Iowa Code section 85.34(7) (2016) provides, in part:

> *b.* (1) If an injured employee has a preexisting disability that was caused by a prior injury arising out of and in the course of employment with the same employer, and the preexisting disability was compensable under the same paragraph of subsection 2 as the employee's present injury, the employer is liable for the combined disability that is caused by the injuries, measured in relation to the employee's condition immediately prior to the first injury. In this instance, the employer's liability for the combined disability shall be considered to be already partially satisfied to the extent of the percentage of disability for which the employee was previously compensated by the employer.

> (2) If, however, an employer is liable to an employee for a combined disability that is payable under subsection 2, paragraph "u", and the employee has a preexisting disability that causes the employee's earnings to be less at the time of the present injury than if the prior injury had not occurred, the employer's liability for the combined disability shall be considered to be already partially satisfied to the extent of the percentage of disability for which the employee was previously compensated by the employer minus the percentage that the employee's earnings are less at the time of the present injury than if the prior injury had not occurred.

Therefore, if Thompson has sustained an industrial disability caused by the January 27, 2017 work injury, it is necessary to consider the combined disability caused by both injuries and the defendants' liability for the combined disability must be considered already satisfied to the extent of the percentage of disability for which Thompson was previously compensated.

Dr. Kuhnlein assigned a six percent whole person impairment to Thompson's left shoulder, and a five percent whole person impairment to Thompson's cervical spine. (Ex. 1, p. 18) As noted above, at the time of the hearing Thompson was fifty-two. (Ex. 3, p. 18) Thompson graduated from high school in 1985 and he has received no additional schooling. (Tr., p. 9; Ex. 3, p. 6) Curries hired Thompson in August 1985. (Tr., pp. 9-10) Thompson continued to work for Curries at the time of the hearing. He has performed the same job for Curries for the past eighteen to twenty years. (Tr., p. 10; Ex. 3, p. 7) He is not looking for other employment.

Following the January 27, 2017, work injury Thompson returned to his job at Curries without restrictions. At the time of the hearing Thompson was performing his normal job without restrictions. While Thompson has returned to his normal job at Curries, he testified he continues to experience problems with burning and sharp pain in his left shoulder when he reaches up to shoulder level or carries objects. (Tr., p. 32) Thompson also relayed when he stacks product at work he tries to keep his left elbow close to his body and he uses his right arm to stack product above his shoulder. (Tr., p. 33) Thompson no longer backs up other areas of the plant. As discussed above, I found Thompson's testimony concerning his ongoing symptoms credible. Considering all of the factors of industrial disability, I find Thompson has sustained a combined thirty percent industrial disability caused by both work injuries. Thompson is awarded 150 weeks of permanent partial disability benefits for the combination of the work injuries at the stipulated weekly rate of $749.18, commencing on the stipulated commencement date of January 28, 2017. Curries and Travelers are entitled to a credit of 100 weeks of permanent partial disability payments ordered by this decision, including a credit for all permanency benefits paid prior to the hearing.

IV. Interest

On December 1, 2017, Dr. Paulson opined Thompson had sustained six percent upper extremity impairments to both of his upper extremities, which is equivalent to an eight percent body as a whole impairment, or forty weeks of permanent partial disability benefits. On April 18, 2018, Curries and Travelers paid Thompson 25 weeks of permanent partial disability benefits at the weekly rate of $734.96 or $18,374.00, for the period of April 6, 2016 through September 28, 2016. (Ex. 7, p. 45) Curries and Travelers did not pay any interest on the benefits that were due and owing in 2016. Under Iowa Code section 85.30 (2016), Thompson is entitled to ten percent interest on the outstanding benefits from the date each payment accrued. Sanchez v. Tyson, File No. 5052008 (Apr. 23, 2018 Ruling on Defendant's Motion to Enlarge, Reconsider, or Amend Appeal Decision Re: Interest Rate Issue) (interest for all weekly benefits payable and not paid when due which accrued before July 1, 2017, is payable at the rate of ten percent; all interest on past due weekly compensation benefits accruing on or after July 1, 2017, is payable at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two percent).

V. Medical Bills

An employer is required to furnish reasonable surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance, hospital services and supplies, and transportation expenses for all conditions compensable under the workers' compensation law. Iowa Code § 85.27(1). The employer has the right to choose the provider of care, except when the employer has denied liability for the injury. Id. "The treatment must be offered promptly and be reasonably suited to treat the injury without undue inconvenience to the employee." Id. § 85.27(4). If the employee is dissatisfied with the care, the employee should communicate the basis for the dissatisfaction to the employer. Id. If the employer and employee cannot agree on alternate care, the commissioner "may, upon application and reasonable proofs of the necessity therefor, allow and order other care." Id. The statute requires the employer to furnish reasonable medical care. Id. § 85.27(4); Long v. Roberts Dairy Co., 528 N.W.2d 122, 124 (Iowa 1995) (noting "[t]he employer's obligation under the statute turns on the question of reasonable necessity, not desirability"). The Iowa Supreme Court has held the employer has the right to choose the provider of care, except when the employer has denied liability for the injury, or has abandoned care. Iowa Code § 85.27(4); Bell Bros. Heating & Air Conditioning v. Gwinn, 779 N.W.2d 193, 204 (Iowa 2010).

Thompson seeks to recover $4,258.72 insurance paid and $2,217.68 in medical bills from Dr. Kloc and Mason City Ambulatory Surgery Center from December 18, 2017, January 15, 2018, and February 8, 2018. (Ex. 6, p. 41) Curries and Travelers provided medical care for Thompson through his appointments with Drs. Aviles and Schmitz. After Drs. Aviles and Schmitz rendered their opinions, Travelers informed Thompson he should see his own doctor for care, and he sought treatment with Drs.

Swisher and Kloc. Based on the evidence presented at hearing, I find the treatment provided to Thompson set forth in Exhibit 6 reasonable and beneficial to Thompson. Bell Bros. Heating & Air Conditioning, 779 N.W.2d at 206; Brewer-Strong v. HNI Corp. 913 N.W.2d 235 (Iowa 2018). Curries and Travelers are responsible for $4,258.72 paid by insurance, and $2,127.68 in out-of-pocket costs paid by Thompson for the medical bills set forth in Exhibit 6.

VI. Independent Medical Examination

Thompson seeks to recover the $4,385.00 cost of Dr. Kuhnlein's independent medical examination. (Ex. 5) Dr. Paulson issued an impairment rating on December 1, 2017. (JE 23, pp. 133-34) Thompson disagreed with the rating, and Dr. Kuhnlein conducted an independent medical examination of Thompson at his request on December 28, 2018. (Ex. 1)

Iowa Code section 85.39 (2016), provides, in part:

> [a]fter an injury, the employee, if requested by the employer, shall submit for examination at some reasonable time and place and as often as reasonably requested, to a physician or physicians authorized to practice under the laws of this state or another state, without cost to the employee; but if the employee requests, the employee, at the employee's own cost, is entitled to have a physician or physicians of the employee's own selection present to participate in the examination. If an employee is required to leave work for which the employee is being paid wages to attend the requested examination, the employee shall be compensated at the employee's regular rate for the time the employee is required to leave work, and the employee shall be furnished transportation to and from the place of examination, or the employer may elect to pay the employee the reasonable cost of the transportation. . . . If an evaluation of permanent disability has been made by a physician retained by the employer and the employee believes this evaluation to be too low, the employee shall, upon application to the commissioner and upon delivery of a copy of the application to the employer and its insurance carrier, be reimbursed by the employer the reasonable fee for a subsequent examination by a physician of the employee's own choice, and reasonably necessary transportation expenses incurred for the examination. . . .

Thompson retained Dr. Kuhnlein to conduct an independent medical examination after Dr. Paulson provided his impairment rating. Thompson is entitled to recover the cost of the independent medical examination.

VII. Costs

Thompson seeks to recover the $100.00 filing fee, $13.34 for service, and $103.25, for the cost of Thompson's deposition. (Ex. 5) Iowa Code section 86.40,

provides, "[a]ll costs incurred in the hearing before the commissioner shall be taxed in the discretion of the commissioner." Rule 876 IAC 4.33(6) provides,

> [c]osts taxed by the workers' compensation commissioner or a deputy commissioner shall be (1) attendance of a certified shorthand reporter or presence of mechanical means at hearings and evidential depositions, (2) transcription costs when appropriate, (3) costs of service of the original notice and subpoenas, (4) witness fees and expenses as provided by Iowa Code sections 622.69 and 622.72, (5) the costs of doctors' and practitioners' deposition testimony, provided that said costs do not exceed the amounts provided by Iowa Code sections 622.69 and 622.72, (6) the reasonable costs of obtaining no more than two doctors' or practitioners' reports, (7) filing fees when appropriate, (8) costs of persons reviewing health service disputes.

The administrative rule expressly provides for the recovery of the costs Thompson seeks. Curries and Travelers shall reimburse Thompson $100.00 for the filing fee, $13.34 for the cost of service, and $103.25 for the cost of Thompson's deposition.

ORDER

IT IS THEREFORE ORDERED, THAT:

For the November 1, 2013 work injury, Curries and Travelers shall pay Thompson one hundred (100) weeks of permanent partial disability benefits at the stipulated weekly rate of six hundred eighty-nine and 21/100 dollars ($689.21), commencing on the stipulated commencement date of April 7, 2016.

For the combination of the November 1, 2013 and January 27, 2017 work injuries, Curries and Travelers shall pay Thompson one hundred fifty (150) weeks of permanent partial disability benefits, at the stipulated weekly rate of seven hundred forty-nine and 18/100 dollars ($749.18), commencing on the stipulated commencement date of January 28, 2017. Curries and Travelers shall receive a credit of one hundred (100) weeks of permanent partial disability benefits paid for the November 1, 2013 work injury, including a credit for all permanent partial disability payments paid for the November 1, 2013 work injury prior to the date of this decision.

Curries and Travelers shall pay accrued weekly benefits in a lump sum together with interest at the rate of ten percent for all weekly benefits payable and not paid when due which accrued before July 1, 2017, and all interest on past due weekly compensation benefits accruing on or after July 1, 2017, shall be payable at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two percent. Sanchez v. Tyson, File No. 5052008 (Apr. 23, 2018 Ruling on Defendant's Motion to Enlarge, Reconsider, or Amend Appeal Decision Re: Interest Rate Issue).

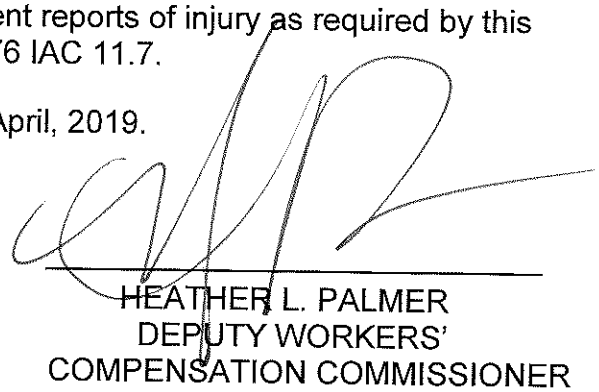
Curries and Travelers are responsible for four thousand two hundred fifty-eight and 72/100 dollars ($4,258.72) paid by insurance, and shall reimburse Thompson two thousand one hundred twenty-seven and 68/100 dollars ($2,127.68) for out-of-pocket costs medical bills paid set forth in Exhibit 6.

Curries and Travelers shall reimburse Thompson for the four thousand three hundred eighty-five and 00/100 dollars ($4,385.00) cost of Dr. Kuhnlein's independent medical examination.

Curries and Travelers shall reimburse Thompson for the one hundred dollar ($100.00) the filing fee, for the thirteen and 34/100 dollar ($13.34) cost of service, and for the one hundred three and 25/100 dollar ($103.25) cost of Thompson's deposition.

Curries and Travelers shall file subsequent reports of injury as required by this agency pursuant to rules 876 IAC 3.1(2) and 876 IAC 11.7.

Signed and filed this 30th day of April, 2019.



HEATHER L. PALMER
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

Copies to:

Martin Ozga
Attorney at Law
1441 – 29th St., Ste. 111
West Des Moines, IA 50266
mozga@nbolawfirm.com

James M. Ballard
Attorney at Law
14225 University Ave., Ste. 142
Waukee, IA 50263
jballard@jmbfirm.com

HLP/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.