BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

RICK BEBENSEE, Claimant, vs. CITY OF WALKER, Employer, and FIREMAN'S INS. CO. OF WASHINGTON, D.C., Insurance Carrier, Defendants.	FILED APR 22 2016 WORKERS COMPENSATION	File No. 5047290 ARBITRATION DECISION Head Note Nos.: 1802; 1803; 1804; 2500 2907; 3000; 4000.2; 4100

STATEMENT OF THE CASE

Rick Bebensee, claimant, filed a petition in arbitration seeking workers' compensation benefits from the City of Walker and its insurer, Fireman's Insurance Company of Washington D.C., as a result of an injury he sustained on December 24, 2012 that arose out of and in the course of his employment. This case was heard in Des Moines, Iowa, and fully submitted on October 1, 2015. The evidence in this case consists of the testimony of claimant and Joyce Bebensee, claimant's exhibits 1 through 9 and defendants' exhibits A through O. Pages 142 and 143 of Exhibit H were excluded as they were not timely disclosed. Administrative notice was taken of the alternate medical care file in this case.

ISSUES

The extent of claimant's temporary disability;

The extent of claimant's permanent disability;

The commencement date of claimant's permanent disability;

Whether claimant is entitled to a finding of permanent total disability based upon the odd-lot doctrine;

Whether claimant is entitled to payment of an independent medical examination;

Whether claimant is entitled to payment of medical expenses;

Whether claimant is entitled to alternate medical care;

Whether defendants are entitled to a credit of 98 weeks paid at the rate of $1,048.64 per week;

Whether a penalty should be assessed for termination of benefits and late payment of benefits; and

Assessment of costs.

The stipulations contained in the hearing report are accepted and incorporated into this decision as if fully set forth. The parties initially disputed in the hearing report, claimant's weekly rate. Both parties agreed in their briefs that the claimant's weekly workers' compensation rate is $1,048.64. This rate is accepted and will be used in this case.

FINDINGS OF FACT

The deputy workers' compensation commissioner, having heard the testimony and considered the evidence in the record, finds that:

Rick Bebensee was 44 years old at the time of the arbitration hearing. Mr. Bebensee was 3 credits short of his high school degree and took adult education classes to earn his degree. He does not know if he has a high school degree or a GED. (Transcript page 17) He attended a community college for less than 1 semester. His only other post-high education has been for the firefighting and medical training he receives in order to be a volunteer firefighter. Claimant has been a volunteer firefighter for about 10 years.

Claimant's vocational history included working security at Marine World, self-employed remodeling/construction, maintenance at a motel, manager/co-owner of a tavern, truck and trailer technician. (Exhibit A, pp. 4, 5)

It was in his role as a volunteer firefighter for the City of Walker, Iowa that claimant was injured[1]. Prior to this injury he was not experiencing back pain.

On Christmas Eve, December 24, 2012, claimant responded to a motor vehicle accident as a volunteer firefighter. Claimant assisted persons involved in the motor

[1] The parties have agreed that claimant suffered a permanent injury that arose out of and in the course of his employment. As such, I will not put in this decision extensive details about his medical treatment.

vehicle accident. The conditions were snowy. Claimant hurt his back while assisting a motorist who went into a ditch. Claimant experienced back pain at the scene of the accident, but was able to ride back to the station. Back at the fire station, claimant realized he had more pain and an ambulance was called and took claimant to St. Luke's Hospital. Claimant testified that he had 3 epidural injections and 2 different sessions of physical therapy: One session lasting 5 weeks and the second lasting 12 weeks. (Tr. p. 24)

Claimant was referred to the University of Iowa Hospitals and Clinics (UIHC) for evaluation and to determine if he would be a candidate for the spine clinic program. Claimant was informed by Dr. Chen he would not be a good candidate for the clinic. (Tr. p. 25)

Claimant sought additional care for his back outside of the workers' compensation system and was able to utilize his wife's medical insurance. Claimant went to Sunny Kim, M.D. Dr. Kim offered massage therapy and testing of his nerves. Claimant testified that some of the treatment was helpful and some was not. (Tr. pp. 27, 28)

Claimant also received treatment from Tork Harman, M.D. He received treatment in the form of epidural steroid injections and ten weeks of physical therapy. Claimant said that the injections were the most helpful of any of the treatment he had received thus far. (Tr. p. 28)

Claimant testified that his pain was getting worse and that his pain had progressed from the middle of his hip and slightly into his leg, and into his leg past his knee. (Tr. p. 30)

Dr. Harman referred claimant to Kevin Eck, M.D. Dr. Eck performed back surgery on January 23, 2015. (Ex. 2, p. 56) Claimant testified that his surgery helped his back pain. (Tr. p. 31; Ex. L, p. 160) The physical therapy he had after surgery helped claimant to stop using a walker and cane and in claimant's opinion was beneficial.

Claimant noticed a hernia while he was in physical therapy before his back surgery. (Ex. L, p. 165) Claimant said that he spoke to his doctor about the problem and was told that if it was not bothering him not to do anything. If it becomes a problem, he was told it could be reassessed. (Ex. L, p. 165) After claimant's back surgery, he returned to physical therapy. Claimant said about two months after his surgery and after he returned to physical therapy, his hernia got worse. Claimant went to the emergency room regarding his hernia on April 1, 2015. He had hernia surgery on April 7, 2015. (Ex. 2, pp. 75, 78) Claimant completed his physical therapy on June 30, 2015.

Subsequent to his surgery, claimant had nerve block injections by Dr. Harman that did not provide claimant relief. (Tr. p. 34)

Claimant testified that he would like to be able to have the epidural injections continue and treatment for his depression. (Tr. p. 35)

At the time of his injury on December 24, 2012, claimant was employed as a diesel tech for West Side Transport. He was earning $16.75 per hour. Claimant was terminated from this position 2 days after his injury. (Ex, L, p. 159) Claimant is currently unable to physically perform the tasks of a diesel tech.

Claimant obtained a job at an auto parts store, AutoZone, working the sales counter. He began working July 8, 2015 as a parts counter salesperson on a 4-6 hour shift at $8.55 per hour. (Ex. H, p. 128) At the time of the hearing he had worked in this position for about a month. (Tr. p. 38) He works part time 4-6 hours, 3 to 4 days a week. He is making $8.55 per hour. Claimant has difficulty lifting some items such as batteries. Claimant testified that after working an 8-hour shift he has also needed to call his wife to drive him home at the end of his shift due to back pain. (Tr. p. 41) Claimant did not think that he could work any more hours than he is working right now. (Tr. p. 42) Claimant has applied for a number of jobs since his injury including some work as security, volunteer services at a hospital, and sales at Sears. (Tr. pp. 60, 61)

Claimant's level of activity at home is sedentary. He is not able to do yard work. He used to mow his parents' lawns. Claimant's family now does this.

Claimant has been informed by physicians that losing weight and stopping smoking would improve his health. And that smoking would make it harder for his back to heal. (Tr. pp. 51, 55)

Joyce Bebensee, claimant's spouse, testified. Her testimony confirmed that since the injury claimant has not been able to do many of the household and yard chores he used to do. Ms. Bebensee assists claimant when he wakes up and has difficulty with pain and getting out of bed.

Ms. Bebensee twice had to pick her up her husband at work at AutoZone and drive him home as he was in too much pain to drive himself. Ms. Bebensee thought it was unlikely that claimant could continue to keep his current job considering the state of his health. (Tr. p. 71)

The claimant was a credible witness. His body movements, eye contact, cadence of testimony, speech patterns, general demeanor, and general consistency were all consistent with a very credible witness. The claimant's spouse was a very credible witness who was able to accurately convey the loss of abilities the claimant has suffered from the back injury.

Claimant saw Dr. Eck in January 2013. Dr. Eck reviewed an MRI. The MRI revealed multiple level spondylosis and mild foraminal narrowing appreciating at L5-S1. He recommended injections, which were declined by the claimant. (Ex. 2, p. 9) At that point in time, Dr. Eck did not recommend surgery. (Tr. p. 50; Ex. 2, p. 9) Claimant returned to Dr. Eck on April 29, 2013. Dr. Eck recommended a repeat MRI due to worsening of symptoms after claimant's epidural injection. (Ex. 2, p. 12) On May 20, 2013, Dr. Eck reported the MRI results.

> Rick Bebensee presents for further evaluation. The most recent lumbar MRI scan shows lumbar spondylosis at L2-3, L3-4, L4-5, and L5-S1. At L5 S1, there is a right paracentral/foraminal annular tear with mild disc protrusion. Only mild L5 foraminal stenosis evident, unchanged in comparison to his previous study. No large predominant disc herniations. No significant central stenosis. No significant abnormalities in the soft tissues overlying the the [*sic*] posterior spine. In the area of the marker, there are no cystic or solid lesions present. No worrisome marrow signal changes. The spinal cord is normal. There is no spinal malalignment.

(Ex. 2, p. 13) Dr. Eck did not believe claimant was a surgical candidate and recommend conservative care. (Ex. 2, p. 13)

Claimant saw Chad Abernathy, M.D., in February 2013. Dr. Abernathy did not recommend surgery. (Ex. D, p. 59; Tr. p. 51) Dr. Abernathy agreed that an epidural steroid injection was a reasonable approach. Dr. Abernathy's diagnosis was lumbosacral strain and he thought claimant would reach maximum medical improvement (MMI) six months after his injury and would be able to return to full employment. (Ex. D, p. 60) I find that this evaluation is an evaluation of no permanent impairment.

Claimant went to the UIHC and saw both Sergio Mendoza, M.D. and Joseph Chen, M.D. On July 3, 2013, Dr. Mendoza examined claimant. He noted that claimant's treatment had consisted of physical therapy, muscle relaxants, nonsteroidal anti-inflammatory drugs, TENS unit, oral steroids, and three epidural injections. (Ex. E, p. 67) Dr. Mendoza recommended claimant quit smoking and lose weight. He also noted that if claimant's condition was not helped by fitness activities and injections there were other treatment options in the future. (Ex. E, p. 69) Dr. Mendoza stated, "The patient may benefit from a circumferential fusion if conservative care fails." (Ex, E, p. 71) On September 25, 2013, Dr. Mendoza was asked to evaluate claimant for surgical options or a referral to the spine rehabilitation program at UIHC. Dr. Mendoza stated that claimant does not have any surgical indication for his back pain and was considered a good candidate for the spine rehabilitation clinic. (Ex. E, p. 91) On September 25, 2015, Dr. Chen informed claimant that he was not a good candidate for the spine rehabilitation clinic. (Ex. E, p. 94) He referred claimant for a functional capacity examination (FCE).

On October 23, 2013, an FCE showed claimant had the capacity to work at the medium demand vocational level as described in the Dictionary of Occupational Titles. (Ex. M, p. 180) The specific restrictions recommended were: 50 pounds waist to floor – occasionally; waist to crown – 40 pounds occasionally; carrying – 40 pounds occasionally; standing work – frequently with positional changes as needed; Sitting – frequently, with positional changes as needed; squatting – frequently; Forward bending (repetitive/sustained) – occasionally. (Ex, M, p. 180)

Dr. Chen reviewed the FCE on November 6, 2013. Dr. Chen did not have another treatment for him and placed him at MMI on that date. He provided a five percent whole body impairment rating. (Ex. E, p. 100) Claimant returned to Dr. Chen on March 12, 2014 due to reoccurring pain. Dr. Chen did not find any lumbosacral radiculopathy. Dr. Chen said that interventional spine providers would not be helpful. (Ex. E, p. 103)

Claimant requested additional medical care and filed a petition for alternate medical care on April 17, 2014. Claimant's alternate care petition was denied.

On May 7, 2014, Dr. Thomas referred claimant to Dr. Kim who, saw claimant on June 3, 2014. Dr. Kim's assessment was, "[c]hronic low back pain with R lumbar radiculopathy due to lumbar annular disc tear." (Ex. 2, p. 18) On June 17, 2014, Dr. Kim performed a right-sided L5-S1 transforaminal epidural steroid injection. (Ex. 2, p. 19) On July 16, 2014, Dr. Kim noted that claimant reported improvement in his chronic lower back pain with left lumbar radiculopathy. (Ex. 2, p. 22) On September 18, 2014, claimant had another right-sided transforaminal epidural steroid injection. (Ex. 2, p. 36)

On September 22, 2014, Dr. Kim responded to questions from claimant's counsel. Dr. Kim agreed that the treatment he was providing was both reasonable and beneficial. (Ex. 2, p. 38) Dr. Kim recommended additional medical care and treatments. (Ex. 2, p. 39)

Claimant returned to Dr. Eck in December 2014. Dr. Eck wrote,

> Based on the patient's current complaints, physical exam findings, previous radiographic imaging studies, and failure to respond to appropriate nonoperative treatments, I think it is reasonable to proceed with an MRI of the lumbar spine for further evaluation. I will also obtained [*sic*] upright radiographs of the lumbar spine. [*sic*] Prior to his next visit with me. After the MRI scan has been completed, he will return [*sic*] review the results and discuss further options for treatment. I strongly encouraged smoking cessation.

(Ex. 2, p. 45) A third MRI was performed by Glen Hammer, M.D. on December 31, 2014. (Ex. F, p. 115; Ex. 2, p. 36) On January 7, 2015, Dr. Harman answered

questions posed by claimant's counsel. Dr. Harman agreed that the treatment claimant had received since June 2013 was reasonable and beneficial in treating claimant's work related condition. (Ex. 2, p. 24) Dr. Harman agreed that the results of the April 16, 2014 FCE were a more accurate assessment of claimant's physical capabilities, rather than the October 25, 2013 FCE. (Ex. 2, p. 48)

On January 6, 2015, Dr. Eck reviewed the MRI and examined claimant. Dr. Eck concluded;

> Based on the patient's current complaints, physical exam findings, previous radiographic imaging studies, and failure to respond to appropriate nonoperative treatments, I think he represents a reasonable candidate for a right-sided L5-S1 micro-hemilaminectomy with discectomy and lateral recess decompression.

(Ex. 2, p. 50) On January 23, 2015, Dr. Eck performed back surgery. His postoperative diagnosis was, "[r]ight lower extremity S1 radiculopathy secondary to right-sided disk herniation and lateral recess stenosis from facet arthropathy at L5-S1 on the right." (Ex. F, p. 119; Ex. 2, p. 56) On February 23, 2015, Dr. Eck reported that the right lower extremity radicular pain present prior to surgery had improved significantly. (Ex. 2, p. 60) On March 10, 2015, Dr. Eck replied to a letter from claimant's counsel. (Ex. 2, p. 65; Ex. F. p. 121) Dr. Eck stated that the treatments he provided claimant were reasonable and beneficial. He thought that claimant would reach MMI three months after his surgery and recommended additional treatments. (Ex. F, p. 121) On April 27, 2015, Dr. Eck found claimant reached MMI. (Ex. 2, p. 81) Dr. Eck stated, "I do believe he will have chronic pain and limitation secondary to his multiple level lumbar degenerative disease. Once he has been cleared by the general surgeon, following recent hernia repair, he can return to work as tolerated with restrictions as defined on the upcoming scheduled functional capacity examination." (Ex. 2, pp. 81, 82) Dr. Eck returned claimant to work with a 30 pound lifting restriction as of July 6, 2015, with limitations in bending and twisting. (Ex. F, p. 126; Ex. 2, pp. 95, 96)

On May 4, 2015, Robin Sassman, M.D. updated her previous independent medical examination (IME) of the claimant. (Ex. 1, pp. 1 – 11) Dr. Sassman had evaluated claimant on October 27, 2014. Dr. Sassman provided a comprehensive medical history which provides a very good history of treatments through the time of her IME. (Ex. 1, pp. 2 – 7) Dr. Sassman's diagnosis was,

> 1. Low back pain with radiculopathy status post right L5-S1 micro hemilaminectomy with discectomy by Kevin Eck, M.D. on January 23, 2015.
>
> 2. Umbilical hernia status post umbilical hernia repair in April of 2015 by Dr. Robert Keating.

(Ex. 1, p. 9) Dr. Sassman found claimant's back condition and hernia related to his work injury. (Ex. 1, p. 9) She did not believe claimant was at MMI for his back condition until he had additional physical therapy. (Ex. 1, p. 10) She found that claimant would be at MMI for the six months from his hernia surgery. (Ex. 3, p. 8) Six months from the surgery would be September 7, 2015. Using the combined values chart found in the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, she found claimant has a 17 percent impairment to the whole body. (Ex. 1. p. 1) She recommended the following restrictions,

> Regarding restrictions, I would recommend limit lifting, pushing, pulling and carrying to 10 pounds occasionally from floor to waist, waist to shoulder and over shoulder height. He may occasionally sit, stand and walk but will need to change positions frequently due to his symptoms. I would recommend rarely stooping, bending, crawling, or kneeling. I would not recommend walking on uneven surfaces or ladders. He should rarely use stairs. I would not recommend the use of vibratory or power tools as these may exacerbate his symptoms.

(Ex. 1, p. 10)

I find that claimant has proven that his hernia was a result of his physical therapy. I based this conclusion on Dr. Sassman's opinion and testimony of the claimant. I find Dr. Sassman's opinion more thorough than the brief conclusion of Dr. Dolphin.

On July 21, 2015, Michael Dolphin, D.O. performed an IME. (Ex. J, pp. 146, 148) Dr. Dolphin stated it was reasonable for claimant to continue his treatment with Dr. Eck and to continue his therapy. He believed claimant would be at MMI as of August 17, 2015. Dr. Dolphin did not believe that claimant's hernia was causally related to his work injury or physical therapy. Dr. Dolphin provided a 13 percent whole body impairment rating. (Ex. J, p. 148) He recommended another FCE.

On June 15, 2015, Kent Jayne, a vocational expert, issued a vocational assessment. (Ex. 3, pp. 1 – 15) At the time of this evaluation claimant had not returned to any work on a full or part-time basis. Using Dr. Sassman's restrictions he concluded claimant capable of work below the sedentary level. (Ex. 3, p. 11) Mr. Jayne stated,

> Even using the physical restrictions as set forth most liberally in the first functional capacity evaluation administered by Mr. Kruzich and taking into account Mr. Bebensee's demonstrated abilities in his vocational capacities, Mr. Bebensee would not be currently employable on a competitive basis in any reasonably stable branch of the labor market.

(Ex. 3, p. 12)

On July 13, 2014, Lana Sellner, M.S., C.R.C. issued a vocational assessment. (Ex. H, pp. 128 – 143) Ms. Sellner determined, based upon Dr. Sassman's restrictions, claimant could perform sedentary work. (Ex. H, p. 138) Ms. Sellner recommended that claimant continue his current part-time work that could lead to full time work. It was her conclusion that claimant had the capacity to perform sedentary work. (Ex. H, p. 141)

Claimant has submitted evidence that payments were delayed for 20 weeks. For the most part, the payments were mailed a few days later than they should have been mailed. (Ex. 7, pp. 9 - 11) I find that defendants did not timely make payments for the following time periods,

Date Issued	Dates Payable	Amount Paid	Amount Late
09/03/2013	08/26/2013-09/01/2013	$1,048.64 (1 week)	$1,048.64
12/11/2013	11/25/2013-12/08/2013	$2,097.28 (2 weeks)	$2,097.28
12/24/2013	12/16/2013-12/22/2013	$1,048.64 (1 week)	$1,048.64
03/04/2014	02/24/2014-03/02/2014	$1,048.64 (1 week)	$1,048.64
04/08/2014	03/31/2014-04/06/2014	$1,048.64 (1 week)	$1,048.64
07/08/2014	06/30/2014-07/06/2014	$1,048.64 (1 week)	$1,048.64
08/05/2014	07/28/2014-08/03/2014	$1,048.64 (1 week)	$1,048.64
08/12/2014	08/11/2014-08/17/2014	$1,048.64 (1 week)	$1,048.64
08/19/2014	0811/2014-08/17/2014	$1,048.64 (1 week)	$1,048.64
08/26/2014	08/18/2014-08/24/2014	$1,048.64 (1 week)	$1,048.64
09/03/2014	08/25/2014-08/31/2014	$1,048.64 (1 week)	$1,048.64
09/09/2014	09/01/2014-09/07/2014	$1,048.64 (1 week)	$1,048.64
09/16/2014	09/08/2014-09/14/2014	$1,048.64 (1 week)	$1,048.64
09/23/2014	09/15/2014-09/21/2014	$1,048.64 (1 week)	$1,048.64
09/30/2014	09/22/2014-09/28/2014	$1,048.64 (1 week)	$1,048.64
10/14/2014	10/06/2014-10/12/2014	$1,048.64 (1 week)	$1,048.64
10/21/2014	10/13/2014-10/19/2014	$1,048.64 (1 week)	$1,048.64

10/28/2014	10/20/2014-10/26/2014	$1,048.64 (1 week)	$1,048.64

I find the total in late payments to be $19,924.16.

Exhibit 7, page 5 states that defendants paid on November 13, 2014, $1,797.67 for the time period November 3, 2014 through November 14, 2014. I find that claimant has not shown this payment to be late.

Claimant has requested medical expenses for treatments after March 12, 2014. (Ex. 8, pp. 1 – 53) A summary is found in Exhibit 8, pages 54 – 56. Claimant has also requested costs in the amount of $8,840.96. (Ex. 9, p. 1)

I find that claimant has made a reasonable, but unsuccessful effort to find full time employment. Commendably, claimant obtained a part-time job at AutoZone. His employer was aware of his limitations and claimant was not required to exceed his limitations. At the time of the hearing, claimant had worked for a short time. Based upon the credible testimony of claimant and Ms. Bebensee, it was apparent that claimant was having very significant difficulties maintaining his part time employment due to his back condition. I further find that because of the December 24, 2012 work injury, the only services that claimant could reasonably perform are so limited in quality, dependability, or quantity that a reasonable stable market for his services does not exist. Considering claimant's age, educational background, employment history, ability to retrain, motivation to return to the workforce, permanent impairment, and permanent restrictions, and the other industrial disability factors set forth by the Iowa Supreme Court, I find that he is wholly disabled from performing work that he would otherwise be qualified and capable of performing. I find that claimant has proven he is permanently and totally disabled as a result of the December 24, 2012 work injury as a volunteer firefighter for the City of Walker.

This finding is based on claimant's inability to obtain regular employment. To his credit, he was able to obtain part-time employment at AutoZone. However, this employment is not full-time hours. Claimant has been a hard worker for the vast majority of his life. I find that as a result of the December 24, 2012 work injury, claimant is not physically capable of performing any of his prior jobs at the City of Walker in the fire department or returning to his work as a diesel mechanic. He cannot perform prior construction, mechanic, and maintenance work nor could he operate a tavern, given the numerous physical tasks that are required in operating a small business. Additionally, the tavern was a family business that has closed. Thus, as a result of the work injury, he can no longer perform the jobs he performed in his adult working life.

REASONING AND CONCLUSIONS OF LAW

The parties stipulated the claimant has a permanent impairment due to an injury that arose out of and in the course of his employment with the City of Walker on

December 24, 2012. Claimant asserts that he is permanently and totally disabled as a result of the December 24, 2012, work injury. Claimant asserts his claim under both the traditional industrial disability analysis and claims that he is an odd-lot employee. The odd-lot claim will be evaluated first.

In Guyton v. Irving Jensen Co., 373 N.W.2d 101 (Iowa 1985), the Iowa court formally adopted the "odd-lot doctrine." Under that doctrine a worker becomes an odd-lot employee when an injury makes the worker incapable of obtaining employment in any well-known branch of the labor market. An odd-lot worker is thus totally disabled if the only services the worker can perform are "so limited in quality, dependability, or quantity that a reasonably stable market for them does not exist." Id., at 105.

Under the odd-lot doctrine, the burden of persuasion on the issue of industrial disability always remains with the worker. Nevertheless, when a worker makes a prima facie case of total disability by producing substantial evidence that the worker is not employable in the competitive labor market, the burden to produce evidence showing availability of suitable employment shifts to the employer. If the employer fails to produce such evidence and the trier of facts finds the worker does fall in the odd-lot category, the worker is entitled to a finding of total disability. Guyton, 373 N.W.2d at 106. Factors to be considered in determining whether a worker is an odd-lot employee include the worker's reasonable, but unsuccessful, effort to find steady employment, vocational or other expert evidence demonstrating suitable work is not available for the worker, the extent of the worker's physical impairment, intelligence, education, age, training, and potential for retraining. No factor is necessarily dispositive on the issue. Second Injury Fund of Iowa v. Nelson, 544 N.W.2d 258 (Iowa 1995). Even under the odd-lot doctrine, the trier of fact is free to determine the weight and credibility of evidence in determining whether the worker's burden of persuasion has been carried, and only in an exceptional case would evidence be sufficiently strong as to compel a finding of total disability as a matter of law. Guyton, 373 N.W.2d at 106.

In this case, I found claimant produced prima facie evidence to establish a claim for permanent total disability. Therefore, the burden of production shifted to the defendants to produce evidence demonstrating the availability of suitable employment.

The employer did produce evidence that demonstrates some vocational abilities. The FCEs and report of Ms. Sellner point to some vocational ability for claimant to engage in full time work.

The claimant has produced evidence that he incapable of returning to full time work. Claimant's and his wife's testimony concerning his difficulties in working part time, the opinion of Mr. Jayne and opinion of Dr. Sassman provide convincing evidence that claimant is an odd-lot employee. He has not been able to obtain steady employment. He found a part-time job paying $8.55 per hour. He has significant pain and he has difficulty even in activities of daily living. His wife and mother provide significant assistance to him. (Ex. 3, p. 7) Having found that claimant proved that the

only services he could presently offer in the labor market are so limited in quality, dependability, or quantity that there does not exist a reasonably stable labor market for those services, I conclude that claimant has proven he is an odd-lot employee and that he is entitled to permanent total disability benefits.

However, even if I did not rely upon the odd-lot doctrine, I would still conclude that claimant is entitled to permanent total disability benefits. Assessments of industrial disability involve a viewing of loss of earning capacity in terms of the injured workers' present ability to earn in the competitive labor market without regard to any accommodation furnished by one's present employer. Quaker Oats Co. v. Ciha, 552 N.W.2d 143, 158 (Iowa 1996); Thilges v. Snap-On Tools Corp., 528 N.W.2d 614, 617 (Iowa 1995).

Total disability does not mean a state of absolute helplessness. Permanent total disability occurs where the injury wholly disables the employee from performing work that the employee's experience, training, education, intelligence and physical capacities would otherwise permit the employee to perform. See McSpadden v. Big Ben Coal Co., 288 N.W.2d 181 (Iowa 1980); Diederich v. Tri-City R. Co., 219 Iowa 587, 258 N.W. 899 (1935).

A finding that claimant could perform some work despite claimant's physical and educational limitations does not foreclose a finding of permanent total disability, however. See Chamberlin v. Ralston Purina, File No. 661698 (App. October 29, 1987); Eastman v. Westway Trading Corp., II Iowa Industrial Commissioner Report 134 (App. 1982).

In the present case, I considered all of the relevant industrial disability factors and found that claimant is wholly disabled. He is physically unable to perform work that his experience, training, education, and intelligence would otherwise have allowed him to perform. The only work that claimant has been able to obtain since leaving the fire department and his diesel mechanic position is part-time. Claimant's injury has rendered him unable to compete in the competitive labor market. I find there are no realistic jobs available to claimant. I conclude that claimant has proven he is permanently and totally disabled even if the odd-lot doctrine is not considered.

Penalty

The relevant portion of section 86.13 provides:

> 4. a. If a denial, a delay in payment, or a termination of benefits occurs without reasonable or probable cause or excuse known to the employer or insurance carrier at the time of the denial, delay in payment, or termination of benefits, the workers' compensation commissioner shall award benefits in addition to those benefits payable under this chapter, or chapter 85,

85A, or 85B, up to fifty percent of the amount of benefits that were denied, delayed, or terminated without reasonable or probable cause or excuse.

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

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

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

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

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

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

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

Iowa Code section 86.13(4)(b) creates a two-prong test that requires the agency to award a claimant penalty benefits if (1) "The employee has demonstrated a denial, delay in payment, or termination of benefits"; and (2) "The employer has failed to prove a reasonable or probable cause or excuse for the denial, delay in payment, or termination of benefits." In order to be considered a reasonable or probable cause or excuse under paragraph "b," an excuse shall satisfy the three criteria listed in paragraph "c." Pettengill v. American Blue Ribbon Holdings, LLC, 14-1511(Court of Appeals, December 23, 2015) WL 9450654.

In this case, I found that claimant has proven a delay in payment of benefits that totals $19,924.16. Defendants did not offer any evidence to dispute the late payments. The defendants argued in their brief that almost all the payments were no more than 2 days late and during a time when they were voluntarily paying a 10 percent permanent partial disability. While it is true the delay was slight, such delays can have a very adverse impact on injured workers. For injured employees, a "short" delay can often have bad consequences. Delay for injured works can mean utility shut-offs, evictions or foreclosure. Defendants offered no explanation as to why the payments were late or that they have instituted systems to avoid late payments in the future. A

substantial reason to award penalty is to encourage compliance with workers' compensation laws. I find that a penalty of $7,500.00 is appropriate in this case so as to encourage timely payments of benefits.

Claimant has also requested payment of penalty for failure to pay more than the ten percent permanent partial disability (PPD). I find that defendant did have reasonable cause and excuse based upon the reports of Dr. Chen and Dr. Abernathy. No penalty is awarded for failing to pay additional PPD.

Request for medical expenses.

Claimant has requested that defendants pay medical expenses. These expenses were not authorized by the defendants.

In Bell Bros. Heating and Air Conditioning v. Gwinn, 779 N.W.2d 193, 206 - 207 (Iowa 2010) the court held concerning unauthorized medical expenses,

> We do not believe the statute can be narrowly construed to foreclose all claims by an employee for unauthorized alternative medical care solely because the care was unauthorized. Instead, the duty of the employer to furnish reasonable medical care supports all claims for care by an employee that are reasonable under the totality of the circumstances, even when the employee obtains unauthorized care, upon proof by a preponderance of the evidence that such care was reasonable and beneficial. In this context, unauthorized medical care is beneficial if it provides a more favorable medical outcome than would likely have been achieved by the care authorized by the employer. The allocation of this significant burden to the claimant maintains the employer's statutory right to choose the care under section 85.27(4), while permitting a claimant to obtain reimbursement for alternative medical care upon proof by a preponderance of the evidence that such care was reasonable and beneficial.
>
> This approach allows the employer to maintain control when the care provided is reasonable and beneficial, but recognizes there are times when multiple, apparently reasonable courses of medical treatment coexist. As such, it gives the employee a chance to recover for reasonable and beneficial but unauthorized medical care when the purposes of allocating to the employer the power to select medical care are not jeopardized. This interpretation of the statute is consistent with the overall approach of section 85.27(4) to balance the control given to the employer with safeguards for the employee. This interpretation is also consistent with our approach to interpret workers' compensation statutes liberally in favor of the worker. (Citation omitted.)

Evidence in administrative proceedings is governed by section 17A.14. The agency's experience, technical competence, and specialized knowledge may be utilized in the evaluation of evidence. The rules of evidence followed in the courts are not controlling. Findings are to be based upon the kind of evidence on which reasonably prudent persons customarily rely in the conduct of serious affairs. Health care is a serious affair.

Prudent persons customarily rely upon their physician's recommendation for medical care without expressly asking the physician if that care is reasonable. Proof of reasonableness and necessity of the treatment can be based on the injured person's testimony. Sister Benedict v. St. Mary's Corp., 255 Iowa 847, 124 N.W.2d 548 (1963).

It is said that "actions speak louder than words." When a licensed physician prescribes and actually provides a course of treatment, doing so manifests the physician's opinion that the treatment being provided is reasonable. A physician practices medicine under standards of professional competence and ethics. Knowingly providing unreasonable care would likely violate those standards. Actually providing care is a nonverbal manifestation that the physician considers the care actually provided to be reasonable. A verbal expression of that professional opinion is not legally mandated in a workers' compensation proceeding to support a finding that the care provided was reasonable. The success, or lack thereof, of the care provided is evidence that can be considered when deciding the issue of reasonableness of the care. A treating physician's conduct in actually providing care is a manifestation of the physician's opinion that the care provided is reasonable and creates an inference that can support a finding of reasonableness. Jones v. United States Gypsum, File No. 1254118 (App. May 16, 2002); Kleinman v. BMS Contract Services, Ltd., File No. 1019099 (App. September 8, 1995); McClellon v. Iowa Southern Utilities, File No. 894090 (App. January 31, 1992). This inference also applies to the reasonableness of the fees actually charged for that treatment.

As noted in a law review article;

> Workers do not truly direct their own care; rather, they follow the recommendations and directions of their medical-care providers. It has been held in agency decisions, as well as in tort claims, that an injured individual's testimony can be sufficient to show the care was reasonable and necessary, and medical bills themselves are based on medical opinions that care was medically reasonable and the costs were appropriate for the care provided.

Establishing Causation in Iowa Workers' Compensation Law: An Analysis of Common Disputes Over the Compensability of Certain Injuries 59 Drake L. Rev. 463, 531 (2011).

In this case claimant's primary care physician, Dr. Thomas, referred claimant to Dr. Kim in May 2014 due to increased pain. (Ex. 2, p. 16) Dr. Kim found in June 2014 that claimant had right lumbar radiculopathy due to a lumbar annular disc tear.

Claimant has followed the advice of physicians in obtaining additional care. It is true that Dr. Chen recommend against certain types of additional care. The record shows that claimant's condition was getting worse and with pain radiating into his leg.

Dr. Eck, Dr. Harman, and Dr. Sassman opined that claimant's care was reasonable and Dr. Dolphin stated in his IME that it was reasonable for claimant to continue his therapy and follow up with Dr. Eck. (Ex. J, p. 148) I find that the care claimant received was reasonable. I also find that it was beneficial. While claimant currently has a debilitating back condition, the care he received did lessen his pain into his leg and has provided him benefit. I base this conclusion on claimant's testimony and the records from Dr. Eck.

The defendants are responsible for the medical expenses found in Exhibit 8.

Request for alternate care.

The employer shall furnish reasonable surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance, and hospital services and supplies for all conditions compensable under the workers' compensation law. The employer shall also allow reasonable and necessary transportation expenses incurred for those services. The employer has the right to choose the provider of care, except where the employer has denied liability for the injury. Section 85.27. Holbert v. Townsend Engineering Co., Thirty-second Biennial Report of the Industrial Commissioner 78 (Review-Reopening October 16, 1975).

Claimant has requested ongoing care for his low back and for depression. Claimant is entitled to care for his low back. In fact, Dr. Chen recommended claimant have some cognitive therapy when he was at the spine clinic at the UIHC.

Defendants shall provide care to the claimant for his low back and a referral to a qualified mental health provider to address claimant's mental health issues related to his work injury. Defendants maintain the right to control medical care.

Request for IME expenses.

Iowa Code section 85.39 provides, in relevant part, as follows:

> 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. (Emphasis added.)

Iowa Code section 85.39

Dr. Sassman's IME was conducted on May 4, 2015 and her report issued on June 10, 2015. Dr. Dolphin's IME and report were done on July 21, 2015. As Dr. Abernathy provided a rating of no permanent impairment on February 2013, claimant is entitled to one IME pursuant to Iowa Code section 85.39. Claimant has requested reimbursed of two IME reports performed by Dr. Sassman. (Ex. 9, pp. 5, 6) Only one report was made part of the evidence. Claimant is entitled to only one IME under Iowa code section 85.39. Dr. Sassman charged $2,062.00 for the IME of May 4, 2015. This IME was Exhibit 1. I award this cost. I decline to order payment of the October 27, 2014 IME report under Iowa Code section 85.39 or as a cost under rule 876 IAC 4.33.

Request for costs

Claimant has requested $4,660.50 for the report of Mr. Jayne. The amount requested by Mr. Jayne is much higher than this agency typically sees from vocational experts. There was no evidence presented to justify this high of an expense. Claimant's case is not vocationally complex. Using my discretion under rule 876 IAC 4.33, I award $2,660.00 of this expense. I order the defendants to pay the filing fee and service costs of $112.96. I award $2,772.96 in costs.

ORDER

Defendants shall pay permanent total disability benefits to the claimant for so long as he is permanently disabled at the weekly rate of one thousand forty-eight and 64/100 dollars ($1,048.64). Benefits commence on December 25, 2012.

Defendants shall have a credit for benefits previously paid.

Defendants shall provide the medical care ordered in this decision.

Defendants shall pay the medical expenses set forth in this decision.

Defendants shall pay claimant two thousand sixty two dollars ($2,062.00) for the IME of Dr. Sassman.

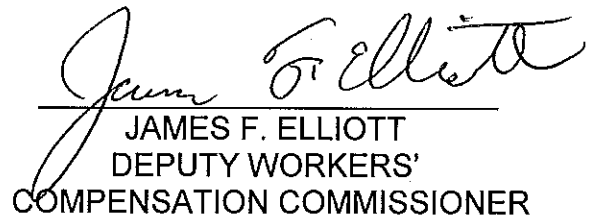
Defendants shall pay costs of two thousand seven hundred seventy-two and 96/100 dollars ($2,772.96).

Defendants shall pay penalty in the amount of seven thousand five hundred dollars and 00/100 dollars ($7,500.00)

All past due benefits shall be paid in a lump sum with interest as provided by law.

Defendants shall file additional reports as required by this agency.

Signed and filed this 22nd day of April, 2016.



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JFE/srs

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.