BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

STEPHANY MARSHALL,

Claimant,

vs.

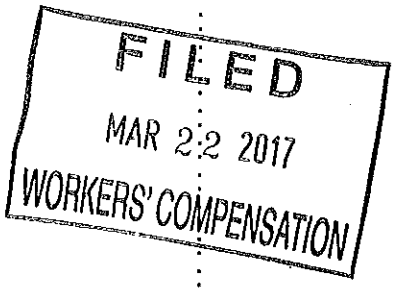
MENARD, INC.,

Employer,

and

PRAETORIAN INS. CO.,

Insurance Carrier,
Defendants.



File No. 5048490

ARBITRATION

DECISION

Head Note Nos.: 1803; 1108; 2502

STATEMENT OF THE CASE

Stephany Marshall, claimant, filed a petition in arbitration seeking workers' compensation benefits against Menard, Inc., and Praetorian Insurance Company, insurer, for a work injury date of March 9, 2013.

This case was heard on December 12 2016, in Council Bluffs, Iowa. The record was left open until January 16, 2017, to allow the defendants to respond to the documents and opinions and video-taped statement of Dr. Becker. The case was considered fully submitted on February 6, 2017, upon the simultaneous filing briefs.

The record consists of joint exhibits AA-KK, claimant's exhibits 8–19, 21-35, 39-45, defendants' exhibits A-H, J, L-P, and the supplemental report of Donald Gammel, M.D., dated January 6, 2017, claimant's testimony.

ISSUES

1. Whether the alleged injury is a cause of permanent disability and, if so, the extent;

2. The appropriate commencement date of benefits;

3. Whether there is a causal connection between claimant's injury and the medical expenses claimed by claimant in exhibit 45.

4. Whether claimant is entitled to potential care and evaluation from Chicago Electrical Trauma Institute Research.

5. Whether claimant is entitled to a 85.39 reimbursement of Jan Golnik, M.D.

6. Costs

STIPULATIONS

The parties stipulate claimant sustained an injury on March 9, 2013, which arose out of and in the course of her employment. At the time of the injury, the claimant's gross earnings were $453.60 per week. She was single and entitled to one exemption. Based on those foregoing numbers, claimant's weekly benefit rate is $297.14.

FINDINGS OF FACTS

Claimant was a 55 year old woman at the time of the hearing. She finished school through the eleventh grade and received her GED in 1994. She received training in hair design and as a medical assistant. Her work history includes working on a family farm, work at a Casino as the Player's club lead staff who maintained player's accounts, handled bus traffic, and occasionally filled in as a host. She had a position as a certified sterile processor at Methodist Hospital, worked dispatch for the Pottawattamie County 911 Center, assisted surgery staff, served as a dental assistant, and then transitioned into security guard work in approximately 2002. She also did janitorial work and order processing until she began work for defendant employer as a box processor. It was one of her highest paying jobs other than the time she spent at the Southwest Iowa Juvenile Detention Center as a juvenile correctional officer. (Ex. 43)

Prior to the injury, claimant maintained she was in very good shape. She belonged to a fitness club, walked five to ten miles on a regular basis and rode her bicycle on the weekends for up to 60 miles. Her stepson testified that he took these rides with her.

On March 9, 2013, claimant was in the process of shutting off a light when her finger touched a bare wire. She was wearing gloves but a hole in a finger exposed her to the wires. As a result, she believes she experienced an electrocution that spread throughout her entire body. She testified that she urinated herself and bit her tongue; however, because she was so close to the end of her shift, she finished work. Shortly thereafter when she was in her car, her nose began to bleed. Several days later, she began experiencing chest pains, left arm pain, facial numbness, severe fatigue, balance problems.

Thomas Stengel wrote out a statement that he witnessed her getting shocked when she turned off the light. He also observed her glove with the hole. He said that the hole was caused by the "sparks from the light." (Ex. 35) Jessien Hoptonstall also saw "sparks ....that arched right over her hand." Jessien described claimant as "shaken up" and that there was a small burn mark on the finger of claimant's glove. (Ex. 34)

The light itself can accommodate 150w to 300w bulbs and 120 volts. (Ex. 31) Anthony Smiley, a supervisor for defendant employer, testified that the light was repaired shortly after the incident occurred.

Claimant first sought medical treatment on March 15, 2013, for her electrocution complaints. (Ex. BB p. 9) Joseph Lynch, M.D., found abnormal palpations.

> She has some left sided chest, arm, and jaw discomfort and occasionally which appear to be very short tachycardia or palpitation episodes lasting a few seconds and these are associated with aches on her left side. These occur approximately twice daily. Electrocardiogram at this time revealed sinus rhythm, left axis deviation. Echocardiogram was performed which revealed normal left ventricular contractility with no valvular problems. Lab work including troponin, CPK, CMP, CBC were normal.

(Ex. BB, p. 9)

He ordered a 24 holter monitor and theorized that claimant suffered a significant shock. (Ex. BB, p. 9) In a visit to Mercy Hospital on March 17, 2013, claimant reported chest pain. Again, the testing was negative other than hyperexpansion consistent with some obstructive pulmonary disease.

DOCTOR NOTES

> Note: patient presents with complaint of chest pain. Patient's chest pain has been intermittent for the past several days after sustaining a shock. Patient has no evidence of any dysrhythmia on her EKG. She appears otherwise well and nontoxic. He does have some nonspecific changes in her EKG. Given the patient's history smoking, and her age, and should benefit from cardiac workup. D-dimer was obtained to evaluate for pulmonary embolism. It was negative. Chest x-ray did not reveal any infiltrate. Patient notes she is pain-free here, although somewhat fatigued. Cardiac enzymes x 3 and EKG's have been unremarkable. Patient is stable for stress testing.
>
> Stress test negative per cardiology.
>
> Patient describes short shooting pain and numbness of face, left chest, and left UI intermittently since being shocked and then afterward is very tired and lethargic for a couple of hours. This has occurred several times, there has been no shaking, tongue biting, incontinence. Will schedule for EEG and then close outpatient f/u with occ. Health.

(Ex. DD, p. 4)

She followed up with LeAnne Vitito on April 1, 2013, with complaints of nonspecific symptoms of facial weakness and numbness along with nonspecific joint

pains. (Ex. DD, p. 12) It was noted that there were no entry or exit wounds from the electrical discharge. (Ex. DD, p. 12) She showed some signs of wheezing, cough, and sputum. (Ex. DD, p. 12) In a visit in 2012, claimant had a respiratory illness that was accompanied by symptoms of dizziness. (Ex. BB) During the April 1, 2013, visit with Ms. Vitito, claimant's symptoms included weakness and pain, but she denied falling, stumbling, being off balance, headaches or vomiting:

> Further discussion with the patient today she continues to have nonspecific symptoms of intermittent shooting pain and numbness in her face, weakness in all of her extremities, joint aches throughout her body that are not specific to one area, fatigue which often requires her to sleep 15 hours a day, "legs that are wobbly when she is standing", dizziness and at times blurred vision that she describes as "seeing clouds". Upon questioning she denies any problems with being off balance, falling, stumbling, headaches, vomiting, trouble with eating, reading either close-up or far away, sleeping, or weakness specific to 1 side of the body or extremity. She is been on light duty but feels that she is not able to perform at this level at times because of the fatigue. She currently denies any further chest pain, palpitations, shortness of breath, or inability to carry our usual activities of daily living because of chest pain or shortness of breath. She denies any history of a stroke, seizures, previous coronary artery disease or MI.

(Ex. DD, p. 12)

Test results showed equal strength in all extremities along with normal station and gait.

> Patient is alert oriented cooperative and I am unable to determine the right reliability of her history. Her descriptions of certain symptoms are somewhat vague and difficult to understand even with probing. Pupils are equal reactive to light, extraocular eye movements are intact, facial muscle movement is symmetrical. Her visual acuity appears to be with normal. No nystagmus on exam. No drooping of the [eye] noted. Lungs are clear to auscultation bilaterally and breath sounds heard well throughout. Heart regular rate and rhythm without a murmur. Radial pulses strong and regular. She has good strength that is equal bilaterally in upper and lower extremities as expected. She has no parasthesias in her upper extremities. When asking her to squat she is unable to do this efficiently because she complains of joint pains. She says these pains are new and she has them in all joints for body nonspecific just to her knees. Circulation sensation are normal in upper extremities as well as in lower extremities. Neurologically there are no focal deficits. I did not find any abrasions burns or breaks in the skin on the left hand primarily index finger.

(Ex. DD, p. 13) Ms. Vitito recommended claimant wait for the EEG results and then determine whether a neurological consultation was necessary. (Ex. DD, p. 13) The EEG was normal, but because of the claimant's subjective reports, she was sent for a neurological consult with Rodica Petrea MD. (Ex. CC, p. 6) On April 5, 2013, claimant reported to Dr. Petrea of symptoms such as regular electrical shocks in her extremities along with numbness on her face, headaches and fogginess in her right eye.

She complained of weakness, but still had sensation in her extremities.

> Now at times she feels shivey and is quivering, feels like she has electrical shocks in hands and feet, legs, like "rewiring". She also feels numbness on her face and headache and right eye foggy and with nausea. She thought it was from hard work, physical activity but she never had this problem before. She feels generalized weak but does not drop things. She did not lose the sensation in her hands and feet. She does not lose control of her bowel or bladder.

(Ex. CC, p. 3) The neurological examination revealed no acute distress, pupils equal, round and reactive to light, normal heart rate and rhythm, normal orientation, memory, attention, language, normal gain, normal motor strength, coordination and reflexes. (Ex. CC, p. 5) Dr. Petrea recommended an MRI of the brain and c-spine, an ophthalmology referral, EMG testing.

The MRI on April 19, 2013, showed no evidence of any brain injury but there were signs of degenerative disease on multiple levels. (Ex. CC, p. 9) On May 3, 2013, Dr. Petrea examined claimant again. She had decreased attention span, short-term memory impairment, and difficulty concentrating along with diminished sensation on the left anterior side of the leg in the L4 distribution. All other tests were largely negative. (Ex. CC, p. 11) Dr. Petrea recommended more tests, prescribed Lyrica, and referred her to PT for gait training due to claimant's subjective complaints as opposed to any positive gait traits upon testing. (Ex. CC, p. 12)

A subsequent MRI on June 7, 2013, again showed only degenerative disease. Claimant continued to complain of weakness, numbness, and falls. Medication and physical therapy was prescribed.

Physical therapy began on June 13, 2013. (Ex. FF, p. 4) During the physical therapy appointment, the therapist noted that claimant had normal strength and her neurological examination was unremarkable but that claimant did have signs of vestibular involvement. (Ex. FF, p 5) A follow up appointment was recommended.

On June 18, 2013, claimant returned to Dr. Petrea. (Ex. CC, p. 14) During that examination, her orientation, memory, attention, language and fund of knowledge were normal. (Ex. CC, p. 16) Dr. Petrea referred claimant to an ENT and neurosurgeon. (Ex. CC, p. 16)

On August 7, 2013, she saw Britt A. Thedinger, M.D., an ear specialist with complaints of dizziness, lightheadedness, positional vertigo, irregular heartbeat, chest pain and numbness on the left side of her face. All tests were normal other than a Dix-Hallpike vertigo test that was positive on the right. (Ex. HH, p, 1) Dr. Thedinger felt her right-sided positional vertigo was related to the shock. (Ex. HH, p, 1) He performed a Semont maneuver which was successful because a follow-up test on September 11, 2013 resulted in a negative positional vertigo testing. (Ex. HH, p, 1, 2) Unfortunately, claimant still described imbalance and "floaty sensation in her head." (Ex. HH, p, 2) Dr. Thedinger recommended a trial of Diazepam and that she work in a sedentary position and avoid bending and stooping.

Claimant requested a second neurological opinion. This was granted.

On October 11, 2013, claimant was seen by Scott H. Goodman, M.D. To Dr. Goodman, she described her symptoms as follows:

> The main concern is left sided symptoms of numbness, episodic weakness, and falls. She notes, on her left side, that she has a weird numbing sensation. It happens all of the sudden and that is when she falls down. It just happens, lasts for 2-3 seconds, then she falls. She injured her grandson once when she was holding her grandson in her arms. She estimates that she has fallen down, 30 or 40 times, since her injury. Generally she does not injure herself. It can happen, randomly, at any time. It lasts just seconds, then her face goes numb again, then she gets nauseated, lightheaded and woozy feeling. She had intermittent dizziness yesterday. She has intermittent left sided numbness. It is like a wave. She gets zaps of electricity on the bottom of her feet and between her toes. This has been getting worse. She gets a numb weird sensation across her face intermittently, still.

(Ex. II, p. 3) Her examination was largely negative although Dr. Goodman did note she had a mild suggestion of giveaway weakness on the left. Her gait was normal as was her coordination. (Ex. II, p. 4)

Dr. Goodman concluded that claimant's symptoms were consistent with a residual deficit from an electrocution injury and that "her most hazardous or disabling symptoms is that she has intermittent and unpredictable falls, due to episodic left-sided dysfunction." (Ex. II) He concluded that she reached MMI and that she should have regular treatment for numbness and pain with Gabapentin and symptomatic treatment for myoclonus with Keppra or Depakote. (Ex. II, p. 5-6) He further recommended physical therapy, avoidance of ladders, heavy or dangerous machinery, and lifting of any degree of weight that could result in injury if she were to fall. (Ex. II, p. 6) Defendants' characterize this as temporary but the restrictions were never lifted by Dr. Goodman.

Claimant underwent an IME with David Gammel, M.D., on December 11, 2013.

> Ms. Marshall's greatest concern at this time is 'falling, and focusing, anxiety, lifes activity and my indepdence [sic]'. She states she has stiffness in 'joints', weakness in 'leftside', numbness and tingling in 'leftside', and pain located in 'its not, its all over', described as 'rubber band snaps' muscle spasms'. She states her pain is worsened with 'fatigue' and relieved by 'time.' She describes the frequency of her pain as frequent (present ¾ to ½ of the time). Ms. Marshall states that her symptoms affect her ability to perform daily activities as 'moderate, interferes with activity.' 'limiting, prevents full activity.' She describes tasks that are difficult for her to perform as 'bending down and getting up, getting up after sitting' and that she is having other difficulties with 'driving, using the computer, dancing, playing with my grandkids, cooking, carring [sic] things, reading for enjoyment to name a few.'

(Ex. C, p. 6) Her pain drawing showed pain in nearly every part of her body. (Ex. C, p. 15) She self-rated her pain as a 7 stating that physical activity was severely limited but in another part of the questionnaire indicated a more mild reaction to the pain. (Ex. C, p. 13; Ex. C, p. 16) During the examination, she exhibited normal gait, the ability to move independently on and off the exam table, shoulders were symmetric, propricoeption and balance were intact. She had full range of motion, no evidence of extremity weakness. There was reduced strength in the left as opposed to the right. (Ex. C, p. 8) The neurological examination was largely negative:

> Neurological examination reveals equal and active deep tendon reflexes in the upper and lower extremities. The biceps reflexes are rated at 3/5 and bilaterally symmetrical. The brachioradialis reflexes are rated at 3/5 and bilaterally symmetrical. The knee reflexes are rated at 3/5 and bilaterally symmetrical. The ankle reflexes are rated at 3/5 and bilaterally symmetrical. Babinski is downgoing, ankle clonus is absent, Rhomberg's test is negative, and straight leg raising is bilaterally negative in the seated position.

(Ex. C, p. 8) Dr. Gammel concluded that claimant had achieved maximum medical improvement (MMI) and that "no permanent impairment rating is warranted for her vague subjective complaints without objective diagnostic or physical findings causally related to the 9 March 2013 incident." (Ex. C, p. 9) In his deposition, Dr. Gammel stated that he did not find her to be giving "phony responses" but that her range of motion tests were not valid. (Ex. 40, p. 19) Dr. Gammel's testing was manual as opposed to using mechanical devices which is preferred when there is a no damage to her neurologic system. (Ex. 40, p. 17)

On January 27, 2014, claimant was seen by Denise Luna, PA-C at Myrtue Medical Center. (Ex. BB, p. 17) Her primary complaints were vertigo, nausea, right-

sided vision problems, left leg weakness, fatigue. (Ex. BB, p. 17) Ms. Luna had no immediate treatment recommendations but continued to follow up with the claimant. Ms. Luna prescribed Effexor which the pharmacy did not have. She noted that the claimant's lawyer suspected claimant had PTSD. (Ex. BB, p. 20) Claimant requested a referral for her emotional distress which Ms. Luna gave. In response to correspondence from the claimant, on February 17, 2014, Ms. Luna deemed claimant was unable to work due to safety concerns. (Ex. BB, p. 23)

Claimant was offered accommodated work within her restrictions on March 14, 2014, September 16, 2014, and December 23, 2014. (Ex. M, p. 1-3) She did not return to work due to the work release signed by Denise Luna, PA-C, dated February 17, 2014.

Claimant presented to Daniel Tranel, Ph.D., for a neuropsychological evaluation on June 11, 2014. (Ex. D) Dr. Tranel found that multiple tests showed no abnormalities and that she had normal neuropsychological function along with average intellectual abilities. (Ex. D, p. 14-15) He found that claimant's depression and anxiety, while genuine, appeared to be from the non-definitive healthcare opinions that "had fostered the notion she was gravely and permanent injured." Further, he could not find it "valid or tenable" that her complaints and symptoms were attributable to the March 2013 accident and therefore, "the March 2013 work accident did not cause any permanent cognitive or psychological injury." (Ex. D)

Claimant was sent back to Dr. Goodman on October 24, 2014, for a subsequent evaluation. (Ex. II, p. 9) He found her neurological condition unchanged. She presented with normal gait, normal sensation, normal deep tendon reflexes, normal strength testing, normal "fund of knowledge, recent and remote memory, attention span, and concentration." (Ex. II, p. 10)

> 53-year-old female presents for followup of multiple neurological symptoms following an electrocution injury in March, 2013. She is not certain why she was asked to come for followup, or who sent her, and neither am I. Her symptoms are unchanged.
>
> My assessment is unchanged from last year. The patient has a post electrocution injury syndrome, with symptoms as described. I stated, last year, that she had reached maximum medical improvement. This opinion is unchanged. I have no opinion regarding the degree of residual disability. She would need a formal disability rating for this, and I am not able to provide one.

(Ex. II, p. 11)

Theodore Becker, Ph.D., was offered as an expert by the claimant. On January 5 2015, he conducted a "performance-based physical capacity evaluation." (Ex. C, p. 25) Dr. Becker's program is not peer-reviewed although components of it are.

The examination lasted 14.5 hours over the course of two days. After the testing, Dr. Becker concluded claimant was not capable of working, largely because of her fatigue levels on day two.

> Physiological responses [elevated heart rate] were elevated to the point she had physiological fatigue that prevents performing sustainable, competitive, and predictable work at any level; her physiological responses elevate over time and corresponding performance worsens, a profile of someone who suffers from physiological fatigue rather than someone who is just deconditioned. Her left sided decreased range of joint motion and 30-40% strength deficits degrade her ability to perform physical tasks on a sustainable basis. Objective evidence of deficits in spatial orientation and balance preclude employment that requires ladders, steps, or scaffolding; should avoid assembly line or areas with operating machinery as a momentary loss of balance could cause serious injury to self or others.

(Ex. C, p. 28)

Dr. Becker owns a business called "Everett Pacific Industrial Rehabilitation." He is a Ph.D., and not a medical doctor. He admits to not being qualified to give opinions on mental health and there is nothing in his background or training or experience that pertains to the study of electrical injury. (Ex. B, Depo of Dr. Becker, p. 7-8) Because he is not a physician or surgeon, he primarily reads the records or "documentation that would be of a similar nature to the tests and expertise in [his] area." (Ex. B, Depo of Dr. Becker, p. 29) He also does not pay much attention to neurologic testing.

> Q. Okay. And so your area of expertise, so we're clear, doesn't include diagnosing conditions for the central nervous system, correct?
>
> A. It does not involve medical diagnostics of any systemic aspect. What I do is do human performance testing related to the functions of those anatomical systems.

(Ex. B, Depo of Dr. Becker, p. 29) To test her "human performance", Dr. Becker ran claimant through a series of tests such as blindfolding her and having her step with her arms elevated. Another test was of her balancing on her right and then her left leg with her arms crossed. (See Ex. 15-19) Claimant obtained a letter from Richard Jimenez, M.D., at the Seattle Arthritis Clinic. (Ex. 24) Dr. Jimenez is a rheumatologist and has worked with patients who have functional impairments due to non-inflammatory musculoskeletal diseases. He did not review the records or examine the claimant but merely gave a testimonial of Dr. Becker's non-peer reviewed examination process and concluded that it was the "gold standard" for FCEs. (Ex. 24)

Despite admitting that he was not a physician or a surgeon or that he had any training or expertise in neurology, Dr. Becker made such conclusions such as claimant's bloody nose was the result of her electrical exposure instead of a broken blood vessel in the nose or some other cause.

> Q. On what do you base that conclusion that the exposure occurred, and that it affected or impacted the Circle of Willis?
>
> A. Well, the electricity has a broad absorption within the body, and as it courses through the upper extremity and down through the body, this is one of the structures in which the electricity would have impacted.

(Ex. B, Depo of Dr. Becker, p. 30) Just a few pages later, he was protesting a question about whether he had ruled out Chronic Fatigue Syndrome because he does not have the "medical privilege" to do so. (Ex. B, Depo of Dr. Becker, p. 429) Further, it appears that Dr. Becker draws his conclusions based on the results he sees from those he has examined in the past, rather than a body of peer-reviewed results.

> Q. What gives you the background necessary to test and evaluate people who have suffered electrical shock injury?
>
> A. Well, I think in particular, the generalized academic process in regards to the doctoral degree associated with biomechanics and then anatomical and neurological sciences, those body systems, allows me to identify the particular tests, which can reveal the presence or absence of a disorder or dysfunction associated with the exposure to electrical injury.
>
> Q. On the basis of the 100 cases or so of people who have claimed to suffer electrical shock, how common has it been for these folks to complain of relatively subjective-type complaints?
>
> A. Well, when doing the interview, their historical account in and of itself would be considered subjective, meaning that until there's some verification, it is what they are telling you. But in regards to their recollection, it's my opinion that it's not subjective. I mean, they're reporting what they consider to be important relative to the questions that are asked, such as, Tell [sic] me about the symptoms that you have experienced as a result of what has occurred.

(Ex. B, Depo of Dr. Becker, p. 50) He states that the inter-test and intra-test data comparisons confirm maximum effort or that the claimant's results aligned with the test results he recorded for his patient pool of around 100 individuals. He concluded that claimant sustained deficits to her spine, closed head injury, extremity atrophy, and loss of strength in her distal left upper extremity. (Ex. 11, p. 56) He recorded temperature variations of the right side as opposed to the left and that her heart rate was elevated during tests. (Ex. 12)

His conclusion regarding claimant is that she is not capable of working and that she could not do competitive work even in a seated position.

> Ms. Marshall is not currently capable of working. An important component of performance based physical capacities evaluation is monitoring physiological responses to activities that raise the patient's heart rate above her resting heart rate. I compare the patient's physiological responses to the predicted responses of someone who is the same age and gender. If the patient's heart rate elevates too high, this indicates that the patient will not be able to sustain work even though the patient may have the ability to perform a task such as lifting a relatively heavy load on a one-time basis. Ms. Marshall's physiological responses are elevated to the point that she suffers from physiological fatigue that prevents her from being able to perform sustainable, competitive, and predictable work in any level of work activity defined in the Dictionary of Occupational Titles. Part of her profile is that her physiological responses elevate over time and her corresponding performance worsens. This is the profile of someone who suffers from physiological fatigue rather than someone who is just deconditioned.

(Ex. 12, p. 4) In the article included in Exhibit 24 that Dr. Becker co-authored, he takes issue with the AMA guidelines regarding maximum heart-rate work tolerances and says that those are incorrect.

> The 2009 American Medical Association (AMA) publication The Guide to the Evaluation of Functional Ability provides a consensus opinion that the physiological end point determining work tolerance is 70% to 85% age-related maximum heart rate (Genovese, 2009). This is an incorrect presentation of oxygen consumption correlated to heart rate for a determination of full-time steady state work tolerance, and is significantly inconsistent with peer-reviewed research and institutional research (Genovese, 2009).

(Ex. 24, p. 7) It would seem, based on this article, that Dr. Becker's conclusions regarding fatigue are not aligned with the AMA guidelines regarding functional ability. It is unclear whether the article is peer-reviewed. There is an editor's note included:

> [Editor's Note: The Editor has not confirmed these statements offered by the author of this article. This information is included as a historical framework, offered by the article's author. The Editor encourages readers to consult with applicable organizations to confirm this information. Or, if any of the referenced persons or organizations wish to offer a rebuttal, the Editor will allow such responses and rebuttals to be published in later issues of this journal.

(Ex. 24, p. 9) It appears that Dr. Becker is marketing a different type of functional examination as is commonly used today and the article in Exhibit 24 is designed to point out the flaws of the existing commercial FCE system that is sold and employed by most physical therapists in Iowa.

Claimant maintains that Dr. Becker's tests and methodologies are more extensive and better suited to test the physical capabilities of the claimant post her electrocution incident than a traditional FCE.

> Q. So bottom line, in Ms. Marshall's case, is she capable of doing sedentary work?
>
> A. She is able to be positioned, meaning to be seated, as would be required in sedentary work. But in regards to the term, quote, work, which is, again, the active engagement in pursuing the tasks, she is not able to sustain, again, the competitive, predictable capacities associated with that category, meaning the sedentary work.

(Ex. B, Depo of Dr. Becker, p. 58) He also concluded that the electrical shock caused claimant's deficits. (Ex. 12, p. 7)

This here appears to be a conclusion in direct contradiction to Dr. Becker's stated expertise. He admits he has not the training, education, or experience to diagnose neurologic issues but then proclaims that the electrical shock was the cause of her deficits.

Dr. Becker's opinions regarding causation are given low weight. He, himself, admits he is not the appropriate expert in those areas. What he does have is the test results of approximately 100 electrocution patients. Those patients are the basis of his inter-rate data and the standards against which the claimant's results were measured against.

Problematically, Dr. Becker does not measure claimant's responses against any other control group or at least it is not presented in his long presentation. For instance, claimant has had past episodes of dizziness, spinal pain, and imbalance. (Ex. AA) A few days prior to her electrocution, claimant was suffering from a left ear pain for which she was being treated by Christy Quillen, ARNP. (Ex. JJ, p. 1)

As he admitted that he is not able to make medical judgments due to the nature of his training and education, Dr. Becker is not able to make a causation opinion regarding the injury. It is also likely, based on the statements in the article in Exhibit 24, that Dr. Becker's testing levels vary from the accepted AMA guidelines. Because of this, his opinions regarding the claimant's functional abilities is also given low weight.

His expertise is limited to testifying and opining about the physical function of an individual and possibly the likelihood of a patient's rehabilitation. He does not indicate that rehabilitation is possible. His remedial recommendations include "the examinee is

considered to need comprehensive multi-specialty intervention concerning the closed head dysfunction presentation, and the asymmetric presentation of the left limbs." (Ex. 11, p. 2; see also Ex. 12, p. 8) I

He did suggest claimant seek out a multi-specialty facility. (Ex. 12, p. 8)

> I have suggested a multi-specialty facility because so many systems are affected when there has been an electrical shock injury. Generally I would favor a facility that has had extensive experience in dealing with these injuries. Secondly, I would support facilities that have built a multi-specialty approach into their evaluation and treatment process. One place that focuses on electrical shock injuries is the Chicago Electrical Trauma Institute. I have not had the opportunity to see the institute's work. Another place that appears to have a team devoted to treating electrical injuries is at University of Florida Health. Some burn centers may have a team who effectively can work up electrical shock injuries. Examples of facilities in your area that are known for their multi-specialty approach include The May Clinic, Rehabilitation Institute of Chicago, and Madonna Rehabilitation Hospital. I do not know the extent to which these facilities have experience in working with patients who have suffered electrical shocks.

(Ex. 12, p. 8) He appeared to be unfamiliar with the University of Iowa Hospital and Clinics as it was not identified in his letter.

Jane Yaffe-Rowell, M.S., performed a disability assessment of the claimant. (Ex. 22) Based on Dr. Gammel's restrictions, claimant would have a zero percent loss of industrial disability. Based on Dr. Becker's restrictions, claimant would not be employable. Based on the FCE, claimant's loss of access to the labor market was approximately 20 percent. (Ex. 22, p. 12) In a subsequent letter, Ms. Yaffe-Rowell agreed that if claimant was not able to sustain an expected level of activity throughout the course of her work day, she would be unemployable. (Ex. 23)

Dr. Gammel gave a subsequent report that found claimant was suffering from small vessel ischemic disease, caused by aging and degenerative processes unrelated to her electrocution. (Ex. C, p. 39)

> 2. Does the nature of electrical shock Claimant allegedly experienced, including nose bleed and incontinence, support permanent injury to claimant's brain or autonomic nervous system?
>
> No.
>
> Why or why not?
>
> While electrical shock by low-voltage (less than 1000V) contact has the potential to cause injury to the brain and autonomic nervous system

> there is no medical indication that has occurred in this case. Ms. Marshall has no evidence of neurocognitive damage based upon a very thorough neuropsychiatric evaluation completed by Daniel Traner, PhD a neuropsychologist at the University of Iowa College of Medicine Neurology Department. Likewise, the multiple physicians who evaluated her, including neurologists, have found no evidence of any permanent autonomic nervous system dysfunction.

(Ex. C, p. 40) In the deposition of Dr. Gammel, he appeared perfunctory and dismissive. He had no comment on Dr. Becker's materials, dismissing them. He admitted that he undertook a manual test of claimant's abilities, range of motion, rather than a mechanical one. He took no temperature readings. He did no endurance testing. He appeared to question whether the electrical incident happened at all. His opinions are given low weight as well.

On August 19, 2015, she sought treatment from Joshua Owens, DC. His whole record of that visit is illuminating.

> STEPHANY MARSHALL is a 5 foot 8 inch 188 pound 54 year old female who has a BMI of 28.6 born on 7/7/1961 who does not currently work due to disability. In general, the patient considers herself to be in good health. The patient states that she performs moderate exercise on a regular basis. The patient scored 20% on a revised Oswestry neck disability index which means she feels as though she has a minimal neck disability.
>
> The patient stated that she has neck problems that are localized to her upper portion of your [sic] neck. The patient also stated that her neck bothers her constantly meaning it bothers her between 76 and 100% of the time. STEPHANY described her upper portion of your [sic] neck problem as stiff. The patient stated that her upper portion of your [sic] neck appears to be getting worse with time. The patient rated the average intensity of her neck problem as a 7 with 0 being nothing and 10 being the worst she feels it could be. When asked about how much the upper portion of your [sic] neck problem has interfered with her work, the patient responded that it has interfered with her work quite a bit. Next, I questioned how much the upper portion of her neck has interfered with her social activities, and she explained that it has interfered with her social activities quite a bit. The patient stated that she has had her upper portion of her neck problem for 2 years. STEPHANY has no idea how her neck problem began. The patient stated that her upper neck pain is always there and that there are no particular aggravators. The patient let me know that her upper portion of her neck becomes better when she uses warm bath, massage, laying face down and heat. The thing that concerns STEPHANY the most about her neck is that t [sic] is not going away.

The patient stated that she has upper back problems that are localized to her entire upper back. STEPHANY described her entire upper back problems as stiff and burning. The patient stated that her entire upper back appears to be getting worse with time. The patient rated the average intensity of her upper back problem as a 5 with 0 being nothing and 10 being the worse she feels it could be. When asked about how much the entire upper back problem has interfered with her work, the patient responded that it has interfered with her work a moderate amount. Next, I questioned how much the entire upper back has interfered with her social activities, and she explained that it has moderate interfered with her social activities. The patient stated that she has had her entire upper back problem for 2 years. STEPHANY has no idea what could have caused her upper back problem. The patient stated that there is no particular aggravating factor, that the pain is always there. The patient let me know that her entire upper back becomes better when she uses warm bath, stretching, massage, heat and bending forward. The thing that concerns STEPHANY the most about her upper back is that t [sic] is not going away.

The patient stated that she has mid back problems that are localized to her entire mid back. STEPHANY described her entire mid back problem as stiff. The patient stated that her entire mid back appears to be getting worse with time. The patient rated the average intensity of her mid back problem as a 5 with 0 being nothing and 10 being the worst she feels it could be. When asked about how much the entire mid back problem has interfered with her work, the patient responded that it has interfered with her work a moderate amount. Next, I questioned how much the entire mid back has interfered with her social activities, and she explained that it has moderately interfered with her social activities. The patient stated that she has had her entire mid back problem for 3 years. STEPHANY does not have any idea what may have caused her mid back problem. The patient stated that there are no particular aggravators for the mid back, and states the pain is always there. The patient let me know that her entire mid back becomes better when she uses warm bath, stretching, laying face down and heat. The thing that concerns STEPHANY the most about her mid back is that it is not going away.

The patient stated that she has hip problems that are localized to her outside of right hip and near her right sacroiliac joint. STEPHANY described her outside of right hip problem as achy and stiff. The patient stated that her outside of right hip appears to be getting worse with time. The patient rated the average intensity of her hip problem as a 6 with 0 being nothing and 10 being the worst she feels it could be. When asked about how much the outside of right hip problem has interfered with her work, the patient responded that it has interfered with her work a moderate amount. Next, I questioned how much the outside of right hip has

interfered with her social activities, and she explained that it has moderately interfered with her social activities. The patient stated that she has had her outside of right hip problem for 2 weeks. STEPHANY does not know of any cause that may have brought about her hip pain. The patient stated that her outside of right hip becomes worse with driving a car, standing up, climbing stairs, traveling, working out, walking, standing and sleeping. The patient let me know that her outside of right hip becomes better when she uses warm bath, stretching, massage, heat and bending forward. The thing that concerns STEPHANY the most about her hip is that it is not going away.

Stephany reports no radiating pain down her arms or her legs with any of her pains.

Regarding STEPHANY's family health history, she does not have an immediate family member with rheumatoid arthritis, heart problems, diabetes, cancer, Lupus, or Amyotrophic Lateral Sclerosis. Therefore, she potentially has a decreased risk for developing those diseases.

The patient informed me that she has had pregnancy in her past.

The patient informed me that she presently has: neck pain, upper back pain, mid back pain, lower back pain near right hip, shoulder pain, hip pain, joint pain and stiffness, visual disturbances, dizziness and smoking/tobacco use. STEPHANY denies currently having any of the following: pregnancy.

The patient denies both having a history of and currently having: headaches, elbow pain, wrist pain, hand pain, upper leg pain, ankle pain, jaw pain, arthritis, Rheumatoid Arthritis, cancer, tumor, asthma, chronic sinusitis, high blood pressure, heart attack, chest pains, stroke, angina, kidney stones, kidney disorders, bladder infection, painful urination, loss of bladder control, abnormal weight change, loss of appetite, abdominal pain, ulcer, hepatitis, liver/gall bladder problems, general fatigue, muscular incoordination, diabetes, excessive thirst, frequent urination, drug/alcohol dependency, allergies, depression, SLE, epilepsy, dermatitis, HIV/AIDS, birth control pills use and hormonal replacement.

When asked about any medications she was taking, the patient informed me that she is currently taking Lasix-one 40mg pill once per day. STEPHANY informed me that she is currently not taking any nutritional supplements. According to the patient, she has had the following surgical procedures: a lumbar laminectomy in 2002, uterine ablation, tonsillectomy, and tubal ligation. She reports that this upcoming September she is to receive an abdominal hernia surgery.

During her free time away from work, STEPHANY likes to walk.

Aside from the above information, Stephany informed me that she was severely electrocuted in 2013. She states since then she has had left sided balance problems. She also reports she has difficulty when going from a seated position to lying on her back. She states she is in a lawsuit for this. She has seen a Dr. Becker in Seattle, who is a neuro-specialist.

The patient has been advised of both the risks and benefits of chiropractic treatment for her condition, and she has consented to receive treatment.

(Ex. KK, p. 1) Dr. Owen treated claimant's back pain with adjustments and traction. (Ex. KK, p. 1) A month later she reported back to Dr. Owen, having driven to New York and back without stopping. (Ex. KK, p. 2) As a result she had increased back and neck pain. On the September 30, 2015, visit, claimant provided a more detailed account of the injuries she believed were associated with the electrocution injury. (Ex. KK, p. 3) During the October 20, 2015, she reported they had driven to Arizona and back again, traveling for a couple of weeks. (Ex. KK, p. 5) She did explain she felt the right hip pain was the result of an altered gait. Dr. Owen noted claimant had a shortened leg. (Ex. KK, p. 5) She said that her memory was not good as a result of the electrocution which was why she had previously declared that the cause of the right hip pain was unknown to her. (Ex. KK, p. 4)

He subsequently revised his opinion and stated that based on her history, the neck, upper back, mid back and right hip pains were sequelae of the electrocution admitting, "I am no expert in electric shock injury and cannot address the exact causes of her left-sided impairment." (Ex. 21)

On June 20, 2016, claimant underwent an FCE with Neal Waccholtz. (Ex. F, p. 1) It was deemed valid.

Ann demonstrates the ability to lift and carry 35 pounds on an occasional basis and 20 pounds on a frequent basis when performed near waist level and below. Her lifting restrictions are primarily related to her concern about aggravation of low back pain complaints with lifting at heavier levels. She does exhibit mild altered mechanics with lifting at these levels, indicating general limitations in strength. Please see the enclosed Functional Capacities Form for a summary of her current capabilities. Based on these findings, Ann is safe to perform work activities within the LIGHT-MEDIUM physical demand level.

Based on test findings, Ann would benefit from the following restriction within the LIGHT-MEDIUM physical demand level:

> 1. Limit prolonged or repetitive forward bending to limit aggravation of low back pain complaints. Forward bending should be restricted to an occasional basis.
>
> Based on overall test findings, Ann does not display significant restrictions in other non-material handling activities including sitting, standing, walking, stair climbing, squatting, etc. She demonstrated a normal gait pattern throughout the exam with equal weight bearing and equal step length. She demonstrated a normal, reciprocal gait pattern during stair climbing. She did not display limitations in balance during performance of functional testing activities.

(Ex. F, p. 1-2)

Claimant continued to seek out adjustments from Dr. Owens. (Ex. KK) Between August 19, 2015 and November 2, 2016, Dr. Owen saw claimant for a total of 35 visits, treating her for neck pain, upper back pain, mid back pain, and right hip pain. (Ex. 21)

On October 12, 2016, claimant was seen by Jan J. Golnick, M.D. On the pain drawing, claimant's subjective complaints were solely left-sided. (Ex. 9, p. 31) During the examination, she exhibited mostly normal symptoms except for a left upper extremity drift when she kept both upper extremities extended. (Ex. 9, p. 12) There was some give-away weakness on the left side that claimant had not exhibited in previous testing. (Ex. 9, p. 12) Her gait was also significantly abnormal—which, again, had not been the case in many previous medical appointments. (Ex. 9, p. 13)

Dr. Golnick opined claimant suffered moderate to severe electrical injury to the nervous system, predominantly on the right side and that she had neuropsychological disorders such as depression, anxiety, and panic attacks secondary to the electrocution injury. (Ex. 8) Dr. Golnick's opinions are based solely on the fact that claimant did not have symptoms of dizziness, vomiting, and so forth.

> [D]izziness, nausea, vomiting, left-sided body weakness, balance difficulties, paresthesia, noise sensitivity, sleep disturbances, fatigue, irritability, depression, frustration, poor concentration, difficulty thinking, blurred vision, light sensitivity, and restless legs with all of these attributed to electrical injury to the brain, brainstem, autonomic nervous system, and probably the peripheral nervous system (nerves and muscles). The basis for that is the fact that she never had these prior to the injury and developed these all after the fact.

(Ex. 9, p. 16) Dr. Golnick confirmed and agreed with Dr. Becker's conclusions that claimant is not employable. (Ex. (, P. 21) Dr. Golnick said that prior to claimant's injury, she had no symptomatology. That is not accurate. Claimant had complaints of muscular pain, dizziness, facial numbness, and blurry vision predating the injury. Those

complaints were not at the level that exist today for the claimant, but her pre-injury medical records are not benign either.

Beginning with Dr. Petrea, claimant reported a number of falls resulting in various injuries such as a bruised elbow and a chipped tooth.

Claimant was seen on occasion for complaints unrelated to her electrocution injury. She suffered from back and neck complaints in 2009. (Ex. AA, p. 2) She specifically noted that sitting made her pain worse and that she had had this pain all her life. (Ex. AA, p. 1) On October 23, 2014, she went to All Care Health Center for left ear pain. (Ex. JJ, p. 1) She was noted to have complaints of dizziness or headaches. (Ex. JJ, p. 3) On July 24, 2015, she reported blood in her urine. (Ex. JJ, p. 5) She described her pain as mild, but constant. On February 19, 2016, she was seen for sinus and a kidney problem. (Ex. JJ, p. 9) She denied any pain. In another visit on May 23, 2016, she reported again for cough and congestion and again denied any pain. (Ex. JJ, p. 13) The claimant's presentation was the same two months later when she visited on July 19, 2016, for cough and congestion with no pain. (Ex. JJ, p. 17)

She claimed to have gained 42 pounds since her injury. In 2009, she weighed 178 pounds. (Ex. BB, p. 1) In late 2012, she weighed 158 pounds. (Ex. BB, p. 3) On August 19, 2015, she weighed 188 pounds. (Ex. KK, p. 1)

Currently, claimant maintains she is largely sedentary. She no longer rides her bike and takes only short walks. She has difficulty adjusting to hot and cold temperatures and cannot do jobs that expose her to the hot or cold. She feels weak on her left side, dizzy and nauseous most of the time.

CONCLUSIONS OF LAW

The party who would suffer loss if an issue were not established has the burden of proving that issue by a preponderance of the evidence. Iowa R. App. P. 6.14(6).

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

The question of causal connection is essentially within the domain of expert testimony. The expert medical evidence must be considered with all other evidence introduced bearing on the causal connection between the injury and the disability. Supportive lay testimony may be used to buttress the expert testimony and, therefore, is also relevant and material to the causation question. The weight to be given to an expert opinion is determined by the finder of fact and may be affected by the accuracy

of the facts the expert relied upon as well as other surrounding circumstances. The expert opinion may be accepted or rejected, in whole or in part. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); IBP, Inc. v. Harpole, 621 N.W.2d 410 (Iowa 2001); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995). Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417 (Iowa 1994). Unrebutted expert medical testimony cannot be summarily rejected. Poula v. Siouxland Wall & Ceiling, Inc., 516 N.W.2d 910 (Iowa App. 1994).

The evidence is considerable that claimant sustained an electrical shock injury that resulted in some significant side effects. The dispute is over the severity of the shock injury and the resulting disability. Defendants seem to assert that claimant is overstating the shock injury itself. Claimant testified and reported consistently to her medical doctors that after the shock, she immediately urinated on herself. At some point, either directly after or in her car approximately 30 minutes later, she had a nose bleed. None of the witnesses corroborated either the urination or the bloody nose. However, one witness stated that the arc of sparks showered over the claimant's hand. A burn mark was noted in the claimant's glove. High voltages are not necessary to result in significant injury per defendant's expert witness, Dr. Gammel.

The probable evidence supports that the claimant sustained an electrical shock injury that had serious and lingering side effects.

The claimant's experts, largely relying on Dr. Becker, conclude claimant is not employable. Dr. Becker's opinions stem from his belief that claimant lacks the endurance to complete a full day's work on a regular basis. Buttressing his opinion is that of Dr. Golnick. Dr. Golnick's neurological examination of claimant found problems with her attention span, immediate recall, calculations, delayed recall, left upper extremity draft when she lifted her arms, slight weakness of the left lower extremity, altered gait, a positive Romberg test, and signs of right central facial weakness.

Claimant's presentation to Dr. Golnick was different than many of claimant's previous medical appointments with multiple physicians. On more than one occasion, she was described as having normal memory, attention, language and fund of knowledge.

It is more likely than not that her physical presentation in the visits with various treating medical providers she saw directly after her injury are more reliable indicators of the post-injury symptoms than those she exhibited four years after the injury for paid-for medical examiners.

Probably the most troubling aspect of the claimant's presentation is the additive nature of her symptoms. She begins with left-sided chest, jaw and arm discomfort along with fatigue and weakness, but by the end of 2015, she was ascribing back and neck pain, unstable gait, headaches, dizziness, depression, sleep problems to the injury. Her gait, something that both Dr. Golnick and Dr. Becker point to as being a strong indicator of her neurological injury, was normal until she saw Dr. Becker. There

was no mention of altered gait in her visits to either Nurse Practitioner Quillen in 2015 and 2016. Nor was it mentioned in an exhaustive summary of symptoms recorded by Dr. Owen on August 2015.

Claimant did suffer an electrocution injury. She has some residual effects. Problematically, she does not present a consistent medical picture. In the most recent medical visits, both to care providers the claimant has chosen, she has failed to report many of the symptoms related to her electrocution injury. In 2015, during visits with NP Quillen, claimant complained only of mild pain but in 2016, she reported no pain at all nor did she report dizziness or nausea or fatigue. It is true that claimant was seeing NP Quillen for cold symptoms but in visits for cold and flu predating her electrocution injury, she reported dizziness, numbness in the face, and instability.

Claimant discussed her hip pain with Dr. Owen but only stated she had left balance problems. In fact, during that same August 2015 visit, she denied current or past problems with headaches, upper leg pain, chest pains, general fatigue, or depression. (Ex. KK, p. 1) Claimant later explains that because of her memory loss, she forgot to ascribe the pains to her electrocution injury but at the end, Dr. Owen notes, "Stephany informed me that she was severely electrocuted in 2013. She states since then she has had left sided balance problems. She also reports she has difficulty when going from a seated position to lying on her back. She states she is in a lawsuit for this." (Ex. KK, p. 2)

It is claimant's presentation to Dr. Owen and NP Quillen that casts a shadow over claimant's assertions that she is completely and totally disabled due to the work injury.

In determining the extent of claimant's disability, I place more reliance on the claimant's treatment records and the opinions of her treating doctors and nurse practitioners.

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

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

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

Dr. Goodman, notwithstanding the checklist letter he signed that was prepared by the defendants, determined that claimant had sustained residual deficits following the electrocution injury. "Her most hazardous or disabling symptoms is that she has intermittent and unpredictable falls, due to episodic left-sided dysfunction," he wrote. (Ex. II, p. 5) He further recommended physical therapy, avoidance of ladders, heavy or dangerous machinery, and lifting of any degree of weight that could result in injury if she were to fall.

The FCE performed by Neil Waccholtz would place claimant in the light duty category although he does not appear to consider claimant's propensity for falling.

Her boyfriend testified that her body exhibits temperature changes and her stepson testified that she is less active. She has gained weight, although not as much as she testified to. During her examination with Dr. Golnick, she stated that she had stopped doing social activities because she lost her social group with whom she would bike and ride with. The defendants attribute her decline of physical activity to this social group loss, but claimant testified that the social group loss occurred because of her injury. I find that her inactivity is due to her physical issues.

Overall, claimant appears to have balance issues related to her electrocution injury. Those balance issues along with some left-sided weakness (as measured by Dr. Goodman) contribute to claimant's loss of industrial disability. The inability to lift because of her propensity for falling would likely make any job other than a sedentary one a hazard for the claimant and for those around her. While claimant has looked for work, she does not appear to be motivated to return to work. Her past work history has included some sedentary work such as dispatching. She has experience in creating juvenile activity programs. There are transferable skills she could utilize in obtaining a sedentary job.

It is determined, based on all the foregoing, that claimant's industrial loss is 85 percent.

The parties disagree as to the IME date. Claimant argues it is February 17, 2014, when NP Luna took claimant off of work while defendants maintain it is October 11, 2013, the date set by Dr. Goodman.

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

substantially similar employment; or (3) the worker has achieved maximum medical recovery. Maximum medical recovery is achieved when healing is complete and the extent of permanent disability can be determined. Armstrong Tire & Rubber Co. v. Kubli, Iowa App., 312 N.W.2d 60 (Iowa 1981). Neither maintenance medical care nor an employee's continuing to have pain or other symptoms necessarily prolongs the healing period.

There was no change in claimant's condition between October 11, 2013, and that of February 17, 2014, nor was there any real treatment between those two dates. It is determined that commencement date of permanent partial disability is October 11, 2013.

The next issue is whether claimant is entitled to a reimbursement of the IME charges of Dr. Golnick. Claimant was allowed additional time to submit evidence so that an award could be made pursuant to. Des Moines Area Regional Transit Authority v. Young, 856 N.W.2d 383 (2014). In, Young the Iowa Supreme Court made clear that 85.39 allows for the recovery of only the examination and not the charges associated with the preparation of the report. While expert reports are recoverable under 876 IAC 4.33, reports of an IME expert are not.

Therefore, the only charges that can be reimbursed under Iowa Code section 85.39 are those associated with the examination. Dr. Golnick's bill for the exam and record review is $4,720.00. (See Claimant's Amended Affidavit and Bill of Costs) While the charge is high, Dr. Gammel charged $3,395.00 for his medical evaluation. (Ex. 39, Gammel Deposition Ex. 102) The medical records for the case are not voluminous. Rather, it is the claimant's expert reports that have padded out the exhibits. Dr. Golnick spent time reviewing depositions and expert reports. Therefore, it is determined that the reasonable fee is equal to that of what Dr. Gammel billed. It is ordered that defendants shall pay $3,395.00 as reimbursement for the 85.39 examination.

Claimant also seeks reimbursement for a chipped tooth. She claimed that she fell just days after the shock and that her tooth was chipped as a result. There are no medical records confirming this incident. Claimant has not carried her burden that the tooth was chipped as a result of a fall following the shock.

The next issue is one of alternate medical care. Claimant would like an evaluation at a facility that specializes in treatment of patients who have suffered electrical shock injuries. Dr. Becker recommends a multi-specialty facility. Dr. Goodman recommended further physical therapy. Defendants are required to provide reasonable medical services. Iowa Code section 85.27.

Claimant sustained an electrical shock injury with significant residual symptoms. She is desirous of ongoing care. Defendants are obligated to provide that care. It is determined that claimant is entitled to care with medical provider that specializes or has experience in treating electrical shock injuries, as well as the physical therapy

recommended by Dr. Goodman and any other treatment that is reasonable and related to her work injury.

ORDER

THEREFORE, it is ordered:

That defendants are to pay unto claimant four hundred twenty-five (425) weeks of permanent partial disability benefits at the rate of two hundred ninety-seven and 14/100 dollars ($297.14) per week from October 11, 2013.

That claimant is entitled to care with medical provider that specializes or has experience in treating electrical shock injuries, as well as the physical therapy recommended by Dr. Goodman and any other treatment that is reasonable and related to her work injury.

That defendants shall pay accrued weekly benefits in a lump sum.

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

That defendants are to be given credit for benefits previously paid.

That defendant shall pay the costs of this matter pursuant to rule 876 IAC 4.33 as itemized in claimant's amended affidavit and bill of costs except for the report of Dr. Golnick.

Signed and filed this 22nd day of March, 2017.

JENNIFER S. GERRISH-LAMPE
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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JGL/kjw

Right to Appeal: This decision shall become final unless you or another interested party appeals within 20 days from the date above, pursuant to rule 876-4.27 (17A, 86) of the Iowa Administrative Code. The notice of appeal must be in writing and received by the commissioner's office within 20 days from the date of the decision. The appeal period will be extended to the next business day if the last day to appeal falls on a weekend or a legal holiday. The notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 1000 E. Grand Avenue, Des Moines, Iowa 50319-0209.