BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

FLORIBERTO DECIGA SANCHEZ,	:	FILED
Claimant,	:	File No. 5052008 MAR 6 2018
vs.	:	APPEAL WORKERS' COMPENSATION
TYSON FRESH MEATS, INC.,	:	DECISION
Employer, Self-Insured, Defendant.	:	Head Note No: 1803

Defendant Tyson Fresh Meats, Inc., self-insured employer, appeals from an arbitration decision filed on August 19, 2016. Claimant Floriberto Deciga Sanchez responds to the appeal. The case was heard on January 28, 2016, and it was considered fully submitted in front of the deputy workers' compensation commissioner on February 29, 2016.

The deputy commissioner found claimant sustained physical and mental injuries which resulted in permanent total disability as a result of the stipulated injury which arose out of and in the course of claimant's employment with defendant on March 6, 2014. Pursuant to Iowa Code section 85.39, the deputy commissioner found claimant is entitled to receive reimbursement from defendant in the amount $2,975.00 for the cost of the independent medical evaluation (IME) performed by Sunil Bansal, M.D., on November 7, 2014. The deputy commissioner also taxed defendant with the following requested costs of the arbitration proceeding totaling $1,387.96: $75.00 for interpretation fees for Dr. Bansal's IME; $100.00 for claimant's filing fee; $12.96 for claimant's service fee; and $1,200.00 for the cost of the psychological report of Catalina D. Ressler, Ph.D.

Defendant asserts on appeal that the deputy commissioner erred in finding claimant sustained permanent total disability as a result of the work injury. Defendant asserts the deputy commissioner erred in failing to find claimant sustained only a temporary aggravation of a pre-existing mental condition. Defendant also asserts the deputy commissioner erred in taxing defendant with more than $300.00 for the cost of Dr. Ressler's report.

Claimant asserts on appeal that the arbitration decision should be affirmed in its entirety.

Those portions of the proposed agency decision pertaining to issues not raised on appeal are adopted as a part of this appeal decision.

Having performed a de novo review of the evidentiary record and the detailed arguments of the parties, pursuant to Iowa Code sections 86.24 and 17A.15, I respectfully disagree with the deputy commissioner's findings and analysis and I reverse the award of permanent total disability. I find claimant is entitled to a running award of healing period benefits. I also reverse the deputy commissioner's taxation of $1,200.00 for Dr. Ressler's report and I find claimant is entitled to reimbursement in the amount of $300.00 for the cost of that report. I provide the following analysis for my decision:

FINDINGS OF FACT

Claimant was 36 years of age at the time of hearing. (Hearing Transcript, page 5) He is single, with no children, and resides in Storm Lake, Iowa. (Id.) Claimant attended nine years of formal schooling in his native Mexico. (Tr. p. 6; Exhibit 16, p. 220) He has received no other formal education, with the exception of a six-month English language course after he arrived in the United States. (Id.) While taking that course, claimant learned a small amount of English. (Id.) He is able to speak a small amount of English and he understands some spoken words. (Tr. p. 7) Claimant is able to read and write a limited amount of English. However, he requires assistance with understanding the entirety of documents. (Id.) He utilizes a computer to watch videos and listen to music, but he has not learned to type. (Id.)

While he resided in Mexico, claimant did not work. Claimant arrived in the United States in 1996. (Tr. p. 9) Upon arrival in the United States, claimant worked in California performing farm labor and packaging produce. (Id.) This work required the ability to lift bags of product weighing 50 pounds. (Tr. pp. 9-10) Claimant performed agricultural labor for six years, earning $8.50 per hour. (Ex. 16, p. 221) Claimant next spent six years working as an industrial glass cutter, work which required him to lift and carry boxes of glass weighing 50 to 60 pounds. (Tr. pp. 10-11; Ex. 16, p. 221) Claimant earned $9.50 per hour in that job. (Ex. 16, p. 221) Next, claimant worked as a laborer tasked with cleaning airplane parts. The work required him to lift and carry 50-to 60-pound airplane parts. (Tr. pp. 11-12; Ex. 16, p. 221) He performed that job for one year and earned $9.00 per hour. (Claimant's testimony; Ex. 16, p. 221)

Claimant denied sustaining any injuries to his head or neck and testified he had no physical restrictions on his head or neck prior to beginning work at defendant. (Tr. p. 13) Claimant also denied any treatment for any mental condition and denied problems with anxiety or depression prior to commencing work at defendant. (Tr. pp. 13-14)

Since March 2009, claimant has worked as a production employee for defendant. (Tr. p. 14; Ex. 16, p. 221) Prior to commencing employment with defendant, claimant passed a pre-employment physical. (Tr. p. 14) Initially, claimant worked in a position

requiring him to cut meat with a knife. (Id.) In 2013, claimant moved into a janitorial position. (Tr. p. 15; Ex. A, p. 10) In the janitorial position, claimant was required to sweep, clean, and wash the area, push pig carcasses if they became stuck, and pick up meat and carcasses which fell onto the floor of the production area. (Tr. p. 15) Claimant testified he could be required to lift 50 to 60 pounds if pieces of meat fell onto the floor. (Id.) Defendant's job description for the janitor position notes a requirement of lifting five to ten pounds, but the ability to use force and move hog carcasses weighing approximately 290 pounds. (Ex. 19, p. 236; Ex. B) Claimant ultimately earned $14.00 per hour. (Ex. 16, p. 221) Claimant testified he considered himself a good worker for defendant and cited his receipt of an acknowledgement for preventing an injury to a coworker. (Tr. p. 17)

Claimant testified he was at work on March 6, 2014, pushing a hog carcass which had become stuck on an overhead rail. While he was pushing, the carcass fell onto claimant, striking him on the back of his head and neck. The force knocked claimant forward and to the floor. During the fall, claimant struck his face, arm and chest on a metal object. He suffered a severe laceration to his head and face, extending from near his left eye, up through his forehead and past his hair line. Claimant testified he was uncertain whether he truly lost consciousness, but explained that for a time he was only able to see black. He testified he was scared and in shock, as his forehead was cut open and bleeding, and he felt pain throughout his body. Claimant testified he feared he was going to die. (Tr. pp. 18-20)

A coworker, Ramiro Zavala, witnessed the accident. He indicated claimant never lost consciousness, as Mr. Zavala spoke with claimant from the time of the injury until claimant was taken away by the nursing staff. (Ex. C)

A record from the plant nursing department notes a nurse was called to the production floor, where claimant was found lying on the floor with a wide laceration above his left eye. The record states claimant was weak and unable to sit up on his own. An ambulance was called. (Ex. 1, p. 38) The ambulance transported claimant to Buena Vista Regional Medical Center (BVRMC). (Ex. 2, pp. 59-60)

At the BVRMC emergency department, claimant was treated for a large laceration of his left forehead and face, with accompanying pain, as well as pain of the left elbow. The large laceration on his head was repaired. However, when claimant was preparing to leave, he suffered a syncopal spell and, as a result, was admitted to the hospital for neurological observation and placed on telemetry. (Ex. 3, pp. 61-67)

While hospitalized, claimant was examined by David Crippin, M.D. Dr. Crippin opined claimant suffered a 12-centimeter laceration on the left side of his forehead and a left elbow contusion. Dr. Crippin opined x-rays of claimant's left elbow were normal and CTs of claimant's head and cervical spine were negative. Dr. Crippin assessed a syncopal spell and large left forehead and frontal laceration. He removed claimant from

work and prescribed Vicodin for pain relief. (Ex. 3, pp. 61-68) Claimant testified he was released from the hospital after approximately 16 hours. (Tr. p. 21)

Defendant referred claimant for care with David Archer, M.D. On March 10, 2014, Dr. Archer examined claimant and assessed a laceration of the face, neck strain, conjunctival hemorrhage, elbow contusion, and chest wall contusion. Dr. Archer ordered physical therapy and recommended claimant utilize Trazadone, tramadol, and ibuprofen. Dr. Archer released claimant to return to work under restrictions, specifically alternating between sitting and standing as needed and keeping the laceration clean and dry. (Ex. 4, pp. 97-98)

Claimant returned to Dr. Archer on March 13, 2014. Dr. Archer removed 50 sutures and opined the laceration appeared well healed. Dr. Archer recommended continued conservative measures of work restrictions, pain medication, and physical therapy. Dr. Archer also recommended an evaluation of claimant's left eye vision by an optometrist. (Ex. 4, pp. 101-102)

That same date, March 13, 2014, claimant was evaluated by Craig Crouch, O.D. Dr. Crouch assessed enophthalmos of the left eye due to trauma and he referred claimant for further evaluation. (Ex. 5, pp. 124-130)

Claimant remained off work from March 6 through March 13, 2014. (Ex. 1, pp. 2, 21) He thereafter returned to work for defendant in a light duty capacity, performing seated duties in the cafeteria. Claimant testified the light duty assignment was bothersome, as he continued to suffer with pain in his head, neck, shoulder and elbow. He also experienced difficulty with the noisy environment, leading him to feel stress and anxiety. Claimant testified he continued to treat with Dr. Archer, but missed work on occasion due to mental issues, headaches, or pain of his chest, elbow, and neck. (Tr. pp. 22-23)

On March 17, 2014, claimant presented to Dr. Crippin with complaints of some anxiety and occasional dizziness. Dr. Crippin assessed a contusion of the chest wall, left frontal contusion and large laceration, left shoulder contusion, dizziness, and "work anxiety ? ptsd." (Ex. 4, p. 104) Dr. Crippin noted he and claimant discussed a possible concussion and post-concussion balance issues, as well the importance of an attempt to work. Dr. Crippin advised claimant to follow up with Dr. Archer in one week. (Ex. 4, p. 105)

The following day, March 18, 2014, claimant presented to Jones Eye Clinic Oculoplastics Service and was evaluated by Yian Jones, M.D. Dr. Jones assessed neurogenic brow apraxia. Dr. Jones indicated claimant's brow ptosis was likely to recover with time. (Ex. 6, p. 131)

On March 26, 2014, claimant returned to Dr. Archer. Dr. Archer described claimant's forehead laceration as "healing nicely." (Ex. 4, p. 106) He discontinued use

of hydrocodone, but issued prescriptions for gabapentin and Trazadone. Dr. Archer cleared claimant to resume full duty work, but indicated claimant should be reintroduced to the workplace "very slowly due to anxiety" regarding reinjury. Dr. Archer raised the possibility of nursing staff at the plant walking claimant through the area in order "to help him deal w[ith] the anxiety of being on the floor again." (Ex. 4, p. 108) Shortly thereafter, Dr. Archer ordered consultations with an ENT specialist for claimant's reports of ear pain, and with neurology for headache complaints. (Ex. 4, pp. 109-110)

Claimant continued to perform light duty, clerical duties in the cafeteria and then he took vacation for two weeks in early April 2014. (Ex. 1, p. 21)

On April 2, 2014, claimant presented to CNOS for evaluation by Michael Nguyen, M.D., a primary care sports medicine physician. Dr. Nguyen noted a history of a head injury, with claimant being referred for concussion evaluation and any recommendations which could increase claimant's response to treatment. Dr. Nguyen indicated defendant's records indicated no loss of consciousness with the accident, but the CNOS form indicated claimant had been rendered unconscious for 10 minutes. As a result, Dr. Nguyen indicated he was uncertain which account was accurate. (Ex. 8, p. 144) Dr. Nguyen detailed the ophthalmologist's diagnosis of brow ptosis secondary to seventh cranial nerve damage which was likely to recover with time. (Ex. 8, p. 144)

Dr. Nguyen noted claimant sat hunched over, made no eye contact, and whispered during the course of examination. He also noted claimant demonstrated flat affect and psychomotor retardation. Dr. Nguyen indicated claimant displayed a "vacant look" and required significant prompting to answer questions. (Ex. 8, p. 144) Dr. Nguyen noted an observable scar extending across claimant's forehead and through his eyebrow to the corner of the eye. He indicated claimant seemed self-conscious of the scar and attempted to hide it under a knit cap. (Ex. 8, p. 146) Claimant described experiencing headaches at the location he struck his head, but Dr. Nguyen opined the headaches appeared more diffuse. (Ex. 8, p. 144)

Following examination, Dr. Nguyen assessed a mood disorder/adjustment disorder. Dr. Nguyen opined the condition might be related to the work injury in that claimant appeared fixated upon and self-conscious regarding the scar. While Dr. Nguyen acknowledged he was unclear whether claimant had any such symptoms preinjury, he opined the current flare of the mood disorder was impacting claimant's ability to recover from a likely concussion. Accordingly, Dr. Nguyen recommended treatment of the mood disorder. He further opined desensitization treatment was appropriate and would likely assist claimant in returning to work. (Ex. 8, p. 146)

Dr. Nguyen assessed a concussion, as claimant's Standardized Assessment of Concussion (SAC) score showed some impairment, including issues with concentration. He opined if claimant had lost consciousness, the mechanism of injury fit the profile of a concussion. He opined the concussion should resolve on its own, but was being confounded by the mood disorder. Dr. Nguyen, accordingly, recommended claimant

follow with Dr. Archer regarding treatment of the mood disorder and expressed agreement with Dr. Archer's recommendations for restrictions and desensitization. (Ex. 8, pp. 146, 148)

On April 10, 2014, claimant returned to Dr. Archer, who noted claimant had been performing clerical work for defendant and was afraid of returning to the production floor. (Ex. 4, p. 111) Dr. Archer continued orders for physical therapy and prescriptions for gabapentin and Trazadone. Dr. Archer opined claimant should begin a progressive desensitization to his work area and return to work full duty, assuming claimant was cleared by Tracey Wellendorf, M.D. (Ex. 4, p. 113)

On April 15, 2014, claimant presented for evaluation with board certified otolaryngologist, Dr. Wellendorf. Claimant complained of ear pain, pressure, tinnitus, and decreased hearing. Dr. Wellendorf assessed otalgia, asymmetrical sensorineural hearing loss, tinnitus, and hearing loss. He opined claimant's complaints of decreased hearing, pain, and ringing were consistent with the sensorineural hearing loss. Accordingly, Dr. Wellendorf recommended an audiogram. (Ex. 9, pp. 149, 151) Claimant underwent the recommended audiogram on April 17, 2014, which revealed bilateral mild sensorineural hearing loss. (Ex. 10, p. 157)

When claimant returned to work following his vacation, he was assigned to a gradual return-to-work program of two, four, six, and then eight hours, as tolerated. (Ex. 1, p. 14, Ex. 4, p. 113)

On April 20, 2014, claimant had been drinking and went onto a property in an attempt to speak with a relative. (Tr. p. 24) The owner of the property called the police and claimant was arrested. (Id.) At the arbitration hearing, claimant testified he had been drinking because of his anxiety, stress and depression which he related to the work injury. (Id.)

On April 22, 2014, claimant presented to the BVRMC Emergency Department and was examined by Terezia Matasovic, M.D. Claimant indicated he was unable to walk that day due to numbness of his arms and legs. He also complained of a headache and chest pain off and on for one month, dating to the work injury. (Ex. 3, p. 80) Dr. Matasovic assessed a suspected seizure secondary to head trauma, chronic headaches, and chronic right chest pain. (Ex. 3, p. 86) Claimant received an injection of Dilaudid and prescriptions for gabapentin and Trazadone. (Ex. 3, p. 91) Dr. Matasovic released claimant to return to full duty work the following day, but she recommended claimant undergo an EEG. (Ex. 3, pp. 86, 95)

Claimant returned to Dr. Archer on April 24, 2014. Dr. Arched noted claimant had previously presented to the emergency room because claimant believed he was "going to have an epileptic attack." Claimant related the event to his work injury, citing a feeling of worthlessness due to the scar and a fear of returning to the plant "because he almost died in there." (Ex. 4, p. 114) Dr. Archer opined it appeared claimant suffered a

hyperventilation spell, as there was no actual observed seizure activity. Rather, Dr. Archer described the event as an anxiety reaction with hyperventilation. Accordingly, Dr. Archer opined claimant did not require an EEG. (Ex. 4, p. 116)

Dr. Archer noted claimant blamed the work injury for the event, but Dr. Archer noted claimant admitted he had been arrested and this may have contributed to claimant's heightened stress level. Claimant reiterated his feelings of worthlessness as a result of the scar and his fear of entering the plant, but Dr. Archer noted claimant did not explain why he held such feelings and refused to answer Dr. Archer's questions regarding a fear of reinjury versus fearing his scar would be viewed as unsightly. (Ex. 4, p. 116) Dr. Archer recommended evaluation by a neuropsychologist, as he believed claimant's symptoms were beginning to sound like a post-traumatic stress reaction "out of proportion to the actual severity of the scar and of the physical trauma." Dr. Archer noted he, Dr. Wellendorf, and Dr. Nguyen discussed claimant's ability to work and agreed claimant could participate in a very gradual return to work period with "lots of time to adjust." (Ex. 4, p. 116) Dr. Archer subsequently agreed evaluation by Amy Mooney, Ph.D., psychologist, would be acceptable. (Ex. 1, p. 17)

On April 29, 2014, claimant returned to Dr. Wellendorf, who reviewed claimant's audiogram and opined it revealed slight hearing loss at one frequency. As Dr. Wellendorf did not possess claimant's preinjury audiograms for comparison, those were requested from defendant. Pending receipt, Dr. Wellendorf issued diagnoses of unspecified otalgia, headache, and asymmetrical mild sensorineural hearing loss. (Ex. 9, p. 155)

Dr. Wellendorf subsequently received claimant's preinjury audiogram records. Dr. Wellendorf indicated he had been asked to opine as to whether claimant's tinnitus and hearing loss were a result of the work injury. He stated:

> It would be difficult to show the cause effect relationship at [*sic*] the patient has had some fluctuating thresholds in the ear but most are likely related also to a wax impaction. At this point I do not believe this should be a factor in regards to his ability for gainful work.

(Ex. 9, p. 156)

On April 30, 2014, claimant spent approximately one and a half hours on the plant floor in an attempt to reintroduce him to the production area. He completed the remainder of his shift in the cafeteria. (Ex. 1, pp. 21, 53)

On May 1, 2014, claimant presented to Dr. Archer wearing a stocking cap covering his forehead. Dr. Archer noted claimant had gained nine pounds and demonstrated worried affect. He noted Dr. Wellendorf had cleared claimant to return to work and recommended a slow return to work effort. (Ex. 4, pp. 117, 119)

Claimant returned to work on May 1, 2014, and spent approximately one hour performing janitorial work on the production floor. At that point, claimant stated he was unable to continue. (Ex. 1, pp. 19, 54)

Claimant testified he attempted to work, but continued to experience difficulty with anxiety, stress, depression, the noisy environment, and constant preoccupation with the work injury. Claimant testified he discussed his concerns with a representative at defendant and was advised he could take leave, but it would be without pay. He was told to return when he felt capable. (Tr. p. 26) As of May 2, 2014, claimant was placed out of the plant on bid walk as a result of his reported inability to return to the production floor. (Ex. 1, pp. 20, 22, 54)

At the referral of defendant, claimant presented to Ames Therapy and Consulting on June 2, 2014. On that date, he underwent a mental health and psychiatric evaluation with psychologist, Amy Mooney, Ph.D., and board certified psychiatrist, Terrence Augspurger, M.D. Those providers issued a report dated July 11, 2014, which contained their findings and opinions. The evaluation included a history, records review, interview of claimant, phone interview with claimant's supervisor, and mental status examination and testing. (Ex. 11, p. 159) Claimant's supervisor, Randy Story, described claimant as a good worker who kept to himself and only communicated with his brothers. (Ex. 11, p. 160)

The report detailed the work injury and indicated claimant alleged an inability to remember the events immediately following the incident, stating he was unconscious and only later awoke in the hospital. However, it was also noted that a witness to the event denied any loss of consciousness by claimant. The providers noted claimant tended to amplify what may have happened to him in the accident, indicating he "nearly died." (Ex. 11, p. 160)

The providers noted claimant suffered with recurrent involuntary and intrusive memories of the accident, distressing dreams, psychological distress, and physiologic reactions to cues that reminded him of the accident. Claimant expressed belief he was ugly and would not be able to find a wife and have a family as a result of the scarring from the laceration. Claimant also described persistent feelings of sadness and depression, with diminished interest in activities and people. He also described irritability, anger, an exaggerated startle response, concentration difficulties, and sleep disruption. (Ex. 11, pp. 160-161) The providers noted claimant seemed to exhibit some dissociative symptoms with a sense of depersonalization and derealization at times. They noted claimant felt he was seriously injured, although the laceration had healed nicely and he did not sustain serious injury to any other body part. However, claimant described exaggerated feelings of worthlessness as a result of the scarring on his face. (Ex. 11, p. 161)

During the course of examination, claimant was described as looking at the ground and making eye contact only once, at which time he smiled. Claimant was

described as appearing somewhat scared and depressed. He was noted to display unspontaneous speech, providing delayed and short answers. Claimant's mood was described as anxious and depressed, with almost flat affect, and an appearance of being almost disassociated. The providers found claimant's memory was difficult to assess and opined claimant's insight and judgment seemed poor. (Ex. 11, p. 162) However, claimant's overall level of functioning was described as good. (Ex. 11, p. 163) Claimant also participated in mental status testing, including a valid MMPI-2 test and cognitive testing. (Ex. 11, pp. 163-164)

Following the interview, records review, testing and examination, Dr. Mooney and Dr. Augspurger issued diagnostic impressions. The first diagnosis was of unspecified anxiety disorder. The providers explained that claimant demonstrated sufficient symptoms for a diagnosis of post-traumatic stress disorder (PTSD). However, they felt the trauma claimant experienced was not severe enough to qualify for a PTSD diagnosis. They also opined claimant's testing and interview suggested claimant suffered with chronic anxiety of a diffuse nature, with components unexplainable by sudden onset PTSD. The second diagnosis was of other specified personality disorder with dependent and compulsive traits indicative of a significant, longstanding mental health disturbance. The third and final diagnosis pertained to a need to rule out an autism spectrum disorder with intellectual impairment. The providers noted claimant possessed the capacity to function independently but demonstrated poor social skills. (Ex. 11, pp. 164-165)

Dr. Mooney and Dr. Augspurger opined claimant would benefit from symptomatic relief of anxiety and depression by way of psychotropic medication. While they noted psychotherapy might also be beneficial, the providers indicated claimant's personality style might result in low potential for change. (Ex. 11, p. 165) The providers opined claimant had a history of chronic anxiety and depression symptoms predating the work injury, as well as personality traits which contributed to his psychological pattern. While they opined the mental condition preexisted the work injury, they opined claimant's work injury intensified the preexisting anxiety disorder and claimant's response to stress. Dr. Mooney and Dr. Augspurger further opined claimant's increased anxiety at least moderately impaired claimant's ability to work. Therefore, they recommended medication management to treat depression and anxiety with the belief such medication would assist with stabilization of claimant's behaviors and allow for a return to baseline levels of functioning. The providers opined claimant demonstrated no objective findings of permanent impairment as a result of the psychological components of his injury. (Ex. 11, pp. 165-166)

Following the evaluation, Dr. Mooney authored a letter to defendant's claims administrator. By this letter, Dr. Mooney opined claimant demonstrated moderate mental limitation with respect to interacting appropriately with others, but expressed belief this limitation was not specifically related to the work injury. She opined the work injury had temporarily increased claimant's anxiety. Dr. Mooney accordingly recommended medication management through another provider, as she had a conflict

of interest due to performance of an independent evaluation. She opined with appropriate medication, claimant would return to his previous level of functioning. In addition to medication management, Dr. Mooney recommended a return to work with gradual exposure to the prior work environment. (Ex. 11, p. 158; Ex. E, p. 2)

Defendant arranged for Dr. Archer to manage claimant's mental health medications. (Ex. G) Claimant returned to Dr. Archer on June 3, 2014. Dr. Archer assessed anxiety, with a history of resolved earache, headaches, and neck strain. Dr. Archer noted he was awaiting notes from a psychologist regarding claimant's anxiety syndrome. Dr. Archer opined claimant achieved maximum medical improvement (MMI) from a medical standpoint with only occasional continued headaches. Dr. Archer opined claimant suffered from no physical injury which prevented him from working full duty. He also opined claimant sustained no permanent impairment. (Ex. 1, p. 23; Ex. 4, pp. 120-122)

On June 11, 2014, claimant returned to Dr. Jones for evaluation. Dr. Jones diagnosed traumatic neurogenic brow ptosis. She opined claimant currently demonstrated no visual impairment due to the brow ptosis and accordingly, released claimant to regular duty work, without restrictions. (Ex. 1, p. 35)

On September 5, 2014, claimant contacted defendant and, despite continued headache complaints, claimant asked to attempt a return to work. Defendant complied and returned claimant to his preinjury janitor position. (Ex. 1, p. 55) Claimant testified he was initially provided a helper to assist with physical tasks. After a short period with a helper, claimant worked alone, but received assistance from coworkers when needed. Upon returning to the plant environment, claimant testified his depression, anxiety and stress levels increased as a result of seeing the site of the work injury and reliving those moments. (Tr. pp. 28-30)

Defendant authored a fill-in-the-blanks letter to Dr. Archer requesting his opinions. By this letter, dated September 19, 2014, Dr. Archer opined claimant had achieved "baseline for pre-existing depression" and opined the prescribed citalopram was intended to treat a preexisting condition. (Ex. 1, p. 29)

On September 22, 2014, claimant presented to Dr. Archer for treatment of his depression and anxiety. Dr. Archer assessed depression, gradually improving. He prescribed Celexa/citalopram and recommended claimant consider counseling with the defendant's plant chaplain. Dr. Archer opined claimant's depression preexisted the work injury and was not work-related. (Ex. 1, p. 30; Ex. 12, pp. 167-168)

Claimant returned to Dr. Archer on October 13, 2014, for evaluation regarding headache complaints. Claimant also reported he had received some relief of his mental health complaints with speaking to the plant chaplain. Dr. Archer assessed subjective headaches and substantial social anxiety. He added tramadol to claimant's medication regimen due to headache complaints, but expressed belief the headaches were a

vegetative sign of claimant's anxiety disorder. Dr. Archer recommended continued counseling with the chaplain and following with Dr. Mooney for anxiety symptoms (Ex. 4, p. 123; Ex. 12, pp. 169-170)

At the request of claimant's counsel, claimant presented on November 7, 2014, for an independent medical evaluation (IME) with board certified occupational medicine physician, Sunil Bansal, M.D. Dr. Bansal issued a report of his findings and opinions dated December 1, 2014. As part of his IME, Dr. Bansal performed a medical records review. (Ex. 13, pp. 171-177) Dr. Bansal also interviewed claimant, who reported he did not lose consciousness following the injury, but was dazed. (Ex. 13, p. 178)

Claimant complained to Dr. Bansal of numbness from his left forehead and cheek area radiating to his left occipital area. He also complained of headaches, neck pain with rotation, impaired concentration, lack of focus, ringing of the left ear with some hearing loss, blurred vision of the left eye, low back pain, pain and numbness of the left elbow and forearm, significant anxiety since the accident, frequent crying spells, and difficulty sleeping. (Ex. 13, pp. 178-179) Claimant reported he was working full duty in his preinjury job, but remained "very fearful at work," with it being very difficult for claimant to work in that environment. (Ex. 13, p. 178) Claimant stated he was able to lift 30 to 40 pounds occasionally and 10 to 20 pounds more frequently. (Ex. 13, p. 179) Dr. Bansal also performed a physical examination of claimant. (Ex. 13, pp. 179-181)

Following records review, interview and examination, Dr. Bansal made the following diagnoses:

With respect to claimant's head, neurological, and psychological conditions, he assessed post-concussive syndrome, PTSD, left ear tinnitus, headaches, and concentration impairment. He also assessed a facial laceration, myofascial pain syndrome of the neck, chest wall contusion, and left elbow sprain. (Ex. 13, pp. 181-182) Dr. Bansal opined claimant sustained only temporary strains to his back and elbow. (Ex. 13, p. 184) Dr. Bansal opined claimant achieved MMI as of June 3, 2014. (Ex. 13, p. 182)

Dr. Bansal opined the mechanism of claimant's work injury was consistent with the head, neck, and mental health pathology he diagnosed. He opined claimant developed "traumatic brain injury sequela" from the head injury. (Ex. 13, p. 182) Dr. Bansal noted conditions of post-traumatic migraines, tinnitus, dizziness, and cognitive impairments have been linked to head trauma in medical literature. (Ex. 13, p. 182-183) With respect to claimant's neck, Dr. Bansal opined the work injury could explain the clinical findings of the trigger points, with claimant complaining of muscle tightness. (Ex. 13, p. 183)

Dr. Bansal opined claimant sustained permanent impairment because of the work injury. As a result of the conditions which Dr. Bansal grouped as related to claimant's head, Dr. Bansal opined claimant sustained six percent whole-person

impairment. Specifically, he opined claimant demonstrated a constellation of neurological impairments classified under the description of a traumatic brain injury. Dr. Bansal identified complaints of dizziness, headaches, tinnitus and concentration difficulties, as well as development of PTSD. Dr. Bansal also opined claimant sustained permanent impairments of three percent whole person due to guarding and decreased range of motion of the neck, and two percent whole person as a result of the disfiguring facial scar, per the AMA Guides to the Evaluation of Permanent Impairment, on skin disorders. He opined claimant sustained no permanent impairment as a result of the chest and elbow injuries. (Ex. 13, p. 184-185)

Dr. Bansal recommended permanent restrictions of a maximum lift of 40 pounds occasionally and 20 pounds frequently. He also advised use of caution with returning claimant to work in an environment which aggravated his PTSD. Dr. Bansal opined claimant should receive care for his mental health complaints, at a minimum, regular evaluations by a specialist and appropriate medications. He also opined claimant's neck complaints might warrant trigger point injections, a TENS unit, and a home exercise program. (Ex. 13, pp. 185-186)

On December 11, 2014, Dr. Jones completed a fill-in-the-blanks questionnaire and thereby opined claimant had attained MMI from an ocular standpoint. Dr. Jones opined claimant continued to demonstrate brow apraxia medially, which had improved and which she anticipated would continue to improve. Dr. Jones opined the brow apraxia did not affect claimant's vision, but might be of cosmetic concern. She opined claimant sustained no functional impairment and released claimant to full duty, without further treatment indicated. However, Dr. Jones recommended claimant follow up in six months. (Ex. 1, pp. 33-34, 36)

At the referral of his attorney, claimant presented on February 20, 2015, to Plains Area Mental Health Center and was evaluated by Christel Rinehart, ARNP. Ms. Rinehart's notes indicate claimant reported he had previously done well on medication for his mental health complaints, but those medications were stopped in November 2014. Claimant expressed a need to return to use of the medications. (Ex. 14, p. 192) Ms. Rinehart assessed PTSD, a history of traumatic brain injury, and occupational concerns. She issued prescriptions restarting Celexa and Trazadone and she also added prazosin for nightmares. Ms. Rinehart recommended claimant participate in psychotherapy. (Ex. 14, p. 194)

On March 3 and March 19, 2015, claimant presented to Plains Area Mental Health Center for psychotherapy with Jessica Mendel, LMSW. (Ex. 14, pp. 195-196)

In March 2015, defendant terminated claimant's employment. (Tr. p. 31) Claimant related his termination to absences attributable to the work injury. (Id.) He acknowledged over half of the accumulated points which led to his termination resulted from no-call/no-shows. (Tr. p. 39) However, claimant testified he was unaware that six

of the eleven points he accumulated were related to no-call/no-shows contemporaneous with his April 2014 arrest. (Id.)

William Sager II, human resources manager for defendant, testified at the arbitration hearing. Mr. Sager confirmed claimant was terminated for accumulation of points due to attendance issues. Mr. Sager explained an employee is terminated for accumulating ten points within a 12-month period. Mr. Sager indicated that different numerical values of points are assigned to different absences: one point for calling in on time for non-work related illness; two points for calling in sick on the first or last day of a work week; and three points for a no-call/no-show. Mr. Sager testified claimant accumulated six points for no-call/no-shows on April 21 and April 22, 2014. Claimant was then a no-call/co-show on January 12, 2015, bringing his total to nine points. On March 9, 2015, claimant called in for a non-work related illness, but as it was at the beginning or end of his work week, he accumulated two additional points. Because claimant accumulated eleven points, defendant terminated his employment. (Tr. pp. 60-70)

Following his termination, claimant applied for and was found eligible to receive unemployment insurance benefits. (Ex. 20, p. 239) IowaWorks offered claimant services through Iowa's Re-Employment Services Program. (Ex. 20, p. 242) During April 2015, claimant made contact with four potential employers inquiring of employment opportunities. (Ex. 2, p. 245) Claimant testified he sought work at large employers and small Mexican stores, but never received an offer of employment. (Tr. p. 34) Claimant expressed doubt as to his ability to work, but indicated he attempted to find a job within his abilities and because of his lack of income. (Id.)

At the referral of claimant's attorney, claimant presented on July 10, 2015, for an independent mental health evaluation with psychologist Catalina Ressler, Ph.D. The evaluation was conducted in Spanish. Dr. Ressler issued a psychological report dated July 18, 2015. (Ex. 15, p. 203)

In her report, Dr. Ressler noted claimant's preinjury life did not include many stressors. However, Dr. Ressler noted claimant experienced mild anxiety with transitions. For example, claimant described difficulty upon moving to the United States and experiencing cultural differences. Dr. Ressler opined claimant never "really fully accultured" to life in the United States, with claimant feeling anxious in situations in which he "feels like an outsider." Dr. Ressler also described mild preinjury symptoms of worry and social anxiety. (Ex. 15, p. 204)

Claimant described the work injury for Dr. Ressler. Claimant indicated he did not lose consciousness as a result of the injury, but he reported he did not recall a great deal from the time the injury occurred until he arrived at the hospital. He described experiencing a great deal of bleeding and feeling quite scared following the injury. (Ex. 15, p. 204)

Claimant informed Dr. Ressler that when he returned to work following the injury, he was assigned to the cafeteria. In this light duty role, claimant reported feeling bored, exhausted, trapped, useless, and annoyed. He also reported overhearing gossip from coworkers, including "how they thought he had died or that he would be paralytic." Claimant reported the gossip affected him personally, and he became progressively depressed and developed increased concern about the injury. (Ex. 15, p. 204)

When claimant was asked about returning to his preinjury job, he indicated he informed defendant he was fearful of returning to the location of the accident. Claimant reported he was told to try to return and attempt to deal with his fear. (Ex. 15, p. 204) Claimant indicated he attempted to return to work in the area, but his fear and the noise levels were intolerable. As a result, claimant ceased working until September 2014, when he began performing small increments of work and was assigned a coworker to assist. After this helper was no longer assigned to him, claimant indicated his coworkers offered him assistance, but as a result, he felt like a burden. Thereafter, his anxiety and depression increased and he began missing work. Dr. Ressler noted claimant was subsequently terminated in March 2015 for absenteeism. (Ex. 15, p. 205)

Claimant participated in a two-hour interview and mental status exam. Dr. Ressler also reviewed claimant's medical records. (Ex. 15, p. 205) Dr. Ressler described claimant as cooperative and open in his response style during the interview and she indicated she was able to easily establish rapport with claimant. Dr. Ressler noted claimant avoided eye contact and kept his face pointed downwards, with his hat sitting low into his eyebrows. (Ex. 15, pp.206-207) She also described claimant as presenting with flat affect and a depressed and anxious mood. Dr. Ressler stated the following in her report, in pertinent part:

> LEVEL OF FUNCTIONING POST·INJURY
>
> I asked Mr. Deciga to speak about his functioning since the accident. He said that he feels this incident had too many consequences for him and perhaps the worst of it is how he feels about himself. He explained that he lives in constant fear and his fears are varied. For example, he said he is scared of: something falling on him again; the chronic headaches not going away; the weakness he still experiences on his left arm; the negative thoughts he has about how he is perceived by others when they see his face; his ability to find a partner and have children; and, the future in general.
>
> Mr. Deciga talked about how lonely he feels and how much his desire to not be a burden to others has kept him from engaging in social events. He said he was an introvert before the accident but now he feels he doesn't even want to be around family. He feels that the social isolation is exacerbating his feelings of depression and general despair. I asked what specifically bothers him when he is around

others and he said he becomes irritable with noise or when there are too many people talking around him. He says that he mostly isolates to have some silence as he feels less anxious in quiet spaces.

When asked about his daily routine, Mr. Deciga said that he finds himself being quite bored, which adds to his feelings of anxiety. He explained that because he can't fall asleep until close to three to five in the morning, he wakes up around 11 am most days if he is able to sleep. He says he then watches the news or gets on the computer and then goes out for a walk or to sit outside for a while. Mr. Deciga said that if he feels too lonely or if his family complains about him being withdrawn, he will make some time to speak with them on the phone. I asked about activities of daily living and Mr. Deciga said that his sister-in-law does all of his cooking but he does his own laundry and helps with chores around the home.

ASSESSMENT PROCEDURES

The procedures of the evaluation included two hours of a clinical interview and mental status exam with Mr. Deciga. The first 15 minutes were spent on introductory activities and going over the consent forms. Mr. Deciga understood that I was not entering into a therapeutic relationship with him and that what we talked about, including the report, would not be confidential.

. . .

In addition to the clinical interview, Mr. Deciga was administered the Minnesota Multiphasic Personality Inventory 2 (MMP1·2). This assessment was administered with the purpose of clarifying his current mental health state; to assist in his diagnosis; and, to aid in the provision of a more comprehensive description of his personality style. The administration was done in Spanish. Cultural norms were used for the scoring of the assessment.

A review of Mr. Deciga's medical records was also completed to gain a full understanding of his concerns and the treatment he has received since the date of the work-related injury. Such review also provided an understanding of the sequence in which his symptoms have progressed. References are made to specific entries in this psychological report where they are particularly relevant.

. . .

The professional opinions that follow are presented with a reasonable degree of professional certainly after the clinical interview; mental status exam; administration and interpretation of the MMPI-2; and, the review of Mr. Deciga's medical records.

RESPONSE STYLE

Mr. Deciga's response style during the interview was cooperative and open. It was easy to establish rapport with him from the beginning of the clinical interview. There was no evidence to believe that he was malingering. The results of the MMPI-2 also provide support for this assertion. Despite this, Mr. Deciga presented with flat affect and his mood was quite depressed and anxious. His range of affect was restricted until he started talking about the future at which time he was fidgety and hopeless in his report.

MENTAL STATUS EXAM

A mental status exam was conducted in order to determine Mr. Deciga's current level of impairment at work and general level of adaptive functioning. The following are the results of such examination:

Mr. Deciga was oriented to all spheres. He seemed excessively tired but was mostly alert and his thought process was coherent and easily understood. His attention and concentration is impaired at this time as evidenced by his inability to spell a simple word backwards or do serial 7s with ease. During the assessment process, items also had to be repeated to him often times as he would easily lose concentration. Mr. Deciga's short-term memory recall also appears to be impacted at this time. He was unable to recall three words five and 30 minutes after he had rehearsed them twice. However, his long-term memory recall did appear to be intact. For example, he seemed to easily recall events, dates, and information about his social history and his remote and recent past. His abstraction skills are adequate and congruent with his level of education (i.e., some high school education). His cognitive abilities are likely in the average range. Mr. Deciga could easily follow simple and complex instructions that were offered verbally. However, he could not complete a simple visual-spatial exercise.

Mr. Deciga's apparent age is approximately the same as his chronological age. He was dressed casually and appropriately for weather and occasion. He is of average height and weight. Interpersonally, he was warm, respectful, and kind. His speech was normal for both rate and volume and his receptive and expressive

language were adequate as well. Mr. Deciga's grooming and hygiene appeared to be good. Behaviorally, he avoided making eye contact and he kept his face down and wore a hat that covered him low into his eye brows: nevertheless, it was easy to establish rapport.

TEST RESULTS

Mr. Deciga was administered the MMPI·2 in Spanish and ethnically appropriate norms were used for the scoring of his profile. Validity scales indicated that he responded to the items in a frank and open manner. Even though there was a tendency on his part to be overly self-critical, Mr. Deciga was cooperative and endorsed psychological symptoms that are consistent with his report and with my impression during the clinical interview.

Symptomatic Patterns: A pattern of symptomatic depression characterizes Mr. Deciga's MMPI·2 clinical profile. The latter was very well defined which increases confidence that the following narrative report is a good indication of Mr. Deciga's current symptomatic behavior. He is presently experiencing a variety of psychological problems. He is feeling quite depressed and anxious, extremely pessimistic, and uninterested in life. He blames and belittles himself to the point that he cannot function in routine daily activities. However, his depression and anxiety are partly situational and may diminish over time with treatment or as stress dissipates. Despite this, Mr. Deciga also indicates a stable pattern of behavior or a personality trait pattern reflecting social withdrawal. His many passive traits, including dependency, low self-esteem, and social isolation, are likely to persist even after the symptom pattern of depression and anxiety subsides.

Mr. Deciga reports a preoccupation with feeling guilty and unworthy. He feels regretful and unhappy about life and seems plagued by anxiety and worry about the future. Mr. Deciga expressed feeling hopeless at times. He views his physical health as failing and reports numerous somatic concerns as would be expected given the pain that has resulted from the injury. Mr. Deciga's recent thinking is likely to be characterized by obsessiveness and indecision. He feels intensely fearful about a large number of objects and activities. This hypersensitivity and fearfulness appear to be generalized at this point and may be debilitating to him in social and work situations.

Interpersonally, Mr. Deciga may come across as intolerant and insensitive to others. He is socially withdrawn, fearful of others, does not make friends easily at this time, and lacks expressiveness and spontaneity in social situations. He allows others to dominate him and

fails to defend himself even when he has been wronged. He may become involved in relationships in which he is mistreated or taken advantage of because he feels that he doesn't deserve better.

DSM·V DIAGNOSIS

309.81 Posttraumatic Stress Disorder with Dissociative Symptoms

ATTORNEY QUESTIONS

On your letter to me dated 07/14/2015, you asked that I provide answers to the following questions considering a reasonable degree of psychological certainty:

1. With respect to Mr. Deciga, what is your psychological diagnosis or diagnoses, if any?

I am certain that Mr. Deciga is suffering from Posttraumatic Stress Disorder (PTSD) with dissociative symptoms. After reviewing his medical records, conducting a thorough clinical interview, and examining the results of his psychological assessment, it is sufficient evidence to support this diagnosis. Mr. Deciga has characteristic symptoms in all four clusters of PTSD symptoms outlined in the Diagnostic and Statistical Manual of Mental Disorders - 5 (DSM-5).

The first cluster of symptoms refers to the re-experiencing of the trauma event. Not only does Mr. Deciga has (sic) repeated nightmares and flashbacks to the event, but he has continuous dissociative reactions of depersonalization (feeling like an outside observer) and derealisation (feeling that the world around him is distant and distorted). The second cluster of symptoms refers to the alterations in arousal. Mr. Deciga particularly struggles with sleep disturbances. He reported that some days he can't fall asleep until close to five in the morning because he is feeling too uneasy and fearful of his nightmares. He also described many instances of hypervigilance. Mr. Deciga reports that he repeatedly checks windows and doors and at times feels as though someone is watching him.

Mr. Deciga also experiences a great deal of difficulty with avoidance. He is constantly preoccupied with thoughts of distressing memories and reminders of the traumatic event. For example, he spends a great deal of time agonizing over the scar on his face and perceives that he is deformed and no one will develop an interest in him. He then worries he will not be able to marry and have a family of his own.

Finally, Mr. Deciga is frequently agonizing with negative alterations of his cognition and mood. Specifically, he has persistent negative beliefs about the future; has strong feeling of alienation; and, a diminished general interest in life. He believes that his future has forever changed and he doesn't fit in with his family or with friends. Mr. Deciga perceives that they are helpful to him because they feel obligated to do so, but he says his irritability and bad mood are undeserving of their attention.

2. Based on your psychological testing and clinical assessment, do you find Mr. Deciga's complaints of pain and/or symptoms in his head and neck to be credible, or is it your opinion that he is malingering?

I believe that Mr. Deciga's experience of pain is genuine and there is no reason to believe that he could be malingering as evidenced by the validity scales in the MMPI-2. All of these scales were within a normal range suggesting that he answered in an honest manner. Validity scales measuring consistency of responses were well within the normal limit. Moreover, it is highly improbable that an individual could generate two very similar profiles over time if the individual was malingering. Mr. Deciga's results on the MMPI-2 that I administered in my office are very similar to those reported as part of a previous mental health evaluation that he completed at Ames Therapy & Consulting, PC on 06/02/2014. The latter offers additional evidence that Mr. Deciga is not falsifying his symptoms or general mental health concerns.

3. With reference to the full-time competitive workplace, what permanent work limitations are appropriate for Mr. Deciga in light of the psychological diagnoses you listed in your response to Question #1, above, if any?

I do not believe that Mr. Deciga is capable of performing his job at this time. His symptoms are severe enough to keep him from functioning effectively in most areas of his life. The main concern that I would have for Mr. Deciga in the workplace would be that of safety. The dissociative symptoms that accompany his PTSD could result in him easily suffering another injury or accident, particularly if he operates machinery or uses sharp objects.

Mr. Deciga is also having a great deal of difficulty with concentration and attention as was noted in the mental status exam as well as the assessment process. Maintaining attention so he can be alert to potential dangers is questionable. Moreover, his ability to retain attention for an extended period of time is simply not possible at this

time and is likely to linger as long as his anxiety persists at this level of severity. Even though Mr. Deciga describes himself as a pacifist, I do not think that he will be capable of behaving in predictable ways in the workplace under his current circumstances. I actually think that his vulnerable state could result in aggressive responses if under enough stress. Mr. Deciga appears to be shy and an introvert. However, his current level of isolation and withdrawal is not likely to subside as long as his depression is so pervasive. I would have concerns about his ability to relate to co-workers and supervisors at this time. Perhaps most importantly, because of his anxiety and depression as well as fear of being in the work area where he suffered the accident, Mr. Deciga is very likely to have problems with absenteeism.

4. Based on your psychological testing and clinical assessment, do you believe that Mr. Deciga is psychologically capable of sustaining full-time employment in the competitive work sector on a long- term basis, in light of your responses to the immediately preceding question? [If so, do you believe that his psychological condition has in any way permanently restricted, limited, or diminished the kind of work that Mr. Deciga is capable of performing on a sustained basis?] Please discuss.

No, I do not believe that Mr. Deciga is capable of sustaining full-time employment in the competitive work sector at this time. As mentioned above, I do not believe that Mr. Deciga is capable of doing so as long as his symptoms remain unchanged. However, at this time it is difficult to predict if his condition will result in permanent impairment. He has not received much treatment beyond the use of psychotropic medications thus far. He reports that the anxiety medication he is currently taking has been somewhat beneficial; however, it is traditional psychotherapy treatment what Mr. Deciga needs at this time.

5. Is it your opinion that there is a relationship/causal connection between Mr. Deciga's 03/16/2014 injury(ies) to his head and neck and his current level of psychological (dys)functioning in terms of the limitations you identified in your response to Question #4, if any? If so, is it your opinion that the injury to Mr. Deciga's head and neck constitutes a substantial contributing factor to his current psychological (dys)functloning?]

Yes. I am certain that there is a direct relationship between Mr. Deciga's injury of 03/16/2014 and his current PTSD symptoms. His assessment, clinical interview, and self-report are all congruent with the timeline of events that have taken place since the injury and in the

aftermath of that event. It was noted in the mental health evaluation that was conducted by Ames Therapy & Consulting, PC that it is likely that Mr. Deciga had a history of anxious symptoms. I agree with the evaluator, but it is also for this reason that he was more prone to developing full PTSD symptomatology. I disagree that he simply is suffering from anxiety and depression as you can see on my explanation to Question #1 above.

6. What future treatment, if any, would you recommend for Mr. Deciga with reference to his psychological diagnoses?

I would first recommend that Mr. Deciga be seen by a psychiatrist for a new medication evaluation. While he reports that his anxiety medication is helping some, he needs additional prescriptions to address the full range of symptoms. For example, when he was taken (sic) the Prozasin 2 mg for nightmares, he reported he was having reduced nightmares but that medication was discontinued.

Mr. Deciga also needs to work with a psychologist that specializes in the treatment of trauma. Because he is not very psychologically minded or sophisticated, I would recommend someone who specializes in forms of treatment that require less insight such as Somatic Experiencing. It is this type of treatment, which can be greatly beneficial in alleviating Mr. Deciga's symptomatology.

It is also important that someone Mr. Deciga perceives as an expert and who understands his difficulties from a cultural context validate his experience. Mr. Deciga can further benefit from someone explaining and normalizing his symptoms given his circumstances. He believes that he "is going crazy" and that he is a burden to most people around him.

While it is not within my scope of practice to comment on Mr. Deciga's physical health concerns, I do believe that he also needs medical attention in reference to his complaints of chronic headaches and weakness on his left arm.

7. Do you causally relate the severity of Mr. Deciga's psychological problems, his psychologically based work limitations, if any, as identified herein, and his need for further psychological treatment, if any, to his 03/16/2014 work injury(ies)?

Yes. I do believe that Mr. Deciga's PTSD symptomatology is causally related to the injury that he sustained on 03/16/2014. I believe that I

> have offered substantial evidence for this assertion in my responses to questions #1 through #6 above.
>
> SUMMARY & CONCLUSIONS
>
> Mr. Deciga meets criteria for posttraumatic stress disorder, which is a direct result of the injury that he sustained on 03/16/2014. The severity of Mr. Deciga's symptoms eventually resulted in him losing his employment. Mr. Deciga's level of adaptive functioning is poor and the lack of timely and adequate psychological treatment for his PTSD have served to maintain the severity of his condition. There is no reason to believe that Mr. Deciga is malingering in any way about his mental health condition

(Ex. 15, pp. 205-210)

On September 11, 2015, Dr. Bansal provided deposition testimony. Dr. Bansal testified he reviewed various records produced after his IME of claimant, including Dr. Ressler's report, claimant's deposition, and various medical records. After this review, Dr. Bansal stood by his opinions as expressed in his IME report. (Ex. 22, p. 248)

Dr. Bansal opined claimant suffered from myofascial pain syndrome of his neck, a soft tissue injury. (Ex. 22, pp. 252-253) Dr. Bansal explained he diagnosed post-concussive syndrome on the basis of claimant sustaining a blow to the head without a loss of consciousness, but with resultant change in cognition and mood. He acknowledged this diagnosis was based upon reported symptoms and not upon performance of testing. (Ex. 22, p. 254) He opined the diagnosis of PTSD was made in accordance with the DSM-V, based upon claimant's subjective reports. (Ex. 22, p. 254) Dr. Bansal opined PTSD can be triggered by a traumatic event. (Ex. 22, p. 263) Also based upon subjective reports were his diagnoses of concentration impairment and headaches. (Ex. 22, p. 255)

Finally, the diagnosis of left ear tinnitus was based upon claimant's report of a ringing sound in his ear. Dr. Bansal indicated tinnitus would not be a finding recorded on a hearing test. (Ex. 22, p. 255) Dr. Bansal initially expressed disagreement with Dr. Wellendorf's opinions on causation of tinnitus. Dr. Bansal based the disagreement upon claimant's subjective report of greater intensity of symptoms following the work injury. (Ex. 22, p. 257) However, following review of medical records which predated the work injury and noting claimant's complaint of ringing of the ears, Dr. Bansal opined he was unable to causally relate the diagnosed tinnitus to the work-related head injury within a degree of medical certainty. (Ex. 22, p. 257)

Dr. Bansal addressed the basis of his permanent impairment ratings, as well. Dr. Bansal opined claimant sustained six percent whole person impairment as a result of the head injury, specifically utilizing the mental status and cognitive impairment section

of the AMA Guides. Dr. Bansal explained he reached this rating using generally the history provided by claimant. Dr. Bansal also noted he did not rate claimant for permanent impairment based on tinnitus. (Ex. 22, pp. 259, 262) With respect to claimant's facial scarring, Dr. Bansal opined claimant sustained permanent impairment, but acknowledged the scarring did not impact claimant's function. (Ex. 22, p. 260) Dr. Bansal also noted claimant sustained permanent impairment as a result of his neck condition, explaining claimant fell between DRE Cervical Categories I and II. (Ex. 22, p. 260-261) Dr. Bansal expanded upon his recommended restrictions of maximum lifts of 40 pounds occasionally and 20 pounds frequently, to state that lifting was to be performed from floor to table level. (Ex. 22, p. 261)

Dr. Bansal testified the majority of his time in professional practice is spent in treatment of patients for employers. (Ex. 22, p. 261) Dr. Bansal testified he also performs IMEs, almost exclusively for claimants, for which he earns approximately $1.3 million dollars annually. (Ex. 22, p. 247)

On October 5, 2015, claimant returned to Ms. Rinehart at Plains Area Mental Health Center. Ms. Rinehart noted she had not evaluated claimant since February 2015 and claimant returned because his prescriptions for medications had lapsed. Claimant reported that while he had utilized his medications, he experienced some improvement in symptoms. Ms. Rinehart resumed claimant's medication regimen and recommended follow up in two months. (Ex. 14, pp. 197, 199) Claimant indicated his break in seeking mental health treatment was due to losing his health insurance after he was fired. (Tr. p. 35)

On October 30, 2015, Dr. Ressler provided deposition testimony. Following her July 2015 evaluation of claimant, Dr. Ressler reviewed the depositions of both claimant and Dr. Bansal, as well as additional mental health records. After doing so, Dr. Ressler stood by the opinions she rendered in her July 2015 report. (Ex. 23, p. 300)

Dr. Ressler opined claimant suffered from PTSD by the DSM-V. Dr. Ressler opined her diagnosis was based upon a precipitating event of the experience of trauma and not upon suffering a brain injury. Under the DSM-V, Dr. Ressler explained that an event can qualify as traumatic if it leads to serious injury, a standard which is subjective to an individual's perception. (Ex. 23, pp. 303-304) Dr. Ressler opined claimant's injury "absolutely" qualified as a serious injury. (Ex. 23, p. 304) She further opined claimant would have qualified for the PTSD diagnosis under the DSM-IV. Dr. Ressler explained that under the DSM-IV, the definition of trauma was more narrowly construed than under the DSM-V. She explained that trauma is subjective by nature and the event experienced by claimant was serious enough in nature to qualify as a traumatic event under the DSM-IV. (Ex. 23, pp. 303-304) By the AMA Guides, Dr. Ressler opined claimant fell within Class 4, indicative of marked impairment. (Ex. 23, p. 314)

Dr. Ressler noted that the report issued by Drs. Mooney and Augspurger described symptoms consistent with a PTSD diagnosis and they simply objected to a

PTSD diagnosis on the belief the trauma claimant suffered was not severe enough to support the diagnosis. (Ex. 23, p. 315) Dr. Ressler expressed disagreement with the opinion rendered by Drs. Mooney and Augspurger that medication would return claimant to a baseline level of functioning. She opined there was no evidence that medication alone would resolve PTSD symptoms. She explained that medication is unable to improve symptoms of dissociation, symptoms of arousal, or symptoms of erratic cognitive and mood changes. (Ex. 23, p. 311)

With respect to claimant's treatment, Dr. Ressler opined claimant became "retraumatized" when he attempted to reenter his prior work environment. She explained that desensitization techniques are useful in treating phobias, but not in treating PTSD. (Ex. 23, p. 315) Dr. Ressler similarly opined that counseling with a chaplain was insufficient treatment, as chaplains lack the training possessed by a psychotherapist. (Ex. 23, p. 313)

Dr. Ressler opined claimant was unable to work as a result of his PTSD. (Ex. 23, pp. 306-307) She further opined she was uncertain if claimant would ever return to work. (Ex. 23, p. 311) Dr. Ressler opined claimant was likely incapable of long term employment given his lack of treatment and the fact he did not represent a good candidate for treatment due to his education level and lack of insight. (Ex. 23, p. 315)

Dr. Ressler testified approximately 95 percent of her professional practice consists of treating patients. (Ex. 23, p. 314) In addition to treating patients, she performs 15 to 20 independent evaluations per year, all for claimants, and the majority of which are for claimant's counsel in particular. (Ex. 23, pp. 299-300)

On December 4, 2015, claimant presented to Ms. Rinehart. He described his condition as "so-so," better since returning to his medication regimen. Ms. Rinehart recommended continued medication use, with claimant to return in one month. (Ex. 14, pp. 202A, 202C) Claimant followed up with Ms. Rinehart on January 4, 2016. At that time, Ms. Rinehart increased claimant's Celexa dosage and recommended he seek to help another person each day, in order to give himself a sense of purpose. (Ex. 14, p. 202J)

Claimant testified he continues to suffer with headaches, as well as neck pain, especially with rotation of his head to the left or with exertion of force. (Tr. pp. 36-37) He utilizes over-the-counter Tylenol and Advil to help reduce the pain. (Tr. p. 37) Claimant also continues to experience a great deal of anxiety, stress, and depression on a daily basis, which he relates to reliving the work injury. (Tr. p. 36) He utilizes the prescribed medications for his mental conditions, which he indicated provide a little relief and allow him to sleep. (Id.)

Claimant remains unemployed, but testified he has continued to seek employment. (Tr. pp. 33-34) He testified he last applied for work at a turkey production facility approximately three weeks prior to the arbitration hearing. (Tr. p. 44) Despite

applying for a production position, claimant does not believe he is capable of performing the work. (Tr. p. 45) Claimant also does not believe he is capable of returning to preinjury employment in agriculture, industrial glass, or airplane parts. (Tr. pp. 10-12) He attributes this inability to his physical restrictions as well as his anxiety, depression, stress levels, and inability to tolerate noisy environments. (Id.) Claimant believes he would be physically capable of performing his preinjury position of cutting meat for defendant, but his mental conditions and the noisy environment would prevent him from performing the job. (Tr. pp. 14-15) Claimant does not believe he is physically or mentally capable of performing his preinjury janitorial position for defendant. (Tr. pp.15-16) Claimant stated he is willing to attempt to work if someone offers him a job. (Tr. pp. 34-35)

Claimant's younger brother, Adan Deciga Sanchez, testified at the arbitration hearing. Adan resided with claimant in Storm Lake, Iowa from 2009 through the date of the work injury. (Tr. p. 58) Adan eventually moved to another residence with his family, but he has remained in close contact with claimant. (Id.) Adan testified claimant did not have any mental problems prior to the work injury and, since the work injury, he has noticed a change in claimant. (Tr. pp. 58-60) Adan described claimant as very anxious, desperate, and depressed. (Tr. p. 59) He stated claimant is now less communicative, more withdrawn from social interaction, and he does not remember conversations. (Id.)

CONCLUSIONS OF LAW

The first issue for determination is whether the injury of March 6, 2014 is a cause of permanent disability.

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 Rule of Appellate Procedure 6.14(6).

The claimant has the burden of proving by a preponderance of the evidence that the alleged injury actually occurred and that it both arose out of and in the course of the employment. Quaker Oats Co. v. Ciha, 552 N.W.2d 143 (Iowa 1996); Miedema v. Dial Corp., 551 N.W.2d 309 (Iowa 1996). The words "arising out of" referred to the cause or source of the injury. The words "in the course of" refer to the time, place, and circumstances of the injury. 2800 Corp. v. Fernandez, 528 N.W.2d 124 (Iowa 1995). An injury arises out of the employment when a causal relationship exists between the injury and the employment. Miedema, 551 N.W.2d 309. The injury must be a rational consequence of a hazard connected with the employment and not merely incidental to the employment. Koehler Elec. v. Wills, 608 N.W.2d 1 (Iowa 2000); Miedema, 551 N.W.2d 309. An injury occurs "in the course of" employment when it happens within a period of employment at a place where the employee reasonably may be when performing employment duties and while the employee is fulfilling those duties or doing an activity incidental to them. Ciha, 552 N.W.2d 143.

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

The question of causal connection is essentially within the domain of expert testimony. The expert medical evidence must be considered with all other evidence introduced bearing on the causal connection between the injury and the disability. Supportive lay testimony may be used to buttress the expert testimony and, therefore, is also relevant and material to the causation question. The weight to be given to an expert opinion is determined by the finder of fact and may be affected by the accuracy of the facts the expert relied upon as well as other surrounding circumstances. The expert opinion may be accepted or rejected, in whole or in part. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); IBP, Inc. v. Harpole, 621 N.W.2d 410 (Iowa 2001); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995). Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417 (Iowa 1994). Unrebutted expert medical testimony cannot be summarily rejected. Poula v. Siouxland Wall & Ceiling, Inc., 516 N.W.2d 910 (Iowa App. 1994).

Claimant sustained a stipulated work injury on March 6, 2014. Defendant provided care and evaluation with a number of medical providers and specialists. Claimant contends he sustained significant permanent disability as a result of the injury, while defendant argues claimant's conditions resolved or returned to baseline levels.

Among claimant's physical injuries were a left elbow contusion/sprain, chest wall contusion, left shoulder contusion, and brow ptosis. No physician opined any of these conditions resulted in permanent impairment or required permanent restrictions. Therefore, I affirm the deputy commissioner's finding that these conditions did not result in permanent disability.

Claimant also claimed injury in the form of tinnitus, ear pain, and hearing loss. Dr. Wellendorf opined it was difficult to establish a cause and effect relationship between the conditions and the work injury. While Dr. Bansal initially opined claimant's tinnitus was work related, he subsequently changed that opinion and indicated he was unable to relate the condition to claimant's work injury. Dr. Bansal did not opine claimant sustained permanent impairment as a result of the tinnitus condition. Therefore, I affirm the deputy commissioner's finding that claimant failed to prove the work injury was a cause of any permanent disability to claimant's ears.

In evaluation of claimant's head injury, Dr. Nguyen opined claimant likely sustained a concussion, although there was lack of clarity on his part as to whether or not claimant lost consciousness. Dr. Bansal opined claimant suffered from

post-concussive syndrome. He also opined claimant suffered from what he deemed to be traumatic brain injury sequela, including complaints of dizziness, headaches, concentration difficulties, and tinnitus, as well as PTSD. The impairment rating assigned by Dr. Bansal with respect to these conditions was based upon claimant's mental status and cognitive impairments; it was not parceled out between the conditions. Therefore, as found by the deputy commissioner, I find it is unclear what portion of the six percent whole person impairment rating is attributable to either the concussion, post-concussive syndrome, or headaches. Dr. Archer expressed the belief that claimant's headaches actually represented a vegetative symptom of claimant's mental health condition. Therefore I agree with the deputy commissioner, who was unable to attribute any specific percentage of permanent impairment or need for work restrictions to claimant's potential concussion syndrome or headaches, and who was unable to find these conditions resulted in permanent impairment. Furthermore, I agree with the deputy commissioner that Dr. Bansal's methodology for rating claimant's permanent disability as a result of the head injury was questionable.

Claimant testified he continues to suffer with symptomatology of his neck, as he experiences pain when he rotates his head to the left and with exertion of force. Dr. Archer made a blanket statement that claimant did not sustain permanent disability as a result of his physical conditions, while Dr. Bansal opined claimant suffered from myofascial pain syndrome of the neck. Dr. Bansal opined claimant demonstrated guarding and decreased range of motion of the neck on examination, findings consistent with claimant's testimony. Dr. Bansal causally related these complaints to the work injury and opined claimant fell in a range between DRE Cervical Category I and II, warranting a permanent impairment of three percent whole person. Dr. Bansal also recommended permanent physical restrictions attributable to the neck condition. There is no convincing evidence in the record that claimant is malingering or that his complaints are not credible. I therefore affirm the deputy commissioner's finding that Dr. Bansal's opinion regarding claimant's neck is entitled to greater weight and I affirm the deputy commissioner's finding that claimant's neck injury resulted in permanent disability.

As a result of the work injury, claimant suffered a significant facial laceration. Despite healthy healing of the laceration, claimant has been left with a quite noticeable scar on the left side of his forehead. The deputy commissioner readily noticed the scar and easily observed the scar extending from claimant's hairline, across his forehead, and into his left eyebrow. (Arbitration Decision, p. 2) Dr. Archer provided a blanket opinion that claimant had not sustained any permanent impairment as a result of his physical injuries, and this is presumed to include the scarring. Dr. Bansal acknowledged the scarring did not impact claimant's functionality, but opined claimant sustained permanent impairment for the disfiguring scar based upon the AMA Guides' discussion of skin disorders. Dr. Jones opined claimant suffered from brow ptosis related to this area and opined it did not impact claimant's function. However, Dr. Jones did acknowledge a potential cosmetic concern. As a result of the work injury, claimant sustained scarring which, although it does not impact the function of claimant's

forehead, it does impact claimant's functioning in social situations and in his attempts to cover the region. I therefore affirm the deputy commissioner's finding that claimant's forehead laceration and scarring resulted in permanent disability.

Finally, claimant alleges he suffered permanent mental injury as a result of the work injury of March 6, 2014. Defendant argues claimant's mental health condition pre-existed the injury and returned to its baseline, preinjury level. Review of claimant's medical records reveals that shortly after the work injury, claimant began to suffer with mental health complaints such as anxiety, stress, and depression. Also repeatedly noted in the medical records is the impact of these symptoms upon claimant's ability to recover from his physical injury and return to work.

Defendant provided claimant with a psychological evaluation by Drs. Mooney and Augspurger. In a lengthy report, those providers opined claimant suffered with an unspecified anxiety disorder. Those providers opined claimant demonstrated sufficient symptomatology to warrant a PTSD diagnosis, but opined the precipitating event was not severe enough to support a true PTSD diagnosis. Drs. Mooney and Augspurger also noted claimant likely had a history of chronic anxiety and traits of a longstanding personality disorder. Additionally, they raised the need to rule out a diagnosis of an autism spectrum disorder with intellectual impairment. In summary, Drs. Mooney and Augspurger opined claimant suffered from chronic anxiety and depression which predated the work injury, but those conditions had been intensified by the event and now impacted claimant's ability to work. Accordingly, Drs. Mooney and Augspurger opined claimant required medication management of his conditions in order to stabilize his conditions and allow for a return to baseline. Drs. Mooney and Augspurger also raised the possibility of claimant receiving benefit from psychotherapy; however, they cautioned claimant's personality traits might indicate low potential for change.

Thereafter, claimant received medication management of his mental health conditions from Dr. Archer. Within approximately three and a half months of the evaluation of Drs. Mooney and Augspurger, Dr. Archer opined claimant had returned to a baseline level of depression and attributed ongoing medication management to a preexisting condition. At that time, claimant had recently returned to work following a four-month leave of absence.

Claimant then underwent the IME with Dr. Bansal, who opined claimant suffered from PTSD. In his report, Dr. Bansal seemingly lumps the PTSD diagnosis in with an injury to claimant's head and sequela of a traumatic brain injury. Dr. Bansal opined these combined conditions warranted a permanent impairment rating of six percent whole person and he urged caution in returning claimant to a work environment which aggravated his PTSD. Claimant also sought treatment with Ms. Rinehart, who assessed PTSD, a history of traumatic brain injury, and occupational concerns. Ms. Rinehart recommended medication management and therapy.

At the referral of claimant's counsel, claimant presented to Dr. Ressler for evaluation. Following examination, Dr. Ressler opined she was certain claimant suffered from PTSD with dissociative symptoms. The diagnosis was based on a precipitating trauma and not upon a traumatic brain injury. She opined claimant met the standard for a PTSD diagnosis under either the DSM-IV or DSM-V. Dr. Ressler opined claimant likely suffered from preexisting anxiety and worry. Dr. Ressler indicated claimant's preexisting tendencies made him more prone to develop PTSD because of the injury. Dr. Ressler opined claimant was not currently capable of maintaining full time employment, based primarily upon safety concerns, doubts regarding claimant's ability to appropriately and predictably react to others, and likely attendance issues. Dr. Ressler opined when claimant attempted to return to work at defendant, he became retraumatized. Dr. Ressler opined claimant would not be capable of returning to work without appropriate treatment, including a medication regimen and psychotherapy with a qualified psychotherapist. Even with such treatment, she expressed hesitation regarding claimant's ability to return to work, as she opined claimant may not be a good candidate for therapy.

Following review of all of the expert opinions regarding claimant's mental status, I affirm the deputy commissioner's finding that the opinion of Dr. Ressler is entitled to the greatest weight. Given the complexity of claimant's mental health condition, I affirm the deputy commissioner's finding that the opinions of mental health professionals are entitled to greater weight than the opinions of occupational physicians. I therefore affirm the deputy commissioner's finding that Dr. Archer's opinion regarding claimant's mental status is entitled to little weight, especially as it seems to be premised in large part upon the report of Drs. Mooney and Augspurger and claimant's return to work. I also affirm the deputy commissioner's finding that Dr. Bansal's opinion regarding claimant's mental health condition is entitled to little weight, particularly as it confusingly conflates a PTSD diagnosis with the physical injury to claimant's head and brain, as opposed to the triggering traumatic event cited by Dr. Ressler, Dr. Mooney, and Dr. Augspurger.

In reviewing the two reports authored by Dr. Ressler and Drs. Mooney and Augspurger, many similarities are apparent. They all indicated it was likely claimant suffered from some preexisting mental health concerns, notably anxiety. They also agreed claimant met the symptomatology requirements for a PTSD diagnosis. However, they disagreed regarding whether the traumatic event experienced was severe enough in nature to support a true PTSD diagnosis. I affirm the deputy commissioner's finding that that distinction seems hollow because the diagnosis assigned to claimant's condition does not change the symptomatology he experiences. The providers all recommended generally the same treatment, notably medication management and potentially psychotherapy. They all agreed claimant may not be a good candidate for psychotherapy, bringing the efficacy of that treatment into question.

Drs. Mooney and Augspurger opined with medication management, claimant's condition would stabilize and allow a return to work. Although claimant did return to work, he was ultimately terminated due to attendance issues. While a majority of

claimant's attendance points were accumulated as a result of his arrest, claimant subsequently missed work for personal reasons. He credibly attributed these absences to his mental health condition. Prior to the work injury, there is no evidence claimant was disciplined for attendance or performance concerns. Therefore, his ability to maintain his employment long-term is speculative. These concerns are precisely those identified by Dr. Ressler in her discussion of claimant's employability and need for dedicated treatment.

Additionally, there is no evidence in the record which indicates claimant suffered from pre-injury mental health conditions which impacted his ability to successfully maintain consistent employment or otherwise function in general. Following the work injury, claimant's employment has been intermittent, spotty, or non-existent. Claimant credibly testified to impacts of his mental health conditions upon his ability to function in life and employment situations, testimony which is consistent with the lay testimony of his brother.

For these reasons, I affirm the deputy commissioner's finding that the opinions of Dr. Ressler are entitled to the greatest weight as to the matter of claimant's mental health. Dr. Ressler opined claimant sustained marked impairment per the AMA Guides and was currently unemployable. It is therefore determined claimant's current mental health conditions are causally related to the work injury of March 6, 2014.

However, I disagree with the deputy commissioner's finding that claimant is entitled at this time to permanent total disability benefits. In light of the following recommendations from Dr. Ressler, I find claimant is entitled to a running award of healing period benefits:

> *6. What future treatment, if any, would you recommend for Mr. Deciga with reference to his psychological diagnoses?*
>
> I would first recommend that Mr. Deciga be seen by a psychiatrist for a new medication evaluation. While he reports that his anxiety medication is helping some, he needs additional prescriptions to address the full range of symptoms. For example, when he was taken (sic) the Prozasin 2 mg for nightmares, he reported he was having reduced nightmares but that medication was discontinued.
>
> Mr. Deciga also needs to work with a psychologist that specializes in the treatment of trauma. Because he is not very psychologically minded or sophisticated, I would recommend someone who specializes in forms of treatment that require less insight such as Somatic Experiencing. It is this type of treatment, which can be greatly beneficial in alleviating Mr. Deciga's symptomatology.

> It is also important that someone Mr. Deciga perceives as an expert and who understands his difficulties from a cultural context validate his experience. Mr. Deciga can further benefit from someone explaining and normalizing his symptoms given his circumstances. He believes that he "is going crazy" and that he is a burden to most people around him.
>
> While it is not within my scope of practice to comment on Mr. Deciga's physical health concerns, I do believe that he also needs medical attention in reference to his complaints of chronic headaches and weakness on his left arm.

(Ex. 15, pp.209-210)

Until such time as the treatment recommended by Dr. Ressler is provided to claimant, claimant is not at maximum medical improvement for the March 6, 2014, work injury and the issue of permanent disability is not ripe for determination. Therefore I find claimant is entitled to healing period benefits from March 6, 2014, through March 14, 2014, from May 2, 2014, through September 5, 2014, and from March 11, 2015, through the present and continuing until such time as claimant is no longer eligible for such benefits under the statute. At that time, defendants shall provide claimant notice before terminating benefits.

Defendant shall select and authorize an appropriate psychologist and/or psychiatrist to evaluate and treat claimant pursuant to Dr. Ressler's recommendations. This authorization shall take place within 30 days from the filing of this appeal decision.

The next issue for determination is whether defendant is responsible for the medical expense itemized in Exhibit 26.

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 seeks an order finding defendant responsible for the BVRMC emergency room expense incurred on April 22, 2014. (Ex. 26, pp. 366, 369) The emergency room physician assessed a suspected seizure secondary to head trauma, chronic headaches, and chronic right chest pain. It is notable that the condition which brought claimant to the emergency department was specifically an inability to walk due to numbness of his arms and legs. After further evaluation, Dr. Archer opined claimant

likely suffered from an anxiety reaction with hyperventilation. Claimant attributed the condition to his work injury, but also acknowledged his recent arrest played a role in his heightened stress level. This event led Dr. Archer to recommend psychological evaluation and led to the referral to Dr. Mooney.

However, the record lacks clarity regarding the precise reasons for the emergency room visit and no physician has specifically causally related the emergency room visit to the work injury. For those reasons, I affirm the deputy commissioner's finding that claimant failed to prove by a preponderance of the evidence that the care was rendered on a compensable claim. Therefore, I affirm the deputy commissioner's finding that defendant is not responsible for the claimed medical expense itemized in Exhibit 26.

The next issue for determination is whether claimant is entitled to reimbursement pursuant to Iowa Code section 85.39 for the cost of Dr. Bansal's IME.

Section 85.39 permits an employee to be reimbursed for subsequent examination by a physician of the employee's choice where an employer-retained physician has previously evaluated "permanent disability" and the employee believes the initial evaluation is too low. The section also permits reimbursement for reasonably necessary transportation expenses incurred and for any wage loss occasioned by the employee attending the subsequent examination.

Defendants are responsible only for reasonable fees associated with claimant's independent medical examination. Claimant has the burden of proving the reasonableness of the expenses incurred for the examination. See Schintgen v. Economy Fire & Casualty Co., File No. 855298 (App. April 26, 1991). Claimant need not ultimately prove the injury arose out of and in the course of employment to qualify for reimbursement under section 85.39. See Dodd v. Fleetguard, Inc., 759 N.W.2d 133, 140 (Iowa App. 2008).

Claimant seeks reimbursement of Dr. Bansal's IME charge in the amount of $2,975.00. (Ex. 13, p. 187) At the time of Dr. Bansal's IME on November 7, 2014, Dr. Archer had previously opined claimant had achieved MMI from a medical standpoint and had sustained no permanent impairment. Dr. Jones had opined claimant demonstrated no visual impairment and released claimant without restrictions. Drs. Mooney and Augspurger had opined claimant demonstrated no objective findings of permanent impairment as a result of the psychological components of his injury and Dr. Archer had opined claimant had returned to baseline with respect to his depression. These opinions triggered claimant's right to a section 85.39 independent medical evaluation. There is no evidence Dr. Bansal's IME charge was unreasonable. Defendant shall therefore reimburse claimant for the cost of Dr. Bansal's IME in the amount of $2,975.00.

The final issue for determination is a specific taxation of costs pursuant to Iowa Code section 86.40 and rule 876 IAC 4.33.

Iowa Code section 86.40 states:

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

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

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

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

Claimant requests taxation of the following costs: interpretation fees for Dr. Bansal's IME ($75.00); filing fee ($100.00); service fees ($12.96); and the psychological report of Dr. Ressler ($1,200.00). (Ex. 24, pp. 343-352) The interpretation fee from Dr. Bansal's IME, the filing fee and the service fee are allowable costs and are taxed to defendant.

In the arbitration decision, the deputy commissioner awarded the total $1,200.00 cost of Dr. Ressler's IME. In Des Moines Area Regional Transit Authority v. Young, 867 N.W.2d 839, 845-846 (Iowa 2015), the Iowa Supreme Court addressed whether an IME expense could be awarded as a cost for obtaining a practitioner's report. The Supreme Court stated that Iowa Code section 86.40 is "confined to costs attributable to the hearing and excludes medical treatment and evaluations" thus eliminating the statutory conflict between sections 85.39 and 86.40. The court held:

> A "report" is a "formal oral or written presentation of facts or a recommendation for action." Black's Law Dictionary 1492 (10th ed. 2014). The word "obtain" is used as a modifier in the rule and means "[t]o bring into one's own possession; to procure, esp[ecially] through effort." Id. at 1247. Thus, the concept of obtaining a report for a hearing is separate from the concept of a physical examination. A "physical examination" is "[a]n examination of a person's body by a medical professional to determine whether the person is healthy, ill or disabled." Id. at 680. The concept of "obtaining" a report is separate from the process of "obtaining" an examination. Our legislature recognized as much by separately authorizing the commissioner to appoint "a duly qualified, impartial physician to examine the injured employee and make report." Iowa Code § 86.38. A medical report for purposes of a hearing is aligned with a prehearing medical deposition. In the context of the assessment of costs, the expenses of the underlying medical treatment and examination are not part of the costs of the report or deposition.

(867 N.W.2d 839, 845-846)

Dr. Ressler's invoice confirms the requested $1,200.00 cost is not for "obtaining" a report for a hearing as contemplated by IAC section 876-4.33 and the supreme court's interpretation thereof and thus may not be taxed as such a cost. As stated in Dr. Ressler's invoice, the cost of the actual report itself was $300.00. The reminder of the $1,200.00 was for testing, records review and interview. (Ex. 15, p. 211) The $300.00 charge for the report itself is a taxable cost. The remaining $900.00 of Dr. Ressler's fee is not taxable and the deputy commissioner's taxation of that $900.00 is reversed.

ORDER

IT IS THEREFORE ORDERED that the arbitration decision filed on August 19, 2016, is MODIFIED as follows:

Defendant shall pay claimant healing period benefits at the weekly rate of four hundred sixteen and 00/100 dollars ($416.00) from March 6, 2014, through March 14, 2014, from May 2, 2014, through September 5, 2014, and from March 11, 2015, through the present and continuing until such time as benefits may cease pursuant to Iowa Code section 85.34(1).

Either party may file a new petition for arbitration for the purpose of assessment of permanent disability when appropriate.

Defendant shall receive credit for benefits paid.

Defendant shall pay accrued weekly benefits in a lump sum together with interest pursuant to Iowa Code section 85.30.

Defendant shall select and authorize an appropriate psychologist and/or psychiatrist to evaluate and treat claimant pursuant to Dr. Ressler's recommendations. This authorization shall take place within 30 days from the filing of this appeal decision.

Defendant shall reimburse claimant for the cost of Dr. Bansal's IME in the amount of two thousand nine hundred seventy-five and 00/100 dollars ($2,975.00).

Pursuant to rule 876 IAC 4.33, defendant shall pay claimant's costs of the arbitration proceeding in the amount of $487.96, and the parties shall split the costs of the appeal, including the cost of the hearing transcript.

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

Signed and filed this 6th day of March, 2018.

Joseph S. Cortese II

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WORKERS' COMPENSATION
COMMISSIONER

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