BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

CYNTHIA KIRKENDALL, Claimant, vs. CARGILL MEAT SOLUTIONS CORP., Employer, and THE INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA, Insurance Carrier, Defendants.	FILED DEC 17 2018 WORKERS' COMPENSATION File No. 5055494 APPEAL DECISION Head Note No.: 1803, 3001, 3002

Defendants Cargill Meat Solutions Corporation, employer, and The Insurance Company of the State of Pennsylvania, insurer, timely appeal from an arbitration decision filed on May 18, 2017, a ruling on motion for rehearing filed on June 6, 2017, and an order nunc pro tunc filed on June 7, 2017. Claimant, Cynthia Kirkendall, cross-appeals. The case was heard on December 14, 2016, and it was considered fully submitted in front of the deputy workers' compensation commissioner on February 2, 2017.

In the arbitration decision, the deputy commissioner found claimant's right shoulder and right carpal and cubital tunnel symptoms were caused by claimant's fall at work on December 10, 2009. The deputy commissioner also found claimant's left shoulder symptoms were a sequela of her work-related right shoulder injury. The deputy commissioner ultimately determined claimant sustained 60 percent industrial disability as a result of her work-related injuries, entitling claimant to 300 weeks of permanent partial disability (PPD) benefits to commence on the stipulated date of July 28, 2011. The deputy commissioner found claimant's weekly benefit rate to be $353.99. Lastly, the deputy commissioner awarded costs in the amount of $6,155.84 for claimant's filing fee, a portion of claimant's vocational expert's expense, claimant's independent medical examination (IME) expenses, and claimant's corresponding medical mileage.

Claimant subsequently filed an application for rehearing on the issue of claimant's weekly benefit rate. In his rehearing ruling, the deputy commissioner determined he erred by using the week containing claimant's work-related injury in his rate calculation. However, the deputy commissioner declined to adopt claimant's rate calculation because claimant failed to provide sufficient evidence regarding the "codes" on claimant's payroll records. The deputy commissioner ultimately found claimant's rate to be $355.83.

The order nunc pro tunc, filed the day after the deputy commissioner's ruling on motion for rehearing, corrected the rate in the Order portion of the decision from $355.87 to $355.83.

On appeal, defendants argue the deputy commissioner's industrial disability award is excessive. Defendants also dispute the deputy commissioner's assessment of costs.

On cross-appeal, claimant argues the deputy erred in his rate calculation.

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

I performed a de novo review of the evidentiary record and the detailed arguments of the parties. Pursuant to Iowa Code sections 17A.15 and 86.24, the portions of the proposed arbitration decision, ruling on motion for rehearing, and order nunc pro tunc relating to issues properly raised on intra-agency appeal are modified in part and reversed in part.

FINDINGS OF FACT

The first issue to be decided on appeal is the extent of claimant's industrial disability. While defendants did not appeal the deputy commissioner's finding that claimant's right shoulder, right carpal and cubital tunnel, and left shoulder conditions were all work-related, a brief summary of claimant's medical treatment is warranted for purposes of clarity.

Claimant sustained a work-related fall on ice on December 10, 2009. After a period of conservative treatment, claimant underwent her first right shoulder surgery on April 7, 2010, by Theron Jameson, D.O. (Hearing Transcript, pp. 30-31) Based on his surgical findings, Dr. Jameson recommended claimant be referred to a specialist. (Tr. p. 31) In response, defendants authorized care with Kyle Galles, M.D. (Tr. p. 31)

Claimant was initially evaluated by Dr. Galles on October 18, 2010, at which point he recommended a right shoulder arthroplasty. (Joint Exhibit 17, p. 2) That surgery was performed on December 17, 2010. (Jt. Ex. 17, p. 5) By July of 2011, claimant was recovering well and reporting only a "little bit of achiness." (Jt. Ex. 17, p. 14) As a result, Dr. Galles placed claimant at maximum medical improvement (MMI)

and assigned permanent work restrictions of "10 to 20 pounds lifting with her right upper extremity, no repetitive work over shoulder height, [and] no climbing of ladders." (Jt. Ex. 17, p. 14) Dr. Galles also assigned a 22.4 percent impairment rating to claimant's right upper extremity. (JE 17, p. 17)

Unfortunately, by May of 2012, claimant returned to Dr. Galles with recurring right shoulder symptoms. (Jt. Ex. 17, p. 28) Dr. Galles performed the first of many right shoulder injections on May 9, 2012. (Jt. Ex. 17, p. 29)

By late summer of 2012, claimant began experiencing left shoulder symptoms, which she attributed to overuse. (Jt. Ex. 14, p. 24) In response, Dr. Galles administered a left shoulder injection on September 26, 2012. (Jt. Ex. 17, p. 44)

After Dr. Galles performed a second right shoulder injection on November 8, 2012, claimant continued to report discomfort with overhead activities but was "fairly comfortable below shoulder height." (Jt. Ex. 17, pp. 51-52) Dr. Galles again placed claimant at MMI for both shoulders and told her to maintain her permanent restrictions of lifting 10 to 20 pounds and no repetitive work over shoulder with either extremity. (Jt. Ex. 17, p. 54)

In a letter dated February 7, 2013, Dr. Galles clarified that claimant's left shoulder impingement symptoms resulted in no permanent impairment, though he recommended claimant try to minimize repetitive overhead activities with her left arm. (Jt. Ex. 17, p. 57)

In June of 2013 claimant returned to Dr. Galles after experiencing "a couple of catching episodes" in her right shoulder. (Jt. Ex. 17, p. 61) In an attempt to minimize the inflammation in claimant's right shoulder, Dr. Galles performed an injection on June 5, 2013. (Jt. Ex. 17, p. 63) A subsequent right shoulder injection was performed on October 30, 2015. (Jt. Ex. 17, p. 74) Claimant also received an injection to her left shoulder on December 4, 2013. (Jt. Ex. 17, p. 75)

Then, starting in June of 2014, claimant began receiving regular injections to both shoulders. Claimant received injections on June 4, 2014 (right); September 3, 2014 (left); October 8, 2014 (right); January 21, 2015 (left); March 11, 2015 (right); June 11, 2015 (right); October 21, 2015 (right); and March 2, 2016 (left). (Jt. Ex. 17, pp. 95, 111, 115, 123, 129, 132, 133, 139)

At claimant's March 2, 2016, appointment, Dr. Galles recommended a right shoulder scope due to claimant's ongoing symptoms and failed conservative treatment. (Jt. Ex. 17, p. 139) A right shoulder arthroscopic acromioplasty was performed on April 19, 2016. (Jt. Ex. 17, p. 142)

Dr. Galles eventually placed claimant at MMI for her right shoulder on July 7, 2016. (Jt. Ex. 17, p. 151) He assigned a 19.4 percent impairment rating for claimant's right upper extremity, which he intended to replace his previous rating because claimant improved after the April 19, 2016, surgery. (Jt. Ex. 17, pp. 151-152) Dr. Galles also

assigned permanent restrictions of "minimizing repetitive work over shoulder height" and "no lifting over 30-40 pounds." (Jt. Ex. 17, p. 151) He again opined that claimant sustained no permanent impairment of her left shoulder. (Jt. Ex. 17, p. 153)

Claimant retuned to Dr. Galles for treatment on November 28, 2016, roughly two weeks before the hearing in this case. (Jt. Ex. 17, p. 155) At the November 28, 2016, appointment, claimant reported bilateral shoulder pain. (Jt. Ex. 17, p. 155) Dr. Galles noted he was concerned about "possible full-thickness rotator cuff tear developing in the RIGHT shoulder." (Jt. Ex. 17, p. 157) Both shoulders were injected. (Jt. Ex. 17, pp. 156-157)

On December 8, 2016, Dr. Galles issued a handwritten response to claimant's attorney regarding his impressions after claimant's November 28, 2016, appointment. Dr. Galles noted claimant's impairment rating of 19.4 percent would "now be higher due to loss of mobility." (Jt. Ex. 17, p. 159) Dr. Galles also indicated he would suggest a 10 to 20 pound lifting limit due to his recent concern for a rotator cuff tear. (Jt. Ex. 17, p. 159)

It appears the November 28, 2016, appointment was claimant's last appointment with Dr. Galles prior to the arbitration hearing.

During the course of claimant's right and left shoulder treatment, claimant was simultaneously experiencing right hand and arm pain. She was initially evaluated for those symptoms in November of 2011. (Jt. Ex. 14, p. 18) When a nerve study showed evidence of right-sided carpal tunnel syndrome, claimant was referred to Benjamin Paulson, M.D., orthopedic surgeon, who evaluated claimant for the first time on January 19, 2012. (Jt. Ex. 17, p. 18) Dr. Paulson administered a carpal tunnel injection. (Jt. Ex. 17, p. 21)

By May of 2012, the injection had worn off and claimant returned to Dr. Paulson with recurring symptoms. (Jt. Ex. 17, p. 32) Dr. Paulson noted claimant was experiencing recurrent right carpal tunnel syndrome along with right cubital tunnel syndrome. Claimant opted for a repeat injection. (Jt. Ex. 17, p. 33) When claimant returned with worsening symptoms in July of 2012, Dr. Paulson recommended surgery. (Jt. Ex. 17, p. 38) Right carpal tunnel and cubital tunnel releases were performed on August 14, 2012. (Jt. Ex. 17, p. 39)

By January of 2013, claimant was doing well but still reported some soreness and numbness in her right hand and elbow. (Jt. Ex. 17, p. 55) Dr. Paulson placed claimant at MMI on January 10, 2013, released her without restrictions, and assigned a six percent impairment rating to claimant's right upper extremity. (Jt. Ex. 17, p. 56)

Unfortunately, by May of 2013, claimant began experiencing recurring pain in her right elbow. (Jt. Ex. 17, p. 58) In response, Dr. Paulson administered a right elbow injection. (Jt. Ex. 17, p. 59) Claimant had subsequent injections in her right elbow on February 6, 2014, and March 27, 2014, before Dr. Paulson ordered a new nerve

conduction study. (Jt. Ex. 17, pp. 81, 86, 89) After that study, Dr. Paulson recommended a repeat right carpal tunnel release. (Jt. Ex. 17, p. 92) That surgery was performed on July 15, 2014. (Jt. Ex. 17, p. 101)

On November 12, 2014, during a follow-up appointment for her carpal tunnel symptoms, claimant reported more right elbow pain. (Jt. Ex. 17, p. 116) Dr. Paulson injected claimant's right elbow. (Jt. Ex. 17, p. 117) By claimant's appointment on January 8, 2015, this elbow pain had "resolved." (Jt. Ex. 17, p. 121)

At claimant's next appointment with Dr. Paulson on February 5, 2015, claimant reported no pain in her elbow and wrist, although she still complained of numbness in her hand. (Jt. Ex. 17, p. 124) As a result, Dr. Paulson placed claimant at MMI and released her with no permanent restrictions. He eventually assigned a four percent impairment rating to claimant's right upper extremity for her right carpal tunnel syndrome, though he noted her epicondylitis had resolved and was "completely asymptomatic." (Jt. Ex. 17, p. 127)

It does not appear claimant returned for any additional treatment with Dr. Paulson after the February 5, 2015, appointment.

Claimant obtained two expert medical opinions in this case, the first of which was from Michael O'Neil, M.D. (Jt. Ex. 22) Dr. O'Neil issued his independent medical examination (IME) report on September 30, 2015, before claimant's third shoulder surgery in April 2016. For this reason, I find Dr. O'Neil's report to be of little probative value.

Claimant obtained a second IME from Sunil Bansal, M.D., in late 2016. (Jt. Ex. 24) In his report, dated November 8, 2016, Dr. Bansal opined claimant sustained 18 percent whole person impairment due to range of motion deficits in her right shoulder and right shoulder arthroplasty. (Jt. Ex. 24, p. 26) He then recommended right shoulder restrictions of "no lifting greater than 10 pounds occasionally, or 5 pounds frequently with the right arm, along with no lifting over shoulder level with the right arm." (Jt. Ex. 24, p. 27)

Regarding claimant's right arm and wrist, Dr. Bansal assigned a four percent right upper extremity impairment rating for claimant's carpal tunnel syndrome and a five percent right upper extremity rating for her right cubital tunnel syndrome. (Jt. Ex. 24, pp. 27-28) Dr. Bansal recommended restrictions of "no lifting greater than 10 pounds occasionally, or 5 pounds frequently with the right arm" to avoid "repeated or sustained elbow flexion" and "frequent turning or twisting with the right arm." (Jt. Ex. 24, p. 30)

For claimant's left shoulder, Dr. Bansal opined claimant sustained two percent whole body impairment due to range of motion deficits. (Jt. Ex. 24, p. 31) Dr. Bansal recommended restrictions of "no lifting greater than 25 pounds occasionally, or 15 pounds frequently with the left arm, along with no lifting over 5 pounds over shoulder

level with the left arm and no frequent over shoulder lifting with the left arm." (Jt. Ex. 24, p. 33)

In a subsequent report, dated December 12, 2016, Dr. Bansal indicated he reviewed the notes from claimant's last appointment with Dr. Galles and Dr. Galles' December 10, 2016, letter to claimant's attorney. Dr. Bansal opined that Dr. Galles' concern about a rotator cuff tear "underscore[s] the importance of the restrictions [Dr. Bansal] assigned in [his] original IME." (Jt. Ex. 24, p. 35)

Given claimant's multiple right shoulder surgeries, ongoing symptoms, and Dr. Galles' opinion that claimant's right shoulder impairment was likely higher than 19.4 percent at the time of the hearing, I adopt Dr. Bansal's right shoulder impairment rating. In light of claimant's continued left shoulder symptoms and need for injections, I also adopt Dr. Bansal's impairment rating for claimant's left shoulder. Lastly, I adopt Dr. Bansal's impairment ratings for claimant's right carpal and cubital tunnel syndrome.

In the arbitration decision, the deputy commissioner adopted the 10-to-20-pound lifting restrictions recommended by both Dr. Galles and Dr. Bansal. On appeal, defendants argue Dr. Galles' "new opinions" issued shortly before hearing "appear to reflect a new concern around the time of hearing rather than a true assessment of permanency." (Defendants' Brief, p. 13) I do not find defendants' argument convincing. Claimant has undergone three right shoulder surgeries and numerous injections, and she testified she has always believed she was under a 10-to-20-pound lifting restriction and did not exceed those limits. (Tr., p. 101) Like the deputy commissioner, I find a 10-to-20-pound lifting restriction for claimant's right shoulder more accurately reflects her actual physical capabilities. Given claimant's numerous left shoulder injections and Dr. Galles' recommendation to avoid repetitive overhead activities with her left arm, I also agree with the deputy commissioner that claimant can only perform moderate lifting with her left arm above shoulder level.

However, even in light of these restrictions and claimant's permanent impairment ratings, I agree with defendants that the facts of this case do not support a 60 percent industrial disability award. Claimant has worked for defendant-employer since 1987. (Tr., p. 14) Claimant has always been employed in the "lower cut" department, and she performed various jobs within that department over the course of her 30-year career with defendant-employer. (See Tr., pp. 19, 22-26)

Claimant was performing the "moisture tech" job at the time of her injury. (Tr., p. 26) Claimant never returned to this position after her injury because she voluntarily bid into a "neck bone" job. (Tr., p. 33) Claimant was able to perform this job within the 10 to 20-pound lifting restriction assigned by Dr. Galles, and she continued to perform the "neck bone" job at the time of the hearing. (Tr. p. 34) Despite her restrictions, she was working six days a week at the time of the hearing, resulting in a 48-hour workweek. (Tr., p. 98) In addition to her full-time job with defendant-employer, claimant was also the secretary for the local union at the time of the hearing. (Tr., pp. 20-21)

Claimant has very high seniority at the plant. (Tr., p. 98) She testified she has no intention of leaving her position with defendant-employer and has not looked for other jobs or applied for social security benefits. (Tr., p. 106)

There is no dispute claimant's course of treatment for her bilateral shoulders and right arm has been arduous. I also acknowledge claimant has work restrictions that would likely preclude her from returning to some of her past jobs, including some of the positions she previously performed for defendant-employer. However, this does not change the fact that claimant remains employed by defendant-employer—the same employer for whom she has worked since 1987—and there is nothing in the record to suggest that claimant's employment status is anything but stable. Claimant testified she is physically capable of performing her current "neck bone" job within her restrictions, and she has maintained this job since she returned to work after surgery in 2010. She also has no intention of leaving her current job. For these reasons, I respectfully disagree with the deputy commissioner and I find claimant sustained 35 percent industrial disability as a result of her December 10, 2009, work injury.

Having found claimant sustained 35 percent industrial disability, the next issue to be decided on appeal is the correct rate at which PPD benefits are to be paid. The deputy commissioner determined in his ruling on motion for rehearing that claimant's average weekly wage is $507.77. On appeal, claimant argues the deputy commissioner erred by not adopting her rate calculation.

More specifically, claimant argues the deputy commissioner's rate calculation improperly omits claimant's overtime hours. In support of this argument, claimant attempts to explain the "codes" listed in claimant's payroll records (Ex. C), but claimant provides no citation to the evidentiary record or hearing transcript in doing so. Thus, I agree with the deputy commissioner that this is a factual issue that needed to be presented at hearing and was not. In other words, even assuming claimant's argument regarding her overtime hours is legally sound, claimant is asking the agency to rely on facts that were not presented at hearing.

Claimant also argues defendants "reneged" on a stipulation regarding the rate at hearing, but the hearing report clearly reflects rate as a disputed issue, and claimant's counsel acknowledged this dispute on the record at hearing. (Hearing Report, p. 1; Tr. p. 7) Claimant was therefore on notice that rate was in dispute and had the opportunity to present evidence regarding the codes on the payroll records at hearing, but claimant failed to provide any such evidence. For these reasons, I affirm the deputy commissioner's determination in his ruling on motion for rehearing that claimant's average weekly wage is $507.77.

CONCLUSIONS OF LAW

The first issue to be addressed on appeal is the extent of claimant's industrial disability.

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).

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

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

Compensation shall be paid in relation to 500 weeks as the disability bears to the body as a whole. Iowa Code section 85.34.

Considering all the relevant factors for industrial disability, I found claimant sustained 35 percent industrial disability. As discussed above, it is of great significance that claimant continues to work for the same employer with whom she has worked for the last 30 years, has no intention of leaving, and can continue to perform the work within her physical restrictions. The deputy commissioner's award of 60 percent industrial disability is therefore modified. 35 percent industrial disability entitles claimant to 175 weeks of benefits.

Having concluded claimant is entitled to 175 weeks of PPD benefits, the next issue to be addressed is the rate at which those benefits should be paid.

Section 85.36 states the basis of compensation is the weekly earnings of the employee at the time of the injury. This section defines weekly earnings as the gross salary, wages, or earnings to which an employee would have been entitled had the employee worked the customary hours for the full pay period in which the employee was injured as the employer regularly required for the work or employment. The various subsections of section 85.36 set forth methods of computing weekly earnings depending upon the type of earnings and employment.

If the employee is paid on a daily or hourly basis or by output, like in this case, weekly earnings are computed by dividing by 13 the earnings over the 13-week period immediately preceding the injury. Any week that does not fairly reflect the employee's customary earnings is excluded, however. Iowa Code section 85.36(6).

Claimant is correct that overtime hours paid to claimant in amounts in excess of claimant's straight time rate are to be included within the rate calculation at their straight hourly rate. See 876 IAC 8.2. However, in this case, I affirmed the deputy commissioner's determination that claimant provided insufficient evidence regarding the overtime hours she alleges were improperly excluded. As a result, like the deputy commissioner, I did not include the hours alleged by claimant to be overtime in the calculation of claimant's average weekly wage.

The weekly benefit amount payable to an employee shall be based upon 80 percent of the employee's weekly spendable earnings, but shall not exceed an amount, rounded to the nearest dollar, equal to 66-2/3 percent of the statewide average weekly wage paid employees as determined by the Department of Workforce Development. Iowa Code section 85.37.

The weekly benefit amount is determined under the above Code section by referring to the Iowa Workers' Compensation Manual in effect on the applicable injury date. Having accepted the parties' stipulations that claimant was married and entitled to two exemptions on her date of injury, and having found claimant's gross average weekly wage was $507.77, I affirm the deputy commissioner and I find claimant's rate for PPD benefits is $355.83 using the rate book with effective dates of July 1, 2009, through June 30, 2010.

The final issue to be address on appeal is the assessment of 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.

Defendants appeal the deputy commissioner's assessment of claimant's deposition transcript ($249.60)1; a portion of claimant's vocational expert's expenses ($2,000.00); and Dr. Bansal's expenses ($3,950.00) plus claimant's related transportation expenses for Dr. Bansal's IME ($105.84).

Regarding the deposition transcript, defendants argue rule 876 IAC 4.33(2), which allows costs to be taxed for "transcription costs when appropriate," does not include copies of deposition transcripts. Defendants rely on Coker v. Abell-Howe Company, 491 N.W.2d 143 (Iowa 1992), in which the court held: "Copies of transcripts of depositions, when the transcripts are not admitted into evidence, are routine litigation expenses incurred in preparing for trial. 'Allowable costs are limited to the cost of the original of depositions and do not include the expense of duplicate copies obtained for convenience of counsel.'" Coker, 491 N.W.2d at 153 (emphasis added). In this case, however, the copy was admitted into evidence as a joint exhibit with no objection from defendants. I therefore affirm the deputy commissioner's assessment of the transcription costs relating to the copy of claimant's deposition transcript in the amount of $249.60. (See Costs Attachment to Hearing Report).

The deputy commissioner awarded $2,000.00 for a portion of the expenses incurred by claimant's vocational expert, Kent Jayne, M.A. Defendants argue the deputy erred by not limiting reimbursement to the cost of Mr. Jayne's report pursuant to the holding in Des Moines Regional Transit Authority (DART) v. Young, 867 N.W.2d 839 (Iowa 2015). I agree. In DART, the court held that only the report of an IME physician—and not the examination itself—could be taxed as a cost pursuant to rule 876 IAC 4.33(6). (Id.) In doing so, the court explained that "a physician's report becomes a cost incurred in a hearing because it is used as evidence in lieu of the doctor's testimony," while "[t]he underlying medical expenses associated with the examination do not become costs of a report needed for a hearing, just as they do not become costs of the testimony or deposition." Id. at 846 (noting additionally that "[i]n the

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[1] It appears the deputy commissioner inadvertently omitted the $249.60 from his costs calculation in his arbitration decision.

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").

I conclude the court's rationale is equally applicable to the expenses incurred by vocational experts. In this case, Mr. Jayne's report became a cost incurred in a hearing because it was used as evidence in lieu of his testimony, while the expenses associated with his vocational assessment did not. Pursuant to Joint Exhibit 29, Mr. Jayne spent 1.8 hours preparing his report, for a total of $351.00. I therefore modify the deputy commissioner's assessment of Mr. Jayne's expenses and tax costs to defendants in the amount of $351.00.

The final cost challenged by defendants is the $3,950.00 charge for Dr. Bansal's IIME. As discussed above, claimant obtained two IMEs in this case, the first of which was with Dr. O'Neil in 2015, followed by Dr. Bansal's IME in 2016. In her brief, claimant does not dispute defendants' assertion that they already reimbursed the cost of Dr. O'Neil's IME. Instead, claimant argues that her multiple surgeries over a lengthy period of time warrant an award for a second IME. This position is contrary to the law. Pursuant to Iowa Code section 85.39, claimant is only entitled to reimbursement for a single IME. See Iowa Code section 85.39; Larson Mfg. Co. v. Thorson, 763 N.W.2d 842, 861 (Iowa 2009) ("Having paid for the prior examination, Larson contends the plain language of section 85.39 precludes its liability for the subsequent examination by Dr. Kuhnlein. We agree, and therefore reverse that part of the commissioner's remand decision ordering Larson to pay for the Kuhnlein examination.") Because defendants already paid for Dr. O'Neil's IME expenses, I find claimant is not entitled to reimbursement for Dr. Bansal's IME or her transportation to Dr. Bansal's appointment under Iowa Code section 85.39.

However, as discussed above, the cost of Dr. Bansal's report can be taxed pursuant to rule 876 IAC 4.33(6). See DART, 867 N.W.2d 839. Joint Exhibit 26 provides that Dr. Bansal's "Physical Examination" totaled $560.00, and his "Record Review and Report" totaled $3,390.00. (Jt. Ex. 26) As mentioned, the court in DART held the "underlying medical expenses associated with the examination do not become costs of a report needed for a hearing, just as they do not become costs of the testimony or deposition." (Id. at 846) (emphasis added). I conclude the expenses for a physician's review of medical records are expenses associated with an examination and therefore cannot be taxed under rule 876 IAC 4.33(6).

In this case, Dr. Bansal did not break down his bill to establish which portion of the $3,390.00 was associated with his report versus his records review. Because claimant did not offer any evidence regarding what was charged solely for Dr. Bansal's report, I conclude no portion of Dr. Bansal's $3,390.00 IME charge can be taxed as a cost under rule 876-4.33. See Reh v. Tyson Foods, Inc., File No. 5053428 (App. March 26, 2018). The deputy commissioner's taxation of Dr. Bansal's expenses is therefore reversed.

I award claimant costs in the amount of $700.60 ($100.00 [filing fee] + $249.60 [copy of claimant's deposition transcript] + $351.00 [Mr. Jayne's report]). 876 IAC 4.33(2), (6), (7).

ORDER

IT IS THEREFORE ORDERED:

The arbitration decision filed on May 18, 2017, ruling on motion for rehearing filed on June 6, 2017, and order nunc pro tunc filed on June 7, 2017 are modified in part and reversed in part.

Defendants shall pay claimant one hundred seventy-five (175) weeks of permanent partial disability benefits at the weekly rate of three hundred fifty-five and 83/100 dollars ($355.83) per week, commencing on July 28, 2011.

Defendants shall pay accrued weekly benefits in a lump sum together with interest at the rate of ten percent for all weekly benefits payable and not paid when due which accrued before July 1, 2017, and all interest on past due weekly compensation benefits accruing on or after July 1, 2017, shall be payable at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two percent. See Gamble v. AG Leader Technology, File No. 5054686 (App. Apr. 24, 2018).

Defendants shall be given credit for permanent partial disability benefits previously paid as stipulated in the Hearing Report.

Pursuant to rule 876 IAC 4.33, defendants shall pay claimant's costs of the arbitration proceeding in the amount of seven hundred and 60/100 dollars ($700.60), 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), defendants shall file subsequent reports of injury as required by this agency.

Signed and filed on this 17th day of December, 2018.

Joseph S. Cortese II

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