BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

DAWN BROWN, Claimant, vs. WITHAM AUTO CENTERS, INC., Employer, and SOCIETY INSURANCE, Insurance Carrier, Defendants.	FILED AUG 10 2017 WORKERS COMPENSATION	File No. 5054260 ARBITRATION DECISION Head Note Nos.: 1108, 1802, 1803

STATEMENT OF THE CASE

Claimant, Dawn Brown, filed a petition in arbitration seeking workers' compensation benefits from Witham Auto Centers, Inc., employer, and Society Insurance, insurance carrier, both as defendants, as a result of a stipulated injury sustained on August 2, 2013. This matter came on for hearing before Deputy Workers' Compensation Commissioner Erica J. Fitch, on August 9, 2016, in Des Moines, Iowa. The record in this case consists of Claimant's Exhibits 1 through 21, Defendants' Exhibits A through V, and the testimony of the claimant and Aaron Potter. The parties submitted post-hearing briefs, the matter being fully submitted on November 4, 2016.

ISSUES

The parties submitted the following issues for determination:

1. Whether claimant is entitled to temporary disability benefits from January 26, 2014 through April 20, 2015;

2. Whether the work injury is a cause of permanent disability;

3. The extent of claimant's industrial disability;

4. The commencement date for permanent disability benefits;

5. Whether defendants are entitled to credit pursuant to Iowa Code section 85.34(4) for benefits paid;

6. Whether defendants are responsible for medical expenses detailed in Exhibit 12;

7. Whether claimant is entitled to reimbursement for an independent medical examination pursuant to Iowa Code section 85.39; and

8. Specific taxation of costs.

The parties filed a hearing report at the commencement of the arbitration hearing. On the hearing report, the parties entered into various stipulations. All of those stipulations were accepted and are hereby incorporated into this arbitration decision and no factual or legal issues relative to the parties' stipulations will be raised or discussed in this decision. The parties are now bound by their stipulations.

FINDINGS OF FACT

The undersigned, having considered all of the evidence and testimony in the record, finds:

Claimant's testimony at hearing was consistent as compared to the evidentiary record, her deposition testimony and her recorded statement. Her demeanor at the time of evidentiary hearing gave the undersigned no reason to doubt claimant's veracity. Claimant appeared to be in obvious discomfort during evidentiary hearing, shifting in her chair, sitting angled on her hips and alternating positions, using a chair or railing for support with transitions and often while standing, slowly transitioning and ambulating, and using a cane with ambulation. Claimant is found credible.

Claimant was 55 years of age on the date of evidentiary hearing. She resides in Readlyn, Iowa, with her husband. Claimant completed 10th grade in high school, but dropped out due to pregnancy. She subsequently obtained her GED in approximately 1990. In the early 1990s, claimant also completed a community college computerized office assistant program and received a certificate. (Claimant's testimony; Exhibit V, Deposition Transcript pages 3-7)

Claimant's work history consists primarily of waitress/cook, apartment manager, manufacturing/assembly, hospitality employee, secretary and bookkeeper, convenience store clerk and cashier, road construction, sorting recycling, lawn care, auto parts store clerk and delivery driver, and her work at defendant-employer. (Claimant's testimony; Ex. O, pp. 2-5; Ex. V, Depo. Tr. pp. 14-34) Claimant testified her work history was sporadic at times due to marital issues with a former spouse, whom she described as controlling and abusive. (Claimant's testimony)

Claimant suffered with severe depression following the sudden death of her son in 1998. (Ex. O, p. 10) Claimant applied for and received Social Security Disability benefits. From 1999 to 2001, claimant utilized psychiatric medications. (Claimant's testimony; Ex. V, Depo. Tr. pp. 74-75) In March 2001, her late son's birthday, claimant

drank to excess and was hospitalized. (Ex. O, p. 10) Claimant received Social Security Disability benefits throughout this time. (Claimant's testimony)

In December 2002, claimant received pain management treatment with Gayathry Inamdar, M.D. and Mark Shockley, M.D. Dr. Inamdar issued diagnoses of lumbar radiculopathy, lumbar strain and lumbar degenerative joint disease. Claimant underwent a series of three lumbar epidural steroid injections (ESI). (Ex. I, pp. 1-3; Ex. J, pp. 2-4)

On May 19, 2007, claimant suffered an alleged work related injury while loading steel with a customer at Walker Auto Salvage. X-rays of the lumbar and cervical spine were unremarkable. Claimant was examined by Kenneth McMains, M.D. of Allen Occupational Health (AOH) for complaints of pain of the neck and bilateral arms. (Ex. 7I, p. 83; Ex. F, pp. 1-2) Dr. McMains assessed chronic multi-level cervical spondylosis, with a history of cervical epidurals, facet injections and radiofrequency ablation. He also assessed diffuse osteoarthritis and bipolar disorder. Dr. McMains opined claimant's symptoms were chronic in nature and were not materially aggravated by the work injury. (Ex. F, pp. 2-4)

From September 2007 through July 2008, claimant treated her neck symptoms with Arnold Delbridge, M.D. (Ex. A, pp. 1-5) Dr. Delbridge authored a report regarding his opinions relative to claimant's condition dated February 23, 2009. Dr. Delbridge noted he treated claimant for neck pain following a work injury on May 19, 2007 at Walker Auto Salvage, yet noted claimant did not respond well to treatment. As a result of the injury, Dr. Delbridge opined claimant sustained a 5 percent whole person impairment due to limited motion of the cervical spine with radicular-like symptoms, but no objective weakness, EMG findings or loss of reflexes. He also recommended restrictions, including no jobs requiring use of a mower or weed whacker, avoidance of bouncing or chronic stress on the neck, and avoidance of jobs requiring repetitive overhead looking or backing up while turning her head to the side, with claimant directed to use a mirror instead. (Ex. 16, pp. 176-180)

Claimant ultimately entered into a compromise settlement in the amount of $22,000.00 regarding the alleged May 19, 2007 injury at Walker Auto Salvage. (Ex. N, pp. 1-6)

On March 20, 2009, claimant presented to Cedar Valley Medical Specialists with complaints related to alleged work injuries sustained on May 19, 2007 and February 10, 2009. Claimant indicated she was injured on May 19, 2007 while helping load steel at Walker Auto Salvage and then injured on February 10, 2009 when she was struck in the back of the head by a gate near a dumpster at O'Reilly Auto Parts. Claimant identified symptoms of her head, neck, bilateral arms, low back and left buttock. (Ex. A, p. 6) In June and July 2010, claimant underwent a course of physical therapy per the orders of Robert Federhofer, D.O., relative to complaints she related to prior work injuries. (Ex. I, pp. 6-11)

In November 2010, claimant presented to the University of Iowa Hospitals & Clinics (UIHC) and was evaluated in the Urology Clinic by Elizabeth Takacs, M.D. Claimant expressed complaints of pelvic pain and incontinence. Claimant reported suffering with chronic pelvic pain since her 2004 hysterectomy; she also described leaking of urine during the day. (Ex. D, p. 1) Claimant returned to Dr. Takacs the following month, at which time she planned to proceed with hydrodistension and possible bladder biopsy procedures on December 17, 2010. (Ex. D, p. 4)

In April 2011, claimant underwent laparoscopic treatment of lesions related to a history of small bowel obstructions. (Ex. C, pp. 1-2)

In June 2011, claimant began work at defendant-employer performing parts delivery. She initially delivered parts within the Waterloo area, but subsequently received a route delivering auto parts throughout Iowa and into Wisconsin. She earned $9.00 per hour. (Claimant's testimony; Ex. O, p. 2; Ex. V, Depo. Tr. pp. 32-34) Defendant-employer's job description for the position of parts department driver/delivery noted the work ranged from light to heavy in nature and required lifting of parts. (Ex. 10, p. 119)

While performing her duties on August 2, 2013, claimant suffered a stipulated work related injury. At hearing, claimant testified she sat down a container of transmission fluid on the floor, turned, and felt a popping in sensation in her low back. She immediate felt pain in her low back and bilateral legs. She was unable to walk and fell into some boxes, where she remained for a few minutes while symptoms improved. After she was able to walk again, claimant returned to her vehicle and proceeded to complete her deliveries; she also telephoned defendant-employer and reported the incident. While she initially felt symptoms in her bilateral legs, claimant testified the right leg pain improved somewhat as the day passed, leaving pain in the left leg. (Claimant's testimony; Ex. V, Depo. Tr. pp. 80, 90) Claimant testified she continued working for several days thereafter, as she believed she strained or pulled a muscle. When her pain continued, she requested medical attention. (Claimant's testimony)

On August 15, 2013, claimant presented to Allen Occupational Health Services (AOH). Claimant completed a pain diagram, noting symptoms in her low back and down the left leg to the foot. (Ex. L, p. 32) Claimant was examined by Dr. Steven Olsen and reported suffering an injury at work on August 2, 2013, when she sat down a container of transmission fluid and felt a pop in her low back, with pain radiating down her left leg. Dr. Olsen assessed a lumbar strain and left radiculopathy to the foot. (Ex. 7A, p. 54; Ex. L, p. 31) Dr. Olsen indicated the condition was work-related and imposed work restrictions of a 5-pound lift; no bending, no industrial vehicle driving; limiting pushing, pulling and reaching; and sitting, standing and walking as necessary. He issued prescriptions for Tramadol and Flexeril. (Ex. 7A, p. 55)

Claimant returned to AOH on August 23, 2013 and was examined by Robert Broghammer, M.D. Claimant completed a pain diagram, noting pain of low back, down the left leg to the foot. (Ex. L, p. 30) Dr. Broghammer assessed a low back strain and

left leg pain. He ordered a course of physical therapy and prescribed Zanaflex. (Ex. F, pp. 6, 17)

On August 30, 2013, claimant completed another AOH pain drawing. On that date, claimant noted pain in her low back, down the left leg to the foot and down the right leg through the buttock to the thigh. (Ex. 7A, pp. 55A)

Claimant testified that during this period, she returned to work and performed light duty work, cleaning shelves. She testified that on September 4, 2013, a representative from defendant-employer approached her, expressed concern she would suffer further injury, and sent claimant home. (Claimant's testimony; Ex. V, Depo. Tr. p. 34)

On September 9, 2013, claimant provided a recorded statement to defendant-insurance carrier. Claimant reported she was injured on August 2, 2013, after placing down a container. At that time, she felt a pop in her low back, felt immediate pain down her left leg, and both legs felt rubbery. When she stood and attempted to walk, the left leg gave out and caused claimant to fall. Claimant reported that at that time, both legs "felt funny," but her right leg "recovered pretty quickly [and] it wasn't as bad." The back and left leg pain continued. (Ex. U, p. 6) Claimant reported she currently suffered with symptoms of the entire left leg and of the right leg down to the knee. (Ex. U, p. 9)

Claimant underwent an MRI of her lumbar spine on September 11, 2013. The radiologist read the results as revealing a disc protrusion at right L3-L4 with mild compression of the exiting right L3 nerve root. The radiologist commented this finding was not likely significant given claimant complained of left-sided symptoms; clinical correlation was suggested. The radiologist also observed a disc bulge at L4-L5 with bilateral neural foraminal stenosis, without evidence of significant nerve compression. (Ex. 7B, p. 68)

On September 13, 2013, claimant returned to Dr. Broghammer in follow up. Claimant completed a pain drawing, noting pain of the low back, down the left leg to the foot and down the right leg to the calf. (Ex. 7A, p. 57) Dr. Broghammer noted claimant complained of worsened low back pain and pain of the bilateral legs. Dr. Broghammer reviewed claimant's MRI, which he opined revealed nerve root compression, but not on the same side as claimant's symptoms. He opined the MRI findings did not explain claimant's symptoms. (Ex. 7A, p. 56; Ex. F, pp. 7, 18)

Dr. Broghammer assessed a low back strain, left radiculopathy, and right radiculopathy. Dr. Broghammer noted claimant initially claimed left-sided radiculopathy and opined this complaint was work related. With respect to the right-sided radiculopathy, Dr. Broghammer noted a question as to the etiology of the complaint, given it was not initially raised. (Ex. F, pp. 7, 18) He continued claimant's work restrictions, ordered a course of physical therapy, and issued a referral for a pain clinic consultation. (Ex. 7A, p. 58; Ex. F, pp. 7, 18)

At the referral of Dr. Broghammer, on October 8, 2013, claimant presented to the Allen Pain Clinic. Claimant completed a medical questionnaire and pain drawing. On the pain drawing, claimant indicated pain of the low back and down the bilateral legs to the feet. A handwritten note adjacent to the diagram noted the pain began on the right side, then changed to the left leg, and was currently present in the bilateral legs. (Ex. L, p. 34)

Frank Hawkins, M.D. examined claimant, who complained of back and bilateral leg pain. Claimant reported the work injury caused back pain, with symptoms initially in the bilateral legs. She indicated the right leg improved shortly after the injury, but symptoms returned, leaving both legs uncomfortable. Dr. Hawkins noted claimant had failed to receive much relief with conservative treatment. Dr. Hawkins expressed he had a "hard time understanding and putting together [claimant's] symptoms and the way that she is carrying about in regards to her pain," given the paucity of findings on claimant's MRI. He, however, proceeded with an L4-L5 ESI. (Ex. 7C, p. 70)

On October 17, 2013, claimant returned to AOH in follow up. She completed a pain drawing, noting pain of the low back, left leg to calf and right leg to foot. (Ex. 7A, p. 61) Due to Dr. Broghammer's absence, claimant was examined by Dr. McMains. Claimant reported the ESI the prior week helped with tailbone pain and her ability to sit, but did not assist with leg symptoms. Claimant reported constant pain in her low back and bilateral legs. (Ex. 7A, p. 59)

Following the appointment, Dr. McMains authored a letter to claimant's case manager summarizing claimant's examination and his recommendations. Dr. McMains indicated he took a history from claimant, who reported feeling a pop in her low back and accompanying pain radiating down her left leg, after setting down a container of transmission fluid on August 2, 2013. Dr. McMains reviewed claimant's September 11, 2013 MRI and opined the findings were normal for claimant's age. As he saw no evidence of cord or nerve compression, Dr. McMains opined he lacked an obvious explanation as to why claimant failed conservative treatment "for such a minor event." (Ex. 7A, p. 62; Ex. F, p. 8) Dr. McMains noted on September 13, 2013, claimant complained of bilateral leg pain, leading Dr. Broghammer to suggest pain clinic evaluation. He opined the left L4-5 injection performed by Dr. Hawkins was of little benefit, as claimant reported decreased tailbone pain, but unchanged bilateral leg paresthesias. (Ex. 7A, pp. 62-63; Ex. F, pp. 8-9)

Following examination, Dr. McMains assessed bilateral lower extremity weakness, symptom magnification, and a high probability of vascular problems. He opined claimant's findings did not support a causal connection between the "mild" work injury and claimant's ongoing symptoms. (Ex. 7A, p. 63; Ex. F, p. 9) Dr. McMains expressed belief the cause of claimant's symptoms was more likely than not a vascular insufficiency, as opposed to spinal disease. Accordingly, he recommended treatment with and transferred care to claimant's primary care provider. Dr. McMains released claimant from care at AOH and opined she demonstrated no evidence of permanent impairment and required no restrictions related to the work injury. He noted claimant

would, however, likely need to remain off work under the direction of a primary care provider or vascular specialist. (Ex. 7A, p. 63)

Claimant testified that after she was released by Dr. McMains, she called her supervisor regarding returning to work. She testified he stated he did not want claimant to return to work until she was "100 percent," due to fear of reinjury. (Claimant's testimony)

On October 21, 2013, claimant presented to her primary care provider, Jonathon Hennings, ARNP, with complaints of back and leg discomfort. She reported the recent ESI resulted in improved back pain, but did not change her leg symptoms. Mr. Hennings assessed a back injury and leg pain. Claimant informed Mr. Hennings that Dr. McMains had recommended evaluation of a potential vascular basis for her symptoms. Mr. Hennings referred claimant for bilateral leg artery and vein studies to rule out circulatory problems. (Ex. 7D, pp. 71-72; Ex. 7J, p. 87)

On October 23, 2013, claimant underwent bilateral venous ultrasound and arterial studies with Eromosele Otoadese, M.D. of Northern Iowa Cardiovascular and Thoracic Surgery. (Ex. 7J, p. 88)

On November 11, 2013, Mr. Hennings removed claimant from work through November 17, 2013 due to injury and scheduled testing. (Ex. 5, p. 40)

On November 11, 2013, claimant presented to Dr. Otoadese for review of the testing results. Dr. Otoadese opined the studies revealed no evidence of deep vein thrombosis or venous insufficiency in claimant's lower extremities. Dr. Otoadese observed a mild resting arterial insufficiency in the bilateral lower extremities. (Ex. 7D, p. 73) Following examination and review of claimant's studies, Dr. Otoadese assessed severe low back pain radiating down the bilateral lower extremities. He opined it was unlikely claimant's symptoms were due to peripheral artery disease and expressed belief that the most likely cause of claimant's symptoms was degenerative disc disease. For the sake of completeness, Dr. Otoadese recommended exercise lower extremity arterial doppler studies and a CT angiography of claimant's abdominal aorta. (Ex. 7D, p. 75)

Claimant returned to Dr. Broghammer on November 27, 2013. Dr. Broghammer assessed idiopathic bilateral leg pain. He recommended EMG/NCV testing and a neurosurgical consultation. (Ex. F, pp. 10, 19)

On December 11, 2013, claimant underwent EMG/NCV studies with neurologist, Ameer Almullahassani, M.D. Dr. Almullahassani opined the results of the studies were normal, with no evidence of lumbosacral radiculopathy from L2 to S1 and no evidence of mononeuropathy. (Ex. 7E, p. 76)

Claimant returned to Dr. Broghammer on December 20, 2013 with complaints of pain in the low back and legs, as well as bowel and bladder incontinence. (Ex. 7A, p. 64) Dr. Broghammer reviewed claimant's EMG/NCV and MRI results, which he

opined offered no explanation for claimant's symptoms. Dr. Broghammer assessed idiopathic lumbago, placed claimant at maximum medical improvement (MMI), and released claimant from care. (Ex. F, pp. 11, 19-20) Dr. Broghammer opined the condition was no longer work related and released claimant to return to work without restrictions. He opined claimant sustained no permanent impairment as a result of the work injury. (Ex. 7A, p. 65; Ex. F, pp. 11, 19-20)

Following the appointment, Dr. Broghammer authored a letter to claimant's case manager. He noted claimant complained of pain and indicated claimant appeared in significant distress. Dr. Broghammer indicated he reviewed claimant's treatment records and at each visit, claimant's symptoms had increased without a particular reason. He opined claimant appeared to demonstrate a significant component of symptom magnification. Dr. Broghammer indicated he informed claimant he did not believe it made "sense" for a patient to suffer a muscle strain in her back and continue to suffer with symptoms four months later. Dr. Broghammer opined claimant's EMG/NCV studies yielded completely normal results, without evidence of radiculopathy, neuropathy or mononeuropathy. Dr. Broghammer indicated he informed claimant of these results and also that he lacked an explanation for claimant's ongoing low back pain "from her alleged injury." (Ex. 7A, p. 66; Ex. F, p. 12)

Dr. Broghammer ultimately opined claimant's symptoms were no longer related to the August 2013 work injury, but rather, were idiopathic in nature and due to genetic and personal conditions "unrelated to any industrial factors." Dr. Broghammer placed claimant at MMI, released her from care and advised claimant to follow up with her primary care provider. He further opined any additional medical care should be undertaken outside of the workers' compensation claim. Dr. Broghammer opined claimant sustained no permanent impairment and required no restrictions as a result of the work injury. (Ex. 7A, p. 66; Ex. F, p. 12)

On December 20, 2013, claimant returned to Mr. Hennings with complaints of low back pain with radiation down her bilateral legs. She also reported suffering some urine and stool incontinence. Claimant informed Mr. Hennings she had been released by AOH to return to full duty work, without restrictions. Mr. Hennings noted claimant appeared frustrated and inquired into her next steps regarding her symptoms. Mr. Hennings assessed a back injury, neuropathy, and bowel and bladder incontinence. He opined claimant's vein and artery testing were negative, without sign of peripheral artery or vascular disease. Mr. Hennings issued claimant a prescription for Percocet and removed her from work pending neurosurgical evaluation with David Beck, M.D. (Ex. 7J, p. 89)

Mr. Hennings authored a separate work excuse, whereby he opined claimant was unable to work. He expressed belief claimant was suffering from a nerve injury of her lumbar and sacral spine. As claimant was not capable of lifting, needed to change positions frequently, and required strong pain medications, Mr. Hennings opined claimant should remain off work until cleared by a neurosurgeon. (Ex. H, p. 1)

That same date, December 20, 2013, claimant authored a handwritten note to "Ron" at defendant-employer. It appears claimant faxed the note, accompanied with the release authored by AOH and the work excuse authored by Mr. Hennings. Claimant indicated she was able to work, in the event defendant-employer possessed work that did not require lifting and which allowed her to change positions. Claimant requested she be contacted regarding if and when she would be able to return to work. (Ex. 9, p. 118)

On January 2, 2014, claimant underwent lumbar spine x-rays, which the radiologist read as revealing early multilevel degenerative disc and facet disease. (Ex. 7F, p. 78)

At the referral of Mr. Hennings, on January 8, 2014, claimant presented for evaluation with neurosurgeon, David Beck, M.D. Dr. Beck performed a physical examination and reviewed claimant's testing results. He opined claimant's EMG and venous doppler studies were normal. He opined claimant's lumbar spine MRI was essentially normal, without an explanation for claimant's complaints of weakness, numbness and incontinence. (Ex. 7G, p. 79) Following review of claimant's test results and examination, Dr. Beck opined there was not "anything wrong" with claimant, anatomically speaking. He opined claimant was not a surgical candidate. Dr. Beck, however, acknowledged the presence of claimant's symptoms. He issued a prescription for Gabapentin to address what he described as "rather bizarre" leg pain. Dr. Beck advised claimant to follow up with Mr. Hennings. (Ex. 7G, p. 80)

On January 10, 2014, claimant presented to Chad Abernathey, M.D. for a neurosurgical opinion. Dr. Abernathey reviewed claimant's history and testing results. He opined claimant's MRI results were essentially unrevealing, with only mild degenerative age-consistent changes and without significant neural compromise. Following examination, Dr. Abernathey assessed a chronic lumbosacral strain following the work injury. He opined claimant was not a surgical candidate, given a paucity of clinical and radiographic findings. Instead, he recommended further conservative measures. Dr. Abernathey opined claimant did not appear "well" and expressed concern claimant may be suffering from an illness or health issue "unrelated to her" workers' compensation claim. Accordingly, he recommended further medical evaluation by claimant's primary care provider to consider other potential causes of claimant's chronic pain. (Ex. 7H, p. 81; Ex. E, p. 2)

Dr. Abernathey also authored a letter directed to Dr. Broghammer indicating he did not believe claimant was a candidate for aggressive neurosurgical management. Dr. Abernathey did express concern with claimant's overall appearance of poor health and recommended work-up by a primary care physician. He expressed belief claimant's pain complaints were possibly related to an underlying medical issue, as opposed to the work injury. (Ex. E, p. 3)

That same date, January 10, 2014, Dr. Abernathey responded to a letter authored by claimant's case manager. Dr. Abernathey indicated agreement with the contents of Dr. Broghammer's December 20, 2013 letter. (Ex. E, p. 1)

On January 21, 2014, claimant returned to Mr. Hennings in follow up. Claimant reported the prescribed Gabapentin provided some relief of leg symptoms, but did not assist with back pain. Mr. Hennings assessed a back injury, lumbar disc herniation with radiculopathy, and neuropathy. He issued prescriptions for Percocet and Gabapentin. (Ex. 7J, pp. 90-91; Ex. H, p. 4)

Claimant returned to Mr. Hennings on February 27, 2014. Mr. Hennings assessed a back injury, lumbar disc herniation with radiculopathy, and neuropathy. He issued prescriptions for Percocet and Gabapentin. (Ex. H, pp. 2-3)

On March 27, 2014, claimant returned to Mr. Hennings in follow up. Mr. Hennings assessed chronic pain syndrome and lumbar disc herniation with radiculopathy. He refilled prescriptions for Percocet and Gabapentin. (Ex. 7J, p. 92)

On May 5, 2014, claimant presented to Mr. Hennings. Mr. Hennings noted claimant reported her attorney had advised her to find another job or apply for unemployment benefits, as defendant-employer had not provided work. Mr. Hennings assessed chronic pain syndrome, lumbar disc herniation with radiculopathy, and neuropathy. He issued prescriptions for Percocet, Gabapentin and a Fentanyl patch, and referred claimant for pain management. (Ex. 7J, p. 93; Ex. H, pp. 6-7)

On May 13, 2014, claimant returned to Mr. Hennings regarding medication use and work restrictions. Claimant reported relief with the Fentanyl patch. Mr. Hennings increased the Fentanyl dosage and continued claimant's prescriptions for Percocet and Gabapentin. (Ex. 7J, p. 94)

The following day, May 14, 2014, claimant telephoned Mr. Hennings requesting clarification on work restrictions. On May 15, 2014, Mr. Hennings expressed belief claimant was capable of working in some capacity, potentially clerical or answering telephones. He restricted claimant from performing lifting, carrying or bending. (Ex. 7J, p. 95)

At the referral of Mr. Hennings, on May 15, 2014, claimant presented to Northern Iowa Pain Management. She was seen by Gayathry Inamdar, M.D. for complaints of low back pain radiating into the bilateral buttocks and legs. Dr. Inamdar assessed lumbar radiculitis secondary to disc displacement and spinal stenosis. He recommended proceeding with a right lumbar transforaminal epidural steroid injection (TESI) at L4-L5 and L5-S1. (Ex. 7K, pp. 97-98) Dr. Inamdar performed a right lumbar TESI at L4-L5 and L5-S1 on May 20, 2014. (Ex. 7I, p. 84)

Claimant testified she discussed returning to work with a representative from defendant-employer. She was advised her driving position was no longer available, but they may had a janitorial position available. Claimant indicated she stated she would discuss the position with Mr. Hennings. (Claimant's testimony)

Claimant testified she and Mr. Hennings discussed defendant-employer's offer of a janitorial position. Claimant testified Mr. Hennings rejected such a position due to the standing and lifting requirements, as well as a fear of reinjury. (Claimant's testimony)

On May 16, 2014, Mr. Hennings authored a letter indicating that due to "recent injuries" and symptoms of pain and weakness, claimant should not return to work until further notice. (Ex. 5, p. 41)

Claimant returned to Dr. Inamdar on June 10, 2014 and reported approximately 50 percent improvement following TESI on May 20, 2014. Dr. Inamdar recommended waiting on further treatment to see if her symptoms improved further or declined. In the event symptoms worsened, he recommended proceeding with a left ESI at L3-L4. He also recommended continued use of Gabapentin. (Ex. 7K, p. 101) On June 30, 2014, Dr. Inamdar performed a lumbar ESI at L3-L4 (Ex. 7I, p. 85)

On July 17, 2014, claimant returned to Dr. Inamdar and reported approximately 25 percent improvement following lumbar ESI on June 30, 2014. (Ex. 7K, p. 102) Dr. Inamdar assessed lumbosacral spondylosis and recommended proceeding with right lumbar facet joint nerve blocks at L3-L4, L4-L5 and L5-S1, as well as a probable lumbar interlaminar epidural. (Ex. 7K, p. 103) On July 23, 2014, Dr. Inamdar performed right lumbar facet joint injects at L3-L4, L4-L5 and L5-S1. (Ex. 7I, p. 86)

Claimant returned to Dr. Inamdar on August 6, 2014 and reported worsening symptoms following the facet injections of July 23, 2014. (Ex. 7K, p. 104; Ex. G, p. 1) Dr. Inamdar issued prescriptions for Tizanidine, Fentanyl and Nucynta. He noted he would also consider performing a right SI joint injection. (Ex. 7K, p. 105; Ex. G, p. 2) On August 11, 2014, claimant underwent a right lumbar ESI at L4-L5. (Ex. 7K, p. 106)

On August 18, 2014, claimant returned to Mr. Hennings in follow up. She reported suffering with continued pain and expressed desire to pursue disability benefits. Mr. Hennings noted claimant complained of worsened low back issues, episodes of falling, and increased incontinence. Mr. Hennings assessed chronic pain syndrome, lumbar disc herniation with radiculopathy, and neuropathy. Mr. Hennings ordered MRIs of claimant's cervical and lumbar spines, and continued claimant's prescription medications. (Ex. 7J, p. 96; Ex. H, p. 5)

On August 20, 2014, claimant returned to Dr. Inamdar and reported 10 percent improvement following right lumbar ESI at L4-L5 performed on August 11, 2014. Dr. Inamdar noted claimant was scheduled to undergo MRI studies, which he intended to review. In the interim, Dr. Inamdar recommended continued conservative treatment. He noted potential treatment options included diagnostic SI joint injection and possible spinal cord stimulation. (Ex. 7K, pp. 106-109)

Claimant underwent the recommended lumbar spine MRI on August 21, 2014. The radiologist read the results as stable compared to the September 2013 study. The radiologist assessed a small intraforaminal disc protrusion at right L3-L4, and minimal indentation of the exiting right L3 nerve root, but no other changes. (Ex. K, p. 1)

In August 2014, claimant applied for Social Security Disability benefits on the basis of her back injury, neuropathy and arthritis. She was subsequently determined eligible for these benefits. (Claimant's testimony; Ex. 20, pp. 197-204; Ex. V, Depo. Tr. p. 58)

Jason Witham, president of defendant-employer, authored an undated letter to claimant regarding the status of her medical condition and ability to return to work. By the letter, Mr. Witham noted claimant had been off work since August 2013 and had not communicated with defendant-employer since receipt of Mr. Hennings' May 16, 2014 note excusing her from work. Mr. Witham requested an update on claimant's status and ability to return to work. He indicated that in order to return to work, claimant must be capable of performing the essential functions of her job or another available position, with or without reasonable accommodations. He stated claimant's preinjury position required frequent sitting, changing of positions, reaching, handling, squatting, stooping, grasping, and entering/exiting of a vehicle; occasional standing, walking, pinching, balancing and use of stairs/ramp; constant exertion of 10 to 20 pounds and frequent exertion of 25 to 50 pounds of force; and occasional lifting up to 65 pounds from various heights, including from floor and above shoulder level. (Ex. 13, pp. 166-167) Mr. Witham noted a request for update had also been sent to Mr. Hennings. (Ex. 13, pp. 167-168a)

On September 5, 2014, claimant presented to Mr. Hennings. Mr. Hennings noted some "mild changes" on claimant's recent MRI and assessed chronic pain syndrome and lumbar disc herniation with radiculopathy. He indicated he was scheduled to conference with claimant's counsel on September 11, 2014 and would respond to a pending inquiry from defendants following that appointment. (Ex. H, p. 11)

On September 23, 2014, Dr. Inamdar performed a right ESI at L3-4. (Ex. 7K, p. 108)

Mr. Witham authored a second, also undated, letter to claimant. A handwritten notation indicates the letter was sent on October 8, 2014. Mr. Witham stated defendant-employer had received no response from Mr. Hennings. Further, Mr. Witham indicated he interpreted a voicemail received from claimant to indicate claimant was unable to meet the essential functions of her prior job and was unable or uninterested in performing other positions at defendant-employer. Accordingly, Mr. Witham informed claimant she had been terminated by defendant-employer. In the event her condition improved, Mr. Witham indicated claimant was welcome to apply for available positions. (Ex. Q, p. 1) Defendant-employer's records indicate claimant was terminated effective October 13, 2014. (Ex. 11, p. 120)

On October 16, 2014, claimant returned to Dr. Inamdar and reported 30 percent improvement following right L3-L4 ESI on September 23, 2014. Dr. Inamdar recommended use of a muscle relaxer and repeat right L3-L4 ESI. (Ex. 7K, pp. 108-109)

Claimant presented to Dr. Inamdar on January 7, 2015 and reported 50 to 60 percent improvement since the right L4-L5 ESI on August 11, 2014. Dr. Inamdar assessed lumbar radiculitis secondary to disc displacement and spinal stenosis. He recommended a TESI at L3-L4. (Ex. 7K, pp. 110-111)

Claimant's counsel conferenced with Mr. Hennings and subsequently authored a statement regarding the substance of that conference. Mr. Hennings signed the statement, expressing agreement with its contents on January 7, 2015. (Ex. 5, pp. 42-43) Mr. Hennings agreed that following the work injury of August 2, 2013, claimant consistently complained of low back pain radiating into the bilateral legs; he also noted a complaint of incontinence. Mr. Hennings indicated claimant displayed no signs of malingering. Mr. Hennings reported knowledge of claimant's history of low back pain and opined the work injury materially aggravated claimant's low back condition. He opined this material aggravation might be permanent. Mr. Hennings further opined the work injury was a substantial contributing factor in causing bilateral lower extremity radicular symptoms, as well as incontinence. He recommended ongoing pain management for the foreseeable future. He further opined the care he had provided claimant, and any charges for such care were fair and reasonable. Mr. Hennings opined claimant was unable to return to work requiring lifting, bending, twisting or standing. He opined claimant may be capable of performing sedentary work, but cautioned the determination would be job-dependent. (Ex. 5, p. 43)

At some point, Mr. Hennings ceased providing medical treatment to patients. (Claimant's testimony) As a result, claimant began seeing Daniel Koos, M.D. of Waverly Health Center. Claimant presented to Dr. Koos on January 15, 2015 in follow up of right upper lobe pneumonia. Claimant also complained of low back pain, which claimant reported was chronic and secondary to degenerative disc disease. (Ex. H, p. 8) Following evaluation, Dr. Koos issued diagnoses, including lumbar disc herniation with radiculopathy. Dr. Koos noted claimant was active and functional, with adequate pain relief. As a result, he decreased claimant's Fentanyl dosage and refilled prescriptions for Percocet and Gabapentin. (Ex. H, pp. 9-10)

Claimant underwent right L3-L4 ESI on January 15, 2015. She returned to Dr. Inamdar on February 3, 2015 and reported 50 percent improvement in symptoms. Dr. Inamdar recommended claimant follow up in 3 months or upon return of pain. In the event continued conservative measures failed, Dr. Inamdar indicated he would consider spinal cord stimulation. (Ex. 7K, p. 112-113)

On February 16, 2015, claimant presented to Dr. Koos, who noted claimant had recently undergone pulmonary function tests which were consistent with mild chronic obstructive pulmonary disease. He noted claimant remained active and functioning, with adequate and well-controlled chronic low back pain. Dr. Koos renewed claimant's prescription for Percocet, Fentanyl and Gabapentin. (Ex. H, p. 14)

At the arranging of claimant's counsel, on April 20, 2015, claimant presented to board certified occupational and environmental medicine physician, Robin Sassman, M.D. Dr. Sassman performed an independent medical examination (IME)

and issued a report containing her findings and opinions dated May 20, 2015. During interview, claimant complained of low back pain with radiation down to her buttocks, right greater than left, as well as an aching sensation, numbness and tingling of her legs and feet. Claimant reported her right leg had given way, causing her to fall and as a result, she utilized a cane with ambulating long distances. (Ex. 1, p. 5) In completion of her IME, Dr. Sassman reviewed medical records dating to 2002, with select records summarized in her report. (Ex. 1, pp. 2-5) Dr. Sassman also performed a physical examination of claimant. (Ex. 1, pp. 6-7)

Following records review, interview and examination, Dr. Sassman assessed low back pain with radiculopathy. Dr. Sassman opined the mechanism of injury suffered by claimant on August 2, 2013 was consistent with claimant's condition. She noted claimant's symptoms had been ongoing since the date of injury and claimant had acknowledged a history of prior back problems for which she received medical care, but denied any ongoing back problems. Dr. Sassman ultimately opined the work injury of August 2, 2013 was "directly and causally related" to claimant's low back pain, radiculopathy and the abnormalities seen on claimant's MRI. (Ex. 1, p. 7)

Dr. Sassman recommended claimant continue pain management treatment with Dr. Inamdar. In the event injections and increased dosages of Gabapentin did not result in improvement, Dr. Sassman indicated she would recommend a neurosurgical evaluation. (Ex. 1, p. 7) Dr. Sassman opined that pain management was unlikely to significantly improve claimant's condition and thus, in the absence of surgery, opined claimant had achieved MMI as of the date of evaluation, April 20, 2015. Dr. Sassman calculated the extent of claimant's permanent impairment, utilizing the range of motion methodology outlined in the AMA Guides. Dr. Sassman opined this method was appropriate given claimant had suffered a recurrent injury at the same level. Based upon lumbar range of motion, sensory deficits, and intervertebral disc and other soft tissue lesions, Dr. Sassman opined claimant sustained a combined permanent impairment of 25 percent whole person. (Ex. 1, pp. 8-9) Dr. Sassman recommended permanent restrictions, including: limiting lifting, pushing, pulling and carrying to 10 pounds rarely; sitting, standing and walking occasionally; changing positions frequently; stairs rarely; no use of ladders or walking on uneven surfaces; and avoidance of vibratory or power tools, as use might exacerbate claimant's symptoms. (Ex. 1, p. 9)

On May 13, 2015, claimant returned to Dr. Koos in follow up. He noted claimant reported her low back symptoms were well-controlled. Dr. Koos issued refills for claimant's medications. (Ex. H, pp. 15-17)

Defendants provided Dr. Broghammer with a copy of Dr. Sassman's IME report for review and comment. (Ex. F, pp. 14-15) Dr. Broghammer issued a responsive report dated June 10, 2015. As he had not examined claimant in over 1 ½ years, Dr. Broghammer indicated he reviewed claimant's entire file; his report contains summaries of claimant's care. (Ex. F, pp. 17-21) After doing so, Dr. Broghammer opined his original opinions remained unchanged and expressed belief his opinions had been corroborated by subsequent records. (Ex. F, p. 21) He continued to opine

claimant's ongoing subjective symptom complex was unrelated to the work injury. He opined claimant sustained no ratable impairment and required no work restrictions as a result of the work injury. Dr. Broghammer further opined the ongoing care claimant received following his release was not related to the work injury, but instead, due to personal and genetic conditions. He suggested contacting Dr. McMains for further corroboration. (Ex. F, p. 22)

Dr. Broghammer indicated he did not agree with Dr. Sassman's opinions or recommendations. He expressed belief Dr. Sassman used the *post hoc ergo propter hoc* argument, i.e. "after this, therefore, because of this," with respect to her opinions. He described Dr. Sassman's argument as opinion, not based in science. (Ex. F, p. 22) With respect to Dr. Sassman's opinion regarding the extent of claimant's permanent impairment, Dr. Broghammer indicated he was unclear as to the "recurrent" injury suffered by claimant and referenced by Dr. Sassman in her rating methodology. He also commented that Dr. Sassman's rating was based purely on claimant's subjective complaints, as it did not account for a lack of radiculopathy on EMG/NCV. Dr. Broghammer expressed belief this methodology was inappropriate. Dr. Broghammer opined there was no reason to undergo a third neurosurgical evaluation, as recommended by Dr. Sassman, given Drs. Beck and Abernathey had already opined claimant was nonsurgical, MRI results showed chronic degenerative changes, and the EMG/NCV studies were negative, without evidence of radiculopathy, polyneuropathy or mononeuropathy. (Ex. F, p. 21) In the event claimant required further treatment, Dr. Broghammer opined that treatment was not related to the work injury and rather, was due to unrelated personal and genetic factors. (Ex. F, p. 22)

Claimant applied to Iowa Vocational Rehabilitation Services for vocational assistance. On July 16, 2015, claimant was notified that she had been determined eligible for vocational rehabilitation services, but had been waitlisted. (Ex. 17, p. 184)

On July 27, 2015, Megan McMillin, PA-C, evaluated claimant for a tender lump on her right lower leg, with accompanying redness, warmth, swelling and achiness. (Ex. H, p. 19) Ms. McMillin ordered a venous doppler study to rule out deep vein thrombosis. (Ex. H, p. 20)

On February 3, 2016, defendants' attorney authored a letter posing questions for Dr. Beck's consideration. (Ex. B, pp. 2-3) Dr. Beck provided responses on February 10, 2016. Thereby, Dr. Beck opined claimant's studies had been normal, including EMG/NCV and MRI studies. He also opined claimant's neurological exam had been normal. Dr. Beck opined claimant's work injury "may be causally related" to her subjective complaints, but noted these subjective complaints were not supported with objective findings. (Ex. B, p. 4)

Following a telephone conference, defendants' counsel also contacted Dr. McMains with a series of questions for his consideration. (Ex. F, pp. 23-24) Dr. McMains authored a responsive letter dated February 12, 2016. Dr. McMains noted claimant's initial complaints were to her low back and left leg, while just prior to undergoing an MRI, claimant developed bilateral radiculopathies, left greater than right.

By the letter, Dr. McMains indicated claimant underwent a thorough workup, which yielded no objective findings beyond age-appropriate degenerative changes of the lumbar spine and with no nerve compression. He opined claimant's ongoing complaints from 2013 onward were not causally related to the work injury. Dr. McMains opined claimant sustained no permanent impairment and required no permanent restrictions as a result of the work injury. (Ex. F, p. 25)

Defendants' counsel also directed a letter to Dr. Broghammer with a series of questions for consideration. (Ex. F, pp. 27-28) Dr. Broghammer authored a response dated February 18, 2016. Dr. Broghammer indicated claimant underwent a thorough workup which revealed appropriate age-related changes of the lumbar spine. He opined claimant's workup revealed evidence of a lumbar strain only, which should have resolved within a matter of weeks, without permanent impairment or a need for restrictions. He further opined claimant's ongoing subjective complaints were not explained by diagnostic studies. Dr. Broghammer expressed belief claimant's ongoing complaints, from 2013 onward, were not causally related to the work injury. (Ex. F, p. 31)

Defendants' counsel also authored a letter to Dr. Abernathey posing questions for consideration. Dr. Abernathey issued a response dated February 24, 2016. He opined claimant's expressed complaints were consistent with her presentation at examination, but noted claimant did not have specific objective findings. Based upon the oral history provided by claimant, Dr. Abernathey opined claimant's complaints were causally related to the work injury. However, due to a paucity of clinical and radiographic findings, he found no permanent impairment and no need for permanent restrictions. (Ex. E, pp. 4-5)

On March 16, 2016, Dr. Abernathey signed a statement authored by claimant's counsel following a conference. (Ex. 6, p. 44) Dr. Abernathey confirmed he examined claimant on January 10, 2014 for a neurosurgical evaluation, due to complaints of low back pain with radicular symptoms to the bilateral lower extremities. Dr. Abernathey indicated he found nothing during claimant's interview or evaluation which led him to doubt claimant's reported history of symptomatology. He opined the reported mechanism of injury was consistent with claimant's reported symptoms and further opined that if claimant continued to report the same symptoms that she had at the time of his evaluation, those symptoms more likely than not remained related to the work injury, assuming no intervening event. (Ex. 6, p. 45)

Dr. Abernathey indicated he did not view findings on claimant's MRI which would produce claimant's symptoms, but agreed it was "certainly possible" for claimant to experience such symptoms without corresponding MRI findings. He agreed he personally, from a neurologic and anatomical standpoint, did not assign permanent restrictions or an impairment rating. Dr. Abernathey acknowledged claimant may have impairment and may require restrictions due to ongoing symptomatology. He deferred to the results of an FCE and/or occupational medicine physician who had more recently evaluated claimant. (Ex. 6, p. 45)

Claimant retained vocational expert and certified rehabilitation counsel, Kent Jayne, to complete an assessment of claimant's earning capacity and vocational potential. Mr. Jayne issued a report containing his findings and opinions dated May 12, 2016. In connection with the assessment, Mr. Jayne interviewed claimant on March 11, 2016. (Ex. 3, p. 21) Claimant completed various vocational questionnaires and tests. (Ex. 3, pp. 17, 21-25) Mr. Jayne also reviewed and summarized select medical records and claim documentation. (Ex. 3, pp. 17-21) Additionally, he detailed claimant's education and work history. (Ex. 3, pp. 23-24)

Mr. Jayne opined the restrictions recommended by Dr. Sassman placed claimant "at less than a sedentary capacity of physical demands," noting the sedentary classification required lifting up to 10 pounds occasionally, while claimant was limited to such lifting on a rare basis. Mr. Jayne opined Dr. Sassman's restrictions limiting claimant to occasional sitting, standing and walking, with the need to frequently change position, further limited claimant's ability to perform sedentary work. (Ex. 3, p. 27) He further found claimant's testing results were not supporting of full-time sedentary work. (Ex. 3, p. 28) Mr. Jayne opined the restrictions imposed by Dr. Sassman, combined with the difficulties claimant experienced during the simulated work session testing, likely precluded claimant from competitive employment. (Ex. 3, pp. 27-28) He opined the combination of restrictions and testing performance resulted in a conclusion claimant was unlikely to retain "sufficient residual marketable skills to permit employment in any reasonably stable branch of the labor market." (Ex. 3, p. 28)

Mr. Jayne performed a labor market survey analysis, which he opined indicated claimant was precluded from the competitive labor market. He opined many of claimant's preinjury abilities were no longer within her capacity and at her current level of functioning, claimant possessed no marketable, transferrable skills. (Ex. 3, p. 29) He specifically opined claimant would be unable to return to her preinjury job or any of the relevant occupations within claimant's work history. (Ex. 3, pp. 27-28) Given claimant's current condition, Mr. Jayne opined it was unlikely that any "feasible vocational rehabilitation plan would have a reasonable likelihood of success" in returning claimant to competitive employability. (Ex. 3, p. 35)

Following her termination by defendant-employer, claimant engaged in a work search. She introduced evidence that she personally contacted eight potential employers regarding employment. (Ex. 17, pp. 181-183; Ex. O, pp. 6-7) Additionally, claimant has worked with a counselor at Iowa Vocational Rehabilitation Services. The two discussed potential job opportunities, including ones with potential accommodations and/or work-from-home opportunities. Claimant testified Iowa Vocational Rehabilitation Services is in the process of procuring a computer for claimant's home which will meet the requirements of work-from-home positions. Claimant testified she desires to return to work in some capacity, in order to feel "useful." (Claimant's testimony)

Claimant testified she continues to suffer with symptoms she relates to the work injury of August 2, 2013. She continues to report pain of her low back. The pain worsens at her tailbone with sitting upright, so she generally angles her body to allow her to sit on either hip. She also feels stabbing pains in her buttocks and legs.

Claimant testified she feels pain in both legs, generally right greater than left. Depending on the position of her body while sitting or lying, claimant can also develop aching and numbness. Claimant testified she is capable of sitting for 15 to 20 minutes in a single position; she then needs to stand or otherwise change position. She also utilizes a cane, as she has experienced difficulty with her right leg giving way or stumbling due to dragging her foot. She received the cane during physical therapy prescribed for the work injury. (Claimant's testimony)

CONCLUSIONS OF LAW

The first issue for determination is whether claimant is entitled to temporary disability benefits from January 26, 2014 through April 20, 2015.

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 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).

When an injured worker has been unable to work during a period of recuperation from an injury that did not produce permanent disability, the worker is entitled to temporary total disability benefits during the time the worker is disabled by the injury. Those benefits are payable until the employee has returned to work, or is medically capable of returning to work substantially similar to the work performed at the time of injury. Section 85.33(1).

Healing period compensation describes temporary workers' compensation weekly benefits that precede an allowance of permanent partial disability benefits. Ellingson v. Fleetguard, Inc., 599 N.W.2d 440 (Iowa 1999). Section 85.34(1) provides that healing period benefits are payable to an injured worker who has suffered permanent partial disability until the first to occur of three events. These are: (1) the worker has returned to work; (2) the worker medically is capable of returning to substantially similar employment; or (3) the worker has achieved maximum medical recovery. Maximum medical recovery is achieved when healing is complete and the extent of permanent disability can be determined. Armstrong Tire & Rubber Co. v. Kubli, Iowa App., 312 N.W.2d 60 (Iowa 1981). Neither maintenance medical care nor an employee's continuing to have pain or other symptoms necessarily prolongs the healing period.

The threshold issue for consideration with respect to claimant's entitlement to additional temporary disability benefits is whether claimant's ongoing complaints, following her release by Allen Occupational Health, are causally related to the stipulated work injury of August 2, 2013.

Claimant credibly testified at hearing that following the August 2, 2013 injury, she felt a pop and suffered pain and symptoms of her bilateral legs. Although the right leg symptoms initially subsided somewhat, leaving the left-sided symptoms more prevalent, claimant testified her right-sided symptoms returned while she remained under care and on light duty. Claimant's hearing testimony is consistent with her deposition testimony, as well as the recorded statement provided shortly after the injury. Additionally, this return of right leg symptoms is reflected in claimant's medical records. Claimant denied such symptoms prior to the stipulated work injury, as supported by her ability to work a physically demanding parts delivery position for defendant-employer.

Following the stipulated work injury of August 2, 2013, defendants referred claimant for medical treatment at AOH. Her care was primarily managed by Dr. Broghammer, who opined claimant's lumbar and left leg symptoms were initially related to the work injury. Claimant subsequently reported right leg symptoms, of which Dr. Broghammer noted he questioned the etiology, given the right-sided symptoms were not immediately reported by claimant. Dr. Broghammer ordered diagnostic imaging and testing.

On October 17, 2013, claimant presented to AOH and was examined by Dr. McMains. Dr. McMains opined claimant's objective findings did not support the existence of a causal connection between her minor work injury and ongoing symptoms. Instead, Dr. McMains opined the etiology of claimant's complaints was vascular in nature. Claimant subsequently underwent vascular testing, after which Dr. Otoadese opined claimant symptoms were unlikely due to peripheral artery disease and were more likely attributable to degenerative disc disease.

Following additional testing, claimant returned to Dr. Broghammer for evaluation. On December 20, 2013, Dr. Broghammer opined claimant's condition was idiopathic and her symptoms were no longer related to the work injury of August 2, 2013.

Shortly thereafter, claimant underwent evaluation by two neurosurgeons. Mr. Hennings referred claimant to Dr. Beck for evaluation, who on January 8, 2014, opined claimant was not a surgical candidate. He opined claimant did not demonstrate an anatomical problem, yet acknowledged claimant's symptoms and prescribed Gabapentin. Presumably at the request of defendants, given the addressed letter to Dr. Broghammer, claimant was examined by Dr. Abernathey. Following evaluation on January 10, 2014, Dr. Abernathey agreed claimant was not a surgical candidate. However, he noted claimant appeared unwell and recommended work up of her complaints by a primary care provider. He indicated it was possible claimant's symptoms were related to a personal health condition. That same date, Dr. Abernathey also expressed agreement with the findings of Dr. Broghammer's December 20, 2013 report.

Thereafter, claimant received treatment with primary care provider, Mr. Hennings. It appears the majority of claimant's treatment focused upon pain management matters, as opposed to work-up of other potential etiologies for claimant's pain. In January 2015, Mr. Hennings noted awareness of claimant's prior back problems and opined the work injury of August 2, 2013 materially aggravated claimant's low back condition. He also opined the work injury was a substantial contributing factor in claimant's bilateral lower extremity symptoms and incontinence.

Claimant was then seen by Dr. Sassman, who opined the work injury was directly and causally related to claimant's low back pain, radiculopathy and the abnormalities viewed on MRI. Dr. Broghammer subsequently reviewed Dr. Sassman's report and reiterated his original opinion that claimant's ongoing subjective symptoms were not causally related to the work injury. He critiqued Dr. Sassman's opinions as not based in science.

A number of opinions were subsequently solicited by counsel for each party. On February 10, 2016, Dr. Beck opined claimant's subjective complaints may be causally related to the work injury, but those symptoms were not supported by objective findings. On February 12, 2016, Dr. McMains opined claimant's ongoing symptoms were not causally related to the work injury and she demonstrated no objective findings. On February 18, 2016, Dr. Broghammer opined claimant's ongoing subjective complaints were unexplained by diagnostic studies and those ongoing symptoms were unrelated to the work injury. On February 24, 2016, Dr. Abernathey opined claimant's complaints were consistent with her presentation, but she lacked specific objective findings. On claimant's oral history, Dr. Abernathey opined claimant's complaints were related to the work injury. He subsequently, on March 16, 2016, opined the mechanism of the work injury was consistent with claimant's symptoms. Dr. Abernathey opined if claimant continued to suffer with the same type of symptomatology and there had been no intervening event, those symptoms were more likely than not causally related to the work injury. He further opined it was certainly possible for a patient to suffer symptoms without MRI findings.

As set forth *supra*, I find claimant was a credible witness. At hearing and at deposition, claimant testified consistently with respect to the location and timing of her

symptoms. Her testimony is supported by her recorded statement, as well as the contemporaneous medical records. I find no reason to discredit claimant's testimony or the histories she provided to treating and evaluating physicians.

After review of the entire evidentiary record, I find the opinions of Dr. Abernathey to be entitled to the greatest weight. Dr. McMains and Dr. Broghammer both opined claimant's ongoing symptoms are not work-related, due in significant part to a lack of objective findings. Dr. Abernathey initially expressed agreement with Dr. Broghammer's opinions; however, he also contemporaneously expressed belief claimant was not well and should be further evaluated for other potential causes of claimant's chronic pain. Dr. Abernathey subsequently opined claimant's complaints were consistent with her physical presentation and the reported mechanism of injury was consistent with her symptomatology. Importantly, Dr. Abernathey agreed it was certainly possible for an individual to suffer with such symptoms in the absence of objective MRI findings. Dr. Abernathey further opined that by claimant's history, he believed claimant's complaints were causally related to the work injury. As set forth *supra*, I find claimant was a credible and accurate historian.

Dr. Abernathey is a neurosurgeon; this expertise leads the undersigned to provide great weight to his opinions with respect to symptomatology and objective findings. Dr. Abernathey's opinion is supported by neurosurgeon, Dr. Beck, who opined it was possible claimant's subjective complaints were causally related to the work injury. Mr. Hennings also opined claimant's complaints were work related.

I provide no weight to the opinions of Dr. McMains. Dr. McMains initially opined claimant's objective findings did not support a causal connection to the work injury and attributed claimant's symptoms to a likely vascular insufficiency. Dr. Otoadese's testing subsequently negated this potential diagnosis and Dr. Abernathey opined claimant could demonstrate symptoms in the absence of objective findings. I similarly find Dr. Broghammer's opinions entitled to little weight, as the opinions are premised in significant part upon a lack of objective findings.

I provide little weight to the opinions of Dr. Sassman on the issue of causation, as she opined the work injury was a direct cause of claimant's symptoms and the abnormalities viewed on claimant's MRIs. Neither Dr. Beck nor Dr. Abernathey opined claimant's MRI demonstrated objective findings attributable to the work injury; I find the opinions of neurosurgeons entitled to greater weight in interpreting MRI findings.

Given I provide the greatest weight to the opinions of Dr. Abernathey, as buttressed by the opinions of Dr. Beck and Mr. Hennings, I find claimant has carried her burden of proving a causal connection between her ongoing symptoms and the work injury of August 2, 2013.

As claimant has proven a causal connection between her ongoing symptoms and the work related injury, the period of her entitlement to temporary disability benefits must be determined.

Following the work injury, defendants paid 20 weeks of temporary total disability benefits in reliance upon the opinions of the physicians at AOH. Claimant argues she is entitled to temporary total disability/healing period benefits from January 26, 2014 through April 20, 2015. By this decision, the undersigned found claimant carried her burden of proving a causal connection between the work injury and her ongoing symptoms.

By sections 85.33(1) and 85.34(1), an injured worker is entitled to temporary total disability/healing period benefits until the worker has returned to work, is medically capable of returning to substantially similar employment, or has achieved maximum medical improvement, whichever should occur sooner. In this matter, claimant has not returned to work for defendant-employer or in any other capacity. Due to her ongoing symptomatology, Mr. Hennings restricted claimant from working and there is no evidence claimant was physically capable of returning to substantially similar employment. Therefore, the end of claimant's entitlement to such benefits is the date claimant achieved MMI. Only Dr. Sassman offered an opinion regarding the proper MMI date given claimant's ongoing symptoms, April 20, 2015. While Dr. Sassman recommended further evaluation and treatment, claimant has already undergone pain management and neurosurgical evaluation; it is unlikely either will result in significant improvement in claimant's symptomatology. It is therefore determined claimant is entitled to additional temporary total disability/healing period benefits, from January 26, 2014 through April 20, 2015, the date she achieved MMI.

The next issue for determination is whether the work injury is a cause of permanent disability.

As set forth *supra*, claimant has proven a causal connection between her ongoing symptoms and the work injury of August 2, 2013. With consideration of the ongoing symptoms, Dr. Sassman opined claimant sustained a permanent impairment of 25 percent whole person based upon the range of motion methodology.
Dr. Broghammer critiqued Dr. Sassman's methodology, but did not offer a contrary rating which considered claimant's ongoing symptomatology. Dr. Abernathey did not assign a permanent impairment rating from a neurological and anatomical standpoint. However, Dr. Abernathey acknowledged claimant's symptomatology might require ongoing restrictions and deferred to a provider who more recently examined claimant. Mr. Hennings opined claimant was unable to perform work requiring lifting, bending, twisting or standing, but may be capable of performing sedentary work. Dr. Sassman recommended permanent restrictions including: limiting lifting, pushing, pulling and carrying to 10 pounds rarely; sitting, standing and walking occasionally; changing positions frequently; stairs rarely; no use of ladders or walking on uneven surfaces; and avoidance of vibratory or power tools, as use might exacerbate claimant's symptoms.

Given Dr. Sassman opined claimant sustained permanent functional impairment and both she and Mr. Hennings recommended limitations with respect to claimant's work-related activities, it is determined claimant has proven the work injury of August 2, 2013 is a cause of permanent disability.

The next issues for determination are the extent of claimant's industrial disability and the commencement date for permanent disability benefits. These issues will be considered together.

Under the Iowa Workers' Compensation Act, permanent partial disability is compensated either for a loss or loss of use of a scheduled member under Iowa Code section 85.34(2)(a)-(t) or for loss of earning capacity under section 85.34(2)(u). The parties have stipulated claimant's disability shall be evaluated industrially.

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

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

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

Claimant was 55 years of age on the date of evidentiary hearing. She did not complete high school, but later received her GED. Claimant also successfully completed a computerized office assistant program in the early 1990s, but the skills she learned are likely outdated given technological changes in recent years. Her work history consists largely of unskilled to semi-skilled positions, each involving manual labor. Given claimant's limited education, age and work history, her eligibility for retraining is questionable.

Claimant suffers from ongoing symptoms as a result of the stipulated work related injury. Dr. Sassman is the only provider to opine as to the extent of claimant's permanent impairment as a result of these ongoing symptoms. She opined claimant suffered a permanent impairment of 25 percent whole person. Dr. Sassman also recommended permanent restrictions and Mr. Hennings opined claimant may be capable of job-specific sedentary work, but should avoid certain tasks. As a result of Dr. Sassman's restrictions and claimant's testing results, vocational expert Mr. Jayne opined claimant was precluded from the competitive labor market. He found Dr. Sassman's restrictions alone limited claimant to less than sedentary work.

Claimant has not returned to work, for defendant-employer or in any other capacity. She solicited assistance from Iowa Vocational Rehabilitation Services, but as yet, has been unable to locate a position meeting her physical abilities and aptitudes. Claimant also submitted evidence of a job search; however, that search is limited in nature. Although claimant has sought vocational rehabilitation assistance, I am unconvinced that contacting eight potential employers is reflective of a thorough and motivated job search.

Upon consideration of the above and all other relevant factors of industrial disability, it is determined claimant sustained a 65 percent industrial disability as a result of the stipulated work-related injury of August 2, 2013. Such an award entitles claimant to 325 weeks of permanent partial disability benefits (65 percent x 500 weeks = 325 weeks), commencing on April 21, 2015, at the conclusion of claimant's healing period. The parties stipulated at the time of the work injury, claimant's gross weekly earnings were $435.29, and claimant was married and entitled to 2 exemptions. The proper rate of compensation is therefore, $301.07.

The next issue for consideration is whether defendants are entitled to credit pursuant to Iowa Code section 85.34(4) for benefits paid. The parties stipulated defendants paid 20 weeks of temporary total disability/healing period benefits at the rate of $358.70. The parties further stipulated to a proper rate of compensation of $301.07. Defendants have therefore proven an overpayment in claimant's weekly rate during these weeks.

Claimant argues defendants are not entitled to a credit for the overpayment against benefits due and owing in this file. In support of his contention, claimant cites to the Iowa Supreme Court case of Swiss Colony, Inc. v. Deutmeyer, 789 N.W.2d 129 (Iowa 2010). In Swiss Colony, the Court ruled the plain language of Iowa Code section 85.34(5) directed that the overpayment of *any* weekly benefits is to be credited against a subsequent injury with the same employer.

However, section 85.34(5) is not the controlling statutory section with respect to the overpayment at issue in this claim. Rather, the undersigned finds section 85.34(4) contains the proper remedy for determining defendants' credit. Iowa Code section 85.34(4) states:

> 4. *Credits for excess payments.* If an employee is paid weekly compensation benefits for temporary total disability under section 85.33, subsection 1, for a healing period under section 85.34, subsection 1, or for temporary partial disability under section 85.33, subsection 2, in excess of that required by this chapter and chapters 85A, 85B, and 86, the excess shall be credited against the liability of the employer for permanent partial disability under section 85.34, subsection 2, provided that the employer or the employer's representative has acted in good faith in determining and notifying an employee when the temporary total disability, healing period, or temporary partial disability benefits are terminated.

Section 85.34(4) is directly on point to the overpayment at issue in this claim. Defendants overpaid claimant's temporary total disability/healing period benefits at a rate over $50.00 higher per week than the rate stipulated to by the parties. As defendants overpaid due to a higher initial computation of rate, defendants are entitled to a credit for overpayment of those temporary disability benefits against the current award of permanent partial disability benefits. Iowa Code section 85.34(4); See McBride v. Casey's Marketing Co., File No. 5037617 (Remand February 9, 2015); See also Love v. Agrizone, Inc., File No. 5048328 (Arb. January 26, 2016); Mollett v. W.N. Morehouse Truck Line, File No. 5048745 (Rehearing April 13, 2016).

This determination is consistent with the case of McBride v. Casey's Marketing Co., File No. 5037617 (Remand February 9, 2015). In McBride, the presiding deputy found defendants were only entitled to a credit for an overpayment of healing period benefits against payments made for future work injuries claimant sustained with the same employer. On appeal, the former workers' compensation commissioner applied the Swiss Colony case and denied defendants' credit argument. Defendants filed a petition for judicial review and the district court judge authored a ruling reversing the commissioner's decision with respect to this issue, concluding section 85.34(5) and the Swiss Colony case did not apply to the overpayment of temporary total disability. Rather, the judge ruled section 85.34(4) applied and remanded the case to the commissioner to apply section 85.34. On remand, the acting workers' compensation commissioner made the following determination:

> In light of the order of Judge Blaine, it is the determination of this acting workers' compensation commissioner; defendants shall take credit against any permanent partial disability benefits for all overpayments defendants made to claimant in the form of healing period benefits. Such a remedy for the credit is provided by Iowa Code section 85.34(4) which specifically addresses healing period benefits. To hold otherwise, would render Iowa Code section 85.34(4) utterly meaningless. Section 85.34(4) is a specific section. It is the section that governs in the present case.

(McBride at page 5)

The undersigned therefore finds defendants are entitled to a credit against permanency benefits ordered in this case in the amount of any overpaid temporary total disability/healing period benefits, in accordance with section 85.34(4) and as applied in McBride. (See also Kreb v. Hometown Restyling, Inc., File No. 5048685 (Arb. August 6, 2015); Rover v. Cambrex Corp., File No. 5046945 (Arb. December 18, 2015).)

The next issue for determination is whether defendants are responsible for medical expenses detailed in Exhibit 12.

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).

By this decision, the undersigned determined claimant proved a causal connection between her ongoing complaints and the work injury of August 2, 2013. Claimant incurred medical expenses in treatment of these ongoing symptoms, as detailed in Exhibit 12. As defendants did not provide care for these conditions and the evidence supports a determination the care sought and charges incurred were reasonable and necessary, these costs are properly borne by defendants. It is therefore determined that defendants are responsible for the expenses claimed in Exhibit 12.

The next issue for determination is whether claimant is entitled to reimbursement for an independent medical examination pursuant to Iowa Code section 85.39.

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 that 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 requests reimbursement of Dr. Sassman's IME in the amount of $3,390.00. Prior to Dr. Sassman's IME, Drs. McMains and Broghammer had each opined claimant sustained no permanent impairment and required no permanent restrictions as a result of the stipulated work injury. These opinions triggered claimant's right to a reimbursable section 85.39 IME.

Dr. Sassman charged a total of $3,390.00 for her IME, itemized as follows: abstract ($850.00); IME report and examination ($1,400.00); and IME hourly rate beyond base ($1,140.00). (Ex. 18, pp. 190, 192) I find nothing inherently unreasonable in Dr. Sassman's charges and no evidence was offered which would indicate Dr. Sassman charged a fee in excess of that which would have been charged by another provider for a comparable exam. Therefore, claimant is entitled to reimbursement for Dr. Sassman's IME in the amount of $3,390.00.

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. November 23, 2010); Muller v. Crouse Transportation, File No. 5026809 (Arb. December 8, 2010). The entire reasonable costs of doctors' and practitioners' reports may be taxed as costs pursuant to 876 IAC 4.33. Caven v. John Deere Dubuque Works, File Nos. 5023051, 5023052 (App. July 21, 2009).

Claimant requests taxation of the costs of: filing fee ($100.00); Dr. Sassman's IME ($3,390.00); Dr. Abernathey's report ($200.00); and the vocational report of Mr. Jayne ($3,022.50). As claimant has proven entitlement to reimbursement of

Dr. Sassman's IME under section 85.39, the expense need not be considered for taxation as a cost. The filing fee and cost of Dr. Abernathey's report are allowable costs and are taxed to defendants.

With respect to taxation of the vocational report of Mr. Jayne, claimant is not permitted to receive reimbursement for the full cost of Mr. Jayne's vocational report as a practitioner's report under rule 4.33. Rather, the Iowa Supreme Court has ruled only the portion of the expense incurred in preparation of the written report can be taxed. Des Moines Area Regional Transit Authority v. Young, 867 N.W.2d 839 (Iowa 2015). Mr. Jayne's fee is not itemized and therefore lacks specificity regarding what portion of the fee is attributable solely to report preparation. Therefore, consistent with the decision of LaGrange v. Nash Finch Co., File No. 5043316 (Appeal July 1, 2015), defendants are taxed with one-third of the portion of fee which includes report preparation. Defendants are taxed with $1,018.39 of Mr. Jayne's vocational fee (33 1/3 percent x $3,022.50 = $1,018.39).

Defendants are taxed with costs in the amount of $1,318.39.

ORDER

THEREFORE, IT IS ORDERED:

The parties are ordered to comply with all stipulations that have been accepted by this agency.

Defendants shall pay unto claimant healing period benefits at the weekly rate of three hundred one and 07/100 dollars ($301.07) for the period of January 26, 2014 through April 20, 2015.

Defendants shall pay unto claimant three hundred twenty-five (325) weeks of permanent partial disability benefits commencing April 21, 2015 at the weekly rate of three hundred one and 07/100 dollars ($301.07).

Defendants shall pay accrued weekly benefits in a lump sum.

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

Defendants shall receive credit for benefits paid as set forth in the decision.

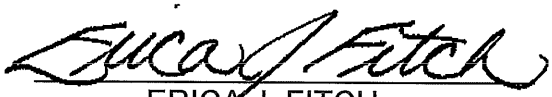
Defendants shall pay claimant's prior medical expenses submitted by claimant at the hearing as set forth in the decision.

Defendants shall reimburse claimant for Dr. Sassman's independent medical examination in the amount of three thousand three hundred ninety and 00/100 dollars ($3,390.00).

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

Costs are taxed to defendants pursuant to 876 IAC 4.33 as set forth in the decision.

Signed and filed this 10th day of August, 2017.



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