BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

SCOTT CLICKNER, Claimant, vs. PRAIRIE FARMS DAIRY, INC., Employer, and INDEMNITY INSURANCE CO. OF NA, Insurance Carrier, Defendants.	:	File No. 20000273.01 ARBITRATION DECISION Head Notes: 1108, 1402.20, 1402.30, 1402.40, 1803.1, 4000

STATEMENT OF THE CASE

Claimant Scott Clickner filed a petition in arbitration seeking worker's compensation benefits against Prairie Farms Dairy, Inc., employer, and Indemnity Insurance Company of North America, insurer, for an alleged work injury date of November 12, 2019. The case came before the undersigned for an arbitration hearing on February 24, 2022, in-person, in Des Moines, Iowa.

The parties filed a hearing report prior to the commencement of the hearing. On the hearing report, the parties entered into numerous stipulations. Those stipulations were accepted and no factual or legal issues relative to the parties' stipulations will be made or discussed. The parties are now bound by their stipulations.

The evidentiary record includes claimant's testimony, Joint Exhibits 1 through 3, Claimant's Exhibits 1 through 11, and Defendants' Exhibits A through G. Prior to hearing, claimant submitted a written objection to Defendants' Exhibit A. The undersigned entered an order overruling the objection on February 15, 2022, and allowing claimant additional time after hearing to obtain rebuttal evidence. As such, the evidentiary record was left open following hearing to allow for claimant to submit an additional exhibit. Claimant submitted Exhibit 2A on March 23, 2022, at which time the evidentiary record was closed. The parties submitted post-hearing briefs on April 15, 2022, and the case was considered fully submitted on that date.

ISSUES[1]

1. Whether claimant sustained an injury to his neck on November 12, 2019;

2. If so, whether claimant has reached maximum medical improvement for his neck;

3. The nature and extent of permanent partial disability claimant has sustained, if any;

4. Payment of claimant's Independent Medical Examination (IME);

5. Alternate medical care;

6. Whether claimant is entitled to penalty benefits pursuant to Iowa Code section 86.13; and

7. Taxation of costs.

FINDINGS OF FACT

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

Claimant's testimony was consistent as compared to the evidentiary record, and his demeanor at the time of hearing gave the undersigned no reason to doubt his veracity. Claimant is found credible.

At the time of hearing, claimant was a 61-year-old person. (Hearing Transcript, p. 11) He is married and has three adult children. Claimant is a high school graduate, and later attended an apprenticeship program to become a journeyman electrician. (Tr., pp. 11-12) In the past, claimant has worked as an over-the-road truck driver, and a maintenance technician for a correctional facility. (Tr., pp. 13-14; Claimant's Exhibit 4, p. 23) Between 2011 and 2017, claimant worked for two separate sand fracking/mining companies. He worked for Pattison Sand from 2011 to 2014, and again for a few months at the end of 2016 until January 2017. He also worked for Hi-Crush, Inc., from 2014 to 2016. (Cl. Ex. 4, p. 23) Claimant testified that he was an electrician and did electrical maintenance at both facilities, which consisted of diagnosing problems, troubleshooting and replacing electrical parts, and working on large motors and large equipment. (Tr., p. 14) He said the two jobs were similar other than Hi-Crush was an above-ground operation, while Pattison was underground. (Tr., p. 15) Claimant did not sustain any work-related injuries at any of his prior jobs. (Tr., pp. 13-16)

[1] The parties included medical benefits as a disputed issue on the hearing report. However, claimant's brief indicates that issue has since been resolved. (Claimant's brief, p. 2)

In February 2017, claimant started working at Prairie Farms Dairy, Inc., defendant employer. (Tr., p. 16) He was hired as a maintenance technician, which he described as involving troubleshooting and electrical work such as replacing motors, but also replacing other parts on machines that might break. The formal job description for claimant's position indicates that employees are required to sit, stand, or walk for prolonged periods of time, and lift, bend, stoop, and push/pull exerting up to 100 pounds of force occasionally, 50 pounds frequently, and 20 pounds constantly in order to move objects. (Cl. Ex. 5, p. 24) Claimant testified that he was required to pass a pre-employment physical when he was hired, which involved strapping weights to his legs and walking up and down stairs, cardio testing, and carrying 40-pound weights across the floor and placing them on shelves overhead. (Tr., pp. 17-18) He was also required to do a lot of squatting, bending, and crawling. (Tr., p. 18) He was able to pass the physical with no accommodations.

At the end of October or beginning of November in 2019, claimant sustained an injury while working. (Tr., p. 23) Claimant described that he was working on a gear drive on a cream cheese vat. (Tr., p. 19) The vat contains an agitator that spins to keep the cream cheese from getting lumps. The gearbox is approximately 150 to 200 pounds and mounted on top of the tank. A motor spins the gearbox, which in turn spins the agitator inside the 1,000-gallon tank. (Tr., p. 20) There is a walkway around the top of the tank, which is probably about 12-feet off the ground, and in order to remove the gearbox claimant had to get on top of the tank, unbolt the gearbox, and pull to lift it off. Claimant described that when the injury happened, he was pulling on the gearbox and felt something in his right shoulder give. He continued working, as they were in the middle of the job, but he "definitely" felt pain. He does not remember if he heard a "pop," but he was in a lot of pain, which he described as an intense burning pain in his shoulder. (Tr., pp. 20-21)

Claimant completed his shift, which consisted of replacing the gearbox they had removed with a new one. After that, his shift was over and he was scheduled for the next seven days off work.[2] (Tr., p. 21) He thought his shoulder would get better during his days off work, so he did not report an injury or seek medical care. (Tr., pp. 21-22) He testified that by the end of the seven days off, his shoulder did feel better, and he did not have the burning pain any longer. (Tr., p. 21) However, after returning to work, his pain slowly returned over a few days. (Tr., p. 23) By November 12, 2019, he was in a lot of pain, and reported the injury to his supervisor. The parties stipulated to that date as the date of injury since that was the day claimant reported it to his employer.

Claimant completed an incident report for his employer. (Cl. Ex. 3, pp. 16-21) His first medical appointment was on December 4, 2019 with Darcy Connelly, PA-C. (Joint Exhibit 1, p. 1) He reported right shoulder pain into his neck, that had been getting worse since the initial work incident had occurred. On physical examination he was noted to have limited range of motion of the right shoulder. (Jt. Ex. 1, p. 2) He was prescribed medications and referred for physical therapy. He was also assigned

[2] Claimant testified that his work schedule at the time was seven days off, eight days on. (Tr., p. 21)

temporary work restrictions of not lifting more than 10 pounds with the right arm. (Jt. Ex. 1, p. 3)

Physical therapy records from December 9, 2019 note that claimant reported pain in the right upper shoulder reaching up into the trapezius muscle and into the back of his neck. (Jt. Ex. 2, p. 11) He continued to report pain through the upper trapezius into the back of his neck over the course of several physical therapy visits. (Jt. Ex. 2, pp. 12-14)

At his follow-up visit with PA-C Connelly on December 26, 2019, claimant continued to have pain, and physical therapy had not made any difference. (Jt. Ex. 1, p. 5) On physical exam, he continued to show decreased range of motion, tenderness, pain, and decreased strength. (Jt. Ex. 1, p. 6) It is also noted that he was "compensating with his trapezius muscle" and was reminded not to lean to the left when trying to raise his right arm. He was referred for an MRI and taken completely off work pending the results. (Jt. Ex. 1, p. 7) He was also told to continue with physical therapy.

At physical therapy, he continued to complain of pain through his upper trapezius into his neck, as well as pain in the anterior aspect of the shoulder. (Jt. Ex. 2, pp. 15-16) By January 6, 2020, he reported the pain up the back of his neck seemed to be the worst, and he was not having any success getting it to calm down. (Jt. Ex. 2, p. 16) The therapist noted he had palpable stiffness and tightness in the pectoralis minor, upper trapezius, and levator scapula. He noted claimant may benefit from dry needling.

Claimant's MRI also took place on January 6, 2020. (Jt. Ex. 2, p. 18) It showed severe tendinosis of the subscapularis, supraspinatus, and infraspinatus tendons, with calcific tendinosis at the infraspinatus and subscapularis tendons; high-grade partial-thickness tears at the supraspinatus, infraspinatus, and subscapularis; moderate acromial joint arthritis with mild subacromial and subdeltoid bursitis; moderate glenohumeral arthritis with thinning and irregularity of articular cartilage and small joint effusion; and possible anterior and posterior labral tears. Following the MRI, claimant continued with physical therapy until he could see an orthopedic surgeon. (Jt. Ex. 2, p. 17)

Claimant saw John Rowe, M.D., on January 15, 2020. (Jt. Ex. 2, p. 20) Dr. Rowe documented the mechanism of injury and claimant's conservative treatment to date. He noted claimant denied prior right shoulder pain. Claimant complained of anterior right shoulder pain, loss of strength and range of motion in the shoulder, and neck and trapezius pain. Claimant also indicated that his pain did not usually radiate below the elbow, but he did have some numbness and tingling in his right hand that he did not recall having prior to the injury. Finally, he described some intermittent medial scapular pain.

After physical examination and review of the MRI, Dr. Rowe's assessment was right shoulder acute partial-thickness tears of the supraspinatus and subscapularis, superimposed on chronic tendinosis, as well as moderate pre-existing degenerative arthritis in the acromioclavicular and glenohumeral joint. (Jt. Ex. 2, p. 24) Dr. Rowe

recommended surgical intervention. With respect to causation, Dr. Rowe opined that claimant's right shoulder injury and need for medical care arose out of and in the course of his usual and customary work, and that claimant's pre-existing arthritis did not previously limit claimant's ability to work. (Jt. Ex. 2, pp. 24-25)

Claimant had surgery on February 6, 2020. (Jt. Ex. 2, p. 26) Dr. Rowe performed a right shoulder arthroscopy with debridement of the glenohumeral joint and biceps tenotomy, coracoid and subacromial decompression, and an open distal clavicle excision. Following surgery, claimant experienced nonspecific chest pressure and dyspnea, and was admitted for observation and evaluation. (Jt. Ex. 2, pp. 28-34) He was discharged the following day, and his postoperative dyspnea was most probably related to the right interscalene block he received, which can block the phrenic nerve and cause paralysis of the hemidiaphragm. (Jt. Ex. 2, p. 37)

Claimant was seen for a physical therapy evaluation on February 10, 2020. (Jt. Ex. 2, p. 38) He reported continued pain in his upper trapezius and neck, as well as some numbness and tingling in his right thumb and fingers and tingling along the back of his arm and into his elbow. Claimant continued with physical therapy. (Jt. Ex. 2, pp. 39-43) He saw Dr. Rowe for a follow-up examination on March 11, 2020. (Jt. Ex. 2, p. 44) Claimant reported he was making progress with physical therapy with diminished pain, improving strength, and very slowly improving range of motion. After physical examination, Dr. Rowe noted that claimant was slowly improving after his right shoulder arthroscopy, and recommended continuing physical therapy twice per week for an additional four weeks, emphasizing range of motion as opposed to strengthening. (Jt. Ex. 2, p. 47)

Following that appointment, claimant was not seen in-person at physical therapy again until April 15, 2020, due to COVID-19 precautions. (Jt. Ex. 2, p. 48) He reported that he continued to work on his home exercise program on his own, however. He continued to have difficulty raising his arm, especially to the side, and had pain to palpation of his rotator cuff and the biceps tendon. The therapist's assessment was that claimant continued to have significant pain, range of motion deficits, and strength deficits of the right shoulder. Claimant was to continue with both his home exercise program and in-person physical therapy. (Jt. Ex. 2, p. 49)

Also on April 15, 2020, Dr. Rowe issued a letter to claimant's employer indicating that claimant could return to work on April 20, 2020, with restrictions of not lifting greater than 40 pounds, and no work at or above shoulder level with the right upper extremity. (Jt. Ex. 2, p. 50) Claimant then followed up with Dr. Rowe on May 20, 2020, and noted persistent pain at the limits of motion in all planes, along with some diminished range of motion. (Jt. Ex. 2, p. 51) He denied pain into the right upper extremity below the elbow or any associated numbness or tingling. After physical examination, Dr. Rowe recommended a corticosteroid injection, in the hopes he could "quiet him down to his previous baseline." (Jt. Ex. 2, p. 55) The injection was performed that day, and while claimant had some "immediate moderation" of his symptoms, it did not provide significant or lasting relief. (Jt. Ex. 2, pp. 56-57)

At his next follow up on June 3, 2020, Dr. Rowe noted claimant continued to demonstrate "significant limitation of active and passive range of motion" in the right shoulder. (Jt. Ex. 2, p. 60) Dr. Rowe discussed his opinion that claimant's persistent symptoms were primarily related to the degenerative arthritis in his right shoulder, which he noted was asymptomatic prior to the work injury. Claimant indicated he was interested in the possibility of a right total shoulder replacement, as he had previously had a successful knee replacement. Dr. Rowe told claimant that he was "a little bit young," and that a total shoulder replacement may not allow him to continue working. However, Dr. Rowe recommended a second opinion regarding further treatment options, and referred claimant to the Mayo Clinic in LaCrosse, Wisconsin. (Jt. Ex. 2, pp. 60-61) He did not place claimant at maximum medical improvement (MMI), because his condition had not returned to his previous baseline.

Claimant saw Charles Nolte, D.O., at the Mayo Clinic on June 18, 2020. (Jt. Ex. 3, p. 67) Claimant reported continued right shoulder pain, as well as numbness into the right hand. He also complained of pain extending from the shoulder up the trapezius to the base of the neck. After reviewing medical records and examining claimant, Dr. Nolte's assessment was adhesive capsulitis right shoulder; status post right shoulder surgery for diagnosis of impingement syndrome, AC joint arthritis, coracoid impingement syndrome, SLAP tear, and partial undersurface rotator cuff supraspinatus tear; and paresthesias multi-dermatomal right upper extremity. (Jt. Ex. 3, p. 70) He opined that claimant's biggest complaints were lack of function and pain in the right shoulder, and believed those were primarily related to adhesive capsulitis after surgery. He also thought the partial undersurface tearing of the rotator cuff could be symptomatic, but it was difficult to assess due to his loss of motion.

Dr. Nolte recommended "aggressive stretching and therapies for up to 1 years (*sic*) time" for claimant's shoulder. (Jt. Ex. 3, p. 70) He stated that once full motion was achieved, there would be a high probability that claimant's pain may resolve, unless it is related to the rotator cuff. If he continued to have pain once full motion was achieved, only then would he consider a rotator cuff repair. With respect to the numbness into claimant's hand, Dr. Nolte recommended an EMG study. In the meantime, he provided claimant with temporary restrictions of not lifting more than five pounds, and no lifting above mid-chest or overhead. (Jt. Ex. 3, p. 72)

On June 23, 2020, Dr. Nolte changed claimant's restrictions. (Jt. Ex. 3, p. 73) He was still restricted from lifting above shoulder height, but he was allowed to lift up to 40 pounds in front of his body as long as the weight was below chest level.

Claimant returned to physical therapy on July 1, 2020, and the therapist noted his ongoing pain and loss of strength and range of motion in his shoulder. (Jt. Ex. 2, p. 62) He also noted claimant had pain through the trapezius into his neck and noted "increased shoulder elevation and the trapezius substitution pattern when performing active range of motion in flexion and abduction." (Jt. Ex. 2, p. 63) He was to continue with physical therapy two to three times per week for the next four weeks. (Jt. Ex. 2, p. 64)

Claimant had an EMG study on July 14, 2020. (Jt. Ex. 3, p. 74) The clinical interpretation showed electrophysiologic evidence of moderate right median neuropathy at the wrist, consistent with a clinical diagnosis of carpal tunnel syndrome. Claimant returned to Dr. Nolte on August 20, 2020. (Jt. Ex. 3, p. 77) He reported ongoing discomfort in the shoulder despite "aggressive" therapies to improve his motion. Dr. Nolte noted that claimant's adhesive capsulitis had improved, although he still lacked some motion. He opined that could be related to glenohumeral arthritis, and determined he would need to "start over" with diagnostic procedures, to include an MR arthrogram, in order to determine the source of claimant's ongoing pain. He concluded that claimant was "clearly not capable of returning to work as he did prior to his injury," and also noted claimant's ongoing carpal tunnel syndrome would need to be corrected in the future. He maintained the 40-pound lifting restriction, and restricted claimant from using his right arm away from his body or above shoulder level until after the MRI. (Jt. Ex. 3, pp. 78-79)

Claimant was to have the MR arthrogram at the Mayo Clinic on September 3, 2020, but it could not be performed due to claustrophobia. (Jt. Ex. 3, p. 80) Instead, he had it done on September 14, 2020 at Crossing Rivers Health. (Jt. Ex. 2, pp. 65-66) Claimant then returned to Dr. Nolte on September 18, 2020, who reviewed the MRI and found glenohumeral arthritis and a partial undersurface tear of the supraspinatus tendon of approximately 40 percent. (Jt. Ex. 3, p. 82) He did not see anything that required surgical management, and recommended a glenohumeral injection for both diagnostic and therapeutic reasons. (Jt. Ex. 3, p. 83) The injection was performed that day, and Dr. Nolte noted that claimant's arc of motion did not improve as expected. (Jt. Ex. 3, pp. 81-83) He received a small amount of pain relief, but no significant improvement. (Jt. Ex. 3, p. 83) As such, Dr. Nolte recommended continued arc of motion exercises and work restrictions, and did not recommend shoulder arthroplasty. He referred claimant to an occupational health specialist for continued treatment.

Claimant saw Brian Withers, D.O., in occupational medicine on September 23, 2020. (Jt. Ex. 3, p. 85) Dr. Withers noted claimant's complaint of right shoulder pain with limited range of motion. He said that claimant reported no real pain in his shoulder at rest, but ongoing difficulty with range of motion, and increased pain symptoms when he reaches the extremes of range of motion. He also reported difficulty with heavy lifting, reaching away from the body, over shoulder height, and behind his back. After physical examination, Dr. Withers recommended a course of work hardening, and continuing with his work restrictions in the meantime. (Jt. Ex. 3, p. 86)

Claimant returned to Dr. Withers on December 2, 2020, after completing his course of work hardening. (Jt. Ex. 3, p. 87) At that time, he reported his shoulder had mildly improved, but overall was about the same. He also reported "a fair amount of discomfort within the trapezius, and that seems to be what has been limiting a lot of his overhead work . . ." While he continued to have limited range of motion in his shoulder, his biggest complaint was the muscle spasms and pain within the trapezius muscle. On physical examination, Dr. Withers noted tenderness and muscle spasms palpated on

the right side of the trapezius muscle. He also noted ongoing limitations with range of motion and pain in the shoulder.

Dr. Withers' assessment was adhesive capsulitis shoulder pain, and trapezius muscle pain and spasm. (Jt. Ex. 3, p. 88) He assigned claimant restrictions of lifting up to 50 pounds, no heavy lifting over shoulder height, and keeping his work "relatively close and light." He referred claimant to physical medicine and rehabilitation as he thought claimant might benefit from trigger point injections into the right trapezius. Other than that, he did not think there was any additional treatment for him with respect to his shoulder.

Claimant had trigger point injections on January 14, 2021. (Jt. Ex. 3, pp. 89-90) He followed up with Dr. Withers on January 28, 2021, and reported he had some relief after the injections, but it lasted less than a day and then his symptoms were back to where they were before the injections. (Jt. Ex. 3, p. 91) Dr. Withers noted that claimant denied numbness or tingling in his arms, hands, or fingers, other than sometimes when he was in bed. Dr. Withers thought that seemed to be more related to carpal tunnel. Claimant reported work "has been going fine," and stated his pain was generally at a level 4 out of 10. He described the pain as "acute in the shoulder and most consistently in the trapezius muscle and it does extend up into the neck." On physical examination, claimant continued to demonstrate some limited range of motion and pain in the shoulder, as well as pain in the right trapezius. Dr. Withers determined that claimant could return to work with no specific work restrictions, but recommended he not lift over 50 pounds overhead, and keep his work fairly close to his body as much as possible. (Jt. Ex. 3, p. 92) He also recommended claimant continue to do home exercises and stretches, and use ice or anti-inflammatories as needed.

Using the 5th Edition of the AMA Guides to the Evaluation of Permanent Impairment, Dr. Withers provided an impairment rating of 3 percent of the whole body for claimant's shoulder, based on range of motion deficits. (Jt. Ex. 3, pp. 93-94) With respect to claimant's restrictions, Dr. Withers clarified that he does not recommend anyone lift greater than 50 pounds overheard. (Jt. Ex. 3, p. 95) He then stated that claimant has no work restrictions but the recommendation he gave was "pretty general information."

Claimant was laid off from his employment at Prairie Farms in March of 2021. (Tr., p. 42) He testified that his boss wanted him to return to maintenance, but he was told that job was no longer available, and he was terminated.

Claimant attended an independent medical evaluation (IME) with Sunil Bansal, M.D., M.P.H., on May 21, 2021. (Cl. Ex. 1, p. 1) Dr. Bansal's report is dated September 2, 2021. (Cl. Ex. 1, p. 14) Dr. Bansal reviewed the medical records and interviewed claimant. (Cl. Ex. 1, pp. 1-9) Under "subjective," Dr. Bansal stated that claimant reported injuries to his neck and right shoulder, and that he has had no specific treatment for his neck. (Cl. Ex. 1, p. 9) Dr. Bansal also recorded that claimant has right shoulder pain and "constant pain in the right side of his neck that radiates down into his shoulder blade."

He stated that claimant indicated he cannot lift objects over 20 pounds overhead and cannot reach behind his back.

On physical examination, Dr. Bansal noted tenderness to palpation over the cervical paraspinal musculature, greater on the right. He also noted spasms over the right trapezius. He provided range of motion measurements but did not indicate whether claimant's range of motion was within normal limits. (Cl. Ex. 1, pp. 9-10) With respect to the right shoulder, testing showed some decreased range of motion when compared to the left shoulder. (Cl. Ex. 1, p. 10) Claimant also had tenderness to palpation on the right shoulder, greatest at the acromioclavicular joint. Finally, claimant had a loss of sensory discrimination over the right ring finger.

With respect to claimant's shoulder, Dr. Bansal agreed with Dr. Withers that claimant reached maximum medical improvement (MMI) for the right shoulder injury on January 28, 2021. (Cl. Ex. 1, p. 11) Using the 5th Edition of the AMA Guides, Dr. Bansal assigned a 5 percent upper extremity impairment rating based on range of motion, and an additional 10 percent upper extremity rating related to claimant's distal clavicle resection. Combined, he assigned permanent impairment of 15 percent of the upper extremity, which converts to 9 percent of the body as a whole.

With respect to claimant's neck, Dr. Bansal opined "cervical neck characteristic of discogenic pathology," and he did not believe claimant had reached MMI for his cervical spine condition. (Cl. Ex. 1, p. 12) He further opined that the cervical discogenic pathology was a result of the work incident on November 12, 2019, when claimant was pulling on the heavy part at work. He explained that claimant's "constellation of neck and shoulder blade pain is related to a cervical discogenic problem." (Cl. Ex. 1, p. 13) He went on to state that inflammation from discogenic disease can manifest clinically to the surrounding musculature, including the trapezius, and that muscle extends to the scapular spine, often felt as shoulder pain. While cervical discogenic pain is "conventionally" known to manifest as a pattern of upper extremity pain and numbness radiation, it is also known to manifest as shoulder blade pain. Ultimately, Dr. Bansal recommended an MRI of the cervical spine for further evaluation. Finally, Dr. Bansal recommended work restrictions of no lifting greater than 40 pounds occasionally, 20 pounds frequently, and no lifting greater than 10 pounds overhead. (Cl. Ex. 1, p. 14)

In June of 2021, claimant was hired to work at 3M Manufacturing in Prairie du Chien. (Tr., p. 43) He continued to work there at the time of hearing. He was hired as an electrical technician. (Tr., p. 44) Claimant explained that the machines at 3M run on a program, and when machines malfunction his job is to plug the machine into a computer and diagnose the problem. Smaller repairs can be completed by the electrical technicians, but larger items are repaired by the mechanics. He testified that it is physically an easier job than his job at Prairie Farms, and he does more diagnostic work than actual repairs. He does not have to do any heavy lifting and does very little overhead lifting. (Tr., p. 45) He enjoys working at 3M, and earns the same if not a small amount more than he earned at Prairie Farms. (Tr., pp. 49-50)

Dr. Withers was provided with a copy of Dr. Bansal's IME report, and responded to a letter regarding same authored by defense counsel dated September 29, 2021. (Jt. Ex. 3, pp. 96-97) Dr. Withers stated that after reviewing Dr. Bansal's report, his diagnosis of the shoulder remained the same, "but it is reasonable to add the discogenic pathology/pain to the diagnosis as he [claimant] had a fair amount of pain at the base of the neck and trapezius." (Jt. Ex. 3, p. 96) He further stated that he did not disagree with Dr. Bansal's finding of cervical discogenic pathology, and it is "reasonable that it contributed to Mr. Clickner's limitations and symptoms." (Jt. Ex. 3, p. 97)

Claimant saw James Milani, D.O., CIME, on January 14, 2022, for an IME at defendants' request. (Def. Ex. A) Claimant described his symptoms at that time to Dr. Milani as pain at the "tip of his shoulder," pointing to the distal acromion/deltoid region. (Def. Ex. A, p. 2) He said his pain runs from that area of his shoulder over the trapezius muscle up to the area behind the right ear. Dr. Milani noted that in differentiating this pain, the pain originated in the shoulder and radiated to the neck, not vice versa. He also noted that he occasionally has pain down the arm to the elbow, originating in the shoulder. However, that pain does not occur often, only when the shoulder is very painful.

Dr. Milani noted that claimant had been working at 3M since June of 2021, in a job that does not require as much lifting or manual activity. Claimant stated that he did not have any specific work restrictions, but that he was not lifting anything over 50 pounds at work due to "general workplace restrictions." (Def. Ex. A, p. 2)

Dr. Milani reviewed medical records and examined claimant. (Def. Ex. A, pp. 3-6) On physical examination, he noted that claimant had tenderness in the posterior cervical muscles, right greater than left, and pain into the right trapezius muscle. (Def. Ex. A, p. 5) Claimant's cervical range of motion was symmetrical, but he had some general decreased range of motion with side bending and rotation, most consistent with the degenerative disc/joint disease seen on imaging. He was able to perform range of motion without significant pain and no radicular symptoms. With respect to his right shoulder, claimant had tenderness to palpation along the lateral aspect of the acromion, as well as tenderness in the infraspinatus region of the scapula, the supraspinatus region, and in the trapezius muscle. Palpation of the AC joint was "quite tender" and reproduced some of his pain. Passive range of motion caused increased pain in the AC joint area and the subacromial region. (Def. Ex. A, pp. 5-6) Dr. Milani also noted that claimant had rotator cuff weakness with abduction, and the further his elbow gets from his body, the more pain he has in his shoulder and the weaker his shoulder feels. (Def. Ex. A, p. 6)

Dr. Milani agreed that claimant was at MMI. (Def. Ex. A, p. 6) Using the 5th Edition of the AMA Guides, Dr. Milani provided a 5 percent upper extremity impairment rating based on range of motion, which is the same as both Dr. Bansal and Dr. Withers assigned for range of motion deficits. However, Dr. Milani did not agree with Dr. Bansal's additional 10 percent rating based on the distal clavicle resection. (Def. Ex. A, pp. 6-7) Dr. Milani opined that the AMA Guides are unclear with respect to rating the distal clavicle resection, so he went to the "source/authorities" to clarify further.

According to Dr. Milani, Dr. Doug Martin helps "contribute to the AMA Guides," and Dr. Martin "clarified that you do not give a rating for distal clavicle resections when it is performed incidental to rotator cuff surgeries." Rather, there is only a rating for the distal clavicle resection when there is a specific injury to the AC joint, which is "a rare occurrence." (Def. Ex. A, p. 7)

Dr. Milani states that he also communicated with Dr. Mohamed Ranavaya, who is the president of the American Board of Independent Medical Examiners and has taught how to use the Guides for "multiple years." He stated that Dr. Ranavaya discussed ratings for distal clavicle resection with "the primary author of the AMA Guides, fifth edition chapter on upper limb," and the underlying criteria is that the distal clavicle resection has to be "at least 2.5 cm to qualify for the rating in table 16-27, page 506." Based on his independent research, Dr. Milani concluded that claimant's specific right shoulder injury and surgery does not qualify for a rating of the AC joint and does not qualify for table 16-17 for a distal clavicle resection.

With respect to claimant's neck, Dr. Milani first noted that cervical discogenic pathology can cause pain down into the shoulder and scapula region. In claimant's situation, he noted that both the mechanism of injury, as well as the symptoms that developed at the time of the injury are important factors to consider. With respect to the symptoms at the time of injury, Dr. Milani noted that claimant reported shoulder symptoms that would radiate from the shoulder to the neck at times. He stated that with cervical discogenic pathology, however, one would expect pain that radiated from the neck region to the shoulder and even into the arm. He further noted that in claimant's case, specific shoulder diagnoses were found that explained the symptoms, and while claimant did eventually experience numbness and tingling in the upper arm, nerve testing found carpal tunnel, but no findings of cervical radiculopathy. He also noted that claimant's shoulder symptoms got worse after surgery, indicating his continued pain was from the shoulder area, not referred from the neck. (Def. Ex. A, p. 7)

Dr. Milani noted that having shoulder pain and holding the shoulder in a protective posture can cause tightness of the shoulder girdle muscles, leading to tightness and soreness in those muscles. He also noted that carpal tunnel syndrome can also cause referred pain up into the shoulder and neck area. Based on the mechanism of injury, reported symptoms at the time of injury, and timeframe of the reported symptoms, Dr. Milani opined that claimant did not sustain cervical discogenic pathology as a result of the work injury.

Dr. Milani added some additional thoughts to his report. First, he noted that if a cervical MRI is performed, it will not be "normal" and will likely show multilevel degenerative disc disease and spondylosis. (Def. Ex. A, p. 8) However, he opined those findings would not be due to the work injury but due to personal and genetic make-up. He stated that the mechanism of injury will need to be considered again if there is further investigation into the cervical region, as well as specific anatomical findings and clinical symptoms. He also noted that from the mechanism of injury, the symptoms that were first reported and claimant's continued symptoms, the most likely scenario is "the known shoulder pathology causing the symptoms and the possibility of median nerve

compression at the wrist/carpal tunnel." He next noted that the shoulder is a complex joint, and as a unit it involves the clavicle, scapula, humerus, and all the muscles involved in the rotator cuff and shoulder girdle.

Dr. Milani defined the muscles making up the shoulder girdle as: "Trapezius muscle including the upper, middle, and lower portions; levator scapulae; rhomboid major; rhomboid minor; stratus anterior; deltoid; pectoralis major; and pectoralis minor."

Dr. Milani further explained that the muscles of the shoulder girdle help stabilize and strengthen the shoulder as a whole, working together with the scapula and allowing it to tilt and rotate. (Def. Ex. A, p. 8) This allows more motion than what the "ball and socket" of the glenohumeral joint provides, which means if the glenohumeral joint range of motion is impaired, as in claimant's case, there is more strain on the shoulder girdle muscles. Additionally, while the shoulder girdle muscles are considered "proximal to the glenohumeral joint," they are directly related to the shoulder function and have to be attached/anchored to the proximal body in order to make the shoulder function as it does. Therefore, Dr. Milani concluded that even though the muscles involved in the shoulder are proximal to the glenohumeral joint, they are still considered part of the shoulder, and claimant's injury was an injury to the shoulder and no other body part. (Def. Ex. A, p. 8)

Dr. Withers responded to a letter authored by defense counsel dated February 8, 2022. (Def. Ex. B, p. 9) The letter asked Dr. Withers whether he continued to believe no further treatment was necessary, given that he added "discogenic pathology/pain" to his diagnoses. Dr. Withers stated no additional treatment was necessary related to the injury. He was also asked to review Dr. Milani's IME report, and whether he agreed with Dr. Milani's opinion that the cervical discogenic pathology was not caused by the work injury. In response, Dr. Withers stated that he "made a reasonable assumption," but stated he would not be able to correlate any neck pathology for causation purposes.

Claimant's attorney also provided a copy of Dr. Milani's IME report to Dr. Bansal, who issued a supplemental report on March 23, 2022. (Cl. Ex. 2A) Dr. Bansal reviewed the report and disagreed with Dr. Milani's analysis. (Cl. Ex. 2A, p. 15.1) First, Dr. Bansal notes that claimant "clearly has radicular neck pain," and his constellation of symptoms had been noted by multiple providers. He specifically noted Dr. Rowe's note on January 15, 2020, which indicated claimant had complained of trapezius pain, which usually did not radiate below his elbow, and that he also had some numbness and tingling in his right hand. (Cl. Ex. 2A, p. 15.2) Dr. Rowe also noted intermittent medial scapular pain. Dr. Bansal opined that claimant had not had an MRI to adequately assess his cervical symptoms. He further could not determine what "mechanism" Dr. Milani would consider clinically significant to aggravate cervical discogenic pathology, and pointed out that claimant was pulling on a "several hundred-pound tank" on the date of injury.

Dr. Bansal noted that the American Academy of Orthopedic Surgeons lists repetitive activities that strain the spine as a risk factor for disc herniations, including jobs that require constant lifting, pulling, bending, or twisting. He also cited to a study that states disc pressure is increased 100 to 400 percent in the forward flexed spine

position, which greatly increases the likelihood of disc bulging and annular tearing. (Cl. Ex. 2A, p. 15.2; citing Nachemson, "AL Disc Pressure Measurements", Spine, 1981 Jan-Feb; 6(1) 93-7).

With respect to the impairment rating, Dr. Bansal notes that the AMA Guides contain no qualifier for the size of a distal clavicle resection in terms of assignment of impairment. He also notes that Dr. Douglas Martin "is neither a contributor or editor for the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition." In conclusion, Dr. Bansal stood by all opinions stated in his IME report. (Cl. Ex. 2A, p. 15.2)

Claimant testified that currently, his right shoulder bothers him all the time. (Tr., p. 36) He described a dull, throbbing pain on a daily basis, ranging between a level 4 and 6 on a scale of 10. (Tr., pp. 36-37) With respect to his neck, he testified that it does not hurt every day; some days it is bad, and others it is okay. (Tr., p. 37) Often it wakes him up at night, and he has to sleep on his stomach with one arm off the bed to try to get comfortable. The more he works and the more he uses his arm, the worse his pain becomes. Before the work injury, claimant enjoyed fishing, hunting, and shooting guns for target practice, but he cannot do those things any longer. (Tr., p. 38) He used to play baseball and football and wrestle around with his grandchildren, which is now difficult due to pain and weakness in his shoulder and neck. (Tr., pp. 38-39) Finally, he is not able to do as much work around the house and yard as before the injury. (Tr., p. 39) He testified that about five or six years prior to the injury, he built an addition onto his home, and that is something he would not be able to do today. (Tr., pp. 39-40) In his current job at 3M, he is able to work within the restrictions Dr. Bansal recommended, and he also abides by those restrictions in his daily life. (Tr., p. 47)

Claimant's testimony regarding his neck pain was that his pain in his right shoulder is generally on the outside of his shoulder. (Tr., p. 53) The pain in his neck radiates "from the muscle above my shoulder through the back of my neck here and into the back of my head." (Tr., p. 53) He testified that his treating doctors told him that his shoulder injury could cause the neck injury. (Tr., p. 55) Many of the medical records that reference claimant's neck or trapezius pain indicate that he reported pain radiating up from his shoulder to the right trapezius muscle, up into his neck. (See Jt. Ex. 1, pp. 1, 6; Jt. Ex. 2, pp. 11-16, 41, 63; Jt. Ex. 3, pp. 67, 87, 91) There is also notation in the records that he was compensating or substituting for his right shoulder with his trapezius muscle, which correlates to how Dr. Milani explained the functioning of the shoulder girdle muscles. (See Jt. Ex. 1, p. 6; Jt. Ex. 2, p. 63; Jt. Ex. 3, p. 77; Def. Ex. A, p. 8)

There is no evidence in the record that claimant sustained a separate, specific injury to his neck. While Dr. Bansal suggests claimant's symptoms are characteristic of cervical discogenic pathology, he appears to have a misunderstanding that claimant has neck pain that radiates down into his shoulder blade. (Cl. Ex. 1, p. 9; Cl. Ex. 2A) Claimant's medical history and testimony indicate the opposite: that the pain originates in his shoulder and radiates up into his trapezius and neck. Further, while Dr. Bansal notes that cervical discogenic pain can manifest as shoulder pain, as Dr. Milani pointed

out, claimant has known shoulder pathology, no findings of cervical radiculopathy, and carpal tunnel syndrome that accounts for the numbness and tingling in his right hand. (Def. Ex. A, p. 7) No physician has definitively diagnosed a neck injury, and Dr. Bansal's suggestion of a cervical disc problem is speculative and based on a flawed understanding of claimant's symptoms. I find Dr. Milani's explanation of claimant's trapezius and neck symptoms to be more convincing and supported by the other medical evidence and claimant's testimony. As such, I find claimant has not carried his burden to prove he sustained an injury to his neck/cervical spine arising out of and in the course of his employment.

With respect to claimant's shoulder, however, I find Dr. Bansal's impairment rating to be more appropriate. Neither Dr. Milani nor Dr. Withers included impairment related to the distal clavicle resection. The distal clavicle resection was a documented part of claimant's shoulder surgery. The AMA Guides include a 10 percent impairment rating based on a distal clavicle resection, with no qualifier related to the size of the resection as Dr. Milani suggested. If the editors wished to include that qualification in the Guides, they could have. As such, I find Dr. Bansal's impairment rating to be more appropriate. Claimant is entitled to 15 percent of the shoulder, or 60 weeks of permanent partial disability (PPD) benefits.

CONCLUSIONS OF LAW

The first issue for consideration is whether claimant sustained an injury to his neck arising out of and in the course of his employment on November 11, 2019. Claimant contends he is entitled to industrial disability, because he sustained injuries to his cervical spine/neck, trapezius muscle, and related to the distal clavicle resection portion of his shoulder surgery. Defendants argue that claimant's injury is limited to a scheduled shoulder injury.

The party who would suffer loss if an issue were not established ordinarily has the burden of proving that issue by a preponderance of the evidence. Iowa R. App. P. 6.904(3)(e). The claimant has the burden of proving by a preponderance of the evidence that the alleged injury actually occurred and that it both arose out of and in the course of the employment. Quaker Oats Co. v. Ciha, 552 N.W.2d 143, 150 (Iowa 1996); Miedema v. Dial Corp., 551 N.W.2d 309, 311 (Iowa 1996). The words "arising out of" refer to the cause or source of the injury. The words "in the course of" refer to the time, place, and circumstances of the injury. 2800 Corp. v. Fernandez, 528 N.W.2d 124, 128 (Iowa 1995). An injury arises out of the employment when a causal relationship exists between the injury and the employment. Miedema, 551 N.W.2d at 311. The injury must be a rational consequence of a hazard connected with the employment and not merely incidental to the employment. Koehler Elec. v. Wills, 608 N.W.2d 1, 3 (Iowa 2000); Miedema, 551 N.W.2d at 311. An injury occurs "in the course of" employment when it happens within a period of employment at a place where the employee reasonably may be when performing employment duties and while the employee is fulfilling those duties or doing an activity incidental to them. Ciha, 552 N.W.2d at 150.

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).

I found that claimant did not prove that he sustained an injury to his neck/cervical spine arising out of and in the course of his employment. There is no evidence in the record that claimant sustained a separate, specific injury to his neck. No physician has definitively diagnosed a neck injury, and Dr. Bansal's suggestion of a cervical disc problem is speculative and based on a flawed understanding of claimant's symptoms, as discussed above. I found Dr. Milani's explanation of claimant's trapezius and neck symptoms to be more convincing and supported by the other medical evidence and claimant's testimony.

Because I found that claimant did not prove he sustained an injury to his neck/cervical spine, the issues of whether claimant has reached MMI for the neck and whether he is entitled to alternate medical care consisting of authorization for an MRI of the cervical spine are moot.

The next issue to consider is whether claimant is entitled to industrial disability based on injury and/or impairment to his trapezius muscle or based on the distal clavicle resection. With respect to the trapezius muscle, claimant argues that the trapezius muscle is not included in the schedule, and as such, claimant's injury should be compensated under Iowa Code section 85.34(2)(v).

It is clear from the medical records and claimant's credible testimony that he has experienced and continues to experience pain in his trapezius muscle. However, pain alone does not extend an injury from a scheduled member to the body as a whole. Lagos v. IBP, Inc., File No 5000782, (Arb., May 17, 2004); Brown v. Schoon Construction, Inc., File No. 913559 (App., December, 1992). Pain that is not

substantiated by clinical findings is not a substitute for impairment. Waller v. Chamberlain Manufacturing, II Iowa Industrial Commissioner Report 419, 425. It is the situs of the impairment resulting from an injury that determines whether it is a scheduled member injury or a body as a whole injury. The anatomical situs of the impairment, not the situs of the injury, governs whether or not an injury is to the body as a whole. Payton v. Sheller-Globe Corp., File No. 895808 (App., April 30, 1993).

In this case, while claimant complains of pain in his trapezius muscle and neck, there is no credible medical evidence to support an injury extending beyond his shoulder. As Dr. Milani noted, claimant had specific shoulder diagnoses that explained his symptoms. He also noted that claimant's shoulder symptoms got worse after surgery, indicating his continued pain was from the shoulder area, not referred from the neck. Finally, Dr. Milani explained that having shoulder pain and holding the shoulder in a protective posture can cause tightness of the shoulder girdle muscles, which include the trapezius, leading to tightness and soreness in those muscles. Additionally, no physician assigned any permanent impairment based on claimant's trapezius pain. The only impairment ratings are for claimant's shoulder related to range of motion deficits and the distal clavicle resection. Therefore, I find claimant has failed to carry his burden to prove that his injury extends beyond the shoulder due to his trapezius pain.

Finally, claimant argues that the distal clavicle resection constitutes an unscheduled injury, based on Rubalcava v. Siouxpreme Egg Prods., Inc., File No. 5066865 (Arb., June 23, 2020). However, since that decision, the Commissioner has provided further analysis of a distal clavicle resection, and determined that any permanent disability resulting from a distal clavicle resection done in order to improve the function of the glenohumeral joint should be compensated as a shoulder under section 85.34(2)(n). Welch v. Seneca Tank, File No. 1647781.01 (App., Oct. 20, 2021). The Commissioner noted the analysis might be different if the claimant had a broken collarbone and the clavicle itself was injured. However, in Welch, as in this case, the claimant's clavicle was altered in close proximity to the glenohumeral joint, as part of a shoulder surgery, in order to improve the function of the joint. As such, I find that claimant's distal clavicle resection does not extend his injury beyond the shoulder.

Claimant did not provide argument in his brief that his shoulder injury alone extends to the body as a whole, but the parts of claimant's shoulder that were injured and subsequently surgically repaired have been found to be part of the shoulder. Chavez v. MS Technology LLC and Westfield Ins. Co., 972 N.W.2d 662 (Iowa 2022). As a result, I conclude claimant failed to prove that any of his injuries or conditions are compensable as unscheduled, whole body injuries under section 85.34(2)(v). Instead, claimant is entitled to compensation for his scheduled member shoulder under section 85.34(2)(n). Claimant's argument regarding his entitlement to industrial disability benefits under section 85.34(2)(v) is therefore moot.

As discussed above, I found Dr. Bansal's impairment rating to be the most accurate, as it was the only rating that included the distal clavicle resection. Neither Dr. Withers nor Dr. Milani assigned an impairment rating based on this table. Dr. Milani explained that he does not believe claimant's specific right shoulder injury and surgery

qualifies for a rating of the AC joint, which he believes to be a prerequisite to assigning a rating for a distal clavicle resection. He further believes the resection has to be at least 2.5 centimeters to qualify for the rating.

The legislature has mandated that determinations of functional impairment under the Iowa Workers' Compensation Act must be made solely by utilizing the AMA Guides adopted for use by the Commissioner. The Commissioner has adopted the Fifth Edition, which includes a 10 percent impairment rating based on a distal clavicle resection, with no qualifier related to the size of the resection as Dr. Milani suggested. If the editors wished to include that qualification in the Guides, they could have. Further, there is no indication in the Guides that a rating for a distal clavicle resection is only indicated when there is a specific injury to the AC joint. Table 16-27 on page 506 of the AMA Guides provides that 10 percent impairment is included for distal clavicle resection. The Guides specifically state that in the presence of decreased motion, motion impairment is derived separately and combined with the appropriate arthroplasty impairment in Table 16-27. Neither Dr. Withers nor Dr. Milani followed the Guides in providing their impairment ratings. Only Dr. Bansal included the rating for the distal clavicle resection, a documented part of claimant's surgery. As such, his opinion regarding permanent impairment of the shoulder is more accurate. Thus, I found claimant has sustained a 15 percent impairment to his right shoulder.

Permanent partial disability compensation for the shoulder shall be paid based on a maximum of 400 weeks. Iowa Code § 85.34(2)(n). Having adopted Dr. Bansal's 15 percent rating, I conclude claimant is entitled to 60 weeks of permanent partial disability benefits.

The next issue to determine is whether claimant is entitled to penalty benefits for failure to voluntarily pay additional permanency benefits upon receipt of Dr. Bansal's IME report. Defendant voluntarily paid 20 weeks of PPD benefits after Dr. Withers issued his impairment rating in February 2021, based on his 5 percent shoulder rating. Defendants argue that they had a reasonable basis to pay that amount, and claimant is not entitled to penalty benefits.

In Christensen v. Snap-on Tools Corp., 554 N.W.2d 254 (Iowa 1996), and Robbennolt v. Snap-on Tools Corp., 555 N.W.2d 229 (Iowa 1996), the supreme court said:

> Based on the plain language of section 86.13, we hold an employee is entitled to penalty benefits if there has been a delay in payment unless the employer proves a reasonable cause or excuse. A reasonable cause or excuse exists if either (1) the delay was necessary for the insurer to investigate the claim or (2) the employer had a reasonable basis to contest the employee's entitlement to benefits. A "reasonable basis" for denial of the claim exists if the claim is "fairly debatable."

Christensen, 554 N.W.2d at 260.

In other words, when an employee's claim for benefits is fairly debatable based on a good faith dispute over the employee's factual or legal entitlement to benefits, an award of penalty benefits is not appropriate under the statute. Whether the issue was fairly debatable turns on whether there was a disputed factual dispute that, if resolved in favor of the employer, would have supported the employer's denial of compensability. Gilbert v. USF Holland, Inc., 637 N.W.2d 194 (Iowa 2001). In this case, the employer reasonably relied on the impairment rating of the authorized treating physician, Dr. Withers, and paid the impairment rating he assigned. While I ultimately concluded Dr. Bansal's rating was more accurate, defendants' conduct in relying on Dr. Withers' rating was not unreasonable. As such, claimant is not entitled to penalty benefits.

Claimant seeks reimbursement for his IME with Dr. Bansal, pursuant to Iowa Code section 85.39. That section 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 made no argument in their brief regarding payment of claimant's IME. I find that Dr. Withers, the employer-retained physician, provided an impairment rating on February 3, 2021. (Jt. Ex. 3, p. 94) Claimant believed that evaluation to be too low, and retained Dr. Bansal to provide a subsequent examination, which took place on May 21, 2021. (Cl. Ex. 1, p. 1) As such, defendants are responsible to reimburse claimant for the entirety of Dr. Bansal's IME fee, totaling $2,951.00. (Cl. Ex. 10, p. 34)

Finally, claimant requests assessment of his costs related to this contested case proceeding. Costs are assessed at the discretion of the agency. Iowa Code section 86.40. In this instance, claimant was partially successful in his claim. Exercising the agency's discretion, I conclude claimant's request for costs should be granted. Defendants shall pay claimant's costs in the amount of $107.88, representing the filing fee and charge for service by certified mail.

ORDER

THEREFORE, IT IS ORDERED:

Defendants shall pay claimant sixty (60) weeks of permanent partial disability benefits, commencing on the stipulated date of January 28, 2021, at the stipulated rate of seven hundred fifty-eight and 47/100 dollars ($758.47).

Defendants shall be entitled to a credit for all permanent partial disability benefits previously paid, including overpayment of the benefit rate, as stipulated in the hearing report.

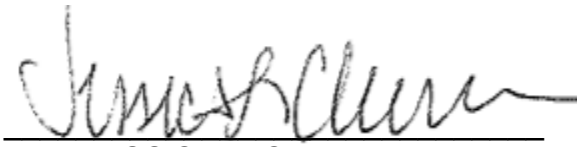
Defendants shall reimburse claimant for Dr. Bansal's IME, pursuant to Iowa Code section 85.39, in the amount of two thousand nine hundred fifty-one dollars and 00/100 ($2,951.00).

Defendants shall reimburse claimant's costs in the amount of one hundred seven and 88/100 dollars ($107.88).

Defendants shall pay accrued weekly benefits in a lump sum together with interest 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.

Defendants shall file subsequent reports of injury (SROI) as required by this agency pursuant to rules 876 IAC 3.1(2) and 876 IAC 11.7.

Signed and filed this _____1st_____ day of July, 2022.



JESSICA L. CLEEREMAN
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served, as follows:

Erin Tucker (via WCES)

Thomas Wolle (via WCES)

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 filed via Workers' Compensation Electronic System (WCES) unless the filing party has been granted permission by the Division of Workers' Compensation to file documents in paper form. If such permission has been granted, the notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 150 Des Moines Street, Des Moines, Iowa 50309-1836. The notice of appeal must be received by the Division of Workers' Compensation 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 legal holiday.