BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

JOSEPH MILLER, Claimant, vs. LENNOX INTERNATIONAL, INC., Employer, and ESIS/ACE AMERICAN INSURANCE, Insurance Carrier, Defendants.	File No. 5044858 APPEAL DECISION Head Note Nos.: 1803, 2700, 2905

FILED
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WORKERS' COMPENSATION

Defendants, Lennox International, Inc., employer, and ESIS/Ace American Insurance, insurance carrier, appeal from a review-reopening decision filed on October 12, 2018.

On March 6, 2019, the Iowa Workers' Compensation Commissioner delegated authority to the undersigned to enter a final agency decision in this matter. Therefore, this appeal decision is entered as final agency action pursuant to Iowa Code section 17A.15(3) and Iowa Code section 86.24.

In October 2013, claimant filed a petition in arbitration seeking workers' compensation benefits. Following an arbitration hearing, the deputy workers' compensation commissioner issued an arbitration decision on February 18, 2015, in which he awarded claimant 10 percent industrial disability as a result of an injury to his cervical spine.

Claimant subsequently filed a review-reopening petition. The hearing on the review-reopening petition was held on November 16, 2017. On October 12, 2018, the deputy workers' compensation commissioner issued a review-reopening decision, in which he found claimant was entitled to review-reopening. Based on the finding of a change of physical condition, the deputy commissioner found claimant's industrial disability increased to 75 percent. The deputy commissioner also ordered defendants to pay the medical costs outlined in Exhibit 6 and the costs associated with claimant's independent medical examination (IME) reports.

Defendants assert on appeal that the deputy commissioner erred in finding claimant sustained a change in condition since the arbitration hearing. Defendants alternatively argue that any change in condition did not warrant an increase in claimant's industrial disability from 10 percent to 75 percent. Defendants further assert the deputy commissioner erred in finding defendants liable for the medical expenses for unauthorized treatment under section 85.27 and in assessing claimant's IME reports as costs under 876 IAC 4.33(6).

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

I performed a de novo review of the evidentiary record before the presiding deputy commissioner. Pursuant to Iowa Code sections 17A.15 and 86.24, those portions of the proposed review-reopening decision filed on October 12, 2018 relating to issues properly raised on intra-agency appeal are affirmed in part with additional findings and modified in part.

FINDINGS OF FACT

The threshold issue to be addressed on appeal is whether claimant sustained a change in condition since the arbitration hearing. With additional fact findings and analysis, as set out below, I affirm the deputy commissioner's finding that claimant sustained a worsening of his physical condition that negatively impacted his earning capacity.

Prior to the arbitration hearing, claimant underwent right-sided foraminotomies at C4-5 and C5-6 on March 7, 2014. (Arbitration Decision, page 5) Claimant had returned to his pre-injury position with defendant-employer as a packer/tugger before the hearing and was working without restrictions in that same position at the time of the hearing "with very modest limitations." (Arb. Dec., p. 7) Claimant was not actively treating for his neck condition on the date of the arbitration hearing, but he was also not pain free. (Arb. Dec., p. 4)

Relying on the opinions of claimant's expert, John Kuhnlein, M.D., the deputy commissioner found that claimant sustained a work-related cumulative injury to his cervical spine. (Arb. Dec., p. 10) Dr. Kuhnlein assigned a 10 percent whole person impairment and lifting restrictions of 50 pounds from floor to waist occasionally and 30 pounds above the shoulder, which the deputy commissioner adopted. (Arb. Dec., p. 6)

On review-reopening, claimant asserted his neck and shoulder pain worsened as a result of changes in his job duties following the arbitration hearing.

Claimant performed four jobs with defendant-employer during the time between the arbitration hearing and his termination in December of 2015: (1) tugger operator (claimant's pre-injury position); (2) copper bender; (3) copper fitter/drill press operator; and (4) brake press operator.

In the tugger operator position, claimant drove a battery operated machine around and delivered parts to his co-workers. Claimant told the Social Security Administration that the heaviest item he had to lift in this position weighed 55 pounds. (Exhibit F, p. 44) At both the arbitration and review-reopening hearing, claimant testified he was able to complete the job duties in this position with hardly any physical symptoms. (Hearing Transcript, p. 15)

When defendant-employer shut the tugger line down, claimant placed himself in the copper group, second shift as a copper bender. (Hrg. Tr., p. 16) As a copper bender, claimant had to lift tubes of copper onto a table and run copper through a machine. (Ex. F, p. 44) This job required claimant to lift 50-pound tubs, and buckets weighing between 30 and 50 pounds. (Ex. F, p. 44; Hrg. Tr., p. 17) If the bins were heavier than 55 pounds, claimant had the option of using a dolly. (Hr. Tr. pp. 62-63) At deposition, claimant testified he did not experience any increase in symptoms while working in the copper group, second shift. (Ex. D, p. 40)

After several months, claimant switched from copper group, second shift to copper group, day shift. (Hrg. Tr., p. 19) The switch resulted in new job duties as a copper fitter/drill press operator. As a drill press operator, claimant utilized a hand drill to drill holes into copper fixtures. (Hrg. Tr., pp. 19-20) As was the case in his previous two roles, claimant was required to lift up to 50 pounds as a copper fitter. (Ex. F, p. 44)

Lastly, in the final weeks of his employment, claimant worked as a brake press operator. (Ex. D, p. 8) As of November 24, 2015, claimant was still going through training for the position. (Joint Exhibit 2, p. 30) In this position, the most claimant had to lift was 20 pounds at waist-level. (Hrg. Tr., p. 64) Despite the lessened lifting requirements, claimant testified that running the brake press increased his symptoms the most. (Ex. D, p. 30)

While claimant was working as a brake press operator, he was operating under restrictions imposed by his psychiatrist, Ilhan Conklu, M.D. (JE 2, p. 23) Claimant was restricted to working 8-hour days with a maximum workweek of 48 hours. (JE 2, p. 23) Despite these restrictions, claimant testified he was "keeping up, pretty much" with production levels. (Hrg. Tr., p. 23)

Claimant acknowledged on a number of occasions that while he was employed with defendant-employer, he was physically and mentally capable of handling the job duties assigned to him. Claimant testified his pain never prevented him from doing his jobs with defendant-employer. (Ex. D, p. 21)

Claimant was terminated in early December of 2015 for having three work rule violations in a twelve-month period. (Ex. D, p. 7; Hrg. Tr., p. 28)

Significantly, between his return to work in April 2014 and his termination in December 2015, claimant did not request or seek medical treatment for complaints of ongoing neck pain. According to the evidentiary record, the only treatment claimant sought between his return to work in April 2014 and his termination in December 2015

was for his mental health. (See JE 2, pp. 15-32) Claimant did not relay any concerns with respect to his neck and/or bilateral shoulders at these mental health evaluations. (See JE 2, pp. 15-32) Claimant first presented for treatment for a worsening of his cervical condition on January 15, 2016, which was roughly a month after he was terminated by defendant-employer. (JE 3, p. 89)

Additionally, there is little evidence in the record that claimant contemporaneously conveyed an increase in symptoms, gradual or otherwise, to co-workers, defendant-employer, or defendant-insurer between April 2014 and December 2015. At hearing, claimant testified he complained to his supervisor, Brian Ewalt, regarding the pain he was experiencing in the workplace. (Hrg. Tr., p. 86) Mr. Ewalt testified he could not remember ever seeing claimant in pain or hearing claimant complain of being in pain at work (Hrg. Tr., pp. 108-109), but even accepting claimant's testimony as true, claimant did not follow up on the comment or request medical treatment thereafter.

Further, the diagnostic images in the evidentiary record do not reveal objective, permanent changes when compared to their earlier studies. X-rays obtained on January 25, 2016, revealed no acute radiographic abnormalities and spondylosis. (JE 2, pp. 41-42) An MRI, dated February 19, 2016, revealed central canal and neural foraminal narrowing and stenosis that was similar in appearance to the prior MRI conducted in August 2013. (JE 2, pp. 43-44) An EMG from August 24, 2016 showed evidence of old, right C5-6 radiculopathy with no active denervation. (JE 1, p. 12)

I acknowledge this evidence, considered alone, tends to support defendants' assertion that claimant did not sustain a change in his physical condition. Significantly, however, the functional capacity evaluations (FCEs) in which claimant participated, claimant's award of Social Security Disability (SSD) benefits, and claimant's need for narcotic pain medication, all of which occurred after his termination, suggest otherwise.

In November of 2016, claimant participated in a residual functional capacity evaluation for purposes of his application for SSD benefits. (Ex. 5, p. 3) It was determined claimant could lift and/or carry up to 20 pounds occasionally and 10 pounds frequently. (Ex. 5, p. 3) Then, on July 7, 2017, claimant participated in a standardized WorkWell FCE that was consistent with the SSD testing. (Ex. 4, p. 1) Based on claimant's functional lifting tests in the WorkWell FCE, it was determined claimant fell into the light physical demand category (lifting up to 20 pounds on an occasional basis). (Ex. 4, p. 3) This was a change compared to Dr. Kuhnlein's earlier restrictions of lifting 30 to 50 pounds, which were adopted in the arbitration decision.

In addition to the change in his lifting capabilities, claimant was deemed disabled by the Social Security Administration after the arbitration hearing. (Ex. 5, p.1) He also acquired a new prescription for narcotic pain medication for increasing neck pain after the arbitration hearing. (JE 3, p. 91) When claimant presented to his personal physician in January 2016, he was prescribed hydrocodone for his burning type pain in the upper neck and radiating pain into his right upper extremity because over-the-counter anti-inflammatories were not providing adequate pain control. (JE 3, pp. 89-90)

Claimant continued to take narcotic pain medication through the date of the review-reopening hearing. (Hrg. Tr., p. 31)

I find the FCEs, considered in tandem with claimant's award of SSD benefits and his prescription for narcotic pain medications, reflect a change in claimant's physical condition since the arbitration hearing.

Both parties obtained expert reports to support their respective positions. The deputy commissioner provided detailed summaries of these report in the review-reopening decision, so the reports of Robert Rondinelli, M.D., William Boulden, M.D., David Segal, M.D., and Dr. Kuhnlein will not be summarized herein. For the reasons set forth by the deputy commissioner, I also find the opinion of Dr. Kuhnlein to be most convincing.

I disagree, however, with the deputy commissioner's reliance on the expert medical opinions of Dr. Segal. There is little doubt Dr. Segal provided a well-written, comprehensive report; however, Dr. Segal's report contains significant errors that are relevant to the formulation of his ultimate conclusion.

Dr. Segal repeatedly references the fact claimant's symptoms returned and progressed from the beginning of 2015 until "the point he had to stop working in October 2015." (Ex. 3, p. 14) This inaccurate belief forms the basis of a number of Dr. Segal's opinions regarding causation. Dr. Segal's factual assumptions and recitations regarding when claimant's alleged symptoms returned and why claimant's employment came to an end are not accurate. Dr. Segal's understanding of the various job titles claimant held throughout 2015 and which duties allegedly aggravated his condition is inconsistent with claimant's own testimony and the evidentiary record as a whole.

As Dr. Segal described it, claimant was relatively symptom free until he switched to the drill press position in early 2015, at which point claimant's symptoms "started" and "progressed" until he had to stop working in October 2015. (Ex. 3, pp. 12, 14) Dr. Segal further opined, "When Mr. Miller started his new job activity on the drill press, it caused tremendous left-sided neck pain and the return of the right-sided arm pain." This statement is at odds with claimant's testimony. At his deposition, claimant testified his symptoms did not become "really noticeable" until he started operating the brake press. (Ex. D, p. 30) Further, claimant testified he first noticed his left shoulder was bothering him, "somewhere after [he] moved in from the copper group to the brake presses." (Ex. D, p. 31) When given the opportunity to discuss the drill press position, claimant downplayed the impact it had on his overall condition, testifying that the repetitive motion of pulling down "kind of bothered" him, but he was "able to cope with it." (Ex. D, p. 41)

Moreover, Dr. Segal's opinion is based upon the mistaken beliefs that: 1) claimant's FMLA leave in October 2015 was attributable to an escalation and progression of claimant's pain and physical symptoms and 2) claimant was completely off work during his FMLA leave. (Ex. 3, pp. 9-10, 12) Claimant continued to work 40 to 48 hours per week during his period of FMLA leave, and the medical records are clear

on the fact claimant's hours were restricted for his mental health condition only. (JE 2, p. 23) Dr. Segal's reliance on this information calls the accuracy of his opinion into question.

For the above reasons, I respectfully disagree with the deputy commissioner regarding Dr. Segal's report. Dr. Segal's opinion is afforded little, if any, weight.

This decision to reject the opinion of Dr. Segal, however, ultimately does not change my finding that claimant sustained a physical change in condition since the arbitration hearing. As discussed above, I agree with Dr. Kuhnlein that transitioning from the medium to heavy physical demand category to the light to moderate physical demand category within a three-year period demonstrates an objective change in functional abilities. (Ex. 1, pp. 6-7) Dr. Kuhnlein also increased claimant's whole body impairment rating from 10 percent to 13 percent. (Ex. 1, p. 8)

Defendants assert Dr. Kuhnlein's opinion should be afforded little to no weight because he did not explain how he arrived at the new impairment rating of 13 percent. Defendants did not appeal the original 10 percent impairment rating that was adopted in the arbitration decision. As such, the 10 percent rating, accurate or not, is the baseline for the review-reopening matter at hand. Further, prior to adjusting his prior impairment rating, Dr. Kuhnlein addressed several factors that led him increase claimant's rating. According to Dr. Kuhnlein, the increase in impairment is attributed to a material change in claimant's medication regimen (over-the-counter versus narcotic pain medication), claimant's employment status, and claimant's decrease in physical abilities as evidenced by two functional capacity evaluations. (See Ex. 1, pp. 6-8) Thus, regardless of the specific percentage increase, the fact remains that Dr. Kuhnlein observed an increase in claimant's functional impairment and adequately explained his observations.

Defendants also assert on appeal any change in claimant's physical condition is based on claimant's subjective statements, and said statements are unreliable due to claimant's credibility. I disagree. While I performed a de novo review, I give considerable deference to findings of fact that are impacted by credibility findings, expressly or impliedly made, by the deputy commissioner who presided at the review-reopening hearing. I find nothing in the evidentiary record to suggest claimant made a deliberate effort to exaggerate or conceal information. Defendants assert several "notable discrepancies" in their appeal brief, none of which are particularly convincing. Further, even if the alleged discrepancies were accurate, they would not give me pause or force me to question claimant's propensity for truthfulness.

Further, claimant's assertion of a significant increase in his pain since the arbitration hearing decision is supported by medical evidence revealing a significant change in the pain medications prescribed since the arbitration proceedings, as discussed above. (JE 3, pp. 89-90)

Relying on Dr. Kuhnlein's opinion, claimant's FCEs, and his need for stronger pain medication, I agree with the deputy commissioner and find that claimant's cervical

spine condition worsened after his arbitration hearing and that the worsening related back to his cumulative injury of December 21, 2012.

The next issue to be addressed on appeal is whether the worsening of claimant's physical condition impacted claimant's overall earning capacity to warrant an increase in compensation, and, if so, the extent of claimant's resulting industrial disability. While I agree with the deputy commissioner's finding that claimant met his burden to prove a worsening of his physical condition, I respectfully disagree with the deputy commissioner's finding that claimant has a 75 percent industrial disability due to the worsening.

In January of 2016, roughly a month after claimant's termination, claimant began reporting issues in his neck to his personal physicians. Although he was presenting with complaints of pain in his neck, claimant was optimistic/perceived he could return to work in a security position. On February 23, 2016, claimant told his psychiatrist, Dr. Conklu, he planned to find a job as a salesman or security officer if his termination was not overturned. (JE 2, p. 46) This perceived ability was never acted upon, however, and claimant never tested the open labor market. Instead, claimant applied for and received SSD benefits. At hearing, claimant testified he did not submit any formal job applications between his termination date and the date of the review-reopening hearing. (Hrg. Tr., p. 40)

Claimant also did not pursue any avenue for retraining or further education. While I acknowledge claimant's prospects for such training are poor given his age, educational background, and alleged memory impairments, I am unconvinced claimant demonstrated motivation to seek alternative employment or participation in the labor market.

The only evidence submitted by claimant to show motivation to return to work is a one-page "employment plan" from Iowa Vocational Rehabilitation Services. (Ex. 7, p. 1) The document is dated October 11, 2017, less than three months from hearing. It notes claimant is interested in working security, the same occupation he told Dr. Conklu he wanted to pursue in January 2016. At hearing, claimant was provided the opportunity to elaborate on the vocational plan. (See Hrg. Tr., p. 52) Despite the plan recommending various services and providing a three-year window in which to assist claimant in his job search efforts, claimant testified the vocational services meeting resulted in "nothing." (Hrg. Tr., p. 53)

I find claimant has not demonstrated motivation to return to work following his termination from defendant-employer in December 2015. Claimant has not demonstrated motivation to re-enter the labor market despite the ability to do so.

Given that there is not a competing vocational opinion, I accept the report of Lana Sellner, M.S., in which she concluded claimant remained employable and physically capable of working in the sedentary to light category of work. (Ex. B, pp. 18, 24-25) After considering the restrictions outlined in the residual capacity evaluation, Dr. Segal's report, and the 2017 WorkWell functional capacity evaluation, Ms. Sellner

opined claimant could perform several jobs that were open and available in his geographical region. (Ex. B, pp. 18-20) At hearing, claimant testified he did not review Ms. Sellner's report. (Hrg. Tr., p. 71)

The only medical evidence that completely restricted claimant from returning to work in any capacity was a pre-written opinion of Steven Scurr, D.O., which was obtained for the purposes of a disability claim through CUNA Mutual Life Insurance. (Ex. 2, p. 1) Dr. Scurr's follow-up opinion, dated August 4, 2017, only provides claimant cannot return to the industrial work with defendant-employer. (Ex. 2, p. 2) Notably, aside from being claimant's long-time personal physician, there is no evidence in the record to bolster Dr. Scurr's medical opinions. Specifically, there is no evidence Dr. Scurr was provided job descriptions or reviewed claimant's FCEs prior to drafting his opinion. For these reasons, I do not find Dr. Scurr's opinions persuasive.

Per Ms. Sellner's report, there is sedentary to light category work available for claimant. Claimant provided insufficient evidence to show he is not employable in these categories.

The vast majority of factors relevant to industrial disability remain constant since the arbitration hearing, with the exception of a slight increase in claimant's whole body impairment rating and more significant lifting restrictions. I respectfully disagree with the deputy commissioner that these changes warrant a 65 percent increase in industrial disability, especially considering that there is still work available to claimant that he is unmotivated to pursue. Instead, considering the situs and severity of claimant's injuries, the permanent impairment ratings, the permanent restrictions, as well as claimant's age, educational background, employment history, and all other factors of industrial disability, I find claimant has proven a 40 percent industrial disability. The deputy commissioner's findings regarding industrial disability are therefore modified.

The next issue to be addressed on appeal is whether defendants are required to pay the unauthorized medical bills contained in Exhibit 6. In the review-reopening decision, the deputy commissioner determined the medical bills outlined in Exhibit 6 were related to claimant's work injury. Without any additional analysis, the deputy commissioner ordered defendants to pay the expenses.

As discussed in my conclusions of law below, the deputy commissioner's determination regarding claimant's medical bills is affirmed in part and modified in part. I make the following additional fact findings regarding claimant's medical treatment after the arbitration decision:

Claimant sought no additional treatment after the arbitration decision until after his termination. At the time he sought treatment with Dr. Scurr in January of 2016, no treatment or specific provider had been authorized by defendants. This was likely due to the fact that claimant had not been actively treating and had not requested any medical treatment from defendants.

It does not appear defendants received any notice or had reason to know that claimant was receiving medical treatment until he filed his petition for review-reopening, which also included a claim for medical benefits, on December 9, 2016. Claimant never requested medical treatment from defendants. (Tr., p. 86) Thus, I find that from the arbitration hearing through December 9, 2016, defendants had no notice or reason to know that claimant wanted, needed, or was receiving medical treatment. I further find that there was no authorized treating physician in place when claimant began receiving treatment in January of 2016, and the care he received had not been authorized by defendants.

After acquiring knowledge of the fact that claimant was likely receiving medical treatment, defendants failed to authorize any medical treatment or provider. Instead, claimant just continued to receive medical treatment from the VA and Dr. Scurr for which he was financially responsible. This treatment was primarily for medication management. Claimant testified that while his symptoms have not necessarily improved through this maintenance care, it has helped "manage" his symptoms. (Tr., p. 35)

CONCLUSIONS OF LAW

The first issue to be decided on appeal is whether claimant sustained a change in condition causally related to the original work injury following the arbitration hearing on November 16, 2014.

In a proceeding to reopen an award for payments or agreement for settlement as provided by section 86.13, inquiry shall be into whether or not the condition of the employee warrants an end to, diminishment of, or increase of compensation so awarded or agreed upon. Iowa Code section 86.14(2).

The party bringing the review-reopening proceeding has the burden of showing that the employee's condition has changed since the original award or settlement was made and that that change in condition relates back to the original injury. Kohlhaas v. Hog Slat, Inc., 777 N.W.2d 387 (Iowa 2009). The change may be either economic or physical. Blacksmith v. All-American, Inc., 290 N.W.2d 348 (Iowa 1980); Henderson v. Iles, 250 Iowa 787, 96 N.W.2d 321 (1959). A mere difference of opinion of experts as to the percentage of disability is not sufficient to justify a different determination on a petition for review-reopening.

To establish a compensable review-reopening claim, claimant must prove by a preponderance of the evidence that the current condition is causally related to the original work injury. Kohlhaas v. Hog Slat, Inc., 777 N.W.2d 387, 392 (Iowa 2009). The principles of res judicata apply, and the agency should not reevaluate facts and circumstances that were known or knowable at the time of the original action. Id.

In this case, the parties presented competing evidence regarding whether claimant sustained a physical change in condition that negatively impacted his earning capacity. Having considered and weighed that competing evidence, I agreed with the

deputy commissioner and found claimant sustained a change in his physical condition that relates back to his original injury. I therefore affirm the deputy commissioner and conclude claimant satisfied his burden to prove he is entitled to review-reopening and an increase of his compensation.

Having concluded claimant established his entitlement to increased compensation through review-reopening, the next issue to be decided on appeal is the extent of the increase in claimant's industrial disability.

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).

There are no weighting guidelines that indicate how each of the factors is to be considered. Neither does a rating of functional impairment directly correlate to a degree of industrial disability to the body as a whole. In other words, there are no formulae which can be applied and then added up to determine the degree of industrial disability. It therefore becomes necessary for the deputy or commissioner to draw upon prior experience as well as general and specialized knowledge to make the finding with regard to degree of industrial disability. See Christensen v. Hagen, Inc., Vol. 1 No. 3 Industrial Commissioner Decisions, 529 (App. March 26, 1985); Peterson v. Truck Haven Cafe, Inc., Vol. 1 No. 3 Industrial Commissioner Decisions, 654 (App. February 28, 1985).

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. Iowa Code section 85.34.

Considering all the above-stated factors relevant to industrial disability, I respectfully disagreed with the deputy commissioner and found claimant sustained a 40 percent industrial disability. I therefore conclude claimant satisfied his burden to prove a 40 percent industrial disability, or a 30 percent increase in his industrial disability since the arbitration hearing. This entitles claimant to an award of an additional 150 weeks of permanent partial disability benefits. Iowa Code section 85.34(2)(u).

The next issue to be decided on appeal is whether defendants are required to pay the unauthorized medical bills contained in Exhibit 6.

Pursuant to Iowa Code section 85.27, defendants have a duty to provide prompt and reasonable medical care for a compensable injury. Assuming defendants fulfil that duty, defendants acquire the right to select the medical providers who provide that care. See Iowa Code § 85.27.

In the instant case, because the deputy commissioner in the arbitration decision found claimant's neck injury to be compensable, defendants' obligation under Iowa Code section 85.27 was triggered, and defendants were ordered to pay all causally related medical expenses incurred through the date of the arbitration hearing.

While defendants' obligation to provide prompt and reasonable medical care under Iowa Code section 85.27 continued beyond the issuance of the arbitration decision, the arbitration decision did not address or identify who would be the authorized treating physician going forward. It also does not appear from the record that defendants identified an authorized treating physician after the arbitration decision. This was likely due to the fact that claimant was not receiving active treatment at the time of the arbitration hearing.

There was no active authorization of a specific provider when claimant began seeking treatment in January of 2016, and claimant did not request authorization for care at any point after his arbitration hearing. Claimant also failed to alert defendants to the fact that he had been receiving treatment until he filed his petition for review-reopening on December 9, 2016. Thus, I found that from the arbitration hearing through December 9, 2016, the care claimant received was unauthorized, and defendants had no notice or reason to know that claimant wanted, needed, or was receiving medical treatment.

After December 9, 2016, however, despite being alerted to the fact that claimant had been or wanted medical treatment via claimant's petition for review-reopening and medical benefits, defendants failed to authorize any care.

Thus, there are essentially two periods of medical expenses at issue that are distinguished by defendants' awareness of claimant's treatment or desire to receive treatment.

As discussed above, Iowa Code section 85.27 bestows both an obligation and a right upon defendants: defendants have a duty to furnish medical care following notice of an injury, and in return defendants acquire the right to control medical care. See Iowa Code § 85.27. That said, Iowa Code section 85.27 also provides protections for claimants that "modify the employer's right to choose medical care in three ways": (1) in an emergency when the employer cannot be reached immediately; (2) when the employee and employer consent to alternative care; and (3) when ordered to provide alternative care by the commissioner after an alternate medical care proceeding. See Bell Bros. Heating and Air Conditioning v. Gwinn, 779 N.W.2d 193, 203-204 (Iowa 2010) (citing Iowa Code § 85.27(4)). "Beyond these circumstances, the employer has the right to select the medical care." Id. at 204.

Claimant is not alleging that any of the care he received after the arbitration hearing was an emergency. Further, defendants never consented to alternate care, nor did claimant at any point seek alternate care through an alternate medical care proceeding. Defendants, therefore, maintained the right to select claimant's care after the arbitration hearing. Id.

However, even when defendants maintain the right to select claimant's care, like in the instant case, "the employer's right to choose the medical care does not prevent the employee from choosing his or her own medical care at his or her own expenses under two circumstances." Id. The first of these circumstances is when defendants deny compensability of the injury. Id.

In this case, while defendants denied claimant had sustained a worsening of his condition entitling him to review-reopening, defendants were not disputing the compensability of the underlying injury—in fact, they could not do so, as the underlying arbitration decision was not appealed and became final agency action. Thus, the first circumstance is not applicable to this case.

"The second circumstance under which an injured employee may select his or her own medical care is when the employee abandons the protections of section 85.27 or otherwise obtains his or her own medical care independent of the statutory scheme." Id. In this scenario, defendants remain responsible for unauthorized care only "upon proof by a preponderance of the evidence that such care was reasonable and beneficial," meaning "it provides a more favorable medical outcome than would likely have been achieved by the care authorized by the employer." Id. at 206.

In this case, none of claimant's care was authorized or chosen by defendants under Iowa Code section 85.27, so it appears the second circumstance is what occurred in this case. However, the facts of this case—both before and after defendants should have recognized claimant was receiving or seeking additional treatment—are slightly different than the facts in Bell Brothers and the Iowa Supreme Court's subsequent decision in Brewer-Strong v. HNI Corporation, 913 N.W.2d 235 (Iowa 2018). In both of those cases, defendants were notified that claimant wanted treatment, and treatment—though rejected by claimant—was authorized.

Here, at least through December 9, 2016, when claimant filed his petition for review-reopening and medical benefits, defendants did not know and had no reason to know that claimant had been receiving medical treatment, and as a result, did not authorize care. Thus, the test set forth in Bell Brothers and reaffirmed in Brewer-Strong must be modified somewhat to account for the fact that defendants' failure to authorize care was based on claimant's own failure to give defendants notice of his desire or need to seek medical treatment. Otherwise, if a claimant's failure to seek authorization or give notice of his desire or need to seek treatment is ignored, claimant's selection of care would always be more favorable than what defendants authorized, which was nothing. In other words, a strict application of the test in this scenario would result in a circumvention of defendants' right to control medical treatment under Iowa Code section 85.27. See Jimmerson v. Ultimate Automotive Service Center, Inc., File No. 5052541 (App. Dec. Feb. 22, 2018)

Instead, I conclude claimant cannot satisfy his burden to prove that the care he received after the arbitration through December 9, 2016 was more favorable than would likely have been achieved by the care authorized by defendants because claimant failed to give defendants the opportunity to authorize care. Defendants cannot be expected to

authorize treatment for an injury or symptoms of which they have no knowledge or notice. See Bell Bros., 779 N.W.2d at 202, 207 (noting the duty of an employer to furnish medical care and the right to control that care attach "following notice of an injury" and "following notice"). The deputy commissioner's conclusion regarding medical treatment received through December 9, 2016 is therefore modified.

When claimant filed his petition for review-reopening and medical benefits on December 9, 2016, however, defendant was alerted to the fact that claimant had been receiving or was seeking medical treatment. The fact that claimant had been selecting his own medical treatment up to that point did not eradicate defendants' duty to offer medical care. "[T]he statute contains no language to indicate the basic duty of an employer to furnish reasonable medical care for compensable injuries is discharged once an employee deprives an employer of its right to control medical care by obtaining alternative care not authorized by the statue." Id. at 205.

Again, in both Bell Brothers and Brewer-Strong, defendants authorized treatment that the claimant rejected. In this case, defendants failed to authorize any treatment, so the Bell Brothers test is not squarely applicable. Still, while the care claimant received after December 9, 2016 was essentially routine medical treatment and medication management, defendants authorized and offered no care. Claimant testified that while his symptoms have not necessarily improved through this maintenance care, it has helped manage his symptoms. Thus, I conclude the maintenance care selected by claimant provided a more favorable medical outcome than no care at all, which is what defendants offered. Thus, I conclude claimant satisfied his burden to prove the unauthorized care he received for his cervical injury after December 9, 2016 was reasonable and beneficial. Defendants are therefore responsible for all treatment related to claimant's neck that was received after December 9, 2016.

The final issue to be decided on appeal is costs.

Defendants challenge the costs awarded by the deputy commissioner pursuant to 876 IAC 4.33(6) for the IME reports of Dr. Kuhnlein and Dr. Segal. I agree with the deputy commissioner's cost assessment for Dr. Kuhnlein's report; however, I respectfully disagree with his assessment of Dr. Segal's report. Because I disagreed with the deputy commissioner's reliance on Dr. Segal's report, I decline to assess it to defendants as a cost in any amount. The deputy commissioner's costs assessment is therefore modified to include $1,558.50 for Dr. Kuhnlein's report and $100.00 for claimant's filing fee, pursuant to 876 IAC 4.33.

ORDER

IT IS THEREFORE ORDERED that the review-reopening decision, filed on October 12, 2018, is affirmed in part with additional fact findings and modified in part.

Defendants shall pay claimant two hundred (200) weeks of permanent partial disability benefits at the weekly rate of five hundred eighty-nine and 03/100 dollars ($589.03) commencing December 9, 2016.

Defendants shall receive credit for all weekly benefits paid to date.

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

Defendants shall pay medical costs as set forth in this decision.

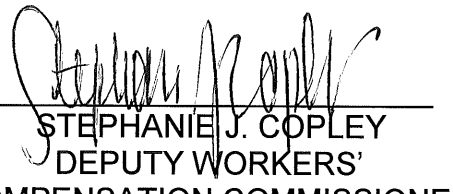
Defendants shall pay the costs of the medical reports of Dr. Kuhnlein in the amount of one thousand five hundred fifty-eight and 50/100 dollars ($1,558.50).

Defendants shall pay claimant's costs of one hundred and 00/100 dollars ($100.00).

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.

The parties shall split the cost of this appeal.

Sign and filed this 5th day of April, 2019.



STEPHANIE J. COPLEY
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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