BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

BRETT SULLIVAN, Claimant, vs. WEST CENTRAL COOPERATIVE, Employer, and FARMLAND MUTUAL INSURANCE COMPANY, Insurance Carrier, Defendants.	:	File No. 5050594 ARBITRATION DECISION Head Note Nos.: 1402.60, 2501, 2700, 2701

STATEMENT OF THE CASE

The claimant, Brett Sullivan, filed a petition for arbitration and seeks workers' compensation benefits from West Central Cooperative, as the employer, and Farmland Mutual Insurance Company, as the insurance carrier. The claimant was represented by Thomas Wertz. The defendants were represented by Jeffrey Lanz.

The matter came on for hearing on May 6, 2020, before deputy workers' compensation commissioner Andrew M. Phillips in Des Moines, Iowa. An order issued on March 13, 2020, by the Iowa Workers' Compensation Commissioner, In the Matter of Coronavirus/COVID-19 Impact on Hearings (Available online at: https://www.iowaworkcomp.gov/order-coronavirus-covid-19 (last viewed May 22, 2020)) amended the hearing assignment order in each case before the Commissioner scheduled for an in-person regular proceeding hearing between March 18, 2020, and June 16, 2020. The amendment makes it so that such hearings will be held by Internet-based video, using CourtCall. The parties appeared electronically, and the hearing proceeded without significant difficulties. The matter was fully submitted on May 15, 2020, after briefing by the parties.

The record in this case consists of Joint Exhibits 1-11, Claimant's Exhibits 1-4, and Defendants' Exhibits A-H. Testimony under oath was also taken from the claimant, Brett Sullivan. Dina Dulaney was appointed the official reporter and custodian of the notes of the proceeding. The exhibits were accepted without objection.

STIPULATIONS

Through the hearing report, as reviewed at the commencement of the hearing, the parties stipulated and/or established the following:

1. There was an employer-employee relationship at the time of the alleged injury.

2. Claimant's injury arose out of, and in the course of, employment, on October 2, 2011.

3. The alleged injury is a cause of temporary disability during a period of recovery, and a cause of permanent disability.

Additionally, there was no dispute as to the entitlement for temporary disability and/or healing period benefits. There was also no dispute as to entitlement to permanent partial disability benefits. The rate of compensation was also not applicable to this proceeding, nor is any credit against any award. Defendants waived their affirmative defenses.

The parties are now bound by their stipulations.

ISSUES

The parties submitted the following issues for determination:

1. The claimant seeks alternate care pursuant to Iowa Code 85.27.

2. The claimant seeks taxation of specific costs paid by the claimant.

FINDINGS OF FACT

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

Brett Sullivan, the claimant, was 40 years old at the time of the hearing. He is currently a resident of Grand Pass, Missouri. Claimant's work history was not discussed at hearing, as it is not relevant to the issues at hand.

On October 2, 2011, the claimant was struck by a train while in the course and scope of his employment. (Testimony). He has no memory of the accident, but reported spending 30-days in the hospital. (Testimony). The claimant reported undergoing significant medical intervention as a result of the accident. (Testimony). Beyond the treatment in the initial aftermath of the work incident, the claimant's medical history is significant for a left knee surgery. (Joint Exhibit 1:1). On November 22, 1999, while the claimant was reportedly in high school, he underwent a left knee examination under anesthesia at the University of Missouri Hospitals and Clinics. (JE 1:1). This surgery included a reconstruction of the left anterior cruciate ligament (ACL) due to a

one-year history of left knee pain and instability. (JE 1:1). During the surgery, it was noted that there was no evidence of any full-thickness tear to the medial meniscus ligament, nor the posterior cruciate ligament. (JE 1:1-2). A partial tear of 50 percent to 60 percent was noted to the anterior cruciate ligament, and it was determined by the operative team that a reconstruction would be needed. (JE 1:2).

On December 14, 2011, the claimant had an MRI of the left knee at St. Anthony Regional Hospital in Carroll, Iowa. (JE 2:4). The MRI results were correlated with x-rays done on October 3, 2011. (JE 2:4). Post-operative changes of an ACL repair were noted. (JE 2:4). The impression from the MRI was an ACL repair with a retear of the neo ligament, a grade II tear of the proximal medial collateral ligament (MCL), and an abnormal appearance of the posterior root of the lateral meniscus, which "could represent an acute meniscal injury but could also be due to prior ACL tear. Therefore, the age is indeterminate." (JE 2:4-5).

Subsequent to the MRI of December 14, 2011, the claimant underwent a revision of an anterior cruciate ligament reconstruction using an Allograft on January 19, 2012, performed by Thomas Dulaney, M.D. (JE 2:6). Historical notes indicate that the claimant had immediate swelling following his work injury, and that he developed feeling of instability and grinding in his knee. (JE 2:6).

On September 17, 2012, Mr. Sullivan was examined by David Hatfield, M.D. at the request of Dr. Goetz. (JE 3:9). During this examination, the claimant reported pain in his back, and noted that he was concerned with swelling into his lower back which included dull and burning pain made worse with standing. (JE 3:9). Dr. Hatfield found Mr. Sullivan to be stable with Romberg testing. (JE 3:10). Finally, Dr. Hatfield noted, "[w]e discussed that one can have symptoms following a trauma without changes for which intervention would be of help." (JE 3:10). An MRI was ordered to investigate further. (JE 3:10).

An unenhanced MRI of the lumbar spine was performed on October 24, 2012, based on claimant's complaints of persistent lower back pain since the work related incident. (JE 2:8). The study was correlated to a CT scan done October 2, 2011, which showed fractures to the transverse process at L3 and L4. (JE 2:8). The fractures were difficult to see on the MRI. (JE 2:8). The lumbar discs were noted to be healthy with no significant degeneration or herniation noted; however, there was minimal bulging of the annulus at L4-5 which was not compressing the neural elements. (JE 2:8).

Dr. Hatfield saw Mr. Sullivan for a repeat examination and review of the MRI results on October 31, 2012. (JE 3:11). The claimant's symptoms were unchanged. (JE 3:11). Dr. Hatfield noted, "I do not believe there is anything to offer surgically. . . . We are both of the opinion that he has reached a point of maximum medical improvement from a back standpoint. . . . I have no restrictions for him from a spine standpoint." (JE 3:11).

Thomas Dulaney, M.D. examined Mr. Sullivan on February 13, 2013, for a recheck of his left knee. (JE 3:13). Overall, it was noted that things were "going OK,"

but it was noted that the claimant was still having mild instability in the left knee including a severe bout of pain several weeks prior. (JE 3:13). No type of recurrent injury or trauma was noted. (JE 3:13). Dr. Dulaney noted upon examination that the proximal tib-fib joint had some instability, but that the fibula fracture was well healed. (JE 3:13). Dr. Dulaney discussed treatment options with the claimant and his wife. (JE 3:13). Dr. Dulaney reported that Mr. Sullivan was "absolutely against the idea of any type of surgery on his left knee. He says he has been wearing his brace daily at work and this has certainly made things tolerable. He would not go through any type of surgery." (JE 3:13). Mild low back pain was also noted during this visit. (JE 3:13).

On September 13, 2013, Mr. Sullivan presented for an independent medical evaluation (IME) and rating with Charles Mooney, M.D. (Defense Exhibit A:1-6). Dr. Mooney recounts the fact that Mr. Sullivan was involved in a motor vehicle accident causing various injuries including: right comminuted fracture involving the acetabulum and L3-L4 fractures of the transverse processes, wedge fracture T8-9 vertebral bodies, fracture of the T8 spinous process, left 9th posterior rib fracture, S5 fracture, distal right clavicle fracture, head trauma with loss of consciousness and amnesia of the event. (Def. Ex. A:1). Dr. Mooney noted that Dr. Hatfield considered Mr. Sullivan to have reached maximum medical improvement on October 31, 2012, with regard to his spinal injuries. (Def. Ex. A:1). Mr. Sullivan complained to Dr. Mooney of "near constant hip and back pain." (Def. Ex. A:2). Dr. Mooney reports wearing an ACL brace continuously through his work day due to occasional breakaway of his left knee, but did not report any dramatic pain complaints to his left knee. (Def. Ex. A:3). Dr. Mooney's examination of the bilateral knees showed full extension and 120-degrees of flexion. (Def. Ex. A:3-4). The left knee demonstrated a 1 to 2+ ACL laxity when compared to the left. (Def. Ex. A:4). Dr. Mooney's assessment of Mr. Sullivan was that he sustained multiple traumas with evidence of thoracic and lumbar fractures, right hip fracture with subsequent total hip arthroplasty, distal right clavicle fracture with essentially normal motion and strength of his shoulder. (Def. Ex. A:4). Dr. Mooney issued impairment ratings based on his examination. (Def. Ex. A:4-6).

The claimant had a repeat lumbar MRI performed on April 3, 2014, at the University of Missouri Health System. (JE 4:32). Michael Aro, M.D., reviewed the MRI and noted no significant issues beyond a minimal to mild lumbar spondylosis with facet arthrosis and mild disc bulging at L4-5. (JE 4:33). Additionally, early subchondral cyst formation was noted at the left facet joint at L4-5. (JE 4:33).

Eden Wheeler, M.D., provided a second opinion upon examination of Mr. Sullivan on September 3, 2014. (JE 5:35). Dr. Wheeler noted that the chief complaints were "[b]ack, legs & knee." (JE 5:35). Dr. Wheeler reviewed the lengthy history of treatment to this point, and indicates that Mr. Sullivan follows up with Dr. Goetz on a yearly basis for his left hip. (JE 5:35). Mr. Sullivan indicated to Dr. Wheeler that Dr. Goetz's office contacted him by telephone and indicated that there was "nothing to do" from a surgical perspective, and recommended pain management, which prompted the visit with Dr. Wheeler for a second opinion. (JE 5:35). During his visit with Dr. Wheeler, the claimant presented with subjective pain complaints to the left

shoulder, low back, left medial thigh, and bilateral lower extremities. (JE 5:36). The claimant also reported "constant left knee pain," but did not disclose any swelling or instability. (JE 5:36). Dr. Wheeler's impression after reviewing the medical records, and examining Mr. Sullivan is: 1. Right central low back pain with differential diagnosis of right SI joint dysfunction and/or facet mediated pain; 2. Leg length discrepancy stemming from right hip surgical interventions from prior fractures; 3. Subjective left knee pain stemming from ACL repairs; and, 4. Left shoulder pain without evaluation or treatment. (JE 5:40-41). Dr. Wheeler spoke to Mr. and Mrs. Sullivan regarding treatment options and noted the following:

1. Consider returning to formal therapy specifically for the lumbar spine with last intervention several months ago. Although Mr. Sullivan reports prior therapy "irritating" his back, I can only see benefit from a core exercise and sacral stabilization program.

2. With therapy, consider TENS unit trial for lumbar complaints with therapy to educate on use.

3. Medication options would include:

    a. Discontinuation of OxyContin without reported benefit for pain.

    b. Trial of cyclobenzaprine for sleep disturbance of 10 mg, one-half to two tablets nightly depending upon response and tolerance.

    c. Trial of Voltaren Gel 4 grams up to 3-4 times daily.

4. If no benefit from the above interventions, then pain management could be considered for right SI joint injections under fluoroscopy, and if no benefit, to consider diagnostic facet block to determine candidacy for facet ablation.

(JE 5:41).

Dr. Wheeler examined Mr. Sullivan for back and leg pain again on November 6, 2014. (JE 5:42). No changes in symptoms were reported, but the claimant continued to report lumbar discomfort. (JE 5:42). Dr. Wheeler's impressions/diagnoses remained unchanged from the previous visit. (JE 5:43). Dr. Wheeler shared with Mr. Sullivan that he could continue to benefit from physical therapy, especially with a new therapist in Sedalia, Missouri. (JE 5:43).

Mr. Sullivan had another follow-up with Dr. Wheeler on December 10, 2014. (JE 5:44). The claimant had completed five sessions of physical therapy, and noted more mobility and looseness, but that he back was "hurting worse." (JE 5:44). A request was made for seven remaining visits of physical therapy. (JE 5:45). Dr. Wheeler's

impression was: 1. Right central low back pain, with lesser right SI joint involvement, and greater facet symptoms with MRI findings of minimal bulging L3-S1 levels and facet arthropathy L4-S1; 2. Continued right medial thigh pain status post arthroplasty; leg length discrepancy status post right hip surgical interventions from prior fractures; and, subjective left knee pain status post ACL repairs. (JE 5:45). Mr. Sullivan is noted to desire to maximize therapy before undertaking invasive treatment. (JE 5:45).

Dr. Wheeler saw Mr. Sullivan again on January 14, 2015, wherein Mr. Sullivan complained of being in considerable pain over the previous few days. (JE 5:46). He described his pain as constant aching, burning, and stabbing in the back, along with aching into the legs. (JE 5:46). Despite the pain, the claimant noted his back pain was improved with therapy. (JE 5:46). Dr. Wheeler spoke with Mr. Sullivan's therapist, who indicated that Mr. Sullivan had attended 12 sessions of physical therapy. (JE 5:47). Dr. Wheeler noted that without focal tenderness, there is the possibility of a radicular component to his back pain, "although his MRI does not necessarily match this with no significant pathology or stenosis identified in the L2-3-4 regions." (JE 5:47). It was noted that the claimant would continue for an additional three to five weeks in physical therapy. (JE 5:47). Dr. Wheeler noted that pain management may still be considered depending on Mr. Sullivan's symptoms, including multiple types of injections. (JE 5:47).

Mr. Sullivan continued his visits to Dr. Wheeler on February 12, 2015, indicating that "[t]he lower part of my back may be better." (JE 5:48). Mr. Sullivan also indicated that the therapy aggravates his complaints of pain. (JE 5:48). He completed 19 physical therapy treatments as of February 11, 2015. (JE 5:48). Pain management options were discussed, including a referral to consider two options for injections. (JE 5:49).

On April 23, 2015, Mr. Sullivan commenced care with Daniel Bruning, M.D., due to low back pain and leg pain. (JE 6:52). The claimant indicated his pain was 6/10. (JE 6:52). Dr. Bruning assessed Mr. Sullivan with lumbar disc displacement, lumbar spondylosis, and lumbar radiculopathy. (JE 6:53). An epidural steroid injection was performed. (JE 6:53).

Dr. Bruning's office saw Mr. Sullivan for a repeat examination on May 8, 2015. (JE 6:55). It was reported that the claimant had 20 percent relief since the last procedure, including two-to-three days where his lower back pain was "tolerable," but that it worsened in the last several days. (JE 6:55). Mr. Sullivan also reported left leg pain. (JE 6:55). Mr. Sullivan also had hyperglycemia after the last injection, and Dr. Bruning stated that the risk for hyperglycemia was too high, thus another steroid injection was not offered. (JE 6:55). A diagnostic facet joint injection was done at L3-5. (JE 6:56).

On May 19, 2015, the claimant again visited Dr. Wheeler. (JE 5:50). He complained that he was feeling worse than he had in several months. (JE 5:50). Mr. Sullivan noted that an epidural steroid injection resulted in him experiencing hyperglycemia. (JE 5:50). Diagnostic facet injections were completed through pain management. (JE 5:50). Dr. Wheeler notes, "I also discussed, however, my continued

opinion that his lumbar MRI does not necessarily correlate with his right inguinal/medial thigh pain. Indeed, only minimal bulging was noted at the right L3-4 disc, with only minimal foraminal stenosis at L4-5 from a mild concentric bulge." (JE 5:51).

Mr. Sullivan was seen again by Devon D. Goetz, M.D. on May 21, 2015. (JE 3:15). The epidural steroid injection done by Dr. Bruning was noted to not be particularly helpful, along with trigger point injections. (JE 3:15). Physical therapy was also noted to increase his pain. (JE 3:15). He complained of a perceived leg length discrepancy, but Dr. Goetz noted nothing significant. (JE 3:15). The claimant visited Dr. Goetz again on March 3, 2016. (JE 3:18).

Dr. Goetz saw Mr. Sullivan on August 9, 2016, for a follow-up. (JE 3:21). Persistent pain in the low back with occasional tingling in the legs and groin was noted. (JE 3:21). This pain is noted to be severe and disabling. (JE 3:21). Mr. Sullivan wanted to consider a second opinion as well as a pain management evaluation. (JE 3:21). He requested a new MRI of his lumbar spine, which Dr. Goetz offered to arrange. (JE 3:21). The MRI of the lumbar spine was performed on September 7, 2016, at Des Moines Orthopaedic Surgeons, P.C., and reviewed by James Choi, M.D. (JE 3:23). The impression from the MRI was that there was no evidence for an acute lumbar spine fracture, and that there was a mild disk bulge at L4-5 and facet hypertrophic changes to bilateral lateral recess narrowing without compression of the traversing L5 nerves. (JE 3:23). A September 14, 2016, nurse's note from Michelle Strait, CMA, indicated that Dr. Goetz recommended another epidural steroid injection. (JE 3:24).

During a follow-up visit with Dr. Goetz on March 6, 2018, Mr. Sullivan noted chronic lower back pain which is intermittently bad. (JE 3:25). He also sought evaluation for his left knee, as he was getting sharp lateral knee pain along with chronic anterior knee pain. (JE 3:25). The 2016 MRI of Mr. Sullivan's lumbar spine showing L4-5 stenosis was also noted. (JE 3:25). A repeat epidural steroid injection was not done, as Mr. Sullivan is a diabetic and was worried about his blood sugars. (JE 3:25). Dr. Goetz notably diagnosed Mr. Sullivan with moderate left knee osteoarthritis post-ACL reconstruction, chronic low back pain with lumbar spinal stenosis. (JE 3:27).

An MRI of the left knee was performed at DMOS Orthopaedic Centers on June 22, 2018. (JE 3:28). This was done based on a referral from Dr. Goetz. (JE 3:28) The impression, as reported by James Choi, M.D. was: mild secondary lateral compartment degenerative changes with suggestion of irregular marginal tear of the posterior horn/root of the lateral meniscus, an intact ACL with a suspected Cyclops lesion, and a presumed myxoid change to the posterior horn of the medial meniscus. (JE 3:28). Dr. Goetz, in a note from June 27, 2018, reports on his review of the MRI and x-rays of the left knee. Dr. Goetz reports that the MRI shows a tear to the posterior horn of the medial meniscus. (JE 3:29). Dr. Goetz reviewed the imaging with Dr. Jason Sullivan who "felt that there is a good chance that he could be helped with arthroscopy," and that Mr. Sullivan would be best served with a referral to Dr. Jason Sullivan, who practices sports medicine. (JE 3:29).

Mr. Sullivan was seen by Central States Medicine beginning on June 22, 2018, for evaluation and management of low back pain. (JE 7:58). There was also a notation of left knee pain in the initial record. (JE 7:58). His MRI results from 2016 were reviewed, and it was noted that his leg paresthesias do not match any dermatome, they are noted to be bilaterally symmetric, and include the entire extremity but spare the perineum. (JE 7:62). An updated MRI was ordered, in addition to bilateral EMGs. (JE 7:62).

On July 17, 2018, Mr. Sullivan admitted himself to Valley Hope for treatment for alcohol dependence. (JE 8:84). It was noted in the initial intake form from July 18, 2018, that Mr. Sullivan drank 24-30 cans of beer per day. (JE 8:84). His examination upon entrance notes a normal physical examination. (JE 8:84-86). He was discharged from Valley Hope on August 3, 2018, with a referral to attend 12 step meetings and a relapse prevention group. (JE 8:87).

Pursuant to a referral from Dr. Goetz, Mr. Sullivan commenced treatment with Dr. Sullivan on August 30, 2018. (JE 3:30). Continued pain in the claimant's left knee was noted since the 2011 revision surgery along with a note that Mr. Sullivan had attempted seven years of conservative management without relief. (JE 3:30). The results of the MRI showing a "possible lateral meniscus tear" were also noted by Dr. Sullivan. (JE 3:30). Dr. Sullivan discussed with the claimant that if his symptoms were stemming from the lateral meniscus, that an arthroscopic surgery would provide a benefit. (JE 3:30). The claimant indicated his agreement with Dr. Sullivan that he would like to proceed with the surgery. (JE 3:30).

Dr. Ledet referred Mr. Sullivan for an MRI on August 30, 2018, at Iowa Diagnostic Imaging, Ankeny North. (JE 9:89). The MRI of the lumbar spine was noted to show no lumbar disc herniation, no spinal canal stenosis, nor neural foraminal stenosis. (JE 9:89). The MRI did show "[v]ery subtle 1 mm focus of intrathecal T1 hypersensitivity right L5 spinal canal nonspecific but has a benign appearance representing an incidental finding of uncertain clinical significance." (JE 9:89).

An EMG was performed on September 5, 2018, at Capital Orthopaedics & Sports Medicine in Clive, Iowa. (JE 10:90). Mr. Sullivan reported having tingling in his legs, along with weakness and fatigue and chronic low back pain. (JE 10:90). The findings from the EMG were noted as: "1. Bilateral sural distal latencies slightly prolonged. 2. Bilateral peroneal and Rt. tibial motor distal latencies normal. Motor NCVs slowed in the legs. 3. No membrane instability to bilateral LE muscles screened and associated paraspinals." (JE 10:91). The conducting physician discussed the findings with Mr. Sullivan and his wife indicating "[e]vidence for mild peripheral neuropathy with motor NCV slowing in the legs but not distally and mild slowing of the sensory nerves." (JE 10:91). No evidence of acute lower extremity radiculopathy was noted. (JE 10:91).

Mr. Sullivan visited Christian Ledet, M.D. at Central States Medicine on October 3, 2018. (JE 7:64). Dr. Ledet was an authorized treating physician. (Claimant Exhibit 3:2). He continued to complain of low back pain, buttocks pain, and lower extremity pain. (JE 7:64). The pain remained unchanged from previous examinations.

(JE 7:64). His current problems were noted to be lumbar radiculopathy and sacroiliitis. (JE 7:66). Lumbar and pelvic MRI results were reviewed, which were "reassuring in that there is no evidence of bio-mechanical impingement." (JE 7:67). An EMG/NCV was also reviewed, which showed, "a picture of peripheral neuropathy with slowing of sensory and motor nerves," which suggests injury associated with the traumatic events. (JE 7:67). Medication based treatments were recommended, to include Lyrica, along with injections. (JE 7:67). Dr. Ledet notes, "[u]ltimately, if we fail to treat the symptoms with the membrane stabilizer medications, we will consider trial of implantable technologies to include spinal cord stimulation." (JE 7:67).

On October 9, 2018, Dr. Sullivan signed the equivalent of a check-box letter from defendants' attorney wherein Dr. Sullivan agreed that Dr. Dulaney did not mention new meniscal findings in his January 19, 2012, operative report. (Def. Ex. B:9-10). Dr. Sullivan agreed that "it is most likely that Mr. Sullivan's current knee symptoms, the June 22, 2017, MRI findings (arthritis/degenerative changes and meniscal changes), and the need for any further treatment (including the left knee scope you have recommended) are related to the original ACL injury and repair performed prior to the October 2, 2011, work (train) injury." (Def. Ex. B:9). Based upon Dr. Sullivan's opinions, defendants denied the need for a left knee arthroscopy. (Def. Ex. F:35; Def. Ex. F:37).

Dr. Ledet examined Mr. Sullivan again on October 26, 2018. (JE 7:68). Dr. Ledet noted that spinal cord stimulation therapy was discussed with Mr. Sullivan, including a trial process and permanent implantation. (JE 7:71). Mr. Sullivan was given educational materials from the spinal cord stimulator manufacturer to review. (JE 7:71). Despite these discussions, Dr. Ledet notes, "I continue to recommended [*sic*] that the injured worker pursue medication based treatments at this time." (JE 7:71).

Mr. Sullivan followed-up with Dr. Ledet at Central States Medicine on December 17, 2018. (JE 7:72). The claimant reported continued lower back pain. (JE 7:72). His current problems were noted as chronic pain due to trauma, and radiculopathy of the lumbar region. (JE 7:74). Dr. Ledet notes that Mr. Sullivan is scheduled for "BH evaluation and planning for SCS trial." (JE 7:74). Dr. Ledet notes further,

> Clinical history, physical examination and radiographic studies indicate that the patient may be a candidate for dorsal column stimulation. The patient is experiencing moderate to severe pain that has been refractory to standard medication therapy. The symptoms are predominately neuropathic in origin. . . . The pain cannot be treated by a curative surgical procedure.

(JE 7:74).

Dr. Ledet examined the claimant again on February 12, 2019, wherein Mr. Sullivan again reported low back pain bilaterally into the right thigh and left knee. (JE 7:76). Dr. Ledet noted that the claimant had completed a behavioral health

evaluation and planning for a spinal cord stimulator trial. (JE 7:78). Dr. Ledet discussed scheduling a thoracic MRI for additional examination of the claimant's spine, but indicated that the plan was to proceed with a trial of implantable technologies. (JE 7:78). Mr. Sullivan returned to Dr. Ledet's office on February 12, 2019, for a biopsychosocial evaluation ahead of a spinal cord stimulator trial. (JE 7:80). Mr. Sullivan rated his pain 9 out of 10 for the prior two weeks, and was noted to be interested in a spinal cord stimulator "in hopes of reducing his pain intensity in his low back and lower extremity by 50% or more allowing him to reduce or eliminate prescription and over the counter medications to manage pain, improve his mood, improve his sleep quality, . . . and possibly return to work in some form." (JE 7:80-81). The social worker who is noted in the medical record indicated that Mr. Sullivan may be at risk of medical non-compliance with the spinal cord stimulator due to a history of non-compliance with checking his blood sugar levels as recommended. (JE 7:82). The biopsychosocial examination of the claimant was authorized by the defendants. (Cl. Ex. 3:3).

Based upon Dr. Ledet's referral of February 12, 2019, Mr. Sullivan had an MRI of his thoracic spine at Ray County Memorial Hospital in Richmond, Missouri. (JE 11:92). Vertebral body heights were noted to be maintained on exam, along with a normal cord. (JE 11:92). Minimal thoracic disc disease was observed, including tiny disc osteophytes at T6-7 and T7-8 with no significant narrowing of the central canal. (JE 11:92).

On March 11, 2019, Joseph J. Chen, M.D., performed an IME on Mr. Sullivan at the request of the defendants. (Def. Ex. C:15-25). Dr. Chen performed a thorough, well-documented review of Mr. Sullivan's treatment records from the time of the work accident through the time of the IME. (Def. Ex. C:15-25). At the time of the examination, Mr. Sullivan reported symptoms of tingling and pain from the waist down in both legs anteriorly and posteriorly. (Def. Ex. C:19). Any type of movement of his spine and legs cause his pain to worsen, so he reported he needs to rest to decrease the pain. (Def. Ex. C:19). Largely due to fragmented care without improvements in his conditions, Mr. Sullivan again reported wanting to proceed with a spinal cord stimulator as suggested by Dr. Ledet. (Def. Ex. C:19). Dr. Chen examined Mr. Sullivan's lumbar spine and noted that the alignment was intact with no areas of swelling or deformity. (Def. Ex. C:20). There was diffuse tenderness to light tactile stimulation of the midline lower lumbar spine and paraspinal muscle mass bilaterally along with difficulty with range of motion. (Def. Ex. C:20). Mr. Sullivan also reported being unable to sit comfortably with either leg crossed on top of the other, which Dr. Chen opined reflected significant hip and gluteal inflexibility. (Def. Ex. C:20). Dr. Chen noted, "[t]here is no doubt that Mr. Sullivan sustained severe trauma to multiple areas of his body as a result of his work injury of October 2, 2011." (Def Ex. C:21). Further, Mr. Sullivan reported "a variety of pain symptoms covering areas of his left knee anteriorly and posteriorly . . . ." along with "aching, stabbing pain mainly in all joints . . . ." (Def. Ex. C:21). Dr. Chen indicated that Mr. Sullivan injured his T8 and T9 vertebral bodies, T8 spinous process, and L3 and L4 transverse processes. (Def. Ex. C:22). Dr. Chen further indicated that the fractures healed in the intervening seven years, and that Mr. Sullivan's current back pain was chronic mechanical and myofascial thoracic and low back pain. (Def. Ex.

C:22-23). Dr. Chen noted that Mr. Sullivan's recovery was promising, as he was able to return to work without needing any medical restrictions, until he separated from employment with the defendant nearly two years post-injury. (Def. Ex. C:23). Dr. Chen opined, "[i]t is my medical opinion that a spinal cord stimulator trial is NOT causally related to Mr. Sullivan's work-related back injury. There are many pathways that one can develop chronic back pain even in the absence of trauma that Mr. Sullivan experienced in 2011." (Def. Ex. C:23). (emphasis omitted). Further, Mr. Sullivan's complaints are noted to not follow dermatomal or myotomal distribution that would be improved by use of a spinal cord stimulator. (Def. Ex. C:23). According to Dr. Chen, "a spinal cord stimulator trial is NOT a reasonable and necessary treatment for his work-related back injury." (Def. Ex. C:24). (emphasis omitted). Dr. Chen concluded his report by recommending a non-surgical course of treatment to reduce the pain which Mr. Sullivan experienced. (Def. Ex. C:25).

On May 9, 2019, William Boulden, M.D., of Capital Orthopaedics & Sports Medicine, performed a records review at the request of defendants. (Def. Ex. D:29-30). Dr. Boulden opined that Mr. Sullivan's pain is "chronic mechanical and myofascial thoracic and low back pain with healed fractures that needed no surgical intervention." (Def. Ex. D:30). Further, Mr. Sullivan has degenerative changes in his back, which are not in need of surgical intervention. (Def. Ex. D:29). Dr. Boulden believes that one reason for the claimant's back pain is that the claimant is a smoker. (Def. Ex. D:29). Dr. Boulden notes that he believes Dr. Chen's assessment is "very well written." (Def. Ex. D:29). Dr. Boulden does not believe that the use of a spinal cord stimulator would be causally related, or reasonable and necessary treatment for his work-related back injury. (Def. Ex. D:30). Dr. Boulden concludes with indicating that Mr. Sullivan's neuropathic pain is not related to his back trauma, nor does he believe the literature supports that opinion. (Def. Ex. D:30).

John Kuhnlein, D.O., MPH, FACPM, FACOEM, provided a record review on behalf of the claimant, dated October 5, 2019. (Cl. Ex. 2:3-5). Dr. Kuhnlein disagrees with the opinions of Dr. Sullivan and Dr. Dulaney. (Cl. Ex. 2:4). It's noted that Dr. Sullivan would not have known what Mr. Sullivan's left knee was like prior to the injury, nor how Mr. Sullivan's left knee situation in 2018 was unrelated to the October 2, 2011, work injury. (Cl. Ex. 2:4). Dr. Kuhnlein opined, "[g]iven the changes with the significant injury, it is more likely than not that the left knee complaints are related to the October 2, 2011, significant injury where Mr. Sullivan was struck by a train." (Cl. Ex. 2:5). Regarding Mr. Sullivan's lower back pain, Dr. Kuhnlein notes that the pain is chronic and has been unresponsive to other forms of conservative treatment. (Cl. Ex. 2:5). Dr. Kuhnlein agrees with Dr. Ledet that a trial of a spinal cord stimulator is what is indicated for the chronic low back pain experienced by Mr. Sullivan, as this is the "end of the treatment trial for such chronic pain." (Cl. Ex. 2:5).

Dr. Ledet responded to an October 21, 2019, letter from claimant's attorney wherein several questions were posed. On November 11, 2019, Dr. Ledet sent a response to the claimant's attorney. (Cl. Ex. 1:5-7). Dr. Ledet noted that he has practiced medicine for more than two decades and performs between 30 and 50 spinal

cord stimulator trials and implants every year. (Cl. Ex. 1:5). Dr. Ledet would not implant a spinal cord stimulator unless there was a substantive improvement in Mr. Sullivan's condition based upon the trial period. (Cl. Ex. 1:5). The only way to determine whether a patient is a good candidate for implantation of a spinal cord stimulator is through the process of trial stimulation. (Cl. Ex. 1:5). Dr. Ledet opines that Mr. Sullivan's chronic pain symptoms are causally related to his work injury. (Cl. Ex. 1:5). Dr. Ledet directly contradicts Dr. Chen and differentiates the type of pain experienced by Mr. Sullivan. (Cl. Ex. 1:6). In fact, Dr. Ledet believes that it is precisely because of Mr. Sullivan's poorly differentiated pain that Mr. Sullivan is a good candidate for a trial of a spinal cord stimulator. (Cl. Ex. 1:6).

In a supplemental opinion dated January 18, 2020, Dr. Chen reviewed the opinions of Dr. Boulden and Dr. Ledet. (Def. Ex. C:26-28). Interestingly, Dr. Chen opens his supplemental opinion by stating that his opinions are "not intended to prevent Mr. Sullivan from getting treatment for his pain. I view my subjective advice similar to a posted warning to hikers to choose a different path because those who have been down that trail are aware of significant pitfalls that may unknowingly lead to treacherous outcomes." (Def. Ex. C:28). Dr. Chen again recommended that the claimant start a general flexibility exercise program, along with simple and consistent walking or swimming. (Def. Ex. C:27).

A supplemental record review was completed by Dr. Boulden, dated January 20, 2020. (Def. Ex. D:31-32). Dr. Boulden reviewed a letter drafted by Dr. Ledet. Dr. Boulden agrees with Dr. Ledet that a spinal cord stimulator requires a trial, but disagrees that Mr. Sullivan would be a good candidate for a spinal cord stimulator trial. (Def. Ex. D:31). Dr. Boulden confirms again that Mr. Sullivan's neurotropic pain is not related to the work accident. (Def. Ex. D:31). Dr. Boulden concludes by stating "[f]inally, I would state that there would be a significant chance that the spinal cord stimulator would not help his back pain at all. I think it is primarily indicated for neurotropic pain issues, but once again, I do not see the correlation between his accident and that." (Def. Ex. D:32).

Dr. Wheeler signed the equivalent of a check-box letter from defendants' attorney wherein she noted she did not recommend a spinal cord stimulator. (Def. Ex. E:33). Based upon Dr. Wheeler's treatment, she agreed with Dr. Chen's opinions, nor would she recommend a spinal cord stimulator for Mr. Sullivan. (Def. Ex. E:33). Dr. Wheeler agreed that a spinal cord stimulator would not be reasonable and necessary medical treatment for the work injury. (Def. Ex. E:34). Since Mr. Sullivan did not follow-up with Dr. Wheeler for subsequent treatment, she questioned whether he would be compliant with ongoing spinal cord stimulator treatment. (Def. Ex. E:34).

On or around March 6, 2020, Dr. Goetz signed the equivalent of a check-box letter from defendants' attorney wherein Dr. Goetz agrees he reviewed multiple MRI's performed on Mr. Sullivan's back and knee. (Def. Ex. B:11-12). Dr. Goetz agreed that he would defer to the October 9, 2018, opinions of Dr. Sullivan, as noted above. (Def. Ex. B:12). With regards to the recommended spinal cord stimulator trial, Dr. Goetz agrees to being aware of the opinions of Dr. Ledet, Dr. Chen, Dr. Boulden, and Dr.

Wheeler. (Def. Ex. B:12). Dr. Goetz agrees that based upon his examinations of the claimant, his review of the MRI findings, and his experience treating patients, it is Dr. Goetz's opinion that the odds of a spinal cord stimulator "working in the long term for Mr. Sullivan are low." (Def. Ex. B:12). Finally, Dr. Goetz indicates that he agrees with the opinions of Dr. Chen, Dr. Boulden and Dr. Wheeler that he would not recommend Mr. Sullivan having a spinal stimulator. (Def. Ex. B:12).

On or around April 2, 2020, Dr. Dulaney, signed the equivalent of a check-box letter from defendants' attorney wherein he agreed that he examined and treated Mr. Sullivan. (Def. Ex. C:13-14). Dr. Dulaney performed a hip surgery and a revision to a left knee ACL surgery on Mr. Sullivan. (Def. Ex. B:13). Dr. Dulaney reviewed Dr. Sullivan's office notes, and the June of 2018 knee MRI. (Def. Ex. B:13). Dr. Dulaney agrees that the arthritic, degenerative, and meniscal changes as noted on the June 22, 2018, knee MRI were not caused by or substantially aggravated by the October 2, 2011 work injury. (Def. Ex. B:13). Finally, Dr. Dulaney noted that since there was no meniscal tear found during the January 19, 2012, knee surgery, it would be difficult for him to relate the current meniscal findings to the October 2, 2011, work injury. (Def. Ex. B:13).

CONCLUSIONS OF LAW

This case has a lengthy procedural history including arbitration awards, and appeals to Iowa district court and the Iowa Court of Appeals. The question before the undersigned is whether or not alternate care pursuant to Iowa Code 85.27 is appropriate.

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 Rule of Appellate Procedure 6.14(6)(e).

Causation

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 medical causation is "essentially within the domain of expert testimony." Cedar Rapids Cmty. Sch. Dist. v. Pease, 807 N.W.2d 839, 844-45 (Iowa 2011). The commissioner, as the trier of fact, must "weigh the evidence and measure the credibility of witnesses." Id. The trier of fact may accept or reject expert testimony, even if uncontroverted, in whole or in part. Frye, 569 N.W.2d at 156. When considering the weight of an expert opinion, the fact-finder may consider whether the examination occurred shortly after the claimant was injured, the compensation arrangement, the

nature and extent of the examination, the expert's education, experience, training, and practice, and "all other factors which bear upon the weight and value" of the opinion. Rockwell Graphic Sys., Inc. v. Prince, 366 N.W.2d 187, 192 (Iowa 1985). Unrebutted expert medical testimony cannot be summarily rejected. Poula v. Siouxland Wall & Ceiling, Inc., 516 N.W.2d 910 (Iowa App. 1994). Supportive lay testimony may be used to buttress expert testimony, and therefore is also relevant and material to the causation question.

The claimant is seeking further medical treatment to include a left knee surgery and trial of a spinal cord stimulator with the potential for implantation of a spinal cord stimulator. The defendants deny that the spinal cord stimulator trial, potential implantation of a spinal cord stimulator, and the left knee surgery are causally related or reasonable and necessary treatment.

The claimant has a history of sustaining a left knee injury during his time in high school. (Testimony). Mr. Sullivan had left knee surgery, including an ACL reconstruction and repair in November of 1999. (JE 1:1-3). After the work injury of October 2, 2011, the claimant experienced pain in his left knee. In December of 2011, Mr. Sullivan underwent an MRI of the left knee, which showed his prior ACL repair, a tear of the proximal MCL and an abnormal appearance of the posterior root of the lateral meniscus. (JE 2:4-5). In January of 2012, Dr. Dulaney performed a revision of the anterior cruciate ligament reconstruction using an Allograft. (JE 2:6). Dr. Dulaney examined Mr. Sullivan again in February of 2013, noting that there was still mild instability in the left knee, and that the claimant was still experiencing pain. (JE 3:13). Mr. Sullivan indicated to Dr. Dulaney at that time that he was against the idea of any type of surgery on his left knee. (JE 3:13). Dr. Mooney performed an IME in September of 2013 wherein the examination found an ACL laxity in the left knee, and no dramatic pain complaints. (Def Ex. A:3-4). In March of 2018, Dr. Goetz diagnosed Mr. Sullivan with moderate left knee osteoarthritis post-ACL reconstruction. (JE 3:27). A repeat MRI of the left knee was performed in June of 2018 which showed mild secondary lateral compartment degenerative changes with suggestion of irregular marginal tear of the posterior horn/root of the lateral meniscus and a presumed myxoid change to the posterior horn of the medial meniscus. (JE 3:28). This was reviewed with Dr. Sullivan who indicated that Mr. Sullivan's left knee could be helped with an arthroscopic surgery. (JE 3:29-30). Dr. Sullivan revised his opinion and agreed, "it is most likely that Mr. Sullivan's current knee symptoms, the June 22, 2017, MRI findings (arthritis/degenerative changes and meniscal changes), and the need for any further treatment (including the left knee scope you have recommended) are related to the original ACL injury and repair performed prior to the October 2, 2011, work (train) injury." (Def. Ex. B:9). As of March 6, 2020, Dr. Goetz indicated that he defers to the October of 2018 opinion of Dr. Sullivan. (Def. Ex. B:12). Finally, as of April 2, 2020, Dr. Dulaney indicated that the arthritic, degenerative and meniscal changes noted in the June of 2018, MRI were not caused by, or substantially aggravated by, the work injury. (Def. Ex. B:13). He further indicated that he found no meniscal tear during the January of 2012, knee surgery. (Def. Ex. B:13).

The only medical expert who supports the need for a left knee surgery is Dr. Sullivan. Dr. Sullivan later revised his opinion to indicate that Mr. Sullivan's left knee complaints were caused by the 1990's injury and surgery, not the October of 2011 work injury. Dr. Dulaney, who performed the ACL revision surgery on Mr. Sullivan in January of 2012, indicated that there was no meniscal tear seen during the surgery. Dr. Dulaney clarified his opinion that there was no causation for the left knee meniscal tear. Based on the record, there are no physicians, including retained experts, that attribute the left knee injury to the work incident of October 2, 2011. Based upon the opinions of Dr. Sullivan and Dr. Dulaney, I find that the left knee meniscus injuries and resulting surgery were not caused by the October 2, 2011, work incident.

Mr. Sullivan has consistently complained of lower back pain. He testified that he continued to have lower back pain at the time of the hearing. (Testimony). Mr. Sullivan sustained injuries to his back in the October 2, 2011, work incident, including: right comminuted fracture involving the acetabulum and L3-L4 fractures of the transverse processes, wedge fracture T8-9 vertebral bodies, fracture of the T8 spinous process, left 9th posterior rib fracture, and S5 fracture. (Def. Ex. A:1). During a September 2012 visit with Dr. Hatfield, Mr. Sullivan was told that he could experience symptoms following a trauma without changes for which any intervention could help. (JE 3:10). An MRI of the lumbar spine was performed on Mr. Sullivan on October 24, 2012. The MRI showed healthy lumbar discs with no significant degeneration or herniation, but also minimal bulging of the annulus at L4-5. (JE 2:8). These bulges were not compressing the neural elements. (JE 2:8). The MRI results were reviewed by treating physician Dr. Hatfield on October 31, 2012. (JE 3:11). During this visit, Dr. Hatfield noted, "I do not believe there is anything to offer surgically." (JE 3:11).

Mr. Sullivan had a repeat MRI of his lumbar spine on April 3, 2014, which showed, no significant issues beyond a minimal to mild lumbar spondylosis with facet arthrosis and mild disc bulging at L4-5. (JE 4:33). Dr. Wheeler provided a second opinion and commenced treatment of Mr. Sullivan on September 3, 2014. (JE 5:35). Dr. Wheeler recommended Mr. Sullivan return to formal physical therapy, and change his medication. (JE 5:41). If there was no benefit, from continued therapy, then Dr. Wheeler noted pain management might be considered for SI injections, or facet block injections to determine Mr. Sullivan's candidacy for facet ablation. (JE 5:41). In December of 2014, Mr. Sullivan indicated to Dr. Wheeler that he wished to maximize physical therapy before undertaking invasive treatment. (JE 5:45). In January of 2015, Dr. Wheeler noted that pain management may still be considered dependent upon Mr. Sullivan's continued symptoms, including consideration for different types of injections. (JE 5:47). Dr. Wheeler also noted that Mr. Sullivan's MRI did not match his back pain with no significant pathology or stenosis in the L2-4 regions. (JE 5:47). In February of 2015, Mr. Sullivan indicated that the lower part of his back may be improved. (JE 5:48). Pain management options, including injections, were again discussed. (JE 5:49).

Mr. Sullivan then underwent an epidural steroid injection in April of 2015. (JE 6:52). The injections caused Mr. Sullivan's diabetes to flare-up. (JE 5:50). In May of

2015, Dr. Wheeler again noted, "I also discussed, however, my continued opinion that his lumbar MRI does not necessarily correlate with his right inguinal/medial thigh pain. Indeed, only minimal bulging was noted at the right L3-4 disc, with only minimal foraminal stenosis at L4-5 from a mild concentric bulge." (JE 5:51). Another MRI was done in September of 2016, which showed a mild disk bulge at L4-5 and facet hypertrophic changes to the bilateral lateral recess narrowing without compression of the traversing L5 nerves. (JE 3:23). Another epidural steroid injection was recommended by Dr. Goetz. (JE 3:34).

In June of 2018, Mr. Sullivan began seeing Dr. Ledet. During this initial visit, MRI results from 2016 were reviewed, and it was noted that Mr. Sullivan's symptoms do not match any dermatome. (JE 7:62). Dr. Ledet ordered an updated MRI. (JE 7:62). The MRI of the lumbar spine showed "[v]ery subtle 1 mm focus of intrathecal T1 hyperintensity right L5 spinal canal nonspecific but has a benign appearance representing an incidental finding of uncertain clinical significance." (JE 9:89). The EMG showed "a picture of peripheral neuropathy with slowing of sensory and motor nerves," suggesting injury associated with traumatic events. (JE 7:67). Dr. Ledet makes his first mention of a trial of implantable technology should medication not work. (JE 7:67). In October of 2018, Dr. Ledet continued to recommend medication based treatments. (JE 7:71). By February of 2019, Dr. Ledet began planning for a trial of a spinal cord stimulator, including a behavioral health analysis and subsequent MRI, both of which were approved by the defendants. (JE 7:82; JE 11:92; Cl. Ex. 3:3)

At this time, a series of IMEs and the equivalents of check-box letters began. Dr. Chen examined Mr. Sullivan during an IME on March 11, 2019. Dr. Chen is board certified in pain management. Dr. Chen noted, ""[t]here is no doubt that Mr. Sullivan sustained severe trauma to multiple areas of his body as a result of his work injury of October 2, 2011." (Def Ex. C:21). Dr. Chen opined, "[i]t is my medical opinion that a spinal cord stimulator trial is NOT causally related to Mr. Sullivan's work-related back injury. There are many pathways that one can develop chronic back pain even in the absence of trauma that Mr. Sullivan experienced in 2011." (Def. Ex. C:23). (emphasis omitted). Further, Mr. Sullivan's complaints are noted to not follow dermatomal or myotomal distribution that would be improved by use of a spinal cord stimulator. (Def. Ex. C:23). According to Dr. Chen, "a spinal cord stimulator trial is NOT a reasonable and necessary treatment for his work-related back injury." (Def. Ex. C:24). (emphasis omitted). Dr. Chen concluded his report by recommending a non-surgical course of treatment to reduce the pain experienced by Mr. Sullivan. (Def. Ex. C:25).

Dr. Boulden, an orthopedic surgeon, opined that Mr. Sullivan's pain is "chronic mechanical and myofascial thoracic and low back pain with healed fractures that needed no surgical intervention." (Def. Ex. D:30). Dr. Boulden does not believe that the use of a spinal cord stimulator would be causally related, or reasonable and necessary treatment for his work-related back injury. (Def. Ex. D:30). Dr. Kuhnlein performed a previous IME and opined in an October 5, 2019 letter that he agrees with Dr. Ledet that a trial of a spinal cord stimulator is what is indicated for the chronic low back pain

experienced by Mr. Sullivan, as this is the "end of the treatment trial for such chronic pain." (Cl. Ex. 2:5).

Dr. Wheeler issued a letter indicating that she agreed with Dr. Chen's opinions, nor would she recommend a spinal cord stimulator for Mr. Sullivan. (Def. Ex. E:33). Dr. Wheeler agreed that a spinal cord stimulator would not be reasonable and necessary medical treatment for the work injury. (Def. Ex. E:34). Finally, Dr. Goetz opined that based upon his examinations of the claimant, his review of the MRI findings, and his experience treating patients, it is Dr. Goetz's opinion that the odds of a spinal cord stimulator "working in the long term for Mr. Sullivan are low." (Def. Ex. B:12). Finally, Dr. Goetz indicates that he agrees with the opinions of Dr. Chen, Dr. Boulden and Dr. Wheeler that he would not recommend Mr. Sullivan having a spinal stimulator. (Def. Ex. B:12).

Two treating physicians, Dr. Goetz and Dr. Wheeler indicate that they do not agree with the requested trial for a spinal cord stimulator. Additionally, Dr. Chen, a board certified pain management physician, and Dr. Boulden, an orthopedic physician, also do not agree with the requested trial for a spinal cord stimulator. On the other hand, treating physician Dr. Ledet, and Dr. Kuhnlein, agree that Mr. Sullivan's chronic pain would be best served by a spinal cord stimulator trial. Dr. Ledet is a pain management physician, while Dr. Kuhnlein specializes in occupational medicine. I find the opinions of Dr. Goetz, Dr. Wheeler, Dr. Boulden and Dr. Chen more persuasive than the opinions of Dr. Ledet and Dr. Kuhnlein.

Alternate Care Under Iowa Code 85.27

Iowa Code 85.27(4) provides, in relevant part:

> For purposes of this section, the employer is obligated to furnish reasonable services and supplies to treat an injured employee, and has the right to choose the care. . . . The treatment must be offered promptly and be reasonably suited to treat the injury without undue inconvenience to the employee. If the employee has reason to be dissatisfied with the care offered, the employee should communicate the basis of such dissatisfaction to the employer, in writing if requested, following which the employer and the employee may agree to alternate care reasonably suited to treat the injury. If the employer and employee cannot agree on such alternate care, the commissioner may, upon application and reasonable proofs of the necessity therefor, allow and order other care.

Iowa Code 85.27(4). See Pirelli-Armstrong Tire Co. v. Reynolds, 562 N.W.2d 433 (Iowa 1997).

The employer has the right to choose the provider of care, except where the employer has denied liability for the injury. Iowa Code 85.27. Holbert v. Townsend Engineering Co., Thirty-second Biennial Report of the Industrial Commissioner 78 (Review-Reopening, October 16, 1975). An employer's right to select the provider of

medical treatment to an injured worker does not include the right to determine how an injured worker should be diagnosed, evaluated, treated, or other matters of professional medical judgment. Assmann v. Blue Star Foods, File No. 866389 (Declaratory Ruling, May 19, 1988). Reasonable care includes care necessary to diagnose the condition and defendants are not entitled to interfere with the medical judgment of their own treating physician. Pote v. Mickow Corp., File No. 694639 (Review-Reopening Decision, June 17, 1986).

By challenging the employer's choice of treatment - and seeking alternate care – claimant assumes the burden of proving the authorized care is unreasonable. See, e.g., Iowa R. App. P. 14(f)(5); Bell Bros. Heating and Air Conditioning v. Gwinn, 779 N.W.2d 193, 209 (Iowa 2010); Long v. Roberts Dairy Co., 528 N.W.2d 122 (Iowa 1995). Determining what care is reasonable under the statute is a question of fact. Long, 528 N.W.2d 122 (Iowa 1995).

An application for alternate medical care is not automatically sustained because claimant is dissatisfied with the care he has been receiving. Mere dissatisfaction with the medical care is not ample grounds for granting an application for alternate medical care. Rather, the claimant must show that the care was not offered promptly, was not reasonably suited to treat the injury, or that care was unduly inconvenient for the claimant. Id. Because "the employer's obligation under the statute turns on the question of reasonable necessity, not desirability," an injured employee's dissatisfaction with employer-provided care, standing alone, is not enough to find such care unreasonable. Id. Reasonable care includes care necessary to diagnose the condition, and defendants are not entitled to interfere with the medical judgement of their own treating physician. Pote v. Mickow Corp., File No. 694639 (Review-Reopening Decision, June 17, 1986).

The undersigned previously noted that I find the opinions of Dr. Goetz, Dr. Wheeler, Dr. Boulden, Dr. Chen, Dr. Dulaney, and Dr. Sullivan, more persuasive than the opinions of Dr. Kuhnlein and Dr. Ledet. Based upon the record, I do not find any information indicating that the claimant has carried their burden of proof to order the alternate care requested. Dr. Chen has outlined a reasonable course of treatment that could serve as an alternative to a trial of a spinal cord stimulator.

Fees

Mr. Sullivan seeks to recover $13.60 for certified mail fees, $1,625.00 for the opinion letter of Dr. Ledet, and $570.00 for the opinion letter of Dr. Kuhnlein. (Cl. Ex. 4:1-5).

Costs are to be assessed at the discretion of the deputy commissioner hearing the case. See 876 Iowa Administrative Code 4.33; Iowa Code 86.40. 876 Iowa Administrative Code 4.33(6) provides:

> [c]osts taxed by the workers' compensation commissioner or a deputy commissioner shall be (1) attendance of a certified shorthand reporter or

> presence of mechanical means at hearings and evidential depositions, (2) transcription costs when appropriate, (3) costs of service of the original notice and subpoenas, (4) witness fees and expenses as provided by Iowa Code sections 622.69 and 622.72, (5) the costs of doctors' and practitioners' deposition testimony, provided that said costs do not exceed the amounts provided by Iowa Code sections 622.69 and 622.72, (6) the reasonable costs of obtaining no more than two doctors' or practitioners' reports, (7) filing fees when appropriate, including convenience fees incurred by using the WCES payment gateway, and (8) costs of persons reviewing health service disputes.

The administrative rule expressly allows the undersigned the discretion to assess costs. In this case, the undersigned declines to assess costs.

Defendants' Motion to Compel IME

In their post-hearing brief, defendants restate their request to compel an IME with Dr. Boulden pursuant to Iowa Code 85.39 and Iowa Rule of Civil Procedure 1.515. The undersigned has now ruled on this motion in writing on two occasions (April 8, 2020, and May 5, 2020), as well as an on the record ruling during the hearing on May 6, 2020. Despite defendants' persistence, no additional evidence has been provided in support of the defendants' motion. There is no good cause shown to compel the IME under Iowa Code 85.39 and Iowa R. Civ. P. 1.515. Additionally, the defendants have had the opportunity to fully and fairly develop their defenses without prejudice. The record in this case closed on May 6, 2020, and upon receipt of post-hearing briefs on May 15, 2020. The defendants' renewed motion is denied.

ORDER

IT IS THEREFORE ORDERED:

1. Claimant's petition for alternate medical care pursuant to Iowa Code 85.27 is denied.

2. Claimant's request for fees is denied.

3. Defendants motion to compel IME is denied.

Signed and filed this 5th day of June, 2020.

ANDREW M. PHILLIPS
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served, as follows:

Thomas M. Wertz (via WCES)

Jeffrey W. Lanz (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.