BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

BRIAN BARRY, Claimant, vs. JOHN DEERE DUBUQUE WORKS OF DEERE & COMPANY, Employer, Self-Insured, Defendant.	:	File No. 5055977.01 REVIEW-REOPENING DECISION Head Note Nos: 1803; 2403; 2404; 2905

STATEMENT OF THE CASE

The claimant, Brian Barry, filed a petition for review-reopening seeking workers' compensation benefits from self-insured employer John Deere Dubuque Works of Deere & Company. Thomas Wertz appeared on behalf of the claimant. Dirk Hamel appeared on behalf of the defendant.

The matter came on for hearing on December 15, 2020, before Deputy Workers' Compensation Commissioner Andrew M. Phillips. An order issued on March 13, 2020, and updated June 1, 2020, August 14, 2020, and October 12, 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 October 13, 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 March 19, 2021. The amendments make it so that such hearings will be held by Internet-based video, using CourtCall. The parties appeared electronically, including the claimant appearing by phone at the consent of the parties. The hearing proceeded without significant difficulties. The matter was fully submitted on January 15, 2021, after briefing by the parties.

The record in this case consists of Joint Exhibits 1-5, Claimant's Exhibits 1-3, and Defendant's Exhibits A-F. Testimony under oath was also taken from the claimant, Brian Barry. Debra Hoadley was appointed the official reporter and custodian of the notes of the proceeding.

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. The claimant sustained bilateral carpal tunnel syndrome arising out of, and in the course of, employment on October 17, 2013.

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

4. The alleged injury is a cause of permanent disability.

5. The disability is a scheduled member disability to the whole person pursuant to Iowa Code section 85.34(2)(s).

6. The claimant's gross earnings were $859.00 per week, and the claimant was married and entitled to two exemptions. This provides a weekly compensation rate of $552.46.

7. That prior to the hearing the claimant was paid 55 weeks of compensation at the rate of $552.46 per week for PPD.

Additionally, entitlement to temporary disability and/or healing period benefits is no longer in dispute, nor are medical benefits, nor are credits against any award. The defendants waived their affirmative defenses.

The parties are now bound by their stipulations.

ISSUES

The parties submitted the following issues for determination:

1. Whether the claimant has proven the prerequisites to demonstrate he is entitled to review-reopening benefits under Iowa Code section 86.14.

2. The extent of permanent disability benefits, if any are awarded.

3. Whether the commencement date for permanent partial disability benefits, if any are awarded, is September 12, 2015.

4. Whether the claimant is entitled to a taxation of costs.

FINDINGS OF FACT

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

Brian Barry, the claimant, is 62 years old. He splits his time between Florida and Dubuque, Iowa. (Testimony). He worked at John Deere for about 10 years at the time of the hearing in this matter. (Testimony). He testified via phone, and under oath at the hearing. He seemed to be an accurate historian.

This case dates back to bilateral carpal tunnel syndrome arising out of, and in the course of employment on October 17, 2013. A hearing was held on February 14, 2017, and a decision was filed by a now retired deputy workers' compensation commissioner on December 13, 2017. The deputy awarded the claimant an 11 percent impairment rating to the body as a whole, ordered the defendant to arrange for an EMG/NCV test within twenty-one (21) days of the order, and awarded the claimant one hundred and 00/100 dollars ($100.00) plus service fees in costs. (Defendant's Exhibit A:9-11).

The 2017 arbitration decision found in the Findings of Fact, the following:

> On March 26, 2014, David S. Field, M.D., a board certified surgeon in orthopedic surgery performed a right open carpal tunnel decompression on the right hand and forearm. Claimant had no intraoperative difficulties and was transported to the recovery room in good condition. Several weeks later, claimant engaged in follow-up care with Dr. Field. Claimant was doing well and the area around his surgical incision was healed too. Claimant did complain of slight palmar soreness, (thenar soreness) on the right hand.
>
> Claimant began complaining of carpal tunnel syndrome on the left side. On May 16, 2014, Dr. Field performed a left open carpal tunnel decompression. Claimant tolerated the surgical procedure without complications and was transported to the recovery room in good condition.
>
> On May 22, 2014, claimant presented to Dr. Field for follow-up care. Claimant had returned to work using his right hand only. He had some stiffness but his numbness had subsided. Claimant's grip strength was improving.
>
> On May 27, 2014, Dr. Field removed the sutures from claimant's left hand. Claimant was told to wear a brace on his left hand while he was at work. Dr. Field released claimant to full duty work with respect to the right carpal tunnel release. Dr. Field released claimant to return to work without restriction on August 12, 2014.
>
> On August 22, 2014, Dr. Field rated claimant as having a permanent impairment. The orthopedic surgeon wrote in his report of the same date:
>
> > In lieu of his evaluation and findings at this time, he has done very nicely with both hands. He has no voice [*sic*]

> complaints. No numbness or paresthesias in either hand. He has appropriate incisional tenderness in the pillar areas.
>
> Our recommendation for impairment rating would be that of approximately 3% impairment of each upper extremity due to the nature of his carpal tunnel syndrome, surgical treatment, and findings at surgery. This is based on the "Guides to the Evaluation of Permanent Impairment", 5th Edition, as published by the American Medical Association, Page 495.
>
> If indeed, a bilateral impairment rating is necessary, he would merit approximately a total of 4% whole person impairment using these Guides, Table 16-3. I would be pleased to provide any further information you so desire. I hope this letter is satisfactory at this time.

On April 21, 2015, claimant returned to Dr. Field. Claimant experienced pain and stiffness in the right hand. He also complained of pain in his wrists and forearms for several weeks. Dr. Field discovered claimant had some mild triggering of the ring and long fingers of each hand. Dr. Field also diagnosed claimant with thenar muscle wasting on the right hand and some tenderness over the flexor carpi radialis interposition graft distally in both wrists and some mild tenderness over the outcropping tendons of the wrists.

Dr. Field recommended:

> PLAN: It appears to me that he has simply a degree of overuse tendinitis and stiffness of his hands with inflammation. He doesn't have a pattern of carpal tunnel. He certainly should be wearing carpal tunnel gloves and he should be on an anti-inflammatory. Celebrex could be a trial if that is available. Reducing the amount of torqueing [*sic*] he is doing with his hands for a period of time could try to get him through this phase. All these factors were reviewed with him today and I will also discuss this with John Deere. It may simply be overuse of his hands, which can happen I'm sure in this job.

Claimant exercised his right to an independent medical examination pursuant to Iowa Code section 85.39. On August 11, 2015, claimant presented to Robin L. Sassman, M.D., MPH, for the examination. Dr. Sassman issued her report on November 18, 2015. The evaluating physician diagnosed claimant with:

1. Bilateral carpal tunnel syndrome; and

2. Bilateral forearm tendonitis, improved.

Dr. Sassman noted:

> Thenar wasting was noted in the right hand. Spurling's [*sic*] was negative. Impingement signs were negative. Reflexes were 2+/4 in the bilateral upper extremities. Durkan's negative. He had normal sensation in the bilateral upper extremities.
>
> An NC-Stat test was completed on bilateral median nerves. The test was normal on the left, but showed right median neuropathy.

Dr. Sassman proposed recommendations for additional medical care. She proposed:

> Given his continued symptoms in the bilateral hands, Mr. Barry may benefit from a repeat EMG/nerve conduction study of the bilateral upper extremities to more accurately determine the level of residual compression that exists for the median nerve and if compression of the ulnar nerve is an issue as well. On the previous EMG the ulnar nerve was normal; however, he continues to have a loss of sensation in the distribution of the ulnar nerve in both hands; therefore, it is reasonable that he be re-evaluated for this.

Dr. Sassman did rate claimant as having a permanent impairment rating. She relied on the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition. Her ratings were calculated as follows:

> With respect to the right carpal tunnel syndrome, and based on the instructions on page 495, Mr. Barry falls into the first category because he had positive clinical findings of median nerve dysfunction and electrical conduction delay. Therefore, from Table 16-15, he has a sensory deficit, so the 39% value was used. Turning to Table 16-10 on page 482, I would place him in a Category 4 using a 25% modifier. When the 39% value is multiplied by the 25% value, 9.75% left upper extremity is derived. I am instructed in *The Guides* to round this number up to 10% upper extremity impairment.
>
> With respect to the left carpal tunnel syndrome, and based on the instructions on page 495, Mr. Barry falls into

> the first category for this as well due to positive clinical findings of median nerve dysfunction although there was no electrical conduction delay. Therefore, from Table 16-15, he has a sensory deficit, so the 39% value was used. Turning to Table 16-10 on page 482, I would place him in a Category 4 using a 25% modifier. When the 39% value is multiplied by the 25% value, 9.75% left upper extremity is derived. I am instructed in *The Guides* to round this number up to 10% upper extremity impairment.
>
> Using the Combined Values Chart on page 604, 10% upper extremity impairment (for the right CTS) is combined with 10% upper extremity impairment (for the left CTS) for a total of 19% upper extremity impairment. Using Table 16-3 on page 439 this is converted to 11% whole person impairment. At first glance, this number appears high; however, given that he still has significant residual symptoms even after surgery, and it has impacted both of his upper extremities, this appears reasonable.
>
> Dr. Sassman acknowledged claimant seemed to be performing well in the position he held at Deere. However, if claimant did change positions, Dr. Sassman restricted claimant from repetitively and forcefully gripping and grasping on more than an occasional basis. The doctor also advised claimant to limit the use of vibratory and power tools. Claimant was advised to use those tools sparingly.

(DE A:3-6). Internal citations from the original arbitration decision have been omitted. In the original decision, the claimant testified that gripping, grasping, pushing, and pulling caused him difficulty. (DE A:6). He described his arm stiffening up on his drive home from work. (DE A:7). He continued to wear wrist braces provided by Dr. Field in order to help him sleep. (DE A:7).

Based upon her review of the evidence, the presiding deputy commissioner found Dr. Sassman's opinions coupled with the claimant's testimony to be more persuasive. (DE A:9). Thus, the presiding deputy commissioner awarded permanent partial disability of 11 percent to the body as a whole. (DE A:9).

Since the last hearing, Mr. Barry testified that he felt he had a worsening of his condition. (Testimony). He testified that his condition currently felt the same as before his surgery. (Testimony). He felt increased numbness in his fingers and hands. (Testimony). He continued working in his original job as an assembler operator for a time. (Testimony). In August of 2018, he became a fabrication inspector. (Testimony). Due to his arms, he was given a physical limitation by an on-site John Deere physician. (Testimony). He testified that the assembler operator position has repetitive use of the

hands and body. (Testimony). The inspector looks at parts of assembled equipment. (Testimony). Upon changing jobs, he felt some improvement in his irritation in his wrists. (Testimony).

Mr. Barry considered retirement prior to the inception of the pandemic due to irritation to his arms and shoulders by his daily work duties. (Testimony). He defrayed this due to the COVID-19 pandemic, and the fact that his family's health insurance is provided by his employment with John Deere. (Testimony; Claimant's Exhibit 2). Mr. Barry indicated that he was off work since April of 2020 due to the ongoing COVID-19 pandemic. (Testimony). Mr. Barry has pre-existing asthma, and felt it was too dangerous to continue working. (Testimony). Since stopping work in April of 2020, the claimant felt less irritation in his wrists, and his pain improved. (Testimony).

He described issues using a shovel on his landscaping. (Testimony). He needs to stretch and ice it after doing outside work. (Testimony). At times, he chooses not to use his arms and hands as much as he normally would. (Testimony). He also did not carry things like he used to, and does not type for long periods of time. (Testimony). He indicated issues with opening pickle jars. (Testimony). He indicated that he tried not to use his arms and hands at all. (Testimony). He also had to stretch and ice while working as an assembler. (Testimony). He continues to take Celebrex. (Testimony). He felt that he was 20% worse than his 2017 injuries. (Testimony).

At the time of the hearing, he was being paid a weekly check from John Deere that was less than what his normal weekly wage would be. (Testimony; CE 2). At the time of the hearing, Mr. Barry was at his condominium in Florida. (Testimony; CE 2). He hoped to obtain the COVID-19 vaccine, and then return to work; however, he had no definite plans for returning at the time of the hearing. (Testimony). He also indicated that he had no desire to have additional surgery. (Testimony).

An NCS/EMG was conducted on August 11, 2015, by Dr. John Kuhnlein. (Joint Exhibit 1:12-13). Dr. Kuhnlein noted that the right median wrist showed a result outside of normal limits. (JE 1:12). Dr. Kuhnlein opined that this represented mild right median neuropathy at the wrist. (JE 1:12).

The parties placed the November 18, 2015, independent medical examination ("IME") of Dr. Sassman into evidence. (JE 1:1-11). I reviewed the report, and found nothing to note beyond what was noted in the previous arbitration decision.

On March 20, 2017, Jill Hunt, M.D., an internal doctor at John Deere, wrote a refill for Mr. Barry's Celebrex. (JE 2:63). Mr. Barry requested another refill on October 16, 2017. (JE 2:62).

In December of 2017, Mr. Barry had some right flank pain, which necessitated a trip to the ER. (JE 2:62).

On January 19, 2018, Janelle Garriott, R.N., scheduled a bilateral upper extremity EMG/NCV with Dr. Sims for February 2, 2018. (JE 2:62).

On February 2, 2018, Mr. Barry had an NCS/EMG performed by Ronald Sims, M.D. (JE 3:64-66). Dr. Sims reviewed the results of the NCS/EMG and opined that the motor conduction test was normal in the right median, left median, and left ulnar nerve areas. (JE 3:65). Dr. Sims found some results outside of the specified normal range in four nerve areas for sensory conduction. (JE 3:65-66). Dr. Sims' diagnosis was that Mr. Barry had bilateral median neuropathy at the wrist involving sensory fibers only. (JE 3:66). The EMG results were faxed from John Deere to Dr. Field for review. (JE 2:62). Dr. Hunt examined Mr. Barry on the same date for ongoing bilateral wrist and forearm pain. (JE 2:61-62). Following his previous treatment, he continued exercises, night splints, and Celebrex. (JE 2:61). Mr. Barry indicated that Dr. Sims informed him that the repeat NCV/EMG testing showed worse results than an EMG performed prior to his surgery. (JE 2:61). Mr. Hunt indicated a willingness to return to Dr. Field for additional evaluation, but then requested the appointment be canceled. (JE 2:61).

Dr. Hunt examined Mr. Barry again on February 7, 2018. (JE 2:60). Mr. Barry indicated continued bilateral wrist and forearm pain. (JE 2:60). He told Dr. Hunt that Celebrex helped with his pain. (JE 2:60). He did not feel any numbing or burning, and told Dr. Hunt that nothing in his job caused symptoms. (JE 2:60). He reported trying to limit use of heavy gripping. (JE 2:60). Dr. Hunt found a neurovascular examination within normal limits, and full range of motion in both wrists. (JE 2:60). Dr. Hunt opined that Mr. Barry had stable bilateral wrist and forearm pain, and that he should continue taking Celebrex, home exercises, and ice/heat. (JE 2:60).

On February 16, 2018, Dr. Hunt re-examined Mr. Barry related to his ongoing bilateral wrist and forearm pain. (JE 2:59-60). Mr. Barry continued wearing his night braces, taking Celebrex, and doing stretches. (JE 2:59-60). Dr. Hunt explained that a hand specialist at the University of Iowa was evaluating whether there were additional treatment options for him. (JE 2:59-60).

Mr. Barry returned to visit Dr. Hunt on March 2, 2018, for his recurrent symptoms. (JE 2:59). Dr. Hunt noted that Dr. Fowler felt nothing further would help Mr. Barry, so he declined to set another appointment. (JE 2:59). The claimant agreed to follow up at Steindler Orthopedics. (JE 2:59).

On March 5, 2018, an appointment was made with Dr. Ebinger at Steindler Orthopedic for March 9, 2018. (JE 2:59).

Thomas P. Ebinger, M.D., examined Mr. Barry at Steindler Orthopedic Clinic on March 9, 2018. (JE 4:70-72). Dr. Ebinger noted that Mr. Barry presented for aching and tingling in both of his hands. (JE 4:70). Dr. Ebinger reviewed Mr. Barry's course of care from 2014 regarding his bilateral carpal tunnel syndrome and resulting surgeries. (JE 4:70). Mr. Barry told Dr. Ebinger that he experienced significant improvements in numbness, tingling, and burning in his hands following his surgery, but noted that the

symptoms failed to completely resolve. (JE 4:70). Mr. Barry further indicated to Dr. Ebinger that he had ongoing aching in his hands and forearms, and woke in the morning with stiffness in his hands. (JE 4:70). He also had numbness and tingling over the dorsum of his thumb and radial aspect of his index finger and middle finger. (JE 4:70). He complained of discomfort in the volar and radial wrists along with tingling as noted above. (JE 4:70). Heavy use of his hands brought on the symptoms. (JE 4:70). Mr. Barry reported triggering in his middle and ring finger of both hands, which is not painful, but is irritating. (JE 4:70). Mr. Barry provided a medication history noting that he took Celebrex on a daily basis along with Tylenol and some other medications. (JE 4:70).

Dr. Ebinger examined the bilateral upper extremities and found excellent range of motion at the elbow. (JE 4:71). Further, Dr. Ebinger found a positive Tinel sign at the bilateral carpal tunnel; however, Dr. Ebinger noted full extension and flexion of all digits. (JE 4:71). Mr. Barry demonstrated triggering and locking of the middle and ring fingers bilaterally with active flexion and extension. (JE 4:72). Dr. Ebinger also found generalized tenderness over the volar forearm and wrist. (JE 4:72). Dr. Ebinger's impression was that Mr. Barry had trigger fingers of the bilateral middle and ring fingers, along with "median nerve irritation in the setting of previous carpal tunnel release, and flexor tendinitis likely secondary to overuse." (JE 4:72). Mr. Barry clarified to Dr. Ebinger that his symptoms were much different than he experienced prior to the carpal tunnel release. (JE 4:72). Dr. Ebinger opined that the carpal tunnel surgery was successful in resolving tingling and burning in Mr. Barry's hands, but that he continued to have symptoms of tendinitis which are most likely related to his employment. (JE 4:72). Dr. Ebinger explained that EMG testing "frequently remains positive after carpal tunnel release despite appropriate nerve decompression." (JE 4:72). Dr. Ebinger also explained treatment options to Mr. Barry, including continued bracing, occupational therapy, and/or focal treatment for the triggering digits. (JE 4:72). Mr. Barry reported that he had no pain with his triggering fingers, so Dr. Ebinger recommended no invasive treatment, but noted that if they became painful, treatment was available. (JE 4:72). Dr. Ebinger allowed Mr. Barry to continue unrestricted work, and did not schedule a follow-up appointment. (JE 4:72-73).

On March 12, 2018, Dr. Hunt examined Mr. Barry for his bilateral forearm pain. (JE 2:58-59). Dr. Hunt explained that Mr. Barry was diagnosed with flexor tendinitis or arthritis at Steindler. (JE 2:58). Dr. Hunt agreed with the diagnosis of bilateral forearm tendinitis. (JE 2:59).

Mr. Barry returned to Dr. Hunt on March 19, 2018. (JE 2:58). He complained of more pain and triggering in the third and fourth digits of his right hand. (JE 2:58). He noted that they do not fully lock up. (JE 2:58). Mr. Barry expressed concern over how long he would be able to work with the constant pain "despite doing everything including wordings [*sic*] splints at night." (JE 2:58). Mr. Barry picked up information regarding taking an inspector test. (JE 2:58).

On April 2, 2018, Dr. Hunt examined Mr. Barry for his continued bilateral wrist and forearm pain. (JE 2:57-58). Mr. Barry noted less pain, and no change in range of motion. (JE 2:57). He could do his job without restrictions, but continued to have daily pain. (JE 2:57). Dr. Hunt diagnosed him with chronic bilateral tendinitis. (JE 2:58).

Mr. Barry returned to Dr. Hunt on April 4, 2018, reporting the same pain. (JE 2:57). Dr. Hunt noted, "[h]e is not able to do the job he will have with restrictions." (JE 2:57). Dr. Hunt also noted that Mr. Barry was working overtime. (JE 2:57). Dr. Hunt communicated Mr. Barry's concerns to "LR." (JE 2:57).

On April 13, 2018, Mr. Barry followed up with Dr. Hunt for volar tendinitis. (JE 2:56-57). Mr. Barry complained of more pain due to helping with his old position at John Deere. (JE 2:56). Mr. Barry indicated that his former supervisor had no one to assist him, so he asked Mr. Barry to do so. (JE 2:56). Mr. Barry had not heard from "LR" regarding a possible job shift due to permanent restrictions. (JE 2:56). He was able to do his job with restrictions. (JE 2:56). Dr. Hunt diagnosed Mr. Barry with chronic bilateral forearm flexor tendinitis. (JE 2:57). On the same date, Dr. Hunt changed Mr. Barry's permanent restrictions to include limited fork truck driving at the request of "LR." (JE 2:56).

Mr. Barry returned to see Dr. Hunt on April 27, 2018. (JE 2:56). He noted no change in his pain or range of motion. (JE 2:56). He took NSAIDs as directed, but no longer used ice/heat. (JE 2:56). He was training new employees on his old position, but did not do it all day. (JE 2:56). Dr. Hunt's diagnosis continued to be chronic bilateral forearm tendinitis. (JE 2:56). She recommended that he continue NSAIDs, exercises, ice/heat, splints, and to follow up in two weeks. (JE 2:56).

Dr. Hunt examined Mr. Barry again on May 9, 2018. (JE 2:55-56). He continued performing his old job periodically with less gripping and torquing than when he performed it on a full-time basis. (JE 2:55). He reported awakening at night at times with pain in his shoulders. (JE 2:55). He awaited a new job change, and attempted to transfer to another position. (JE 2:55). His range of motion increased. (JE 2:55). He could do his job with restrictions. (JE 2:55). He continued to express tenderness in both forearms. (JE 2:55). Dr. Hunt's diagnoses and recommendations remained the same from the April 27, 2018, visit. (JE 2:56).

On May 23, 2018, Mr. Barry returned to Dr. Hunt's office. (JE 2:55). He continued to await a change in jobs, and noted working a variety of jobs in his old department. (JE 2:55). He noted less pain. (JE 2:55). He was unable to do his job with restrictions. (JE 2:55). Dr. Hunt requested Mr. Barry follow up in two weeks to check on progress in finding him a job to fit his permanent restrictions. (JE 2:55).

Mr. Barry returned to Dr. Hunt's office on June 1, 2018, for continued follow up. (JE 2:54-55). Mr. Barry reported pain in his shoulders that awakened him five nights per week. (JE 2:54). Mr. Barry told Dr. Hunt that the union and "LR" are pushing him to take an inspector's exam. (JE 2:54). Mr. Barry expressed fear that he could not pass

the test to become an inspector. (JE 2:54). He reported using various study aids in order to attempt to pass. (JE 2:54-55). Dr. Hunt's diagnosis continued to be bilateral forearm tendinitis. (JE 2:55). Dr. Hunt continued to recommend NSAIDs, exercises, splints, and a follow-up in one to two weeks. (JE 2:55).

Ms. Garriott sent a refill of the claimant's prescription on July 20, 2018. (JE 2:54).

In early August of 2018, Mr. Barry requested an appointment with Dr. Hunt due to shoulder pain. (JE 2:54). On August 8, 2018, Dr. Hunt re-examined Mr. Barry for bilateral forearm pain. (JE 2:54). He reported no change in pain or range of motion. (JE 2:54). He continued to perform his job with restrictions, and reported doing less things that cause irritation to his arms. (JE 2:54). He expressed concern to Dr. Hunt about his shoulder pain. (JE 2:54). Dr. Hunt found mild tenderness on examination. (JE 2:54). Dr. Hunt's impression was bilateral forearm and shoulder pain. (JE 2:54). Dr. Hunt ordered physical therapy to commence on August 15, 2018. (JE 2:53-54).

Mr. Barry retuned to visit Dr. Hunt on August 17, 2018, noting less pain and increased range of motion. (JE 2:53). He continued to take NSAIDs, used ice/heat as needed, and continued stretching and exercises. (JE 2:53). One visit of physical therapy helped. (JE 2:53). He continued to perform his job with restrictions, and reported excitement on being made an inspector. (JE 2:53). Dr. Hunt requested he return in one week. (JE 2:53).

Upon the request of Dr. Hunt, Mr. Barry returned on August 24, 2018. (JE 2:53). Mr. Barry expressed no change in shoulder pain, and experienced aching upon awakening. (JE 2:53). His left side pain was worse than the right. (JE 2:53). Physical therapy was not helping, but Mr. Barry expressed optimism that it would work. (JE 2:53). His new job as an inspector was going well. (JE 2:53).

On August 31, 2018, Mr. Barry returned to visit Dr. Hunt. (JE 2:52-53). Mr. Barry reported more pain since his physical therapy session. (JE 2:52). His arms were irritated all week, which caused him difficulty sleeping. (JE 2:52). He also had numbness in his little and ring fingers on both hands. (JE 2:52). He continued to awaken due to the pain, and also iced his shoulders. (JE 2:52). He told Dr. Hunt that working as an inspector was "the best thing that's happened in many years." (JE 2:52). Dr. Hunt requested Mr. Barry return in one week. (JE 2:52-53).

Mr. Barry returned to Dr. Hunt on September 7, 2018, for bilateral shoulder pain. (JE 2:51-52). He complained of more pain due to some of the exercises and physical therapy. (JE 2:51). He mentioned that his pain awakened him after three hours of sleep. (JE 2:51). He used ice and Tylenol in order to sleep a full six to seven hours. (JE 2:51). He noted to Dr. Hunt that physical therapy was not helping. (JE 2:51). He noted concern about numbness in his right and little fingers bilaterally. (JE 2:51).

On September 14, 2018, Dr. Hunt examined Mr. Barry for his continued bilateral shoulder pain. (JE 2:51). Mr. Barry described increased pain after physical therapy, which he blamed on "the pulley things." (JE 2:51). His hands improved after changing jobs, and his fingers showed increased range of motion. (JE 2:51). He was able to do his job with his restrictions. (JE 2:51).

Mr. Barry returned to visit Dr. Hunt on September 24, 2018. (JE 2:50). He complained of bilateral shoulder pain and noted no change in pain. (JE 2:50). He also showed no change in range of motion in his shoulders. (JE 2:50). He complained of increased pain when using pulleys in physical therapy. (JE 2:50). He used Biofreeze to help him sleep at night. (JE 2:50). His hands improved with his new job, but he still used braces. (JE 2:50). Dr. Hunt reviewed x-rays with Mr. Barry, but did not comment in the records as to the results. (JE 2:50).

On September 26, 2018, Dr. Hunt visited with Mr. Barry regarding his condition at the time. (JE 2:49). Mr. Barry noted no change in his pain despite 12 sessions of physical therapy. (JE 2:49). He showed no changes in range of motion. (JE 2:49). After physical therapy, he reported increased pain. (JE 2:49). Mr. Barry expressed concerns with not improving with physical therapy and his x-rays only showing "some arthritis" in his left shoulder. (JE 2:49).

Mr. Barry returned to visit Dr. Hunt again on October 3, 2018, for bilateral shoulder pain. (JE 2:48). He reported more pain since his MRI because the MRI was a "tight fit." (JE 2:48). He continued to express concern about arthritis found on the MRIs of his shoulders "because it was discussed that this would not be work related." (JE 2:48). Physical therapy helped, and he wished to continue physical therapy. (JE 2:48). The MRI showed rotator cuff issues. (JE 2:48). Upon examination, Dr. Hunt found no tenderness over the medial elbows or cubital tunnels. (JE 2:48).

Dr. Hunt examined Mr. Barry on October 10, 2018, for bilateral shoulder pain. (JE 2:47). Mr. Barry indicated that the pain in his right shoulder kept him up for most of the prior evening. (JE 2:47). He had pain in the back of the shoulder blade, but noted that his left shoulder was better. (JE 2:47). During this visit, he reported that physical therapy was not helping him, and that it may be causing him more pain. (JE 2:47). Dr. Hunt discontinued physical therapy. (JE 2:47).

On October 17, 2018, Mr. Barry again visited Dr. Hunt. (JE 2:46). He reported more pain in the left elbow and right shoulder. (JE 2:46). He indicated concern about a period of dizziness and loss of balance. (JE 2:46). He felt that he may have been dehydrated. (JE 2:46).

Mr. Barry reported to Robert B. Bartelt, M.D., on October 24, 2018 with a chief complaint of bilateral shoulder pain. (JE 5:74-75). Dr. Bartelt noted MRI results for the left and right shoulder showing rotator cuff issues. (JE 5:74). Mr. Barry told Dr. Bartelt that he had numbness and tingling in his right hand at the fifth digit along with bilateral locking of the third and fourth digits. (JE 5:74). Dr. Bartelt diagnosed Mr. Barry with an

incomplete tear of the right rotator cuff, tendinopathy of the left rotator cuff, trigger finger of an unspecified finger, and right hand paresthesia. (JE 5:75). Dr. Bartelt opined, "[p]atient has a lot going on." (JE 5:75). Dr. Bartelt further opined that Mr. Barry's hands showed "fairly classic triggering" of the third and fourth digits of both hands. (JE 5:75). Dr. Bartelt concluded that the numbness and tingling in Mr. Barry's hands were consistent with an ulnar neuropathy on the right side. (JE 5:75). Dr. Bartelt allowed Mr. Barry to return to work with his current restrictions. (JE 5:75).

Mr. Barry complained to Dr. Hunt of additional triggering of his right third and fourth digits, along with numbness in his ring and little fingers bilaterally on October 26, 2018. (JE 2:45). He indicated triggering has not occurred in the morning since he moved off the assembly role. (JE 2:45).

On October 29, 2018, Mr. Barry returned to Dr. Hunt's office for continued shoulder pain. (JE 2:44). He reported less pain since his sleep improved. (JE 2:44). He took Flexeril, which helped, and felt that the injections previously provided no help. (JE 2:44). Upon examination, he had full range of motion in each shoulder. (JE 2:44).

Dr. Hunt examined Mr. Barry again on November 2, 2018, for his continued complaints of bilateral shoulder pain. (JE 2:43-44). He reported no change in range of motion, and a decrease in pain. (JE 2:43).

On November 12, 2018, Mr. Barry visited Dr. Hunt for his continued shoulder pain. (JE 2:43). He noted less pain since some injections and starting Flexeril. (JE 2:43). He was awakened only occasionally by pain, rather than regularly. (JE 2:43). He visited Florida the week prior and reported concerns because of increased pain in his shoulders after swimming. (JE 2:43).

Mr. Barry visited Amanda Addison, N.P., on December 10, 2018. (JE 2:41). Mr. Barry found less pain since an injection, but it remains. (JE 2:41). He felt 40 percent improved. (JE 2:41). He expressed a desire to avoid additional physical therapy because he felt it worsened things. (JE 2:41).

On January 4, 2019, Ms. Addison re-examined Mr. Barry for his continued bilateral shoulder pain. (JE 2:40-41). He noted that Flexeril made him groggy, so he did not take it often. (JE 2:40). He did stretches and exercises regularly. (JE 2:40). He continued to feel 40 percent better. (JE 2:40).

Mr. Barry continued to complain of bilateral shoulder pain to Ms. Addison on January 18, 2019. (JE 2:40). He reported no changes from his prior appointment with Ms. Addison. (JE 2:40). He used Tylenol, Biofreeze, and positioning to make himself comfortable at night. (JE 2:40). He requested a different medication than Flexeril. (JE 2:40). He rated his pain at one to two out of 10. (JE 2:40).

On February 13, 2019, Ms. Addison examined Mr. Barry. (JE 2:38-39). Mr. Barry reported receiving two cortisone shots between his January appointment and this

appointment. (JE 2:38). He reported being told of bilateral rotator cuff issues. (JE 2:38). He indicated a lack of desire to have surgery for his rotator cuff issues. (JE 2:38).

Mr. Barry visited Ms. Addison again on February 27, 2019, reporting tightness and limited range of motion in his shoulders. (JE 2:37). He took cyclobenzaprine at night with Celebrex. (JE 2:37). He had a pain psychology meeting, which he felt was "interesting," and that on a daily basis his pain was "hardly noticeable." (JE 2:37). However, at night, his pain increased. (JE 2:37).

On March 13, 2019, Mr. Barry reported to Ms. Addison for a repeat examination. (JE 2:35-36). Mr. Barry felt he was improving, and that the night prior to this appointment was the first that he did not require Flexeril to sleep. (JE 2:35). He continued with therapy. (JE 2:35-36). Ms. Addison told him to continue physical therapy. (JE 2:36).

Mr. Barry told Ms. Addison that he awoke on March 27, 2019, with severe bilateral shoulder pain. (JE 2:34-35). He took Tylenol and used ice for relief. (JE 2:34). Physical therapy provided great improvement in loosening his shoulders. (JE 2:34). After taking Celebrex, Tylenol and Biofreeze, his pain was 0 out of 10. (JE 2:34). Ms. Addison told him to continue taking NSAIDs and Celebrex. (JE 2:35). She also counseled him to continue exercises and physical therapy. (JE 2:35).

On May 22, 2019, Mr. Barry visited Ms. Addison for his continued shoulder complaints. (JE 2:31-32). He told her that he slept better, and made "good progress." (JE 2:31). He stopped taking Flexeril since the last visit in March. (JE 2:31). Ms. Addison told Mr. Barry to continue taking the medication regimen that was working, as well as continuing the exercises and physical therapy. (JE 2:32).

Ms. Addison examined Mr. Barry again on June 20, 2019. (JE 2:29-30). He continued to report improvement with physical therapy. (JE 2:29). He slept better, and moved to Tylenol for pain relief. (JE 2:29). Ms. Addison's recommendations remained unchanged. (JE 2:30).

On July 16, 2019, Mr. Barry returned to Ms. Addison due to his continued shoulder complaints. (JE 2:27). He reported receiving an injection in his right shoulder the prior day. (JE 2:27). He did not get a left shoulder injection because it was doing well. (JE 2:27). Another doctor and Mr. Barry decided that he would not continue physical therapy. (JE 2:27). He reported sleeping better. (JE 2:27). Ms. Addison recommended he continue his medication regimen, home exercise plan, and massage from Dubuque Physical Therapy. (JE 2:27).

Mr. Barry visited with Ms. Addison again on August 14, 2019, for his shoulder complaints. (JE 2:25-26). Mr. Barry told Ms. Addison that his shoulders were doing well. (JE 2:25). He continued a home exercise program, and had been continuing massage therapy. (JE 2:25). He noticed more tingling in his fingers. (JE 2:25). Ms.

Addison recommended that he continue his medication regimen, home exercise program, and massage therapy. (JE 2:26).

On August 29, 2019, Mr. Barry requested a refill on his Celebrex. (JE 2:25).

On September 17, 2019, Mr. Barry followed up with Ms. Addison. (JE 2:24). He reported that his shoulders were doing "good." (JE 2:24). He continued with massage therapy, but not physical therapy, as that caused his pain to flare. (JE 2:24). He used Tylenol before bed and Celebrex in the morning. (JE 2:24). Ms. Addison requested that he return in one month. (JE 2:24).

Mr. Barry continued his treatment with Ms. Addison on October 23, 2019. (JE 2:23). He told her that his shoulders were doing well. (JE 2:23). He continued massage therapy and stretching, but cut it to one day per week. (JE 2:23). He noted that if he did anything extra, it "irritates it." (JE 2:23).

On November 20, 2019, Mr. Barry again visited Ms. Addison for his shoulder complaints. (JE 2:22). He continued to report that his shoulders were doing well with massage therapy once per week. (JE 2:22). Ms. Addison noted, "[h]e does report that the tingling in his hands never goes away especially his right ring finger in [*sic*] pinky finger." (JE 2:22).

Mr. Barry returned to Ms. Addison's office on January 13, 2020, for his continued bilateral shoulder complaints. (JE 2:20-21). Mr. Barry noted that he had bilateral cortisone injections in his shoulders during a December visit with Dr. Bartelt. (JE 2:20). He shoveled snow the weekend prior, which caused increased pain. (JE 2:20). He also noted improved sleep. (JE 2:20). Ms. Addison requested that he return in one month. (JE 2:21).

On February 17, 2020, Ms. Addison examined Mr. Barry again. (JE 2:19). He continued massage and felt "the same." (JE 2:19). He reported to Ms. Addison that he got more and more uncomfortable at night and would like another injection from Dr. Bartelt. (JE 2:19). He planned on retiring the first week of April, and would then move to Florida. (JE 2:19).

On March 16, 2020, he reported to Dietmar Grentz, M.D., that he hoped to get another injection from Dr. Bartelt. (JE 2:18). He told Dr. Grentz that his last day of work before retirement was April 3, 2020. (JE 2:18). Dr. Grentz recommended that Mr. Barry continue medication, home exercises, and massage therapy. (JE 2:18). He also told Mr. Barry to follow up with Dr. Bartelt on March 25, 2020. (JE 2:18).

On March 24, 2020, a provider sent a note to John Deere indicating that Mr. Barry should be kept off work due to a high risk of complications from COVID-19. (JE 2:17). Mr. Barry has pre-existing asthma, which presented a significant risk. (JE 2:17). Dr. Grentz visited with Mr. Barry via telephone on March 30, 2020. (JE 2:16). Mr. Barry reported that he would not be moving to Florida due to the COVID-19 pandemic. (JE

2:16). He reported to Dr. Grentz that his wrists "do ok" if he followed his permanent restrictions. (JE 2:16). He indicated that if he did too much, his wrists swell up. (JE 2:16).

In May of 2020, Mr. Barry spoke to several people in John Deere Occupational Health to indicate that he delayed his retirement. (JE 2:15). Another provider confirmed that Mr. Barry should continue to be off work due to his pre-existing conditions. (JE 2:15). These notes continued to be issued through August of 2020.

On October 13, 2020, Mr. Barry reported to UnityPoint Health St. Luke's Hospital for an independent medical examination ("IME") with Stanley C. Mathew, M.D., F.A.A.P.M.R. (Claimant's Exhibit 1:7-12). Dr. Mathew is board certified in physical medicine and rehabilitation and pain medicine. (CE 1:12). Dr. Mathew reviewed medical records dating back to October of 2013. (CE 1:7-9). Mr. Barry told Dr. Mathew that he had discomfort of 6 out of 10 in his shoulders, wrists, forearms, and hands. (CE 1:9). Upon physical examination, Dr. Mathew found tenderness to the bilateral medial and lateral tendons of the elbow, tenderness to the forearm, pain with range of motion in the bilateral wrists, and decreased sensation in the medial three fingers of each hand. (CE 1:10). Dr. Mathew's impressions were: bilateral carpal tunnel syndrome, status post bilateral carpal tunnel decompression surgery, bilateral forearm tendonitis, bilateral multidigit trigger finger, bilateral rotator cuff tendonitis, bilateral upper extremity weakness, and chronic pain in bilateral upper extremities. (CE 1:11).

Dr. Mathew answered a series of questions posed by claimant's counsel regarding the claimant's physical condition. (CE 1:11-12). Dr. Mathew opined that Mr. Barry's carpal tunnel syndrome worsened since the arbitration decision issued on December 13, 2017. (CE 1:11). At the time of the examination, Mr. Barry described worsening forearm pain, stiffness, weakness, numbness, and tingling that have progressively worsened. (CE 1:11). Dr. Mathew utilized Table 16-18 of the 5th Edition of the AMA Guides to Impairment to evaluate Mr. Barry's impairment. (CE 1:11). He rated Mr. Barry's impairment as follows: 10 percent to each of the elbows, 15 percent upper extremity impairment for the wrists, and 15 percent as a result of loss of function of his finger joints. (CE 1:11). Dr. Mathew further stated, "Mr. Barry has developed chronic pain and weakness that are not adequately considered by the guides [*sic*]." (CE 1:11). Dr. Mathew added additional permanent restrictions including avoiding lifting more than five pounds repetitively, repetitive use of the hands, and repetitive use of a keyboard. (CE 1:11). Dr. Mathew recommended continued pain management, pain psychology, and potentially further surgical intervention. (CE 1:11). Regarding Mr. Barry's shoulder complaints, Dr. Mathew indicated that these are new and separate conditions not attributable to the bilateral wrist, hand, finger, and forearm diagnoses. (CE 1:12).

CONCLUSIONS OF LAW

Iowa Code section 86.14 governs review-reopening proceedings. When considering a review-reopening petition, the inquiry "shall be into whether or not the condition of the employee warrants an end to, diminishment of, or increase of compensation so awarded." Iowa Code section 86.14(2). The deputy workers' compensation commissioner does not re-determine the condition of the employee adjudicated by the former award. Kohlhaas v. Hog Slat, Inc., 777 N.W.2d 387, 391 (Iowa 2009). The deputy workers' compensation commissioner must determine "the condition of the employee, which is found to exist subsequent to the date of the award being reviewed." Id. (quoting Stice v. Consol. Ind. Coal. Co., 228 Iowa 1031, 1038, 291 N.W. 452, 456 (1940)). In a review-reopening proceeding, the deputy workers' compensation commissioner should not reevaluate the claimant's level of physical impairment or earning capacity "if all of the facts and circumstances were known or knowable at the time of the original action." Id. at 393.

The claimant bears the burden of proving, by a preponderance of the evidence that, "subsequent to the date of the award under review, he or she has suffered an *impairment or lessening of earning capacity proximately caused by the original injury*." Simonson v. Snap-On Tools Corp., 588 N.W.2d 430, 434 (Iowa 1999)(emphasis in original).

What is to be determined is whether Mr. Barry has established a change in condition following the 2017 hearing. Mr. Barry retained Dr. Mathew to produce an opinion with regard to his alleged change in condition. Dr. Ebinger also provided an opinion, though not via an IME like Dr. Mathew's opinion. When considering expert testimony, the trier of fact may accept or reject expert testimony, even if uncontroverted, in whole or in part. Frye v. Smith-Doyle Contractors, 569 N.W.2d 154, 156 (Iowa Ct. App. 1997). 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, 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).

In the 2017 decision, the presiding deputy adopted the opinions of Dr. Sassman. Dr. Sassman used Table 16-15 due to sensory deficits suffered by Mr. Barry. Based upon Table 16-15, Dr. Sassman assigned a 39 percent impairment rating. She then used Table 16-10 on page 682 of the Guides to place Mr. Barry into Category 4 and assigned a 25 percent modifier. Based upon these ratings, Dr. Sassman assigned a 9.75 percent impairment rating to both the right and left upper extremities. Dr. Sassman rounded this up to a 10 percent impairment rating and utilized the combined values chart to provide a 19 percent upper extremity impairment rating. Dr. Sassman converted this to a whole person impairment rating using Table 16-3 on page 439 of the Guides. Dr. Sassman provided restrictions to Mr. Barry of no repetitive or forceful

gripping and grasping on more than an occasional basis. Dr. Sassman also told Mr. Barry to limit the use of vibratory and power tools.

Since the 2017 hearing, Mr. Barry reports a subjective worsening of his condition. He also moved positions from an assembler operator to an inspector. Changing jobs provided him relief from some of his symptoms. Mr. Barry continues to take Celebrex. Mr. Barry planned on retiring in April of 2020, but delayed his retirement due to the COVID-19 pandemic. He is currently living in Florida with his wife until he is medically cleared to return to work.

Mr. Barry testified in his 2017 hearing, and again during this review-reopening proceeding, that he had issues opening a jar of pickles. He further testified as to issues using a shovel while landscaping, and noted that he chose to use his arms and hands less than he would. He claimed that he felt 20 percent worse than prior to the 2017 injuries. He did not elaborate as to how he arrived at this amount.

In February of 2018, Mr. Barry had a repeat EMG based upon a referral made by John Deere. Dr. Sims told Mr. Barry that the results of the EMG were worse than the EMG performed prior to the carpal tunnel surgeries. Dr. Sims diagnosed Mr. Barry with bilateral median neuropathy at the wrist involving sensory fibers only. Dr. Hunt at John Deere referred Mr. Barry to Steindler Orthopedic. Dr. Ebinger examined him. Mr. Barry told Dr. Ebinger that heavy use of his hands brought on numbness and tingling in his fingers, as well as discomfort in the volar and radial wrists. Dr. Ebinger opined that Mr. Barry had trigger fingers of the bilateral middle and ring fingers, as well as "median nerve irritation in the setting of previous carpal tunnel release, and flexor tendinitis likely secondary to overuse." Dr. Ebinger explained that EMG testing frequently remains positive after carpal tunnel release despite an appropriate nerve decompression. Dr. Ebinger allowed Mr. Barry to work unrestricted and provided limited treatment recommendations. Dr. Hunt agreed with Dr. Ebinger's diagnoses.

Through 2018, Mr. Barry continued to complain of forearm pain; however in late summer of 2018, Mr. Barry's complaints about his forearm and wrist pain transitioned to treatment for, and complaints of, bilateral shoulder pain. Mr. Barry's shoulder complaints and/or injuries are not at issue in this case. The question is whether Mr. Barry's carpal tunnel syndrome worsened.

In October of 2018, Mr. Barry visited Dr. Bartelt, and informed him of numbness and tingling in his right hand at the fifth digit along with bilateral locking of the third and fourth digits. Dr. Bartelt indicated that the right side issues were consistent with ulnar neuropathy. His active treatment for his wrist complaints appears to have ceased in the middle of 2018.

Claimant's counsel arranged for an IME with Dr. Mathew in October of 2020. Dr. Mathew found tenderness to the bilateral medial and lateral tendons of the elbow, tenderness to the forearm, pain with range of motion in the bilateral wrists, and decreased sensation in the medial three fingers of each hand. Dr. Mathew utilized the

5th Edition of the AMA Guides to assign increased impairment ratings for Mr. Barry. Dr. Mathew used Table 16-18 to assign impairment ratings for Mr. Barry's elbows, wrists, and finger joints. Dr. Mathew further opined that "Mr. Barry has developed chronic pain and weakness that are not adequately considered by the guides [*sic*]."

Based upon the preponderance of the evidence in the record, I find that Mr. Barry has not proven a change in condition. While Mr. Barry claims a 20 percent worsening of his condition, he has not shown such by an objective measurement. While the claimant argues that an EMG from 2018 showed a worsening of his condition based upon an alleged statement of Dr. Sims, that is not included in Dr. Sims' record. Dr. Ebinger indicated that electrodiagnostic testing remains positive after carpal tunnel release. Mr. Barry testified to some of the same issues during the arbitration hearing and the review-reopening proceedings. He also sought little treatment for his alleged continued issues. If he continued to have pain that worsened, it would be reasonable for him to seek treatment. Mr. Barry did not, and instead concentrated his treatment on his shoulders. Further, I did not find Dr. Mathew's report persuasive. Dr. Mathew based his rating off an incorrect section of the Guides by using Table 16-18 and Section 16.7 rather than proper sections dealing with carpal tunnel syndrome.

Costs

Claimant seeks the award of costs as outlined in Claimant's Exhibit 3. Costs are 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(86) 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 for the taxation of costs for a filing fee, deposition transcription costs, and the reasonable costs of obtaining no more than two doctors' or practitioners' reports. In this matter, the filing fee is $100.00. The deposition fees for claimant are $48.40. The costs of Dr. Mathew's record review and report compilation is $1,561.32. I decline, in my discretion, to award costs in this matter.

ORDER

THEREFORE, IT IS ORDERED:

The claimant shall take nothing further in this matter.

The parties shall bear their own costs.

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

Signed and filed this 23rd day of April, 2021.

ANDREW M. PHILLIPS
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

The parties have been served, as follows:

Thomas Wertz (via WCES)

Dirk Hamel (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.