BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

RICHARD HUFF, Claimant, vs. CRST EXPEDITED, INC., Employer, and AIG INSURANCE COMPANY, Self-Insured, Defendant.	File No. 5063162 A P P E A L D E C I S I O N Headnotes: 1402.40; 1403.10; 1802; 1803; 2701; 2079; 3002

Defendants CRST Expedited, Inc., employer, and its insurer, AIG Insurance Company, appeal from an arbitration decision filed on June 19, 2018. Claimant Richard Huff cross-appeals. The case was heard on March 19, 2018, and it was deemed fully submitted in front of the deputy workers' compensation commissioner on April 11, 2018.

The deputy commissioner found claimant had not yet reached maximum medical improvement (MMI) with respect to several of his conditions resulting from the stipulated April 24, 2016, work-related injury. As a result, the deputy commissioner found the issue of the extent of claimant's permanent disability was not ripe for adjudication. The deputy commissioner found claimant was entitled to a running award of healing period benefits from April 24, 2016. The deputy commissioner found claimant's weekly benefit rate for the injury to be $457.31. The deputy commissioner found claimant is entitled to penalty benefits in the amount of $4,011.63. The deputy commissioner found the agency lacked jurisdiction to decide claimant's claim for alternate medical care with respect to accessible housing, transportation services, and in-home nursing services. The deputy commissioner found claimant did not establish his entitlement to alternate medical care for his remaining claims, except as it related to the psychological treatment recommended by Christopher Leber, M.D. The deputy commissioner ordered defendants to pay the entirety of claimant's claimed costs.

On appeal, defendants assert the deputy commissioner inappropriately included per diem payments in the weekly benefit rate calculation. Defendants additionally assert the deputy commissioner erred in her penalty award and costs assessment.

Like defendants, claimant on cross-appeal also asserts the deputy commissioner erred in the rate calculation. Claimant additionally asserts the deputy commissioner erred in the alternate medical care findings and in finding claimant is not at MMI. Claimant asserts the extent of his permanent disability is ripe for determination and claimant asserts he is permanently and totally disabled. Lastly, claimant asserts the deputy failed to address his request that defendants be ordered to pay the costs of Dr. Leber's in-home assessment.

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

I performed a de novo review of the evidentiary record and the detailed arguments of the parties. Pursuant to Iowa Code sections 86.24 and 17A.15, the arbitration decision filed on June 19, 2018 is affirmed in part, modified in part, and reversed in part.

Permanent Disability/Extent

I affirm the deputy commissioner's finding that claimant is not at MMI for several of his conditions, meaning the extent of claimant's permanent disability is not ripe for determination. I affirm the deputy commissioner's findings, conclusions, and analysis pertaining to that issue.

Weekly Benefit Rate

Both parties appealed the deputy commissioner's rate calculation. The deputy commissioner found claimant's weekly benefit rate to be $457.31. In doing so, the deputy commissioner included in claimant's gross earning a $.10 per mile per day payment. Defendants argue on appeal that this per diem payment should be excluded from claimant's gross earnings.

Evidence in this case regarding claimant's use of the per diem payment is negligible but for a few lines of testimony at hearing.

Q. Were you paid a per diem?

A. Yes, we were.

Q. How much was that per diem?

A. 10 cents a mile.

Q. What did you use that per diem for?

A. Well, that's basically your living expenses on the road to eat and whatever you want to do while you're out there trucking across the country.

(Hearing Transcript, p. 51-52)

Neither party offered items such as receipts or invoices regarding claimant's expenses while on the road.

Claimant's rate is calculated after first determining his gross earnings. The statute defines "gross earnings" as "recurring payments by the employer to the employee for employment, before any authorized or lawfully required deduction or withholdings." Iowa Code section 85.61(3) Specifically excluded from this definition are "reimbursement of expenses" and "expense allowances." Id.

In their appeal brief, defendants cite Bowers v. Premium Transportation Staffing, Inc., File No. 5040646 (Arb. Dec., Nov. 5, 2013) and Naylor v. Fagen, File No. 5049149 (Arb. Dec., Nov 9, 2015) as authority for their position that claimant's per diem payments should be excluded from the gross earnings calculation. In both cases the claimants were paid a flat per diem payment no matter what their actual expenses were. And in both cases the deputy commissioner excluded only the portion of the per diem payment that related to reimbursement for actual expenses, and the remainder was included in claimant's rate calculation as actual income. See id.; see also Bowers, 872 N.W.2d 199 (Iowa Ct. App. 2015) (table) (affirming deputy commissioner).

The difference in this case from Bowers and Naylor, however, is that claimant received his per diem payments based on the number of miles he drove. Instead of a flat rate like in Bowers and Naylor, claimant's per diem payments in this case were tied directly to hours worked and work performed.

For that reason, the per diem payments in this case much more closely resemble the payments in Phillips v. C & K Transport, File No. 844999 (App. May 26, 1993):

> There does not appear to be any rational nexus between the number of miles driven and the amount of expenses incurred for meals and lodging. The expenses for a day of layover would differ little from a day when many miles were driven. It is determined that the so-called "per diem allowance" was not a bona fide allowance for meals and lodging or a reimbursement of expenses incurred for those purposes. It was a payment based on the amount of work performed.

Because there was no such nexus in Phillips, the deputy commissioner in that case included the entirety of the per mile per diem payments in the claimant's gross weekly wages.

I acknowledge claimant in this case testified the $.10 per mile per day payments were for living expenses. However, this testimony appears to reflect claimant's general understanding of per diem payments. There is no evidence in the record that those payments were actually tied in any way to reimbursement for claimant's expenses. Instead, like in Phillips, the payments were tied to work performed regardless of what

claimant's actual expenses were. Thus, I find the per diem payments in this case were not a bona fide allowance for expenses. As a result, I find the $.10 per mile per day payments should be included in claimant's gross earnings.

This is consistent with the general rule in Iowa that the workers' compensation statutes should be interpreted liberally for the benefit of the injured worker. Brewer-Strong v. HNI Corp., 913 N.W.2d 235 (Iowa 2018); Xenia Rural Water Dist. v. Vegors, 786 N.W.2d 250 (Iowa 2010); Kohlhaas v. Hog Slat, Inc., 777 N.W.2d 387 (Iowa 2009); 2800 Corp. v. Fernandez, 528 N.W.2d 124 (Iowa 1995).

For these reasons, I affirm the deputy commissioner's inclusion of the per diem payments in claimant's gross earnings.

Turning next to which of the 13 weeks should be used for claimant's rate calculation, the deputy commissioner used the pickup dates listed on the payroll statements in Joint Exhibit 33 as the best evidence of claimant's workweek. However, I agree with claimant the pickup date does not necessarily reflect the fact that a trip may have spanned multiple days or even weeks. Thus, the pickup date may not accurately assign wages to the week in which they were actually earned. Instead, claimant's wages are better represented by the "pay period" dates. I therefore modify the deputy commissioner's rate calculation and I use the pay period dates as asserted by claimant.

I agree with claimant that the pay periods of March 30, 2016, through April 5, 2016, from, March 16, 2016, through March 22, 2016, and from January 27, 2016, through January 31, 2016, are not representative of claimant's customary earnings because his earnings during those periods were too low. However, I also find that the pay period of April 6, 2016, through April 12, 2016 is not representative of claimant's customary earnings because his earnings for that week were too high. I instead substitute the pay period of December 22, 2015, through December 27, 2015. Iowa Code section 85.36(6) ("A week which does not fairly reflect the employee's customary earnings shall be replaced by the closest previous week with earnings that fairly represent the employee's customary earnings.") Thus, the 13 weeks used in claimant's rate calculations are as follows:

Week	Dates	Wages
1	4/13/16 – 4/19/16	$1,085.09
2	3/23/16 – 3/29/16	$555.37
3	3/9/16 – 3/15/16	$523.83
4	3/2/16 – 3/8/16	$592.42
5	2/24/16 – 3/1/16	$639.35

6	2/17/16 -2/23/16	$791.46
7	2/10/16 – 2/16/16	$463.98
8	2/3/16 – 2/9/16	$535.42
9	1/20/16 – 1/26/16	$1,093.64
10	1/13/16 – 1/19/16	$981.93
11	1/6/16 – 1/12/16	$699.12
12	12/30/15 – 1/5/16	$441.54
13	12/22/15 – 12/27/15	$615.42
	Total Gross	**$9,018.57**

The total of the representative weeks, $9,018.57, divided by 13 weeks results in gross average weekly earnings of $693.73. Using claimant's status as single and entitled to one exemption, and applying it to the rate book in effect at the time of the injury, I find claimant's weekly benefit rate to be $427.54.

Penalty/Overpayment

The parties stipulated defendants paid 98 weeks of benefits at the rate of $375.44. Having found claimant's rate to be more than the rate at which defendants paid those benefits, I find there was no overpayment. To the contrary, I must address whether defendants' underpayment of the rate warrants an award of penalty benefits.

Iowa Code section 86.13 governs compensation payments. Under the statute's plain language, if there is a delay in payment absent "a reasonable or probable cause or excuse," the employee is entitled to penalty benefits of up to fifty percent of the amount of benefits that were denied, delayed, or terminated without reasonable or probable cause or excuse. Iowa Code section 86.13(4); see also Christensen v. Snap-On Tools Corp., 554 N.W.2d 254, 260 (Iowa 1996) (citing earlier version of the statute). "The application of the penalty provision does not turn on the length of the delay in making the correct compensation payment." Robbennolt v. Snap-On Tools Corp., 555 N.W.2d 229, 236 (Iowa 1996). If a delay occurs without a reasonable excuse, the commissioner is required to award penalty benefits in some amount to the employee. Id.

The statute requires the employer or insurance company to conduct a ""reasonable investigation and evaluation" into whether benefits are owed to the employee, the results of the investigation and evaluation must be the "actual basis" relied on by the employer or insurance company to deny, delay, or terminate benefits, and the employer or insurance company must "contemporaneously convey the basis for

the denial, delay, or termination of benefits to the employee at the time of the denial, delay, or termination of benefits."" Iowa Code section 86.13(4)(a). An employer may establish a "reasonable cause or excuse" if "the delay was necessary for the insurer to investigate the claim," or if "the employer had a reasonable basis to contest the employee's entitlement to benefits." Christensen, 554 N.W.2d at 260. "A 'reasonable basis' for denial of the claim exists if the claim is 'fairly debatable.'" Burton v. Hilltop Care Center, 813 N.W.2d 250, 267 (Iowa 2012). "Whether a claim is 'fairly debatable' can generally be determined by the court as a matter of law." Id. An issue of law is fairly debatable if viable arguments exist in favor of each party. Covia v. Robinson, 507 N.W.2d 411 (Iowa 1993). An issue of fact is fairly debatable if substantial evidence exists which would support a finding favorable to the employer. Gilbert v. USF Holland, Inc., 637 N.W.2d 194 (Iowa 2001).

When considering an award of penalty benefits, the commissioner considers "the length of the delay, the number of delays, the information available to the employer regarding the employee's injuries and wages, and the prior penalties imposed against the employer under section 86.13." Schadendorf v. Snap-On Tools Corp., 757 N.W.2d 330, 336 (Iowa 2008). The purposes of the statute are to punish the employer and insurance company and to deter employers and insurance companies from delaying payments. Robbennolt, 555 N.W.2d at 237.

In this case, I find the issue of claimant's rate was fairly debatable. Whether a week is representative of claimant's customary earnings is a fact-specific determination, and I find there was substantial evidence supporting the weeks used and rejected by defendants in their calculation. While I ultimately did not adopt defendants' application of Jacobson Transp. Co. v. Harris, 778 N.W.2d 192 (Iowa 2010), they offered a viable argument in their favor.

I also find defendants contemporaneously conveyed the basis of their asserted rate. As noted by the deputy commissioner, Joint Exhibit 25 contains correspondence between the parties. Claimant's counsel notified defendants that she believed defendants were underpaying claimant's benefits based on an incorrect rate on December 16, 2016, January 3, 2017, January 18, 2017, and January 20, 2017. (JE 25, pp. 6-11) By January 27, 2017, defendants' counsel sent a letter back to claimant's counsel stating defendants had received claimant's wage records and calculated claimant's rate under Jacobson. (Ex. F, p. 36)

The deputy commissioner awarded penalty benefits because "Exhibit F does not provide a chart or other explanation of the calculations." However, it is clear from the letter that there was a chart attached, and claimant makes no contention otherwise. (Ex. F, p. 36) Thus, the deputy commissioner's finding regarding defendants' contemporaneous conveyance of the basis for their rate calculation is respectfully reversed.

For these reasons, I find the imposition of penalty benefits is inappropriate, and the deputy commissioner's penalty award is respectfully reversed.

Costs

I will next address the deputy commissioner's taxation of claimant's costs. Defendants appeal the deputy commissioner's taxation of the full costs of the services provided by Chrisopther Leber, M.D., and Robert Rondinelli, M.D.

Dr. Leber indicated $750.00 of his invoice was related to a report, and the remainder of the $6,500.00 was for "the production of a standard life care plan." (Joint Exhibit 32, p. 11)

Per his invoice, Dr. Rondinelli's $3,250.00 charge was for time spent on "Review of Records; Medical Opinion; Impairment Rating; Disability Evaluation; (all include comprehensive report) Work Comp." (JE 32, p. 7) Dr. Rondinelli did not break down his bill to establish which portion of the $3,250.00 was specifically associated with his report.

In Des Moines Regional Transit Authority (DART) v. Young, 867 N.W.2d 839 (Iowa 2015), the court held that only the report of an IME physician—and not the examination itself—could be taxed as a cost pursuant to rule 876 IAC 4.33(6). In doing so, the court explained that "a physician's report becomes a cost incurred in a hearing because it is used as evidence in lieu of the doctor's testimony," while "[t]he underlying medical expenses associated with the examination do not become costs of a report needed for a hearing, just as they do not become costs of the testimony or deposition." Id. at 846 (noting additionally that "[i]n the context of the assessment of costs, the expenses of the underlying medical treatment and examination are not part of the costs of the report or deposition"). Based on this language, I have previously found that the expenses for a physician's review of medical records are expenses associated with an examination and therefore cannot be taxed under rule 876 IAC 4.33(6). Kirkendall v. Cargill Meat Solutions Corp., File No. 5055494 (App. Dec., 17, 2018).

In past cases, I have declined to tax any costs when invoices are not broken down to reflect which portion of charges are associated with reports versus other, non-taxable tasks. Kirkendall v. Cargill Meat Solutions Corp., File No. 5055494 (App. Dec., 17, 2018); Reh v. Tyson Foods. Inc., File No. 5053428 (App. March 26, 2018). Thus, I decline to do so in this case as well.

Dr. Rondinelli did not break down his bill to establish which portion of the invoice was for his report, nor did claimant offer any evidence regarding what was charged solely for Dr. Rondinelli's report. I therefore conclude no portion of Dr. Rondinelli's charge can be taxed as a cost under rule 876-4.33. The deputy commissioner's taxation of the costs set forth in Dr. Rondinelli's invoice is therefore respectfully reversed.

Because only $750.00 was attributable to Dr. Leber's IME report, I conclude only that portion can be taxed as a cost. The deputy commissioner's taxation of the full $6,500.00 as set forth in Dr. Leber's invoice is therefore modified.

Request for Dr. Leber's In-Home Assessment

As an alternative to a cost assessment, claimant seeks the full cost of Dr. Leber's in-home assessment in the amount of $12,806.88 as an Iowa Code section 85.27 medical expense. Claimant asserts Dr. Leber's life care plan was medical treatment under Iowa Code section 85.27. However, I find Dr. Leber's examination and report was for purposes of obtaining an expert opinion and not for purposes of treatment. I recognize his opinions served as the basis for some of my findings regarding claimant's entitlement to appliances under Iowa Code section 85.27, but Dr. Leber performed a one-time evaluation for purposes of generating an expert opinion. I therefore find Dr. Leber's in-home assessment is not reimbursable under Iowa Code section 85.27.

Alternate Medical Care

On cross-appeal claimant makes several arguments regarding his entitlement to alternate care. I will first address claimant's assertion that the deputy commissioner erred in her determination that the agency did not have jurisdiction to decide claimant's entitlement to alternate care in the form of accessible housing, transportation services, and in-home nursing services.

Claimant previously sought those same services via two applications for alternate medical care in May and July of 2017. The deputy commissioner denied those applications on the basis that none of claimant's medical providers had opined that those services were necessary. The deputy commissioner's decisions were eventually appealed to the Iowa District Court and Iowa Court of Appeals.

In the midst of those appeals, claimant's claim proceeded to hearing in arbitration. At the arbitration hearing, claimant made a specific and new request for alternate medical care. (Hearing Report; Tr., pp. 8-9)

In the arbitration decision, however, the deputy commissioner found the agency lacked jurisdiction to decide claimant's entitlement to accessible housing, transportation services, and in-home nursing services given the pending appeals of former alternate medical care decisions.

On March 6, 2019, after the parties' appeal of the arbitration decision was fully submitted, the Court of Appeals remanded the alternate medical care decisions back to the agency to make the factual determinations on each of claimant's requests without the legal requirement each request must be supported by medical evidence.

On December 13, 2019, the deputy commissioner issued a remand decision in which she again denied claimant's requests for accessible housing, transportation services, and in-home nursing services. That decision has since been appealed and is currently pending before the Iowa District Court.

In summary, there are three separate claims for alternate medical care at issue: the May 2017 application, the July 2017 application, and the claim made at the arbitration hearing in March of 2018.

Each application for alternate medical care constitutes a separate contested case proceeding. See 876 IAC 4.1(15); 4.48(3) Defendants do not dispute the fact that claimant submitted new evidence in support of his claim for alternate medical care at the arbitration hearing. More specifically, claimant submitted the reports of Dr. Rondinelli and Dr. Leber at the arbitration hearing, neither of which were in existence at the time of claimant's two earlier applications for alternate medical care.

While I agree with the deputy commissioner that the agency no longer had jurisdiction over the May 2017 and July 2017 applications for alternate medical care, I respectfully reverse the deputy commissioner's finding that the agency did not have jurisdiction over claimant's new claim for accessible housing, transportation services, and in-home nursing services that was made at the time of the arbitration hearing. This was a new claim with new evidence. I must therefore address the merits of those requests.

With respect to accessible housing, claimant seeks "the entire cost of Huff's housing, which provides wheelchair accessible entry and exit from the residence including a secondary exit in case of emergency; kitchen enabling Huff to adequately store food, cook, and do dishes; bathroom enabling Huff to toilet, bathe, use the sink, and attend to personal hygiene from the safety of his wheelchair; bedroom and closet; laundry facilities; and safe access to things such as his mailbox, garbage, the sidewalk, and transportation." (Appeal Brief, p. 30 n. 16) Claimant did not provide any cost estimates for those modifications.

In support of those requests, claimant offered the opinions of Dr. Rondinelli, who stated claimant requires a "barrier free and wheelchair accessible" residence, and Dr. Leber, who recommended claimant have "wheelchair-accessible housing." (JE 18, p. 6; JE 19, p. 40) No additional specifics were offered by either physician. Claimant, however, did offer an assessment of his ability to perform his activities of daily living (ADLs) performed by the Coastal Regional Commission of Georgia Area Agency on Aging. (JE 13)

At the time of the hearing, claimant was living in a second-floor apartment in a student-housing community. (Tr., pp. 23, 27)

Iowa Code section 85.27 provides in pertinent part:

> The employer, for all injuries compensable under this chapter or chapter 85A, shall furnish reasonable surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance and hospital services and supplies therefor and shall allow reasonably necessary transportation expenses incurred for such services.

> The employer shall also furnish reasonable and necessary crutches, artificial members and appliances....
>
> An "appliance" is defined as
>
> > hearing aids, corrective lenses, orthodontic devices, dentures, orthopedic braces, or any other artificial device used to provide function or for therapeutic purposes.
> >
> > Appliances which are for the correction of a condition resulting from an injury ... are compensable under Iowa Code section 85.27.

876 IAC 8.5.

In Quaker Oats Co. v. Ciha, the Iowa Supreme Court found that home modifications were "'other artificial device[s]' constructed to provide 'function' for" the claimant. 552 N.W.2d 143, 156 (Iowa 1996). The court found that the specific home modifications sought were "merely an extension" of the claimant's wheelchair, and as such, they were appliances necessary for claimant's care. Id.

In this case, I find claimant did not establish how the entire cost of his housing is a substitute for function lost in claimant's injury. I acknowledge that claimant did not require traditional housing before his work injury because he lived in his truck. However, claimant offered no proof at the time of the hearing that his work injury left him incapable of finding housing that could be accommodated to meet his needs. See Paulino v. C-Tec Inc., File No. 5019047 (App. July 17, 2008). Claimant, therefore, failed to prove that housing is an appliance in this case.

Claimant also seeks several specific modifications to his housing. Complicating the matter is the fact that claimant did not offer proof as to whether his current living situation would allow such modifications. Regardless, I find a wheelchair accessible entry and exit from the residence is a necessary appliance for claimant's work-related condition. In the ADL assessment, the case manager found claimant cannot perform most essential components of getting in and out of his apartment due to the stairs. (JE 13, p. 3) I similarly find that claimant requires modifications to his bathroom to enable him to toilet, bathe, use the sink, and attend to personal hygiene from the safety of his wheelchair. The ADL assessment found that claimant cannot perform most essential components of bathing or grooming, including getting in and out of his bathing area, in his current apartment. (JE 13, pp. 1-2)

I do not find claimant proved he requires kitchen modifications as a result of his work injury. The ADL assessment indicated claimant can perform most essential components of preparing his meals in his current living situation. (JE 13, p. 3) I similarly do not find claimant proved he requires modifications to his bedroom or closet. The ADL assessment indicated claimant can perform most essential components of getting dressed and getting in and out of normal sleeping places. (JE 13, p. 2) Lastly, I do not

find claimant proved he requires modifications to his laundry facilities. The ADL assessment indicated he has no issues with the laundry facilities. (JE 13, p. 3)

In summary, I find claimant proved a wheelchair accessible entry and exit from his residence and modifications to his bathroom are necessary appliances under Iowa Code section 85.27. I find claimant failed to prove his burden for the remainder of his accessible housing claims.

I now turn to his claim for transportation services. Claimant seeks "wheelchair accessible transportation, including purchase of a van and the cost of converting it to be wheelchair accessible." (App. Brief, p. 30) In support of this claim, claimant cites the opinions of Dr. Leber and Dr. Rondinelli. While both Dr. Rondinelli and Dr. Leber agree that claimant needs "transportation assistance to and from various destinations such as a physician's office, bank, grocery stories, and similar destinations in his community" given his "wheelchair-confined" state, I find neither of their opinions support claimant's request for the purchase of a van. (JE 18, p. 7; JE 19, p. 40)

First, Dr. Rondinelli indicated claimant could not feasibly operate a motor vehicle even with an adaptation given the current condition of his right lower extremity. (JE 18, p. 7) Further, claimant told Dr. Leber he "does not want [a vehicle] at the current time." (JE 19, pp. 37, 40) Thus, I find the evidence does not support claimant's request for a van or the cost of converting a vehicle to be wheelchair accessible.

However, Dr. Rondinelli indicated paratransit services such has handicap accessible bus services, vans, etc. "would be instrumental" in assisting claimant with his ADLs outside the home. (JE 18, p. 7) Like in Manpower Temporary Services v. Sioson, such services are "necessary in order to make [claimant's] wheelchair fully useful." 529 N.W.2d 259, 264 (Iowa 1995). Without such services, he is essentially limited to his apartment. Thus, because claimant is wheelchair-bound as a result of his work-related injuries, I find such paratransit services are a necessary appliance under Iowa Code section 85.27 for which defendants are responsible.

Claimant also seeks in-home nursing services. In support of his claim for in-home services for assisting with ADLs, claimant cites to a page from Dr. Leber's report (JE 19, p. 42) regarding claimant's disabilities. While Dr. Leber does indicate on this page that claimant has a decreased ability to perform his ADLs as a result of his work injuries, there is nothing on this page regarding what in-home services claimant requires, if any. Claimant also cites to several pages from Dr. Rondinelli's report (JE 18, pp. 5-6, 9), but again, these pages only address claimant's limitations and not what services claimant requires, if any. I therefore find insufficient evidence that claimant requires in-home services for assisting with ADLs.

Dr. Leber does indicate claimant requires the assistance of a home health aide for two hours per week, which would account for services directly associated with providing nursing and/or attendant care. (JE 19, pp. 49-50) However, Dr. Leber does not provide any explanation as to which of claimant's conditions require nursing and/or

attendant care. Claimant actually testified at the time of his hearing that he does not require assistance. (Tr., p. 90) I therefore find insufficient evidence that claimant required a home health aide at the time of the hearing.

Claimant also cross-appeals several requests for care that the deputy commissioner addressed on the merits in the arbitration decision. The first of these requests on cross-appeal is claimant's request for durable medical equipment. Claimant seeks a custom AFO brace, shower chair, walker, cane, and power scooter with accessories, all of which were recommended by Dr. Leber. (JE 19, p. 49) However, Dr. Leber failed to provide any explanation as to why the equipment he recommended is necessary.

Defendants already provided claimant with a manual wheelchair and a walker. (Tr., p. 85) Claimant offered no testimony regarding his needs for a custom AFO brace, different walker, cane, or scooter. I acknowledge Dr. Rondinelli mentioned a power scooter in his report (JE 18, p. 7), but this was in terms of outside transportation in the community. Because I found defendants must provide claimant with paratransit services, there is no additional need for a power scooter. I therefore find insufficient evidence that claimant requires a custom AFO brace, walker, cane, or power scooter.

With respect to the shower chair, I already determined above claimant is entitled to modifications to his bathroom to make it wheelchair accessible. I find the shower chair is a component of these modifications. The deputy commissioner's findings with respect to claimant's request for durable medical equipment are therefore affirmed but for the request for a shower chair, which is respectfully reversed.

Lastly, claimant seeks treatment with a physiatrist. Claimant wants a physiatrist to be authorized as a "gatekeeper" to "help ensure [claimant] does not become more deconditioned, develop additional muscle atrophy, suffer preventable falls, develop pressure ulcers, or develop other preventable complications resulting from his wheelchair dependent status." (App. Brief, p. 34) This gatekeeping function claimant seeks is all prospective in nature, however.

Claimant's treating orthopedist discharged claimant until he quit smoking. (JE 12, p. 5) Claimant was receiving ongoing care for his ulcer at the time of the hearing, but he testified he did not require pain medication or assistance with his wounds. (Tr., pp. 89-91) Should claimant's condition deteriorate and require additional care, claimant can at that time seek authorization for additional treatment and if necessary seek alternate medical care. However, I agree with the deputy commissioner that claimant failed to prove that the care authorized by defendants for claimant's ulcer was unreasonable. I find insufficient evidence that claimant requires care with a physiatrist.

ORDER

IT IS THEREFORE ORDERED that the arbitration decision filed on June 19, 2018, is affirmed in part, modified in part, and reversed in part.

Defendants shall pay claimant a running award of healing period benefits from April 24, 2016, at the rate of four hundred twenty-seven and 54/100 dollars ($427.54), until such time as benefits shall cease pursuant to Iowa Code section 85.34.

Defendants shall pay accrued weekly benefits in a lump sum together with interest at the rate of ten (10) percent for all weekly benefits payable and not paid when due which accrued before July 1, 2017, and all interest on past due weekly compensation benefits accruing on or after July 1, 2017, shall be payable at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two (2) percent. See Gamble v. AG Leader Tech., File No. 5054686 (App. Apr. 24, 2018).

Defendants are responsible for all medical bills set forth in Joint Exhibit 31, totaling one hundred four thousand three hundred twelve and 09/100 dollars ($104,312.09).

Defendants are responsible for the following under Iowa Code section 85.27: a wheelchair accessible entry and exit from claimant's residence; modifications to claimant's bathroom to enable him to toilet, bathe, use the sink, and attend to personal hygiene from the safety of his wheelchair, including but not limited to a shower chair; and also paratransit services. Defendants are likewise responsible for a psychological assessment, evaluation, and any recommended treatment as set forth in the arbitration decision.

Pursuant to rule 876 IAC 4.33, defendants are assessed the following of claimant's costs of the arbitration proceeding: one hundred and 00/100 dollars ($100.00) for the filing fee, twelve and 92/100 dollars ($12.92) for service, one hundred fifty and 00/100 dollars ($150.00) for the cost of the alternate medical care hearing transcript, seven hundred and fifty 00/100 dollars ($750.00) for Dr. Leber's report, one hundred eighty-nine and 00/100 dollars ($189.00) for the cost of the alternate care hearing transcript, the cost of the hearing videographer, and the cost of the hearing court reporter and transcript, and the parties shall split the costs of the appeal, including the cost of the hearing transcript.

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

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

JOSEPH S. CORTESE II
WORKERS' COMPENSATION
COMMISSIONER

The parties have been served as follows:

R. Saffin Parrish-Sams	Via WCES
Chris Scheldrup	Via WCES