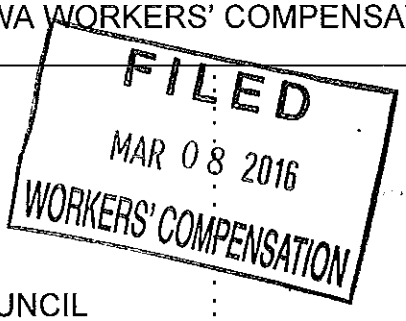
BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER



KELLY BARRETT,

Claimant,

vs.

AMERISTAR CASINO COUNCIL BLUFFS, INC.,

Employer,

and

HARTFORD ACCIDENT & INDEMNITY INSURANCE CO.,

Insurance Carrier,
Defendants.

File No. 5046572

ARBITRATION

DECISION

Head Note Nos.: 1108.50; 1801; 1802; 2206; 2500; 2450

STATEMENT OF THE CASE

The claimant, Kelly Barrett, brings a workers' compensation claim against Ameristar Casino Council Bluffs, Inc., employer and Hartford Accident and Indemnity Insurance Co., insurance carrier, both as defendants for an injury arising out of April 19, 2013, incident when a patron allegedly bumped into claimant while she was working at the defendants' place of employment.

The record consists of testimony of the claimant, claimant's exhibits 1 through 27, and defendants' exhibits A through Y.

The case was heard on December 14, 2015 and considered fully submitted as of January 11, 2016.

ISSUES

1. Whether the claimant sustained an injury on April 19, 2013 which arose out of and in the course of her employment.
2. Whether the alleged injury was the cause of some temporary disability during a period of recovery.
3. Whether the alleged injury was the cause of some permanent disability.
4. If so, whether the disability was industrial in nature.
5. The extent of that disability.
6. Whether claimant is entitled to reimbursement of payment of medical expenses.

7. Whether claimant is entitled to alternate care under Iowa Code section 85.27.
8. When the claimant has reached maximum medical improvement.

STIPULATIONS

The parties agree that at the time of the claimant's alleged injury she was an employee of the defendant employer. They further agree that the commencement date for any permanent partial disability benefits would be June 9, 2015.

At the time of the alleged injury the claimant's gross earnings were $455.00 per week. She was single and entitled to exemptions. Based on those foregoing numbers, the parties stipulate the weekly benefit rate to be $301.09.

While the defendants dispute responsibility for the medical bills in Exhibit 27, they agree that the fees and prices charged by the providers were fair and reasonable, the treatment was reasonable and necessary.

Prior to the hearing claimant was paid 27.05 weeks of compensation at the rate of $295.22 per week.

FINDINGS OF FACT

Claimant, Kelly Barrett, was 45 years of age at the time of the hearing. She has a high school education.

Following high school, claimant joined the Navy and served for a total of eight years initially as a Hospital Corpsman and then she began to take college classes to learn to be an x-ray technician. She did not complete those courses and instead transferred to an administrative personnel position where she worked with records and other documents.

She has a class B commercial driver's license and prior to her employment with the defendant employer, she drove a garbage truck as well as working as a school bus and motor coach driver for approximately 11 years. Her other driving experience included armored car driver and security guard. She worked approximately seven years as a correctional officer. She was terminated from her correctional position due to absenteeism. (Exhibit L) In the more distant past, she had experience as a stable attendant caring for horses along with maintenance of an apartment complex.

She worked for defendant in 2004 through 2006 and then recently returned to employment with defendant employer on 2011. It was the claimant's practice to work two jobs at a time.

Claimant's past medical history is significant for a fall from a horse in 1992 which resulted in ongoing back complaints. (Ex. E) X-rays in 1998 revealed minimal degenerative joint disease and spina bifida occulta. (Ex. E, p. 1) She had a

concentrated spate of treatment in the spring and early summer of 2001. (Ex. E) After 2001, claimant received no medical care or treatment for any back pain until April 19, 2013.

On April 19, 2013, claimant was working the roulette table. She waved off the bets but suffered a collision when a guest cut through the pit and ran into her from behind. She twisted upon impact and felt a pull in her back. She informed her floor supervisor what had happened when she finished her shift.

Claimant believes that the incident happened at 6:30 p.m. There is a video in evidence taken of that time that shows no such collision. However, Gregory Nothstine was deposed and his deposition testimony supports the description of the incident by the claimant. He identified that the time of the event was 7:45 p.m., instead of the 6:30 p.m. time frame Ms. Barrett originally had identified. He observed a gentleman with gray hair walk past behind the 2018 dealer and exit between tables 2018 and 2019 where claimant was working. Mr. Nothstine also testified that it was not uncommon for patrons to attempt shortcuts behind the dealers in order to go to and from the restrooms.

Mr. Nothstine walked away from Barrett to another table to address an issue and when he returned approximately five minutes later, Barrett reported to him that a player passed behind and ran into the claimant. Mr. Nothstine remembered that Barrett had back pain and worried whether she would be able to finish her shift. She did.

She testified in her deposition and in her answers to interrogatories that the man was running when he struck her and that she experienced intense low back pain after the collision. At the time of her injury, however, she refused medical care.

The testimony of claimant's supervisor Mr. Nothstine, as well as the personal statement he filled out shortly after the event as well as the claimant's own testimony confirm that claimant was struck by a patron and that she sustained some injury. (Exhibit 2)

On April 20, 2013, following the conclusion of her shift, claimant sought care at Ortho West Urgent Care. She reported that her back symptoms began when she was dealing at work, backing up and turning slightly when a customer ran into her. She described the pain as aching and radiating into her left lower leg. She was given pain medication and discharged. (Ex. 4, pp. 6 to 7)

She was then seen at Allegiant Creighton Health by LeAnne Vitito, a nurse practitioner. (Ex. 7) She reported to Ms. Vitito that she had had prior problems in the remote past. X-rays revealed a slight narrowing of disk space at L4 – 5 and very minimal levoscoliosis at the same. (Ex. 7, p. 17) On examination, she exhibited good range of motion. Ms. Vitito diagnosed claimant with lumbar strain and recommended a few mild restrictions. (Ex. 4, pp. 13, 14)

As recommended, claimant returned a week later to see Ms. Vitito on May 1, 2013. Claimant exhibited good range of motion although had some slight increase in pain when she flexed as well as when she walked on her toes. (Ex. 7, p. 18) Ms. Vitito believed it was prudent to refer claimant to the back pain center for further evaluation and order some physical therapy to see if the pain could be relieved.

After her visit with Ms. Vitito, claimant was placed in a seated job and given the light-duty restrictions. The claimant reported to her physical therapist on May 1, 2013 that claimant was unable to finish her shift because she was in so much pain. Upon examination, claimant exhibited pain upon right side bending. (Ex. 7, p. 23) She began physical therapy on May 1, 2013.

Her pain ebbed and flowed during the six visits of physical therapy. (Ex. 7, p. 29) Upon discharge on July 25, 2013, the claimant said that the pain was more of a dull ache but she reported numbness in her left foot. Her trunk range of motion was within normal functional limits although she did exhibit pain with left side bending. (Ex. 7, p. 2)

On May 24, 2013, claimant was seen by Kip A. Burkman, M.D., at Allegiant Creighton Clinic for back pain and numbness into her legs. (Ex. H) On examination she exhibited decreased light touch at the left lateral calf, left dorsolateral foot and left posterior thigh as well as a decreased pinprick sensation at the left lateral/posterior calf, left dorsal/lateral/plantar foot. (Ex. 9, p. 36) Dr. Burkman recommended an MRI. (Ex. 9, p. 36) Dr. Burkman also recommended the claimant be off work until further notice.

She returned on June 10, 2013 to follow up on her MRI. The MRI showed deformity with hypertrophic changes on the left S1 facet that was medially displacing the left S1 nerve root within the central canal. (Ex. 9, p. 42) Dr. Burkman recommended she undergo an EMG to further aid in diagnosis.

She was kept off of work again until August 9, 2013 at which time Dr. Burkman wrote a note "returned to work as of 8/10/13 on roulette in craps tables only. Maximum lift/carry 20 pounds occasionally. Work six hours/day for 5 days/week." (Ex. 9, p. 46) Claimant underwent steroid injection on April 23, 2013, June 25, 2013 and August 13, 2013 with Tyrus S. Soares, M.D., but experienced no lasting relief. (Ex. 12, p. 74)

Dr. Burkman believes that the injury the claimant sustained to her back interfered with an already altered area giving rise to symptoms of low back pain. The work comp injury did not cause the facet enlargement or displacement of the nerve, but triggered the symptoms. (Ex. 9, p. 48) Dr. Burkman wrote another work release for the claimant keeping her off of work from September 9, 2013 until September 16, 2013. (Ex. 9, p. 51)

She returned to follow up on September 26, 2013 after an EMG test which was normal[1]. (Ex. 9, p. 53) Claimant reported that she only worked 2-4 hours a day despite being released to do 6 hours because "there is not enough basis to keep her there." (Ex. 9, p. 53) She continued to have pain at a 7-8 out of 10 and cramps and paresthesia type intense sensations down the left leg. (Ex. 9, p. 53) She was given a prescription for Parafon Forte DSC and instructed to begin water therapy. (Ex. 9, p. 54) Initially, she was unable to go to water therapy due to a bowel condition.

On October 22, 2013, claimant took herself to Bryan Medical Center – East emergency room with reports of pain in her back and diarrhea. (Ex. 16, p. 89) She then returned to Dr. Burkman on October 30, 2013. (Ex. 9, p. 57) Claimant still exhibited decreased light touch and pinprick sensations on the left lateral calf and left foot. (Ex. 9, p. 58) He recommended she continue to increase her core strength and undertake a home exercise treatment. (Ex. 9, p. 6463)

At her physical therapy appointment on October 14, 2013, therapist Angela Davis reported that claimant's posture revealed decreased lumbar lordosis. Claimant ambulated with a slightly antalgic gait with a slightly decreased stance time on the left lower extremity. (Ex. 15, p. 80) Her lumbar range of motion was approximately 75 percent of normal and she had increased tenderness to palpation at the L4 through S1 left paravertebral musculature.

The plan was to see her three times a week for two weeks. (Ex. 15, p. 80) Claimant attended the scheduled physical therapy only half the time. (Ex. 15, p. 82) By November 21, 2013, Ms. Davis reported that claimant had a total of 9 visits. Her back pain was unchanged and aquatic therapy was not helpful. Claimant complained of a severe rash on her chest, hands and feet since the commencement of water therapy. The therapist did not believe future water therapy would be helpful. (Ex. 15, p. 83) Ms. Davis also noted that claimant, "Unlike other patients[,] does not seem to have less pain while in the water." (Ex. 15, p. 83)

Her final visit was on November 26, 2013. After that date, claimant did not attend another scheduled appointment and did not return phone calls. (Ex. 15, p. 84)

She reported to the emergency room at Bryan Medical Center-East on October 22, 2013, with complaints of back related pain. (Ex. 16, p. 85) She described the pain as dull and sharp but with no radiation. (Ex. 16, p. 88) The examination noted full range of motion with movement and no joints tender to palpation. Her straight leg

[1] There is some dispute in the records about the EMG results in 2013. A VA record of 7/8/2014, referred to an EMG performed one year earlier showed a L5 radiculopathy. It is unknown whether this information was obtained via a medical report or the claimant's personal history. Dr. Trinh noted that the EMG in 2001 showed chronic and active left L5 radiculopathy.

raise tests were negative. (Ex. 16, p. 89) Chad Duval, M.D., prescribed Percocet and injections of Ketorolac Tromethamine and Valium. (Ex. 16, p. 89)

On December 10, 2013, Huy D. Trinh, M.D., issued an IME report wherein he concluded that claimant's MRIs showed additional disc degeneration in her most recent MRI and that an EMG study completed in 2001 showed chronic and active left L5 radiculopathy but the 2013 EMG results were normal. (Ex. J, p. 2) Dr. Trinh concluded that the symptoms claimant expressed were related to her pre-existing condition rather than any traumatic injury. He believed she was at MMI as of December 9, 2013, the date of his examination, and that she did not need permanent work restrictions. (Ex. J, p. 3)

After her failed physical therapy, claimant was sent to Christopher M. Criscuolo, M.D. (Ex. 17) She exhibited normal range of motion with lumbar paravertebral spasm. (Ex. 17, p. 93) He recommended myofascial trigger point injections. (Ex. 17, p. 94) The initial injection received a good response and she returned for a second. (Ex. 17, p. 96; Ex. 19, p. 116)

On August 7, 2014, claimant was seen by Rahul Sharma at the VA Clinic for depression, anxiety and back pain. She was prescribed medication and instructed to follow up. (Ex. 18, p. 113)

A functional capacity evaluation was performed on June 9, 2015, by Jay Herman DPT. (Ex. 20) Over the day, claimant experienced an increase in negative symptoms. As a result, the evaluator concluded "client's physical capabilities fall in the ranges of light category." (Ex. 20, p. 124)

The following is a definition of light category.

> Exerting up to 20 pounds of force occasionally, and/or up to 10 pounds of force frequently and/or a negligible amount of force continuously to move objects. Physical demand requirements are in excess of those for sedentary work. Even though the weight lifted may be only a negligible amount, a job should be rated light if: 1) it requires walking or standing to a significant degree; 2) it requires sitting most of the time but entails frequent use of arm or leg controls; and/or 3) it requires working at a production rate pace entailing the constant handling of materials even though the weight of those materials is negligible.

(Ex. 20, p. 124)

Mr. Herman expanded on his report in a deposition taken on October 27, 2015. (Ex. X) He testified that claimant exhibited some signs that her effort was not consistent with movement patterns that should occur. (Ex. X, p. 6) But in other tests, she exhibited good effort. Ultimately he wrote in his report that she had worked hard and gave good effort through the evaluation. (Ex. 20, p. 124)

She then began treatment with John W. McClellan M.D., at the Nebraska Spine Center LLP (Ex. 21, p. 129) On examination, she had reduced range of motion, tenderness to palpation at the L3-S1 region, and a negative straight-leg test. (Ex. 21, p. 132) Plain x-rays showed five lumbar type vertebrae, her right hemipelvis raised higher than the left, mild joint space narrowing bilaterally in the hips, and decreased disc height through the entire lumbar spine. (Ex. 21, p. 135) The CT taken on June 25, 2015, showed "mild L4-5 spinal stenosis secondary to concentric disc bulging" and "multilevel facet joint osteoarthritis, most pronounced on the left at L5-S1." (Ex. 21, p. 138)

Dr. McClellan's physician's assistant, Sarah Stamm PA-C, concluded that claimant had permanently aggravated a pre-existing condition on the L5/S1 region and that her sciatica would not ever resolve. "She will likely go onto a chronic nerve injury if she has not already," Ms. Stamm wrote. (Ex. 21, p. 136)

Dr. McClellan authored an opinion letter for the claimant wherein he opined that claimant had sustained a work related injury causing chronic lumbar pain and left sciatica as a result of an aggravation of a pre-existing injury. (Ex. 21, p. 140) Dr. McClellan recommended surgical repair of the comminuted pedicle fracture. (Ex. 21, p. 145)

On June 24, 2015, Jane Yaffe-Rowell, MS, issued an industrial disability assessment. (Ex. 23, p. 179) Ms. Yaffe-Rowell concluded the restrictions in the FCE would prevent claimant from returning to full duty work as a Table Games Dealer. (Ex. 23, p. 190)

The physical requirements included in the work description include only occasional lifting 10 pounds and under along with frequent walking and constant standing. Despite the sit/walk/stand restrictions in the FCE, the physical requirements of the Table Games Dealer seem largely within the FCE results which recommend claimant sit for a total of 3-4 hours, stand for 3-4 hours or walk 2-3 hours, frequently changing position. (Ex. 23, p. 184)

Based on claimant's pain levels and the FCE along with claimant's education and work experience, Ms. Yaffe-Rowell concluded claimant had lost 48 percent access to the labor market and a 30 percent loss of earning capacity. (Ex. 23, p. 190) This figure was later revised after Yaffe-Rowell learned of claimant's new employment. Prior to the new position, Yaffe-Rowell estimated that claimant's wage loss was between 10 to 17 percent at a minimum. After the new employment, Yaffe-Rowell revised that figure to be zero percent to 17 percent and thus modifying claimant's earning capacity loss to 25 percent. (Ex. 23, p. 193)

Dean Wampler, M.D., performed an independent medical examination of the claimant at the behest of the defendants. (Ex. R) The report was issued on November 6, 2015, a day after the examination. (Ex. R, p. 1) Dr. Wampler noted that the left L5-S1 facet fracture was the result of a degenerative process and not a traumatic injury, similar to what Dr. Burkman opined earlier. During examination, she

exhibited diminished light touch sensation and pinprick sensitivity in the lateral calf and dorsum of the left foot. The straight leg test increased left low back pain. She could bend forward more than 60 degrees but hesitated straightening due to pain. The rest of the test results were within normal range. (Ex. R, p. 5)

Dr. Wampler diagnosed claimant with:

> Ms. Barrett has pre-existing spine abnormalities that include congenital spinal bifida at L5-S1. This development defect has resulted in advanced degenerative changes at this level. Increasing stress to the posterior elements from the developmental defect has resulted in a pedicle stress fracture of L5. This is not a traumatic or acute fracture. The bone spurs and disc abnormalities have resulted in a chronic left L5 radiculopathy.

(Ex. R, p. 5)

Dr. Wampler does not necessary discount the claimant's account of how the injury occurred but doubted that the blow could produce the symptoms that claimant professed to suffer.

> Instead, it is vastly more likely that Ms. Barrett's pre-existing developmental abnormality has developed over time into a chronic degenerative process that has resulted in chronic L5 radiculopathy. There is no reason to believe that a bump to the back in 2013 could produce her symptoms, exam findings and diagnostic tests showing her current spine disease and defects.

(Ex. R. p. 5)

He also noted that a pedicle fracture is the "end result of degenerative stress and strain to her spine structures" and that "substantial impact is required for pedicle fracture...Getting bumped by another person without falling down would not cause a traumatic pedicle fracture." (Ex. R, p. 6) He concluded that claimant suffered a muscular strain that resolved around April 30, 2013. (Ex. R, p. 7)

Ronald R. Schmidt, MS, performed a loss of earning capacity analysis at the request of the defendants. (Ex. S) He concluded, primarily because claimant had returned to comparable employment she sustained between zero and 5 percent reduction in earning power. (Ex. S, p. 4) He did acknowledge that prior to her injury, claimant was able to meet the Medium physical demand level and after her physical ability dropped to Light physical duty. (Ex. R, p. 3)

On April 19, 2013, claimant suffered her injury. On August 17, 2013, she returned to work after a release from her physician. Claimant worked through September 29, 2013. On September 29 and 30, 2013, claimant missed work due to an

allergic reaction to the aquatherapy. Claimant provided a doctor's note and those absences were removed from her record.

On October 13, 2013, claimant had a bad reaction to medication she was taking for the pain. She was absent from work from October 13, 2013, through October 27, 2013. On October 27, 2013, she was terminated. On October 30, 2013, claimant obtained a note from her physician excusing her from work until November 4, 2013. Defendant employer refused to accept the doctor's note.

Claimant is currently employed at a new casino dealing craps and serving as a supervisor. (Ex. 23, p. 192) Her wage is $16.89 per hour and she works approximately 32 hours a week, making more than she did prior to the injury. Claimant maintains her new employer is accommodating claimant's restrictions. (Ex. 23, p. 192) Her job description requires the ability to stand 60 minutes at a time on carpeted floor, hardwood floor, or footstool, reach, deal cards, and be able to handle high levels of stress. (Ex. N, p. 4)

In 2011 and 2012, claimant was part of the Nebraska Stampede, a women's football team. The Stampede was a tackle football league and claimant played on the offensive and defensive line. In a statement Jennifer Zelenka, a co-worker and teammate of the claimant, maintained that claimant withdrew from the team primarily because of injuries and other time commitments. Claimant disagreed and testified that Zelenka was not a substantial part of the team. (Ex. U)

Zelenka stated that claimant practiced and played in one game. Claimant testified that her schedule did not allow her to take time off on Saturdays for the game and agreed she did not play more than two games in the season of 2012.

CONCLUSIONS OF LAW

The party who would suffer loss if an issue were not established has the burden of proving that issue by a preponderance of the evidence. Iowa R. App. P. 6.14(6).

The claimant has the burden of proving by a preponderance of the evidence that the alleged injury actually occurred and that it both arose out of and in the course of the employment. Quaker Oats Co. v. Ciha, 552 N.W.2d 143 (Iowa 1996); Miedema v. Dial Corp., 551 N.W.2d 309 (Iowa 1996). The words "arising out of" referred to the cause or source of the injury. The words "in the course of" refer to the time, place, and circumstances of the injury. 2800 Corp. v. Fernandez, 528 N.W.2d 124 (Iowa 1995). An injury arises out of the employment when a causal relationship exists between the injury and the employment. Miedema, 551 N.W.2d 309. The injury must be a rational consequence of a hazard connected with the employment and not merely incidental to the employment. Koehler Electric v. Wills, 608 N.W.2d 1 (Iowa 2000); Miedema, 551 N.W.2d 309. An injury occurs "in the course of" employment when it happens within a period of employment at a place where the employee reasonably may be when

performing employment duties and while the employee is fulfilling those duties or doing an activity incidental to them. Ciha, 552 N.W.2d 143.

The greater weight of the evidence supports a finding that claimant was jostled by a customer and sustained some kind of injury flowing from that physical encounter. The supervisor observed a gentleman in the area of the claimant around the time she was injured. Despite the fact that the area was small and not likely to support a person running through it, there was at least one patron observed by Mr. Nothstine to have wandered behind the claimant's roulette table. Further, Mr. Nothstine testified that it does happen, from time to time, that patrons are in that area trying to take shortcuts to the restrooms. While the surveillance footage did not show any collision, Mr. Nothstine appears to have more accurately pegged the time of the incident earlier than the claimant had reported. Mr. Nothstine, unlike the claimant, had access to a clock and recorded the incident shortly after he was informed of it. The surveillance video did not include the time period Mr. Nothstine recorded the event occurred.

The next question is the extent of the injury. Claimant asserts she's suffered a severe and lasting injury arising from the work incident. In support of her claim, she points to Dr. Burkman's medical notes which opine that the person who ran into claimant triggered symptoms arising from her degenerative condition. Dr. McClellan agrees although he diagnosed claimant with having suffered a comminuted pedicle fracture.

Dr. Wampler does not believe that claimant sustained a pedicle fracture as a result of any collision with a gambler at the casino. Low-impact type of contact could not have caused pedicle fractures and instead Dr. Wampler opines that a football injury is more likely the cause of a pedicle facture.

It is not likely that the collision was with great force. A collision of force would have likely alerted the people around claimant, including Mr. Nothstine who was in the general vicinity of the claimant when the impact occurred, but had no contemporaneous awareness of a collision.

It is more likely than not that claimant's pedicle fracture was caused by her football activities than a mild impact with a patron at the casino.

However, Dr. Burkman and Dr. McClellan agree that claimant sustained an aggravation of a pre-existing condition. She had back pain in the remote past with care ending around 2001. The medical providers all agree that claimant had degenerative disease and more recent testing shows evidence of a pedicle fracture that needs surgical repair.

However, prior to the impact at the defendant employer's place of business, claimant was not regularly treating with any physician for her back. Following the impact, she had varying complaints of pain in her low back with radiation down the left side.

The greater weight of the evidence supports a finding that claimant sustained an aggravation of a pre-existing condition including degenerative disease and the pedicle fracture.

However, the ongoing pain and discomfort claimant is suffering does not appear to be related to the aggravation. Dr. McClellan diagnosed claimant's primary issue as the pedicle fracture, as did Dr. Wampler. Claimant's pedicle fracture is not related to the work injury.

Therefore it is determined that claimant sustained a temporary aggravation of her back condition and that Dr. McClellan returned claimant to substantially similar work as of September 16, 2013. Claimant held herself out as ready, willing and able to work in the unemployment hearing in Nebraska and testified that she was able to work at the time of her termination. Claimant is entitled to temporary benefits for the days she was off of work from the time of her injury on April 19, 2013, to September 16, 2013.

Because her ongoing problems are not related to her work injury, the issues regarding permanency are moot.

Medical expenses related to claimant's condition up to September 16, 2013, shall be reimbursed by the defendants.

Additionally, claimant seeks an order that she be allowed to undergo surgical repair of her pedicle fracture and that defendants be charged with the responsibility of any disability, either temporary or permanent, as well as the medical expenses incidental to such surgery. As it has been determined that the pedicle fracture is not related to her work injury, claimant is not entitled to such an order.

ORDER

THEREFORE IT IS ORDERED:

Claimant sustained a work related injury arising out of and the in the course of her employment on April 19, 2013.

The work-related injury was a temporary aggravation of a pre-existing injury and condition and claimant's entitlement to temporary benefits ended when she was capable of returning to substantially similar employment as of September 16, 2013.

That defendant is to pay unto claimant temporary total benefits from April 19, 2013, to September 16, 2013, at a rate of three hundred one and 09/100 dollars ($301.09).

That defendants shall pay accrued weekly benefits in a lump sum.

That defendants shall pay interest on unpaid weekly benefits awarded herein as set forth in Iowa Code section 85.30.

That defendants are to be given credit for benefits previously paid.

That each party shall bear their own costs.

Signed and filed this 8th day of February, 2016.

JENNIFER S. GERRISH-LAMPE
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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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 in writing and received by the commissioner's office 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 a legal holiday. The notice of appeal must be filed at the following address: Workers' Compensation Commissioner, Iowa Division of Workers' Compensation, 1000 E. Grand Avenue, Des Moines, Iowa 50319-0209.