BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

ALFRED FRANCES COTÈ,

Claimant,

vs.

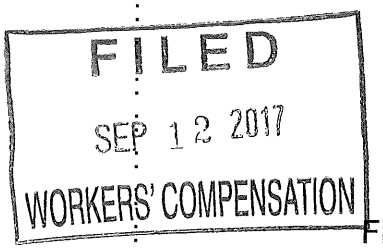
FEDERAL MOGUL CORP.,

Employer,

and

TRAVELERS INDEMNITY COMPANY OF CT.,

Insurance Carrier,
Defendants.



File No. 5054541

ARBITRATION

DECISION

Head Note Nos.: 1803; 2500

STATEMENT OF THE CASE

This is a proceeding in arbitration. The contested case was initiated when claimant, Alfred Frances Coté, filed his original notice and petition with the Iowa Division of Workers' Compensation. The petition was filed on September 22, 2015. Claimant alleged he sustained an injury on November 24, 2013. (Original notice and petition.)

For purposes of workers' compensation, Federal-Mogul Corp., defendant, is insured by Travelers Indemnity, Company of Ct, defendant. Defendants filed their answer on October 27, 2015. They denied the occurrence of the work injury. A First Report of Injury was filed on September 15, 2014.

The hearing administrator scheduled the case for hearing on September 19, 2016. The hearing took place in Des Moines, Iowa at 150 Des Moines Street. The undersigned appointed Ms. Roxann Zuniga as the certified shorthand reporter. She is the official custodian of the records and notes.

Claimant testified on his own behalf. The parties offered joint exhibits, marked 1 through 26. Defendants offered exhibits marked A through I. All proffered exhibits were admitted as evidence in the case.

The original transcript was filed on September 27, 2016. Post-hearing briefs were filed on October 21, 2016. The case was deemed fully submitted on that date.

The parties filed a hearing report at the commencement of the arbitration hearing. On the hearing report, the parties entered into various stipulations. All of those stipulations were accepted and are hereby incorporated into this arbitration decision and no factual or legal issues relative to the parties' stipulations will be raised or discussed in this decision. The parties are now bound by their stipulations.

STIPULATIONS

The parties completed the designated hearing report. The various stipulations are:

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

2. Temporary benefits are no longer an issue;

3. The parties agree if permanency is found, the permanency is an industrial disability;

4. The parties agree, if a permanent work injury is determined, claimant reached maximum medical improvement on November 25, 2013;

5. The parties agree, the weekly benefit rate is $827.18;

6. Defendants have waived any affirmative defenses they may have had available;

7. Prior to the date of the hearing, defendants paid claimant zero weeks of permanent partial disability benefits; and

8. The parties agree certain costs that are detailed were paid by claimant.

ISSUES

The issues presented are:

1. There is a dispute whether claimant sustained an injury on November 24, 2013 which arose out of and in the course of his employment, although the parties admit there was an exposure on that date;
2. There is a dispute whether there is a cause of temporary disability during a period of recovery;
3. There is a dispute whether there is a cause of permanent disability;
4. If there is a permanent disability, there remains the issue of the extent of the disability; and
5. Whether claimant is entitled to medical expenses pursuant to Iowa Code section 85.27.

FINDINGS OF FACT

This deputy, after listening to the testimony of claimant at hearing, after judging his credibility, and after reading the evidence, and the post-hearing briefs, makes the following findings of fact and conclusions of law:

The party who would suffer loss if an issue were not established has the burden of proving the issue by a preponderance of the evidence. Iowa Rule of Appellate Procedure 6.14(6).

Claimant is 58 years old and married. He is the legal guardian of his 17 year-old grandson. Claimant is right hand dominant. For a number of years, claimant has been morbidly obese. Many physicians have counseled claimant to lose weight.

Claimant is a high school graduate. He has an Associate of Arts degree in Applied Science in industrial electricity electronics from New Hampshire Vocational Technical College in Portsmouth, New Hampshire. He also attended night school at Northern Essex Community College in Massachusetts in criminal justice. He also spent a year of study at New Hampshire Technical Institute in Concord, New Hampshire studying emergency medicine. (Transcript, pages 10-11) Claimant is considered to be a master electrician.

In 2002, claimant developed West Nile virus. He came into contact with mosquitoes while he was on a picnic with his grandchildren. (Tr., p. 14)

Claimant was referred for treatment to Nidal Alkurdy, M.D., at Burlington Neurology & Sleep Clinic, P.L.C. Claimant reported to Dr. Alkurdy the following medical history at his appointment on October 21, 2002:

> HISTORY OF PRESENTING COMPLAINT:
>
> The patient is a 44 year old right handed male who started about 5 weeks ago experiencing diarrhea with generalized fatigue. A few days later, the patient was having cold-like symptoms with high grade fever and severe headache, the patient was admitted to the hospital. Initially the patient was treated for pneumonia and was started on antibiotics and Flagyl. The patient's symptoms continued to get worse with increased headaches, fluctuations in his blood pressure and heart rate, hearing, and smelling loss with an episode of severe vertigo balance problems and numbness sensation involving the left side of his face, left arm and leg. Most of his symptoms are slightly better now although he is still getting recurrent severe headaches with dizziness. The patient has been having episodes of confusion. The patient has been taking Ibuprofen occasionally with limited help. The patient was informed last week that his blood test was positive for West Nile Virus.

(Ex. A, page 1)

Dr. Alkurdy diagnosed claimant as follows:

IMPRESSION:

Recent West Nile Viral infection proven by serology. I believe the patient is having post viral symptoms with possible feature of mild post viral encephalitis and possible small ischemic stroke that would explain the objective finding with the neurological exam. I am requesting MRI MR angiogram of the brain and carotids and EEG. I am checking his sed rate. I am starting the patient on Indocin 25 mg three times a day with food for the next two weeks. The patient may need a short course of steroids if that does not help. Follow up in two weeks.

(Ex. A, pp. 2-3)

On October 24, 2002, claimant was admitted to the Great River Medical Center in West Burlington, Iowa. (Ex. A, p. 4) Dr. Alkurdy diagnosed claimant with:

IMPRESSION: Post West Nile virus. The patient has a feature of cranial nerve neuropathy, dysphagia, left-sided numbness and mild weakness. I suspect this is a possible complication of his initial viral infection. We will try and give supportive and systematic treatment. The patient will receive speech and swallowing evaluation. MRA of the brain. I will also check him for Lyme disease.

(Ex. A, p. 5)

On January 10, 2003, claimant underwent neurophyschological screening at Great River Mental Health Care. (Ex. B, p. 1) Mr. Gary Szymula, Ph.D., administered a battery of tests. Dr. Szymula diagnosed claimant with a "Cognitive Disorder, NOS." (Ex. B, p. 3) The neuropsychologist found:

IMPRESSION

1. Mr. Cote is showing mild to moderate deficits in verbal memory on serial learning tests, 6th grade skills in arithmetic computation, but otherwise he performed within a normal range or higher on all measures of cognition including verbal memory. (Pared Associates, and Prose Recall learning.) He also showed superior intellectual ability. The math and memory deficits seem very selective and not likely the result of medication as one might expect of a greater degree of dysfunction. The Center for Disease Control and medical literature have identified mental status and neurologic change in some West Nile patients.

(Ex. B, p. 3)

Dr. Szymula recommended the following ideas:

1. We discussed the use of a notebook & calculator on his job to help with his current deficits relating to memory or relating to verbal memory and math computation. Mr. Cote also suggested the use of a palm pilot to help organize & I was in full agreement with this.
2. Possibly consider a trial of medication to assist with memory.
3. Consider a retest in about 6-12 months.
4. Other than the above concerns in #1, I do not see any need for changes in Mr. Cote's immediate environment. His returning to work would depend more on issues relating to pain control, as he feels at this point he can handle the cognitive related issues.

(Ex. B, p.3)

Claimant underwent two spinal taps. (Ex. A, p. 6) He reported spontaneous improvement of his symptoms, including memory and dizziness after each spinal tap. (Ex. A, p. 6) Then claimant was prescribed Diamox 250 mg to be taken four times per day. (Ex. A, p. 6)

On April 3, 2003, claimant visited the University of Iowa Hospitals and Clinics, Department of Neurosurgery. Claimant was evaluated for headaches, lower extremity paresthesias and visual changes. (Ex. C, p. 1) Claimant reported the following conditions:

> Mr. Cote is a 45-year-old male who is status post infection with West Nile virus in October 2002. Since that time, he has had episodic severe headaches with paresthesias in his lower extremities, gait instability, dysphasia, difficulty with cognition, blurring and blotchiness of vision especially peripherally. He was then followed by you who referred him to us from his neurology clinic for possible CSF diversion. The patient has been treated locally with three high volume lumbar punctures, all of which immediately and completely relieved his symptoms. No records are available at this time for those lumbar punctures. However, the patient states his pressures were 21, 22 and 28 respectively.

(Ex. C, p. 1)

Steven G. Kraljic, M.D., and Matthew A. Howard, III, M.D., diagnosed claimant with a possible variant of an idiopathic intracranial hypertension, possibly related to the infection in October 2002. (Ex. C, p. 2) As a result of the suspected diagnosis, claimant was admitted to the Department of Neurosurgery from April 24, 2003 through April 29, 2003. He underwent right frontal intracranial pressure monitor placement. (Ex. C, p.3) The evaluation lasted 48 hours. Claimant did not experience increased intracranial pressure until the last several hours. The physicians suspected problems with the ICP monitor. (Ex. C, p. 3)

Claimant also underwent magnetic resonance venography testing, (MRV) at the University of Iowa. MRV testing is a type of imagining used to visualize veins in the body. Carlos A. Santiago, M.D., and Seon Kyu Lee, M.D., Ph.D., diagnosed claimant with:

> **Impression/Recommendations:** Mr. Cote is suffering from a possible pseudomotor cerebri. All of his previous diagnostic assessment are not conclusive. However, his MRV did show a possible stenosis at the left transverse sinus that he is experiencing right now. The plan of the service is to do an angiogram with a venogram to see if there is indeed true stenosis. We would also do internal sinus pressure measurements to determine if there is indeed increased venous pressure in the brain. Assuming the results are positive then we would schedule him for a dual sinus angioplasty and a possible stenting under general anesthesia. This was presented to him with associated risk and he was agreeable to undergo the procedure. They will be scheduled at the next available time.

(Ex. C, p. 5)

On August 13, 2003, claimant returned to the Department of Neurology. (Ex. C, p. 6) Jing C. Patrinostro, M.D., M.P.H., and Coleman O. Martin, M.D., examined claimant. Their opinions were:

> **Summary:** Mr. Cote is a 45-year-old right-handed male with a status post West Nile Virus infection last fall. Since then, he has daily headache, facial pain, and multiple neurological deficits. He had one episode of loss of consciousness last Sunday. Multiple medical work ups have not been able to explain his complaints. He does say he feels better temporarily after CSF removal. Increased intracranial pressure is one of possibility for his headache but with inpatient pressure monitoring is [sic] pressure appears to be normal. The EEG and brain MRI have ruled out possible seizure or other brain pathology. MRV was done and suggestive of transverse sinus occlusion, but later angiogram did not show any significant stenosis. CSF analysis in April was significant for protein 54, no other abnormality was found. At present time, the treatment recommendation is to increase the Topamax to 200 mg per day. A written titration of Topamax has been provided to the patient. He will return to this clinic in 6 weeks. A review of the literature finds headache cited as a common initial manifestation in the West Nile virus infection. I was unable to find any mention of chronic headache being more common after West Nile virus infection.

(Ex. C, p. 7)

Claimant visited the Internal Medicine Infectious Disease Department at the University of Iowa Hospitals and Clinics on December 8, 2003. (Ex. C, p. 8) He was diagnosed with "Post-West Nile virus syndrome." Shelley Jones, M.D., and Bradley E. Britigan, M.D., advised claimant:

> PLAN: We discussed with the patient that, in general, most patients in his age group who are infected with West Nile virus do well, and have a mild illness. However, a small percentage of patients do continue to have neurologic problems after the infection. We also explained that, in general, patients who continue to have neurologic problems, have a wide variety of symptoms and signs, and that each patient is different. We feel that at least some of his neurologic symptoms could be consistent with post-West Nile virus syndrome or, in other words, chronic sequelae of this infection.
>
> But, in summary, we do not have any good evidence that this is an infection that has a chronic relapsing course. In addition, there have been no good treatments shown to be helpful with West Nile virus. We explained this to the patient and also stated that we would defer therapy for his specific neurologic complaints to the expertise of the neurologists.
>
> We also discussed with him that his Sleep Study showed evidence of obstructive sleep apnea, and encouraged him to follow up with the pulmonologists. We discussed with him that obstructive sleep apnea can cause some of his symptoms, specifically sleepiness, forgetfulness, headache and fatigue.

(Ex. C, pp. 9-10)

Claimant returned to the Neurology Department on April 19, 2004. Claimant reported his headaches were approximately the same as in prior months. (Ex. C, p. 11) Claimant described his headaches as pressure throughout his head. (Ex. C, p. 11) Martin Coleman, M.D., provided the following impressions:

> IMPRESSION: Mr. Cote is a 46-year-old man with daily headache problems. He was previously seen in Infectious Disease regarding his West Nile Virus status. It was Infectious Disease's impression that he did not have continued West Nile Virus infection. Indeed his CFS chemistries and cell counts have been negative. I am not sure what to make of his headaches and do not know if they are even West Nile Virus related. In the past he states that albuterol was helpful to make his headaches go away. When he had pneumonia and he would use his inhaler, it improved his headache substantially. For lack of a better option we are going to try this. I am looking into neurologists in Florida who might have more familiarity with West Nile virus.

(Ex. C, p. 11)

On September 18, 2012, claimant presented to the Blessing Hospital in Quincy, Illinois with complaints of a fever and a headache. (Ex. D, p. 1) Claimant related to the physician, Musab U. Saeed, M.D., "I have seen him several years ago where he wanted an evaluation for chronic West Nile infection and was in the middle of working with a lawyer to get a medical opinion about possibly work related injury because of mosquito bites at work." (Ex. D, p. 1) Dr. Saeed diagnosed claimant with:

1. Headaches.
2. Previous history of positive serologies for West Nile.
3. Numbness of his feet and unusual sensation in his mouth.
4. Hypertension.
5. Obesity.

(Ex. D, p. 2) Dr. Saeed could not make a definitive statement whether all of claimant's symptoms were related to the West Nile disease. (Ex. D, p. 2)

On February 12, 2013, claimant returned to the University of Iowa with persistent headaches. He reported he had an episode of viral encephalitis in September of 2012 and he had to be hospitalized. At the University of Iowa, Regina S. Won, M.D., treated claimant for his headaches. Claimant stated he had an increase in the frequency and severity of the symptoms he experienced as a result of his West Nile disease. (Ex. C, p. 19) Dr. Won ordered another battery of neuropsychological tests. (Ex. C, p. 20)

Joe Barrash, PhD, Associate Clinical Professor in the Department of Neurology conducted a neuropsychological evaluation. He formulated the following impressions:

> Although memory performance on a word list test was mildly below that of our exam ten years ago, other performances tended to be identical to or higher than previously. He again demonstrates a non-specific, very mild relative weakness in aspects of cognitive efficiency. Other aspects of cognitive functioning are generally in the average to high average range. Overall Mr. Cote's results any changes in have been very limited and mild. Findings and reported course are consistent with, but not diagnostic of, encephalitis.
>
> **RECOMMENDATIONS**
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> 1. Compensatory strategies to enhance memory performance, like use of lists and notes, should be very effective.
> 2. Present circumstances do not suggest a need for follow-up neuropsychological evaluation. However, we would be glad to examine Mr. Cote again, if indicated.

(Ex. C, p. 21)

On October 29, 2013, claimant visited his family medical clinic. (Ex. E, p. 1) Claimant complained of a sore throat, lymph node tenderness, a sore mouth, neck pain, bilateral ear pain, congestion, sinus pressure, dizziness, headaches, weakness, and various joint pains. (Ex. E, p. 1) Claimant was diagnosed with acute sinusitis. (Ex. E, p. 3) Claimant returned to the same clinic on November 18, 2013. (Ex. E, p. 6) Claimant was suffering from two conditions. He had venous stasis dermatitis and a sore throat. (Ex. E, p. 6)

During his arbitration hearing, claimant testified, he ultimately recovered from West Nile disease with the exception that he had a compromised immune system. (Tr., pp. 14-15) Claimant also testified the virus was stored in the kidney and he periodically had kidney issues. (Tr., p. 15)

On November 24, 2013, claimant was working on a SOLO annealing oven. Claimant described the purpose of the machine on direct examination. He testified:

> Q. (By Mr. Pothitakis) Tell us what that is.
>
> A. It's a piece of equipment. It was actually built for being used in Europe, but it is a piece of equipment that they run small nickel - - well, it's nickel - - boy, here we go with the word I want to use. Nickel alloy. I'm sorry. I couldn't say nickel alloy.
>
> It runs nickel alloy parts that have copper stuffed inside the nickel alloy parts. It runs them on a - - from a vibratory system, it feeds them onto a metal belt that has sides. It's kind of a - - it's like a screen except it's much thicker, and thin it has sides, so it's a u-shaped belt.
>
> And it runs them in a very slow speed through an oven which I've checked lately to see how long it is. It's about 16 feet long.
>
> Q. Okay.
>
> A. It's superheated at 900 degrees Celsius. I know that one now. I had to look that one up. I couldn't remember if it was Celsius, Fahrenheit. It is Celsius which is about 1,700 degrees. And then they spray into that cracked ammonia. And they have natural gas fires at the beginning and the end of the oven, so where the parts go in and where the parts go out.

(Tr., pp. 33-34)

Claimant continued to describe the process during his direct examination. He testified:

> THE WITNESS: Cracked ammonia, they take the ammonia, run it through a valve, you know, a safety valve.

THE COURT: Sure.

THE WITNESS: And then after that they run it through a [sic] electric solenoid that runs out the control panel, and then there's a regulator. And then it goes through a coil that goes through what's called a heating muff, an electric hearing muff that brings it up to 900 degrees Celsius.

And once you do that to the ammonia, it becomes what they call cracked, and it becomes 75 percent pure hydrogen, 25 percent nitrogen, and you get a small amount of ammonia residue which you can still smell ammonia from it.

And they literally pipe that into the furnace that's open at both ends and to cause a chemical reaction with the metal parts.

THE COURT: Okay.

Q. (By Mr. Pothitakis) So the parts come on a conveyor on one side of the 16-foot oven, and they slowly move through it, and then they come out the other end of the oven?

A. Correct.

Q. And at each end of that oven, there, there are open fires; is that correct?

A. Big natural gas fires with flues up above it - - the hydrogen and the hydrogen sulfite it creates is highly flammable, so you have to have those at each end so it doesn't escape.

It causes it to burn instantly after, after the chemical reaction and goes up the flues as carbon monoxide if everything is working right.

(Tr., pp. 35-36)

Claimant had worked on the SOLO annealing oven on several previous occasions. When the technician, "Keith" arrived at 11:00 p.m., claimant and Keith went to inspect the machine. Keith started the machine so he and claimant could determine the problems. There was a hiss, and warm gas was flowing very swiftly from the machine near claimant. He smelled ammonia and another bad odor. Keith was on his knees and started yelling. He jumped up and backwards, and then turned off the oven. Claimant testified what he experienced:

But I was sitting down on that chair right next to it. It hit me so hard, I couldn't get up. It just - - I instantly got a really bad headache, irritated my eyes and my mouth. I immediately realized I was a bit confused.

I still couldn't get up. After he got it shut off, he came over to me and helped me up because it just really got me really bad.

(Tr., p. 48)

He came over and helped me up. I was having trouble walking. I remember being very confused. I already had a terrible headache. I mean it was just fierce. And he helped me back to his office.

(Tr., p. 49)

A. And I started feeling worse. I started noticing that my right arm and hand was shaking some. I felt really funny and kind of tingly on my right side, my right arm. I felt funny in my face.

I can't remember which side of my face offhand right now, but one side or the other, one or both sides of my face - - it was one side of my face that felt funny.

And I decided to sit it out for a few minutes and just sit in the air-conditioning, you know, fresh air. It's a fresh - - it's a room that's got a lot of fresh air in it.

(Tr., pp. 49-50)

A. And I decided I needed to get up because we normally record - - all the calls we go on, we have to keep track of the time on it.

So I went into the computer which is just outside of his office. I got up and went over to it and decided I better put the call in and realized that immediately I could not use the mouse because my hand was shaking so bad that my fingers kept on hitting the mouse keys back and forth.

And I just kept on like double, triple, hundred clicking stuff, if you know what I mean, and I realized that I couldn't even do that. I just couldn't function at all, so I went back and sat down and - -

(Tr., pp. 50-51)

Claimant proceeded to the emergency room at Great River Medical Center in West Burlington, Iowa. He had a myriad of symptoms including tremors in the right arm, hand and fingers. He had numbness on the right side of his face, confusion, and a headache. He began to have stinging and burning in both eyes. (Ex. 1, p. 1) He was told he had a transient ischemic attack, (TIA) or a temporary clot or blockage to the brain. (Ex. 1, p. 2) Sometimes TIA's are called mini strokes or warning strokes.

On the morning of November 25, 2013, Rachel Oliverio, D.O., diagnosed claimant with:

1. Toxic Effects, Gases
2. Transient Ischemic Attack.

(Ex. 1, p. 4)

Dr. Oliverio determined claimant could return to regular duty. (Ex. 1, p. 4) Claimant was advised to take one aspirin per day and to follow up with a neurologist. (Ex. 1, p. 4)

Anil Dhuna, M.D., a board certified doctor in Neurology, examined claimant on December 5, 2013. Claimant reported experiencing some problems with slight headaches and occasional shakiness of the right side and right eye droopiness. (Ex. 2, p. 1) Dr. Dhuna assessed claimant's condition as:

> **ASSESSMENT AND PLAN:**
>
> Patient is a 35 [sic] year old male who had exposure at work to superheated anhydrous ammonia. Shortly after exposure he had burning in his eyes, shortness of breath and then right-sided weakness and incoordination. His symptoms are greatly improved but he still has some trouble with right hand tremor and right eye ptosis. My suspicion is that the stress of the chemical exposure may have precipitated a mild stroke. The patient has significant risk factors for stroke with obesity and hypertension. The patient is to continue taking aspirin daily. I am arranging for an MRI scan of the brain and a carotid ultrasound. He's had a recent lab work-up by his primary care physician and I will make sure a cholesterol work-up has been done. Patient is to continue working full-time without restrictions. Follow-up scheduled in 3 weeks.

(Ex. 2, p.4)

Claimant returned to Dr. Dhuna on January 9, 2014. Both MRI Testing and EEG exam results were within normal ranges. (Ex. 2, p. 7) Dr. Dhuna diagnosed claimant with a central tremor that may have been exacerbated by exposure to anhydrous ammonia. However, the neurologist could not rule out a small clinical vascular event. Claimant could also have experienced a mild underlying essential tremor exacerbated by stress. (Ex. 2, p. 7)

On February 16, 2014, claimant presented to the emergency room once again at the Great River Medical Center in West Burlington, Iowa. (Ex. 4, p. 7) Claimant voiced complaints of a burning feeling in his throat, chest and both eyes. He was feeling dizzy and he had a headache. Claimant also described right-sided facial numbness. (Ex. 4, p. 7) Claimant was advised to follow up with Dr. Dhuna. (Ex. 4, p. 27)

Claimant visited the University of Iowa Hospitals and Clinics on April 16, 2014. (Ex. 5) Harold P. Adams, M.D., conducted a physical examination of claimant. The following is the assessment and plan Dr. Adams proposed:

> Mr. Cote has asymmetrical neurological impairments detected on examination. He has treatment worse on the right than on the left. This is primarily an action and posture tremor. He also has some early signs of parkinsonism with some element of rigidity and bradykinesia particularly of the right arm. The presence of a head tremor is somewhat unusual for parkinsonism. My working hypothesis is that he has a Parkinson syndrome. This often starts asymmetrically. At present, the right side appears to be more severely affected than the left. The rationale for the diagnosis of parkinsonism includes the tremor, rigidity, and the bradykinesia. To further ascertain whether this is the correct diagnosis, we are doing imaging studies of the brain to look for metabolic derangements that would support the diagnosis of parkinsonism. If he does have parkinsonism my plan is to treat him with pramipexole. A short him to have followup in our movement disorders clinic. [sic]
>
> He asked about the possible relationship between his neurological findings and his exposure to ammonia. At present, it is unclear if a couple of episodes of environmental ammonia exposure can cause these types of neurologic impairments. There is a relationship between elevated blood ammonia levels in patients with liver failure who subsequently develop a parkinsonian syndrome. I think it is unlikely that he has had a stroke.

(Ex. 5, p. 3)

On April 23, 2014, claimant sent an e-mail message to Dr. Adams. Claimant informed the physician there was more than just ammonia that he encountered on November 24, 2013. (Ex. 5, p. 19)

Dr. Adams ordered DaTscan SPECT Imaging in May 2014. The SPECT scan is the acronym for single-photon emission computed tomography. It is a test using nuclear medicine tomographic imaging and it employs gamma rays. The tests were conducted in the Radiology Department at the University of Iowa Hospitals and Clinics. The results showed:

> Impression: Findings of bilaterally decreased putaminal uptake (right slightly worse than left) is suspicious for early Parkinsonian syndrome.

(Ex. 5, p. 5)

Dr. Dhuna examined claimant on June 4, 2014. Dr. Dhuna reviewed the diagnosis and plan formulated by the physicians at the University of Iowa Hospitals and Clinics. (Ex. 2, p. 10) He did not disagree with their diagnoses. The neurologist wrote in his clinical notes for June 4th:

> The patient most likely has essential tremor but he did have a SPECT scan for possible atypical Parkinson's disease.

(Ex. 2, p. 10)

On July 1, 2014, Dr. Adams again examined claimant in the stroke clinic. Dr. Adams provided his opinions in the assessment and plan portion of his clinical notes for July 1, 2014. Dr. Adams opined:

> Mr. Cote continues to have tremor and some other evidence of raised the concern of a Parkinsonian syndrome. This is not Parkinson's disease. He does not have postural instability His movements are generally quite good. His findings are primarily the rigidity with some element of cogwheeling in the right upper extremity. The imaging study is supportive of the diagnosis of a Parkinsonian syndrome.
>
> The cause for his Parkinsonian syndrome has not been established. His symptoms began after exposure of possible toxic substances in an incident at work. This has been an [sic] major concern for him and his employer. The nature of the toxic substances has not been established. Initially, there was concern about ammonia. I cannot find evidence of a [sic] ammonia playing a role in the development of parkinsonian syndrome but there are a number of other substances including heavy metals that may produce neurologic symptoms. I am unsure how we can move forward to establish a cause and effect relationship.
>
> Fortunately, he is able to work and is continuing to work with some mild restrictions. Those restrictions seem quite reasonable. I would recommend continuing those restrictions while he continues to work. He is improved with beta blockers. I continue the medication....

(Ex. 5, p. 9)

On September 24, 2014, defendants sent claimant to Fredric E. Gerr, M.D., at the University of Iowa Hospitals and Clinics. The purpose of the appointment was for an independent medical examination. Dr. Gerr opined to a reasonable degree of medical certainty there was no causal relationship between the exposure to the ammonia substances or other contents of the vented gas and claimant's condition. (Ex. 5, p. 17) The basis for Dr. Gerr's opinion is as follows:

> Although the reported tight temporal relationship between the onset of Mr. Cote's tremor and his exposure to gasses vented from annealing oven on November 24, 2013, are suggestive of a causal relationship, there is no biomedical evidence that such an exposure is capable of causing his condition. Specifically, despite careful investigation, there are no case reports nor any descriptions of rapid-onset, persistent Parkinsonism following acute exposure to any anhydrous ammonia (or nickel, copper, or zinc) in the biomedical literature. Furthermore, there is no epidemiological evidence that such exposures are capable of causing a nearly instantaneous onset Parkinsonian illness (nor Parkinsonian illness of less raid [sic] onset). In addition, the rapidity of onset of the condition (ie, within minutes to hours) makes a toxicological cause resulting from the annealing oven exposure virtually impossible.

(Ex, 5, p. 17)

Dr. Gerr diagnosed claimant with a Parkinsonian syndrome. The physician based his opinion on the opinions of the treating neurologists and the results of the objective nuclear testing. (Ex. 5, p. 17) Dr. Gerr continued claimant's permanent restriction of no use of ladders. (Ex. 5, p. 18)

On April 29, 2015, claimant presented to the University of Kansas, Department of Neurology in Kansas City, Kansas. Richard M. Dubinsky, M.D., examined claimant for the purpose of evaluating and treating claimant for essential tremor. (Ex. 9, p. 1) Dr. Dubinsky was adamant he would not address questions of causation due to exposure to hydrogen sulfide gas. (Ex. 9, p. 1) Dr. Dubinsky found:

> **Abnormal movements:** There was a 5-7 Hz tremor in his hand both at rest and with action. The amplitude markedly increased when he took a contained [sic] close to his mouth as if to drink. The tremor was more severe the further his hand was from his body.

(Ex. 9, p. 2)

> **Assessment and Plan:**
>
> Essential Tremor
>
> He has essential tremor that historically worsened after occupational exposure to hydrogen sulfide gas. So far he has had good benefit from propanodol 20 mg twice a day, though it only last [sic] about four hours. There is no clinical evidence of parkinsonism or Parkinson's disease with a normal sense of smell [.] I am not concerned about incipient PD at this time.
>
> We discussed other treatments including the use of primidone, topirimate and gabapentin.

(Ex. 9, pp. 2-3)

> According to the Mayo Clinic, "Essential Tremor" is defined as:
>
> Essential tremor is a nervous system (neurological) disorder that causes involuntary and rhythmic shaking. It can affect almost any part of your body, but the trembling occurs most often in your hands – especially when you do simple tasks, such as drinking from a glass or tying shoelaces.
>
> It's usually not a dangerous condition, but essential tremor typically worsens over time and can be severe in some people. Other conditions don't cause essential tremor, although it's sometimes confused with Parkinson's disease.
>
> Essential tremor can occur at any age but is most common in people age 40 and older.

"Essential Tremor Overview – Mayo Clinic," www.mayoclinic.org/diseases-conditions/essential-tremor/home/ovc -20177826, January 20, 2016.

Again, according to the same overview, the symptoms and signs of essential tremor are:

1. Begin gradually, usually on one side of the body
2. Worsen with movement
3. Usually occur in the hands first, affecting one hand or both hands
4. Can include a "yes-yes" or "no-no" motion of the head
5. May be aggravated by emotional stress, fatigue, caffeine, or temperature extremes.

The staff at Mayo Clinic compare essential tremor with Parkinson's disease. The staff write:

> **Timing of tremors.** Essential tremor of the hands usual occurs when you use your hands. Tremors from Parkinson's disease are most prominent when your hands are at your sides or resting in your lap.
>
> **Associated conditions.** Essential tremor doesn't cause other health problems, but Parkinson's disease is associated with stooped posture, slow movement, and shuffling gait. However, people with essential tremor sometimes develop other neurological signs and symptoms, such as unsteady gait (ataxia).
>
> **Parts of body affected.** Essential tremor mainly involves your hands, head and voice. Parkinson's disease tremors usually start in your hands, and can affect your legs, chin and other parts of your body.

> **Causes** About half of essential tremor cases appear to result from a genetic mutation, although a specific gene hasn't been identified. This form is referred to as familial tremor. It isn't clear what causes essential tremor in people without a known genetic mutation.

"Essential Tremor Overview – Mayo Clinic," www.mayoclinic.org/diseases-conditions/essential-tremor/home/ovc -20177826, January 20, 2016.

Claimant returned to Dr. Dhuna after the visit to Dr. Dubinsky. (Ex. 2, p. 11) Dr. Dhuna noted claimant believed he had been exposed to hydrogen sulfide on November 24, 2013. Dr. Dhuna noted: "This would explain when he first was exposed to this chemical, the smell of rotten eggs and the then loss of smell initially." (Ex. 2, p. 11) Dr. Dhuna surmised:

> Patient is a 57-year old male who had exposure to super heated [sic] anhydrous ammonia and according to the patient the gas also included hydrogen sulfide exposure. If Hydrogen sulfide was present in the gas exposure, there have been case reports with acute toxic exposure causing acute neurological symptoms including tremors, confusion, loss of consciousness and delirium. This may explain his acute symptoms after the exposure on November 30, 2013. [sic] Also there have been cases with acute exposure of Hydrogen Sulfide exceeding to 280 mg/m3 causing long-term neurological effects with tremors, reduced motor function, ataxia, and cognitive deficits. It would be possible that if the patient had been exposed to hydrogen sulfide at these dosages, that his present neurological symptoms could be related to his industrial exposure. There is no sulfide at these dosages, that his present neurological symptoms could be related to his industrial exposure. There is no other etiology for his tremors determined at this point. His neurological symptoms have occurred after his acute exposure and have remained. He is to continue on his Inderal for control of his central tremors. Follow up scheduled for 4 months.

(Ex. 2, p. 13)

Approximately, four or five months after claimant had his examination with Dr. Dubinsky, the night supervisor, Mr. Nick Heins, asked claimant to test for hazardous gases in the plant,. (Tr., p. 83) He tested for hydrogen sulfide levels, among other gases. (Tr., p. 83) Claimant walked through the entire plant with the testing equipment. (Tr., p. 85) When he was five or six feet from the SOLO annealing oven, the test equipment showed there was an excess amount of hydrogen sulfide. Claimant observed one of the fire burners was inoperable. The oven was not performing in a proper manner. The hydrogen sulfide level was not at a really high level but it was high enough to warrant a hazardous reading. (Tr., p. 86) It is important to note: on the date of claimant's exposure, he was sitting on a chair just one foot from the exit to the oven where the ammonia entered the oven.

Mr. Gary S. McCauley, Environmental Engineer at Federal-Mogul in Burlington, conducted sampling in the plant in order to determine the presence of hydrogen sulfide. The sampling was conducted on March 14, 2016. In a report with the same date, Mr. McCauley described the OSHA limits for hydrogen sulfide. He also described his own findings after sampling on March 14th. Mr. McCauley wrote:

> OSHA limits for hydrogen sulfide exposures are: Exposures must not exceed 20 parts per million (ppm) (ceiling) with the following exception: if no other measurable exposure occurs during the 8-hour work shift, exposures may exceed 20 ppm, but not more than 50 ppm, (peak), for a single time period up to 10 minutes.
>
> On March 14, 2016, using a Drager tester with hydrogen sulfide tubes (5-60 ppm), I sampled the air at the entrance, exit, and directly above the Solo annealing oven. All samples were taken within 2 inches of the surface of the oven. The oven was full and operating at 860 degrees C. None of the 3 tubes showed any measurable amount of hydrogen sulfide leaving the oven.

(Ex. 10, p. 2)

Subsequently, claimant secured an expert opinion from Mr. Harry J. Elston, Ph.D., CIH, of Midwest Chemical Safety, LLC. Dr. Elston explained the chemical processes in the plant as he understood them. He wrote:

> 27 July 2016
>
> Re: Fred Cote
>
> Dear Mr. Pothitakis:
>
> I have reviewed the case materials that you have sent regarding Mr. Cote's occupational exposure to hydrogen sulfide (H_2S). There are two questions that must be answered:
>
> 1. Are the working conditions such that a sufficient amount of hydrogen sulfide could be produced? And;
>
> 2. Did exposure occur?
>
> <u>Working Conditions</u>
>
> In his statement, Dr. Anil Dhuna states that hydrogen sulfide exposure exceeding 280 mg/m3 can cause long term neurological effects. Are the working conditions such that this amount could be produced?

A review of the materials provided by your office show that at the time of the injury, Mr. Cote's employer was engaged in the hydrogen annealing of nickel wire in order to remove trace sulfur contamination. Hydrogen was supplied by "cracking" anhydrous ammonia into nitrogen and hydrogen:

$$2NH_3 \rightarrow N2 + 3H_2$$

Sulfur is a trace contaminant in nickel wire, on the order of 20 ppm(w) [McCauley, Federal-Mogul Report, 14 March 2016]. During the annealing process, sulfur will react with the excess hydrogen gas to form hydrogen sulfide:

$$H_2 + S \rightarrow H_2S$$

20 ppm(w) sulfur is equal to 20 mg sulfur per kilogram of wire. Likewise, approximately 21 mg of hydrogen sulfide will be produced per kilogram of material, based on the reaction above. This is not a trivial amount of hydrogen sulfide. A mere 13 kilograms (28 lbs) of wire will produce over 280 mg of hydrogen sulfide. Likewise, combustion of hydrogen sulfide (a flammable gas) is disfavored because of the nitrogen-rich atmosphere in the furnace. Therefore, I conclude the conditions are sufficient to establish a relatively high level of hydrogen sulfide due to process concerns. Clearly if there is more nickel wire in the process, more hydrogen sulfide will be produced which in turn will increase the overall concentration.

Exposure

Mr. Cote stated that at the time of the injury, there was a strong odor of "rotten eggs" which he and a co-worker noted. The "rotten egg" odor is a characteristic odor of hydrogen sulfide, therefore the odor is indicative of an exposure to hydrogen sulfide but not of the concentration to which he or his co-worker were exposed.

Measurements taken by Federal-Mogul months after the incident are a "snapshot-in-time" and may not accurately represent the working conditions when the incident occurred.

Conclusions

Given that it is possible to produce an amount of hydrogen sulfide sufficient to warrant Dr. Dhuna's concern and that Mr. Cote reported odors characteristic of a hydrogen sulfide exposure, it is reasonable to conclude that Mr. Cote was more-likely-than-not acutely exposed to hydrogen sulfide in the working environment. If one assumes that the location were [sic] Mr. Cote was working at the time of the exposure was about one

cubic meter in volume, it is reasonable to conclude that Mr. Cote was more-likely-than-not acutely exposed to a concentration of hydrogen sulfide at a level at or above Dr. Dhuna's concern.

I reserve my right to revise this analysis should any new information be presented.

Sincerely,

Harry J. Elston, PH.D., CIH
Principal
Midwest Chemical Safety, LLC

(Ex. 8, pp. 1, 2)

Counsel for claimant obtained a written statement from Dr. Dhuna regarding claimant's condition and the cause thereof. On February 24, 2016, the treating neurologist stated:

1. My name is Dr. Anil Dhuna and I am a board certified neurologist practicing in Burlington, Iowa.

2. I have provided care and treatment to Alfred Cote as it relates to some neurological issues which I understand began on November 24, 2013.

3. I saw him on December 5, 2013 where he was suffering from tremor like symptoms in his right upper extremity as well as confusion and headaches.

4. I understand he underwent care at other medical facilities and then he ultimately returned to my office on September 10, 2015.

5. He has a diagnosis of essential tremor.

6. I understand the history be that he has no family history of essential tremor, and there was no change in medication at the time of his initial problems in November 2013. I understand the history be that the tremors came on suddenly after the exposure.

7. The history presented to me by Mr. Cote was that his exposure on November 30, 2013 included a high level exposure to hydrogen sulfide. This is important as a curative exposure to hydrogen sulfide exceeding 200 ppm (280 mg/m3) can cause long term neurological effects, tremors, reduced motor function, ataxia, and cognitive deficits. I reviewed materials that confirm this causal connection between hydrogen sulfate and the symptoms.

8. Based on the history presented to me, it would be my opinion that Mr. Cote's chemical exposure at work on November 24, 2013 was a substantial contributing factor to his current neurological symptoms.

9. Unfortunately for Mr. Cote this condition has now been ongoing for over two years. I believe it is the essential tremors are permanent. The only treatment that can be provided is medications, which I currently have him on to try and minimize the symptoms.

10. It is my opinion within a reasonable degree of medical certainty that is, more likely than not, 51% or greater certainty that based on the history presented to me that a substantial contributing factor to Mr. Cote's essential tremors is the work related exposure of November 30, 2013.

(Ex. 6, p. 1)

After Dr. Dhuna issued his opinion on medical causation, counsel for defendants contacted Dr. Gerr for a subsequent opinion on medical causation. Dr. Gerr did not change his ultimate opinion. He did explain why he did not modify it. He indicated if claimant had been exposed to hydrogen sulfide, the smell of rotten eggs would have been pervasive in medical records prior to September 10, 2015. (Ex. 7, p. 2) Secondly, Dr. Gerr opined high levels of hydrogen sulfide would not only affect the nervous system but those same high levels could affect other systems of the body such as the lungs. (Ex. 7, p. 3) Claimant had no lung involvement after the exposure on November 24, 2013.

Then Dr. Gerr stated:

> There is no known association between exposure to hydrogen sulfide and essential tremor nor between hydrogen sulfide and Parkinsonian syndrome or Parkinson's disease, the diagnoses made by the neurologists who examined Mr. Cote. As noted earlier, exposure to high levels of hydrogen sulfide are associated with potentially permanent neurological impairment. However, such impairment does not manifest as essential tremor nor as parkinsonian illness.

(Ex. 7, p. 3)

Finally, Dr. Gerr reported hydrogen sulfide is not a toxicant at very low levels of exposure. Moreover, the physician stated, hydrogen sulfide is produced by the human body in small quantities. Dr. Gerr thought those small quantities could be beneficial for tissue health. (Ex. 7, p. 3)

Near the end of his direct examination, claimant testified about his abilities to perform his job duties. He testified as follows:

Q. (By Mr. Pothitakis) Okay. Do you have any problems performing your work?

A. Yes.

Q. What problems do you have performing your work that you associate with the chemical exposure and the tremors that you have?

A. First of all, doing extension ladders or vertical ladders - - if I say a vertical ladder, do you know what I mean?

Q. Explain it to me.

A. Like if you put a ladder on the side - - outside of a building that goes straight up so you just climb on the rungs. Anything like that, I have a serious problem with now. In fact, I almost got hurt at home from, from trying to do that at home because my right hand, sometimes the tremors start depending on how I move my hand and my fingers open up and they will release.

That's why I drop things all the time. I drop light fixtures and screws and parts and tools all the time. It's really a problem.

But anyways, my hand will release, and if I'm in the process of bringing my hand from - - my left hand up to the next rung and I'm holding on with the right hand and all of a sudden it releases, I start to fall, and you have to catch yourself.

Q. What other problems have you had at work with doing your job with, say, tools?

A. Hand tools are very bad because my hands shake, and I have to use my left. I'm starting to compensate some with them but use my left hand to try to coordinate the shaking to turn screws.

I'm working with live electrical panels all the time, something typically something electricians do all the time, but it's very freaky to be in there sometimes because if the tremors trigger while I have my hand in there - - a lot of times I've been trying to wear rubber gloves and stuff because I'm scared to death I'm going to hit something.

(Tr., pp. 93-95)

RATIONALE AND CONCLUSIONS OF LAW

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 claimant has the burden of proving by a preponderance of the evidence that the injury is a proximate cause of the disability on which the claim is based. A cause is proximate if it is a substantial factor in bringing about the result; it need not be the only cause. A preponderance of the evidence exists when the causal connection is probable rather than merely possible. George A. Hormel & Co. v. Jordan, 569 N.W.2d 148 (Iowa 1997); Frye v. Smith-Doyle Contractors, 569 N.W.2d 154 (Iowa App. 1997); Sanchez v. Blue Bird Midwest, 554 N.W.2d 283 (Iowa App. 1996).

The question of causal connection is essentially within the domain of expert testimony. The expert medical evidence must be considered with all other evidence introduced bearing on the causal connection between the injury and the disability. Supportive lay testimony may be used to buttress the expert testimony and, therefore, is also relevant and material to the causation question. The weight to be given to an expert opinion is determined by the finder of fact and may be affected by the accuracy of the facts the expert relied upon as well as other surrounding circumstances. The expert opinion may be accepted or rejected, in whole or in part. St. Luke's Hosp. v. Gray, 604 N.W.2d 646 (Iowa 2000); IBP, Inc. v. Harpole, 621 N.W.2d 410 (Iowa 2001); Dunlavey v. Economy Fire and Cas. Co., 526 N.W.2d 845 (Iowa 1995). Miller v. Lauridsen Foods, Inc., 525 N.W.2d 417 (Iowa 1994). Unrebutted expert medical testimony cannot be summarily rejected. Poula v. Siouxland Wall & Ceiling, Inc., 516 N.W.2d 910 (Iowa App. 1994).

While a claimant is not entitled to compensation for the results of a preexisting injury or disease, its mere existence at the time of a subsequent injury is not a defense. Rose v. John Deere Ottumwa Works, 247 Iowa 900, 76 N.W.2d 756 (1956). If the claimant had a preexisting condition or disability that is materially aggravated, accelerated, worsened or lighted up so that it results in disability, claimant is entitled to recover. Nicks v. Davenport Produce Co., 254 Iowa 130, 115 N.W.2d 812 (1962); Yeager v. Firestone Tire & Rubber Co., 253 Iowa 369, 112 N.W.2d 299 (1961).

When an expert's opinion is based upon an incomplete history it is not necessarily binding on the commissioner or the court. It is then to be weighed, together with other facts and circumstances, the ultimate conclusion being for the finder of the

fact. Musselman v. Central Telephone Company, 154 N.W.2d 128, 133 (Iowa 1967); Bodish v. Fischer, Inc., 257 Iowa 521, 522, 133 N.W.2d 867 (1965).

The weight to be given an expert opinion may be affected by the accuracy of the facts the expert relied upon as well as other surrounding circumstances. St. Luke's Hospital v. Gray, 604 N.W.2d 646 (Iowa 2000).

Expert testimony may be buttressed by supportive lay testimony. Bradshaw v. Iowa Methodist Hospital, 251 Iowa 375, 380; 101 N.W.2d 167, 170 (1960).

The commissioner as trier of fact has the duty to determine the credibility of the witnesses and to weigh the evidence. Together with the other disclosed facts and circumstances, and then to accept or reject the opinion. Dunlavey v. Economy Fire and Casualty Co., 526 N.W.2d 845 (Iowa 1995).

This is an interesting but puzzling case. Claimant consulted with a myriad of specialists from several University Medical Centers. He conferred with all types of neurologists, neuro-radiologists, and he underwent countless diagnostic tests. Nevertheless, physicians cannot agree upon a concrete diagnosis for claimant. Currently, it appears claimant suffers from essential tremor. The tremor did develop after the SOLO annealing oven malfunctioned on November 23, 2013. It is unknown whether claimant was exposed to anhydrous ammonia, hydrogen sulfide, both or neither. There is no doubt there was an exposure to something in the air but no sampling was done at the time. There is no empirical data to support an over-exposure to anything. No one knows the length of time claimant spent sitting on a chair next to the annealing oven. As a consequence, there is no data to establish the amount of time claimant was exposed.

The exposure adversely impacted claimant immediately. He was unable to manipulate the mouse of his computer because of tremors in his right hand. Claimant sought emergency medical care at the Great River Medical Center. From the onset of his medical treatment, claimant complained of right arm, hand and finger tremors. He had other symptoms as well. He was confused, he developed a severe headache, he developed a hoarse voice, both eyes were burning, the right side of his face became numb, he had sustained some toxic effects immediately following the exposure. In short, claimant sustained an injury that arose out of and in the course of his employment.

However, the salient issue is the medical cause for the right hand, and right arm tremors. The other symptoms dissipated with time. Dr. Elston, the certified industrial hygienist, cannot state claimant was over exposed to hydrogen sulfide on the day in question. Dr. Elston did not conduct any sampling in the battery plant. He did not even tour the facility.

Mr. McCauley, the plant environmental engineer, conducted sampling for hydrogen sulfide. The date the sampling occurred was on March 14, 2016. The results do not affect what did or did not occur on November 24, 2013. The sampling data is irrelevant.

Most of the medical professionals ignored the issue of medical causation with respect to the diagnoses they offered claimant. Dr. Oliverio opined claimant had a transient ischemic attack but claimant was returned to work without any restrictions. Dr. Adams questioned whether ammonia exposure in the workplace could cause neurologic impairments such as a Parkinson syndrome. Dr. Dubansky refused to discuss whether hydrogen sulfide could cause essential tremor. No medical provider produced any literature or scientific studies to establish hydrogen sulfide was a cause for essential tremor. Many of claimant's symptoms were the same as the ones he expressed after he developed West Nile Virus.

Dr. Gerr is a professor of occupational and environmental health at the University of Iowa. He has a very impressive curriculum vitae. He does not find a causal relationship between claimant's condition and exposure to hydrogen sulfide. Dr. Gerr is emphatic when he writes: "There is no known association between exposure to hydrogen sulfide and essential tremor nor between hydrogen sulfide and Parkinsonian syndrome or Parkinson's disease, the diagnoses made by the neurologists who examined Mr. Cote." (Ex. 7, p. 3)

Dr. Dhuna and his former partner, Dr. Alkurdy, have treated claimant since October 21, 2002 when claimant began treating for symptoms resulting from West Nile disease. Dr. Dhuna is board certified in neurology. He has seen claimant on numerous occasions. He found causal connection based on the history reported to him by claimant. (Ex. 6, p. 1) However, claimant reported he was exposed to hydrogen sulfide when there was no empirical data to support claimant's contention. Dr. Dhuna's opinions are not accorded any weight since the opinions are not based upon accurate facts.

It is the determination of the undersigned; claimant has failed to prove by a preponderance of the evidence that his condition of essential tremor is causally connected to any exposure he sustained on November 24, 2013.

The next issue for resolution is the matter of medical charges and medical mileage. The employer shall furnish reasonable surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance, and hospital services and supplies for all conditions compensable under the workers' compensation law. The employer shall also allow reasonable and necessary transportation expenses incurred for those services. The employer has the right to choose the provider of care, except where the employer has denied liability for the injury. Section 85.27. Holbert v. Townsend Engineering Co., Thirty-second Biennial Report of the Industrial Commissioner 78 (Review-Reopening October 1975).

Since claimant did sustain some temporary conditions immediately following the exposure on November 24, 2013, defendants are liable for medical costs incurred during the months of November and December 2013. Those medical costs include medical mileage as well. See: Iowa Code section 85.27.

The final issue is costs to litigate.

Iowa Code section 86.40 states:

> Costs. All costs incurred in the hearing before the commissioner shall be taxed in the discretion of the commissioner.

Iowa Administrative Code Rule 876—4.33(86) states:

> Costs. Costs 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, (8) costs of persons reviewing health service disputes. Costs of service of notice and subpoenas shall be paid initially to the serving person or agency by the party utilizing the service. Expenses and fees of witnesses or of obtaining doctors' or practitioners' reports initially shall be paid to the witnesses, doctors or practitioners by the party on whose behalf the witness is called or by whom the report is requested. Witness fees shall be paid in accordance with Iowa Code section 622.74. Proof of payment of any cost shall be filed with the workers' compensation commissioner before it is taxed. The party initially paying the expense shall be reimbursed by the party taxed with the cost. If the expense is unpaid, it shall be paid by the party taxed with the cost. Costs are to be assessed at the discretion of the deputy commissioner or workers' compensation commissioner hearing the case unless otherwise required by the rules of civil procedure governing discovery. This rule is intended to implement Iowa Code section 86.40.

Iowa Administrative Code rule 876—4.17 includes as a practitioner, "persons engaged in physical or vocational rehabilitation or evaluation for rehabilitation." A report or evaluation from a vocational rehabilitation expert constitutes a practitioner report under our administrative rules. Bohr v. Donaldson Company, File No. 5028959 (Arb. November 23, 2010); Muller v. Crouse Transportation, File No. 5026809 (Arb. December 8, 2010) The entire reasonable costs of doctors' and practitioners' reports may be taxed as costs pursuant to 876 IAC 4.33. Caven v. John Deere Dubuque Works, File Nos. 5023051, 5023052 (App. July 21, 2009).

The following costs are assessed to defendants:

Filing fee $100.00

Service fee $ Unknown

Medical Reports from Great River Medical Center in West Burlington, Iowa.

ORDER

THEREFORE, IT IS ORDERED:

Defendants shall reimburse claimant for medical costs and medical mileage as detailed in the body of the decision.

Costs are assessed to defendants as detailed in the body of this decision.

Defendants shall file all reports as required by law

Signed and filed this 13th day, of September, 2017.

Michelle A. McGovern

MICHELLE A. MCGOVERN
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.