BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

SUSAN MOSS,	FILED	File No. 5058548
Claimant,	JAN 16 2019	ARBITRATION DECISION
vs.	WORKERS' COMPENSATION	
WEST DES MOINES SCHOOL DISTRICT,		
Employer, Self-Insured, Defendant.		Head Notes: 1108.50, 1402.40, 1403.10, 1803, 2501, 2907

STATEMENT OF THE CASE

Susan Moss, claimant, filed a petition in arbitration seeking workers' compensation benefits from West Des Moines School District, self-insured employer. Hearing was held on September 19, 2018 in Des Moines, Iowa.

Susan Moss and David Maxwell both testified live at trial. The evidentiary record also includes joint exhibits JE1-JE5, claimant's exhibits 1-7, and defendant's exhibits A-K.

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.

The parties submitted post-hearing briefs on November 2, 2018.

ISSUES

The parties submitted the following issues for resolution:

1. The extent of permanent disability claimant sustained as a result of the stipulated work injury.

2. Whether claimant is entitled to payment of past medical expenses?

3. Assessment of costs.

FINDINGS OF FACT

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

Claimant, Susan Moss, sustained an injury arising out of and in the course of her employment with West Des Moines School District on April 12, 2016. At the time of her injury she was working as a cashier in the food service area. There was a dispute with a special needs student about the number of items the student had on her tray. The student threw her tray to the ground in anger. As Susan bent down to pick up the tray, the student kicked Susan in the forehead. The kick caused Susan to land on her bottom on the floor. Susan felt immediate back pain and was taken via wheelchair to the nurse's office. She laid down in the nurse's office. She could not walk. An ambulance took Susan to the hospital. (Testimony)

At the hospital Susan denied any history of prior back injuries. A CT of the lumbar spine was performed. The impression from the CT was acute compression fracture involving the L1 vertebral body with approximately 35 percent vertebral body height loss, and chronic right L5 pars interarticularis fracture. Susan was prescribed medications for muscle spasms and pain. (JE1)

On April 19, 2016, Susan was seen by Sara Glover, PA-C at Methodist Occupational Health and Wellness. She continued to have back pain, despite her medications. Her dose of hydrocodone was increased. It was also recommended that Susan see a spine surgeon at DMOS. Susan was restricted to modified duty. (JE3, pp. 42-44)

Sara Glover, PA-C saw Susan again on April 29, 2016. Susan reported that her symptoms were better. She had not worked since the last appointment because the employer did not have any suitable duties for her. She rated her pain as 7 or 8 out of 10. Susan reported the increased dose of hydrocodone helped. Susan was to continue with sedentary duty, but her hours were increased from 4 to 8 per day. (JE3, pp. 47-50)

On May 5, 2016, Susan saw Lynn M. Nelson, M.D. at DMOS. He noted that Susan did have polio as a child and has residual right upper extremity and left lower extremity weakness due to the polio. A lumbar x-ray revealed scant right lumbar scoliosis, and 35-40 percent L1 anterior compression fracture. He prescribed Metaxalone. His impression was low back pain; L1 compression fracture, acute; and post-polio syndrome. He felt that her fracture should heal over a three-to-four-month time frame. Dr. Nelson recommended that she maintain an erect posture and avoid heavy lifting, kyphoplasty, or bracing. He restricted her to a ten-pound lifting limit and no repetitive bending and twisting. She was to follow up on May 26, 2016. (JE2, pp. 27-29)

Susan returned to Dr. Nelson on May 26, 2016. She reported slight improvement in her symptoms. She still had low back pain and some occasional sharp pains in her right lateral thigh. She had not returned to work because she had the summer off. She was to return for a recheck on July 7, 2016. Dr. Nelson anticipated a full release to return to work in the fall. He restricted her to 20-pound lifting and no repetitive bending and twisting. (JE2, pp. 30-33)

Dr. Nelson saw Susan again on August 11, 2016. She reported improvement overall. Her low back pain was intermittent. She also reported some neck pain and stiffness which she attributed to tramadol usage. Dr. Nelson felt that her fracture had healed. He noted that within reason she could be fully active. She was released to return to work without restrictions. She was provided a refill of Metaxalone; he did not refill her hydrocodone prescription. No return appointment was made. (JE2, pp. 34-36)

On August 23, 2016, Dr. Nelson stated Susan attained maximum medical improvement (MMI) as of August 11, 2016. She had no permanent work restrictions as a result of the injury. Pursuant to the AMA Guides, Dr. Nelson assigned 10 percent permanent partial disability as a result of the work injury. (Def. Ex. E, p. 26)

Susan returned to see Dr. Nelson on October 27, 2016. She reported some increase in pain when she returned to work. Her pain was a 7 out of 10. Her pain occasionally ranged from stiff to sharp. She also reported tingling throughout her low back. She said the only time she felt good was when she was taking pain medication. At the time of the October visit she was taking four tablets of Aleve per day and Skelaxin. She was back working at the school without restrictions. The doctor's impression was low back pain, myofascial; L1 compression fracture, healed; and post-polio syndrome. Dr. Nelson did not see any indication for further treatment. He felt that her fracture was well healed. He refilled the Skelaxin prescription. She was again released to work with no restrictions. No return appointment was made. (JE2, pp. 37-39)

Susan returned to Sara Glover, PA-C on December 8, 2016. She had been working full duties since August. She reported that her employer was having her do less heavy lifting. Susan stated she saw Dr. Nelson over a month ago and he told her she did not need any more medications or treatment. She described her pain as 5-6/10. She still has a lot of stiffness in her lower back and it was difficult for her to get her full range of motion. It was also difficult for Susan to get up and down from a sitting position, and sitting or standing for too long caused her pain in her back. She had been taking Aleve two tablets twice a day for pain and Skelaxin twice a day for spasming. She tried to stop these medications but that seemed to flare her back pain. The assessment was lumbar compression fracture, resolved; lumbar strain. Sara Glover, PA-C recommended continued use of Skelaxin and ordered physical therapy to try to get Susan back to her preexisting state. (JE3, pp. 51-53)

On January 3, 2017, Susan returned to Sara Glover, PA-C. Susan had been to three sessions of physical therapy. Susan felt like the therapy was helping her pain and

range of motion. She still had some occasional sharp pain in her back, but it seemed to be getting better. She rated her pain as 1-2 out of 10. She reported no pain that radiated down her legs or any numbness or tingling in her legs. The assessment was lumbar strain, improving; history of lumbar compression fracture. Sara Glover, PA-C referred Susan for six more sessions of physical therapy, for a total of 12. She was to continue Skelaxin twice a day and over-the-counter Aleve as needed for pain. (JE3, p. 58)

Between January 19, 2017 and February 6, 2017, Susan attended physical therapy at Advantage PT and Rehab. The February 6, 2017 note states that overall Susan was feeling better. She was not pain free, but reported feeling 50-60 percent better. The therapist noted there was slower than expected progress, but consistent objective gains. (JE4)

On February 7, 2017, Susan returned to see Sara Glover, PA-C for follow-up of her low back pain and previous lumbar compression fracture. Susan reported that since her last visit she felt her symptoms had become worse. She felt very tight in her back over the last one to two weeks. Susan reported lifting her 30-pound grandchild around one week ago and that seemed to make her symptoms worse. She felt very sore afterward and the pain in her back made it difficult for her to sleep at night. She wanted something to help her sleep. Overall, she felt like the physical therapy helped, but she still had pain with bending at the waist, when trying to carry too much, and getting up and down throughout the day. Sara Glover, PA-C felt that the evaluation was consistent with continued pain in Susan's low back despite several sessions of therapy and full recovery from the compression fracture. Susan was given prescriptions for Skelaxin and hydrocodone. She was allowed to continue full duties because she felt like she was able to perform her duties. Sara Glover, PA-C recommended that Susan not lift her grandson or do any other heavy lifting. She was referred for an MRI due to her seemingly worse symptoms. Sara Glover, PA-C indicated that Susan's symptoms were work-related. (JE3, pp. 59-62)

A February 17, 2017 MRI revealed an L1 compression fracture with 55 percent height loss. (JE2, pp. 40-41)

Susan returned to see Sara Glover, PA-C on February 21, 2017. Susan reported that her symptoms since the last visit were somewhat better. She reported her pain as 5-10. She continued to experience tightness in her back. She was attempting to take less of the muscle relaxers and pain medication. Sara Glover, PA-C felt the evaluation was consistent with lumbar spondylosis as seen on the MRI. There was some degenerative disc disease in her spine that Sara Glover, PA-C felt was likely contributing to the continued symptoms. However, she continued to have pain in the area from the previous compression fracture as well. Susan was referred to pain management. She was still released to full duty. (JE3, pp. 63-65)

On March 29, 2017, Susan was seen at The Iowa Clinic pain management by Karla Stapes, ARNP. Susan reported back pain since April 12, 2016. She rated her

pain as 5-6/10. Susan reported her pain was aggravated when she did not take medications. The assessment was chronic narcotic dependence; history of compression fracture of vertebral column; and chronic bilateral low back pain without sciatica. She was prescribed Cyclobenzaprine at bedtime and Hydrocodone-Acetaminophen. (JE5, pp. 82-84)

Susan continued to follow-up at the pain clinic approximately once every three months between March of 2017 and June of 2018. She reported her pain as 5 out of 10. The last note from the pain clinic is dated June 14, 2018. The treatment at that time consisted of hydrocodone 5/325 1 tablet 4 times a day, Metaxalone and cyclobenzaprine. Susan reported adequate relief. She was to follow-up in three months. (JE5)

At the request of her attorney, Susan underwent an IME with Sunil Bansal, M.D. on February 6, 2017. Dr. Bansal stated that as a result of the April 12, 2016 work injury, Susan sustained an acute L1 compression fracture. He placed her at MMI as of October 27, 2016 when she was released from care by Dr. Nelson. Pursuant to the AMA Guides he assigned 10 percent whole person impairment. Dr. Bansal restricted her to no lifting over 25 pounds occasionally and no lifting over 10 pounds frequently. No frequent bending or twisting. Although this IME occurred shortly after the lifting incident, there is no mention of the incident in this report. (Cl. Ex. 4)

On February 27, 2018, at the request of the defendants, Susan underwent an IME with John D. Kuhnlein, D.O. His diagnoses were head contusion, resolved; L1 compression fracture, healed; and chronic low back pain. Dr. Kuhnlein was asked, if Susan's current back symptoms were causally related to the April 12, 2016 work incident. He responded:

> Ms. Moss denied any low back pain before this incident, and there is no evidence in the currently available file to suggest that she had pre-existing back pain. The records indicate that she has had continuous back pain since the incident. She had the intervening incident in approximately February 2017 while lifting her grandson, but this was a short-term exacerbation of her pre-existing condition. She denies any other intervening low back injuries. She had the pre-existing degenerative disease in the lumbar spine with chronic right L5 spondylolysis, as noted on x-rays taken the day of the injury, and so there was pre-existing degenerative disease in the lumbar spine, with no evidence in the currently available file that it was symptomatic before this injury.
>
> With no other evidence of any pre-existing low back pain and no other reasonable explanation for her current back pain, her current back symptoms are causally related to the April 12, 2016, work incident.

(Def. Ex. A, pp. 7-8)

Dr. Kuhnlein placed Susan at MMI as of February 21, 2017, the date she was referred for pain management. Based on the AMA Guides, he assigned 10 percent whole person impairment for the L1 compression fracture. Dr. Kuhnlein noted Susan was working fewer hours per day and per week than she did at the time of the injury due to budget cutbacks. She was still performing the same job as before the injury. Given her current work conditions and ability to stretch and massage her painful areas throughout the day, Dr. Kuhnlein felt she did not require any permanent work restrictions beyond occasional bending and twisting. (Def. Ex. A, pp. 1-9)

On October 24, 2017 Dr. Nelson wrote a letter to the defendants. Dr. Nelson noted that Susan had sustained a 40 percent compression fracture of her L1 vertebral body. He felt that her fracture healed uneventfully and her oval spinal alignment remained normal. According to Dr. Nelson, patients with healed compression fractures with normal spinal alignment typically have very good clinical results without significant residual pain or limitations. Dr. Nelson reaffirmed that he did not see any need for any activity restrictions for Ms. Moss. (Def. Ex. F, pp. 27-28)

Dr. Bansal saw Susan again in August of 2018 and issued a supplemental report. In the review of medical records portion of this report there is mention of the lifting incident and Susan's treatment in early 2017. However, there is no further mention of the lifting incident. There is no explanation from Dr. Bansal about how, or if, the lifting incident affected Susan's condition. It is not clear what consideration, if any, Dr. Bansal gave the lifting incident. After reviewing additional treatment records Dr. Bansal placed Susan at MMI as a result of her injury as of June 14, 2018, the date of her last appointment at the pain clinic. His opinions with regard to permanent impairment and restrictions did not change. He felt that Susan would benefit from continued treatment with a pain specialist. (Cl. Ex. 5) Because Dr. Bansal fails to provide any rationale or even comment on the lifting incident, I do not find his causation opinions regarding her current symptomatology and ongoing treatment to be persuasive.

Dr. Nelson wrote another letter to defendants on August 14, 2018. He could not state that Susan's ongoing need for pain management was the result of the April 12, 2016 compression fracture. (Def. Ex. G)

Also on August 14, 2018, Karla Stapes, ARNP signed a check-the-box type letter authored by defendants. She indicated that she was unable to state whether or not Susan's need for ongoing pain management was necessary due to the April 2016 compression fracture, or necessary for some other reason or cause. (Def. Ex. H) The letter is not in the words of the medical practitioner and lacks her rationale. Therefore, I do not find this document to be persuasive and I give it very little weight.

On August 15, 2018, Sara C. Glover, PA-C wrote a letter to the defendants. She opined:

> the incident Ms. Moss described with lifting her 30 pound grandson between January-February 2017 caused a significant aggravation in her

> lower back symptoms. She had been improving with physical therapy with minimal reported pain on 01/03/2017, and she attributed her worsening symptoms on 02/07/2017 to this non-work related incident. She had a significant worsening in her symptoms after this described non-work related episode that continued.

(Def. Ex. D, p. 25)

Sara C. Glover, PA-C ultimately opined, "the need for the pain management referral on 02/21/2017 is not related to her work injury and L1 compression fracture on 04/12/2016, but more so for her ongoing low back pain after lifting her grandson and her history of lumbar spondylosis as seen on the MRI findings." (Def. Ex. D, p. 25)

A review of Ms. Glover's own clinical notes reveals that her opinion is based on an inaccurate statement of the facts of the case. In the history portion of her causation statement Ms. Glover stated that after Susan lifted her grandson she had significant worsening of symptoms that continued. However, in her February 21, 2017 clinical note, Ms. Glover stated, "[a]t the last visit she had noted that her symptoms had gotten somewhat worse after lifting up her grandson, but she notes that since then she feels like this flare of symptoms has gotten somewhat better." (JE 3, p. 63) Because Ms. Glover's causation opinion is based on an inaccurate history I do not find the opinion to be persuasive.

On August 16, 2018, Dr. Kuhnlein authored a lengthy missive to the defendants wherein he changed his opinion regarding causation. Dr. Kuhnlein's first report was dated March 13, 2018, over one year after the lifting incident involving Susan's grandson. In that initial report Dr. Kuhnlein clearly stated the lifting incident was a short-term exacerbation. However, in this August 2018 report, Dr. Kuhnlein now states the lifting incident was not an exacerbation, but a new injury. Dr. Kuhnlein opined that Susan's current low back pain was not related to the pre-existing compression fracture, but was related to the intervening incident when she lifted her grandchild. The August 2018 report does not state that he was provided additional treatment records, it merely indicates that defendants asked for an addendum to his prior report. Dr. Kuhnlein's drastic change in opinion right before the arbitration hearing in this matter is troubling to the undersigned. Nonetheless, Dr. Kuhnlein does provide his rationale for his opinions, including how the lifting incident affected Susan. Therefore, if forced to select one expert's opinion regarding causation, I find Dr. Kuhnlein's opinion carries the greatest weight. (Ex. B)

I find that Susan has carried her burden of proof to show by a preponderance of the evidence that she sustained an L1 compression fracture as a result of the April 12, 2016 work injury. I further find that claimant has demonstrated that she sustained 10 percent whole person functional impairment as a result of the compression fracture. The opinions of Dr. Nelson, Dr. Bansal, and Dr. Kuhnlein support this finding. (Cl. Ex. 4, Def. Ex. A, Def. Ex. E, p. 26)

However, I find claimant has failed to carry her burden to show that her ongoing problems are related to the work injury. For the reasons set forth above, I found Dr. Kuhnlein's causation opinion to be the most persuasive. Dr. Kuhnlein ultimately opined that the lifting incident was a new injury. Dr. Kuhnlein felt that Susan's ongoing low back pain was not related to the pre-existing compression fracture, but was related to the intervening incident when she lifted her grandchild. Regardless of Dr. Kuhnlein's opinion, claimant failed to produce a reliable, persuasive expert opinion to demonstrate that her ongoing symptoms are work-related.

I find claimant has demonstrated that she sustained permanent impairment to her body as a whole as a result of the work-related compression fracture. Thus, a determination must be made regarding her claim for industrial disability.

We now turn to the issue of whether Susan has any activity restrictions placed on her as a result of the April 12, 2016 work injury. I find that the preponderance of the evidence demonstrates that she does not. This finding is supported by the majority of opinions of the medical experts in this case. The only doctor to give Susan any restrictions is Dr. Bansal. However, for the same reasons that I did not find his causation opinions to be persuasive, I do not find his opinion regarding restrictions to be persuasive. I find that Susan has failed to show by a preponderance of the evidence that any restrictions she might have are related to the work injury. She has returned to work and admitted that she is capable of performing her job duties. The medical providers who treated Susan (Dr. Nelson, Sara Glover PA-C, and Karla Stapes, ARNP) have released her to return to work with no restrictions on her activities. Dr. Kuhnlein did not assign any activity restrictions as a result of the compression fracture. (Def. Ex. A, pp. 8-9) Susan testified at hearing and in her deposition that she is able to perform her job and receives the same amount of help from her coworkers now as she did prior to the injury. (Testimony; Def. Ex. K, p. 40)

At the time of the hearing Susan was 61 years of age. She is a high school graduate. Her employment history includes working at McDonald's while in high school. She also worked in food service and as a CNA at a hospital. For approximately twenty years Susan ran an in-home daycare. She has also assisted her husband with clerical work in the operation of their real estate/rental property business. She was hired by the West Des Moines School District in 2006. Since that time she has worked in the food service department. Initially, she worked with food preparation, served food, and cleaned. More recently, her job duties consisted primarily of cashiering and serving food over the lunch hour. She would also help with clean up, laundry, and dishes.

Susan testified that while she is able to perform her current job duties, she has more difficulty now than she did prior to the injury. Bending over causes her pain. She is required to do at least some bending in her job. Even prior to the lifting incident, Susan was experiencing pain while performing her work duties.

Considering Susan's age, educational background, employment history, ability to retrain, motivation to maintain her job, length of healing period, permanent impairment,

and lack of permanent restrictions, and the other industrial disability factors set forth by the Iowa Supreme Court, I find that she has sustained a 15 percent loss of future earning capacity as a result of her work injury.

We now turn to Susan's claim for payment of past medical expenses. Specifically, claimant is seeking reimbursement for an expense at Hy-Vee Pharmacy on April 12, 2016, the date of the injury, in the amount of $32.99. This charge appears to be an expense associated with her prescription for hydrocodone and cyclobenzaprine. Defendant offers no argument as to why this expense should not be their responsibility. Based on a review of the record, it appears that this expense was reasonable and necessary because of the work injury. Thus, I find defendant is responsible for this medical expense.

Claimant is also seeking payment of a September 7, 2018 Hy-Vee Pharmacy expense in the amount of $188.99. This appears to be for a prescription for pain medication from Karla Staples, ARNP. However, because I found that Susan failed to prove that her ongoing back complaints are related to the work injury, I find that this expense was not necessary because of the work injury. Therefore, defendant is not responsible for this expense.

Claimant also stated on the hearing report that she anticipates billing her health insurance carrier for any treatment related to the work injury, including pain management. However, I find that claimant has failed to carry her burden of proof to show by a preponderance of the evidence that her ongoing back pain is related to the work injury. I further find, based on the flawed opinions of Dr. Bansal, Susan failed to prove any treatment after the February 2017 lifting incident was necessary due to the work injury. Thus, claimant's request for defendant to be responsible for any treatment after that time fails.

Finally, both sides are seeking assessment of costs. I find that each side was somewhat successful in this case. Therefore, I exercise my discretion and do not assess any costs. Each side shall bear their own costs.

CONCLUSIONS OF LAW

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

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).

Since claimant has an impairment to the body as a whole, an industrial disability has been sustained. Industrial disability was defined in Diederich v. Tri-City R. Co., 219 Iowa 587, 258 N.W. 899 (1935) as follows: "It is therefore plain that the legislature intended the term 'disability' to mean 'industrial disability' or loss of earning capacity and not a mere 'functional disability' to be computed in the terms of percentages of the total physical and mental ability of a normal man."

Functional impairment is an element to be considered in determining industrial disability which is the reduction of earning capacity, but consideration must also be given to the injured employee's age, education, qualifications, experience, motivation, loss of earnings, severity and situs of the injury, work restrictions, inability to engage in employment for which the employee is fitted and the employer's offer of work or failure to so offer. McSpadden v. Big Ben Coal Co., 288 N.W.2d 181 (Iowa 1980); Olson v. Goodyear Service Stores, 255 Iowa 1112, 125 N.W.2d 251 (1963); Barton v. Nevada Poultry Co., 253 Iowa 285, 110 N.W.2d 660 (1961).

Compensation for permanent partial disability shall begin at the termination of the healing period. Compensation shall be paid in relation to 500 weeks as the disability bears to the body as a whole. Section 85.34.

Based on the above findings of fact, I conclude that Susan carried her burden of proof to show that she sustained permanent injury to her body as a whole as the result of the April 12, 2016 work injury. I further conclude that as a result of that work injury she sustained 15 percent industrial disability and as such is entitled to 75 weeks of permanent partial disability benefits.

Claimant is also seeking payment of past medical expenses. 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).

Based on the above findings of fact, I conclude defendant is responsible for the expense of the April 12, 2016 pharmacy bill, but not the September 7, 2018 pharmacy bill. Thus, defendant is responsible for past expenses in the amount of $32.99.

Claimant also makes a broad assertion that she anticipates billing her health insurance carrier for any treatment related to the work injury, including pain management. Based on the above findings of fact, I conclude that claimant has failed to carry her burden of proof to show by a preponderance of the evidence that her ongoing back pain is related to the work injury. I further conclude, based on the flawed opinions of Dr. Bansal, Susan failed to prove any treatment after the February 2017 lifting incident was necessary due to the work injury. Thus, claimant's request for defendant to be responsible for any treatment after that time fails.

Finally, both parties seek an assessment of costs. Costs are to be assessed at the discretion of the deputy hearing the case. 876 IAC 4.33. In this case, I found that each party was partially successful and therefore each party shall bear their own costs.

ORDER

THEREFORE, IT IS ORDERED:

All weekly benefits shall be paid at the stipulated rate of one hundred ninety-three and 62/100 dollars ($193.62).

Defendant shall pay seventy-five (75) weeks of permanent partial disability benefits commencing on the stipulated commencement date of August 11, 2016.

Defendant shall be entitled to credit for all weekly benefits paid to date.

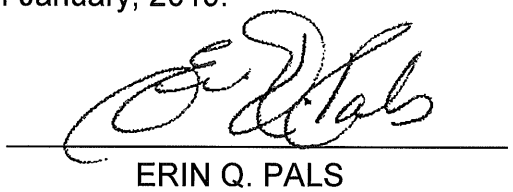
Defendant shall pay accrued weekly benefits in a lump sum together with interest at the rate of ten percent for all weekly benefits payable and not paid when due which accrued before July 1, 2017, and all interest on past due weekly compensation benefits accruing on or after July 1, 2017, shall be payable at an annual rate equal to the one-year treasury constant maturity published by the federal reserve in the most recent H15 report settled as of the date of injury, plus two percent. See Deciga Sanchez v. Tyson Fresh Meats, Inc., File No. 5052008 (App. Apr. 23, 2018) (Ruling on Defendants' Motion to Enlarge, Reconsider or Amend Appeal Decision re: Interest Rate Issue).

Defendant is responsible for medical expenses as set forth above.

Each party shall bear their own costs.

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

Signed and filed this 16th day of January, 2019.



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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.