BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

GARY PALZKILL,

Claimant,

vs.

EAGLE WINDOW & DOOR,

Employer,

and

OLD REPUBLIC INSURANCE COMPANY,

Insurance Carrier,
Defendants.

File Nos. 5041363; 5041368

ARBITRATION DECISION

Head Note No.: 1803

STATEMENT OF THE CASE

Claimant, Gary Palzkill, filed petitions in arbitration seeking workers' compensation benefits from Eagle Window and Door, employer, and Old Republic Insurance Company, insurance carrier, both as defendants, as a result of stipulated injuries sustained on August 21, 2006 and August 27, 2010. This matter came on for hearing before Deputy Workers' Compensation Commissioner, Erica J. Fitch, on February 27, 2014, in Des Moines, Iowa. The record in this case consists of claimant's exhibits 1 through 16, defendants' exhibits A through K, and the testimony of the claimant. The parties submitted post-hearing briefs, the matter being considered fully submitted on June 6, 2014.

ISSUES

In File No. 5041363 (Date of Injury: August 21, 2006)

The parties submitted the following issues for determination:

1. The extent of claimant's industrial disability;

2. Whether claimant is entitled to payment of medical mileage; and

3. Specific taxation of costs.

The stipulations of the parties in the hearing report are incorporated by reference in this decision.

In File No. 5041368 (Date of Injury: August 27, 2010)

The parties submitted the following issues for determination:

1. Whether the injury of August 27, 2010 is a cause of permanent disability; and if so,

2. The extent of claimant's industrial disability;

3. Whether claimant is entitled to payment of medical mileage; and

4. Specific taxation of costs.

The stipulations of the parties in the hearing report are incorporated by reference in this decision.

FINDINGS OF FACT

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

Claimant's testimony was consistent as compared to the evidentiary record and his deposition testimony. His demeanor at the time of evidentiary hearing gave the undersigned no reason to doubt claimant's veracity. Claimant was polite, personable, well-spoken, and demonstrated very good eye contact. The undersigned observed claimant demonstrate obvious pain behaviors including: placing his hands on both sides of his chair when seated; alternating between sitting and standing, each time using the table for support when changing positions; shifting in his chair from front to back; lifting his right foot slightly; and sitting with the right leg extended. Claimant is found credible.

Claimant was 54 years of age at the time of hearing. Claimant graduated high school in 1977, with a "B" average. His work history consists of work as a laborer/beekeeper, cook, groundskeeper, kitchen manager, restaurant co-owner and chef, and his work for defendant-employer. When claimant began work at defendant-employer, he described himself as in generally good health, taking no prescription medications for any health condition and receiving no care for any low back condition. (Claimant's testimony; Exhibit 15, Deposition Transcript pages 10-14)

On July 5, 1999, claimant began work at defendant-employer, a window and door manufacturer. Claimant began as a laborer in the machining department, earning approximately $7.00 per hour. For one year, he floated throughout the department doing various tasks, including feeder and rework. Thereafter, claimant worked cutting

and finishing window frames. His duties required lifting of approximately 20 pounds, bending, reaching, and prolonged standing. (Claimant's testimony; Ex. 15, Depo. Tr. pp. 25-29; Ex. H, p. 3)

In April 2000, claimant began part-time work at Diamond Jo Casino (Diamond Jo) as a line cook. Claimant worked up to 34 hours per week, in addition to his full time work at defendant-employer. He earned $7.00 per hour. After several years, claimant became a pastry chef. (Claimant's testimony; Ex. 15, Depo. Tr. pp. 14-15; Ex. H, p. 3)

Claimant testified he began to suffer with back complaints during the year 2000. (Claimant's testimony) In June 2000, claimant presented to David Field, M.D. Claimant reported he injured his low back at work at defendant-employer when he lifted, slipped, and then attempted to catch a bundle of wood. Dr. Field assessed a hip pointer injury and recommended conservative care. (Ex. 11, p. 1) Following less than one month of conservative care, Dr. Field released claimant to full duty work. (Ex. 11, pp. 14-15) Claimant testified his complaints resolved completely. (Claimant's testimony)

In November 2003, claimant sought care with Craig Schultz, D.O. Claimant reported complaints of low back pain after butchering turkeys at home. He also reported a history of back problems from time to time, occurring several times per year. Dr. Schultz assessed an acute lumbosacral strain and recommended an exercise program, as well as use of ice and heat. (Ex. A, p. 6) Claimant testified his complaints resolved. (Claimant's testimony)

In January 2005, claimant sought medical care after stopping a bundle of door jambs from falling at defendant-employer. Claimant was diagnosed with an acute low back sprain and was provided conservative care. Approximately two weeks' post-injury, claimant was released at maximum medical improvement (MMI). (Ex. 13, pp. 1-7)

In June 2006, claimant suffered a work injury at Diamond Jo after tripping over a stack of floor mats. Michael Stenberg, M.D. diagnosed an acute low back sprain and ordered conservative care. Dr. Stenberg placed claimant at MMI within one week of the work injury and released claimant to regular duties. (Ex. 2, p. 3; Ex. 13, pp. 9-12; Ex. A, pp. 1-3, 5) Claimant testified his symptoms consisted of a "wrenched" back, without radicular symptoms. Claimant testified he returned to work full duty without restrictions at both defendant-employer and Diamond Jo. He did not file a workers' compensation claim or receive workers' compensation benefits. (Claimant's testimony)

On August 21, 2006, claimant flipped a piece of window jamb and felt a pop in his back. A short time later, claimant testified his back began to hurt. Claimant reported the injury to defendant-employer and was referred for care at Mercy Medical Center (Mercy). (Claimant's testimony; Ex. 15, Depo. Tr. p. 41; Ex. H, p. 6)

At Mercy on August 21, 2006, claimant was evaluated by Richard Koehler, M.D. Claimant complained of low back pain radiating into the left leg after lifting and twisting

holding boards. Dr. Koehler assessed low back pain with radiculopathy and a suspicion of disc disease. He prescribed Lortab and removed claimant from work for 24 hours. (Ex. 4, pp. 1, 8, 11)

After receiving care at Mercy, claimant was referred to Peggy Mulderig, M.D., also on August 21, 2006. (Claimant's testimony) Dr. Mulderig noted complaints of low back pain with radiation into the left leg, which claimant related to work duties. After examination, Dr. Mulderig assessed left lower extremity radiculopathy and prescribed physical therapy and a Medrol Dosepak. Dr. Mulderig also removed claimant from work until the following day and imposed work restrictions of standing and walking limited to ten minutes per hour; no repetitive bending, lifting or twisting; and a maximum lift, carry, push, or pull of ten pounds. (Ex. 2, pp. 1, 3, 5; Ex. 13, p. 11; Ex. A, pp. 1, 5)

Claimant continued to follow up with Dr. Mulderig, with Dr. Mulderig recommending continued conservative care and gradually decreasing claimant's work restrictions. (Ex. 2, pp. 4-5, 8)

On September 19, 2006, Dr. Mulderig ordered a lumbar spine MRI. (Ex. 2, pp. 9-10) Claimant underwent lumbar spine x-rays and MRI on September 27, 2006. The radiologist read the x-rays as revealing mild degenerative changes. The radiologist read the MRI as revealing a multilevel degenerative disc bulge, with superimposed very small protrusions at L3-4 and L4-5, and mild left neural foraminal narrowing at L5-S1, as well as an abnormal marrow signal pattern. (Ex. 5, pp. 1-2; Ex. B, p. 1)

On September 29, 2006, claimant returned to Dr. Mulderig who opined the MRI showed some neural foraminal narrowing at L5-S1, which correlated with claimant's symptoms. She indicated the MRI also revealed some marrow signal changes, which claimant needed to evaluate further under personal health insurance. Dr. Mulderig reduced claimant's work restrictions and referred claimant for an epidural steroid injection. (Ex. 2, pp. 11-12)

At physical therapy on October 11, 2006, claimant reported an abrupt onset of back discomfort while moving quickly to avoid a dog. (Ex. 3, p. 25; Ex. B, p. 2) The following day, claimant presented to Christine Burds, ARNP. Claimant reported an increase in back pain over the weekend, but this pain resolved. (Ex. B, p. 3)

Claimant underwent epidural steroid injection and reported relief of his leg symptoms to Dr. Mulderig on October 16, 2006. Dr. Mulderig accordingly decreased claimant's work restrictions. (Ex. 2, pp. 13-16)

On November 6, 2006, claimant suffered an exacerbation of back pain while at work for defendant-employer. Claimant reported an increase of pain while squatting/bending to pull a door jamb off a lower shelf. Claimant presented to the nurse's station and physical therapy. By the time of evaluation with Dr. Mulderig later that day, claimant's pain had lessened. Dr. Mulderig noted claimant had plateaued and

referred claimant to David Field, M.D. for a second opinion evaluation. (Ex. 2, pp. 17-19, 23; Ex. 3, p. 34)

Claimant presented to Dr. Field on November 13, 2006. Dr. Field opined claimant's radiology studies revealed degenerative disc disease of the lumbar spine. Following examination, Dr. Field opined there was no evidence of definitive disc herniation or findings to support surgical intervention. He recommended continued conservative treatment, including a back brace, anti-inflammatories, physical therapy, and potentially a repeat epidural injection. (Ex. 6, pp. 1-2)

Per Dr. Field's recommendation, claimant received a repeat lumbar epidural injection on November 22, 2006. (Ex. 2, pp. 22-23) Following epidural, claimant's pain increased, leading Dr. Mulderig to order a repeat MRI of the lumbosacral spine. (Ex. 2, pp. 25-26; Ex. 4, pp. 14, 17) Claimant underwent the repeat MRI on November 27, 2006. The radiologist read the results as revealing a small central disc herniation at L4-L5 extending to the right with effacement of the thecal sac, and disc bulges at L1-L2, L3-L4, and L5-S1 without spinal stenosis. (Ex. 4, p. 14)

Claimant returned to Dr. Mulderig on November 28, 2006. At that time, Dr. Mulderig opined claimant's MRI was unchanged from prior studies. Dr. Mulderig removed claimant from work for the remainder of the day, to return to work the following day under stricter restrictions. Dr. Mulderig also ordered continued physical therapy. (Ex. 2, pp. 26-28)

Claimant returned to Dr. Mulderig on December 19, 2006. At that time, Dr. Mulderig opined claimant was failing to improve with current treatment. She opined claimant may potentially improve with time and ordered a functional capacity evaluation (FCE) to determine a safe level of work functioning. (Ex. 2, pp. 32-33) The following day, claimant was discharged from physical therapy for lack of progress. (Ex. 3, p. 58)

On January 4, 2007, claimant underwent FCE with Dan Focht, M.A., OTR. Mr. Focht opined the results of the examination were valid. Claimant demonstrated a maximum lift of 26 pounds occasionally and a maximum carry of 30 pounds occasionally. Mr. Focht opined this 28-pound average lifting capacity placed claimant in the light physical demand category of occupations. Other functional limitations included rare ladder use and occasional sitting, bending, reaching, stair climbing, squatting, kneeling, walking, and leg/arm movements. Claimant demonstrated a 30 to 45 minute sitting tolerance and tolerance for 20 to 30 minutes of stationary standing before adaptive weight-shifting and walking was required. Mr. Focht expressed belief claimant's condition would improve if he remained diligent in his home exercise protocol. (Ex. 3, pp. 64-67)

Dr. Mulderig reviewed claimant's FCE on January 11, 2007. At that time, Dr. Mulderig noted claimant's FCE demonstrated a maximum lifting capability of 28 pounds and limitation of bending and lifting to an occasional basis. Dr. Mulderig

assessed left lower extremity radiculopathy, released claimant from care, and imposed permanent restrictions of a maximum lift, carry, push or pull of 30 pounds and no repetitive bending, lifting, or twisting of the back. Dr. Mulderig advised claimant the natural progression of his type of injury would expect improvement with time. (Ex. 2, pp. 34-36; Ex. C, p. 1)

Claimant testified he returned to his full duty work, but performed his duties differently than he had prior to the work injury. Specifically, claimant testified he began to lift one item at a time, as opposed to two. Claimant indicated this change in action was allowed by defendant-employer. Claimant testified he never returned to the same pace of production as prior to the work injury, but defendant-employer accepted claimant working as fast as he could manage. (Claimant's testimony)

In response to inquiry from defendants' third party administrator, on February 1, 2007, Dr. Mulderig authored a letter opining claimant achieved MMI from the work injury of August 21, 2006 on January 11, 2007. She opined claimant fell within DRE lumbar category 2 based upon findings consistent with the mechanism of injury and non-verifiable radicular complaints. As a result of the injury and not considering any preexisting condition, Dr. Mulderig opined claimant sustained a permanent impairment of 5 percent whole person. (Ex. 2, pp. 37-38; Ex. A, p. 7) Defendants paid claimant 25 weeks of permanent partial disability benefits, reflecting Dr. Mulderig's 5 percent whole person rating. (Claimant's testimony)

On August 17, 2007, claimant presented to Joseph Garrity, M.D. with low back and left leg complaints. Claimant reported his back pain never improved following release by Dr. Mulderig and actually worsened. He complained of low back pain and numbness down the left leg to the toes, as well as a small amount of pain down the right leg to the calf. Dr. Garrity prescribed a Medrol Dosepak, Flexeril, and Lortab, and removed claimant from work pending evaluation by Dr. Mulderig. (Ex. 2, pp. 42-45)

Claimant was reevaluated by Dr. Mulderig on August 20, 2007. X-rays of lumbosacral spine revealed mild degenerative changes. Dr. Mulderig ordered physical therapy and imposed temporary restrictions more stringent than the permanent ones previously imposed. The work restrictions are noted only as standing, walking, and sitting limited by claimant's comfort. However, Dr. Mulderig also referenced claimant had been working under permanent restrictions already imposed. (Ex. 2, pp. 46-48; Ex. 5, p. 3)

Mr. Focht discharged claimant from physical therapy on September 7, 2007, opining claimant had returned to baseline. He instructed claimant on a home exercise program prior to discharge. (Ex. B, p. 4)

Claimant returned to Dr. Mulderig on September 11, 2007. At that time, claimant reported continued discomfort and intermittent pain reaching a level up to an 8 ½ out of 10. Claimant also reported the ability to ride in a car for only 20 to 25 minutes, but he

was able to tolerate his regular work. Examination revealed left leg pain with straight-leg raise, some left back pain, flexion to 70 degrees and extension to 20 degrees. Dr. Mulderig assessed low back pain and released claimant from care to continue his home exercise program. Dr. Mulderig released claimant to full duty work and imposed no permanent restrictions. (Ex. 2, pp. 55-56; Ex. B, p. 5)

Claimant thereafter continued to work at both defendant-employer and Diamond Jo. Despite Dr. Mulderig's release to return to work, claimant testified he always considered himself under the permanent restrictions imposed by Dr. Mulderig in January 2007 and Dr. Mulderig never informed him these restrictions had been rescinded. (Claimant's testimony)

Claimant received a performance evaluation from Diamond Jo in April 2010. Claimant was noted to meet or exceed expectations on all criteria, with an overall rating classification of exceeds expectations. (Ex. I, pp. 21-22)

On August 27, 2010, claimant testified his low back became very sore and he began having difficulties with his right leg, including pain and numbness of the foot. Claimant testified the right lower extremity complaints represented a new symptom, as his prior radicular symptoms had been limited to the left lower extremity. (Claimant's testimony)

Claimant was directed for care with Dr. Garrity on August 30, 2010. At that time, claimant complained of low back pain with right leg pain and numbness. Dr. Garrity noted a history of low back pain approximately five years prior, at which time he had back surgery. Claimant reported noticing a decline in his back about six months prior, a dramatic increase in back pain approximately six weeks prior, followed by development of pain and numbness of the right foot. Following examination, Dr. Garrity assessed pain of the low back with right L5 paresthesias. He prescribed physical therapy, Medrol Dosepak, and hydrocodone-acetaminophen. Dr. Garrity also imposed work restrictions of standing, walking and sitting by comfort; very limited sitting; lift, carry, push, or pull ten pounds maximum; and no repetitive bending, lifting, or twisting of the back. (Ex. 2, pp. 57-58, 61; Ex. D, pp. 1-2)

Claimant testified Dr. Garrity's reference to a prior back surgery was incorrect, as he has never undergone back surgery. (Claimant's testimony) There are no other records in evidence which reference claimant undergoing back surgery at any time.

Claimant continued to follow up with Dr. Garrity and Dr. Stenberg. On September 17, 2010, Dr. Garrity ordered a lumbar spine MRI. (Ex. 2, pp. 64, 66) On October 5, 2010, Dr. Stenberg issued a third request for authorization of the lumbar spine MRI, as claimant's current therapy regimen had not proven effective. (Ex. 2, pp. 69-71) On October 14, 2010, Dr. Stenberg altered claimant's work restrictions to standing, walking and sitting by comfort; lift, carry, push, or pull ten pounds maximum; no repetitive bending, lifting, or twisting of the back; no exposure to sitting, if possible;

and claimant must be allowed to change positions as needed for comfort. He again requested authorization of the lumbar spine MRI. (Ex. 2, p. 74) Due to an increase of symptoms, on October 22, 2010, Dr. Stenberg removed claimant from work. (Ex. 2, pp. 77-78)

On October 25, 2010, claimant underwent x-rays and MRI of his lumbar spine. The radiologist opined the x-rays revealed mild degenerative changes. (Ex. 5, p. 5) The radiologist read the MRI as revealing diffuse degenerative disc desiccation, minimal disc protrusions at L3-L4 and L4-L5, and neural foraminal narrowing at left L5-S1. The radiologist compared the MRI to the prior MRI study of September 27, 2006 and opined no significant changes were present, with the exception of a somewhat more normal overall marrow pattern. (Ex. 5, p. 4)

Claimant returned to Dr. Stenberg on October 26, 2010. He referred claimant back to Dr. Mulderig and imposed work restrictions of sitting, standing, and walking by comfort; a five-pound maximum lift, carry, push, or pull; no kneeling, crawling, climbing, squatting, running, or jumping; no repetitive bending, lifting, or twisting of the back; no exposure to sitting, if possible; and the need to change positions as needed. (Ex. 2, p. 82) Claimant attended his final session of physical therapy on October 27, 2010, at which time he was instructed on a home exercise program. (Ex. 3, p. 100)

On November 8, 2010, claimant returned to Dr. Stenberg, who opined claimant's lumbar spine MRI was essentially unchanged from the study of 2009. Claimant reported he had been released by his therapist with a home exercise program. Dr. Stenberg advised claimant to continue the home exercise program and return in one week. He imposed restrictions of sitting, standing, and walking by comfort; an eight-pound maximum lift, carry, push, or pull; kneeling, crawling, climbing, squatting, running, and jumping limited by comfort; limited repetitive bending, lifting, or twisting of the back; no exposure to sitting, if possible; and the need to change positions as needed. (Ex. 2, pp. 83-85)

Claimant returned to Dr. Stenberg on November 15, 2010, at which time Dr. Stenberg noted he continued to wait on authorization of claimant's return to Dr. Mulderig for evaluation and management of his condition. Dr. Stenberg imposed work restrictions of sitting, standing, and walking by comfort; an eight-pound maximum lift, carry, push, or pull; kneeling, crawling, climbing, squatting, running, and jumping as limited by comfort; no repetitive bending, lifting, or twisting of the back; no exposure to sitting, if possible; and the need to change positions as needed. (Ex. 2, pp. 86-88)

On December 21, 2010, claimant returned to Dr. Mulderig. Dr. Mulderig reviewed claimant's diagnostic studies and opined claimant demonstrated lumbar degenerative disc disease with some degenerative changes to the facet joint at the left L5-S1 level, but no nerve root impingement. She offered diagnostic lumbar medial branch blocks to determine the source of claimant's pain. (Ex. 2, pp. 95-96)

Dr. Mulderig performed medial branch blocks at the L5 level on February 3, 2011. (Ex. 2, p. 106) Claimant returned to Dr. Mulderig the following day and reported 80 to 90 percent pain relief following the medial branch blocks. Accordingly, Dr. Mulderig recommended lumbar radio frequency ablation. (Ex. 2, pp. 107-108)

On February 8, 2011, claimant presented to Dr. Stenberg, accompanied by Sue Gaul, nurse case manager. Ms. Gaul provided Dr. Stenberg video of a job to review. Claimant testified the employee on the video was performing rework, a lighter duty version of his regular job. (Claimant's testimony; Ex. 2, p. 109) Ms. Gaul inquired if claimant's employment at defendant-employer caused his current symptoms. Dr. Stenberg indicated he could not state claimant's employment was the cause of claimant's condition, but did opine claimant's employment was a contributing factor to claimant's condition. Dr. Stenberg recommended return to Dr. Mulderig for radiofrequency ablation to burn the nerve endings. (Ex. 2, pp. 109-110)

On March 17, 2011, Timothy Miller, M.D. performed the recommended facet denervation/RF lesioning procedure. (Ex. 7, p. 2) Claimant followed up with Dr. Miller on April 14, 2011, at which time Dr. Miller noted claimant was substantially better following RF lesioning. Despite improvement, Dr. Miller noted continued difficulties with forward flexion and lifting. Dr. Miller assessed disc and joint pain, with four-level degenerative disc changes. He placed claimant at MMI and expressed belief permanent restrictions were warranted but he did not feel it necessary to put claimant through a FCE to determine these restrictions. Dr. Miller imposed no restriction on lifting above waist level, as lifting at this level was generally limited to 50 pounds. He imposed restrictions of lifting below waist level of a maximum of 30 pounds frequently and 50 pounds occasionally. (Ex. 7, pp. 3-5; Ex. E, p. 1)

On May 12, 2011, Dr. Miller authored a letter opining claimant presented with preexisting back problems, but his condition was exacerbated by a work injury on August 27, 2010. Dr. Miller stated he was "torn" as to whether claimant's condition warranted impairment. Specifically, Dr. Miller questioned if claimant fell within DRE category 1, a low back strain without prolonged difficulty, warranting no impairment rating, or DRE category 2, low back changes with degenerative findings and persistent mechanical back pain. Given his imposition of permanent restrictions, Dr. Miller opined claimant should fall within DRE category 2, warranting a five percent whole person impairment. (Ex. 7, p. 6; Ex. E, p. 2)

Claimant testified the facet denervation procedure did not eliminate all his symptoms, but took away a large portion of his pain. Claimant testified the procedure provided relief for approximately one year. He continued to have difficulties with his right foot, however. Claimant testified he continued to regularly perform the home exercise program prescribed by Dr. Miller. (Claimant's testimony)

Claimant continued to work for defendant-employer and at Diamond Jo. (Claimant's testimony) A performance evaluation from Diamond Jo from May 2012 described claimant as meeting expectations in all criteria. (Ex. I, pp. 18-19)

On June 18, 2013, claimant presented for claimant's independent medical evaluation (IME) with board certified occupational and environmental medicine physician, Robin Sassman, M.D. Dr. Sassman issued a report of her findings and opinions dated July 16, 2013. At the time of evaluation, claimant reported low back pain radiating to the right foot, numbness of the right foot, and his left leg occasionally giving out. Claimant reported pain ranged from a level 4 to level 10 on a 10-point scale, with an average pain level of 6. (Ex. 8, p. 7)

Following interview, records review and examination, Dr. Sassman assessed low back pain with radiculopathy. Dr. Sassman opined the disc herniation noted on claimant's MRI was directly and causally related to the incidents on August 21, 2006 and August 27, 2010. She further opined claimant's work at defendant-employer, as well as the two work injuries, aggravated the underlying degenerative changes of claimant's lumbar spine. She supported her opinion with claimant's need to repetitively lift and twist at work since 1999, activities Dr. Sassman opined placed the low back at risk for injury. (Ex. 8, p. 9)

Dr. Sassman recommended a repeat lumbar spine MRI to instruct on further treatment options. Once completed, Dr. Sassman recommended a second surgical opinion. If non-surgical, Dr. Sassman recommended a return to Dr. Miller for pain management. Finally, Dr. Sassman indicated claimant may benefit from evaluation by a physical medicine rehabilitation specialist or from participation in the Spine Rehabilitation Program at the University of Iowa. Dr. Sassman indicated she did not believe claimant had achieved MMI, pending completion of her treatment recommendations. Should these steps not be followed, she assigned an MMI date of January 18, 2013. (Ex. 8, pp. 9-10)

Despite opining claimant had not achieved MMI, Dr. Sassman also issued an opinion on the state of claimant's current permanent impairment. Based upon the lumbar range of motion methodology, Dr. Sassman found a combined 24 percent whole person impairment. However, Dr. Sassman cautioned calculating impairment based upon range of motion can result in a rating being skewed higher as a result of pain-induced guarding. Dr. Sassman opined the resultant impairment for claimant based upon the range of motion method was equivalent to a fusion surgery under the DRE classification method. She opined this impairment appeared high. Therefore, she calculated claimant's permanent impairment on the DRE method. By the DRE method, Dr. Sassman opined claimant fell within DRE lumbar category 3, with a 13 percent whole person impairment due to significant limitations on claimant's activities due to pain. (Ex. 8, p. 11)

While acknowledging claimant's need for restrictions may change with further care, Dr. Sassman recommended restrictions of lifting, pushing, pulling and carrying a maximum of 30 pounds rarely from floor to waist, 50 pounds occasionally from waist to shoulder, and 30 pounds rarely over the shoulder. She also recommended claimant sit, stand and walk occasionally, but should be allowed to change positions frequently due to pain. Additional restrictions included no use of vibratory or power tools; rare use of stairs or ladders; rare stooping, bending or walking on uneven surfaces; and no crawling or kneeling. (Ex. 8, p. 11)

Due to Dr. Sassman's recommendation for a second surgical opinion, defendants arranged for evaluation by neurosurgeon, Chad Abernathey, M.D., on October 23, 2013. Dr. Abernathy noted claimant suffered from chronic low back pain since a work injury in August 2007. Claimant reported his symptoms became more prominent over the years, leading to significant right leg pain. Dr. Abernathy assessed a clinical presentation of a chronic lumbosacral strain and recommended MRIs of the lumbar and thoracic spines. (Ex. 9, p. 1; Ex. G, p. 1)

Claimant underwent lumbar and thoracic spine MRIs on October 30, 2013. The radiologist read the lumbar spine MRI as revealing: L5-S1 disc-osteophyte complex mostly in the left anterolateral and lateral paraspinous regions, but also with a broadly based protrusion or bulge in the left far lateral position abutting the exited nerve root, as well as moderate narrowing of the lateral left foramen; disc bulging at L3-L4 and L4-L5, most pronounced at L3-L4; and no evidence of central spinal stenosis. (Ex. 9, p. 5; Ex. F, p. 1) The radiologist read the thoracic spine MRI as revealing degenerative disc disease at C6-C7. (Ex. 9, p. 4; Ex. F, p. 3)

Following MRIs, claimant returned to Dr. Abernathey on October 30, 2013. Dr. Abernathey opined the MRIs were unrevealing, demonstrating only mild degenerative changes consistent with age and without significant neural compromise. Dr. Abernathey opined claimant was not a surgical candidate and recommended further conservative treatment. (Ex. 9, p. 2; Ex. G, p. 2)

In November 2013, claimant voluntarily moved from the machining department of defendant-employer to the materials area. Claimant explained he believed the new position would be easier on his back, as it did not require as much reaching, lifting, or carrying. Claimant testified his duties as a materials handler require retrieval of parts and he uses a push cart to avoid carrying items. He lifts only approximately five pounds as a materials handler. (Claimant's testimony)

Claimant testified over time his work as a pastry chef at Diamond Jo became too "taxing" on his back, leading him to request a reduction of his hours. He acknowledged his hours varied over the course of his employment at Diamond Jo. Shortly after Thanksgiving 2013, claimant testified he provided notice of his intention to quit employment. At that time, claimant worked only approximately 6 hours per week; he earned approximately $14.00 per hour. (Claimant's testimony)

Review of claimant's wage records at Diamond Jo reveals the following earnings. In 2006, claimant worked 820.25 hours and grossed $9,644.15. In 2007, claimant worked 701.75 hours and grossed $8,676.39. In 2008, claimant worked 917.50 hours and grossed $11,735.46. In 2009, claimant worked 1,526.00 hours and grossed $20,323.08. In 2010, claimant worked 1,129.75 hours and grossed $15,037.02. In 2011, claimant worked 967.00 hours and grossed $13,131.30. In 2012, claimant worked 545.25 hours and earned $7,475.38. (Ex. I, pp. 3-17)

Personnel records from Diamond Jo indicate claimant was terminated effective March 13, 2014 due to elimination of his position. The separation date indicates claimant last worked on November 27, 2013 and describes the separation as involuntary, due to position elimination. (Ex. K, pp. 3-4)

On May 30, 2014, claimant authored an affidavit regarding the personnel records obtained from Diamond Jo regarding the termination of claimant's employment. Claimant indicated in later fall 2013, he decided to quit his employment at Diamond Jo as his ongoing symptoms from the alleged work injuries were making his continued employment at Diamond Jo too difficult on top of his full time employment at defendant-employer. Claimant indicated he provided his direct supervisor, Chad Schissel, with four weeks' notice. Claimant worked these four weeks and then was scheduled for no more hours at Diamond Jo. Claimant indicated Mr. Schissel resigned shortly after claimant provided notice and apparently failed to advise other supervisors regarding claimant's resignation. Claimant stated prior to receiving the personnel forms created in March 2014, he was never notified of any involuntary separation or elimination of his prior position. (Ex. 16, pp. 1-2)

At evidentiary hearing, claimant reported continued difficulties he relates to the alleged work injuries. Claimant testified his low back pain is constant in nature and ranges from a level 4 to a level 9 on a 10-point scale. Low back pain increases with sitting, twisting, and lifting. He also believes the strength of his back has decreased. Right buttock pain ranges from a level 2 to a level 6 and right leg pain ranges from a level 2 to a level 5; pain in both areas increases with sitting. Claimant continues to have constant numbness and tingling in his right foot, which leads to difficulty in functioning, including difficulty lifting the foot, stubbing his toes frequently, and dragging the foot when walking. Claimant relates the right buttock, leg and foot symptoms to the 2010 alleged injury. He self-treats with use of aspirin, estimated as 5 to 6 doses per day, every day. Claimant has no medical treatment planned, but indicated he would be amenable to undergoing repeat nerve treatment, if offered. (Claimant's testimony)

Claimant testified his symptoms cause sitting to be very uncomfortable and his tolerance for sitting varies day to day. While seated, claimant may have to shift positions after only a few minutes. When travelling by car, claimant testified he needs to stop periodically to change positions. He tries to avoid lifting as much as possible; when lifting is required, claimant attempts to plan ahead, secure help, or break loads into lighter weights. He is capable of lowering himself to the ground, but has difficulty

rising from a squat and needs to support himself upon something to rise to standing. Claimant testified he is generally able to stand, although he occasionally leans to his left while standing. Claimant testified to notable difficulty walking, as he has difficulty walking in a straight line and sometimes veers to the right. Claimant stumbles, which he attributes to his right foot, and cannot ambulate on uneven surfaces or for long distances. (Claimant's testimony)

Claimant testified defendant-employer provided him light duty work and accommodated his limitations by allowing him to work at a slower pace. Claimant continues to work for defendant-employer, full time with some seasonal overtime. In 2013, claimant performed 215 hours of mandatory overtime. He works in the materials area and testified he would be unable to complete his preinjury work in the machining area as he did before the alleged work injuries. Claimant testified his work in the materials department involves less weight and twisting, and he is able to use a cart for support. Even with this support, claimant testified his back hurts by the end of a workday. At the time of evidentiary hearing, claimant earned approximately $16.00 per hour; this hourly wage is approximately $6.00 higher than he earned in 2006 and approximately $2.00 higher than he earned in 2010. Claimant denied applying for work outside of defendant-employer. (Claimant's testimony) Review of claimant's tax records reveals the following earnings from defendant-employer: $25,877.92 in 2011; $31,049.57 in 2012; and $34,772.85 in 2013. (Ex. J, pp. 1-3)

Claimant does not believe he is capable of returning to work similar to his prior work as a cook or restaurant owner/manager, due the twisting, walking, standing, and uneven surfaces required. Although claimant continued working as a pastry chef at Diamond Jo for a time, claimant highlighted his choice not to continue such work due to his back limitations. He acknowledged an ability to return to some aspects of beekeeping, but noted he would be unable to lift frames from the hives. (Claimant's testimony)

Claimant testified to alterations in his activities of daily living as a result of the alleged work injuries. He is no longer able to mow his lawn, garden, or engage in more than minimal snow removal. Claimant's wife performs the cleaning tasks, while claimant does perform some cooking and baking. The two grocery shop together, where claimant uses the cart for balance. Claimant's sleep habits and intimate times with his wife have been negatively impacted due to pain. He also reported difficulty with personal grooming such as washing his back, as well as changing his manner of dressing to avoid heavy shoes or shoes which must be repeatedly tied as opposed to slipped on and off. He is no longer able to engage in recreational fishing or pheasant hunting due to the involvement of uneven ground or the need to sit still. While claimant maintains his hobby farm raising game birds, claimant has altered the manner in which he performs his chores, including making multiple trips at lighter weights of food and water. (Claimant's testimony)

CONCLUSIONS OF LAW

In File No. 5041363 (Date of Injury: August 21, 2006):

The sole issue for determination is the extent of claimant's industrial disability.

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

Under the Iowa Workers' Compensation Act, permanent partial disability is compensated either for a loss or loss of use of a scheduled member under Iowa Code section 85.34(2)(a)-(t) or for loss of earning capacity under section 85.34(2)(u). The parties have stipulated claimant's disability shall be evaluated industrially.

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.

Claimant was 54 years of age on the date of evidentiary hearing. He is a high school graduate, but lacks other specialized education or training. Claimant's work history consists of work as a laborer/beekeeper, cook, groundskeeper, kitchen manager, restaurant co-owner and chef, and his work for defendant-employer. The majority of claimant's employment has come in the employ of defendant-employer or in the restaurant industry, specifically as a cook or chef. Any negative impact upon claimant's ability to perform work in these fields therefore negatively impacts his earning capacity.

On August 21, 2006, claimant suffered a stipulated injury to his low back, leading to a diagnosis of low back pain with left lower extremity radiculopathy. Claimant received conservative treatment, including physical therapy and epidural steroid injections. Following treatment, claimant underwent an FCE which found claimant demonstrated a 28-pound average lifting capacity, placing him in the light physical demand category. Other functional limitations included rare ladder use and occasional sitting, bending, reaching, stair climbing, squatting, kneeling, walking, and leg/arm movements. Based upon the FCE results, Dr. Mulderig imposed permanent restrictions of a maximum lift, carry, push or pull of 30 pounds and no repetitive bending, lifting, or twisting of the back. Dr. Mulderig also opined claimant sustained a 5 percent whole person impairment as a result of the work injury.

Approximately seven months later, claimant suffered a flare of back pain. Dr. Mulderig noted claimant had been working under permanent restrictions. She then imposed a restriction of standing, walking, and sitting as limited by comfort. She did not reiterate the permanent work restrictions she imposed seven months prior. Following treatment, the physical therapist opined claimant returned to baseline and Dr. Mulderig subsequently released claimant to full duty work without restrictions noted, despite continued reports of pain and limitations.

While Dr. Mulderig's September 2007 release notes no permanent restrictions, the undersigned finds it unlikely Dr. Mulderig intended to remove all permanent restrictions previously assigned. Dr. Mulderig's original imposition of work restrictions was based upon a valid FCE which demonstrated an average lifting capacity of 28 pounds. Dr. Mulderig did not opine claimant's condition had improved over the interim and no longer warranted permanent restrictions. To the contrary, she noted continued significant pain complaints. The physical therapist opined claimant returned to baseline, i.e. returned to the condition which warranted permanent restrictions, not that the sum of claimant's complaints resolved.

Given these background facts and the fact Dr. Mulderig never specifically revoked the previously imposed permanent restrictions, the undersigned believes it more likely Dr. Mulderig intended to release claimant without restrictions attributable to the August 2007 flare, as opposed to releasing claimant without restrictions from the August 2006 work injury. To summarily remove all permanent restrictions after a valid FCE demonstrated notable restrictions quite simply does not appear to be a prudent exercise of medical judgment. The undersigned accordingly finds permanent restrictions were warranted following the August 21, 2006 work injury and those restrictions remained in effect until claimant suffered the second work injury on August 27, 2010.

This finding is consistent with claimant's belief his restrictions were never revoked and he accordingly acted within those restrictions during his continued employment. Claimant has demonstrated motivation and commitment to continued work. Defendant-employer has consistently offered and claimant consistently accepted

light duty work subsequent to the August 21, 2006 work injury and subsequent flares. Following the work-related injury of August 21, 2006, claimant continued to work at defendant-employer in the machining department until 2013, following the second work-related injury. Claimant was capable of performing this work, although with modifications allowed by his employer. Claimant also continued to work at Diamond Jo until November 2013.

Claimant's earnings from defendant-employer at the time of the second work injury and at the time of evidentiary hearing were higher than at the time of the August 2006 low back injury. Claimant also continued working at Diamond Jo from 2006 until following the subsequent low back injury in August 2010. His hourly wage at Diamond Jo was higher at the time he left employment than at the time of the August 2006 work injury. Additionally, claimant worked more hours at Diamond Jo in 2008, 2009, 2010, and 2011 than he worked in 2006.

Upon consideration of the above and all other relevant factors of industrial disability, it is determined claimant sustained a 15 percent industrial disability as a result of the stipulated work-related injury of August 21, 2006. Such an award entitles claimant to 75 weeks of permanent partial disability benefits (15 percent x 500 weeks = 75 weeks), commencing on the stipulated date of August 22, 2006. The parties stipulated at the time of the work injury, claimant's gross weekly earnings were $489.69, and claimant was single and entitled to 1 exemption. The proper rate of compensation is therefore, $308.41.

In File No. 5041368 (Date of Injury: August 27, 2010):

The first issue for determination is whether the injury of August 27, 2010 is a cause of permanent disability.

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).

Claimant sustained a stipulated work-related injury on August 27, 2010. Claimant was diagnosed with low back pain and right lower extremity radiculopathy. Following treatment, claimant's low back and right lower extremity symptoms remain. While claimant has continued to complain of intermittent back complaints dating to the August 2006 work injury, these complaints have become constant. Additionally, claimant now relates significant right leg and foot difficulties which were not present prior to the stipulated injury of August 27, 2010. The existence of continued complaints and functional limitations caused by these complaints supports a determination the August 27, 2010 work injury was a cause of permanent disability.

Three physicians have authored opinions regarding whether the work injury of August 27, 2010 is a cause of claimant's complaints and if so, the extent of permanent disability and need for permanent restrictions. Dr. Stenberg opined claimant's employment was a contributing factor to development of claimant's condition. Dr. Miller opined claimant's condition was exacerbated by a work injury on August 27, 2010. Although Dr. Miller expressed reservation in assigning a permanent impairment, he imposed permanent work restrictions and accordingly opined a 5 percent whole person impairment had been sustained. Dr. Sassman opined claimant's condition was work-related and imposed conditional permanent restrictions and a 13 percent whole person impairment rating.

No physician opined claimant's continued complaints are not related to the August 27, 2010 work injury. No physician opined claimant's complaints resolved and returned to the baseline level present following the August 21, 2006 work injury. As there is no medical opinion to counter the opinions of Drs. Stenberg, Miller, and Sassman, it is determined claimant has met his burden of proving the work injury of August 27, 2010 is a cause of permanent disability.

The final issue for determination is the extent of claimant's industrial disability.

As an initial matter, it must be stated that a proper analysis of the extent of claimant's industrial disability as a result of the August 27, 2010 low back injury also includes consideration of claimant's condition immediately prior to the work-related injury, as claimant's condition is viewed as a whole. Specifically, in consideration of the extent of industrial disability sustained as a result of the August 27, 2010 low back injury, the undersigned also considers the impact of claimant's August 21, 2006 low back injury. Accordingly, the factors set forth *supra* with respect to the analysis of the extent of claimant's industrial disability sustained as a result of the August 21, 2006 work injury have been considered in determining the extent of claimant's industrial

disability following the August 27, 2010 work injury, but will not be restated in this section of the decision.

Following the stipulated injury of August 27, 2010, Dr. Miller opined claimant sustained a 5 percent whole person impairment and imposed work restrictions on below waist level reaching of 30 pounds frequently and 50 pounds occasionally. Dr. Miller's permanent impairment rating of 5 percent is the same numerical impairment imposed by Dr. Mulderig in February 2007 and is determined on the same basis, i.e. DRE lumbar category 2. Dr. Miller's permanent restrictions are compatible with the permanent restrictions imposed by Dr. Mulderig in January 2007, and found by the undersigned to remain in effect until the August 27, 2010 work injury.

The permanent restrictions recommended by Dr. Sassman consisted of lifting, pushing, pulling and carrying a maximum of 30 pounds rarely from floor to waist, 50 pounds occasionally from waist to shoulder, and 30 pounds rarely over the shoulder; sit, stand, and walk occasionally, with the ability to change positions frequently; no use of vibratory or power tools; rare use of stairs or ladders; rare stooping, bending or walking on uneven surfaces; and no crawling or kneeling. Dr. Sassman's restrictions are similar to those imposed by Drs. Mulderig and Miller. While similar, Dr. Sassman is the only physician to opine as to permanent restrictions required as a result of both work injuries, as opposed to viewing the injuries in isolation. The restrictions recommended by Dr. Sassman are further consistent with claimant's testimony regarding his own abilities and limitations. For this reason, the undersigned adopts Dr. Sassman's restrictions in determining the extent of claimant's industrial disability as a result of the August 27, 2010 work injury.

In addition to opining as to claimant's need for permanent restrictions, Dr. Sassman opined claimant fell within DRE lumbar category 3, warranting a 13 percent whole person rating based on significant limitations on claimant's activities due to pain. As with respect to permanent restrictions, Dr. Sassman again is the only physician to opine as to the extent of claimant's permanent impairment as a result of both work injuries. Her opinion considered the significant impact of claimant's ongoing symptoms upon his activities. Her opinion, again, is consistent with claimant's own credible testimony. Accordingly, the undersigned adopts Dr. Sassman's opinion on the extent of permanent functional impairment sustained by claimant as a result of the work injury of August 27, 2010.

Following the August 27, 2010 work injury, defendants consistently offered and claimant consistently accepted work. Claimant remained employed in the machining department until November 2013, when he voluntarily elected to move into the materials area. Claimant testified the materials handler position does not require as much reaching, lifting, or carrying as did his work in the machining department. Additionally, claimant's duties in this position comport well with the restrictions recommended by Dr. Sassman and adopted herein. Namely, claimant's lifting is limited to only approximately five pounds and claimant is allowed to alternate positions. Whether

claimant would have been capable of continued employment in the more strenuous machining department is questionable, especially given claimant's credible testimony that he continues to have pain in his back at the conclusion of a workday on his lighter natured job.

In addition to claimant's employment with defendant-employer, claimant's primary field of employment has been as a cook/chef. The restrictions imposed by Dr. Sassman do not automatically foreclose claimant's return to this field. This finding is supported by claimant's ability to continue part-time employment at Diamond Jo following the August 27, 2010 work injury.

However, claimant's employment at Diamond Jo eventually ended. Claimant credibly testified he voluntarily resigned employment due to his inability to continue such work as a result of back complaints. Claimant's testimony regarding the chain of events which led to his termination is accepted by the undersigned. What is notable is claimant stated he was unable to continue employment at Diamond Jo as the job became too taxing on top of his existing full time work at defendant-employer. Therefore, it is likely claimant retains the ability to function in a similar position absent other physical employment. Therefore, such positions likely remain available to claimant in the labor market.

While claimant has remained employed by defendant-employer and currently earns more than he did at the time of the August 27, 2010 work injury, claimant has lost income as a result of the work injury. This lost income is represented by claimant's ultimate need to resign his employment at Diamond Jo due to physical complaints. Claimant continued to work at Diamond Jo following the work injury. However, claimant worked over 150 fewer hours and earned nearly $2,000.00 less at Diamond Jo in 2011 than he had in 2010. This fact supports claimant's testimony he requested a reduction in hours due to complaints. It similarly lends credence to claimant's testimony he eventually was unable to tolerate continued part-time employment at Diamond Jo.

Claimant's earnings at defendant-employer increased nearly $9,000.00 from 2011 to 2013. However, as a result of the work injury of August 27, 2010, claimant was unable to continue his part-time employment at Diamond Jo. In 2009, the year immediately prior to the work injury, claimant grossed over $20,000.00 from his part-time employment at Diamond Jo. Admittedly, claimant's hours and earnings varied at Diamond Jo over the years of his employment. The loss of $20,000.00 in income from part-time employment is a significant loss, especially given claimant's annual earnings at defendant-employer were less than $35,000.00 in 2013.

Upon consideration of the above and all other relevant factors of industrial disability, it is determined claimant sustained a 40 percent industrial disability as a result of the stipulated work-related injury of August 27, 2010. Such an award entitles claimant to 200 weeks of permanent partial disability benefits (40 percent x 500 weeks = 200 weeks), commencing on the stipulated date of October 27, 2010. The parties

stipulated at the time of the work injury, claimant's gross weekly earnings were $511.58, and claimant was single and entitled to 1 exemption. The proper rate of compensation is therefore, $326.97.

In Both Files:

The first issue for determination is whether claimant is entitled to payment of medical mileage. At the time of evidentiary hearing, defendants stipulated payment for the claimed medical mileage would be paid by defendants. Therefore, no determination on this issue is required.

The final issue for determination is a specific taxation of costs pursuant to Iowa Code section 86.40 and rule 876 IAC 4.33. Claimant requests taxation of the costs of: $100.00 filing fee and $126.35 for a copy of claimant's deposition transcript. Defendants do not dispute taxation of these costs. These are allowable costs and are taxed to defendants.

ORDER

THEREFORE, IT IS ORDERED:

In File No. 5041363 (Date of Injury: August 21, 2006):

Defendants shall pay unto claimant seventy-five (75) weeks of permanent partial disability benefits commencing August 22, 2006 at the weekly rate of three hundred eight and 41/100 dollars ($308.41).

In File No. 5041368 (Date of Injury: August 27, 2010):

Defendants shall pay unto claimant two hundred (200) weeks of permanent partial disability benefits commencing October 27, 2010 at the weekly rate of three hundred twenty-six and 97/100 dollars ($326.97).

Defendants shall receive credit of seventy-five (75) weeks for permanent partial disability benefits awarded in File No. 5041363 as set forth in the decision.

In Both Files:

Defendants shall pay claimant's prior medical mileage submitted by claimant at the hearing as set forth in the decision.

Defendants shall pay accrued weekly benefits in a lump sum.

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

Defendants shall receive credit for benefits paid.

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

Costs are taxed to defendants pursuant to rule 876 IAC 4.33.

Signed and filed this 22nd day of May, 2015.

ERICA J. FITCH
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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EJF/srs

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.