BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

JACK BURK,

Claimant,

vs.

ALLEGIS GROUP, INC. d/b/a AEROTEK,

Employer,

and

INDEMNITY INSURANCE COMPANY OF NORTH AMERICA,

Insurance Carrier,
Defendants.

File No. 5054104

ARBITRATION DECISION

Head Note Nos.: 1108, 1803, 1804

STATEMENT OF THE CASE

Claimant, Jack Burk, filed a petition in arbitration seeking workers' compensation benefits from Allegis Group, Inc. d/b/a Aerotek, employer, and Indemnity Insurance Company of North America, insurance carrier, both as defendants, as a result of a stipulated injury sustained on May 16, 2012. This matter came on for hearing before Deputy Workers' Compensation Commissioner Erica J. Fitch, on April 7, 2016, in Council Bluffs, Iowa.

On the date of evidentiary hearing, numerous objections were raised regarding the evidence offered for consideration. Due to time constraints, the parties agreed to participate in a post-hearing conference regarding the totality of the written evidence which was offered, either at the time of hearing, or subsequently, due to omission or in response to pending objections. Following a series of correspondence between the undersigned and the attorneys of record, on May 12, 2016, the written record was finalized. The record in this case consists of Claimant's Exhibits 1 through 31, Defendants' Exhibits A through T, and the testimony of the claimant and Claudia Burk. The parties submitted post-hearing briefs, the matter being fully submitted on September 29, 2016.

ISSUES

The parties submitted the following issues for determination:

1. Whether claimant is entitled to temporary disability benefits from December 5, 2013 through October 13, 2015;

2. The extent of claimant's industrial disability;

3. The commencement date for permanent disability benefits;

4. Whether defendants are responsible for claimed medical expenses; and

5. Whether claimant is entitled to reimbursement for an independent medical examination under Iowa Code section 85.39.

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.

FINDINGS OF FACT

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

Claimant was 64 years of age on the date of evidentiary hearing. He resides in Council Bluffs, Iowa, with his wife of 45 years, Claudia. He and Claudia are the parents of four children. One son and a grandson reside with claimant. The grandson is autistic and holds a very close relationship with claimant. Claimant graduated high school; he lacks other formal postsecondary or vocational education or training. (Claimant's testimony)

Claimant testified his work history includes as a farm laborer, assembly line worker, concrete laborer, construction laborer, maintenance worker and heavy equipment operator. In 1993, claimant moved to Council Bluffs and began work for Fagen Construction. Claimant worked as a forklift operator and concrete laborer. In 1994, while performing his duties, claimant fell into an excavated hole. He suffered with a "slipped disc" in his neck and required multiple surgeries on his left foot. (Claimant's testimony) Charles Taylon, M.D. treated claimant's cervical injuries and performed an anterior cervical discectomy and fusion in 1995. (Exhibit 21A, page 1) Michael McGuire, M.D. treated claimant for his left foot injuries. (Ex. 23A, p. 1)

Following multiple surgeries on his left foot, claimant's left leg was ultimately amputated below the knee. (Claimant's testimony) He received a left leg prosthetic,

which was crafted and maintained by Burton Prosthetics. The majority of related complaints and adjustments were handled by Mike Tillia. Review of the offered records reveals claimant required periodic evaluation of his prosthetic, with the number of visits varying in frequency. (Ex. Q, pp. 105-122)

After losing his foot, claimant testified he suffered with depression, saw a psychiatrist, and utilized prescription medications for his mental condition. Claimant applied for and received Social Security Disability benefits. He received Social Security Disability benefits for a few years following the work injury at Fagen Construction. (Claimant's testimony)

Claimant ultimately rehabilitated himself and returned to work at an apartment complex managed by his wife. Claimant was tasked with performance of a variety of maintenance duties. In approximately 2001, claimant was struck in the head by a piece of wood while checking the property during a storm. Claimant testified he suffered with a concussion and for a time, experienced confusion and forgetfulness. Claimant applied for and again received Social Security Disability benefits for a period of time. (Claimant's testimony)

In June 2003, claimant presented to Mercy Hospital Emergency Department with complaints of severe headaches. Cory Wilson, M.D., evaluated claimant and noted a history of chronic headaches dating to head trauma two years prior. He described claimant as a very poor historian, with poor memory and altered mental status. Claimant was admitted to the hospital. A CT of claimant's head was negative; a CT of the chest revealed hiatal hernia, fatty liver and cardiomegaly. Dr. Wilson assessed headaches with altered mental status and severe hypertension. (Ex. K, pp. 48-52)

Claimant was discharged from the hospital the following day by Winfred Manda, M.D. Dr. Manda noted claimant's admission diagnoses as severe hypertension, acute and chronic confusion, post-concussion syndrome by history, major depressive disorder (MDD), chronic headaches, and personality disorder, probable passive-aggressive type. Claimant's final diagnosis was designated as severe uncontrolled hypertension. Claimant was issued prescriptions for Toprol XL, Lisinopril, Neurontin and Effexor. (Ex. K, p. 53)

Later that same month, claimant returned to the emergency room with complaints of chest pain, as well as chronic headaches, chronic confusion, status post closed head injury, anxiety and depression. Stress testing was recommended. (Ex. K, pp. 54-56)

Claimant's relevant medical history includes diagnoses of high blood pressure/hypertension, right knee arthroscopy, multiple episodes of diverticulitis and abdominal pain, prostatitis, left leg pain, anxiety, and chronic low back pain. (Claimant's testimony; Ex. H, p. 31; Ex. J, pp. 35, 37-38; Ex. I, pp. 32-33)

When claimant recovered from his 2001 head injury, he began to work as an operating engineer. From 2004 to 2009, claimant worked for Operating Engineers Local

Union 571. He operated a variety of heavy equipment on projects in Iowa, Nebraska and Missouri. Claimant testified he successfully passed a preemployment physical and denied any breathing difficulties, neuropathy, cognitive issues or depression. (Claimant's testimony; Ex. E, p. 1) Review of a selection of Iowa tax records reveals claimant and his wife reported joint earnings of $35,412.00 in 2008, including unemployment and Social Security benefits. (Ex. C, p. 5) Records from 2009 indicate claimant earned $5,163.00 in 2009. (Ex. C, p. 6) Claimant testified his federal tax records would best reflect his earnings during his employment through the union, as he worked in multiple states. (Claimant's testimony) These records are not in evidence.

Due to insufficient employment opportunities through the union, in 2010, claimant began work for Plumrose. He worked for the ham processor making boxes and operating a forklift. (Claimant's testimony; Ex. E, p. 1) In June 2010, claimant's wife suffered a stroke. Claimant was tasked with caring for his wife and also assisted her with her farmers' market business. (Claimant's testimony)

In October 2010, claimant accepted employment with defendant-employer, a staffing agency. (Ex. E, p. 1) He was placed with a construction company, who assigned claimant to run heavy equipment at an ethanol plant. Claimant testified he underwent a preemployment physical and suffered with no breathing difficulties, neuropathy, cognitive issues, depression, or right leg problems. Claimant testified his pay ranged from $15.00 to $23.50 per hour. (Claimant's testimony) The tax records in evidence from 2010 reveal joint earnings, between claimant and his wife, of $24,018.00. (Ex. C, p. 7)

In 2011, claimant periodically presented to his personal physician, Vikrant Salaria, M.D., in follow up of hypertension, left leg pain, and anxiety. Claimant received prescriptions for these conditions, including Neurontin for nerve pain and Xanax for anxiety. (Ex. J, pp. 39-41) Claimant also received emergency care for what was described as a flu-like illness, which had also caused symptoms in claimant's wife and granddaughter. Complaints included abdominal pain, urinary tract infection symptoms, shortness of breath, cough, body aches and fever. Claimant was diagnosed with acute bronchitis and received a prescription for azithromycin. (Ex. K, pp. 57, 59)

Claimant returned to Dr. Salaria on August 11, 2011 with complaints of chest pain. Dr. Salaria listed claimant's current medications as Toprol XL, amlodipine, aspirin and Lipitor. Following examination, Dr. Salaria assessed left precordial chest pain, hypertension, hyperlipidemia, generalized anxiety, and a family history of coronary disease. Dr. Salaria admitted claimant to the hospital for further testing. (Ex. K, pp. 60-61) Chest x-rays revealed borderline cardiomegaly. (Ex. K, p. 62) Claimant was discharged the following day, August 12, 2011, with a final diagnosis of non-cardiac chest pain, hypertension, and gastroesophageal reflux. His treatment plan consisted of observation and use of Toprol, Norvasc, aspirin, Vicodin and Nexium. (Ex. K, pp. 63-64, 73)

Claimant continued to work at the ethanol plant throughout 2011, but the placement ended due to lack of work. He testified he was off work for a few days before defendant-employer offered a new placement. In December 2011 or January 2012, defendant-employer placed claimant with Weston Solutions, a construction company tasked with rebuilding levees. Claimant testified he was assigned to work as a "fuelly," fueling heavy equipment. His duties required claimant to add additives into fuel tankers, fuel up equipment from tankers, and also travel about the job site refueling equipment utilizing a smaller truck. Claimant testified he loved his job and worked significant hours, from 80 to 100 hours per week. (Claimant's testimony)

In early 2012, claimant received treatment on two occasions for a sore throat. He was diagnosed with pharyngitis and uvulitis; he received prescription medication to treat his condition. (Ex. K, pp. 65-72) Claimant presented to Burton Prosthetics for evaluation related to his left leg prosthetic in January and March 2012. (Ex. Q, pp. 117-122) On March 19, 2012, claimant presented to Dr. Salaria with complaints of right knee pain, left elbow pain and hypertension. Dr. Salaria assessed benign essential hypertension, elbow arthritis, tennis elbow, and primary osteoarthritis of the lower leg. Dr. Salaria administered a Kenalog injection of claimant's elbow. He also noted use of the following medications: Xanax, Norvasc, aspirin, Toprol XL and Nexium. (Ex. J, pp. 42-44)

On April 5, 2012, claimant returned to Dr. Salaria with complaints of abdominal pain, right knee pain, left elbow pain and swelling, and hypertension. Dr. Salaria assessed benign essential hypertension, tennis elbow, edema, primary osteoarthritis of the lower leg, and abdominal cramping. Dr. Salaria performed a Kenalog injection and added a prescription for meloxicam to claimant's existing medication regimen. (Ex. J, pp. 45-47) Claimant admitted he received a prescription for Xanax, but testified he did not take the medication as he believed he was not permitted to use the drug while working. (Claimant's testimony)

As time passed on the assignment with Weston Solutions, claimant testified he began to suffer with some symptoms he now relates to breathing in diesel fumes. Claimant represented he experienced headaches, some difficulty breathing, bloody noses, and on one occasion, coughed up blood. Claimant testified at the time, he did not connect the symptoms to his work duties. (Claimant's testimony; Ex. 31, Claimant's deposition of August 22, 2012, Depo. Tr. pp. 40-43; Ex. S, Depo. Tr. pp. 40-43; See also Ex. 31, pp. 73-74) Claimant also stated that during this time, the diesel would overflow and run into his boots; he stated his right foot eventually began to go numb. (Ex. 31, pp. 76-77)

Claimant testified he took a few days off in mid-May 2012 to visit his ailing mother. When he returned to work on May 16, 2012, claimant testified his equipment had not been properly stored. Claimant testified when he turned on the power takeoff on the tanker, diesel fuel sprayed him in the face. Claimant testified fuel went into his eyes, melted a contact lens, ran up his nose and down his throat, and knocked him to the ground, where he became drenched in fuel. (Claimant's testimony; Ex. 31,

Claimant's deposition of August 22, 2012, Depo. Tr. pp. 44-45; Ex. S, Depo. Tr. pp. 44-45; See also Ex. 31, pp. 84-85)

Claimant testified he felt a burning sensation over his body. He rinsed his eyes, removed the contact lens, and put on his eyeglasses. Claimant testified his supervisor gave him permission to leave. He then drove to his home in Council Bluffs, where he bathed in an effort to remove the fuel from his skin. His wife then transported claimant for medical care. (Claimant's testimony; See also Ex. 31, pp. 85-87)

That date, May 16, 2012, claimant presented to First Care Medical Center (First Care) and was examined by Shelly Nanda, M.D. Claimant reported suffering with a burning sensation in his groin area, following an accidental fuel spill. Dr. Nanda diagnosed skin abnormality and a rash, secondary to chemical exposure. She recommended claimant utilize over the counter medications for the groin irritation, including calamine, Benadryl, and Cortaid cream. Dr. Nanda advised claimant to call if he developed cough, congestion or additional skin problems. (Ex. 1A, p. 1-4)

Claimant testified after the work injury, he returned to his duties as a fuelly. However, a supervisor at Weston Solutions found him slumped over in a work truck. The supervisor, Mark Major, told him to go home and heal; he assured claimant that he would receive a paycheck. (Claimant's testimony)

On May 18, 2012, claimant returned to First Care and was evaluated by Dr. Salaria. Dr. Salaria noted complaints which included hypertension, as claimant had brought literature regarding hypertension and diesel exposure. Claimant also complained of coughing blood the prior day. Dr. Salaria assessed hemoptysis, chemical exposure and benign essential hypertension. He ordered a series of labs and tests, including chest x-rays. (Ex. 1B, pp. 1-3; Ex. 2A, pp. 1-2)

On May 23, 2012, Dr. Nanda examined claimant in follow up. At that time, claimant reported complaints of breathing difficulties, some headaches and occasional dizziness. Claimant also reported experiencing some anxiety with respect to the safety of the job site. Dr. Nanda issued a prescription for Xanax, as well as additional testing. She also removed claimant from work. (Ex. 1C, pp. 1-5) Claimant subsequently underwent an echocardiogram, chest x-rays, and duplex and Doppler studies. (Ex. 2B, pp. 1-2; Ex. 2C, pp. 1-2; Ex. 2D, pp. 1-2)

Claimant followed up with Dr. Nanda on May 29, 2012 with continued complaints of anxiety, occasional shortness of breath, and some nausea and vomiting. (Ex. 1E, pp. 1-3)

On May 30, 2012, claimant presented to the Mercy Hospital Emergency Department. The primary complaint is listed as lower abdominal pain following diesel fuel exposure. (Ex. 2E, pp. 1, 4) Claimant also complained of cough, body pain and generalized weakness. (Ex. 2E, p. 7) Following a series of labs and tests, claimant

was diagnosed with abdominal pain of an unknown etiology. (Ex. 2E, pp. 4-6) Claimant received Ultram and was advised to follow up with Dr. Salaria. (Ex. 2E, p. 6)

The following day, May 31, 2012, claimant returned to Dr. Nanda. Claimant complained of abdominal pain and anxiety. Dr. Nanda noted claimant was scheduled for pulmonary evaluation the following week. She refilled claimant's Xanax and recommended evaluation with Dr. Eggers. She excused claimant from work indefinitely. (Ex. 1F, pp. 1-4)

On June 2, 2012, claimant returned to the Mercy Hospital Emergency Department with complaints of chest pain, abdominal pain and secondary anxiety. He was admitted to the hospital for evaluation. (Ex. 2G, pp. 1-12) While hospitalized, claimant underwent chest x-rays, CTs of the chest and abdomen, and repeat echocardiogram. (Ex. 2J, pp. 1-5, 9; Ex. 3B, pp. 1-9; Ex. 3C, pp. 1-2; Ex. 3D, p. 1) Claimant also received a gastrointestinal evaluation by John Mitchell, M.D., who recommended an upper gastrointestinal endoscopy. (Ex. 2K, pp. 1-3; Ex. 2L, pp. 1-3) Claimant subsequently underwent the recommended upper GI endoscopy. (Ex. 2O, pp. 1-3) Claimant was discharged from the hospital on June 4, 2012. (Ex. 2I, pp. 1-4; Ex. 2N, pp. 1-4)

On June 6, 2012, claimant presented for evaluation by pulmonologist, Susanna Von Essen, M.D. Dr. Von Essen reviewed claimant's medical records and performed a physical examination. Dr. Von Essen opined claimant's lung function tests were normal, but claimant complained of a convincing history of shortness of breath. She opined claimant's testing and chest x-ray revealed cardiomegaly and evidence of heart failure. When coupled with peripheral edema and shortness of breath, she indicated an echocardiogram would be advisable. (Ex. 4A, pp. 1-3)

Dr. Von Essen assessed "acute, intensive exposure to diesel fuel." She noted claimant swallowed some fuel, potentially aspirated some, suffered with blistering and generally had not "felt well since" the event. Dr. Von Essen indicated uncertainty as to why claimant had not felt well and indicated that by history, he seemed to suffer a neurologic response to the diesel exposure. Dr. Von Essen also noted concern regarding short term memory loss and indicated this symptom had been described in cases of "severe acute diesel fume exposure." Accordingly, she recommended neuropsychological testing. (Ex. 4A, p. 3) Dr. Von Essen also indicated uncertainty regarding the cause of claimant's chest pain. (Ex. 4A, p. 4)

Claimant underwent the echocardiogram recommended by Dr. Von Essen on June 14, 2012. (Ex. 4D, pp. 1-5) Dr. Von Essen subsequently reviewed the results and opined the test showed diastolic function grade II abnormality, a form of congestive heart failure which she noted is often related to poorly controlled hypertension. Dr. Von Essen opined heart failure explained claimant's shortness of breath complaints. She also opined poor control of blood pressure was likely contributing to the presence of heart failure systems. Dr. Von Essen noted that exposure to diesel exhaust "is

associated with the presence of hypertension and can raise blood pressure acutely." (Ex. 4A, p. 4; Ex. O, p. 96)

On June 22, 2012, claimant presented to the Nebraska Medical Center emergency room with complaints of chest pain. Claimant was admitted to the hospital and discharged on June 23, 2012. (Ex. 5A, pp. 1-2; Ex. 5B, pp. 1-7)

On June 30, 2012, claimant participated in an overnight oximetry test at Aspen Medical Monitoring. The results revealed a high number of desaturation events, potentially representing a sleep breathing disorder. A sleep test was recommended and a notation made which indicated claimant may qualify for oxygen supplies under Medicare coverage. (Ex. 6A, pp. 1-6)

Claimant presented to William Hughes, DPM on July 6, 2012 and July 9, 2012. Dr. Hughes' records are handwritten and largely illegible. (Ex. 7A, pp. 1-2) Dr. Hughes authored a letter dated July 11, 2012. By this letter, Dr. Hughes represented claimant had presented with complaints of a burning sensation in the bottom of his right foot. Dr. Hughes noted claimant had been involved in a work injury resulting in inhalation and ingestion of diesel fuel, as well as blistering of the right foot. Dr. Hughes expressed belief claimant's pain was neuropathic in nature and recommended appropriate consultation. (Ex. 7B, p. 1)

On July 11, 2012, claimant returned to Dr. Von Essen in follow up. Dr. Von Essen opined claimant's lung function had improved slightly and expressed uncertainty regarding the severity of claimant's shortness of breath. Accordingly, she recommended consultation with a congestive heart failure specialist. Dr. Von Essen also ordered spirometry and CPAP autotritration testing. (Ex. 4C, pp. 1-2)

Claimant returned to Dr. Hughes on July 13, 2012. Dr. Hughes' handwritten notes are largely illegible. (Ex. 7A, p. 2)

On July 18, 2012, claimant presented to Pulmonary and Infectious Disease Associates for evaluation by Jorge Alvarez, M.D. Dr. Alvarez noted complaints of persistent dyspnea, cough and shortness of breath following exposure to fumes and an inhalation injury. (Ex. 12A, p. 1) Dr. Alvarez performed an examination and assessed dyspnea, as well as nocturnal hypoxemia by history. Dr. Alvarez also assessed a differential diagnosis of reactive airways dysfunction syndrome (RADS), following diesel exhaust exposure. He requested claimant's prior pulmonary testing results and recommended continued use of an albuterol inhaler. (Ex. 12A, p. 2)

At the referral of Dr. Von Essen, on July 27, 2012, claimant presented to Nebraska Medical Center for neuropsychological evaluation with psychologist, James Levy, PhD. Dr. Levy noted claimant experienced a history of exposure to diesel fumes for approximately seven months, resulting in changes in mood, personality and memory. Then on May 16, 2012, claimant was "pinned" in a stream of diesel fuel, causing some ingestion and his body to be covered in fuel. Following this event, claimant reported

experiencing cognitive problems, poor memory, problematic attention/concentration, and increasing irritability. (Ex. 8A, p. 1) Dr. Levy administered a series of psychological tests, which he opined yielded valid results. (Ex. 8A, p. 2)

Following interview and evaluation, Dr. Levy opined claimant's neurocognitive profile demonstrated severe verbal learning deficits, mild slowing of information processing speed, severe depression and severe anxiety. He opined the results were consistent with diagnoses of mild cognitive impairment, major depression and generalized anxiety disorder. Dr. Levy opined there appeared to be a "direct connection" between the work-related exposure and claimant's complaints of mood and memory problems. He recommended outpatient counseling and medication management. (Ex. 8A, p. 3; Ex. 8B, p. 1)

On July 30, 2012, claimant presented to Alegent Health and was examined by personal physician, John Thomas, M.D. Claimant complained of breathing issues, difficulty with speech, and swelling of his right foot. Following examination, Dr. Thomas assessed memory problems and recommended a head MRI and neurology consult. He also assessed RADS and recommended claimant continue to treat pulmonary symptoms with Dr. Alvarez; Dr. Thomas also recommended an ENT consult of claimant's throat. Finally, Dr. Thomas assessed neuropathy, for which he prescribed Lyrica. Dr. Thomas referred claimant to Inderjit Panesar, DPM for wound care on his right foot. (Ex. 17A, pp. 1-4) Dr. Thomas removed claimant from work indefinitely. (Ex. 17B, p. 1)

Pursuant to Dr. Thomas' referral, on August 1, 2012, claimant presented to Miller Orthopaedic Affiliates for evaluation of his right foot by Dr. Panesar. Following examination, Dr. Panesar assessed peripheral neuropathy and onychocryptosis and onchomycosis of the right hallux nail. Dr. Pansesar opined that claimant's incurvated and thickened nail had the possibility of infection, the pain from which might not be noticed by claimant given the peripheral neuropathy. In order to avoid the potential for further infection, Dr. Panesar recommended a total nail avulsion. (Ex. 11A, p. 2)

Also pursuant to Dr. Thomas' recommendation, on August 3, 2012, claimant presented for evaluation by otolaryngologist, Crystal Selvk, D.O. Claimant expressed complaints of feeling as if his throat would close, beginning following an injury on May 16, 2012. Dr. Selvk performed an examination and nasal laryngoscopy. She ordered a modified barium swallow study to evaluate dysphagia. Dr. Selvk also recommended claimant participate the in the bronchoscopy procedure scheduled with Dr. Alvarez, as his symptoms may be due to restrictive lung disease. (Ex. 9A, p. 1; Ex. 9B, pp. 1-2)

On August 3, 2012, Dr. Alvarez authored a letter to claimant's counsel with updated information on claimant's condition. Specifically, Dr. Alvarez indicated claimant underwent a methocholine inhalation challenge test, with positive results. Dr. Alvarez explained the test was a criteria for a diagnosis of reactive airways dysfunction syndrome (RADS). He indicated claimant had therefore been scheduled to undergo a diagnostic bronchoscopy. (Ex. 12C, p. 1) Dr. Alvarez explained the long-term

treatment of RADS was similar to that associated with chronic obstructive asthma. He opined claimant would continue to experience respiratory symptoms for a minimum of one year and might experience bronchial hyper-responsiveness for several years. Dr. Alvarez imposed work restrictions precluding claimant from working in any occupation involving exposure to gas, fumes, vapors or other inhalation agents. (Ex. 12C, p. 1)

On August 6, 2012, claimant underwent a brain MRI. (Ex. 17F, p. 1)

On August 7, 2012, Dr. Panesar performed the recommended total nail avulsion procedure. (Ex. 11B, p. 1) He clarified he was not providing treatment of conditions related to the work injury. He indicated he was not treating any lesions of claimant's foot, but rather, an ingrown toenail. Dr. Panesar did not impose any restrictions and offered no opinions with respect to claimant's work injury. (Ex. 11C, p. 1)

On August 9, 2012, claimant presented to Creighton Medical Associates Neurosurgery Clinic for evaluation by neurosurgeon, Charles Taylon, M.D. Dr. Taylon noted claimant presented for initial evaluation of peripheral neuropathy. Claimant complained of pain in his neck, right foot, and stomach. With respect to the right foot, claimant reported numbness, burning and pain at a level 8 on a 10-point scale. Claimant indicated the symptoms began following diesel exposure. (Ex. N, p. 90) Dr. Taylon performed an examination and assessed idiopathic peripheral neuropathy. He recommended EMG/NCV testing, to be followed by a neurology consultation. (Ex. 10B, pp. 1-3; Ex. N, pp. 91-92)

Following evaluation, Dr. Taylon authored a letter to Dr. Salaria. Dr. Taylon noted claimant was seen in evaluation of right foot numbness and burning, as well as memory decline. He noted claimant reported chronic exposure to diesel over a period of approximately seven months, as well as a recent acute massive exposure. Dr. Taylon opined claimant may or may not be experiencing diesel fuel poisoning, but opined claimant did demonstrate a right lower extremity peripheral neuropathy. He also noted claimant complained of cognitive changes. As a result, Dr. Taylon reiterated his recommendation for EMG/NCV studies, followed by an evaluation with a neurologist. (Ex. 10A, p. 1; Ex. N, p. 93)

On August 10, 2012, claimant presented to the Jennie Edmundson Hospital Emergency Department with complaints of shortness of breath and the sensation of his airway closing. Scott Smith, M.D. examined claimant and ordered a series of labs, chest x-rays and an EKG. Dr. Smith assessed dyspnea and anxiety over breathing. Dr. Smith prescribed prednisone, albuterol, alprazolam and hydrocodone-acetaminophen. He advised claimant to follow up with Dr. Thomas and Dr. Alvarez. (Ex. 18C, pp. 1-6) Dr. Smith opined claimant's conditions were related to the work-related ingestion/inhalation injury. (Ex. 18C, p. 16)

On August 12, 2012, claimant was transported by ambulance to the emergency room at Jennie Edmundson Hospital after suffering an overnight episode of acute onset shortness of breath and difficulty breathing. He was evaluated by Matthew

Fryzek, M.D., who noted a history of diesel fuel inhalation injury, complicated by RADS and also, per claimant, short-term memory deficits, headaches, sore throat, chest pain and peripheral neuropathy. Claimant received respiratory treatments, IV steroids, and oxygen. He was admitted to the hospital for bronchospasm related to the work-related inhalation injury. Dr. Alvarez evaluated claimant while he was hospitalized. Dr. Fryzek discharged claimant from the hospital on August 15, 2012, with diagnoses including shortness of breath secondary to acute bronchitis and mucous plugging, complicated by RADS attributable to the diesel inhalation injury. At discharge, claimant was prescribed oral prednisone and an albuterol nebulizer. (Ex. 12D, pp. 1-2; Ex. 12F, p. 1; 13A, pp. 1-3; Ex. 18C, p. 17; Ex. 18E, pp. 1-3; Ex. L, pp. 77d-77e)

In response to inquiry from claimant's counsel, on August 17, 2012, Dr. Alvarez opined claimant's RADS was caused, aggravated, accelerated or lighted up by the May 16, 2012 work injury. (Ex. 12E, p. 1) Dr. Alvarez also reviewed provided medical records and opined claimant's recent hospitalization was associated with the inhalation exposure injury. (Ex. 12F, p. 1)

On August 20, 2012, Dr. Taylon authored a letter directed to claimant's counsel. He expressed belief that the records in his possession were suggestive that diesel fuel exposure played a role in claimant's ongoing symptoms. However, Dr. Taylon indicated the right leg condition was not within his field of expertise, thus resulting in a recommendation for EMG/NCV testing and a neurology consultation in order to determine causation and treatment options. (Ex. 10C, p. 1; Ex. N, p. 94)

On August 21, 2012, claimant was taken to the emergency room at Jennie Edmundson Hospital after awakening from his sleep with significant shortness of breath and productive cough. He was admitted to the hospital, where he underwent examination, labs and testing. Claimant was assessed with shortness of breath, complicated by reactive/restrictive lung disease with possible underlying bronchitis. A second diagnosis noted a diesel fuel ingestion/inhalation injury, complicated by development of RADS, short-term memory deficits, headaches, sore throat, chest pain and peripheral neuropathy, per claimant's report. (Ex. L, pp. 77a-77c) The medical record is incomplete and does not include the plan of treatment.

At the referral of Dr. Levy, on August 21, 2012, claimant presented to Nebraska Medical Center Psychology Department for evaluation by psychologist Cecilia Poon, PhD. (Ex. 8C, pp. 1-2; Ex. 8F, p. 1) Dr. Poon opined claimant demonstrated cognitive and emotional symptoms consistent with diagnoses of post-traumatic stress disorder (PTSD) and major depressive disorder (MDD), severe without psychotic features. (Ex. 8E, p. 1; Ex. 8F, p. 1)

On August 22, 2012, claimant returned to Dr. Thomas in follow up of restrictive lung disease and shortness of breath followed by vomiting. Dr. Thomas assessed RADS, neuropathy, hematuria, and memory problems. Dr. Thomas prescribed a series of medications and recommended a urology consult regarding the hematuria. (Ex. 17G,

pp. 1-2) He subsequently opined claimant was unable to work and required ongoing care for RADS, which was attributable to diesel exposure. (Ex. 17H, p. 1)

Claimant sat for a deposition with defendants' counsel on August 22, 2012. (Ex. 31; Ex. S)

Claimant's attorney authored a letter to Dr. Hughes requesting his opinions regarding claimant's right foot condition. On August 23, 2012, Dr. Hughes opined claimant's loss of skin and need for podiatry care was a result of burns caused by the diesel exposure on May 16, 2012. (Ex. 7D, p. 1)

Claimant's attorney provided Dr. Von Essen with Dr. Alvarez's records of August 17, 2012 for review. On August 23, 2012, Dr. Von Essen expressed agreement with Dr. Alvarez's conclusions. (Ex. 4D, p. 1)

Dr. Fryzek authored a letter to claimant's attorney dated August 24, 2012. He represented claimant's diagnoses as RADS due to the diesel inhalation injury, severe anxiety and depression, and suspected PTSD with multiple psychosomatic complaints. He opined claimant's pulmonary issues were likely secondary to the work injury. With respect to the psychological conditions, Dr. Fryzek recommended psychiatric evaluation, as he was unable to definitively attribute the memory and neuromuscular complaints to the work injury. (Ex. 13C, p. 1)

Dr. Alvarez authored a note dated August 27, 2012 indicating claimant remained under his care and would require ongoing medical care for RADS. Dr. Alvarez indicated the ongoing need for care was secondary to the work-related injury. (Ex. 12G, p. 1)

On August 28, 2012, claimant returned to Dr. Poon for a therapy session. Dr. Poon issued an impression of PTSD and MDD, recurrent, severe without psychotic features. (Ex. 8F, pp. 1-2)

Pursuant to Dr. Taylon's recommendation, on August 30, 2012, claimant presented to Alegent Creighton Clinic for evaluation by neurologist, Blanca Marky, M.D. Dr. Marky performed EMG/NCV testing and opined the results revealed evidence of chronic axonal motor peripheral polyneuropathy. She assessed idiopathic peripheral neuropathy and recommended a series of labs and tests. (Ex. P, pp. 97-101)

On September 4, 2012, claimant presented to the Jennie Edmundson Emergency Department and was again seen by Dr. Smith. Claimant complained of shortness of breath and dizziness as he performed work outside his home. Claimant explained his therapist had recommended he push his activity level and as a result, he performed some outdoor physical labor. He then developed shortness of breath and passed out. (Ex. 18F, p. 2) Dr. Smith ordered labs, a chest x-ray, and echocardiogram. He diagnosed anxiety and hyperventilation with a syncopal episode. Dr. Smith advised claimant to follow up with Dr. Thomas and Dr. Alvarez. (Ex. 18F, pp. 3-5)

Claimant returned to Dr. Thomas on September 6, 2012 in follow up of the recent hospitalization for syncope. Following examination, Dr. Thomas assessed syncope and advised claimant to rise slowly and stay hydrated. He also assessed neuropathy, issued prescriptions for Vicodin and Neurontin, and recommended follow up with Dr. Marky. (Ex. 17I, pp. 1-2)

Claimant returned to Dr. Poon for counseling on September 11 and September 25, 2012. Dr. Poon's diagnoses of PTSD and MDD remained the same; she also indicated a need to rule out adjustment disorder with mixed emotional features. (Ex. 8F, pp. 2-5)

On October 1, 2012, claimant returned to Dr. Marky in follow up. Dr. Marky reviewed claimant's test results and again assessed idiopathic peripheral neuropathy. She indicated that thus far, she had been unable to link the cause of claimant's neuropathy or neurological symptoms to his work-related diesel exposure. Dr. Marky noted neuropathy can be hereditary and memory deficits can be secondary to depression or lack of sleep. (Ex. P, pp. 102-104)

On October 3, 2012, claimant returned to Dr. Alvarez for evaluation. Claimant complained of shortness of breath, gasping for air, cough with occasional bloody sputum, lightheadedness and dizziness. Dr. Alvarez noted claimant had recently been hospitalized on two occasions. Following examination, Dr. Alvarez assessed RADS and hemoptysis secondary to acute bronchitis. He recommended increased dosages of diuretics and participation in a pulmonary rehabilitation program. (Ex. 12I, p. 1) Dr. Alvarez causally related claimant's need for pulmonary rehabilitation to the work injury. (Ex. 12J, p. 1)

Claimant returned to counseling with Dr. Poon on October 9, 2012. Claimant expressed continued difficulty in locating a psychiatric care provider, but expressed agreement with pursuing such care. Dr. Poon restated her prior diagnoses of PTSD and MDD. (Ex. 8F, pp. 6-7) Dr. Poon subsequently placed claimant in inactive status upon assumption of care by a psychiatrist. (Ex. 8F, p. 7)

On October 15, 2012, claimant presented to Dr. Thomas with complaints of right leg and foot swelling. Following examination, Dr. Thomas assessed neuropathy and recommended rest, elevation of the leg, and podiatry evaluation. He also assessed vomiting, for which Dr. Thomas referred claimant to Midwest GI for evaluation. (Ex. 17J, pp. 1-3)

On October 24, 2012, claimant returned to Burton Prosthetics. Mike Tillia evaluated claimant's left leg prosthetic. Mr. Tillia indicated claimant was suffering with problems related to the "effects" of the work-related diesel injury. He explained claimant's left leg prosthetic did not fit due to weight gain attributable to inactivity and vascular and respiratory injuries. Mr. Tillia recommended a socket change. (Ex. 25A, p. 1) The two began an extended process of measuring, fitting and securing the socket change and prosthesis. (Ex. 25A, pp. 6-9, 18)

In response to inquiry from claimant's counsel, Dr. Alvarez authored a letter containing his opinions on claimant's pulmonary condition dated October 30, 2012. Dr. Alvarez opined claimant demonstrated a class 2 impairment by the pulmonary function section of the AMA Guides to the Evaluation of Permanent Impairment. The referenced class of impairment allows for ratings of 10 to 25 percent whole person. (Ex. 12L, pp. 1-2) Dr. Alvarez imposed permanent work restrictions and opined claimant was entirely unable to perform his "regular job." Dr. Alvarez restricted claimant to no physical activities of climbing stairs, bending and lifting; and no work in or around inhalants or aerosolized chemicals. He also recommended a functional capacity evaluation (FCE) to outline further restrictions. (Ex. 12L, p. 1)

At the arranging of claimant's counsel, on November 5, 2012, claimant presented to James Mathisen, Psy.D. for psychological evaluation. Dr. Mathisen interviewed claimant and performed a records review. (Ex. 16A, pp. 1-4) He also administered mental functioning testing and personality/emotional functioning testing. (Ex. 16A, pp. 4-5) Following evaluation, Dr. Mathisen assessed MDD, severe without psychosis, and somatoform disorder. (Ex. 16A, p. 5) He opined claimant did not demonstrate mild neurocognitive disorder and further specifically indicated he did not diagnose PTSD. (Ex. 16A, p. 6) Dr. Mathisen opined claimant's psychological testing results were not consistent with malingering, exaggeration or seeking secondary gain. (Ex. 16A, p. 6)

Dr. Mathisen opined both claimant's diagnoses had been "permanently aggravated" by the work injury. (Ex. 16A, p. 5) He further opined claimant had not achieved maximum medical improvement (MMI) for either condition. Dr. Mathisen expressed belief claimant would benefit from treatment, including cognitive behavioral therapy and psychiatric consultation regarding medications, but cautioned that claimant's prognosis was poor. Dr. Mathisen opined claimant was incapable of completing a 40-hour work week due to his mental conditions. (Ex. 16A, p. 7)

On November 6, 2012, claimant presented for follow up with Dr. Thomas, who assessed shortness of breath and depression. He continued to monitor claimant's various medications. (Ex. 17K, pp. 1-3)

Claimant returned to Dr. Alvarez in follow up on November 14, 2012. At that time, Dr. Alvarez recommended continued participation in pulmonary rehabilitation. He also restricted claimant from working in any capacity. (Ex. 12M, pp. 1-2)

On December 3, 2012, claimant presented to Alegent Health Psychiatric Associates and was evaluated by Craig Seamunds, M.D. Dr. Seamunds' notes of that day are handwritten. (Ex. 19A, p. 1) He subsequently confirmed claimant was under his care secondary to the work injury. Dr. Seamunds opined claimant required ongoing mental health treatment and medications as a result of the work injury of May 16, 2012. (Ex. 19B, p. 1)

Claimant returned to Dr. Thomas on December 10, 2012 for medication check. Dr. Thomas assessed congestive heart disease and neuropathy. He recommended a

neurology consult, cardiology referral, echocardiogram, and labs. (Ex. 17L, pp. 1-3) Claimant underwent the recommended echocardiogram on December 12, 2012. (Ex. 17M, pp. 1-2)

On December 27, 2012, claimant was evaluated by Ann Narmi, M.D. of Alegent Heart and Vascular Specialists. Claimant expressed complaints of chest tightness and heaviness, as well as leg swelling. (Ex. 15A, p. 1) Following examination, Dr. Narmi assessed atypical chest pain, hypertension, dyslipidemia, preserved left ventricular systolic function, and palpitations. She recommended a medication regimen and ordered a stress EKG, to be followed by 48 hours of monitor use to evaluate palpitations. (Ex. 15A, p. 2)

On January 9, 2012, claimant presented to Dr. Thomas in follow up of recent cardiac tests. Following review and examination, Dr. Thomas assessed premature ventricular contraction. He recommended continued cardiac rehabilitation and medications. (Ex. 17N, pp. 1-2) Dr. Thomas also issued a prescription for a right leg brace. (Ex. 25A, p. 10) He subsequently opined claimant's left leg prosthesis functioned well, but claimant would benefit from a right leg brace. (Ex. 17O, p. 1)

In order to fulfill Dr. Thomas' order for a right knee brace, on January 10, 2013, claimant presented to Burton Prosthetics. Paul Monestero evaluated claimant and indicated he suffered with a right drop foot, resulting in instability and risk of falling. He began the process of fitting claimant for a right AFO brace. (Ex. 25A, pp. 11-14, 17) The brace was delivered to claimant on February 7, 2013. (Ex. 25A, p. 38)

On January 14, 2013, claimant returned to Dr. Seamunds in follow up of his mental health conditions. Dr. Seamunds' records are handwritten; his diagnosis appears to include PTSD. (Ex. 19C, p. 1)

At the referral of defendants, on January 16, 2013, claimant presented to the University of Iowa College of Medicine for neuropsychological assessment with Daniel Tranel, PhD. Dr. Tranel issued a report containing his findings and opinions dated February 2, 2013. (Ex. R, p. 125) In completing his report, Dr. Tranel reviewed various medical records and claimant's August 22, 2012 deposition transcript. (Ex. R, pp. 125-138) During interview, claimant reported cognitive and behavioral changes, including decreased concentration and memory, which fluctuated with fatigue and shortness of breath. Claimant also reported affect and mood changes, including nightmares and daytime flashbacks of the drowning sensation he felt during his injury, as well as the belief that the work injury shortened his lifespan. (Ex. R, pp. 138-139)

Claimant also participated in clinical testing and assessment activities. (Ex. R, pp. 139-141) Dr. Tranel opined claimant demonstrated mildly atypical results on direct symptom validity tests for cognitive function. He opined this suggested that non-neurologic factors contributed to the resulting neuropsychological profile. (Ex. R, p. 141) He opined claimant's MMPI-2 validity profile was suggestive of "profound overreporting of cognitive symptoms," with claimant endorsing symptoms and

complaints which were inconsistent or very rarely associated with neurologic dysfunction or injury. (Ex. R, p. 142)

Dr. Tranel opined the results of the neuropsychological and psychological evaluations led to two specific findings. First, he opined claimant's cognitive function was intact, with normal intellectual abilities, intact memory, and no indication of acquired deficits in areas of higher cognitive functioning. He opined claimant's cognitive functioning had improved from the time of Dr. Levy's evaluation. Second, Dr. Tranel opined claimant endorsed "profoundly elevated reports" of a variety of physical and psychological symptoms, which he opined was consistent with a somatoform disorder. Dr. Tranel opined claimant's symptoms report went "far beyond (by many standard deviations)" what was expected of an individual with bona fide neurological and/or psychiatric conditions. Given these findings, Dr. Tranel opined he found no evidence of PTSD, generalized anxiety disorder, MDD or other psychiatric condition which could be validly attributed to the work injury. (Ex. R, p. 143)

Dr. Tranel also critiqued the basis of certain mental health providers' opinions. Specifically, he expressed belief that much of claimant's pre-injury medical and psychological history was missing from the histories noted by other providers, including Drs. Levy, Poon and Fairbanks. He opined this inaccuracy led to misdiagnosis. Dr. Tranel highlighted claimant's history of head injury and traumatic brain injury; history of multiple physical complaints; and history of psychological and psychiatric problems beyond those surrounding his amputation injury, including MDD and anxiety disorder. (Ex. R, p. 143)

Dr. Tranel ultimately opined that based upon records review and evaluation findings, the work injury did not cause any permanent cognitive or psychological condition. (Ex. R, p. 143) He opined it was plausible the work injury resulted in a temporary aggravation of some of claimant's preexisting and longstanding psychological problems, yet noted claimant had a "proclivity to dramatically over-report" symptoms. Dr. Tranel opined he assigned no diagnosis attributable to the work injury. He also opined claimant did not demonstrate impairment in cognitive or psychological function attributable to the work injury. Dr. Tranel opined claimant achieved MMI on January 16, 2013 and required no permanent restrictions. He opined claimant was capable of working and claimant's fitness for work at the time of evaluation was the same as it had been prior to beginning his work assignment in December 2011. (Ex. R, p. 144)

On or about January 25, 2013, claimant's counsel provided copies of Dr. Mathisen's November 5, 2012 report to various providers for review. On January 28, 2013, Dr. Von Essen expressed agreement with Dr. Mathisen's findings. (Ex. 4E, p. 1) On January 28, 2013, Dr. Poon indicated she disagreed with Dr. Mathisen's findings and indicated claimant exhibited symptoms of PTSD and MDD, severe without psychotic features, at the time of her initial evaluation on August 21, 2012. (Ex. 8G, p. 1) On January 28, 2013, Dr. Alvarez expressed agreement with Dr. Mathisen's findings. (Ex. 12Q, p. 1) On January 29, 2013, Dr. Hughes indicated he agreed with Dr. Mathisen's findings, but with the caveat he had limited interaction with claimant and was

a "non-professional" in that field. (Ex. 7E, p. 1) On February 8, 2013, Dr. Seamunds expressed agreement with Dr. Mathisen's findings, but also noted he believed claimant did meet the criteria for a diagnosis of PTSD. (Ex. 19D, p. 1)

Claimant's attorney subsequently provided Dr. Seamunds with copies of the reports of both Dr. Mathisen and Dr. Tranel for review. Dr. Seamunds expressed disagreement with the conclusions of both providers, specifically noting he did not agree with a diagnosis of somatoform disorder. He also opined claimant's work injury aggravated or caused claimant's PTSD and MDD. (Ex. 19E, pp. 1-2)

On January 30, 2013, Mr. Tillia authored a letter to claimant's attorney regarding the status of claimant's left leg prosthesis and adjustments. He indicated immediately following the work injury, adjustments were made to respond to the initial edema present. Additional changes and adjustments were subsequently required as a result of claimant's weight gain. Mr. Tillia indicated claimant gained weight when he was unable to function at preinjury levels and this gain added to the existing problem with edema. As a result, claimant outgrew his prosthetic, leading Mr. Tillia to cast and fit a new socket. Mr. Tillia also noted that during sessions with claimant, claimant appeared winded and fatigued, which represented noticeable changes from pre-injury. Mr. Tillia also explained that volume fluctuation can occur for several reasons and expressed belief that the cause of the fluctuation should be identified by claimant's physicians. (Ex. 25A, pp. 15-16)

On February 7, 2013, claimant presented to Mr. Tillia with left leg prosthetic fitting complaints. Mr. Tillia indicated the socket was cracked and needed to be replaced. (Ex. 25A, p. 20)

Claimant followed up with Dr. Alvarez on February 13, 2013, who recommended continued medication use and pulmonary rehabilitation. (Ex. 12S, p. 1) In response to inquiry from claimant's counsel, on March 15, 2013, Dr. Alvarez opined claimant remained disabled secondary to the work injury. (Ex. 12T, p. 1)

On February 27, 2013, claimant returned to Dr. Thomas for evaluation. Dr. Thomas assessed weakness and recommended labs and a cardiology evaluation. (Ex. 17P, pp. 1-2) Dr. Thomas subsequently opined claimant would benefit from a functional capacity evaluation (FCE). (Ex. 17Q, p. 1)

On March 12, 2013, claimant presented for an FCE with Dave Schremmer, PT. Mr. Schremmer authored a letter to Dr. Thomas dated March 18, 2013 regarding the results of the FCE. Mr. Schremmer described the evaluation as limited in nature, due to medical issues which limited claimant's safe testing levels. He described claimant as cooperative, but indicated other medical conditions implicated risk and safety concerns in proceeding. As a result of the limited nature of the testing, Mr. Schremmer indicated he was unable to determine claimant's functioning levels. He was also similarly unable to identify accurate work restrictions which were attributable to the work-related injury. (Ex. 20A, p. 1) Mr. Schremmer subsequently indicated it was unsafe to perform an FCE

and thus, he deferred to claimant's medical providers regarding function levels. (Ex. 20A, p. 2)

Claimant followed up with Dr. Narmi on February 28 and March 26, 2013. (Ex. 15B, pp. 1-2; Ex. 15C, p. 2) At the March 26, 2013 visit, claimant reported he had suffered a syncope event. Following examination, Dr. Narmi added an assessment of syncope, most likely related to vasovagal mechanism. She ordered a stress test and event recorder. (Ex. 15C, p. 2)

On March 28, 2013, claimant presented to Timothy Tse, M.D., for psychiatric evaluation. Claimant described the work injury and his resulting feelings and symptoms. Claimant also reported a history of anxiety and depression, which included medication treatment. He denied experiencing depression or anxiety symptoms immediately prior to the work injury. (Ex. 22A, pp. 1-2) Dr. Tse administered a mental status exam. (Ex. 22A, pp. 3-4)

Dr. Tse diagnosed PTSD and MDD, severe. He opined claimant continued to demonstrate significant depressive and post-traumatic stress symptoms. (Ex. 22A, p. 4) Dr. Tse indicated he found no medical evidence that claimant experienced mental symptoms or underwent psychiatric treatment immediately prior to the work injury. (Ex. 22A, pp. 4-5) Accordingly, he opined it was more probable than not that the work injury and its sequela, "triggered" claimant's MDD and PTSD. (Ex. 22A, p. 5)

Dr. Tse opined claimant had not achieved MMI for his psychiatric or medical conditions. He noted claimant demonstrated deficits in activities of daily living, social functioning and cognitive functioning. Dr. Tse further opined claimant's functional abilities were greatly impacted by his psychiatric symptoms. He recommended continued care with a psychiatrist, but described claimant's prognosis as poor. (Ex. 22A, pp. 4-5)

On March 29, 2013, claimant returned to Dr. Alvarez in follow up. Dr. Alvarez noted claimant demonstrated increasing weight gain associated with fluid retention. He assessed RADS, dyspnea and weight gain with suspected fluid retention. Dr. Alvarez ordered cardiac testing, to be followed by diagnostic pulmonary catheterization and right heart catheterization. (Ex. 12V, p. 1) Pursuant to Dr. Alvarez's orders on April 1, 2013, claimant underwent a myocardial SPECT study and cardiac stress tests. (Ex. 2Q, pp. 1, 3-13) On April 2, 2013, claimant underwent right pulmonary artery catheterization and right heart catheterization, performed by Dr. Alvarez. (Ex. 12X, p. 1; Ex. 18, p. 1; Ex. L, p. 74)

On April 10, 2013, claimant returned to Dr. Alvarez in follow up. Dr. Alvarez assessed RADS, dyspnea, weight gain with fluid retention, mild pulmonary hypertension, and elevated pulmonary capillary wedge pressure. Dr. Alvarez adjusted claimant's medications and recommended evaluation by a cardiologist, as well as potentially with an endocrinologist. (Ex. 12Y, pp. 1-2)

Claimant returned to Dr. Alvarez for evaluation on May 13, 2013. Dr. Alvarez noted claimant underwent a repeat methocholine challenge test, again with positive results. He assessed persistent RADS and fluid retention. He altered claimant's medications and recommended claimant consider an endocrinology consultation via his primary care provider. (Ex. 12Z, pp. 1-2)

On June 7, 2013, claimant returned to Dr. Thomas for evaluation. Dr. Thomas assessed fluid retention and ordered a series of labs. (Ex. 17R, pp. 1-2)

In response to inquiry from claimant's counsel, Dr. Alvarez authored responses dated June 11, 2013. Dr. Alvarez thereby agreed he continued to believe claimant's RADS was caused by the work injury. He further agreed that claimant remained permanently and totally disabled. (Ex. 12AA, p. 1)

On August 7, 2013, claimant returned to Dr. Alvarez for evaluation. Dr. Alvarez recommended a long-acting beta-agonist to be used in nebulizer treatments. (Ex. 12BB, p. 1)

On September 11, 2013, Dr. Alvarez authored a handwritten note indicating claimant had not yet achieved MMI and an MMI date would be determined by the end of summer 2014. (Ex. 12BB, p. 1)

Claimant returned to Dr. Thomas on September 12, 2013 for medication management. He also expressed complaints of shortness of breath. Dr. Thomas assessed RADS, for which he prescribed medications, ordered labs, and recommended evaluation with Dr. Alvarez. Dr. Thomas also assessed chronic pain syndrome and issued an orthopedic referral to Dr. McGuire and a pain consultation referral to Dr. West. (Ex. 17S, pp. 1-3) Dr. Thomas subsequently clarified the issued prescription for Vicodin was to treat chest pain due to a restricted airway and leg pain due to nerve damage. (Ex. 17V, p. 1)

On September 12, 2013, Mr. Tillia authored a prescription to replace the inserts in claimant's left leg prosthetic. He indicated replacements were needed "due to wear and tear." (Ex. Q, p. 124) Claimant received the supplies on September 23, 2013. (Ex. 25A, p. 25)

On October 24, 2013, claimant presented to Dr. Alvarez for evaluation. Dr. Alvarez assessed acute sinusitis. (Ex. 12CC, p. 1)

In response to inquiry from claimant's counsel, on November 5, 2013, Dr. Alvarez opined he believed updated pulmonary function tests would be beneficial prior to an upcoming IME. (Ex. 12DD, p. 1) Claimant underwent the tests and returned to Dr. Alvarez in follow up on November 13, 2013. Dr. Alvarez reviewed claimant's pulmonary function testing results and opined his condition was currently stable. He recommended continued medication use. (Ex. 12EE, p. 1; Ex. 12FF, p. 1)

At defendants' arranging, on December 4, 2013, claimant presented to the University of Iowa Hospitals & Clinics Pulmonary Department for an independent medical examination (IME) with pulmonologist and occupational medicine physician, Patrick Hartley, M.D. During interview, claimant reported that during his work as a fuelly, his work boots would fill with diesel fuel and he noticed some numbness of his feet. Claimant's wife also reported claimant suffered with headaches, vomiting and irritability. Claimant reported that on May 16, 2012, he suffered an injury after being sprayed with diesel fuel, at which time he was sprayed in the face, his clothes were saturated, he swallowed fuel, and the fuel entered his eye and damaged his contact lens. He reported feeling nauseated and suffering with a burning sensation over his body. After the event, claimant reported he drove back to Council Bluffs, bathed at his home, and then presented to his physician's office. (Ex. M, pp. 79-80)

Dr. Hartley performed a records review, which required review of "over 14 [pounds] of medical records." (Ex. M, p. 83) Dr. Hartley abstracted and referenced some key records, both pre- and post-injury, in his report. (Ex. M, pp. 83-86) Dr. Hartley also personally examined claimant and claimant completed an exercise desaturation test. (Ex. M, pp. 82-83)

Following interview, records review and examination, Dr. Hartley opined claimant suffered with permanent pulmonary impairment attributable to the work injury. He expressed agreement with Dr. Alvarez's diagnosis of RADS and opined claimant had achieved MMI for the condition. Dr. Hartley performed an impairment rating utilizing the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition. By the asthma guidelines, Dr. Hartley opined claimant fell within a class 2 impairment level, corresponding to a rating range of 10 to 25 percent whole person. Dr. Hartley ultimately assigned a 20 percent whole person rating to claimant's condition. (Ex. M, p. 87)

With respect to activity limitation, Dr. Hartley opined claimant's exercise limitation and pulmonary symptoms appeared "disproportionate" to the objective test results. He also opined it was difficult to determine the impact of other factors, i.e. anxiety, deconditioning and neuropathy, on claimant's exercise limitation. (Ex. M, p. 87) Dr. Hartley expressed agreement with Dr. Alvarez's permanent restrictions due to RADS, and specifically recommended claimant be permanently restricted from working in environments with likely exposure to inhaled irritant dust, fumes, smoke, vapors, gases or mists. However, Dr. Hartley disagreed with Dr. Alvarez's description of claimant as permanently and totally disabled. Dr. Hartley expressed belief that such a conclusion was beyond the purview of medical providers. (Ex. M, p. 88)

Dr. Hartley also expressed opinions with respect to claimant's psychological status and peripheral neuropathy. Dr. Hartley expressly deferred to mental health professionals with regard to the psychological aspects of claimant's claim. With respect to the peripheral neuropathy claim, Dr. Harley opined that following medical research and discussion with colleagues, he did not believe that claimant's exposure to diesel fuel caused the pure chronic motor axonal peripheral neuropathy demonstrated by claimant. (Ex. M, p. 88)

At the arranging of claimant's counsel, on December 14, 2013, claimant presented for IME with board certified orthopedic surgeon, Michael McGuire, M.D. Dr. McGuire issued a report containing his findings and opinions dated January 11, 2014. During interview, claimant described the May 16, 2012 work injury, subsequent treatment and ongoing conditions. Dr. McGuire also performed a medical records review. (Ex. 23A, p. 1) He noted on the date of injury, claimant aspirated and swallowed fuel, and his right foot and leg were soaked in diesel. (Ex. 23A, p. 2) Dr. McGuire also performed a neuromusculoskeletal examination, focusing on the right lower extremity. (Ex. 23A, pp. 1-2)

Dr. McGuire noted claimant originally presented with a chemical burn on the skin of his right foot and leg, and claimant now complained of loss of sensation in the right lower extremity. Dr. McGuire opined claimant suffered chronic and acute exposure to diesel fuel, with the combined local and systemic effect resulting in loss of sensation of the right lower extremity, below the knee. However, he also indicated the "systemic effects of ingestion/aspiration" were beyond his scope of expertise. (Ex. 23A, p. 2)

Dr. McGuire opined claimant had achieved MMI and had sustained permanent impairment to his right lower extremity condition. He opined the impairment was limited to the right lower extremity from an orthopedic standpoint. Although he considered diagnoses of causalgia and/or chronic regional pain syndrome with respect to claimant's right lower extremity, Dr. McGuire opined claimant's condition was best described as pure sensory loss. On this basis, Dr. McGuire opined claimant sustained a permanent impairment of 17 percent lower extremity or 7 percent whole person. Dr. McGuire opined claimant was no longer capable of working in the typical heavy construction industry. He recommended claimant undergo a formal FCE and seek vocational rehabilitation. (Ex. 23A, pp. 2-3)

On January 17, 2014, claimant returned to Mr. Tillia for evaluation of his left leg prosthesis. Mr. Tillia opined that as a result of weight gain, claimant was unable to properly fit into the socket and when he was active, the prosthesis failed to provide adequate protection. He performed an alignment adjustment and began the process of creation of a new socket. (Ex. 25A, p. 26) During the subsequent fitting process, Mr. Tillia noted claimant's volume fluctuations were "difficult to get a handle on." (Ex. 25A, p. 30)

Claimant continued to follow up with Dr. Thomas on January 17 and February 17, 2014. (Ex. 17V, pp. 1-3; Ex. 17W, pp. 1-2) At the February 17, 2014 visit, claimant complained of right knee pain, swelling and limited range of motion, as well as a sore on his left leg. Dr. Thomas aspirated claimant's right knee and scheduled an excision of a dermatofibroma from claimant's left leg. (Ex. 17W, pp. 1-2)

On March 21, 2014, claimant returned to Dr. Alvarez for evaluation. Dr. Alvarez assessed wheezing, with a history of RADS. He prescribed oral Medrol and ordered continued inhalation therapy treatments. (Ex. 12GG, p. 1)

Claimant returned to Dr. Alvarez on April 4, 2014. Dr. Alvarez noted claimant had undergone allergy skin testing that day, with negative results. Following examination, Dr. Alvarez assessed wheezing, clinically improving, and hypoxemia, continuing with oxygen supplementation. Dr. Alvarez recommended continued use of respiratory medications and inhalation therapy. He also ordered a CT angiogram of claimant's chest. (Ex. 12HH, p. 1) Claimant underwent the recommended CT angiogram on May 16, 2014, which revealed no definite pulmonary embolism. (Ex. L, p. 76)

On May 21, 2014, claimant presented to Dr. Thomas with complaints of left leg swelling. Dr. Thomas assessed lymphedema and prescribed medications, ordered a venous Doppler test, and referred claimant for a lymphedema physical therapy consultation. (Ex. 17X, p. 1; Ex. 17Y, p. 1)

Claimant returned to Dr. Thomas in follow up on June 30, 2014. Claimant complained of right leg pain, weakness and burning. Dr. Thomas assessed right leg pain. He also deferred to Dr. McGuire's expertise regarding the extent of permanent impairment to claimant's right leg. (Ex. 17X, p. 1; Ex. 17Z, pp. 1-2)

Claimant's counsel retained Gail Leonhardt of North Central Rehabilitation to perform an earning capacity assessment. Mr. Leonhardt performed an in-person interview of claimant on July 14, 2014. He noted claimant was 62 years old, with a high school education. He described the majority of claimant's past work experience as being construction-related, including as a fuel technician, operating engineer and construction laborer. He noted at the time of the work injury, claimant was working as a fuel technician, which is considered a light exertion position. Mr. Leonhardt also noted that for a large portion of his career, claimant worked as a heavy equipment operator/operating engineer, which is a considered a medium exertion position. Both positions were noted as involving exposure to fuel and fumes. (Ex. 24A, pp. 3, 9)

Mr. Leonhardt reviewed claimant's medical and psychological records. (Ex. 24A, pp. 3-9) He subsequently addressed claimant's work-related abilities with respect to the opinions offered by each evaluating provider. Based upon Dr. Tranel's opinion claimant suffered no impairment in cognitive or psychological functioning, Mr. Leonhardt indicated claimant would not have sustained any loss of earning capacity. Based upon Dr. McGuire's opinion claimant was no longer able to perform heavy construction-related tasks, Mr. Leonhardt indicated claimant would be precluded from performing any of his past work. Mr. Leonhardt also indicated he questioned the "wisdom" of claimant, at 62 years of age, participating in vocational rehabilitation. Based upon Dr. Mathisen's opinion claimant had not achieved MMI, but was unable to work 40 hours per week due to his mental disorders, Mr. Leonhardt indicated claimant appeared permanently disabled. Based upon Dr. Tse's opinion claimant was not at MMI, but his prognosis was poor, Mr. Leonhardt indicated claimant was temporarily and totally disabled. Based upon Dr. Alvarez's opinion claimant should not be exposed to gas fumes, vapors or other inhalation agents, Mr. Leonhardt indicated claimant would be precluded from past work. He opined claimant would be eligible for entry level unskilled work, such as a

convenience store clerk or security guard. He noted such positions carry wages of approximately $9.00 per hour, which represented a loss in wage rate of 79 percent as compared to claimant's preinjury rate of $42.00 per hour. Given Dr. Alvarez's restrictions, Mr. Leonhardt opined claimant sustained a loss of earning capacity in the range of 75 to 85 percent. Finally, Mr. Leonhardt noted that Dr. Levy opined claimant was incapable of working. (Ex. 24A, pp. 9-10)

On August 5, 2014, Mr. Tillia performed a repeat adjustment of claimant's left leg prosthetic to account for volume changes. (Ex. 25A, pp. 34-35)

Mr. Leonhardt authored an addendum to his earning capacity assessment, dated September 12, 2014. By that report, Mr. Leonhardt again noted that claimant sustained no loss of earning capacity in utilizing the opinions authored by Dr. Tranel. He opined the remaining medical and psychiatric opinions contained a "common thread." Mr. Leonhardt noted Dr. McGuire opined claimant was unable to work in construction-related activities. He indicated this restriction precluded all of claimant's past work. As a result of the preclusion of all past work and claimant's age, Mr. Leonhardt opined claimant was permanently and totally disabled. Mr. Leonhardt noted Dr. Mathisen opined claimant was unable to complete a 40-hour work week and as a result, Mr. Leonhardt opined claimant was permanently and totally disabled. He noted Dr. Levy opined claimant was not able to return to work and as a result, Mr. Leonhardt opined claimant was permanently and totally disabled. As Dr. Tse opined claimant was not at MMI, Mr. Leonhardt opined claimant was temporarily and totally disabled from employment. (Ex. 24B, p. 1) Mr. Leonhardt opined the opinions of Drs. McGuire, Mathisen, Tse and Levy all supported a conclusion claimant was permanently and totally disabled. Given Dr. Alvarez's restriction prohibiting exposure to fumes, vapors or inhalants, Mr. Leonhardt opined claimant would be capable of performing entry level, unskilled employment in certain fields. He opined such work would result in a 79 percent wage loss, supporting an opinion claimant suffered a loss of earning capacity of 75 to 85 percent. (Ex. 24B, p. 2)

Claimant continued to follow up with Dr. Thomas. (Ex. 17AA, pp. 1-3) At a visit on October 6, 2014, Dr. Thomas evaluated claimant's hypertension and chronic nerve pain of the right leg. Dr. Thomas noted claimant had undergone an orthopedic consultation, with physical therapy recommended. Accordingly, Dr. Thomas ordered a course of physical therapy in addition to medications. (Ex. 17AA, 3; Ex. 17BB, pp. 1-3) Claimant returned to Dr. Thomas on October 15, 2014 with complaints of severe pain of the right lower leg and concerns regarding function. Dr. Thomas noted claimant experienced severe neuropathy. He ordered x-rays of the right knee and ankle, prescribed medication, and referred claimant to podiatry. (Ex. 17DD, p. 2; Ex. 17EE, pp. 1-5) Claimant participated in the course of physical therapy. (Ex. 17FF, p. 5)

At the referral of Dr. Thomas, on October 20, 2014, claimant presented for evaluation by Patrick Barnes, DPM. Dr. Barnes noted claimant suffered with a painful right heel for several months, for "no known reason." (Ex. 26A, p. 1) Dr. Barnes ordered x-rays and performed an examination. He assessed gout of the right ankle,

calcaneal spur of the right heel, plantar fasciitis of the right foot, and peripheral neuropathy of the right leg and foot. Dr. Barnes opined there was a chance claimant had gout and further, that it was possible his use of diuretics contributed to development of hyperuricemia. He recommended a course of labs and testing, in addition to use of a prescription NSAID. (Ex. 26A, pp. 2-3)

Claimant underwent the laboratory testing recommended by Dr. Barnes. Following review of the results, Dr. Barnes telephoned claimant on October 22, 2014 and advised claimant that the testing did not confirm the gout diagnosis. (Ex. 26A, p. 5) Claimant returned to Dr. Barnes in follow up on November 21, 2014. At that time, Dr. Barnes expressed continued belief claimant suffered from gout of the right ankle. He recommended observation of the condition. (Ex. 26A, p. 6)

On January 9, 2015, claimant returned to Dr. Alvarez. Following examination, Dr. Alvarez assessed RADS secondary to inhalation injury, improved wheezing, and accelerated hypertension. He recommended continued inhaler therapy and use of oxygen. (Ex. 12II, p. 2)

At the arranging of claimant's counsel, on January 17, 2015, claimant presented to Dr. Taylon for an independent medical evaluation. Dr. Taylon authored a 1 ½ page report containing his findings and opinions on January 22, 2015. Claimant reported exposure to fumes for a period of approximately 6 months and then on May 16, 2012, he was sprayed with fuel. Dr. Taylon noted claimant had subsequently undergone extensive treatment, including evaluation by Dr. Taylon. Dr. Taylon opined at a prior evaluation on August 9, 2012, Dr. Taylon believed claimant demonstrated a likely peripheral neuropathy of the right leg. At an evaluation on January 17, 2015, claimant complained of right lower extremity symptoms, as well as what Dr. Taylon opined sounded like myoclonic jerks of claimant's body. (Ex. 21A, p. 1)

Dr. Taylon performed a physical examination. (Ex. 21A, pp. 1-2) He then opined it was more likely than not that the work injury, via ingestion of diesel, the topical effect of diesel on the skin, or some combination of both, caused neuropathic pain and peripheral neuropathy of the right lower extremity. Dr. Taylon indicated he was uncertain as to what condition the "jerks" represented and opined he was unable to causally relate the symptom to the work injury. Dr. Taylon opined a 2012 MRI of claimant's brain was normal for his age and did not demonstrate lesions warranting intervention. Accordingly, he recommended a watch-and-wait approach to any possible neurodegenerative disorder. (Ex. 21A, p. 2)

Dr. Taylon expressed agreement with the 7 percent whole person rating assigned by Dr. McGuire regarding the right lower extremity. He described claimant as "significantly restricted," given his bilateral leg injuries. Dr. Taylon recommended a permanent restriction limiting claimant to "desk type sedentary work." (Ex. 21A, p. 2) He subsequently clarified this restriction was assigned from a neurosurgical and/or orthopedic standpoint, and he did not intend to comment as to claimant's more restrictive pulmonary limitations. (Ex. 21B, p. 1)

On February 24, 2015, claimant returned to Mr. Tillia for evaluation of his left leg prosthesis. Mr. Tillia opined the current prosthesis provided claimant with inadequate protection and further indicated changing sockets was no longer an option. As a result, they began the process for replacement of the prosthetic. (Ex. 25A, pp. 36, 40-41)

On March 26, 2015, Aishwarya Patil, MBBS, examined claimant's left leg and the poorly fitting prosthesis. Dr. Patil recommended a vacuum socket. (Ex. 25A, pp. 47-52) At the same appointment, Mr. Tillia evaluated claimant. Claimant was wearing a diagnostic socket as part of the fitting process. Consistent with Dr. Patil's opinion, Mr. Tillia prescribed the new socket, as well as a compressive garment. (Ex. 25A, p. 42)

The following day, March 27, 2015, Dr. Alvarez examined claimant and opined claimant's RADS was symptomatic. He added an additional prescription to claimant's medication regimen. (Ex. 12KK, p. 1)

Claimant also continued to follow up periodically with Dr. Thomas. At a medication check on April 27, 2015, Dr. Thomas assessed COPD, hypertension, neuropathy and chronic pain syndrome. (Ex. 17EE, p. 1; Ex. 17FF, p. 6) On August 17, 2015, claimant presented to Dr. Thomas with complaints of right-sided back pain and a lump, as well as some edema and a mass on his right thigh. Dr. Thomas assessed right-sided thoracic back pain, abdominal mass, dermatofibroma, and edema. He ordered a course of testing, refilled medications, and scheduled claimant for lesion excision. (Ex. 17HH, pp. 1-4) Dr. Thomas performed a punch biopsy on September 2, 2015. (Ex. 17HH, p. 4; Ex. 17II, pp. 1-4)

Claimant returned to Dr. Alvarez in follow up on September 14, 2015. Dr. Alvarez assessed RADS and wheezing. He recommended continued medication and oxygen supplementation, with claimant to use oral steroids as needed for wheezing. (Ex. 12LL, p. 1)

On October 7, 2015, claimant sat for a second deposition. (Ex. 31; Ex. T)

Dr. Alvarez authored a letter directed to claimant's attorney dated October 14, 2015. In the letter, Dr. Alvarez restated a diagnosis of RADS, following an acute inhalation injury on May 16, 2012. Dr. Alvarez opined the work injury was a direct cause of claimant's lung condition and resulting symptoms. He opined claimant's condition qualified as a class 3 pulmonary dysfunction, from which he suspected several flares in coming years. Dr. Alvarez indicated future treatment would be needed, including routine diagnostic testing and inhaler therapy involving nebulizations of medications and daily inhaler treatments, on a daily and chronic basis. With respect to activity, Dr. Alvarez imposed work restrictions, limiting claimant's exposure from any inhalation agents, including smoke, dust, or other fumes and/or vapors. (Ex. 12NN, pp. 1-2)

On November 17, 2015, claimant returned to Dr. Thomas and complained of right leg neuropathy, "now into [his] back." (Ex. 17JJ, p. 1) Claimant expressed interest in

seeing another neurologist. Dr. Thomas assessed neuropathy and pain. He continued claimant's medication regimen and issued a referral to a neurologist of claimant's choice. (Ex. 17JJ, pp. 1-4)

On December 4, 2015, claimant returned to Dr. Alvarez in follow up. Chest x-rays revealed no acute cardiopulmonary findings. Dr. Alvarez recommended continuation of claimant's existing treatment regimen. (Ex. 12OO, p. 1; Ex. L, p. 77)

Claimant presented to Dr. Thomas on January 5, 2016 with complaints of right leg pain. Dr. Thomas commented claimant's current right leg below-the-knee brace was causing stress. As a result, Dr. Thomas ordered an above-the-knee brace. (Ex. 17KK, pp. 1-4; Ex. 17LL, p. 1)

On February 5, 2016, defendants served answers to interrogatories. Thereby, defendants admitted claimant sustained a work-related respiratory/pulmonary injury. Defendants also confirmed Dr. Alvarez acted as an authorized physician. Defendants denied the work related injury caused any neurological, psychological, mental, prosthetic, neuropathic, nerve pain, cognitive, chest pain, sleep apnea, heart, foot, and/or knee and leg conditions. (Ex. A, pp. 2-3)

On February 15, 2016, Dr. Alvarez issued answers to questions posed by claimant's counsel. Dr. Alvarez thereby opined that due to claimant's pulmonary injuries attributable to the May 16, 2012 work injury, he did not believe claimant would be capable of returning to work. (Ex. 12PP, p. 1) He also signed a subsequent letter dated February 17, 2016, opining claimant was no longer able to "maintain gainful employment" as a result of the work-related pulmonary injury. (Ex. 12QQ, p. 1)

On February 24, 2016, Dr. Thomas issued responses to inquires posed by claimant's counsel. Dr. Thomas thereby opined claimant was unable to work due to pulmonary issues secondary to the work injury of May 16, 2012. (Ex. 17MM, p. 1)

Mr. Leonhardt reviewed additional medical opinions and issued a second addendum to his earning capacity assessment dated February 29, 2016. He noted Dr. Thomas had recently opined claimant was unable to work and Dr. Alvarez opined claimant was unable to return to work due to pulmonary issues. Mr. Leonhardt opined these opinions "confirm[ed] the total disability opinions" asserted previously by other physicians. He opined the opinions also strengthened "the overwhelming opinion" that claimant was permanently and totally disabled. (Ex. 24C, pp. 1-2)

Claimant continued to periodically follow up with Dr. Seamunds in 2014 and 2015. He continued to participate in psychotherapy and Dr. Seamunds prescribed medication for claimant's conditions. (Ex. 19F, pp. 1-13) On March 4, 2016, Dr. Seamunds issued a response to inquiry from claimant's counsel. By this document, Dr. Seamunds opined he did not believe claimant was capable of returning to work as a result of medical issues related to the May 16, 2012 work injury. Dr. Seamunds noted

he expected claimant to experience permanent and unresolved disability. (Ex. 19H, p. 1)

Claimant testified he continues to regularly follow up with Dr. Thomas, Dr. Alvarez and Dr. Seamunds. He follows their treatment recommendations and takes the prescriptions ordered by these providers. Claimant testified he continues to suffer with various symptoms he relates to the work injury. Claimant testified he uses oxygen at nighttime hours and occasionally throughout the day. He also cannot tolerate the presence of household cleaners, perfumes, or vapors, as the exposure results in closure of his airway. He experiences difficulty breathing, particularly with exposure to fumes and/or temperature and humidity extremes. Claimant testified he feels as if a large snake is squeezing his chest, causing a feeling of suffocation. Claimant complained of continued bilateral leg swelling, resulting in more frequent changes to his prosthetic. He also described depression symptoms, including testifying he feels useless, worthless and hopeless due to his inability to return to work and provide for his family. Claimant has not applied for work since his unsuccessful return to work at defendant-employer in May 2012. (Claimant's testimony)

Claimant's wife, Claudia Burk, testified at evidentiary hearing. Ms. Burk testified following claimant's assignment to Weston Solutions, he began to become irritable and experience bloody noses. After approximately 2 to 3 months, she testified claimant began to complain of shortness of breath. Following the May 16, 2012 work injury, she testified claimant's behavior changed; she explained he experiences bad mood swings, severe depression, panicky behavior, excessive worrying, worsened memory, and a general feeling of lack of control over finances and medical care. Ms. Burk testified claimant seems angry at his reliance on others and testified he sometimes now acts like a "bully." Ms. Burk testified claimant continues to suffer with swelling; she testified claimant's left leg prosthetic has required more frequent adjustment since the May 16, 2012 work injury and claimant experiences greater difficulty in finding comfortable positions. She further testified claimant is unable to be as active as he was prior to the work injury. (Ms. Burk's testimony)

Ms. Burk's testimony was direct, knowledgeable and consistent with the evidentiary record. Her demeanor was excellent and provided the undersigned with no reason to doubt her veracity. Ms. Burk is found credible.

Claimant's testimony at evidentiary hearing was consistent as compared to the evidentiary record, testimony at two depositions, and in a sworn statement. Claimant often used terms and descriptions one could describe as exaggerated; however, the flourishes did not detract from the consistency of his accounts or serve as an inaccurate basis for medical opinions. Claimant's demeanor at the time of evidentiary hearing gave the undersigned no reason to doubt claimant's veracity. Claimant is found credible.

CONCLUSIONS OF LAW

Claimant has claimed the stipulated work injury resulted in physical and mental ailments beyond those agreed to by defendants. In order to properly consider the issues presented for determination, it must first be determined whether claimant has proven a causal connection between the stipulated work injury and the claimed ailments. At the time of evidentiary hearing and by post-hearing brief, claimant specified the conditions he claims are causally related, in some fashion, to the work injury of May 16, 2012. Causation will only be analyzed with respect to these enumerated claims: pulmonary and respiratory system; left leg prosthetic; neuropathy, nerve pain, and/or pain of the right lower leg and foot; psychological/mental health; and neurological and cognitive deficits. Claimant further clarified he made no claims with respect to his heart or chest pain, sleep apnea, or abdominal/gastrointestinal conditions. Defendants stipulated claimant sustained injury to his pulmonary and respiratory system as a result of the work injury of May 16, 2012. Defendants deny liability for any other claim of 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).

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).

As defendants have stipulated to a causal relationship between the work injury and claimant's respiratory and pulmonary conditions, no additional analysis is needed. The remaining claims shall be addressed individually.

Claimant claims a causal connection exists between the work injury and his need for adjustments to the left leg prosthetic he acquired as a result of a 1995 work injury. Claimant argues he has required more frequent changes, alterations, adjustments and replacement as a result of volume changes attributable to the work injury. Mr. Tillia, who has worked extensively with claimant in respect to his left leg prosthetic both pre- and post-May 16, 2012 injury, indicated claimant suffered with weight gain following the work injury and accordingly, required adjustments, changes and replacement. However, Mr. Tillia fell short of opining the need for such changes was causally related to the work injury. Mr. Tillia acknowledged volume fluctuations could occur for a number of reasons and indicated the cause of such fluctuations should be determined by an appropriate physician. The evidentiary record lacks such a supportive opinion from a physician. As no physician or provider has specifically causally related the work injury with the changes in claimant's left leg and resultant changes with respect to the prosthetic, I find claimant has failed to meet his burden of proof with respect to a causal connection between the work injury and left leg condition.

Next, claimant claims a causal connection exists between the work injury and claimant's complaints of right lower extremity pain, nerve pain and/or peripheral neuropathy. Dr. Taylon, a neurosurgeon, evaluated claimant shortly following the work injury in 2012. At that time, he diagnosed peripheral neuropathy and referred claimant for evaluation by a neurologist, as the condition was outside the scope of his expertise. That neurologist, Dr. Marky, evaluated claimant and assessed peripheral neuropathy; she opined she had been unable to link the condition to the work injury. Claimant subsequently underwent three independent medical evaluations, with Drs. Taylon, McGuire and Hartley. Dr. Taylon opined the work injury, via ingestion and/or the topical effects of diesel, caused neuropathic pain and peripheral neuropathy. Dr. McGuire, an orthopedic surgeon, similarly opined that the combined local and systemic effects of diesel exposure caused claimant to sustain sensory loss of his right lower leg. Dr. McGuire acknowledge the systemic impact of ingestion was beyond the scope of his expertise, however. Finally, Dr. Hartley, a pulmonologist and occupational health physician, opined claimant suffered from peripheral neuropathy. With respect to causation, Dr. Hartley indicated that following research and conferring with colleagues, he did not believe the neuropathy was caused by the work injury.

Following review of the medical opinions, I find the opinions of Drs. Taylon and McGuire to be entitled to the greatest weight. Dr. Taylon and Dr. McGuire offered consistent opinions, expressing belief that the work injury resulted in right lower extremity symptomatology, either via the ingestion/systemic effects, topical/local effects, or some combination of both. In addition to peripheral neuropathy, Dr. Taylon opined claimant suffered from neuropathic pain and Dr. McGuire found claimant suffered from ratable pure sensory loss. Causation with respect to either of these complaints was not specifically addressed by either Dr. Marky or Dr. Hartley. Accordingly, I find the

opinions of Dr. Taylon and Dr. McGuire more accurately address the full extent of claimant's right lower extremity condition. Although each physician acknowledged some limitation in their fields of expertise, I find both are qualified surgeons whose opinions are entitled to great weight, despite their lack of specialty in an aspect of claimant's condition. It is therefore determined that claimant has carried his burden of proving a causal connection between his right lower leg condition and the work injury.

Next, claimant argues a causal connection exists between the work injury and psychological and mental health conditions. Six providers have provided care or evaluation of mental health concerns following claimant's work injury. Dr. Levy, a psychologist, evaluated claimant in July 2012. At that time, he assessed mild cognitive impairment, major depression and generalized anxiety disorder. He opined these conditions were directly connected to the work injury. Dr. Poon, a psychologist, treated claimant in 2012 and diagnosed PTSD and MDD. Dr. Mathisen, a psychologist, evaluated claimant in November 2012. He diagnosed MDD and a somatoform disorder, which he opined were permanently aggravated by the work injury. Dr. Seamunds, a psychiatrist, treated claimant from 2012 through at least 2015. Dr. Seamunds diagnosed PTSD and MDD, which he opined were caused or aggravated by the work injury. Dr. Tse, a psychiatrist, evaluated claimant in March 2013. He diagnosed PTSD and MDD, which he opined were triggered by the work injury and its sequela. Dr. Tranel, a neuropsychologist, evaluated claimant in January 2013 and offered no diagnoses of claimant's conditions. He opined he was unable to find evidence of any mental health condition which could be attributed to the work injury, due to testing results demonstrating profound overreporting of symptoms; he acknowledged the plausibility that the work injury resulted in temporary aggravation of claimant's mental health conditions.

Of the six opining providers, five offered opinions as to a potential causal relationship between claimant's work injury and his mental health condition(s). Four of these providers opined the work injury either caused or aggravated claimant's mental health conditions. These providers included two psychologists, Drs. Levy and Mathisen, and two psychiatrists, Drs. Seamunds and Tse. One of the psychiatrists, Dr. Seamunds, provided treatment of claimant from 2012 up through the date of hearing. Dr. Seamunds is therefore, qualified and in the best position to assess claimant's conditions over time. Although Dr. Tranel offered a qualified and thorough evaluation, I find the weight of the evidence supports a conclusion that claimant did suffer with mental health symptomatology as a result of the work injury. There is insufficient evidence to warrant discrediting the opinions of the Drs. Levy, Mathisen, Seamunds, and Tse. It is therefore determined claimant has carried his burden of proving the work injury resulted in mental health injuries.

Finally, claimant claims he suffers with neurological and cognitive deficits as a result of the work injury. Dr. Levy opined claimant demonstrated mild cognitive impairment in July 2012. Dr. Poon subsequently opined claimant's cognitive symptoms were consistent with diagnoses of PTSD and MDD. Thereafter, Dr. Mathisen opined claimant did not demonstrate a cognitive disorder and Dr. Tranel opined claimant's

cognitive function was intact. Based upon these opinions, it is determined claimant has failed to prove, by a preponderance of the evidence, that the work injury caused a stand-alone diagnosis of neurological and/or cognitive deficits. While cognitive deficits may be associated with claimant's mental health conditions, as indicated by Dr. Poon, claimant has offered insufficient evidence to prove claimant suffered with a distinct diagnosis pertaining to deficits in neurological and/or cognitive functioning.

It is therefore determined claimant has proven, by a preponderance of the evidence, that the work injury is causally connected to claimant's pulmonary and respiratory, right lower extremity, and mental health conditions.

The next issues for determination are whether claimant is entitled to temporary disability benefits from December 5, 2013 through October 13, 2015, the extent of claimant's industrial disability, and the commencement date for permanent disability benefits. These intertwined issues will be considered together.

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.

Total disability does not mean a state of absolute helplessness. Permanent total disability occurs where the injury wholly disables the employee from performing work that the employee's experience, training, education, intelligence and physical capacities would otherwise permit the employee to perform. See McSpadden v. Big Ben Coal Co.,

288 N.W.2d 181 (Iowa 1980); Diederich v. Tri-City R. Co., 219 Iowa 587, 258 N.W. 899 (1935).

A finding that claimant could perform some work despite claimant's physical and educational limitations does not foreclose a finding of permanent total disability, however. See Chamberlin v. Ralston Purina, File No. 661698 (App. October 29, 1987); Eastman v. Westway Trading Corp., II Iowa Industrial Commissioner Report 134 (App. 1982).

Claimant was 64 years of age on the date of evidentiary hearing. He is a high school graduate, but lacks formal postsecondary or vocational education or training. The vast majority of claimant's work history has involved manual, physical labor. Past positions include as a laborer, assembly line worker, maintenance, construction, and heavy equipment operator. Claimant's prior earnings in such roles are unclear and his work history is somewhat sporadic, due in part to past injuries or familial responsibilities. Given claimant's age, educational background and work experience, I find claimant is not a likely candidate for retraining. This conclusion is supported by the unrebutted opinions of vocational expert, Mr. Leonhardt.

On May 16, 2012, claimant suffered a stipulated work related injury. By this decision, the undersigned determined claimant proved he sustained injuries to his pulmonary and respiratory system, right lower extremity, and mental health, as a result of this diesel exposure. As a result of the pulmonary and respiratory injury, Dr. Hartley opined claimant demonstrated a class 2 pulmonary impairment, warranting a permanent impairment rating of 20 percent whole person. Dr. Alvarez opined claimant suffered a more severe class 3 pulmonary impairment. By the AMA Guides, a class 3 pulmonary impairment corresponds to a permanent impairment rating of 26 to 50 percent whole person. As a result of the right lower extremity injury, Dr. McGuire opined claimant sustained a 17 percent lower extremity or 7 percent whole person impairment. Both Dr. Thomas and Dr. Taylon deferred to or expressed agreement with Dr. McGuire.

In addition to sustaining permanent functional impairment, physicians have recommended permanent restrictions with respect to claimant's conditions. With respect to claimant's pulmonary condition, Dr. Hartley recommended a restriction specifically limiting claimant to no exposure to inhaled irritant dust, fumes, smoke, vapors, gases or mists. For a prolonged period, Dr. Alvarez imposed a similar restriction, prohibiting exposure to inhalation agents, including smoke, dust, fumes and/or vapors. However, Dr. Alvarez subsequently opined claimant was incapable of working as a result of his pulmonary injuries; this opinion was also shared by Dr. Thomas. As a result of the right lower extremity injury, Dr. McGuire restricted claimant from performance of heavy construction work and Dr. Taylon limited claimant to desk-type sedentary work. Additionally, claimant's treating psychiatrist, Dr. Seamunds, opined claimant was unable to return to work due to his medical conditions.

Drs. Alvarez, Thomas and Seamunds provide claimant ongoing treatment of his work-related pulmonary, right lower extremity and mental conditions. Each physician opined, shortly prior to evidentiary hearing, that claimant was unable to return to work. These opinions were not rebutted by defendants. Additional providers, including Drs. McGuire, Taylon, and Hartley, have recommended restriction in claimant's functioning levels. The impact of these restrictions was considered by vocational expert, Mr. Leonhardt, who expressed belief the provider opinions overwhelmingly supported a conclusion claimant is permanently and totally disabled. Defendants offered no rebuttal vocational information or opinion.

The severity of claimant's work restrictions, at the very least, precludes claimant's return to the majority, if not all, of his pre-injury employment history. He successfully attempted to return to work at defendant-employer immediately following the work injury, but has not returned to work in any capacity since that time. Admittedly, claimant has not sought employment or retraining; however, claimant has suffered with significantly debilitating work-related injuries. While claimant has not shown an effort to return to work following the work injury, I find claimant has demonstrated motivation to continued employment in the past. On two occasions, claimant received Social Security Disability benefits for medical conditions; on each occasion, claimant returned to work. Claimant initially received such benefits following a work-related injury which resulted in cervical fusion and ultimately a below-the-knee amputation of his left leg. Claimant thereafter returned to work and suffered a head injury which resulted in missed time from work.

In each instance, claimant returned to work and was ultimately hired by defendant-employer in October 2010. By the evidentiary record, it appears defendant-employer found claimant a worthy employee, as claimant remained employed and was referred for placements. Claimant began work at Weston Solutions several months prior to the work injury and appears to have been a successful employee, as he earned a significant gross average weekly wage of $2,264.91. As claimant has demonstrated a history of returning to work following significant injuries and had returned to a position wherein he earned significant income, I believe claimant is a motivated person. Claimant undoubtedly had preexisting conditions at the time of the work injury and continues to suffer with comorbid conditions, however, these conditions did not appear to interfere with claimant's ability to work contemporaneous with the work injury of May 16, 2012.

Given claimant's age, educational background, significant functional impairment and permanent work restrictions, it is determined claimant is currently permanently and totally disabled. Claimant is therefore entitled to permanent total disability benefits commencing May 17, 2012 and continuing during the period claimant remains permanently and totally disabled. The parties stipulated at the time of the work injury, claimant's gross earnings were $2,264.91 and claimant was married and entitled to two exemptions. The proper rate of compensation is therefore, $1,327.48. Claimant is not entitled to overlapping healing period benefits for this injury and defendants are entitled to credit for indemnity benefits paid.

The next issue for determination is whether defendants are responsible for claimed 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 16, 1975).

Claimant has not proven entitlement to all medical expenses included in evidence at Exhibit 29. The claimed medical expenses include treatment for conditions which are not compensable, are not verified by accompanying medical records, and are at times, indecipherable as to the basis of the charge. Therefore, defendants are not found responsible for all the medical expenses claimed in Exhibit 29. Rather, defendants are found generally responsible for all medical care causally related to the conditions found compensable by this decision, as well as for any medical treatment authorized by defendants. Accordingly, defendants are found responsible for medical expenses causally related to claimant's pulmonary and respiratory conditions, right lower extremity condition, and mental health conditions. Defendants shall hold claimant harmless for such expenses and reimburse claimant for any associated out of pocket expenses personally incurred. In order to facilitate payment, claimant shall update Exhibit 29 and serve defendants with an updated itemization of medical expenses related to the compensable conditions and any authorized care which remains outstanding. Defendants remain responsible for ongoing care of causally related conditions.

The final issue for determination is whether claimant is entitled to reimbursement for an independent medical examination under Iowa Code section 85.39.

Section 85.39 permits an employee to be reimbursed for subsequent examination by a physician of the employee's choice where an employer-retained physician has previously evaluated "permanent disability" and the employee believes that the initial evaluation is too low. The section also permits reimbursement for reasonably necessary transportation expenses incurred and for any wage loss occasioned by the employee attending the subsequent examination.

Defendants are responsible only for reasonable fees associated with claimant's independent medical examination. Claimant has the burden of proving the reasonableness of the expenses incurred for the examination. See Schintgen v. Economy Fire & Casualty Co., File No. 855298 (App. April 26, 1991). Claimant need not ultimately prove the injury arose out of and in the course of employment to qualify for reimbursement under section 85.39. See Dodd v. Fleetguard, Inc., 759 N.W.2d 133, 140 (Iowa App. 2008).

Claimant requests reimbursement for Dr. Taylon's January 2015 IME in the amount of $1,500.00. The bodily condition addressed by Dr. Taylon's IME was claimant's right lower extremity injury. At the time of Dr. Taylon's IME, no employer-retained physician had offered an opinion as to the extent of claimant's permanent disability sustained as a result of the right lower extremity injury. As no employer-retained physician had opined as to the nature and/or extent of permanent disability, claimant cannot prove entitlement to reimbursement of Dr. Taylon's IME under Iowa Code section 85.39. Accordingly, claimant is not entitled to reimbursement of Dr. Taylon's IME.

ORDER

THEREFORE, IT IS ORDERED:

The parties are ordered to comply with all stipulations that have been accepted by this agency.

Defendants shall pay unto claimant permanent total disability benefits at the weekly rate of one thousand three hundred twenty-seven and 48/100 dollars ($1,327.48), commencing May 17, 2012 and continuing during the period claimant remains permanently and totally disabled.

Defendants shall receive credit for benefits paid.

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 are found responsible for claimant's medical expenses as set forth in the decision.

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 876 IAC 4.33.

Signed and filed this 21st day of June, 2017.

ERICA J. FITCH
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.