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IN THE SUPREME COURT OF IOWA

No.: 22-0471

Polk County No. CVCV 061324

MID AMERICAN CONSTRUCTION LLC AND GRINNELL MUTUAL,
Petitioners-Appellants,

vs.

MARSHALL SANDLIN,
Respondent-Appellee.

APPEAL FROM THE IOWA DISTRICT COURT
IN AND FOR POLK COUNTY
THE HON. SCOTT D. ROSENBERG, JUDGE

PETITIONERS-APPELLANTS' REPLY BRIEF

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STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

I. THE CLAIMANT WOULD NOT BE ENTITLED TO THE REIMBURSEMENT FOR THE COSTS OF AN *IOWA CODE* § 85.39 EXAMINATION AS THERE WAS NO RATING OF IMPAIRMENT BY A PHYSICIAN RETAINED BY THE EMPLOYER OR ITS INSURANCE CARRIER

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II. EVEN IF THE CLAIMANT IS ENTITLED TO AN *IOWA CODE* § 85.39 EXAM, THE COSTS OF THE EXAMINATION ARE UNREASONABLE PURSUANT TO *IOWA CODE* § 85.39.

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BRIEF POINT I

THE CLAIMANT WOULD NOT BE ENTITLED TO THE REIMBURSEMENT FOR THE COSTS OF AN *IOWA* CODE § 85.39 EXAMINATION AS THERE WAS NO RATING OF IMPAIRMENT BY A PHYSICIAN RETAINED BY THE EMPLOYER OR ITS INSURANCE CARRIER.

Argument

The Claimant faults the Defendants for relying on a Supreme Court precedent specifically defining what would be physician "retained" by the employer for purposes of *Iowa Code* § 85.39. However, the Iowa supreme Court precedent *IBP, Inc. v. Harker* is the controlling legal precedent interpreting the specific language of *Iowa Code* § 85.39 at issue. *IBP, Inc., v. Harker*, 633 N.W.2d 322 (Iowa 2001). In the *Harker* case, the Claimant chose his own physicians, and there were several referrals made to other doctors who saw the Claimant as a part of his care. *Id.* at 324. In the end as the Claimant chose his own initial treating doctor, who later made the referrals to the doctors offering the ratings, the Claimant was not entitled to an examination pursuant to *Iowa Code* § 85.39. *Id.* at 326–327. The Iowa Supreme Court interpreted *Iowa Code* § 85.39 in terms of what it meant for a physician to be "retained by the employer". *Id.* at 326. The Iowa Supreme Court determined that the word "retained" for purposes of *Iowa Code* § 85.39 would mean a physician <u>chosen</u> by the employer, and merely being paid by the employer was not adequate. *Id.* at 327.

As the Iowa Supreme Court has already interpreted what it means to be retained by the employer for purposes of *Iowa Code* § 85.39, the issue becomes whether a physician chosen by the employer and its insurance carrier provided a rating of impairment to trigger *Iowa Code* § 85.39. While the Workers' Compensation Commissioner as well as the District Court, and the Claimant, appear to distinguish the facts from *Harker*, the distinction is one without significance. In *Harker* the injured worker was allowed to choose his own treating physician under Nebraska law, but the case ended up being brought under Iowa workers' compensation law. In the end, the reason the Claimant chose his treating doctor does not change the reasoning and analysis, all that mattered was that the Claimant initially chose his first treating physician who made the later referrals.

The Claimant really articulates no substantial factual argument as to why it should not be determined that he selected Dr. Isaak at Medical Associates to be his treating physician. Indeed, it appears the Workers' Compensation Commissioner in his Appeal Decision agreed with the Employer and its Insurance Carrier as to this point. The Claimant states that this was the only treatment option available. The Claimant told his Employer his foot was hurting, and that he would like to take the day off. (Hrg. Tr. p. 40, lines 8-12; App. p. 101). The Claimant then called the Employer later in the day and told him that he needed to go see a doctor, but the Employer did not tell him to go anywhere. (Hrg. Tr. p. 40, lines 15-20; App. p. 101).

The Claimant testified that he asked about going to Medical Associates, to which the Employer replied that he could go there, or whatever. (Hrg. Tr. p. 41, lines 1-3; App. p. 102). The Employer did not have any suggestions or comment. (Hrg. Tr. p. 41, lines 1-14; App. p. 102). The Claimant was clear that the Employer did not pick Medical Associates. (Hrg. Tr. p. 41, lines 15-17; App. p. 102). The Claimant is the one who suggested going to Medical Associates Clinic. Therefore, just as in *Harker*, the Claimant here chose his initial treating physician. In fact, Medical Associates is where the Claimant had previously gone for his own personal health treatment, and he considered them to be his personal family doctors. (Hrg. Tr. pp. 25, lines 8-12; App. p. 93; and 39-41, lines 9-17; App. pp. 100-102; Def. Ex. G, Dep. p. 9, lines 3-8; App, p. 84).

Dr. Isaak then sent the Claimant to Dr. Hughes, and the Claimant has testified that he did contact the Insurance Carrier, but they did not direct him to Dr. Hughes. (Hrg. Tr. p. 42, lines 11-24; App. p. 103). Again, this is much as the case in *Harker* where the initial treating doctor made a subsequent referral. Again, it appears the Workers' Compensation Commissioner agreed on this point in the Appeal Decision.

The Claimant argues that because the Employer or its Insurance Carrier were later in contact with the treating doctor, that somehow changes them to having selected that physician. However, there is no support for such a contention. Even if an injured worker selects his or her own treating doctor, the employer or its insurance

carrier would have to be in contact with that physician for purposes of paying for care, and getting work restrictions or any additional opinions that are necessary to continue to administer the claim. That does not mean they have chosen that physician or retained that physician per *Harker*.

Thus, the only difference between this case and *Harker* is why the injured worker selected the treating doctor. In this case, the injured worker was allowed to select his own physician by acquiescence, as well as the employer and its insurance carrier choosing not to exercise their right under *Iowa Code* § 85.27, rather than under the mandates of Nebraska workers' compensation law. In the end, there really is no difference as the injured worker still gets to select his or her own care. The result is the same. There is no rational reason for a distinction. The Employer did not direct the Claimant anywhere, and the Claimant ended up selecting his own treatment.

Claimant argues the reason he chose Medical Associates was that it was the only place open. This is an admission Claimant chose Medical Associates. The Claimant was seeking care over several days. Other clinics would have been open. Claimant chose Medical Associates because it was close to his home and, more importantly was his normal personal clinic. Regardless, if Claimant went to a different clinic, the result would still be the same. He chose the clinic.

It appears the Workers' Compensation Commissioner and the District Court found that the chain of physicians chosen by the Claimant was broken with Dr. Kennedy. The Claimant argues that he had no hand in the selection of Dr. Kennedy. While the Claimant may not have sought out Dr. Kennedy by name, the facts as outlined in the foregoing are clear. Dr. Isaak was selected by the Claimant at Medical Associates. Medical Associates was the Claimant's personal doctors, and where he had gone for medical treatment in the past. Dr. Isaak made a referral to Dr. Hughes to treat the Claimant's foot. Dr. Hughes did not perform impairment ratings and, when a final evaluation became necessary, she chose to refer the Claimant to Dr. Kennedy. This is confirmed by both Dr. Hughes and Dr. Kennedy. The Claimant indicates that Tri-State Occupational Health has no association with Medical Associates. This is not the case as Dr. Kennedy made clear that Tri-State Occupational Health is a joint venture between Mercy Hospital and Medical Associates. It is associated with Medical Associates. This is likely why Dr. Hughes stated that it was her typical procedure to send an injured person to occupational health when it became necessary to provide an impairment rating.

The Claimant testified at various points he believed the Insurance Carrier may have sent him to Dr. Kennedy. The Claimant was simply mistaken. In the end he testified that he did not know. Therefore, there is no basis in the evidence to indicate that the Employer and its Insurance Carrier made the choice to send the Claimant to

Dr. Kennedy. The primary evidence is from Dr. Kennedy and Dr. Hughes that Dr. Hughes made the referral. Dr. Hughes selected Dr. Kennedy for the Claimant as she would send patients that needed an impairment rating to occupational health. This is no different than any other medical referral, such as an x-ray, MRI or a specialty evaluation. The Claimant was sent for a specialty evaluation to perform an impairment rating as it became necessary.

The Claimant also points out that Dr. Kennedy has performed evaluations in other cases for employers and insurance carriers. That is irrelevant to the facts of this case. What may or may not have happened in another case is not a finding of fact in this case. All that must be assessed is whether Dr. Kennedy was a "retained" physician under *Iowa Code* § 85.39. This would mean that the Employer and its Insurance Carrier would have had to have chosen Dr. Kennedy. The evidence actually shows that there is an unbroken chain of referrals from the original physician that the Claimant chose. The facts are not substantially different than the *Harker* case, and the results should be the same.

The Claimant also argues, as there is a correspondence from the Insurance Carrier, that somehow supports his contention that he is entitled to an *Iowa Code* § 85.39 exam. However, what is in that letter does not change the law. Whether or not the Claimant is entitled to an examination is one to be examined under *Iowa*

Code § 85.39. The issue was properly raised, and submitted to the Agency. So the correspondence is of no significance in determining the legal issue presented.

Lastly, the Claimant also argues that the costs associated with Dr. Kennedy's report and evaluation were paid by the Defendants. However, *IBP, Inc. v. Harker*, clearly establishes that merely paying a doctor is not enough to make a physician retained by the Employer and its Insurance Carrier. This has already been established clearly by prior Iowa Supreme Court precedent.

As indicated in the foregoing, the Workers' Compensation Commissioner and District Court have misinterpreted the Iowa Supreme Court precedent in *IBP, Inc. v. Harker*, and a review of the interpretation of the law will be reviewed for correction of errors at law. Further, the facts in evidence at hearing when applied to the appropriate law, show that the Agency determination is irrational, illogical and wholly unjustifiable. Additionally, any finding that the Defendants selected or retained Dr. Kennedy is not supported by substantial evidence in this record. The evidence clearly shows that Dr. Hughes did not perform impairment ratings, and would make a referral to Occupational Health for that purpose. Dr. Kennedy is with Occupational Health and received the referral from Dr. Hughes. This is confirmed by both of the doctors. Further, the Occupational Health Clinic where Dr. Kennedy practices medicine is affiliated with Medical Associates, and Dr. Hughes made a

referral within the network of facilities that the Claimant was already being seen in at the time the referral was needed.

Indeed, the errors in the construction of the case law from the Iowa Supreme Court is evidenced in the Agency level decisions cited to by the Claimant in his brief. The Iowa Supreme Court has already held that the definition of a physician retained by the Employer and its Insurance Carrier, would mean a physician that is chosen by the employer and its insurance carrier. However, in the Agency level decisions cited by the Claimant it appears that this definition is being ignored, or given an unduly narrow construction in contravention of Supreme Court precedent.

This then turns to several Agency level decisions that the Claimant argues support his contention. The first case cited to is *Trumbo v. Johnson Community School District*, File No. 5047946 (Arb. June 13, 2016). However, the *Trumbo* case presents an entirely different scenario in that the Claimant was taken to the emergency room, and was actually taken by ambulance directly to the hospital after the injury. This injury was handled as an emergency, and the care was provided immediately at the hospital. This is unlike the *Harker* case, and the present case, where the injured person had time to select a physician and did take time to select a physician. While the Claimant may argue that Medical Associates was the only clinic available, that could be the case in numerous localities where there may be more limited options for having medical care performed. Also, it was noted in the

Trumbo case that the injured worker was pressured to go back to Dr. Vittetoe by the employer and its insurance carrier, or his claim would be closed. The Claimant had already actually missed several appointments with Dr. Vittetoe prior for purposes of getting an impairment rating completed. There is no indication that the Claimant was being pressured to go to Dr. Kennedy, and the Claimant could not even be sure that the Employer and its Insurance Carrier in this case picked or set up that evaluation. There is no indication that the Claimant was being coerced or otherwise forced to go to Dr. Kennedy.

In terms of *Levasseur v. New Start Financial, Inc.*, the decision is simply wrong. *Levasseur v. New Start Financial, Inc.*, File No. 5048702 (Arb. June 8, 2015). There is no substantial discussion in the *Levasseur* case about why *IBP, Inc., v. Harker* does not apply. Indeed, it appears that the main dispute was about causation based upon the reports of several doctors. *Id.* at p. 5. The Agency discusses whether the three doctors would be "employer's physicians" for purposes of *Iowa Code* § 85.39; but states there is no guidance on that issue. *Id.* at 10. However, there is in fact guidance from the appellate courts on this issue. The law has already been interpreted, and there is no need for any further construction of the statute. If the Employer and its Insurance Carrier do not select the physicians in question, *Iowa Code* § 85.39 cannot be triggered. There is nothing that indicates merely seeking an opinion from a physician that was not selected by an employer

and insurance carrier somehow transforms them into a retained physician. Indeed, if that was the case, then *Harker* would have had to come out differently. In that case, physicians chosen by the injured worker authored impairment ratings, and this was not enough to trigger *Iowa Code* § 85.39. In short, the law is clear that for a physician to be retained by the employer and its insurance carrier, that physician must be one that is chosen by the employer and its insurance carrier, not merely paid.

Similarly, the case of *Bill v. Ambassador Steel Corp.* is different as well. *Bill v. Ambassador Steel Corp.*, File No. 5026746 (Arb. June 10, 2010). While the specific doctor who authored the opinion was dictated by alternate care in the *Bill* case, the original treating doctor made a referral to the University of Iowa Hospitals, and the physician there in turn made a referral for a carpal tunnel release at the University of Iowa Hospitals or at a local clinic. *Id.* This is how the physician who later authored the ratings became involved as they were a local physician, and the Claimant sought alternate care to have a local provider do the treatment. In short, the employer and its insurance carrier did not have the right to direct care. There was merely an order for alternate care under *Iowa Code* § 85.27. However, the Employer and its Insurance Carrier would argue that this case was also incorrectly decided. To be "chosen" by the employer and its insurance carrier is what is necessary for a physician to be retained. In the sense that alternate care gives the Claimant his or her choice of physician, that physician can no longer be said to be

chosen by the employer and its insurance carrier. Further, merely choosing to request an opinion from the physician that the Claimant has picked to provide care, is not enough under the law either. Again, the *Harker* case would have had to come out differently if that was the case.

The Claimant also argues cases in regards to statutory construction. However, there is no new issue of statutory construction presented. The statute, and the specific language at issue in this case, has already been interpreted. There is no law that indicates there is to be a liberal construction of Iowa Supreme Court precedent.

In the end, the Claimant states that this is some kind of dangerous precedent to set in this particular case. There really is no dangerous precedent in allowing an employer and its insurance carrier to not exercise their right to direct care under *Iowa Code* § 85.27. The injured worker gets to select their own treating physicians. If an employer and its insurance carrier choose to not select a physician, the Claimant gets a rating from a physician of his own choice in the end anyway. As such, Dr. Kennedy's rating did not trigger *Iowa Code* § 85.39, and the award of the costs associated with the independent medical examination of Dr. Taylor should be reversed.

BRIEF POINT II

EVEN IF THE CLAIMANT IS ENTITLED TO AN *IOWA CODE* § 85.39 EXAM, THE COSTS OF THE EXAMINATION ARE UNREASONABLE PURSUANT TO *IOWA CODE* § 85.39.

Argument

The Claimant argues that the issue regarding what is reasonable for his 85.39 examination is one of substantial evidence. This is not correct. The legislature amended *Iowa Code* § 85.39 to include a definition of what would be the reasonable charge for an examination under that *Code* section. This issue involves the interpretation of that statutory language, and the impact of that statutory amendment. Issues regarding statutory interpretation will be reviewed for errors of law, and no deference will be given to an Agency interpretation of the Workers' Compensation Act. *Trujillo v. Quality Egg, L.L.C.*, 878 N.W.2d 759, 768-769 (Iowa 2016). This issue will also involve the application of fact to law as well as potential issues of substantial evidence.

The Claimant discusses issues regarding the "scope" and "actual charge" of the examination with Dr. Taylor. The issue that the Claimant is identifying with the scope of the examination of Dr. Taylor, involves interpretation of *Iowa Code* § 85.39, and the new amendments to that *Code* section. *Iowa Code* § 85.39(2) now contains language that indicates that the reasonable charge for an examination will now only be based upon the typical fee charged "to perform an impairment rating in the local area where the examination is conducted". *Iowa Code* § 85.39(2). The *Code* now specifically states that the only reasonable cost is that of performing an impairment rating, this does not mean that the Claimant cannot get other opinions,

but it does mean that the only thing that will be compensated under *Iowa Code* § 85.39 is the cost to perform an impairment rating. The issue that the Claimant is identifying "as to scope" is one of statutory interpretation.

The Claimant concedes that this case falls under the post 2017 version of *Iowa Code* § 85.39. The *Code* specifically states what a "reasonable" cost associated with an examination is to be. *Iowa Code* § 85.39. That fee "shall be based on the typical fee charged by a medical provider to perform an impairment rating in a local area where the examination occurred." *Iowa Code* § 85.39(2). The *Code* specifically limits the charges to the costs of performing an impairment rating. This is different than an independent medical examination which could touch on issues far beyond a simple impairment rating such as causation, diagnosis, treatment, restrictions, maximum medical improvement or an impairment rating as well. It is clear that the legislature has chosen to put some limit on the reasonableness of charges in enacting amendments to *Iowa Code* § 85.39, and the specific limitation is to define reasonable as the costs to perform an impairment rating. The *Code* does not include any additional opinions, or a full independent medical examination. The District Court interpreted this new language to change nothing. The legislature could have stated that the reasonable costs was that of performing an independent medical examination, but chose to specify that it was the cost to perform an impairment rating. It is presumed that when the legislature amends a statute that there was an

intention to change the law, not just leave it as is. *Chavez v. MS Technology LLC*, 972 N.W.2d 662, 670 (Iowa 2022) (citing *Colwell v. Iowa Dep't of Hum. Servs.*, 923 N.W.2d 225, 235 (Iowa 2019)).

This is further supported by the original portions of *Iowa Code* § 85.39. Specifically, *Iowa Code* § 85.39 specifies that the injured worker may only have an examination when there has been "an evaluation of permanent disability" by a physician that was retained by the employer, "and the employee believes this evaluation to be too low . . .". *Iowa Code* § 85.39(2). In short, the Claimant is getting an evaluation to rebut an impairment rating authored by an employer retained physician that is believed to be too low. The legislature went further to define this as the Claimant could get the reasonable costs of performing an impairment rating. The Claimant has asked for the wrong thing of Dr. Taylor. The Claimant requested numerous opinions beyond just an impairment rating, and an impairment rating would typically only involve measurements, or a diagnosis based evaluation under the *AMA Guides to the Evaluation of Permanent Impairment (5th Ed.).* It does not require the additional evaluations that might be necessary, or the review of additional records, to get opinions on causation, permanent restrictions, additional treatment, maximum medical improvement or a myriad of other issues beyond a function impairment rating. While these opinions certainly would be beneficial to the Claimant at hearing, the legislature has chosen to limit the reimbursable costs

associated with an *Iowa Code* § 85.39 examination to just the cost of performing an impairment rating.

The Claimant argues reasonableness was always a part of *Iowa Code* § 85.39, and the assessment of the costs of an examination. While it is true that the *Code* did provide that the injured worker would be reimbursed "the reasonable fee for a subsequent examination by a physician of the employee's own choice", the *Code* now goes further to specify what will be defined as reasonable. *Iowa Code* § 85.39(2). The reasonable costs are to perform an impairment rating alone. The Iowa legislature did not choose to include language that it was the cost to perform an independent medical examination, but specifically chose to limit the language to the cost of performing an impairment rating. If reasonable still means what it has all along, then there was no need for the Iowa legislature to include additional language specifically defining the term. In interpreting a statute, effect must be given to all of the language so that none of it becomes superfluous. *Trujillo V. Quality Egg, L.L.C.*, 878 N.W.2d 759, 770 (Iowa 2016).

What the Claimant is arguing for is that this language is superfluous as it does nothing. Examining the statute all that was originally stated was that "[i]f an evaluation of permanent disability has been made by a physician retained by the employer", the injured worker would be able to have an evaluation with a physician of their choice. *Iowa Code* § 85.39(2). This defined the triggering factor to get an

examination. What it meant is that a rating would have to be provided for permanent disability by a physician chosen by the employer and its insurance carrier. In defining what the reasonable costs are, the legislature chose to limit what could be a compensable examination under *Iowa Code* § 85.39 to the costs of performing an impairment rating. This now makes it consistent with the triggering factor to get the exam in the first place.

The *Code* now also limits an *Iowa Code* § 85.39 examination only to situations where the injury for which the worker is being examined is determined to be compensable. *Iowa Code* § 85.39(2). If the injury being evaluated ends up not being a compensable one, the Claimant would receive nothing under *Iowa Code* § 85.39. This further supports an interpretation that the legislature sought to limit what would be compensable under *Iowa Code* § 85.39. Not only to limit the reimbursement for expenses under *Iowa Code* § 85.39 only to compensable injuries, but also only to an impairment rating. If the injured worker is seeking a full independent medical examination, same would touch upon, at least potentially, issues such as the causal connection between the alleged injury or condition and the injured worker's employment. If the alleged condition ends up not being compensable, the injured worker would not have gotten anything under *Iowa Code* § 85.39 to pay for the examination. This would even be the case in the eventuality that a rating was authored by an employer retained physician, which would have otherwise triggered

Iowa Code § 85.39 before the 2017 Amendments. All of this read together with the original *Iowa Code* § 85.39(2) only further shows that the legislature is intending to limit what is included, and the scope of an examination under *Iowa Code* § 85.39(2).

An *Iowa Code* § 85.39(2) examination is only triggered in response to a rating from an employer retained physician that the injured worker believes to be too low. This is the issue that was discussed by the Iowa Court of Appeals in *Kern v. Fenchel, Doster & Buck, P.L.C.*, 2021 WL 3890603 (Iowa App. 2021). The Iowa Court of Appeals did not address the issue presented in this case, or the amendments made to *Iowa Code* § 85.39 in 2017.

Further, the *Code* now limits that the *Iowa Code* § 85.39 exam is only compensated if the injury itself that is being evaluated is compensable. This is regardless of whether *Iowa Code* § 85.39 would have been triggered anyway. Additionally, the *Code* now goes on to limit what is reasonable to the costs of performing an impairment rating. *Iowa Code* § 85.39(2). Nothing could be clearer in the language that the reasonable costs are now limited only to performing an impairment rating. The *Code* does not state that it is to perform an independent medical examination, to obtain opinions on causation, restrictions, maximum medical improvement or any other issue that would be beneficial to the case. The *Code* specifically states that the reasonable cost is only to perform an impairment rating. The *Code* is clear and unambiguous about what is specified. This is

consistent with the other language in the statute, and the other portions of the new Amendments to *Iowa Code* § 85.39. The Claimant wants to argue for business as usual and ignore the new statutory language. This was what was done by the Agency and the District Court. However, the law is clear that language and statute should not be superfluous, and that this language should mean something. The language is clear by its own terms what it means.

This also makes sound policy sense as well. The Claimant has no incentive to try to contain the costs of an *Iowa Code* § 85.39 exam, and in this case has used it to obtain additional opinions beyond just an impairment rating. The legislature has sought to narrow what can be covered under an *Iowa Code* § 85.39 exam, if the Claimant wants to receive reimbursement for the full cost. *Iowa Code* § 85.39 is a means by which an injured worker who is dissatisfied with an impairment rating authored by an employer retained physician, may get an impairment rating from a physician of their own choice. It is not a means to shift all of the costs of obtaining expert opinions for an eventual trial. Indeed the Iowa Supreme Court has indicated that cost is a valid reason to choose between two reasonable courses of treatment under *Iowa Code* § 85.27 for an employer and its insurance carrier. *Long v. Roberts Dairy Co.*, 528 N.W.2d 122, 124 (Iowa 1995).

The language of the statute is clear, and unambiguous. *Iowa Code* § 85.39(2) is only triggered in response to an impairment rating, and now only provides for the

reimbursement of the costs of obtaining an impairment rating from a different physician. The Iowa Supreme Court has already determined that a statute dealing with costs are to be strictly construed. *Coker v. Abell-Howe Co.*, 491 N.W.2d 143, 151 (Iowa 1992). The Claimant argues that somehow this new language is only as to the purpose of the evaluation, a distinction as to an evaluation for an impairment rating as opposed to initial treatment. However, that is a distinction that makes no sense in terms of the law. An evaluation for initial treatment would not trigger *Iowa Code* § 85.39. There would be no rating of impairment from any employer retained physician. At the point when an *Iowa Code* § 85.39 exam occurs, there would be a rating already completed. The Claimant wants to broaden the language to include opinions beyond just obtaining an impairment rating.

This then turns to the issues about the actual costs of Dr. Taylor's evaluation. The Claimant admits that *Iowa Code* § 85.39 does define reasonableness as "the typical fee charged by a medical provider performing an impairment rating in the local area where the examination is conducted." *Iowa Code* § 85.39(2). The only support that the Claimant has in the record for his proposition that Dr. Taylor's fees were reasonable is essentially a boiler plate line at the end of Dr. Taylor's report.

While the Claimant would be the one to suffer the loss, and has the burden of proof in this matter, the Employer and Insurance Carrier have introduced into evidence the charges from Dr. Kennedy for performing an impairment rating in the

locale of Claimant's exam. This was $174.25. (Def. Ex. C, p. 1). Even Dr. Taylor's own clinic, Medix, charges a $500.00 flat fee to perform an impairment rating evaluation for one body part. (Def. Ex. E, p. 1; App. p. 80). Therefore, the clinic where Dr. Taylor works, would only charge $500.00 to perform an impairment rating rather than a full independent medical examination. The *Code* is clear that the Claimant should only receive the reasonable costs, and those reasonable costs are the charges to perform an impairment rating. The only evidence really of the reasonable cost is these two pieces of unrebutted evidence.

The Employer and its Insurance Carrier in this matter have introduced into evidence the fees charged by Dr. Kennedy to perform an impairment rating in Dubuque, Iowa, as well as Medix's own fee schedule for providing an impairment rating for one body part. As the party who had suffered the loss in this matter, the Claimant would bear the burden of proof in establishing the reasonableness of his submitted charges under *Iowa Code* § 85.39. Thus the Claimant would need to show that the amount submitted is the typical fee charged by a medical provider to perform an impairment rating in the locality in question.

As the Claimant argued in his brief, Dr. Kennedy does perform a fair amount of evaluations in the locality of her clinic. The amount paid, as well as Dr. Kennedy's original amount charged, are both in the record. This clearly shows the typical fee charged in that locality for a functional impairment rating. Likewise, the

fee schedule for Medix is for the evaluator chosen by the Claimant himself. It would seem disingenuous to argue that the Claimant's own designated evaluator's fee schedule is somehow not indicative of what should be charged for a functional impairment rating.

What has happened in this instance is that the Claimant has asked for something besides an evaluation of impairment. The Claimant asked for a full independent medical examination. This is not something that is indicative of some type of imbalance or injustice as the Claimant appears to argue in looking at the difference between Dr. Kennedy and Dr. Taylor's bills. If the Claimant had asked for an impairment evaluation for one body part, he would have been charged $500.00 in line with the fee schedule introduced into evidence. This would have resulted in an impairment rating which the Claimant would have introduced into evidence. Likely, the impairment rating would have been the same as the one in Dr. Taylor's full independent medical examination. What this does show is the fact that the Claimant has no incentive to try to contain the costs of his evaluation. Essentially, this is used as a free means to push the costs of expert opinions onto an employer and its insurance carrier. This is further exemplified in this particular case in that the amount billed by Dr. Taylor for his full exam is more than the value of the benefits that resulted from the impairment rating he offered. The Claimant was awarded three weeks of benefits at the rate of $373.90 per week. This would total

$1,121.70. The costs submitted for Dr. Taylor's independent medical examination were $2,020.00. As such, the costs of Dr. Taylor's evaluation was almost $900.00 more than the eventual award of benefits for Dr. Taylor's assigned impairment rating.

As noted by the Appellants in their original brief, the language contained in Dr. Taylor's own evaluation does not indicate that his fees are typical of a medical provider to perform an impairment rating in the locality where the examination occurred. (Cl. Ex. 1, p. 8; App. p. 75). All the language states is that the Doctor felt that his fees were reasonable based upon his training and certifications, the time spent to get a history and perform the exam, and the time spent to prepare the report. Nowhere does it state that this is typical to perform an impairment rating in Cedar Rapids, Iowa. This is what the Claimant needed to show in order to have the expenses found to be reasonable under the language contained in *Iowa Code* § 85.39(2). The evidence that was relied upon, and submitted by the Claimant to carry his burden, nowhere makes any statement that would state what the typical charges are in that locality to perform an impairment rating. All that the language would indicate is that the Doctor felt that the fees he charged were reasonable for the services he performed. However, this does not state anything about the charges that would be typical for a medical provider in the locality.

Even the Workers' Compensation Commissioner seemed to question the reasonableness of the charges, and states in the Appeal Decision that "I acknowledge the fee schedule from Dr. Taylor's office suggests his office offers an independent medical exam and a less expensive impairment rating/restrictions exam. Presumably, this would be a case in which the less expensive impairment rating/restrictions exam would be appropriate." (Appeal Decision, p. 5; App. p. 36). The Commissioner then goes on to state this is a presumption that was outweighed by Dr. Taylor's statement in his report. However, as noted in the foregoing, Dr. Taylor's statement in his report does not meet the burden that is required under the statutory amendments to be shown as a reasonable charge.

The Claimant argues that Dr. Kennedy did not do the same type of thing as Dr. Taylor. However, this is not the case. Both doctors performed an examination, and both doctors authored an impairment rating. As argued by the Petitioners, that is what the *Code* would actually specify the costs to perform an impairment rating. Where the two reports seem to differ is in terms of the additional add-ons beyond an impairment rating. Evidently, Dr. Taylor summarized additional medical records, and put additional time into authoring a more lengthy report. Though the Appellants would posit that to perform an impairment evaluation all that would be necessary is an actual examination, and some measurements or a diagnosis based upon the criteria in the *AMA Guides to the Evaluation of Permanent Impairment (5th Ed.)*, a

lengthy recapitulation of a course of treatment, and an equally lengthy report that summarizes a course of treatment, would not be necessary to perform an impairment evaluation. Indeed, the Workers' Compensation Commissioner would seem to acknowledge this fact in the Appeal Decision, but then went on to ignore it in awarding the full value of Dr. Taylor's evaluation.

The Workers' Compensation Commissioner and District Court just did business as usual in terms of assessing an independent medical examination. The Agency and District Court ignored the statutory amendments, and the findings that needed to be made, and evidence the Claimant needed to introduce, to have an award of an evaluation under *Iowa Code* § 85.39.

This touches upon statutory construction as argued in the foregoing, and the Petitioners' Judicial Review Brief, as well as substantial evidence and is irrational, illogical and wholly unjustifiable when one applies the law to the facts.

The Claimant also makes some argument about the locality where the examination occurred. However, this only further illustrates the deficiency of the Claimant's own evidence. The Claimant does not define what locality means, nor does the statute specifically state the same. Though the Claimant has offered nothing about what the locality would be, or what would be typically charged in that locality to perform an impairment rating, what is in evidence is the billing statement from Dr. Taylor, the billing statement from Dr. Kennedy and Medix's own fee schedule.

As such, the Claimant would fail in his burden of proof to establish the costs typically charged by a medical provider to perform an impairment rating in the local area where the examination was conducted. The Agency's findings that the fees were reasonable should be reversed.

CONCLUSION

Dr. Kennedy is not a physician retained by the Employer and its Insurance Carrier to trigger *Iowa Code* § 85.39, and the Claimant is not entitled to an examination under *Iowa Code* § 85.39. However, even if the Claimant could get an examination under *Iowa Code* § 85.39, the charges of Dr. Taylor are unreasonable and are not in line with the charges to perform an impairment rating. Further, the amount of the charges of Dr. Taylor would be unreasonable in this case. For the reasons set forth in this Reply Brief and the Appellants' Brief, the award of Dr. Taylor's fees should be reversed.

CERTIFICATE OF COMPLIANCE

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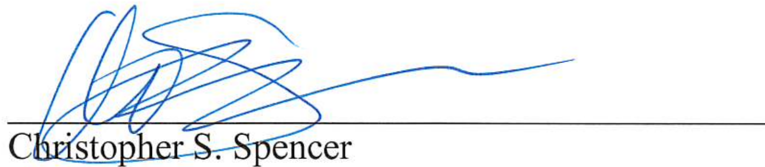

Christopher S. Spencer

6/17/23
Date

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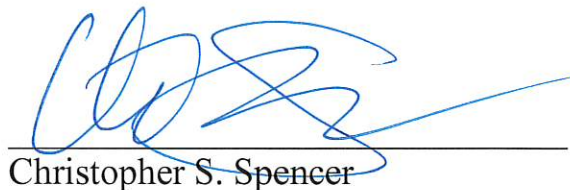
I, Christopher S. Spencer, member of the Bar of Iowa, hereby certify that on June 17, 2022, I or a person acting on my behalf served the above Petitioners-Appellants' Reply Brief to the Respondent-Appellee's attorneys of record, Zeke R. McCartney, via EDMS in full compliance with *Rules of Appellate Procedure and Rules of Civil Procedure.*



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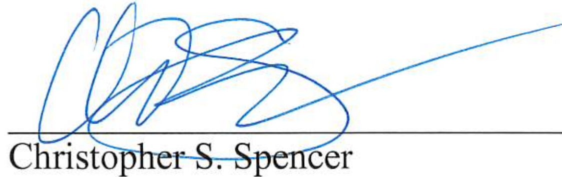
I, Christopher S. Spencer, hereby certify that I, or a person acting in my direction, did file the attached Petitioners-Appellants' Reply Brief upon the Clerk of the Iowa Supreme Court via EDMS on this 17th day of June, 2022.



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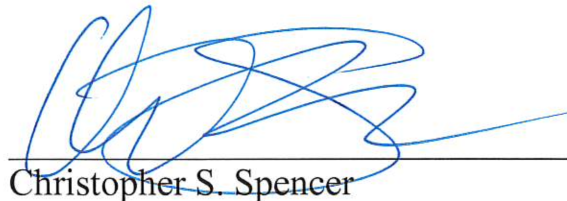
The undersigned attorney does hereby certify that the actual cost of producing the foregoing Petitioners-Appellants' Reply Brief was $0 because of service and filing via EDMS.



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