ALASKA WORKERS' COMPENSATION BOARD

P.O. Box 115512 **Juneau, Alaska 99811-5512**

JOSE W. ORELLANA, Employee, Claimant,	)	FINAL DECISION AND ORDER
v.	)	AWCB Case No. 201101306
INTERNATIONAL SEAFOODS OF ALASKA, Employer,	)	AWCB Decision No.14-0069
and	)	Filed with AWCB Anchorage, Alaska on May 23, 2014
SEABRIGHT INSURANCE. CO., Insurer, Defendants.	)	

Jose Orellana's November 23, 2011 and March 6, 2012 claims were heard on April 22, 2014 in Anchorage, Alaska. This hearing date was selected on January 14, 2014. Mr. Orellana (Employee) appeared, represented himself, and testified. Attorney Elise Rose appeared and represented International Seafoods of Alaska and Seabright Insurance Company (Employer). Witnesses included David Cooper and William Baer, M.D. Yolanda Martinez-Ley and Silvia Sarmiento served as interpreters. The record closed at the hearing's conclusion on April 22, 2014.

ISSUES

Employee contends he is entitled to past and future medical costs related to a detached retina in his left eye, his right thumb and hand, and post-traumatic stress disorder (PTSD), including related transportation, because the work injury was the substantial cause of those conditions.

Employer concedes Employee was injured at work, but contends the work injury is not the substantial cause of the conditions for which Employee seeks treatment.

1. Is the work injury the substantial cause of the conditions for which the Employee seeks medical benefits?

Employee contends he continues to be disabled from the work injury, and is entitled to temporary total disability (TTD) from October 28, 2011 until he becomes medically stable. Employer contends Employee has been medically stable since May 2011, and, therefore, is not entitled to additional TTD.

2. Is Employee entitled to additional TTD?

Employee contends he is entitled to greater permanent partial impairment (PPI) benefits than what he was paid. Employer contends it has paid PPI benefits according to the only impairment rating given to Employee.

3. Is Employee entitled to additional PPI benefits?

Employee contends the board should order another second independent medical evaluation (SIME) to address his left eye and right hand claims. Employer contends there is no medical dispute on those issues that would justify an SIME.

4. Should an SIME be ordered to address Employee's left eye and right hand?

FINDINGS OF FACT

The following findings of fact and factual conclusions are established by a preponderance of the evidence:

1. Employee was born and raised in El Salvador, but has lived in the United States for several years. His conversational English is excellent, but he requires interpreters for complex technical or medical information. (Employee, Observation).
2. On January 23, 2011, Employee was changing a split-rim forklift tire, when the tire exploded injuring his head, face, and right hand. (Claim, November 23, 2011).
3. Employee was taken to the emergency room at Providence Kodiak Island Medical Center (PKMC). Employee stated "he was knocked to the ground, but does not think he lost any

consciousness. For a few seconds, he 'couldn't see' as he had blood in his eyes but was able to feel his way to the door and by that time he could see out of both eyes . . . ." He was diagnosed with a laceration of the left eyelid involving the tear duct, a left ethmoid sinus fracture, a contusion of the right eye with a laceration of the right eyebrow, and a fracture of the metacarpal of the right thumb. His visual acuity was tested, both visual fields were intact, no vitreous bleeding was noted, and the retinal vessels of both eyes were examined. He was referred to Alan Wolf, M.D., for his hand, and was referred to an ophthalmologist in Anchorage. (PKMC, Emergency Room Note, January 23, 2011).

4. On January 24, 2011, Employee was seen by Robert Arnold, M.D., an ophthalmologist, in Anchorage. Dr. Arnold noted Employee was able to see with both eyes with full visual field and his retinas were normal. The laceration of the left eyelid was repaired surgically. Providence Alaska Medical Center, procedure note, January 24, 2011).
5. On January 26, 2011, after returning to Kodiak, Employee was seen by Dr. Wolf for his hand injury. Dr. Wolf determined the hand was too swollen for surgery at that point. (Wolf, Orthopaedic Clinic Note, January 26, 2011).
6. On February 1, 2011, Dr. Wolf performed an open reduction, internal fixation on Employee's right thumb. (PKMC, Operative Report, February 1, 2011).
7. On February 3, 2011, Employee was seen by John Shank, D.O., in Kodiak for a post-op examination of his eye. Employee reported blurred vision, but Dr. Shank noted he appeared to be healing well. (Shank, Examination Record, February 3, 2011).
8. On February 10, 2011, Employee reported to Dr. Shank that he was experiencing flashes of light at the periphery of his vision. Dr. Shank noted that Employee continued to heal well and warned Employee about retinal detachment. (Shank, Examination Record, February 10, 2011).
9. On February 16, 2011, Employee saw Elizabeth Roberts, M.D., to have the stitches from his eye surgery removed. Employee reported short-term memory difficulties. Dr. Roberts had concerns about post-concussive syndrome, and ordered a CT scan. (Kodiak Community Health Center, chart note, February 16, 2011).
10. On February 17, 2011 Employee returned to Dr. Shank. Employee again reported flashes of light as well as light sensitivity. (Shank, Examination Record, February 17, 2011).

11. On February 17, 2011, Dr. Shank released Employee to return to work. The release is dated February 17, 2010, exactly one year prior to Employee's visit with Dr. Shank. Employee contends the release is not relevant as it is dated prior to the work injury. There is no evidence that Employee had been seen Dr. Shank before the work injury. The work release was misdated; the correct date is February 17, 2011, the date Dr. Shank saw Employee. (Shank, Work Release, February 17, 2011; Observation).
12. On February 18, 2011, a CT scan of Employee's brain was normal. (PKMC, Radiology Report, February 18, 2011).
13. On February 28, 2011, Employee returned to Dr. Arnold. Dr. Arnold noted excellent results from the surgery although Employee reported occasional flashes and spots in his vision. He noted Employee had previous Lasik surgery, and after examination found Employee to have 20/20 vision in both eyes with some correction needed for astigmatism and some vitreous degeneration in Employee's left eye "no RD [retinal detachment] present now." (Arnold, chart note, February 28, 2011).
14. On March 16, 2011 Employee returned to Dr. Roberts with complaints of headache, short-term memory difficulties, and sleeping problems. Dr. Roberts noted her continued concern about post-concussive syndrome and referred Employee for neuropsychiatric testing. (Kodiak Community Health Center, chart note, March 16, 2011).
15. On March 24, 2011, Employee was again seen by Dr. Shank. Employee reported flashes of light as well as floaters in his left eye. Dr. Shank noted that retinal imaging showed a normal and fully attached retina. (Shank, Examination Record, March 24, 2011).
16. On March 31, 2011, Dr. Wolf removed the last pin and wire from Employee's right thumb. (Wolf, Orthopaedic Clinic Note, March 31, 2011).
17. On May 5, 2011, Employee was seen by Richard Fuller, Ph.D. for a neuropsychological evaluation. Employee reported to Dr. Fuller that he had lost consciousness for about 30 seconds after the injury, that he was unable to balance and fell three times trying to stand after the injury, and that he believed he died for a short period of time after the tire exploded. Employee reported daily headaches, fatigue, as well as memory and sensory problems. Most, if not all, of the testing done by Dr. Fuller was in English. Dr. Fuller diagnosed post-concussion syndrome and PTSD, but did not explain what criteria he used for the PTSD

diagnosis nor how those criteria were satisfied. Dr. Fuller recommended psychotherapy for the PTSD. (Fuller, Neuropsychological Evaluation, May 5, 2011).

18. On May 18, 2011, Employee's hand was x-rayed, and Dr. Wolf released him to work with a 30 to 40 pound lift restriction. Dr. Wolf anticipated Employee would reach maximum improvement within two months. He prescribed physical therapy twice a week for one month for Employee's hand. (Wolf, Orthopaedic Clinic Note, May 18, 2011).
19. On June 6, 2011, after one physical therapy session, Employee requested he be discharged. (PKMC, Hand Therapy Treatment Record, June 6, 2011).
20. On June 9, 2011, after reviewing Dr. Fuller's report, Dr. Roberts restricted Employee from working for three months to allow him to get good rest and counseling for the PTSD and post-concussive syndrome. (Kodiak Community Health Center, chart note, June 9, 2011).
21. Employee returned to Dr. Roberts on July 7, 2011. She extended Employee's work restriction until October 2011. (Kodiak Community Health Center, chart note, July 7, 2011).
22. On August 8, 2011, PA-C Tammy Holforty referred Employee to Welby Jensen, M.D., for his PTSD. (Kodiak Community Health Center, chart note, August 8, 2011).
23. On August 9, 2011, Employee returned to Dr. Shank. Dr. Shank again noted a normal and fully attached retina with no evidence of retinopathy. (Shank, Examination Record, August 9, 2011).
24. On August 19, 2011, Employee saw Dr. Jensen for his PTSD. Employee told Dr. Jensen that he became distressed around tires. Dr. Jensen did not find much improvement since the neuropsychological testing in May, but Employee was reticent about seeing a therapist or returning for a follow-up appointment. (Jensen, Psychiatric Evaluation, August 19, 2011).
25. On August 29, 2011, Employee was again seen by PA-C Holforty. He reported he had stopped taking all his medications because he did not like the way they made him feel. He also reported he had seen Dr. Jensen but did not take any of his advice. He wanted to "just stay home." (Kodiak Community Health Center, chart note, August 29, 2011).
26. Anthony Woodward, M.D., an orthopedic surgeon, performed an employer's medical evaluation (EME) of Employee's right thumb on September 21, 2011. The evaluation was conducted through a Spanish interpreter. Dr. Woodward diagnosed a healed fracture of the right thumb metacarpal. The substantial cause of the fracture was the January 23, 2011 work injury, but Employee was medically stable as of the May 18, 2011 x-ray, and there were no

restrictions on his work activities. Dr. Woodward noted Employee had lost some range of motion, and rated Employee with a two percent PPI. No further treatment was recommended. (Woodward, EME Report, September 21, 2011).

27. M. Sean Green, M.D., a neurologist, performed a neurological EME on September 21, 2011. Employee told Dr. Green that he had recently resumed taking his medications after about two weeks without them. Dr. Green reviewed Employee's medical records since the injury. Employee described a wide variety of bizarre neurologic symptoms for which there was no objective explanation, which Dr. Green found indicative of conversion disorder or malingering. Dr. Green stated Employee was not suffering from concussion or traumatic brain injury. He explained that the neurological symptoms of concussion or traumatic brain injury were most severe immediately after the injury and gradually improved, contrary to the progression of Employee's symptoms. He found no neurologic conditions, but stated that if there had been any neurologic consequences of the work injury, they were medically stable by mid-March 2011. (Green, EME Report, September 21, 2011).
28. David Glass, M.D., a psychiatrist, also saw Employee on September 21, 2011 for a psychiatric EME. Dr. Glass reviewed Employee's medical records since the work injury. His interview of Employee was conducted in Spanish through an interpreter. He noted that Employee's MMPI-2 (Minnesota Multiphasic Personality Inventory-2) results were "wildly abnormal," and indicative of malingering or symptom exaggeration. Dr. Glass stated Employee did not meet the DSM-IV criteria for PTSD, and points out that Dr. Fuller did not document the criteria for PTSD. Dr. Glass noted that one of the criteria for PTSD is a feeling of intense fear, helplessness, or horror at the time of the traumatic event, and there is no indication in the record he had such feelings at the time. A second criterion is intense psychological distress or reactivity on exposure to a cue for the traumatic event. Dr. Glass noted that Employee did not meet this criterion as he was able to return to work on his cars. Dr. Glass also opined that while Employee presented some aspects of other criteria, he did not believe Employee's symptomatology rose to a level to meet those criteria. Dr. Glass diagnosed conversion disorder, which is when a "patient's subjective physical complaints are not in keeping, or explained, on the basis of actual physical pathology, objective physical findings or known medical illness, or malingering, which is "the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external

incentives such as avoiding work . . . pursuing financial compensation . . . etc." He explained that neither disorder was caused or worsened by the work injury, but were due to constitutional, developmental, or psychosocial causes. (Glass, EME Report, September 21, 2011).

29. William Baer, M.D., an ophthalmologist, examined Employee for an EME on September 22, 2011. Dr. Baer stated the injury could have been the cause of the vitreous detachment, which in turn could have caused the flashes of light and floaters. Dr. Baer's examination showed a normal eye with no vitreous detachment or large floaters at the time. He explained that while the floaters were possibly the result of the work injury, they also occur spontaneously, are common, and are an annoyance, not a disability. He noted the surgery to repair the tear duct was well done with no residual dysfunction. (Baer, EME Report, September 22, 2011).
30. On October 7, 2011, Employer controverted TTD after October 7, 2011, and all further medical care based on the EME reports. (Controversion Notice, October 7, 2011).
31. On November 1, 2011, Employee was given another neuropsychological evaluation by Nan Truitt, Ph.D. Dr. Truitt noted Employee had been diagnosed with PTSD. While Dr. Truitt reviewed Dr. Fuller's previous neuropsychological evaluation, nothing in her report indicates she reviewed any other medical reports or the EME reports of Drs. Green and Glass. Dr. Truitt noted that in some instances Employee's test results were worse than the results of Dr. Fuller's testing. Dr. Truitt concluded Employee suffered from post-concussion syndrome, PTSD, cognitive disorder, and traumatic brain injury. (Truitt, Neuropsychological Evaluation, November 1, 2011).
32. On November 23, 2011, Employee filed a claim based on injuries to his head, face, and right hand seeking TTD, a compensation rate adjustment, medical and transportation costs, and attorney fees. (Claim, November 23, 2011).
33. At some point, Employee moved to Kennewick, Washington. He explained that about February or March, 2012, he began experiencing a "curtain" over part of the vision in his left eye. (Employee).
34. On March 6, 2012, Employee filed an amended claim that included PPI greater than two percent, a request for an SIME, and withdrawing his claim for a compensation rate adjustment. (Amended Claim, March 6, 2012).

35. On April 2, 2012, Dr. Glass reviewed Dr. Truitt's report. He questioned whether Dr. Truitt gave adequate consideration to the EME panel's concerns Employee was exaggerating his symptomatology. He reaffirmed the conclusions in his September report. (Glass, Supplemental EME Report, April 2, 2012).
36. On May 7, 2012, Employee was seen by Jonathan Crosier, M.D. Employee complained of headache and insomnia, and was referred to a neurologist. Dr. Crosier did not report any complaints of vision problems, other than bilateral vision loss as a symptom of Employee's headaches. Dr. Crosier's examination of the fundus of both eyes was normal. Employee reported no joint pain, stiffness, or muscle weakness. (Tri-Cities Community Health, Chart Note, May 7, 2012).
37. On June 6, 2012, Employee was seen by Sarabjit Atwal, M.D. a neurologist. Employee reported to Dr. Atwal that he had seen an ophthalmologist who told him there was nothing wrong with his left eye. Employee denied any joint pain, stiffness, or muscle weakness. Dr. Atwal determined Employee was likely experiencing migraine headaches as part of a post-concussion syndrome, but he could not rule out analgesic overuse as the cause. (Kadlec Health Systems, Notes Reports, June 6, 2012).
38. On July 25, 2012, Ronald Turco, M.D., performed a psychiatric SIME. Because Employee complained of spots and problems with his left visual field, Dr. Turco checked Employee's visual field and found no defects. Dr. Turco noted that while Employee has some symptoms of PTSD, he reports no intrusions or flashbacks. He diagnosed a mixture of conversion disorder, conscious manipulation, and possible malingering. When he talked to Employee about seeing a psychologist or psychiatrist, Employee responded that he didn't think that would be helpful. Dr. Turco opined that work was the substantial cause of Employee's conversion disorder, and while Employee was capable of returning to work, he would not be medically stable until he received psychological treatment. (Turco, SIME Report, July 25, 2012).
39. On September 7, 2012, Employee was examined by Lynn Orr, Ph.D., in connection with Employee's application for Social Security benefits. Dr. Orr diagnosed cognitive disorder, mood disorder, and anxiety, but not PTSD. (Orr, Psychological Evaluation, August 2, 2012).

40. On January 22, 2013, Employee was seen by Jared Holman, ARNP, at Tri-Cities Community Health clinic for eye problems and headache. Employee complained of blurred vision, pain, and left vision loss. (Tri-Cities Community Health, Chart Note, January 22, 2013).
41. On January 30, 2013, on referral from ARNP Holman, Employee saw Ali Zaide, M.D., an ophthalmologist. Dr. Zaide diagnosed a detached retina in Employee's left eye and recommended surgery. The retina was detached from the 7:00 position to the 12:30 position on the nasal side of the eye. (Zaide, New Patient Encounter Form, January 30, 2013).
42. On February 4, 2013, Dr. Zaide completed a Physician's Report form stating retinal detachment could be seen six to twelve months after trauma, but it was not possible to definitively determine Employee's work injury caused the detachment. (Zaide, Physician's Report, February 4, 2013).
43. On February 28, 2013, Employee was seen by Paamdeep Singh, M.D., Salman Porbandarwalla, M.D., and Gurunadh Vemulakonda, M.D., at Harborview Medical Center Ophthalmology Center in Seattle. (Harborview Medical Center, Clinic Note, February 28, 2013).
44. On March 6, 2013, Employee underwent scleral buckle procedure to repair the detached retina. (Operative Report, March 6, 2013)
45. On March 19, 2013, the retinal detachment recurred. The vitreous humor was removed, the retina was surgically reattached, and silicone oil was injected. (Operative Report, March 20, 2013).
46. On April 18, 2013, Dr. Porbandarwalla wrote that Employee's retinal detachment could be secondary to the work injury, but noted Employee did not present to a clinic for almost two years after the injury. (Porbandarwalla, letter, April 18, 2013).
47. On May 3, 2013, Dr. Baer reviewed additional medical record related to Employee's eye. He reiterated that he had specifically examined Employee's left eye during the September 22, 2011 EME, and found no evidence of retinal tears, breaks, or other pathology. He noted Employee's prior Lasik surgery for myopia, and explained that while Lasik surgery corrects the vision, it does not reduce other risks of myopia, one of which is retinal detachment. He further explained that the greater the degree of myopia the greater the risk of retinal tears or detachment. He noted Employee was substantially myopic before the Lasik surgery. He

opined Employee's retinal detachment was due to his myopia, not the work injury. (Baer, Supplemental EME Report, May 3, 2013).

48. In May 2013, Employer sent Dr. Porbandarwalla a copy of Dr. Baer's EME report together with written questions. Dr. Porbandarwalla deferred to Dr. Baer's findings regarding the detached retina and stated the employment was not the substantial cause of Employee's current condition. (Employer May 8, 2013 letter with Dr. Porbandarwalla's response).
49. On June 17, 2013, Employee returned to Dr. Wolf complaining of right thumb tenderness and wrist pain. An x-ray revealed some mild irregularity at the base of the metacarpal. Dr. Wolf diagnosed right thumb traumatic CMC [carpometacarpal] joint arthritis. (Wolf, chart note, June 17, 2013).
50. On July 17, 2013 Dr. Wolf responded to written questions from Employee. Dr. Wolf stated the work injury was the substantial cause of Employee current condition and he was not released to return to work. The only further medical treatment indicated was "reevaluation." (Wolf, responses to Employee questions, July 17, 2013).
51. On August 7, 2013 the silicone oil was removed from Employee's eye. (Porbandarwalla, Progress Note, August 8, 2013).
52. On February 11, 2014, Dr. Arnold responded to written questions from Employee. Dr. Arnold "kind of" agreed that impact could cause a later retinal detachment. In response to Employee's question as to whether a "vitreous traction" could remain undiagnosed for seven months, Dr. Arnold stated that a large retinal detachment should not be missed with a deliberate retinal examination. (Arnold, responses to Employee questions, February 11, 2014).
53. Employee testified he complained to his doctors about the "curtain" in his vision beginning in February or March 2012, but no one was able to diagnose the problem as a detached retina until Dr. Zaidi in January 2013. He argued that because the vitreous detachment and the retinal detachment were in the same area of his eye they must be related. He stated his hand has been painful and weak since the injury, but he had not sought treatment as it was not as important to him as his eye and the PTSD. He worked for a while in 2012 at an auto dealership in Washington. (Employee).
54. David Cooper, a safety coordinator for Employer, knew Employee prior to the work injury, and visited him several times after the accident. In the weeks after the injury, he saw

Employee working on several vehicles in the driveway of his home. He had asked Employee to help with light renovation work at his home, and Employee did so. Employee was initially anxious to return to work, but Employee began to talk more about moving to Washington. (Cooper).

55. Dr. Baer stated he did not see any retinal detachment when he examined Employee in September 2011. He pointed out that while one doctor might miss the retinal detachment, Employee had been seen by several doctors in 2011 and 2012, and it was highly improbable that they would all have missed the problem if it existed. He acknowledged trauma could cause retinal detachment, but considered Dr. Zaidi's statement that retinal detachment could occur six to twelve month period after trauma to be very generous. He explained that there was no causal connection between Employee's 2011 vitreous detachment and his later retinal detachment in the same area, except that both were risks of myopia. He further explained that based on the medical reports from Employee's retinal attachment surgery, his myopia was significant and was the cause of the retinal detachment.
56. On May 5, 2014 after the hearing, Employer filed an additional medical record. Because the record had closed at the conclusion of the hearing, the additional medical record was not considered.

PRINCIPLES OF LAW

> **AS 23.30.001. Intent of the legislature and construction of chapter.** It is the intent of the legislature that
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> (1) this chapter be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter;
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> (2) workers' compensation cases shall be decided on their merits except where otherwise provided by statute;
> . . .
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> (4) hearings in workers' compensation cases shall be impartial and fair to all parties and that all parties shall be afforded due process and an opportunity to be heard and for their arguments and evidence to be fairly considered.

The board may base its decision not only on direct testimony, medical findings, and other tangible evidence, but also on the board's "experience, judgment, observations, unique or

peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987).

> **AS 23.30.010. Coverage.**
> (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.
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> **AS 23.30.095. Medical examinations.**
> (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. . . .
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> (k) In the event of a medical dispute regarding determinations of causation, medical stability, ability to enter a reemployment plan, degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's independent medical evaluation, the board may require that a second independent medical evaluation be conducted by a physician or physicians selected by the board from a list established and maintained by the board. The cost of an examination and medical report shall be paid by the employer. The report of an independent medical examiner shall be furnished to the board and to the parties within 14 days after the examination is concluded. . .
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> **AS 23.30.110 Procedure on claims.**
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> (g). An injured employee claiming or entitled to compensation shall submit to the physical examination by a duly qualified physician which the board may require.

The Alaska Workers' Compensation Appeals Commission (AWCAC) in *Bah v. Trident Seafoods Corp.*, AWCAC Decision No. 073 (February 27, 2008) addressed the board's authority to order an SIME under AS 23.30.095(k) and AS 23.30.110(g). With regard to AS 23.30.095(k), the AWCAC confirmed "[t]he statute clearly conditions the employee's right to an SIME . . . upon the existence of a medical dispute between the physicians for the employee and the employer." *Id.* Under AS 23.30.110(g), the board has discretion to order an SIME when there is a significant gap in the medical evidence or a lack of understanding of the medical or scientific evidence prevents the board from ascertaining the rights of the parties and an opinion would help the board. *Id.* at 5.

The AWCAC further stated, before ordering an SIME, it is necessary to find the medical dispute is significant or relevant to a pending claim or petition and the SIME would assist the board in resolving the dispute. *Id.* at 4. Under either AS 23.30.095(k) or AS 23.03.110(g), the purpose for ordering an SIME is to assist the board. It is not intended to give employees an additional medical opinion at the expense of employers when employees disagree with their own physician's opinion. *Id.*

> **AS 23.30.120 Presumptions.**
> (a) In a proceeding for the enforcement of a claim for compensation under this chapter it is presumed, in the absence of substantial evidence to the contrary, that
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> (1) the claim comes within the provisions of this chapter; . . . .

Under AS 23.30.120(a)(1), benefits sought by an injured worker are presumed to be compensable. *Meek v. Unocal Corp.*, 914 P.2d 1276, 1279 (Alaska 1996). The presumption of compensability is applicable to any claim for compensation under the workers' compensation statute, including medical benefits. *Carter,* 818 P.2d at 665; *Meek*, 914 P.2d at 1279; *Moretz v. O'Neill Investigations*, 783 P.2d 764, 766 (Alaska 1989); *Olson v. AIC/Martin J.V.*, 818 P.2d 669, 675 (Alaska 1991).

Application of the presumption involves a three-step analysis. To attach the presumption of compensability, an employee must first establish a "preliminary link" between his or her injury and the employment. *See, e.g., Tolbert v. Alascom, Inc.*, 973 P.2d 603, 610 (Alaska 1999). Medical evidence may be needed to attach the presumption of compensability in a complex

medical case. *Burgess Constr. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). However, an employee "need not present substantial evidence that his or her employment was a substantial cause of his disability." *Fox v. Alascom, Inc.*, 718 P.2d 977, 984 (Alaska 1986) "In making the preliminary link determination, the Board may not concern itself with the witnesses' credibility." *Excursion Inlet Packing Co. v. Ugale*, 92 P.3d 413, 417 (Alaska 2004).

If the employee establishes the preliminary link, then the employer can rebut the presumption by presenting substantial evidence that demonstrates that a cause other than employment played a greater role in causing the disability or need for medical treatment or by substantial evidence that employment was not the substantial cause. *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 (Mar. 25, 2011) at 7); *Atwater Burns Inc. v. Huit*, AWCAS Decision No. 191 (March 18, 2014). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Fireman's Fund Am. Ins. Companies v. Gomes*, 544 P.2d 1013, 1015 (Alaska 1976). The determination of whether evidence rises to the level of substantial is a legal question. *Id.* Because the employer's evidence is considered by itself and not weighed at this step, credibility is not examined at this point. *Veco, Inc. v. Wolfer*, 693 P.2d 865, 869-870 (Alaska 1985).

If the presumption is raised and not rebutted, the claimant need produce no further evidence and prevails solely on the raised but un-rebutted presumption. *Williams v. State*, 938 P.2d 1065 (Alaska 1997). "If the employer rebuts the presumption, it drops out, and the employee must prove, by a preponderance of the evidence, that in relation to other causes, employment was the substantial cause of the disability, need for medical treatment, etc. Should the employee meet this burden, compensation or benefits are payable." *Runstrom* at 8.

> **AS 23.30.155. Payment of compensation**
> (a) Compensation under this chapter shall be paid periodically, promptly, and directly to the person entitled to it, without an award, except where liability to pay compensation is controverted by the employer. To controvert a claim, the employer must file a notice, on a form prescribed by the director . . . .

> **AS 23.30.185. Compensation for temporary total disability.**

> In case of disability total in character but temporary in quality, 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the disability. Temporary total disability benefits may not be paid for any period of disability occurring after the date of medical stability.
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> **AS 23.30.190. Compensation for permanent partial impairment; rating guides.**
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> (a) In case of impairment partial in character but permanent in quality, and not resulting in permanent total disability, the compensation is $177,000 multiplied by the employee's percentage of permanent impairment of the whole person. The percentage of permanent impairment of the whole person is the percentage of impairment to the particular body part, system, or function converted to the percentage of impairment to the whole person as provided under (b) of this section. The compensation is payable in a single lump sum, except as otherwise provided in AS 23.30.041, but the compensation may not be discounted for any present value considerations.
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> (b) All determinations of the existence and degree of permanent impairment shall be made strictly and solely under the whole person determination as set out in the American Medical Association Guides to the Evaluation of Permanent Impairment, except that an impairment rating may not be rounded to the next five percent. The board shall adopt a supplementary recognized schedule for injuries that cannot be rated by use of the American Medical Association Guides.

The Alaska Workers' Compensation Appeals Commission (AWCAC) held AS 23.30.190 does not “allow” an employee to obtain a PPI rating, but requires the claimant to “obtain a rating” if he wants a PPI award and is dissatisfied with the employer's doctor's rating. *Stonebridge Hospitality v. Settje*, AWCAC Decision No. 153 (June 14, 2011).

ANALYSIS

1. Is the work injury the substantial cause of the conditions for which the Employee seeks medical benefits?

This is a factual question to which the presumption of compensability applies. Employee contends the work injury was the substantial cause of three conditions: his detached retina, his thumb and hand injury, and his PTSD or related psychological condition. Each condition will be examined in turn.

a. Employee's detached retina:

Employee needed only "some," or "minimal," relevant evidence to raise the presumption. In determining whether the presumption is met, credibility is not considered nor is the evidence weighed against competing evidence. Both Dr. Zaide's February 4, 2013, Physician's Report and Dr. Porbandarwalla's April 18, 2013 letter stating Employee's retinal detachment could be secondary to the work injury are sufficient to raise the presumption.

To rebut the presumption, Employer was required to present substantial evidence demonstrating that employment was not the substantial cause or that a cause other than employment played a greater role in causing Employee's disability and need for medical treatment. Again, credibility is not considered nor is the evidence weighed against competing evidence at this step. Employer successfully rebutted the presumption through Dr. Baer's reports and testimony. Because Employer rebutted the presumption, Employee must prove by a preponderance of the evidence that the work injury was the substantial cause of his retinal detachment.

To the extent Employee contends the detached retina occurred at the time of injury, but was not noticed or was undiagnosed, his argument is not persuasive. According to the medical records, between the injury and the diagnosis of the detached retina on January 30, 2013, Employee's retinas were examined eight times. It is not conceivable that qualified doctors would have missed a significant detached retina eight times. Employee's detached retina did not occur at the time of his work injury.

Employee's testimony that he first began experiencing a loss of vision, or "curtain" in his left eye in February or March 2012 is given little weight. The first mention in the medical records of a visual problem other than floaters or flashes in his left eye is Employee's complaint of a visual field defect to Dr. Turco at the SIME in July 2012, although Dr. Turco found his visual fields to be normal at that time. Although Employee included bilateral vision loss as a symptom of his headaches when he saw Dr. Crosier in May 2012, a retinal detachment in his left eye would not cause loss of vision in both eyes. Nothing in the medical records suggests the retinal detachment occurred before July 2012 at the earliest – well beyond the six to twelve month window given by Dr. Zaidi.

Employee pointed out that the retinal detachment occurred in the same area of the eye as his earlier vitreous detachment, suggesting a causal link between the two. No doctor has stated that a vitreous detachment can cause a later retinal detachment. Dr. Baer explained that, despite the timing, there was no causal connection to the injury; both conditions were due to employee's preexisting myopia. Dr. Baer is persuasive; even if the vitreous detachment was caused by the work injury, there is no causal link between the vitreous detachment and Employee's later retinal detachment.

Because neither Dr. Zaidi nor Dr. Porbandarwalla were aware of Employee's earlier ophthalmologic examinations when they stated the work injury could have cause the retinal detachment, those opinions are given less weight. Additionally, Dr. Zaidi stated it was not possible to determine that the work injury cause the detachment. And while Dr. Porbandarwalla initially stated the retinal detachment could be caused by the work injury, after reviewing Dr. Baer's report, he deferred to Dr. Baer's conclusion that the work injury was not the substantial cause of the detached retina.

Dr. Baer's report and testimony were the most probative and are given the most weight. He explained there was evidence Employee had significant myopia prior to the Lasik surgery. Myopia is caused by an elongated eyeball. While the Lasik surgery corrected Employee's vision, it did not change the shape of Employee's eyeball, and, as a result, Employee remained at risk for complications of myopia. Both vitreous detachment and retinal detachment are risks of myopia, and the worse the myopia, the greater the risk. Employee has not shown by a preponderance of the evidence that work was the substantial cause of his detached retina.

b. Employee's brain/psychological injury:

To raise the presumption as to psychological injury, Employee needed only "some," or "minimal," relevant evidence. Credibility is not considered nor is the evidence weighed against competing evidence. Dr. Fuller's May 5, 2011 report diagnosing Employee with post-concussive syndrome and PTSD as a result of the injury raises the presumption.

To rebut the presumption, Employer needed to present substantial evidence demonstrating that employment was not the substantial cause or that a cause other than employment played a greater role in causing the need for medical treatment for Employee's brain or psychological condition. Again, credibility is not considered nor is the evidence weighed against competing evidence at this step. Employer successfully rebutted the presumption through the reports of Dr. Green, Dr. Glass, and Dr. Turco. Because Employer rebutted the presumption, Employee must prove by a preponderance of the evidence that the work injury was the substantial cause of his current need for medical treatment for his brain or psychological injury.

Little weight is given to Dr. Fuller's opinion. There is no evidence he relied on anything other than Employee's statements in making his diagnosis. For example, Dr. Fuller apparently accepted Employee's statement he had lost consciousness, had balance problems, and had "died," even though that was contrary to what he reported the day of the injury. Additionally, although Dr. Fuller performed diagnostic testing, his diagnoses are conclusory; he does not address how or why he believes Employee met the criteria for the various diagnoses.

Likewise, little weight is given to Dr. Jensen's report. He appears to have relied on Employee's statement that being around tires caused distress, even though that is inconsistent with Employee's work on cars shortly after his injury. There is no evidence Dr. Jensen reviewed any medical records other than Dr. Fuller's report. He does not report conducting any diagnostic testing, but appears to have accepted Dr. Fuller's diagnoses. He does not explain why or how Employee met the diagnostic criteria for PTSD.

Little weight is also given to Dr. Truitt's report. She also appears to have relied on Dr. Fuller's diagnoses, failed to review Employee's medical records, and she does not address the diagnostic criteria for her diagnoses.

More weight is given to Dr. Green and Dr. Glass, both of whom reviewed Employee's relevant medical records since the work injury. Dr. Green noted Employee had "bizarre" neurological symptoms without any objective explanation which was indicative of conversion disorder or malingering. Particularly persuasive is that he pointed out that the neurological symptoms of

concussion or traumatic brain injury are most severe immediately after the injury and gradually improve, contrary to Employee's history where the symptoms increased with time.

Dr. Glass's interview was conducted in Spanish through an interpreter, and as a result his conclusions are likely more reliable. Dr. Glass notes Employee's description of the injury is "rather dramatic," and points out the discrepancy between Employee's later descriptions of the injury and that given in the emergency room. Dr. Glass points out that Dr. Fuller did not document the criteria for PTSD. Dr. Glass noted that one of the criteria for PTSD is a feeling of intense fear, helplessness, or horror at the time of the traumatic event, and there is no indication in the record he had such feelings at the time. A second criterion is intense psychological distress or reactivity on exposure to a cue for the traumatic event. Dr. Glass points out that Employee does not meet this criterion as he was able to return to work on his car. Dr. Glass also opined that while Employee presented some aspects of other criteria, he did not believe Employee's symptomatology rose to a level to meet the criteria. He stated that Employee's MMPI-2 (Minnesota Multiphasic Personality Inventory-2) results showed that Employee was emphasizing his distress and symptoms. He diagnosed Employee with conversion disorder, malingering, or a combination of both. He explained that neither disorder was caused or worsened by the work injury, but were due to constitutional, developmental, or psychosocial causes.

Dr. Turco's opinion is also given significant weight. He also reviewed Employee's medical records after the work injury. He too noted a mixture of conversion elements, conscious manipulation and possible malingering as well as bizarre neurological symptoms inconsistent with a specific organic problem. He diagnosed Employee with conversion disorder and possible malingering. Dr. Turco disagreed with Dr. Glass and stated the work injury would be the substantial cause of the conversion disorder, but agreed it would not be the substantial cause of malingering. Treatment for conversion disorder would consist of psychological or psychiatric counselling, but Employee has rejected that approach on at least two occasions stating it would not be helpful.

Some weight is also given to Dr. Orr's opinions. While Dr. Orr had at least some of Employee's medical records since the work injury, it does not appear she had either of the neuropsychiatric evaluations or the psychiatric reports. She noted Employee's responses raised concerns of malingering. Most importantly, despite being aware of the work injury and Employee's subsequent complaints, Dr. Orr did not diagnose PTSD.

The preponderance of the evidence is that Employee does not have post-concussive syndrome or PTSD. The one diagnosis that Drs. Green, Glass, Turco, and Orr agreed on is malingering, which is unrelated to the work injury. Employee has not shown by the preponderance of the evidence that the work injury was the substantial cause of his need for treatment of a brain or psychiatric condition.

c. *Employee's hand injury:*

To raise the presumption as to his hand injury, Employee needed only "some," or "minimal," relevant evidence, and credibility is not considered nor is the evidence weighed against competing evidence. Dr. Wolf's June 17, 2013 diagnosis of traumatic CMC joint arthritis and his July 17, 2013 statement that it was due to Employee's 2011 work injury are sufficient to raise the presumption.

To rebut the presumption, Employer needed to present substantial evidence demonstrating that employment was not the substantial cause or that a cause other than employment played a greater role in causing the need for medical treatment for Employee's hand. Again, credibility is not considered nor is the evidence weighed against competing evidence at this step. Employer successfully rebutted the presumption through Dr. Woodward's report stating Employee's fracture had healed, he was medically stable, and needed no further treatment. Because Employer rebutted the presumption, Employee must prove by a preponderance of the evidence that the work injury was the substantial cause of his current need for medical treatment for his wrist.

Employee was released to work by Dr. Wolf on May 18, 2011. He terminated the physical therapy for his hand on June 6, 2011 after one session. From that date until he saw Dr. Wolf on

June 17, 2013, the medical records do not show that he complained even once of hand or wrist pain to a medical provider. To the contrary, on at least two occasions the providers documented that there was no reported joint pain, stiffness, or muscle weakness. Given Employee's lack of complaints for over two years and the fact that the May 18, 2013 x-ray showed only mild irregularity, Dr. Wolf's diagnosis of traumatic arthritis in Employee's thumb serious enough to completely preclude him from work is problematic. It appears Dr. Wolf's diagnosis is based more on Employee's complaints than the physical evidence. Symptom magnification is a characteristic of malingering. Given the likelihood Employee magnified his symptoms, Dr. Wolf's diagnosis is given no weight. Employee has not proved by a preponderance of the evidence that work was the substantial cause of the need for medical treatment for his current hand condition.

2. Is Employee entitled to additional TTD?

Employee contends he is due TTD for periods after October 7, 2011, the date he was last paid TTD benefits. To establish his eligibility for further TTD, Employee must show that he was disabled due to the work injury and not medically stable. These are factual questions to which the presumption of compensability applies.

To raise the presumption he is entitled to additional TTD, Employee needed only "some," or "minimal," relevant evidence. Credibility is not considered nor is the evidence weighed against competing evidence. Dr. Wolf's July 17, 2013 work restriction raises the presumption.

To rebut the presumption, Employer needed to present substantial evidence demonstrating that employment was not the substantial cause of Employee's disability. Again, credibility is not considered nor is the evidence weighed against competing evidence at this step. Employer successfully rebutted the presumption through the reports of Dr. Glass, Dr. Green, who both stated that Employee was psychiatrically or neurologically medically stable or could return to work on September 21, 2011, by Dr. Woodward's opinion that in regard to Employee's hand injury he could return to work on September 21, 2011, and by Dr. Baer's opinion that Employee's eye was medically stable and he could return to work as of September 22, 2013.

Because Employer rebutted the presumption, Employee was required to prove by a preponderance of the evidence that he was temporarily disabled after October 7, 2011 because of the work injury. He did not do so. As previously noted, Dr. Wolf's July 17, 2013 work restriction is not credible, and it is given no weight. The last work restriction in the records prior to Dr. Wolf's July 2013 restriction is Dr. Robert's July 7, 2011 three month restriction based on the diagnoses of PTSD and post-concussive syndrome. And, as also noted above, the preponderance of the evidence is that Employee does not have post-concussive syndrome or PTSD. Much more weight is given to the EME doctors, Dr. Green, Dr. Glass, Dr. Woodward, and Dr. Baer, all of whom found Employee medically stable and able to return to work by September 22, 2011. Employee's claim for additional TTD will be denied.

3. Is Employee entitled to additional PPI benefits?

Employee acknowledges he was paid for the two percent PPI based on Dr. Woodward's rating. He further acknowledged that he had no other rating. Consequently, under *Settje*, he cannot raise the presumption he is entitled to a higher rating. His claim for additional PPI benefits will be denied.

4. Should an SIME be ordered to address Employee's left eye and right hand?

Employee contends the board should order an SIME under AS 23.30.095(k), because medical disputes exist between his doctor and Employer's doctor as to causation and treatment. Employer contends any dispute between its doctor and Employee's attending physician is not significant and an SIME is unnecessary.

As the commission noted in *Bah*, there are three requirements before an SIME can be ordered under AS 23.30.095(k). First, there must be a medical dispute between Employee's attending physician and an EME. Second, the dispute must be significant. Third, an SIME physician's opinion would assist in resolving the dispute.

There is no significant medical dispute as to whether employment was the substantial cause of Employee's retinal detachment. Although Drs. Zaidi and Porbandarwalla stated an injury could have caused Employee's retinal detachment, neither was aware of Employee's earlier

ophthalmologic examinations at the time. Dr. Zaidi stated it was not possible to determine that the work injury cause the detachment. And after reviewing Dr. Baer's report, Dr. Porbandarwalla deferred to Dr. Baer. There is no substantial medical dispute as to the causation of Employee's retinal detachment.

Dr. Wolf's June 17 chart note and July 17, 2013 work restriction might be seen as creating a medical dispute regarding Employee's hand and wrist. Because Dr. Wolf's report is not credible and was given no weight, the dispute is not significant, and an SIME physician's opinion would not assist in resolving the dispute. Employee's request for an SIME will be denied.

CONCLUSIONS OF LAW

1. The work injury is not the substantial cause of the conditions for which Employee seeks medical benefits.
2. Employee is not entitled to additional TTD.
3. Employee is not entitled to additional PPI benefits.
4. An SIME will not be ordered to address Employee's left eye and right hand.

ORDER

1. Employee's November 23, 2011 and March 6, 2013 claims are denied.

Dated in Anchorage, Alaska on May 23, 2014.

ALASKA WORKERS' COMPENSATION BOARD

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Ronald P. Ringel, Designated Chair

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Ronald Nalikak, Member

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Stacy Allen, Member

APPEAL PROCEDURES

This compensation order is a final decision. It becomes effective when filed in the office of the board unless proceedings to appeal it are instituted. Effective November 7, 2005 proceedings to appeal must be instituted in the Alaska Workers' Compensation Appeals Commission within 30 days of the filing of this decision and be brought by a party in interest against the boards and all other parties to the proceedings before the board. If a request for reconsideration of this final decision is timely filed with the board, any proceedings to appeal must be instituted within 30 days after the reconsideration decision is mailed to the parties or within 30 days after the date the reconsideration request is considered denied due to the absence of any action on the reconsideration request, whichever is earlier. AS 23.30.127.

An appeal may be initiated by filing with the office of the Appeals Commission: 1) a signed notice of appeal specifying the board order appealed from and 2) a statement of the grounds upon which the appeal is taken. A cross-appeal may be initiated by filing with the office of the Appeals Commission a signed notice of cross-appeal within 30 days after the board decision is filed or within 15 days after service of a notice of appeal, whichever is later. The notice of cross-appeal shall specify the board order appealed from and the ground upon which the cross-appeal is taken. AS 23.30.128.

RECONSIDERATION

A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accord with 8 AAC 45.050. The petition requesting reconsideration must be filed with the board within 15 days after delivery or mailing of this decision.

MODIFICATION

Within one year after the rejection of a claim, or within one year after the last payment of benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, a party may ask the board to modify this decision under AS 23.30.130 by filing a petition in accord with 8 AAC 45.150 and 8 AAC 45.050.

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of JOSE W. ORELLANA, employee / claimant; v. INTERNATIONAL SEAFOODS OF ALASKA, employer; SEABRIGHT INSURANCE CO., insurer / defendants; Case No. 201101306; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on May 23, 2014.

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Pamela Murray, Office Assistant