ALASKA WORKERS' COMPENSATION BOARD

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

GARY R. DAVIS, Employee, Claimant, v. WRANGELL FOREST PRODUCTS, Employer, and WAUSAU UNDERWRITERS INSURANCE COMPANY, Insurer, Defendants.	)	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 198803834 AWCB Decision No. 17-0049 Filed with AWCB Juneau, Alaska on May 2, 2017

Gary Davis's (Employee) January 30, 2017 petition for a second independent medical evaluation (SIME) was heard in Juneau, Alaska on April 18, 2017, a date selected on March 1, 2017. Employee appeared telephonically, represented himself and testified. Attorney Martha Tansik appeared and represented Wrangell Forest Products and Wausau Underwriters Insurance Company (Employer). The record closed at the hearing's conclusion on April 18, 2017.

ISSUE

Employee contends another SIME with a neurosurgeon is necessary to address his left knee injury because there is a dispute between his physician and Employer's physician regarding the cause of his left knee injury and the first SIME physician seems to support both physicians' opinions. Employee also contends a SIME by a neurosurgeon will provide more evidence the

March 1988 work injury damaged the nerves in his back, which will assist in determining whether the nerve damage caused his left knee injury. Employee contends the work injury to his back caused him to sustain an injury to his left knee and the orthopedist who conducted the first SIME did not understand the cause of his left knee injury. Employee requests his petition for a SIME with a neurosurgeon be granted.

Employer contends there is no basis for another SIME with a neurosurgeon. Employer contends another SIME will not assist in resolving the dispute regarding the compensability and causation of Employee's left knee injury and need for medical treatment and there was no gap in the medical evidence. Employer contends Employee is requesting a SIME because he did not like the first SIME physician's opinion. Employer contends the first SIME physician stated a referral to a neurosurgeon is inappropriate and another SIME would be costly and inefficient. Employer requests Employee's petition for a SIME with a neurosurgeon be denied.

Shall Employee's petition for a SIME with a neurosurgeon be granted?

FINDINGS OF FACT

The following facts are reiterated from *Gary R. Davis and Wrangell Forest Products v. C&R Logging Company*, AWCB Decision No. 89-0064 (March 9, 1989) (*Davis I*), are undisputed or are established by a preponderance of the evidence:

1) On January 21, 1987, Employee injured his back when a log rolled on him while employed with C&R Logging Company. (*Id.*).

2) On March 9, 1988, Employee reported he injured his back again carrying coils of haywire while employed with Employer. (*Id.*).

3) On May 5, 1988, John Gibson, M.D., performed an L3-4 micro discectomy. He noted the following operative findings, "There were epidural adhesions present binding down the nerve root. In addition, there was a bulging disc." (*Id.*).

4) On December 26 and 28, 1988, David Samani, M.D., evaluated Employee's right knee. Employee reported he injured his right knee on December 25, 1988, when walking, he slipped on ice, and his left knee gave out causing him to twist his right knee. Dr. Samani diagnosed a right

medial meniscal tear and recommended a diagnostic arthroscopy. (Dr. Samani, Progress Report, December 26, 1988).

5) On January 11, 1989, Joseph Shields, M.D., recommended arthroscopic knee surgery and opined Employee's "back and subsequent nerve difficulties with his left leg caused his left leg to give way and that is the direct cause of the fall and the injury to Employee's right knee." He opined Employee's right knee difficulties are attributable to the March 1988 work injury. (Dr. Shields, January 11, 1989).

6) On January 12, 1989, Employee underwent right knee trochlea debridement and arthroscopic partial medial meniscectomy. Dr. Shields diagnosed a medial meniscus tear with minimal fraying of the anterior cruciate ligament and traumatic chondromalacia of the trochlear side of the patella-femoral joint. (Dr. Shields, Operative Report, January 12, 1989).

7) On June 6, 1989, Employee had back surgery. Hamid Mehdizadeh, M.D., performed a bilateral laminectomy at L3-L4 levels with cauda equine decompression of the and exploration of the L3-L4 nerve root bilaterally, a laminectomy at L4-L5, a left sided discectomy at L3-L4 with decompression of the L3-L4 nerve root on the left side, a posterior interbody fusion of L3-L4 using a cadaver back bone, and placed Harrington rods between L3-L4 with a cross link between the Harringtons rods. Dr. Mehdizadeh also performed a posterior and anterior and posterolateral fusion at the L3-L4 levels. (Dr. Mehdizadeh, Operative Report, June 6, 1989).

8) On December 3, 1990, a compromise and release (C&R) settlement agreement was approved. It settled indemnity benefits for Employee's March 3, 1988 work injury; medical benefits remained open. (C&R Settlement Agreement, December 3, 1990).

9) On December 12, 2012, Brent Adcox, M.D., an orthopedic spine surgeon, examined Employee's left knee and ordered an MRI. Dr. Adox noted:

> [Employee] has a history of left knee pain for quite some time. He has a little genu varum in that knee with a history of some torn cartilage in that knee and surgical treatment of that. The knee hurts when he is walking on unsteady ground. It feels like it catches.

Dr. Adcox opined the medial aspect of the knee of Employee's knee had some early degenerative change, secondary to his previous meniscectomy. (Dr. Adcox, Chart Note, December 12, 2012).

10) On December 12, 2012, an x-ray of Employee's left knee showed significant medial compartment narrowing with subchondral sclerosis consistent with degenerative osteoarthritis. (William S. Roberts, M.D., X-Ray Report, December 12, 2012).

11) On December 12, 2012, Employee's left knee posteromedial meniscus demonstrates demonstrated an absent free edge consistent with a vertical tear or bucket-handle-type tear, possible small displaced meniscal fragments in the medial compartment, focal loss of articular cartilage on the medial femoral condyle with corresponding subcondylar edema in the femoral condyle, a small Baker's cyst, and small joint effusion. (Dr. Roberts, MRI Report, December 12, 2012).

12) On January 3, 2013, Dr. Adcox diagnosed Employee with a left medial meniscus tear and left medial femoral condyle chondromalacia and recommended left arthroscopic knee surgery for a partial medial meniscectomy. Dr. Adcox noted Employee "had no specific injury" to his left knee. (Dr. Adcox, Chart Note, January 3, 2013).

13) On January 22, 2013, Employee had left knee surgery, which included a partial medial meniscectomy and subchondral medial femoral condyle drilling. Employee had been suffering with knee pain for "quite some time" and had a "history of a previous medial meniscectomy that did well." (Dr. Adcox, Operative Report, January 22, 2013).

14) On May 6, 2013, Dr. Adcox stated Employee "is better than he was prior to surgery but he still has some startup pain. This is all related to his osteoarthritis he has in his knee." He noted Employee "understands his preexisting osteoarthritis is the likely underlying source of all of his pain, as it is startup pain and it gets better with time." (Dr. Adcox, May 6, 2013).

15) On May 29, 2013, Michael R. Fraser, Jr., M.D., an orthopedist, performed an Employer Medical Evaluation (EME). Dr. Fraser stated Employee reported he injured his left knee in December 2012, while walking on a treadmill when Employee got a shooting pain down the right leg which caused Employee to stumble and twist his left knee on the treadmill. Dr. Fraser diagnosed Employee with left knee osteoarthritis with varus gonarthrosis. He opined Employee's left knee condition is unrelated to the March 1988 work injury and the March 1988 work injury is not the substantial factor for the left knee arthritis and need for treatment. He stated the substantial cause of arthritis in Employee's left knee is Employee's weight, activity level and genetic disposition. (Dr. Fraser, EME Report, May 29, 2013).

16) On October 27, 2014, Employee visited Dr. Adcox to discuss if work was a substantial factor in the need for medical treatment for his left knee. Dr. Adcox noted:

> [Employee] had a note from [Employer] regarding his request for my opinion on the left knee and its[sic] relevance to a work-related low back injury and a right knee injury that occurred back in 1988. [I had an] in-depth conversation with [Employee] [about] his history of intermittent radicular pain stemming from his low back injury. He was on a treadmill when he had radicular pain emanating from his lumbar spine, which caused him to wince, have a misstep onto the rail twisting the knee with a subsequent injury; therefore, I believe as this individual's treating physician to a reasonable degree of medical certainty that his left knee injury is related in consequence to his lumbar spine injury from 03/09/88 as the cause of the twisting to his left knee.

Dr. Adcox diagnosed a left knee meniscus tear subsequent to an injury precipitated by radicular pain from his back causing an "unfortunate accident on a treadmill." (Dr. Adcox, Chart Note, October 27, 2014).

17) On August 28, 2013, Employee filed a claim for a lower back injury but did not indicate which benefits he was seeking on the claim form. (Claim, August 28, 2013).

18) On September 3, 2013, Employee confirmed he is seeking medical benefits for his lower back and left knee. (Prehearing Conference Summary, September 3, 2013).

19) On September 22, 2015, the parties stipulated to a SIME by an orthopedist and that the parties may add neurosurgery as a specialty if, after evaluation by both parties' physicians, a neurosurgical dispute exists and the parties stipulate to include neurosurgery as an additional specialty. (Prehearing Conference Summary, September 22, 2015).

20) On November 13, 2015, Employee saw Kristen Jessen, M.D., for a neurological consultation. Dr. Jessen noted in 2013 Employee fell on a treadmill, injuring his left knee during the fall. She assessed Employee with diabetic polyneuropathy and lumbosacral radiculopathy. She suspected Employee "had an episode of radicular pain which caused the left lower extremity to buckle which in turn caused the left knee damage, which was sustained during the fall." (Dr. Jessen, Chart Note, November 13, 2015).

21) On January 12, 2016, the parties filed a SIME Request form signed by both Employer and Employee listing "orthopedic physician" as the medical specialty required for the SIME. (SIME Request form, January 12, 2016).

22) On March 23, 2016, Peter E. Diamond, M.D., an orthopedist, performed a SIME. Dr. Diamond diagnosed Employee with (1) lumbar sprain/strain secondary to the January 1987 incident; (2) L3-4 herniated disc secondary to the March 1988 incident; (3) status post multiple surgeries with failed back syndrome secondary to L3-4 herniated disc; (4) history of right knee arthroscopy with right knee partial medial meniscectomy and chondromalacia of trochlea; (5) and history of left knee arthroscopy, partial medial meniscectom and treatment of Grade IV chondromalacia, medial femoral condyle of the left knee. He opined the March 1988 work injury was a substantial factor in causing disability and the need for treatment for Employee's lumbar and right knee injuries and but was not a substantial factor in the recent medical treatment for the left knee. Dr. Diamond stated he would revise his opinion if there is documentation the episode described on the treadmill resulted in the left knee injury; however, only the meniscus tear would be the consequence of the treadmill incident, but not of the underlying arthritic condition. Dr. Diamond analyzed Employee's medical record and stated:

> The etiology of the left leg giving out is unclear, but it would be reasonable to conclude, to a reasonable degree of medical probability, that the left leg collapse on 12/28/88 was related to the lumbar injury, and therefore, that the right knee problem with subsequent medical meniscectomy is attributable to the [March 1988] injury.
> . . . .
>
> The first mention of knee pain is by Dr. Adcox on 12/12/12, noting that [Employee] had a history of left knee pain for 'sometime,' noting a history of prior surgery for a cartilage tear from which the examinee recovered. However, the records available to me do not document previous left knee surgery. It is unclear whether a left knee injury and arthroscopy had previously occurred, or if Dr. Adcox and/or [Employee] are conflating the left knee with the right knee.
>
> Moreover, there is a reference in an Independent Medical Evaluation to a note by Dr. Adcox on 10/27/1[sic], documenting an injury specifically secondary to radicular pain while [Employee] was on a treadmill for his lumbar spine injury, causing him to wince, misstep, and twist the knee. Unfortunately, the laterality is not specified in this note, and all I have is a second-hand copy, rather than the original note.
>
> However, a further note by Dr. Adcox on 1/3/13 again indicates no specific injury to the left knee, just chronic, intermittent knee pain.
> . . . .

> I cannot determine, to a reasonable degree of medical probability, the etiology of the left knee pain, but it appears clear that the examinee had pre-existent arthritis prior to the 1/22/13 left knee arthroscopy.
>
> It would therefore be my opinion, based on the records available to me, that the right knee meniscus tear and a portion of subsequent arthritis are secondary to the [March 1988] injury, but that the left knee condition is not, in fact, demonstrably secondary to the lower back injury. Ascribing the right knee is based on the assumption that [Employee]'s left leg gave out because of radicular pain and/or weakness.
> . . . .

Dr. Diamond said it is inappropriate for Employee's left knee to be examined by a neurosurgeon and further treatment for either knee would "most reasonably be performed by an orthopedic surgeon." (Dr. Diamond, SIME Report, March 23, 2016).

23) On January 30, 2017, Employee filed a petition for a SIME along with a letter and a SIME request form. Employee stated a neurosurgeon is required for the SIME. Employee attached portions of medical reports he asserts demonstrates a dispute warranting an SIME by a neurosurgeon. Employee's letter stated:

> I have always maintained since the beginning of this dispute that nerve damage from my original injury is responsible for the injury to my left knee. This dispute between myself and [Employer] has gone on for three years with no resolution in sight.
>
> I have enclosed parts of medical records supporting both my side and the side of [Employer]. You will notice that medical reports form Dr. Diamond seem to support both sides. This to me is very confusing.
>
> It is my belief that a neurosurgeon may help resolve this dispute. . . . (Employee, Petition, January 30, 2017; SIME Request Form, January 30, 2017).

24) On February 6, 2016, Employer opposed Employee's petition for a SIME with a neurosurgeon. (Employer, Answer, February 6, 2016).

25) On March 1, 2017, the parties stipulated to a hearing on April 18, 2017 on Employee's petition for a SIME with a neurosurgeon. (Prehearing Conference Summary, March 1, 2017).

26) At the April 18, 2017 hearing, Employee argued his petition for a second SIME by a neurosurgeon should be granted because his left knee injury was caused by his March 1988 work injury and Dr. Diamond did not understand the cause of Employee's left knee injury. Employee

contended a SIME by a neurosurgeon would assist the board by providing more evidence regarding the nerve damage he sustained in his back from the March 1988 work injury and would address whether the March 1988 work injury caused his left knee injury. Employee stated he injured his right knee in 1988 in a way similar to the way his left knee was injured in 2012 and he is confused by Dr. Diamond opining the right knee was work related and the left knee was not work related. Employee testified he had been complaining about left knee pain for thirty years and he believes the nerve damage to his back caused his left knee injury. (Record).

27) Employer accepted compensability for the March 1988 back injury and December 1988 right knee injury. (Record).

PRINCIPLES OF LAW

AS 23.30.001. Intent of the legislature and construction of chapter.
It is the intent of the legislature that
(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;
. . . .

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 23.30.095. Medical treatments, services, and examinations.
. . . .

(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. . . .

AS 23.30.110. Procedure on claims.
. . . .

> (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 place or places shall be reasonably convenient for the employee. . . .

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 §095(k) and §110(c). Under either section, the commission noted the purpose of an SIME is to assist the board, not an employee or an employer. The AWCAC referred to its decision in *Smith v. Anchorage School District*, AWCAC Decision No. 050 (January 25, 2007), and referencing AS 23.30.095(k) said:

> [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.

The commission in *Bah* stated when deciding whether to order an SIME, the board typically considers the following criteria, though the statute does not require it:

1) Is there a medical dispute between Employee's physician and an EME?
2) Is the dispute significant? And
3) Will an SIME physician's opinion assist the board in resolving the disputes?

It also stated when there is a significant gap in the medical or scientific evidence and an opinion by an SIME physician will assist in resolving the issue, an SIME may be ordered under AS 23.30.110(g).

> Ordering an SIME is not proper if it serves no purpose to the board by advancing its understanding of the medical evidence or by filling in gaps in the medical evidence, where that gap in the evidence, or lack of understanding of the medical evidence, prevents the board from ascertaining the rights of the parties in the dispute before the board.

Bah at 5.

ANALYSIS

Shall Employee's petition for a SIME with a neurosurgeon be granted?

The purpose of an SIME is not to assist either an employee or an employer. *Bah*. When there is a medical dispute between an employee's physician and an employer's physician, an SIME may be ordered. AS 23.30.095(k). Although a significant medical dispute regarding causation exists between Employee's physicians and Employer's physician, the dispute is no different than it was when Employee and Employer stipulated to an SIME with an orthopedic physician. Employee's contention Dr. Diamond seems to confusingly support both parties' physicians is based upon (1) Employer accepting compensability for the right knee injury, which was opined by Dr. Shields to be caused by radicular pain in the lumbar spine; (2) Dr. Adcox's and Dr. Jessen's opinions the left knee injury was caused by radicular pain in Employee's lumbar spine; and (3) Dr. Diamond's opinion the right knee injury is related to the March 1988 work injury and the left knee injury is not. Employee is attacking the credibility of Dr. Diamond's opinion by arguing the medical record supports his contention both knees were injured similarly by radicular pain from his lumbar spine. This argument goes to the weight of Dr. Diamond's opinion but does not create a gap in the medical evidence to warrant an SIME under AS 23.30.110(g) or create a medical dispute between Employee's physician and Employer's physician permitting an SIME under AS 23.30.095(k) or

Employee correctly contends there is a dispute between Dr. Adcox and Dr. Fraser regarding whether work related nerve damage in his back is a substantial factor in his need for left knee medical treatment. There is ample evidence in the medical record concerning Employee's back injury, including his lumbar radiculopathy. In addition to Dr. Diamond's SIME report, there are opinions from three different physicians regarding the cause of Employee's left knee injury. An additional SIME physician opinion will not assist the board in resolving the dispute. *Bah*; *Smith*; *Rogers & Babler*.

Employee seeks a second opinion because he does not like SIME physician Dr. Diamond's opinion. It is inappropriate to order an SIME when the sole purpose is to provide Employee with an additional opinion at Employer's expense. *Bah*.

An SIME is discretionary and is appropriate only when it will assist in deciding the parties' disputes. AS 23.30.095(k). An SIME will not assist in ascertaining the parties' rights or making

determinations regarding the parties' disputes. Disputes exist in the record; however, there is sufficient evidence regarding causation to make a determination regarding Employee's claims. *Rogers & Babler*.

Another SIME will delay this case and cause unnecessary expense to Employer, contravening the Act's intent to provide quick, efficient, fair and predictable benefits at a reasonable cost. AS 23.30.001(1). Employee's January 30, 2017 petition for a SIME with a neurosurgeon will be denied.

CONCLUSION OF LAW

Employee's petition for an additional SIME with a neurosurgeon shall not be granted.

ORDER

Employee's January 30, 2017 petition for an additional SIME with a neurosurgeon is denied.

Dated in Juneau, Alaska on May 2, 2017.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Kathryn Setzer, Designated Chair

/s/
Charles Collins, Member

/s/
Bradley Austin, Member

PETITION FOR REVIEW

A party may seek review of an interlocutory other non-final Board decision and order by filing a petition for review with the Alaska Workers' Compensation Appeals Commission. Unless a petition for reconsideration of a Board decision or order is timely filed with the board under AS 44.62.540, a petition for review must be filed with the commission within 15 days after service of the board's decision and order. If a petition for reconsideration is timely filed with the board, a petition for review must be filed within 15 days after the board serves the reconsideration decision, or within 15 days from date the petition for reconsideration is considered denied absent Board action, whichever is earlier.

RECONSIDERATION

A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accordance 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 accordance 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 Interlocutory Decision and Order in the matter of Gary R. Davis, employee / claimant; v. Wrangell Forest Products, employer; Wausau Underwriters Insurance Company, insurer / defendants; Case No. 198803834; dated and filed in the Alaska Workers' Compensation Board's office in Juneau, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on May 2, 2017.

/s/
Dani Byers, Workers' Compensation Technician