ALASKA WORKERS' COMPENSATION BOARD

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

BRYON J. WILLIAMS, Employee, Petitioner, v. FAIRBANKS GOLD MINING, INC., Employer, and LIBERTY MUTUAL FIRE INSURANCE COMPANY, Insurer, Respondants.	)	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 200221229 AWCB Decision No. 15-0153 Filed with AWCB Fairbanks, Alaska on November 27, 2015

Bryon Williams' (Employee) May 19, 2015 petition seeking a second independent medical evaluation (SIME) was heard in Fairbanks, Alaska on August 13, 2015, a date selected on July 15, 2015. Attorney Jason Weiner represented Employee. Attorney Constance Livsey represented Fairbanks Gold Mining, Inc. (Employer). There were no witnesses. Since Employee's petition is based, in part, on a recently taken deposition, the record was held open until a transcript could be filed. The record closed upon filing of the transcript on September 9, 2015.

ISSUE

Employee contends there are differences of medical opinions such that an SIME should be ordered. His petition contends Employer's medical evaluation (EME) physician opined the instant, 2002 work injury was not a substantial factor in Employee's current disability; whereas, an SIME physician in a different case, which involved a subsequent work injury with a different Employer, opined Employee's disability resulted from unspecified, prior injuries. Employee's

hearing arguments also primarily contend another dispute exists in the medical record as well. Employee contends, at deposition, the EME testified he believed Employee's former treating physician, Robert Dingeman, M.D., who reported Employee had a weakness in his anterior cruciate ligament (ACL), was mistaken. However, Employee contends the EME also testified if Employee's former treating physician was not mistaken, and Employee did have weakness in his ACL in 2002, then the EME would consider the instant injury a substantial cause of Employee's current disability.

Employer opposes Employee's petition on numerous bases. It denies the opinion of its EME in this case, and the SIME physician in the different case, are contradictory. Rather, Employer contends these physicians' opinions simply address separate issues in different cases. Employer also contends statutory and decisional authority condition an SIME upon a difference in opinion between an employee's physician and an employer's physician, not between an employee's physician and an SIME physician. It further contends no physician has opined Employee's 2002 work injury is a substantial factor in his disability or need for medical treatment, and all physicians who have opined on the subject have stated Employee's torn ACL most likely occurred during his non-work related injuries in 2005 and 2006, and his arthritic knee is the result of a non-work related, 1992 all-terrain vehicle (ATV) accident.

Should an SIME be ordered?

FINDINGS OF FACT

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

1) In 1992 Employee injured his right knee, at age 15, in an ATV accident. The injury caused a tibia/fibula fracture that required placement of a tibial intramedullary rod and a right fibular osteotomy. (Compromise and Release Agreement, September 9, 2014; Shriner's Hospital report, November 20, 1994).

2) On July 1, 2001, Employee sought treatment at the Fairbanks Memorial Hospital for "sharp" pain in his right knee following a motorcycle accident. He reported a "big injury to his tibia and fibula many years ago," which resulted in some muscular deformation and hardware placement. An x-ray showed effusion in the knee joint, the intramedullary rod, some calcification and what appeared to be a small fracture in intercondyloid eminence. Acute right knee sprain was diagnosed

and Employee was prescribed Ibuprofen and Vicodin. (Emergency Record, July 1, 2001; X-ray report, July 1, 2001).

3) On October 8, 2002, Employee treated for right knee pain and Bextra was prescribed. (Marshall chart notes, October 8, 2002).

4) On November 4, 2002, Employee sought treatment at the Fairbanks Memorial Hospital for right knee pain. X-rays showed effusion in the knee joint, the intramedullary rod, and calcification in the intercondyloid eminence, which had mildly progressed since the July 1, 2001 x-ray. The radiologist commented the calcification "may relate to avulsion injury from the intercondyloid eminence and anterior cruciate ligament injury. The swelling appears new since the 1 July 2001 study." (Outpatient Admission Record, November 4, 2002; X-ray report, November 4, 2002).

5) On November 9, 2002, Employee reported stepping on a rock and twisting his right knee while working for Employer as a welder. X-rays showed the same intramedullary rod and intercondyloid eminence noted on previous studies, but did not show an acute fracture. Effusion in the knee joint "may" have been present. The radiologist remarked "[c]omparison with an old film, if one is available, might be helpful to evaluate the significance of the intercondylar bony changes which are identified. Is there any clinical evidence of anterior cruciate ligament injury?" Employee's knee was immobilized and he was ordered to follow up with his orthopedic physician. (Report of Occupational Injury or Illness, November 9, 2002; Emergency report, November 9, 2002; X-ray report November 9, 2002).

6) On November 19, 2002, a right knee magnetic resonance imaging study (MRI), showed many of the same findings as on previous studies, including the intramedullary rod. No underlying meniscal injury was evident. The radiologist also reported "[the anterior cruciate ligament is quite diminutive in appearance, however, does remain intact as seen on the coronal images. No definite collateral ligament injury is appreciated." (MRI report, November 19, 2002).

7) On December 10, 2002, Robert Dingeman, M.D., evaluated Employee's right knee. Upon physical examination, Dr. Dingeman found "some fairly significant discomfort in the posterolateral aspect of the subpatellar pouch"; "mature, nontender," effusion; and "minimal" anterior drawer sign. After reviewing x-rays and MRIs, Dr. Dingeman's impressions were: 1) posttraumatic loose bodies and arthrofibrotic tears, right knee, industrial related, and 2) preexistent residuals open fracture right tibia. Dr. Dingeman suggested Employee receive an injection for comfort. (Dingeman report, December 10, 2002).

8) On January 8, 2003, Employee saw Dr. Dingeman for further evaluation of his right knee. Upon physical evaluation, Dr. Dingeman noted effusion, "1 + anterior and posterior instability," and a positive medial grind test. Dr. Dingeman also reported synovial inflammation, old scarring and collapse of the distal tibia. He planned to do an arthroscopy to remove loose bodies. (Dingeman report, January 8, 2003).

9) On January 16, 2003, Dr. Dingeman performed a medial meniscectomy, chondroplasty and partial synovectomy, and noted "[t]here was an intact anterior cruciate ligament which was definitely bipartite." (Operative Report, January 16, 2002).

10) On January 22, 2003, Employee saw Dr. Dingeman for a follow-up, during which Dr. Dingeman discussed the arthroscopy and his findings in detail. Dr. Dingeman anticipated keeping Employee off work for six weeks, and for him to begin physical therapy the following week. (Dingeman report, January 22, 2003).

11) On January 29, 2003, Employee began physical therapy. (Physical Therapy Evaluation, January 29, 2003).

12) On January 29, 2003, Dr. Dingeman evaluated Employee and they had a long discussion about removing a soft tissue loose body or cartilaginous fragment that remained in Employee's knee. Employee was concerned about "something slipping in and out" of his knee joint, and wanted Dr. Dingeman to attempt to remove the loose body in his office, but Dr. Dingeman explained "things are much more complicated and the risks are more severe" with what Employee proposed. A repeat arthroscopy was tentatively planned. (Dingeman report, January 29, 2003; Dingeman report, February 11, 2003).

13) On February 11, 2003, Dr. Dingeman performed repeat arthroscopic surgery of Employee's right knee and removed "mature" chondral loose bodies. While searching for the loose bodies, he noted a full-thickness fragmented femoral articular intracondylar fracture with fissuring down to the chondral bone. Dr. Dingeman performed a lateral release and debridement of the fractures, along with an incidental synovectomy. Post-operative x-rays showed a deformity of the intercondyloid eminence from old injury, a loose ossific density in the joint space, which may have represented an osteochondral fragment, and an ossific density lateral to the lateral tibial plateau, which appeared to have been a new finding according to Dr. Dingeman. (Operative report, February 11, 2003; x-ray report, February 11, 2003).

14) On February 14, 2003, Employee followed-up with Dr. Dingeman, who diagnosed "residual loose bodies, right knee." (Dingeman report, February 14, 2003).

15) On February 19, 2003, Employee followed-up with Dr. Dingeman, who began his report, "[Employee] called in for pain medicine refill. He states he gets goofy on Darvocet, and needs something stronger. Today we refilled his Tylenol #3." Dr. Dingeman discussed Employee's care with him and thought the medial meniscus tear and acute chondral fractures in the interarticular notch were "probably" work-related; however, the "troublesome" loose bodies probably dated from Employee's prior severe leg trauma. Dr. Dingeman concluded his report, "[a]gain, script today for Tylenol 3. He needs to wean of [sic] this very rapidly." (Dingeman report, February 19, 2003).

16) On February 26, 2003, Employee followed-up with Dr. Dingeman and they reviewed the video recording of Employee's arthroscopy. Dr. Dingeman reported the following regarding that visit:

> With concerns over his knee findings, and the severity of his condition, we already discussed his viewing of the arthroscopy today. We allowed him to watch it and answer questions as they came out. . . . [Employee's] responses during the video were unique, as will be documented.
>
> . . . . The meticulous release was outlined. He had some concerns; "You cut my tendon." "You cut my tendon." The nature of the region not being his patellar tendon as demonstrated by the fact that he can extend his knee, was emphasized several times. . . .
>
> . . . . The office manager had been in and out over the course of the procedure, with her own curiosity as to what was going on. Many of his initial comments were communicated in her presence. . . .
>
> He reached a point in this, "I've had enough." Out at the desk he then stated, "I don't see what a big deal this is about loose bodies." It was again emphasized, as had been during the course of the discussion, how meticulous one has to be with any compromised articular cartilage, particularly his changes. He then said, "Well, I need to get this back. I work hard and I need to play hard." He then stated, "You and Dr. Becker and everybody else are all alike. Now you are fucking around with my kneecap."
>
> Taken back for a moment I then informed him that we had taken an extraordinary time to explain the condition of his knee, and attempted to address him in a way that a mechanically-inclined young male would understand the unique difficulties of living tissue. I informed him that I was offended by his tone and manner. . . .

> On further reflection over the course of his care, his dissatisfaction and unhappiness with how he was treated in another office, it appears that despite incredible attempts to bring him into an understanding of his care, that he may be well self-directed on his degree of compliance and expectation. I find this a little unusual. Young Mr. Williams has been shown the compassion and comprehension, and extra time needed, in people who have already incurred devastating injuries to their lower leg. We have not had access as yet to the records from Shriner's Hospital. Evidently, he had a severe open fracture of his tibia as a teenager. He underwent multiple procedures for infection. He had at least two types of internal fixation. He has the mesh graft on his proximal medial calf. We had talked at length of our concern for potentially stirring up any latent infection at the time of his initial procedure.

(Dingeman report, February 26, 2003).

17) On March 10, 2003, Employee followed-up with Dr. Dingeman, who began his report by noting, "Young Mr. Williams is substantially more subdued today." Employee began physical therapy. (Dingeman report, March 10, 2003; North Pole Physical Therapy report, March 18, 2003).

18) On April 3, 2003, Employee saw Dr. Dingeman for a follow-up visit, who reported Employee's examination was "positive for strength improvement," and Employee had "good definition in his muscle." However, Employee's anterior drawer was "increased 1+ over the other knee." "This [was] consistent with a partial ACL injury seen at his arthroscopy." (Dingeman report, April 3, 2003).

19) On June 3, 2003, Employee saw Gregory Grunwald, D.O., for continued right knee pain while out-of-state. On physical examination, Dr. Grunwald found Employee's medial and lateral collateral ligaments within normal limits, negative drawer's tests, no palpatory tenderness and no effusions. Dr. Grunwald prescribed Vicodin and referred Employee for a consultation. (Grunwald report, June 3, 2003).

20) On July 9, 2003, Employee followed-up with Dr. Dingeman for further evaluation. Dr. Dingeman decided to reevaluate Employee after additional x-rays were taken, but concluded "[i]t is more than likely for a trial return to work." He also had concerns with Employee returning to work based on the medial meniscus tear and chondral loss superimposed on the old posttraumatic changes and loose bodies. Dr. Dingeman commented, "sorting out what is old and new cannot be determined totally objectively." (Dingeman report, July 9, 2003).

21) On July 10, 2003, x-rays showed Employee's right knee was unchanged since February 2003. (X-ray report, July 9, 2003).

22) On July 21, 2003, Employee saw Dr. Dingeman "insisting that his knee is not right and something needs to be done." Dr. Dingeman ordered a functional capacities evaluation to determine what Employee's actual endurance and strength were at that point. (Dingeman report, July 21, 2003).

23) On September 29, 2003, Dr. Dingeman declared Employee medically stable and assigned him a 3 percent permanent partial impairment (PPI) based on the torn meniscus. Dr. Dingeman anticipated work restrictions, such as no walking unassisted over uneven ground or repeated squatting, kneeling or crawling. (Dingeman report, September 29, 2003).

24) On January 24, 2004, Employee was scheduled for an EME with Stephen Marble, M.D., but did not attend. Dr. Marble then performed a records review and thought it was "certainly possible" Employee's work injury caused movement of a preexisting loose body in Employee's knee, but it was "obvious" the work injury did not cause knee instability, loose bodies, meniscus tears, synovitis or mechanical changes in the knee, all of which Dr. Marble opined were preexisting. Although Dr. Marble thought movement of the loose bodies may have aggravated Employee's synovitis, he did not think any additional medical treatment was necessary as a result of Employee's work injury. (Marble report, January 24, 2004).

25) On April 17, 2004, Employee attended an EME with Dr. Marble. Upon physical examination, Dr. Marble found Employee's right knee to be normal. Anterior and posterior drawer, Lachman's and McMurray's tests were negative. Dr. Marble's opinions remained unchanged from his January 24, 2004 report. However, Dr. Marble clarified, although he thought Employee's work injury aggravated his knee condition, it did not result in any long-term, permanent alteration of Employee's knee. Dr. Marble also noted Employee acknowledged during the examination he had felt "weird stuff" [in his knee] prior to the work injury, and opined "[a]gain, it is readily apparent that the loose bodies predated this benign event." Dr. Marble attributed Employee's surgical procedures to his preexisting, lower extremity trauma, and concluded the work injury "was not a substantial factor in altering or reducing this gentleman's physical capacity." (Marble report, April 17, 2004).

26) On June 21, 2006, Employee presented to the Fairbanks Memorial Hospital Emergency Department and reported he was "goofing off last P.M. and twisted, knee gave out." Right knee x-rays showed the intramedullary rod, numerous bony ossicles and a large joint effusion, but no

fractures. Employee was ordered to follow-up with Mark Wade, M.D. (Emergency Record, June 21, 2006; Discharge Instructions, June 21, 2006).

27) On June 27, 2006, Employee sought treatment from Dr. Wade and reported he injured his right knee "while he was playing around and felt a pop . . . on December 20, 2005." Dr. Wade evaluated Employee's right knee, suspected an anterior cruciate ligament (ACL) tear, and ordered a magnetic resonance imaging (MRI) study. (Wade report, June 27, 2006).

28) On July 7, 2006, a right knee MRI showed degenerative changes to the medial meniscus, a "probable" old avulsion in the ACL at the tibial insertion, irregular articular cartilage and joint effusion. (MRI report, July 7, 2006).

29) On July 11, 2006, Employee followed-up with Dr. Wade, who recommended ACL reconstruction that would require removal of the intramedullary rod. (Wade report, July 11, 2006).

30) Between July 22, 2006 and August 15, 2007, Employee periodically treated with Peter Marshall, M.D., whose handwritten chart notes are largely illegible. The notes do, however, refer to Employee wearing a knee brace. (Marshall chart notes, July 22, 2006 to August 15, 2007; observations).

31) August 27, 2013, Employee reported injuring his right knee at work four days previously while working for a different employer. Employee's description of the injury was, "Replacing the floor in GTI's exhaust. I tripped on a piece of angle iron and had to step down in the hole, noticed some immediate pain but continued to work the rest of the day on my knees welding. By the next morning my knee was immobile, stayed off all weekend. Pain is significantly less but needs attention." (Report of Occupation Injury or Illness, August 27, 2013).

32) On September 3, 2013, Employee sought treatment from Dr. Wade and reported he reinjured his knee after stepping in a hole at work. Dr. Wade discussed conservative treatment and surgical intervention with Employee and noted "[p]atient is opting for surgical intervention . . . ." (Wade report, September 3, 2013).

33) On December 6, 2013, Lance Bingham, M.D., performed an EME for Employee's August 23, 2013 injury. Employee reported to Dr. Bingham his knee felt more unstable than previously. On physical examination, Dr. Bingham found:

> There is normal alignment of both knees. Range of motion of the knees is 0 to 120 degrees bilaterally. There is no crepitation with flexion and extension of either patella. Both patellae are stable to medial and lateral pressure. There is no joint

> line pain, medial or lateral, of either knee. . . . No medial or lateral instability is noted."

Dr. Bingham thought the August 23, 2013 work injury was a substantial factor in Employee's spraining his right knee, but opined that condition had resolved. Dr. Bingham also diagnosed "documented instability of the right knee," and noted Employee had worn a neoprene brace with metal hinges for many years. Dr. Bingham thought ACL repair surgery was reasonable, but the 2013 work injury was not a substantial factor in that need for treatment. (Bingham report, December 6, 2013).

34) On January 16, 2014, Dr. Wade wrote on a "To Whom It May Concern" letter, in which he opined the physical labor Employee performed "could have" aggravated his preexisting condition. Dr. Wade noted Employee was previously able to work with the assistance of a brace, but Employee now states he cannot work. (Wade letter, January 16, 2014).

35) On January 29, 2014, Employee underwent surgery to remove the intramedullary rod and screws. (Operative Report, January 29, 2014).

36) On January 31, 2014, a right knee MRI showed a hardware artifact from the removed rod and screws but the lateral and medial meniscus appeared grossly intact. The anterior cruciate ligament was not well visualized, but there was an uncovering of the posterior horn of the lateral meniscus, "a secondary sign of ACL instability." (MRI report, January 31, 2014).

37) On February 4, 2014, Employee saw Dr. Wade for a follow-up visit. Dr. Wade planned to schedule Employee for ACL reconstruction with bone-patella tendon-bone allograft and removal of osseous fragment in six to eight weeks once Employee had healed from his most recent surgery. (Wade report, February 4, 2014).

38) On February 28, 2014, Dr. Bingham issued an addendum EME report. After reviewing recent medical records, Dr. Bingham indicated his opinions had not changed since his initial report. While Dr. Bingham thought Dr. Wade's proposed ACL reconstruction was medically reasonable, he did not think the August 23, 2013 work injury was a substantial factor in that need for treatment. (Bingham report, February 28, 2014).

39) On May 28, 2014, William Curran, M.D., performed a secondary independent medical evaluation (SIME) for Employee's August 23, 2013 injury. X-rays taken that day showed a threaded bone screw in the proximal medial tibial metaphysis, mild tri-compartmental osteoarthritis, loose bodies in the suprapatellar recess and medial and lateral osteophytosis. Dr.

Curran diagnosed right knee sprain, which he thought was causally related to the August 23, 2013 work injury, and he also opined that injury had aggravated Employee's tricompartmental osteoarthritis. In the discussion section of Dr. Curran's report, he cited Dr. Wade's June 27, 2006 and July 11, 2006 reports that indicate Employee tore his anterior cruciate ligament in December 2005 or June 2006. "Subsequent to those two dates, [Employee] was found to have significant anterior cruciate laxity right knee which necessitated a right knee brace." Dr. Curran opined the substantial cause of Employee's disability was "progressive deterioration of an arthritic unstable right knee," and thought Employee required right knee surgery consisting of arthroscopic debridement, removal of loose bodies, probable chondroplasties and anterior cruciate ligament reconstruction. However, Dr. Curran thought Employee's surgical prognosis was guarded because, "[w]hile the anterior cruciate ligament reconstruction will provide much-needed stability . . . it will not prevent ongoing deterioration of an already compromised joint." (Curran report, May 28, 2014).

40) On September 8, 2014, a compromise and release (C&R) agreement was approved, settling claims arising from Employee's August 23, 2013 work injury. (C&R Agreement, September 8, 2014).

41) On February 27, 2015, Charles Craven, M.D., performed an EME for Employee's November 9, 2002 work injury, which he thought resulted in right knee strain. Like Dr. Marble, Dr. Craven opined the 2002 work injury temporarily aggravated Employee's right knee symptomology and necessitated Dr. Dingeman's first arthroscopic procedure on January 16, 2003, but was not a substantial factor in causing the findings at that time of loose bodies, chondromalacia, synovitis and degenerative tearing of the medial meniscus. Citing Dr. Wade's June 27, 2006 report and the July 7, 2006 MRI, Dr. Craven opined Employee's anterior cruciate ligament tear and unstable knee resulted from the non-industrial events of December 20, 2005 and June 20, 2006, and he emphasized "[t]here is no study or examination which would substantiate a diagnosis of anterior cruciate ligament instability prior to this time." (Craven report, February 27, 2015 (emphasis in original)).

42) On August 5, 2015, the parties took Dr. Craven's deposition, during which he testified Dr. Dingeman's reports contain varying descriptions of Employee's ACL examinations. For examples, Dr. Dingeman's December 10, 2002 report documented "minimal" anterior drawer, a test for ACL competence, but Dr. Craven found Dr. Dingeman's notes in this regard "difficult to

interpret;" similarly, Dr. Craven found Dr. Dingeman's January 8, 2003 note, documenting "one plus anterior and posterior instability" difficult to interpret as well. Dr. Craven explained there is "some subjectivity to ACL testing," and then discussed the objective evidence. The November 19, 2002 MRI, Dr. Craven testified, showed a "diminutive" ACL, which means a smaller-than-expected ACL that could indicate prior damage. However, Dr. Craven pointed out there was no edema or fluid within the ligament on the MRI that would have suggested an ACL tear. Additionally, Dr. Craven testified a bone bruising pattern occurs on the femur and tibia bones with a torn ACL and such bone bruises are not present on the November 19, 2002 MRI. Most importantly, Dr. Craven thought Dr. Dingeman's January 16, 2003 operative report, which noted no anterior drawer, was indicative of a normal ACL examination. In that report, Dr. Craven testified, Dr. Dingeman also described observing an "intact" anterior cruciate ligament, and the "gold standard objective test is to look at the ligament with your eyeballs at the time of the surgical arthroscopy." Dr. Craven also discussed one of Dr. Dingeman's postoperative reports, which mentions a partial ACL tear. It was Dr. Craven's opinion Dr. Dingeman had an error in recollection in what he had identified during surgery, which Dr. Craven testified is not uncommon. Dr. Craven stated: "I have done it myself. Two or three months have gone by from a surgery, and you believe what you remembered, but it may not be correct as to what was actually documented at the time of surgery." Dr. Craven then pointed out two subsequent evaluations by different doctors, which indicated normal ACL examinations. Rather than the November 9, 2002 work injury, Dr. Craven instead attributed Employee's ACL insufficiency to non-industrial injuries in June 2006 or December 2005, and cited the June 21, 2006 Fairbanks Memorial Hospital report, Dr. Wade's June 27, 2006 report and the July 7, 2006 MRI report, as support for his opinion. (Dingeman dep., pp. 22-24, 29-30).

43) Employee's cross-examination of Dr. Craven on his opinions concerning Employee's ACL extends over 12 pages of the deposition transcript. (*Id*. at 35-47).

44) During Dr. Craven's deposition, the following exchanges took place on cross-examination:

> By [Employee's attorney]:
>
> Q Well, doesn't Dr. Dingeman mention instability?
>
> A In his preoperative, one of his preoperative notes, as you said he alludes to a side-to-side difference. In one of his postoperative follow-up examinations he

alludes to a partial ACL tear. But again I would opine that that represents recollection recall at that point or incorrect recall. The overarching issue comes back to the operative report at which time under anesthesia the ACL examination was normal, and upon arthroscopic examination the ACL was within normal limits.

Q So let's say it's not the error. Let's say it wasn't an error, and if we could ask Dr. Dingeman now . . . and there was ACL instability. Then would you say that – that in fact in 2002. Then would you say that the 2002 was a substantial cause of his current condition?

A No.

[Employer's Attorney]: And I'm going to interject here. I'm going to object on the basis of speculation and assuming facts not in evidence. Dr. Craven, go ahead and answer.

[Dr. Craven]: That's a theoretical discussion, but again I will confidently say that Dr. Dingeman's records were in error, because the ACL was normal on examination, and subsequent examiners Dr. Gurgeman and Dr. Marble, found an intact ACL examination. So I cannot otherwise explain Dr. Dingeman's varying ACL examinations documented throughout the record.

By [Employee's attorney]:

Q Yeah, but I don't – that's not the question I asked.

A Okay.

Q I am saying if Dr. Dingeman's observations were not in error –

A Okay.

Q --and there was an anterior cruciate ligament problem in 2002 –

A Okay.

Q --would you say the 2002 injury is a substantial cause of [Employee's] current instability?

[Employer's attorney]: Same objection. Go ahead and answer.

[Dr. Craven]: To clarify, sir, are we a substantial cause or a substantial factor?

[Employee's attorney]:

Q A substantial fact – a substantial cause.

A A substantial cause. That would – okay. Let me try to answer as frankly as I can. If Dr. Dingeman's records were not in error, and he opined that there was a partial ACL tear, okay – so when you say some damage to the ACL, let's say a partial ACL tear. I would go back to the point that after the period of care for Dr. Dingeman …that objective examination was not substantiated by Dr. Gurgeman nor Dr. Marble. So Dr. Gurgeman and Dr. Marble found a normal ACL examination. So if there was a purported partial ACL tear, as documented by Dr. Dingeman, it would not have been clinically significant, as two prior or two subsequent physician's found normal ACL examination. . . . And I hope I am answering -- I am trying to answer –

. . . .

Q I am saying, okay, Dr. – I just want to go back. If you can answer the question without debating whether there was instability or there was not.

A Okay.

Q If Dr. Dingeman's report was correct and the subsequent doctors were wrong –

A Okay. Fair.

Q -- would the ACL tear in 2002, partial ACL tear be considered by you a substantial cause of [Employee's] current instability?

A Fair enough.

[Employer's attorney]: Same objections.

[Dr. Craven]: Okay. Fair enough.

[Employer's attorney]: Let me finish my objection. Basically you are asking if the medical facts were totally different, you would reach a different conclusion?

[Employee's attorney]: No, I'm not saying that.

[Employer's attorney]: Yeah, you are.

[Employee's attorney]: You know, [Employer's Attorney], don't argue with me, please. Let me just ask the question.

[Dr. Craven]: Okay.

[Employee's attorney]:

Q Dr. Craven, can you please answer the question.

> A Sure. So I am gathering my thoughts here. So looking at Dr. Dingeman's final note from April 3rd, 2003, he describes an Anterior Drawer Test that is increased over the other knee consistent with a partial ACL injury seen in the arthroscopy. Again, I will note, I will caveat my answer, that there was no partial ACL injury seen in arthroscopy. But under the assumption that the April 3rd, 2003, note is correct, and the gentleman has a partial ACL injury that produces a clinical instability, as documented by Dr. Dingeman on April 3rd, 2003, and we negate the examinations of Dr. Grunwald in June 2003 and Dr. Marble's IME of 2004, then the answer to your question, assuming that Dr. Dingeman's examination is the last one, that a partial ACL tear with clinical instability would be a substantial factor in the claimant's current condition.
>
> Q Okay. That's what I need to know.
>
> A Yes, sir. I'm sorry. I was not trying to be elusive on that, but I was trying to answer the question honestly and – and – anyways.
>
> Q With me, as long as you have answered it, at the end of the day, that's all I care about. I understand. You are very polite about it, so you did a good job.

(*Id*. at pp. 41-47).

45) On May 19, 2015, Employee filed his instant petition, which contends:

> Dr. Craven's report stated he felt [Employee's] 2002 work injury is not a substantial factor in any knee-related physical limitations that would be impose [sic] on [Employee] at the present time. This opinion is contradictory to what Dr. William Curran states in an SIME that was performed on [Employee] in a separate matter on May 28, 2014, where Dr. Curran believes that [Employee's] continuing problems were from prior injuries he sustained.

Employee also attached a copy of Dr. Curran's May 28, 2014 SIME report to his petition. (Employee's petition May 19, 2015).

46) On August 7, 2015, Employee filed his hearing brief, which contends:

> The deposition of Dr. Charles Craven was taken on August 5, 2015. At the deposition, Dr. Craven summarized his opinions on cross-examination. He said (and this is paraphrased, as the parties do not have his completed deposition yet) that he believed Dr. Robert Dingeman, who had reported that [Employee] had a weakness in his ACL was mistaken. However, Dr. Craven also said that if Dr. Dingeman was not mistaken, and [Employee] did have a weakness in his ACL back in 2002, then the 2002 injury would be a substantial cause [sic] of his current disability and medical condition.

> . . . . Dr. Wade's treating physician [sic] believes that [Employee's] current condition is the result of an aggravation of a prior injury. The SIME physician, Dr. Curran, believes the current condition is a result of a deterioration of an arthritic unstable knee, which is unstable due to prior injuries, including the 2002 injury. Dr. Dingeman believed that [Employee's] ACL was compromised as a result of the 2002 injury. Dr. Craven believes that Dr. Dingeman was mistaken when he said that {Employee] had a damaged ACL, but if Dr. Dingeman was correct, the 2002 injury would be considered a substantial cause of [Employee's] current condition. At worst, there is a difference of opinions amongst physicians. At best, Dr. Craven, on behalf of employer, has not only admitted to a clear difference of opinions between Dr. Dingeman and himself, but has also admitted that, if Dr. Dingeman was not mistaken (and there is no basis to believe he just made a "mistake"), the 2002 injury is a substantial cause of [Employee's] current condition.

(Employee's hearing brief, August 7, 2015).

PRINCIPLES OF LAW

> **AS 23.30.095. Medical treatments, services, and 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. . . . The board may authorize continued treatment or care or both as the process of recovery may require. When medical care is required, the injured employee may designate a licensed physician to provide all medical and related benefits. The employee may not make more than one change in the employee's choice of attending physician without the written consent of the employer. Referral to a specialist by the employee's attending physician is not considered a change in physicians. Upon procuring the services of a physician, the injured employee shall give proper notification of the selection to the employer within a reasonable time after first being treated. Notice of a change in the attending physician shall be given before the change.
> . . . .
>
> (h) Upon the filing with the division by a party in interest of a claim or other pleading, all parties to the proceeding must immediately, or in any event within five days after service of the pleading, send to the division the original signed reports of all physicians relating to the proceedings that they may have in their possession or under their control, and copies of the reports shall be served by the party immediately on any adverse party. There is a continuing duty on all parties to file and serve all the reports during the pendency of the proceeding.
> . . . .
>
> (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. . . .
>
> **AS 23.30.110. Procedure on Claims.** (a) . . . the board may hear and determine all questions in respect to the claim.
> . . . .
>
> (c) Before a hearing is scheduled, the party seeking a hearing shall file a request for a hearing together with an affidavit stating that the party has completed necessary discovery, obtained necessary evidence, and is prepared for the hearing.
> . . .
>
> (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 physician or physicians as the employee, employer, or carrier may select and pay for may participate in an examination if the employee, employer, or carrier so requests. Proceedings shall be suspended and no compensation may be payable for a period during which the employee refuses to submit to examination. . . .

The regulation at 8 AAC 45.090(b) provides for orders requiring an employer to pay for an employee's examination pursuant to AS 23.30.095(k) or §110(g). Section 095(k) and §110(g) are procedural in nature, not substantive, for the reasons outlined in *Deal v. Municipality of Anchorage*, AWCB Decision No. 97-0165 (July 23, 1997), at 3; *see also Harvey v. Cook Inlet Pipe Line Co.*, AWCB Decision No. 98-0076 (March 26, 1998). Considering §135(a) and §155(h), wide discretion exists under AS 23.30.110(g) to consider any evidence available when deciding whether to order an SIME to assist in investigating and deciding medical issues in contested claims, to best "protect the rights of the parties."

The Alaska Workers' Compensation Appeals Commission (Commission) 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(g). With regard to §095(k), the Commission referred to its decision in *Smith v. Anchorage School District*, AWCAC Decision No. 050 (January 25, 2007), at 8, in which it 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.

The Commission further stated in *dicta*, 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 will assist the board in resolving the dispute. *Bah* at 4.

The Commission outlined the board's authority to order an SIME under §110(g), as follows:

> [T]he board has discretion to order an SIME when there is a significant gap in the medical or scientific evidence and an opinion by an independent medical examiner or other scientific examination will help the board in resolving the issue before it. . . . 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 evidence, or lack of understanding of the medical evidence, prevents the board from ascertaining the rights of the parties.

Id. at 5.

Under either §095(k) or §110(g), the Commission noted the purpose of ordering an SIME is to assist the board, and the SIME 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.* 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?

Deal at 3. *See also, Schmidt v. Beeson Plumbing and Heating*, AWCB Decision No. 91-0128 (May 2, 1991). Accordingly, an SIME pursuant to §095(k) may be ordered when there is a medical dispute, or under §110(g) when there is a significant gap in the medical or scientific evidence. Further the Commission held an SIME may be ordered when, because of a lack of understanding of the medical evidence, the parties' rights cannot be ascertained. It stated:

> 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 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 8.

The decision to order an SIME rests in the discretion of the board, even if jointly requested by the parties. *Olafson v. State Department of Transportation*, AWCAC Decision No. 06-0301 (October 25, 2007), at 6. Although a party has a right to request an SIME, a party does not have a right to an SIME if the board decides an SIME is not necessary for the board's purposes. *Id*. at 8. A party does not have "veto" rights over the board's choice of physician. *Id*. at 10. An SIME is not a discovery tool exercised by the parties; it is an investigative tool exercised by the board to assist it by providing disinterested information. *Id*. at 15.

> **AS 23.30.135. Procedure before the board.** (a) In making an investigation or inquiry or conducting a hearing the board is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by this chapter. The board may make its investigation or inquiry or conduct its hearing in the manner by which it may best ascertain the rights of the parties. . . .

The board has broad statutory authority in conducting its investigations and hearings. *Tolson v. City of Petersburg*, AWCB Decision No. 08-0149 (August 22, 2008); *De Rosario v. Chenenga Lodging*, AWCB Decision No. 10-0123 (July 16, 2010). The board may use relaxed evidentiary standards while conducting its hearings. *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249; 1257 (Alaska 2007). AS 23.30.135 gives the workers' compensation board wide latitude in making its investigations and in conducting its hearings, and authorizes it to receive and consider, not only hearsay testimony, but any kind of evidence that may throw light on a claim pending before it. *Cook v. Alaska Workmen's Compensation Board*, 476 P.2d 29 (Alaska 1970).

> **AS 23.30.155. Payment of compensation.**
> . . . .
>
> (h) The board may upon its own initiative at any time in a case in which payments are being made with or without an award, where right to compensation is controverted, or where payments of compensation have been increased, reduced,

terminated, changed, or suspended, upon receipt of notice from a person entitled to compensation, or from the employer, that the right to compensation is controverted, or that payments of compensation have been increased, reduced, terminated, changed, or suspended, make the investigations, cause the medical examinations to be made, or hold the hearings, and take the further action which it considers will properly protect the rights of all parties.

8 AAC 45.052. Medical summary. (a) A medical summary on form 07-6103, listing each medical report in the claimant's or petitioner's possession which is or may be relevant to the claim or petition, must be filed with a claim or petition. The claimant or petitioner shall serve a copy of the summary form, along with copies of the medical reports, upon all parties to the case and shall file the original summary form with the board.

. . . .

8 AAC 45.070. Hearings

. . . .

(b) Except as provided in this section and 8 AAC 45.074(c), a hearing will not be scheduled unless a claim or petition has been filed, and an affidavit of readiness for hearing has been filed. . . . The board has available an Affidavit of Readiness for Hearing form that a party may complete and file. The board or its designee will return an affidavit of readiness for hearing, and a hearing will not be set if the affidavit lacks proof of service upon all other parties, or if the affiant fails to state that the party has completed all necessary discovery, has all the necessary evidence, and is fully prepared for the hearing.

. . . .

8 AAC 45.090. Additional examination.

. . . .

(b) Except as provided in (g) of this section, regardless of the date of an employee's injury, the board will require the employer to pay for the cost of an examination under AS 23.30.095(k), AS 23.30.110(g), or this section.

ANALYSIS

Should an SIME be ordered?

Employee's representation of the medical record is not supported by the facts. For examples, in his petition, Employee contends, "Dr. Curran believes that [Employee's] continuing problems were from prior injuries he sustained." In fact, Dr. Curran's May 28, 2014 report, which Employee attached to his petition, does not directly attribute Employee's disability and need for medical treatment to any injuries at all, but rather, more generally, to the "progressive

deterioration of an unstable arthritic right knee." Dr. Curran reiterates this opinion several times in his report. Furthermore, although Employee did not clarify to what "continuing problems" he was referring, to the extent he specifically meant those associated with an unstable right knee, the only prior injuries responsible for that condition, according to Dr. Curran, were the non-industrial injuries of December 2005 or June 2006.

Employee contends in his hearing brief, "Dr. Wade's treating physician [sic] believes that [Employee's] current condition is the result of an aggravation of a prior injury." In fact, what Dr. Wade wrote in his January 16, 2013 letter was, the physical labor Employee performed could have aggravated his preexisting condition. Dr. Wade did not mention any injury at all in his letter, let alone the 2002 work injury, but rather merely referred to "physical labor," without clarifying whether such physical labor was performed at work or not.

In his hearing brief, Employee contends, the "SIME physician, Dr. Curran, believes the current condition is a result of a deterioration of an arthritic unstable knee, which is unstable due to prior injuries, including the 2002 injury." As just set forth above, the portion of Employee's statement, before the comma, is accurate, but the portion after it, simply is not. Again, Dr. Curran attributed the laxity in Employee's knee to the non-industrial injuries of December 2005 or June 2006, not the 2002 work injury.

Employee contends in his hearing brief, "Dr. Dingeman believed that [Employee's] ACL was compromised as a result of the 2002 injury." In fact, Dr. Dingeman's opinions on causation are set forth in his February 19, 2003 report, which states Employee's meniscus tear and acute chondral fractures in the interarticular notch were "probably" work-related; however, Dr. Dingeman thought the "troublesome loose bodies" probably dated from Employee's prior severe leg trauma, *i.e.*, the 1992 ATV accident. Nowhere is Employee's ACL even mentioned in that report; and it is wholly unknown where else in the medical record Dr. Dingeman attributes a "compromised ACL" to the 2002 work injury.

However, the "dispute," to which Employee attributes the greatest significance, is set forth in his hearing brief:

> The deposition of Dr. Charles Craven was taken on August 5, 2015. At the deposition, Dr. Craven summarized his opinions on cross-examination. He said

> (and this is paraphrased, as the parties do not have his completed deposition yet) that he believed Dr. Robert Dingeman, who had reported that [Employee] had a weakness in his ACL[,] was mistaken. However, Dr. Craven also said that if Dr. Dingeman was not mistaken, and [Employee] did have a weakness in his ACL back in 2002, then the 2002 injury would be a substantial cause [sic] of his current disability and medical condition.
>
> . . . . Dr. Craven believes that Dr. Dingeman was mistaken when he said that [Employee] had a damaged ACL, but if Dr. Dingeman was correct, the 2002 injury would be considered a substantial cause of [Employee's] current condition. At worst, there is a difference of opinions amongst physicians. At best, Dr. Craven, on behalf of employer, has not only admitted to a clear difference of opinions between Dr. Dingeman and himself, but has also admitted that, if Dr. Dingeman was not mistaken (and there is no basis to believe he just made a "mistake"), the 2002 injury is a substantial cause of [Employee's] current condition.

In fact, Dr. Craven set forth considerable evidence on which to conclude Dr. Dingeman was mistaken in his recollection of the January 16, 2003 arthroscopy when he wrote in his April 3, 2003 report, "[Employee's increased drawer over the other knee] [was] consistent with a partial ACL injury seen at his arthroscopy." These bases include the November 9, 2003 MRI report, which noted neither edema within the ligament, nor bone bruising, characteristic of an ACL tear; Dr. Dingeman's January 16, 2003 operative report, which noted no anterior drawer during surgery and an "intact" ACL upon visual examination; Dr. Grunwald's June 3, 2003 report, which notes a normal ACL examination; and Dr. Marble's April 17, 2004 report, which also notes a normal ACL examination.

Nevertheless, undeterred by the evidence, Employee's attorney doggedly attempted, over the course of 12 pages of deposition transcript, to have Dr. Craven disregard all of the above-mentioned reports, and to hypothetically assume Employee did have a torn ACL in 2002-2003, and then opine the 2002 work injury was a substantial factor in Employee's present-day disability and need for medical treatment. This questioning by Employee's attorney clearly left Dr. Craven bewildered, and drew multiple objections from Employer's attorney, including the following:

> [Employer's attorney]: Let me finish my objection. Basically you are asking if the medical facts were totally different, you would reach a different conclusion?
>
> [Employee's attorney]: No, I'm not saying that.

[Employer's attorney]: Yeah, you are.

Employer's objection is entirely, well taken. The fallacy of an alleged opinion manufactured out of Employee's circular logic is not a basis for an SIME. Employee's petition will be denied.

CONCLUSION OF LAW

An SIME will not be ordered.

ORDER

Employee's May 19, 2015 petition is denied.

Dated in Fairbanks, Alaska on November 27, 2015.

ALASKA WORKERS' COMPENSATION BOARD

/s/_____
Robert Vollmer, Designated Chair

/s/_____
Sarah Lefebvre, Member

/s/_____
Jacob Howdeshell, 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 BRYON J. WILLIAMS, employee / petitioner; v. FAIRBANKS GOLD MINING, INC., employer; LIBERTY MUTUAL FIRE INSURANCE COMPANY, insurer / respondants; Case No. 200221229; dated and filed in the Alaska Workers' Compensation Board's office in Fairbanks, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on November 27, 2015.

/s/_____
Jennifer Desrosiers, Office Assistant