ALASKA WORKERS' COMPENSATION BOARD

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

MANUEL D. RODRIGUEZ-ROACH, Employee, Claimant, v. MANOR MANAGEMENT OF ALASKA, INC, Employer, and LIBERTY MUTUAL, Insurer, Defendants.	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 201508629 AWCB Decision No. 20-0052 Filed with AWCB Anchorage, Alaska on July 1, 2020

Manuel D. Rodriguez-Roach's (Employee) claim was heard on the written record on June 25, 2020, in Anchorage, Alaska, a date selected on April 29, 2020. An April 29, 2020 hearing request gave rise to this hearing. Attorney Robert Rehbock represents Employee; attorney Stacey Stone represents Manor Management of Alaska, Inc. and its insurer (Employer). The record closed on June 24, 2020, when the parties filed and the designee approved a stipulation changing the June 25, 2020 oral hearing to a hearing on the written record; however, it reopened on June 25, 2020, after the panel deliberated and had questions about the medical evidence.

ISSUE

Employee contends he needs additional treatment for his right knee, including but not limited to surgical revision of his right total knee replacement. He contends his work injury with Employer remains the substantial cause of the need for his additional right knee treatment.

Employer contends Employee's right knee work injury has been medically stable since 2019. It contends he needs no further treatment and his claim should be denied.

After reviewing the medical records and the parties' hearing briefs and exhibits, the panel had questions and found a need for additional briefing. The record is reopened to receive the parties' additional briefing on whether a current medical dispute should be sent back to second independent medical evaluator (SIME) William Curran, M.D., to review medical records filed since his April 8, 2019 report. These include but are not limited to computer tomography (CT) images and conflicting CT readings and a medical recommendation for additional right knee surgery. The question is whether Dr. Curran should review these new records, address the dispute between two radiologists who reviewed the same images and address the surgical recommendation.

Should the parties submit briefing on whether there should be a supplemental SIME?

FINDINGS OF FACT

A preponderance of the evidence establishes the following facts and factual conclusions:

1) On May 21, 2015, Employee injured his right knee at work when he was moving a picnic table while walking on uneven ground and twisted his knee. (First Report of Injury, June 5, 2015).

2) On May 18, 2018, Scot Youngblood, M.D., orthopedic surgeon, examined Employee for an employer's medical evaluation (EME). He diagnosed a work-related right knee sprain with medial and lateral meniscus tears, which he opined were medically stable. Other diagnoses including mild right knee arthritis and obesity were preexisting and in his view not caused or aggravated by the work injury. In his opinion, the work injury was not the substantial cause of the need for any additional right knee treatment. (Youngblood report, May 18 2018).

3) On July 18, 2018, Mark Caylor, M.D., orthopedic surgeon, who had previously performed a post-injury arthroscopic procedure on Employee's knee, performed a right total knee arthroplasty, commonly called a knee replacement, on him. (Caylor report, July 18, 2018).

4) On April 4, 2019, Dr. Caylor said he initially performed arthroscopic surgery on Employee's right knee, but when he did not do well, did a total right knee replacement to address Employee's chronic right knee pain. Unfortunately, Employee did not do well after the knee replacement surgery either. Dr. Caylor eventually performed a bone scan to look for prosthesis loosening "because there was micromovement in the prosthesis that's generating all this inflammation." The bone scan came back negative for movement but showed synovitis, which is inflammation in the knee and soft tissues; synovitis long after an arthroplasty is uncommon. In his view, Employee may have lifelong disability because if he cannot extend his knee fully, he cannot stand on his feet very long. Dr. Caylor opined Employee was, as of April 4, 2019, probably as "good as he was going to get" but nonetheless referred him to Stephen Tower, M.D., for another opinion. (Deposition of Mark T. Caylor, M.D., April 4, 2019).

5) On April 8, 2019, Dr. Curran performed an SIME on Employee. Pertinent to the pending issue, he opined the May 21, 2015 work injury is the substantial cause of Employee's need for medical treatment. Dr. Curran stated Employee is not medically stable and needs additional right knee treatment; he recommends a "sympathetic block lumbar spine." (Curran report, April 8, 2019).

6) On May 10, 2019, orthopedic surgeon Dr. Tower said Employee's primary diagnosis is complex regional pain syndrome (CRPS) related to his multiple knee operations following his work-related injury. (Tower report, May 10, 2019).

7) On July 15, 2019, well after Dr. Curran's evaluation, Deryk Anderson, D.O., evaluated Employee's right knee and found he had anterior knee pain that could be caused from a slightly oblique-cut patella. Dr. Anderson discussed potential right knee replacement revision surgery and Employee was going to consider it. Dr. Anderson was reluctant to do revision surgery because it may not improve Employee's range of motion; he first recommended range of motion exercises to see if this increased Employee's right knee function. (Anderson report, July 15, 2019).

8) On July 16, 2019, Heath McAnally, M.D., opined Employee's "pretty significant sleep apnea" interferes with his ability to heal and predisposes him to "severe chronic unrelenting pain." He recommended treating Employee's sleep apnea to address his chronic pain problem. If more conservative measures did not improve Employee's situation, he would consider a lumbar

sympathetic block. While Dr. McAnally could not make a direct link between Employee's work injury and his sleep apnea, in his opinion the sleep apnea needs to be treated regardless of its cause to mitigate Employee's pain from his work injury. (Deposition of Heath McAnally, July 16, 2019).

9) On August 6, 2019, Dr. Tower examined Employee's painful right knee and associated CRPS. He recommended Employee avoid additional right knee surgery because surgery tends to exacerbate CRPS. (Tower report, August 6, 2019).

10) On September 17, 2019, the parties settled Employee's claim but left future medical benefits "open," meaning not waived or settled. The agreement states:

> Except as set forth herein as necessary to resolve ongoing medical disputes, employee and employer waive their right to request a second independent medical evaluation pursuant to AS 23.30.095(k), and to ask the board to conduct an evaluation under AS 23.30.110(g), as relates to the issues resolved in this Agreement. (Settlement Agreement, September 17, 2019).

11) On October 24, 2019, Dr. McAnally gave Employee a right lumbar sympathetic block "as advised by his IME physician" to address Employee's CRPS symptoms in his right leg. (McAnally report, October 24, 2019).

12) On October 28, 2019, Employee called Dr. McAnally's office to report "no improvement" following his right lumbar sympathetic block injection. (McAnally report, October 29, 2019).

13) On November 11, 2019, Dr. Youngblood prepared an addendum EME report. He reviewed additional records extending through September 4, 2019. Dr. Youngblood reiterated opinions from his earlier EME report and opined Employee needed no further medical treatment to address the May 21, 2015 work injury; he disagreed with Employee's attending physicians' diagnoses, particularly CRPS and right radiculopathies, and specifically recommended against genicular nerve blocks. (Youngblood report, November 11, 2019).

14) On November 14, 2019, Employee reported to Dr. McAnally's assistant, Evan Evanson, PA-C, "severe pain" in his right lower extremity. He had recently undergone a lumbar sympathetic block with only brief relief thereafter. Employee had been to see Dr. Anderson who recommended surgical intervention for Employee's laterally deviated patella; he was interested in pursuing this but his fiancée was about to have a baby so he wanted to delay surgery. PA-C Evanson suggested a lumbar sympathetic plexus block might be appropriate given Employee's CRPS diagnosis. (Evanson report, November 14, 2019).

15) Dr. McAnally's chart notes are difficult to follow; each note has the service date on the upper left-hand corner but midway through, each report appears to include information from the "(INITIAL VISIT)." Thus, each report appears to describe what Employee's symptoms are, "Today," but it is unclear if those were his complaints on the "initial visit" or on the date stated on each report. (McAnally reports November 14, 2019 and January 15, 2020; observations).

16) On January 15, 2020, Dr. McAnally found minimal evidence supporting CRPS but found audible and palpable crepitus in Employee's right knee with active motion. He suggested focusing "on a potential orthopedic solution" instead of on CRPS. Dr. McAnally referred Employee to Brian Haughom, M.D., orthopedic surgeon. (McAnally report, January 15, 2020).

17) On January 22, 2020, Dr. Haughom referred Employee for a right knee CT. The history referenced, "Pain due to internal orthopedic prosth dev." Christopher Reed, M.D., radiologist, reported his interpretation of the CT results as follows:

> TECHNIQUE: CT examination of the knee was performed without intravenous contrast to determine component rotation by the method of Berger and Rubash.
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> FINDINGS: A total knee arthroplasty is present with patellar resurfacing. The femoral component is 1 degrees [sic] internally rotated with respect to the epicondylar axis. This measurement falls within the normal limits for femoral component rotation. Normal is 18 +/- 2.6 degrees of internal rotation.
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> Thus, the tibial component demonstrates 20 degrees internal rotation. . . .
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> IMPRESSION: Total knee arthroplasty. The femoral component demonstrates 1 degrees [sic] internal rotation with respect to the epicondylar axis and the tibial component shows 20 degrees internal rotation with respect to the axis of the patellar tendon. (Reed report, January 22, 2020).

18) On February 4, 2020, Dr. Haughom reviewed the CT scan with Employee and said it showed "the tibial component internally rotated 20 degrees." He could "likely improve" Employee's knee "with a revision of his right total knee arthroplasty." Employee wanted to proceed with the surgery "pending workers' compensation approval." (Haughom report, February 4, 2020).

19) On April 29, 2020, the parties met with the board's designee to schedule a hearing. The issues identified for hearing included medical compensability, further care, attorney fees and costs. They did not include an additional SIME. (Prehearing Conference Summary, April 29, 2020).

20) On May 1, 2020, Lisa Ballehr, D.O., radiologist, at Dr. Youngblood's referral reviewed Employee's January 22, 2020 right knee CT images. Her findings included:

> Osseous: Tricomponent total knee arthroplasties in place. Prosthetic components are well-seated and normally aligned. No periprosthetic bone erosion, loosening and no findings of periprosthetic fracture. Joint spacers in place.
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> General: Small joint effusion. No soft tissue mass or significant fluid collection about the knee. The visualized muscles are normal in density and caliber.
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> Impression:
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> 1. Tricomponent total knee arthroplasty in place with no significant postoperative complicating features.
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> 2. Small joint effusion.
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> Key points: Original report is not provided for correlation. (Ballehr report, May 1, 2020).

21) Employee contends he is entitled to an order awarding prospective care, pursuant to the Alaska Supreme Court's *Summers* opinion, so Dr. Haughom can proceed with the right total knee arthroplasty revision surgery he recommends. He contends the May 21, 2015 work injury was the substantial cause for the initial total knee replacement surgery; consequently, Employee contends all treatment flowing from that surgery is also compensable. Employee also apparently seeks an order awarding other recommended care, such as lumbar sympathetic blocks, to treat Employee's CRPS. He contends Dr. Youngblood has not commented on the CT findings from January 2020, which present a new and "objective cause" for Employee's continued, chronic right knee symptoms. Employee relies primarily on Dr. Curran's report for causation and Dr. Haughom's opinion for treatment. Dr. Curran ascribes causation to Employee's work injury; Dr. Haughom recommends surgery to fix a prosthesis "installed 20% out of alignment." In short, Employee contends the work-related right knee arthroplasty resulted in "harm caused by medical treatment for a compensable injury," which is itself compensable under Alaska law. He further contends a decision finding Employee's ongoing care compensable would place liability on Employer and resolve Medicaid liens; he also seeks attorney fees and costs. (Hearing Brief, June 18, 2020).

22) Employer contends Employee's right knee has been medically stable for at least one year. It relies on Dr. Youngblood's EME opinions and reports from Drs. Curran, Anderson, Tower and

McAnally, all of whom it contends recommend against right total knee arthroplasty revision surgery. Absent a favorable response from more conservative treatments, Employer contends Employee is not entitled to any additional medical care for his right knee; consequently, it contends he is also not entitled to an attorney fee or cost award. (Employer's Hearing Brief, June 18, 2020). 23) No medical report in Employee's agency file addresses the disagreement between radiologists Drs. Reed and Ballehr, who reviewed the same CT images; this creates a gap in the medical evidence. There is a qualifying medical dispute between these two radiologists: Dr. Reed found part of Employee's right knee prosthesis was rotated 20 degrees; by contrast, Dr. Ballehr found the prosthesis' components were "normally aligned." Dr. Curran has never seen the CT images, Drs. Reed's and Ballehr's CT interpretations, or Dr. Haughom's surgical recommendation. The panel members, who are not radiologists or medical doctors, lack medical understanding on these opinions and cannot determine the significance, if any, of Dr. Reed's 20 degree rotation finding versus Dr. Ballehr's "no significant postoperative complicating features" interpretation of the same, January 22, 2020 right knee CT images. (Agency file; experience, judgment and inferences from the above).

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 . . . to ensure . . . quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers. . . .

The board may base its decision on not only 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 (Alaska 1987).

> **AS 23.30.005. Alaska Workers' Compensation Board**. . . .
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> (h) . . . Process and procedure under this chapter shall be as summary and simple as possible. . . .

> **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. . . .
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> (k) In the event of a medical dispute regarding . . . the amount and efficacy of . . . treatment, or compensability between the employee's attending physician and the employer's independent medical evaluation, the board may require . . . a second independent medical evaluation. . . .
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> **AS 23.30.110. Procedure on claims**. . . .
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> (g) An injured employee claiming . . . compensation shall submit to the physical examination by a duly qualified physician which the board may require. . . .

Bah v. Trident Seafoods Corp. AWCAC Decision No. 073 at 2-3 (February 27, 2008), acknowledged the board's ability to order an SIME under AS 23.30.095(k), when there is a "qualifying medical dispute, and under AS 23.30.110(g), when a "significant gap" in the medical evidence or when a "lack of understanding of the medical evidence" prevents the board from "ascertaining the rights of the parties in the dispute before the board."

> **AS 23.30.135. Procedure before the board**. (a) In . . . 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. . . .
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> **8 AAC 45.065. Prehearings**. . . .
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> (c) After a prehearing the board or designee will issue a summary of the actions taken at the prehearing, the amendments to the pleadings, and the agreements made by the parties or their representatives. The summary will limit the issues for hearing to those that are in dispute at the end of the prehearing. Unless modified, the summary governs the issues and the course of the hearing.
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> **8 AAC 45.070. Hearings**. . . .
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> (g) . . . the prehearing summary . . . governs the issues . . . of the hearing. . . .

> **8 AAC 45.120. Evidence**. . . .
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> (m) The board will not consider evidence or legal memoranda filed after the board closes the hearing record, unless the board, upon its motion, determines that the hearing was not completed and reopens the hearing record for additional evidence or legal memoranda. The board will give the parties written notice of reopening the hearing record, will specify what additional documents are to be filed, and the deadline for filing the documents.

ANALYSIS

Should the parties submit briefing on whether there should be a supplemental SIME?

Employee previously settled his claim and left only medical benefits unresolved. He now seeks an order awarding him additional medical care for his right knee. AS 23.30.095(a). Dr. Curran previously performed an SIME. AS 23.30.095(k). However, since Dr. Curran's SIME report, additional medical evidence has been obtained. Specifically, Dr. Reed interpreted a January 22, 2020 CT as showing a 20 percent rotation in part of Employee's right knee prosthesis; and relying on that interpretation, Dr. Haughom recommends a revision to Employee's right knee arthroplasty. On the other hand, Dr. Ballehr's interpretation of the same CT images reveals no apparent misalignment. The fact-finders are not medical doctors or radiologists; they do not have the expertise to understand what, if any, Dr. Reed's findings mean, or if they are even accurate.

The different CT interpretations between Employee's attending physician Dr. Lee and Employer's EME physician Dr. Ballehr create another, unaddressed, medical dispute. AS 23.30.095(k). The fact-finders have no idea what the "Berber and Rubash" method is, what significance if any a "20 degrees internal rotation" of the tibial component has on Employee's right knee symptoms, or if Dr. Ballehr's CT interpretation is more accurate than Dr. Reed's. No physician has directly addressed this medical dispute. Dr. Curran has never seen the CT scan images, Drs. Reed's and Ballehr's CT interpretations or Dr. Haughom's surgical recommendation. *Rogers & Babler*. This creates a "gap" in the medical evidence; the medical complexity of the issues addressed in the radiologists' disparate reports creates a "lack of understanding of the medical evidence" in the fact-finders. *Bah*. For these reasons, the panel is considering asking Dr. Curran to address these

most recent records and offer his opinion on the radiologists' findings, and any effect these findings may have on Employee's right leg symptoms and appropriate treatment. AS 23.30.110(g).

The question of an additional SIME was not raised as an issue for hearing; accordingly, to protect all parties' due process rights, the parties will be given a chance to brief this issue. 8 AAC 45.065(c); 8 AAC 45.070(g); AS 23.30.135(a). Proceeding in this fashion will help ensure "quick, efficient, fair, and predictable" delivery of medical benefits to Employee if he is entitled to them, at a reasonable cost to Employer, and will create a more "summary and simple" adjudicative process. AS 23.30.001(1); AS 23.30.005(h). Otherwise, the fact-finders will decide the case's merits on evidence they may not fully understand.

To best ascertain their rights and to assure due process, this decision will direct the parties to file optional briefs addressing whether or not Dr. Curran should review the recent medical records and answer additional questions based thereon. AS 23.30.135(a); 8 AAC 45.120(m). The parties will be directed to file and serve optional five-page briefs by no later than July 8, 2020; the record will close on that date and a decision will issue determining if a supplemental SIME should be ordered.

CONCLUSION OF LAW

The parties should submit briefing on whether there should be a supplemental SIME.

ORDER

1) The hearing record is reopened to allow the parties to submit additional briefing only.
2) The parties may submit an optional five-page brief addressing whether or not Dr. Curran should review medical records obtained and filed since his SIME report, and answer questions speaking to disagreements between Drs. Lee's and Ballehr's CT interpretations and the significance, if any, of their respective findings and whether they affect Dr. Curran's treatment recommendations.
3) The parties' optional briefs must be filed and served by no later than July 8, 2020, at which time the record will close and a decision will issue on this supplemental SIME question.

Dated in Anchorage, Alaska on July 1, 2020.

ALASKA WORKERS' COMPENSATION BOARD

/s/
William Soule, Designated Chair

/s/
Sara Faulkner, Member

/s/
Nancy Shaw, 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 Manuel D. Rodriguez-Roach, employee / claimant v. Manor Management of Alaska, Inc., employer; Liberty Mutual, insurer / defendants; Case No. 201508629; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by certified U.S. Mail, postage prepaid, on July 1, 2020.

/s/
Kimberly Weaver, Office Assistant