ALASKA WORKERS' COMPENSATION BOARD

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

MICHAEL D WOOD, Employee, Claimant, v. WESTWARD SEAFOODS, Employer, and SOMPO AMERICA FIRE & MARINE INS, Insurer, Defendants.	)	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 201900856 AWCB Decision No. 21-0042 Filed with AWCB Anchorage, Alaska on May 18, 2021.

Employee Michael D Wood's December 12, 2020 petitions for second independent medical evaluations (SIME) were heard on March 17, 2021 in Anchorage, Alaska, a date selected on February 2, 2021. Employee's January 22, 2021 hearing request gave rise to this hearing. Attorney Robert Bredesen represented Michael D. Wood (Employee). Attorney Jeffrey Holloway represented Westward Seafoods and its insurer (Employer). There were no witnesses. All participants appeared telephonically. The record closed at the hearing's conclusion on March 17, 2021.

ISSUES

Employee contends there are significant disputes between his attending physicians and Employer's medical evaluators (EME) regarding causation and treatment of Employee's head and right knee injuries. Therefore, he contends an SIME should be ordered.

Employer contends the disputes between Employee's attending physicians and EME physicians concerning Employee's head injury are insufficient to warrant an SIME.

It also contends there are no significant disputes between Employee's attending physicians and EME physician Jonathon Dickens, M.D., concerning causation of the right knee disability and need for medical treatment. Nevertheless, it agreed that if an SIME is ordered on the right knee, one should also be ordered on the left shoulder. In addition Employer contends Employee's claims for his right knee are barred by AS 23.30.100; thus no SIME on the right knee should be ordered.

1) Should an SIME be ordered on Employee's head, right knee and left shoulder injuries?

Employee contends he is entitled to a medical stability determination, functional capacity evaluation (FCE), and permanent partial impairment (PPI) rating pursuant to AS 23.30.110(g). Employer did not expressly contend Employee was not entitled to the above, but it is assumed it is opposed.

2) Should a medical stability determination, functional capacity evaluation and permanent impairment rating be ordered?

FINDINGS OF FACT

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

1) On January 14, 2019, Employee reported he was walking outside at work when he slipped and fell, hitting the back of his head, left elbow and shoulder on the ground. He also bit his tongue. (First report of injury, January 17, 2019).

2) On January 14, 2019, Employee was treated at Iliuliuk Family and Health Services (IFHS) in Dutch Harbor after his fall. Vincent Perino, PA evaluated Employee, who reported he was walking between buildings and had fallen on the ice, striking the back of his head and losing consciousness. When he regained consciousness he was not sure where he was and called his wife to ask her. She explained he was in Dutch Harbor. Employee was able to stand up on his own and went to the clinic. He complained of a headache, but denied double vision, nausea or vomiting or any numbness or tingling or weakness in his extremities. Employee had blurry

vision initially, but his vision had since cleared; he also had a little sensitivity to light. He complained of pain in his left upper back. Employee stated he drank three to four beers every other day. PA Perino performed a physical examination and noted back pain, neck stiffness and light-headedness. PA Perino noted Employee was oriented to person, place and time, his head was normal and atraumatic, without tenderness, contusions, abrasions, hematomas or depressed skull fractures. Employee's eyes were normal except for scleral icterus. Employee complained of pain with forward and lateral flexion and extension against resistance. PA Perino noted Employee had a normal mood and affect, behavior judgment and thought content. No lab work or imaging was obtained. Employee was diagnosed with a closed head injury and acute left-sided thoracic back pain. He was released from work for two days to return without any restrictions. (PA Perino clinic note, January 14, 2019).

3) On March 12, 2019 Employee was again seen at IFHS, this time by Robert Gneiting, NP. Employee complained of acute pain in both knees, worse on the right. He stated his work required a lot of bending, kneeling and crouching. He reported a fall in January, after which his knee pain became worse. Bilateral knee x-rays showed mild joint space narrowing in the bilateral medial femoral tibial compartments and mild bilateral narrowing in the mediopatellofemoral compartment, worse on the left. There were no fractures or osteochondral defects or joint effusion. He was given knee braces to use when working, ibuprofen for pain and told to use ice packs four times a day. (NP Gneiting clinic note, March 12, 2019).

4) On March 25, 2019, Employee was seen at Peterson Regional Health Medical Center (PRHMC) Emergency Department (ED) in Texas for complaints of a right knee injury which had occurred two months earlier in Alaska. On physical examination Employee was alert, with clear speech, articulate, and oriented to person, place and time. There were no new neurological signs or indication of blurred vision, loss of balance, headache, altered mental status, focal weakness, numbness or slurred speech. A knee x-ray showed no acute abnormality, but some sclerosis and possible subchondral cystic change. (NP Pawlak ED note, March 25, 2019).

5) On April 10, 2019, Benjamin Harper, M.D. treated Employee at the PRHMC ED for shakes, tremors, and suicidal ideation. It was noted he had a history of alcoholism. Employee was alert, oriented to person, place and time, with fluid speech and normal cranial nerves. He was found to have acute renal failure, acidosis, alcohol dependence, withdrawal delirium, alcohol hepatitis and

alcohol gastritis with bleeding. He was discharged to the Salvation Army. (Dr. Harper's ED note, April 10, 2019 and Pacheco discharge summary, April 15, 2019).

6) On May 4 and 9, 2019, Employee presented in the PRHMC ED for left chest pain and alcohol abuse. He was discharged to the Salvation Army. (Rondales Rhoade, M.D. ED note, May 4, 2019 and Heather Harris, M.D. ED note, May 9, 2019).

7) On May 13, 2019, Employee was admitted to Lutheran Hospital in Indiana on transfer from Marion General Hospital, where he had been admitted the prior day after a fall to the floor and a seizure witnessed by family members. A head computerized tomography (CT) scan showed a possible subdural hematoma. Magnetic resonance imaging (MRI) of the brain showed a minor, recent, acute right subdural hemorrhage without abnormal mass effect. Employee reported he also had a seizure four months earlier after slipping on the ice and hitting his head in Alaska. (ED clinical notes, May 13, 2021).

8) On August 13, 2019, Employee saw Kelli Linsenmayer, NP, for his dizziness, headaches, right knee pain and left shoulder pain. He reported having suffered a concussion with a brain bleed approximately three months before. However, he stated he was in Arkansas for several months so he missed the neurosurgery consult that had been scheduled for him. He had suffered persistent headaches while in Arkansas. The headaches were dull, occurring multiple times daily in the frontal and parietal lobes. He also complained of tunnel vision, lightheadedness and falls. Employee also stated he had a history of four to five concussions as a child when he played football and karate. Employee reported he was on a trip to Alaska when he slipped and hit his right knee, hearing a pop. He reported the pain had improved since the initial injury, but he still felt the knee was unstable and he still had pain. NP Linsenmayer referred him to physical therapy for treatment for his right knee and left shoulder and to neurology for his post-traumatic headaches. (NP Linsenmayer clinic note, August 13, 2019).

9) On September 3, 2019, Employee followed up with NP Linsenmayer for his complaints of dizziness and lightheadedness, which had come and gone since his head injury several months before. He also complained of right knee and left shoulder pain. The left shoulder pain had been present for over two years. He reported not having imaging of his left shoulder and he thought it was chronic pain perhaps due to arthritis or an old sports injury. Employee was referred to physical therapy (PT) for conservative treatment for six weeks. (NP Linsenmayer clinic note, September 3, 2019).

10) On September 6, 2019, on referral from NP Linsenmayer, Employee consulted with Jennifer Hite, NP for right knee and left shoulder pain. He reported a history of shoulder dislocation and chronic shoulder pain. Employee stated the right knee pain had begun as the result of a fall. The pain was located in the medial aspect of the right knee. (NP Hite clinic note, September 6, 2019).

11) On September 6, 2019, x-ray of the left shoulder showed mild degenerative changes, mild to moderate arthritis of the acromioclavicular (AC) joint, hyperdensity of the glenoid, and slight spurring under the AC joint. (W.M. Roper, M.D. clinic note, September 6, 2019).

12) On September 23, 2019, on referral Kelli Linsenmayer, NP, neurologist Hal Dickson, M.D., of Eastern Indiana Neurology, P.C., evaluated Employee for headaches, post-concussional syndrome, and "some apparent blood products noted on imaging." Dr. Dickson performed a history and physical examination and noted Employee had apparently hit his head with a fairly severe concussion in January in Alaska and had had problems with falling down repetitively since. He was seen at Marion General Hospital in May 2019, where a head CT scan was performed, which showed some apparent blood products. Employee reported episodes of visual change and "feeling as though he is out of his body." He was having bi-occipital aching headaches one to two times per week, lasting up to one hour. He also reported he had been sober for 53 days. Review of systems was positive for ulcers, colitis, rectal bleeding, question of seizures, hypertension, coughing up blood, dizziness, skin cancer, swollen and painful joints, possible stroke, headaches, double vision and convulsions. On physical examination Dr. Dickson noted no abnormalities except a gait which was mildly broad based with presence of a Romberg sign. He also noted Employee had had multiple concussions throughout his life, culminating in a severe one in January. Dr. Dickson planned to see Employee for follow up in one to two months. (Dr. Dickson clinic note, September 23, 2019).

13) On October 18, 2019, Employee was treated by Jennifer R. Hite, NP at Central Indiana Orthopedics for an injury to his right knee due to a fall nine months earlier. Employee reported the steroid injection he had received on September 11, 2019 had not improved his knee pain. The pain was located along the medial joint line, concerning for a meniscal tear. A right knee MRI was ordered. Employee was also treated for his ongoing left shoulder pain, which had continued after he had completed physical therapy. He received a steroid injection to the left shoulder. (NP Hite clinic note, October 18, 2019).

14) On January 14, 2020 Dr. Dickson saw Employee for follow up of headaches and post-concussional syndrome. He had reviewed Employee's head imaging from May 2019 and stated there was no intracranial hemorrhage at that point. Employee reported his headaches had decreased in frequency to three times per week in the bifrontal regions. On physical examination, there was minimal bitemporal tenderness and higher cortical functions, speech, and cranial nerves appeared intact. (Dr. Dickson clinic note, January 14, 2020).

15) On March 3, 2020, Employee was assessed by orthopedic surgeon Salil Rajmaira, M.D. of Central Indiana Orthopedics for his right knee pain. Employee reported right knee pain had begun a year previously after a fall. Aching, sharp, stabbing and throbbing pain in the medial aspect of his right knee were constant and getting worse. Dr. Rajmaira reviewed the imaging studies of the right knee, noting the March 3, 2020 x-ray showed marked diminution of the medial joint space with changes at the medial femoral condyle, most likely to represent avascular necrosis. The October 25, 2019 MRI was consistent with avascular necrosis of the medial femoral condyle and also showed moderate patellofemoral arthritic changes. Dr. Rajmaira discussed continued nonsurgical care versus referral to a surgeon who deals with allografting or autografting procedures of the femur. Dr. Rajmaira told Employee the avascular necrosis might be related to his history of heavy drinking. (Dr. Rajmaira clinic note, March 3, 2020).

16) On May 11, 2020, Employee underwent right total knee arthroplasty for severe degeneration and significant avascular necrosis, medial femoral condyle. (Operative Report, May 11, 2020).

17) On July 13, 2020, Employee saw NP Linsenmayer for severe headaches that had started that morning. He was to follow up with the neurologist and neuropsychologist for management of his previous head injury. He reported he was to undergo left shoulder surgery in three days' time. (Clinic note, July 13, 2020).

18) On August 3, 2020, neuropsychologist Kristin Perrone, PhD, on referral from Dr. Dickson, saw Employee for a neuropsychological evaluation. Dr. Perrone noted Employee had had a fall in January 2020 (sic), which resulted in a closed head injury with loss of consciousness for an unspecified period of time. Employee reported periods of amnesia during the morning since his injury as well as memory concerns, difficulty with attention and concentration, word finding, disorientation and confusion, repeating himself, and forgetting things. He had stopped driving and since shortly after his head injury and had concerns about living at home due to his memory

difficulties. He reported symptoms of depression, including anhedonia, changes in weight and appetite, low energy and motivation and difficulty in concentrating or making decisions. He reported three past suicide attempts, the most recent having been six years previously. He reported generalized anxiety. Employee also endorsed symptoms of posttraumatic stress syndrome (PTSD), including a history of physical and sexual trauma, nightmares, avoidance of thoughts and reminders, detachment from others, insomnia, hypervigilance and exaggerated startle responses, some of which had improved over time. Employee was friendly, cooperative and appeared to make his best effort during the examination. His neurocognitive profile was marked for average intellectual functioning, roughly commensurate with an estimate of premorbid functioning. Dr. Perrone opined Employee did not need assisted living accommodations at that time. Employee's memory profile was marked for extremely low ability to recall information immediately after it was presented and borderline ability to recall information following a delay. Dr. Perrone opined these memory deficits were consistent with Employee's report of a head injury and subsequent memory concerns. She stated factors such as PTSD, stress, depression, and anxiety can contribute to difficulty with memory and concentration. Dr. Perrone diagnosed Employee with major depressive disorder, recurrent episode, moderate; generalized anxiety disorder; PTSD; diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequel, and major neurocognitive disorder due to traumatic brain injury; and unspecified alcohol-related disorder. The recommendations for treatment were the use of mnemonics, continued outpatient therapy with a therapist to assist with symptoms of depression, anxiety, PTSD, and the development of coping strategies for memory deficits. She also recommended Employee be monitored for signs of neurocognitive problems and follow up neuropsychological testing in one to two years for any signs of degeneration. (Dr. Perrone evaluation, August 3, 2020).

19) On September 10, 2020, Employee was evaluated by neurologist Kevin F. Connally, M.D. in an EME. Dr. Connally reviewed his medical history and performed a physical examination. Employee reported he had persistent cognitive problems, including a poor short-term memory. He also complained of headaches which occurred about three times weekly and which he had not had before his fall. Employee reported he had what he called "seizures," which lasted about 20 to 30 seconds, and during which his whole body would shake; he would remain awake during these episodes. He stated he had periods of time in which he has lost track of what was

happening and does not remember afterwards what happened. Employee also reported he had episodes of true vertigo after his fall at work and still has a sense of dizziness. He stated the medication gabapentin helped with this. On physical examination Dr. Connally noted Employee was alert, oriented and could understand and cooperate with the details of the neurologic examination. Attention, concentration, and language function were all intact. Dr. Connally noted Employee's knee reflexes were absent bilaterally. In the upper extremities, the brachioradialis, biceps and triceps reflexes were absent. In the low extremities, Employee had a distal loss of pin perception. He also had difficulties with proprioception and diminished vibratory perception. Dr. Connally stated Employee had the following neurological diagnoses: 1) cerebral concussion, January 2019, resolved without residual; 2) vertigo and dizziness; 4) major motor seizure unrelated to the January 2019 work injury; 5) no neurologic impairments secondary to the January 2019 work injury; 6) possible dissociative reactions, unrelated to the January 2019 work injury; 7) left carpal tunnel syndrome, unrelated to the January 2019 work injury; 8) electrophysiologic evidence of left ulnar neuropathy, unrelated to the work injury; 9) peripheral neuropathy, probably secondary to alcohol consumption and unrelated to the work injury; and 10) chronic alcohol abuse, now in remission. (Dr. Connally EME report, September 10, 2020).

20) Employee's neurological examination was normal, with the exception of a peripheral neuropathy marked by diminished vibratory perception and pin perception in a stocking pattern over both lower extremities. He opined there were no neurologic impairments or issues secondary to the work injury. He further opined the work injury would have been the substantial factor in the need for disability and or treatment for two weeks following the work injury. (*Id*.).

21) Employee's conditions, although not related to the work injury, were not medically stable and required further evaluation and treatment. The most significant factor in bringing about the need for further treatment was uncontrolled use of alcohol. (*Id*.).

22) Employee had no ratable impairment due to the January 2019 work injury and no neurologic restrictions secondary to the work injury. (*Id*.).

23) On September 10, 2020, orthopedic surgeon Dr. Dickens reviewed Employee's medical records and performed a physical examination in an EME. He diagnosed Employee with right knee avascular necrosis, preexisting the January 2019 work injury, and status post total right knee arthroplasty, unrelated to the work injury. Dr. Dickens also diagnosed a left shoulder labral

tear, acromioclavicular joint arthritis and paralabral cyst, status post left shoulder arthroplasty, labral tear, distal clavicle excision, and cyst decompression on July 16, 2020. He opined the substantial cause of disability due to the left shoulder condition was the left shoulder acromioclavicular joint arthritis, labral tear, and paralabral cyst, which were aggravated by the work injury. Employee's left shoulder was predicted to reach medical stability by January 15, 2021, six months after the surgery. Past treatment of the left shoulder had been reasonable. The most significant factor bringing about the need for further treatment would be the left shoulder surgery, and the most significant factor bringing about the surgery is the degenerative shoulder arthritis and labral degeneration. No PPI rating was done due to ongoing therapy. As Employee's left shoulder was not yet medically stable, work status could not be assessed, but Employee would be able to participate in light duty as of the date of the exam. (Dr. Dickens EME report, September 10, 2020).

24) Dr. Dickens clarified that his opinion on the substantial cause of the need for Employee's July 16, 2020 left shoulder surgery was the pre-existing and degenerative findings, including acromioclavicular joint arthritis, labral degeneration, and tear, all of which were related to chronic and repetitive activities. (Dr. Dickens' response to Employer's questions, November 9, 2020).

25) On September 19, 2020, Employee was examined by clinical neuropsychologist Alan Breen, Ph.D., in an EME. He reviewed Employee's medical history and performed an in-person examination. The neuropsychological examination was invalid and the neurocognitive results could not be considered reliable for the purposes of diagnosis or assessment because Employee's self-report regarding cognitive problems likely overestimated the problems. Dr. Breen diagnosed Employee with alcohol dependence in early remission by self-report. He opined posttraumatic stress disorder, major depression, minor neurocognitive difficulties associated with alcohol should be considered rule-out diagnoses requiring more information. There were no diagnoses associated with the January 2019 slip-and-fall work injury. (Dr. Breen EME report, September 8-9. 2020).

26) Dr. Breen opined the most significant factor in any of Employee's neuropsychological cognitive difficulties, if they exist, is Employee's alcohol dependence. As Employee was able to work after the January 2019 work injury until his dismissal in March 2019, it is unlikely on a

more-probable-than-not basis, that the work injury produced symptoms that would prevent him from working. (*Id*.).

27) On January 14, 2020, attending physician neurologist Dr. Dickson saw Employee for follow up of headaches and post-concussional syndrome. He had reviewed Employee's head imaging from May 2019 and stated there was no intracranial hemorrhage at that point. Employee reported his headaches had decreased in frequency to three times per week in the bifrontal regions. On physical examination, there was minimal bitemporal tenderness and higher cortical functions, speech, and cranial nerves appeared intact. (Dr. Dickson clinic note, January 14, 2020).

28) Repeated concussions may have a cumulative effect. (Experience, judgment, observations, and inferences drawn from all of the above).

29) Knee replacement surgery, post-operative disability and physical therapy are expensive. (Experience, judgment, observations).

30) At hearing on March 17, 2020, Employee's attorney Mr. Bredesen stated Employee testified at his deposition the pain in his right knee developed over time and he told his supervisor about his right knee pain on several occasions. (Hearing record, March 17, 2021).

31) At hearing the parties stipulated that if an SIME was ordered on the right knee, an SIME should also be ordered on the left shoulder. (Hearing record, March 17, 2021).

PRINCIPLES OF LAW

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 . . . .
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> (k) In the event of a medical dispute regarding determinations of causation, medical stability, ability to enter a reemployment plan, degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's independent medical evaluation, the board may require that a second independent medical evaluation be conducted by a physician or physicians

> selected by the board from a list established and maintained by the board. The cost of an examination and medical report shall be paid by the employer. ...

AS 23.30 095(k) is procedural, not substantive. *Deal* v. *Municipality of Anchorage*, AWCB Decision No. 97-0165 (July 23, 1997) at 3. Wide discretion exists under AS 23.30.095(k) 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 (AWCAC) in *Bah v. Trident Seafoods Corp.*, AWCAC Decision No. 073 (February 27, 2008), addressed authority to order an SIME under §095(k) and AS 23.30 110(g). *Bah* used "SIME" to apply to evaluations ordered under both sections. With regard to §095(k), the AWCAC cited *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.

Bah further stated in *dicta*, before ordering an SIME it is necessary for the board to find the medical dispute is significant or relevant to a pending claim or petition and the SIME would assist the board in resolving the dispute. *Bah v. Trident Seafoods Corp.*, AWCAC Decision No. 073 (February 27, 2008), at 4. *Bah* noted the purpose of ordering an SIME is to assist the board, and it is not intended to give employees an additional medical opinion at the expense of employers when employees disagree with their own physician's opinion *Id*. 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 an employee's physician and an EME?
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> 2) Is the dispute significant? and
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> 3) Will an SIME physician's opinion assist the board in resolving the disputes?

Deal, AWCB Decision No. 97-0165 (July 23, 1997), at 3.

> AS 23.30.100. Notice of Injury or Death.
> Notice of an injury or death in respect to which compensation is payable under this chapter shall be given within 30 days after the date of such injury or death to the employer.
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> . . . .

> (d) Failure to give notice does not bar a claim under this chapter
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> > (1) if the employer, an agent of the employer in charge of the business in the place where the injury occurred, or the carrier had knowledge of the injury or death and the board determines that the employer or carrier has not been prejudiced by failure to give notice;
> > (2) if the board excuses the failure on the ground that for some satisfactory reason notice could not be given;
> > (3) unless objection to the failure is raised before the board at the first hearing of the claim for compensation in respect to the injury or death.
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> AS 23.30.110. Procedure on claims.
> (a) Subject to the provisions of AS 23.30.105, a claim for compensation may be filed with the board in accordance with its regulations at any time after the first seven days of disability ... and the board may hear and determine all questions in respect to the claim ....
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> . . . .
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> (g) An injured employee claiming or entitled to compensation shall submit to the physical examination by a duly qualified physician which the board may require. …
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> . . . .

The Alaska Supreme Court in *Tobar v. Remington Holdings, LP*, 447 P.3d 747, 757 (Alaska 2019) said the Act authorizes the board to order an SIME when requested under §§095(k) and 110(g) and 8 AAC 45.092(g) allows it to order one on its own motion. *Tobar* cited with approval from the commission's *Bah* decision, which said the board can 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.

> 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 in 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 . . . .

In Fred Meyer, Inc. v. Updike, AWCAC Decision No. 120 (October 29, 2009), the employee had waived her right to all benefits through settlement, with the exception of future medical care. A

dispute arose about medical care and the board, on its own motion, ordered an SIME under AS 23.30.110(g). The commission held the board erred in ordering an SIME under §110(g) because the employee claimed only medical benefits rather than "compensation." *Updike* held §095(k) provided proper authority to order an SIME when medical benefits alone are claimed so long as there is a qualifying medical dispute.

> AS 23.30.155. Payment of compensation.
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> (h) The board may upon its own initiative at any time in a case … where right to compensation is controverted . . . make investigations, cause the medical examinations to be made. . . .which it considers will properly protect the rights of all parties.

ANALYSIS

1. Should an SIME be ordered on Employee's head, right knee and left shoulder injuries?

A) Head injury and ongoing post-concussive disability and need for medical treatment.

Although Employer accepted Employee's January 14, 2019 head injury as work related, the parties disagree concerning whether Employee's ongoing post-concussive disability and need for medical treatment are compensable. The parties disagree whether there are significant disputes between Employee's attending physicians Drs. Dickson and Perrone and EME physicians Drs. Connolly and Breen.

As the Commission noted in *Bah*, there are generally three requirements before an SIME can be ordered under §095(k), although they are not required by the statute. First, there must be a medical dispute between an employee's attending physician and an EME physician. *Bah*; *Smith*. Second, the dispute must be significant. Third, it must be determined an SIME physician's opinion would assist in resolving the dispute.

Here, the record includes disagreement on the whether Employee's ongoing post-concussive disability and need for medical treatment are caused by his January 14, 2019 head injury.

Employee's treating physician neurologist Dr. Dickson in his September 23, 2019 evaluation noted Employee had suffered multiple concussions throughout his life, culminating in a severe one in January in Alaska. He had problems with falling down since that time. Dr. Dickson recommended follow up in one or two months. It is well known repeated concussions may have a cumulative effect. *Rogers & Babler*.

Dr. Dickson referred Employee to neuropsychologist Dr. Perrone for evaluation. In her August 3, 2020 evaluation, Dr. Perrone attributed Employee's ongoing post-concussive disability and need for medical treatment to his January 2020 (sic) fall, which had resulted in a closed head injury and loss of consciousness for an unspecified period of time. She opined Employee's memory deficits were consistent with his report of a head injury and subsequent memory concerns. Recommended further treatment included outpatient therapy to develop coping strategies for memory deficits and to assist with the symptoms of depression, anxiety and PTSD. Follow up neuropsychological testing was recommended in one or two years for any signs of degeneration.

Both EME neurologist Dr. Connolly and neuropsychologist Dr. Breen in their September 9 and 10, 2020 reports opined Employee's January 14, 2019 work injury caused only a mild and temporary concussion and there was no work-related need for treatment.

This is a preliminary, procedural hearing on Employee's two petitions requesting an SIME. *Deal*. The SIME statute does not require a party to demonstrate a medical dispute to any particular degree of certainty or to meet a legal standard. Here, Employee's treating physicians opined Employee's ongoing post-concussive disability and need for medical treatment were caused by the work injury, whereas the EME physicians state the work injury produced only a mild and temporary concussion and no further work-related treatment was necessary. Thus, there is a medical dispute between Employee's attending physicians and the EME physicians and Employee has met the first prong of the test for an SIME.

The second prong is whether the dispute is "significant." Ongoing disability and medical treatment cannot be considered insignificant issues. Employee is claiming temporary total

disability (TTD), temporary partial disability (TPD), PPI, transportation costs, medical treatment and penalties and interest. These are potentially significant benefits. *Updike*. Moreover, the dispute between Employee's attending physicians and the EME physicians is significant as without compensability there can be no compensation. The causation and treatment disputes are significant and justify an SIME. *Bah*.

The third *Bah* factor is whether an SIME would be helpful to the fact-finders in resolving the dispute. This case involves a complex medical history and complex medical issues over a long period with many treating physicians in many locations. There are significant medical disputes between Employee's neurologist and neuropsychiatrist on the one hand and the EME neurologist and neuropsychiatrist on the other regarding causation and the need for ongoing treatment. It would assist the fact-finder to have an SIME by an impartial neurologist and neuropsychiatrist to offset any possible bias. Therefore the opinions of a qualified neurologist and neuropsychiatrist will help the fact-finders establish facts and best ascertain all parties' rights. AS 23.30.135. Therefore; Employee's petition for an SIME will be granted and a neurologist and a neuropsychiatrist will perform the SIME.

B) Right knee and left shoulder.

Employer first contends Employee's claims for his right knee disability and need for medical treatment are barred by §100 as Employee did not report the right knee injury to the Employer until December 9, 2019. However, Employee testified in his deposition the right knee symptoms developed over time and he did in fact report this injury to his supervisor at work several times. In addition, even if Employee had not reported the right knee injury within 30 days of being aware of the injury, the fact he was suffering from a concussion and memory problems after his January 14, 2019 fall is a satisfactory reason notice could not be given. §100(d)(2). Therefore, Employee's claims for his right knee disability and need for medical treatment are not barred by §100.

The parties disagree over whether there are significant medical disputes between Employee's attending physicians and EME physician Dr. Dickens sufficient to justify an SIME under §095(k). Employee's attending physician NP Jennifer Hite, noted on October 18, 2019, the

cause of Employee's right knee disability and need for medical treatment was the injury when he had fallen over nine months previously. His attending physician Dr. Rajmaira stated on March 3, 2020 Employee needed a right knee replacement due to right knee pain of more than one year's duration. He also noted the symptoms had begun as a result of a fall. Although Dr. Rajmaira noted the right knee avascular necrosis might be related to his history of heavy drinking, he did not state the patellofemoral arthritic changes might be due to the heavy drinking, nor did he state the January 14, 2019 fall did not aggravate the underlying avascular necrosis and patellofemoral arthritic changes to cause the disability and need for medical treatment.

By contrast, EME physician Dr. Dickens opined Employee's right knee disability and need for medical treatment were due to pre-existing avascular necrosis and unrelated to the work injury.

As noted above, the SIME statute does not require a party to demonstrate a medical dispute to any particular degree of certainty or to meet a legal standard. As the record shows there is disagreement between Employee's attending physicians and the EME physician concerning whether the cause of Employee's right knee disability and need for medical treatment was the work injury, the first prong of the test has been met.

The disability and medical treatment for Employee is claiming and has received for his right knee are potentially significant benefits. *Updike*. As noted above, without compensability, there can be no compensation. Employee already underwent a right knee replacement. The pre-surgery disability, the surgery itself, and subsequent disability and treatment are expensive. There are significant disputes between Employee's attending physicians NP Hite and Dr. Rajmaira on the one hand and EME physician Dr. Dickens on the other concerning compensability and treatment. The causation and treatment disputes are significant and justify an SIME. *Bah*.

The third *Bah* factor is whether an SIME would be helpful to the fact-finders in resolving the dispute. Whether or not Employee's right knee disability and need for medical treatment arose out of and in the course of his employment with Employer is a complex medical issue and the medical history is also complex. An opinion from an impartial qualified orthopedic surgeon

would offset any bias and assist the fact-finder to establish facts and best ascertain all parties' rights under §135. Therefore, Employee's petition for an SIME will be granted and an orthopedic surgeon will perform the SIME. As the parties stipulated at hearing if an SIME was ordered for the right knee, one would also be ordered for the left shoulder, an orthopedic surgeon will also perform an SIME on Employee's left shoulder.

2) Should a medical stability determination, functional capacity evaluation and permanent impairment rating be ordered?

Employee contends a medical stability determination, a functional capacity evaluation and a PPI rating should be ordered pursuant to §110(g). In *Bah*, as noted above, the commission held the SIME is intended to assist the fact-finders. Despite a long course of disability and medical treatment for Employee's head and right knee injuries, there have been predictions of, but no determinations of medical stability, and partly because of this, no functional capacity evaluations or PPI ratings. This constitutes a significant gap in the medical or scientific evidence and an SIME or other scientific examination will be helpful for the fact-finders in resolving the issues of Employee's postconcussive, right knee and left shoulder disabilities and need for medical treatment and in determining the rights of the parties. *Bah*; *Tobar*; AS 23.30.110(g); AS 23.30.135; AS 23.30.155. The selected orthopedic SIME physician will be asked to refer Employee to a qualified physical therapist (PT) or other provider for the functional capacity evaluation component and each SIME physician will be asked to provide a date of medical stability and a PPI rating within their specialties, as part of the SIME.

CONCLUSIONS OF LAW

1) An SIME will be ordered on Employee's head, right knee and left shoulder injuries.

2) A medical stability determination, functional capacity evaluation, and permanent partial impairment rating will be ordered.

ORDER

1) Employee's December 18, 2020 petition for an SIME regarding Employee's post-concussive problems is granted.

2) Employee's December 18, 2020 petition for an SIME regarding Employee's right knee is granted.

3) An SIME on Employee's left shoulder is ordered based on the parties' stipulation at hearing.

4) The parties are directed to attend a prehearing conference within 30 days at which the designee will set forth process and procedures for an SIME.

5) An SIME will be performed by a neurologist and neuropsychologist and an orthopedic surgeon selected in accordance with the Alaska Workers' Compensation Act, applicable regulations and procedures.

6) The neuropsychologist's evaluation will include Employee's ability to think clearly and focus, as well as how long Employee can function cognitively over an eight hour day.

7) A PCE or FCE will be performed by a physical therapist at the SIME orthopedic physician's referral to an appropriate specialist.

Dated in Anchorage, Alaska on May 18, 2021.

ALASKA WORKERS' COMPENSATION BOARD

_/s/_____
Judith DeMarsh, Designated Chair

_/s/_____
Bronson Frye, Member

_/s/_____
Nancy Shaw, Member

PETITION FOR REVIEW

A party may seek review of an interlocutory or 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 MICHAEL D WOOD, employee / claimant v. WESTWARD SEAFOODS, employer; SOMPO AMERICA FIRE & MARINE INS, insurer / defendants; Case No. 201900856; 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 May 18, 2021.

/s/
Kimberly Weaver, Office Assistant II