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Issue Date: 13 April 2012

Case No.: 2011-LHC-00880

OWCP NO.: 02-172417

In the matter of

SOLIMAN SOLIMAN
Claimant,

v.

GLOBAL TERMINAL & CONTAINER SERVICES
Employer

and

SIGNAL MUTUAL INDEMNITY ASSN. LTD.
Carrier

Appearances:

Robert J. DeGroot, Esq.
For the Claimant

Francis M. Womack, III, Esq.
For the Employer

Before: RALPH A. ROMANO
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act (the "Act"), 33 U.S.C. § 901, *et seq.*, and implementing regulations found at 20 C.F.R. Part 702, brought by the Claimant against his Employer. The Act provides for payment of medical expenses and compensation for disability or death of maritime employees, other than seamen, injured on navigable waters of the United States or adjoining areas.

I conducted a hearing on this claim on September 29, 2011 in New York City. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure for Administrative Hearings before the Office of Administrative Law Judges, 29 C.F.R. Part 18.

At the hearing, Claimant's Exhibits (CX) A through L and Employer's Exhibits (EX) 1 through 16 were admitted into evidence without objection.[1] Transcript ("T.") at 3. The record was held open after the hearing to allow parties to submit additional medical evidence. The parties submitted closing arguments by January 30, 2012, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all Exhibits, the testimony at hearing, and the arguments of the parties.

STIPULATIONS

At the hearing, the parties entered into the following stipulations:

- The date of injury is January 28, 2008;
- The accident occurred on the Employer's premises;
- This claim falls within the jurisdiction of the Act;
- An employee-employer relationship existed at the time of the injury;
- There was timely notice of claim, timely filing, and timely notice of controversion;
- An informal conference was held on April 20, 2010;
- Medical benefits were paid under § 7 of the Act;
- The Claimant's average weekly wage is $1,397.49; and
- The Claimant returned to work on October 2, 2008.

T. at 5-6.

These stipulations have been admitted into evidence and are therefore binding upon the Claimant and the Employer. *See* 20 C.F.R. § 18.51; *Warren v. Nat'l Steel & Shipbuilding Co.*, 21 BRBS 149, 151-52 (1988). Although coverage under the Act cannot be conferred by stipulation, *Littrell v. Or. Shipbuilding Co.*, 17 BRBS 84, 88 (1985), I find that such coverage is present here. I have carefully reviewed the foregoing stipulations and find that they are reasonable in light of the evidence in the record. As such, they are hereby accepted as findings of fact and conclusions of law.

ISSUES

As discussed by the parties at the hearing, the issues remaining for resolution are as follows:

- Whether temporary total disability benefits are due for August 2008 until January 2009;
- Whether the Claimant has reached maximum medical improvement[2] and therefore is entitled to compensation for permanent disability; and

[1] Claimant's Exhibit M (Dr. Scannapiego's deposition) and Employer's Exhibit 17 (Dr. Spitzer's deposition) were received in my office in December 2011, and are herewith received into the record.
[2] This issue includes a discussion of whether the Claimant's refusal to undergo a third eye procedure is reasonable.

- The extent (if any) of that permanent disability.

T. at 6-7.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Disability Payments to Date

Temporary total disability was paid from January 30, 2008 until August 21, 2008 at a weekly rate of $931.66, for a total of $27,284.233. T. at 6.

Summary of the Testimonial Evidence

The Claimant

The Claimant testified, under affirmation, at the hearing. He stated that he was born in December of 1953 and began working as a longshoreman in 2005. T. at 12-13. The Claimant testified that on January 28, 2008, something hit him near his left eye while he was working. He stated that he immediately felt dizzy and began bleeding. T. at 13. The Claimant testified that after receiving emergency medical attention, he left work for the day. T. at 14. He stated that he returned the following day, but was sent home by his foreman after the Claimant complained of seeing "black." T. 14. The Claimant stated this was the first time he ever injured his left eye. T. at 27. He acknowledged, however, that he had cataract surgery in his left eye two-and-a-half years before the accident. T. at 33.

The Claimant testified that he sought medical attention in Jersey City and eventually saw a specialist at Hudson Eye Center. T. at 15. The Claimant testified that, upon examination, the specialist told him he needed surgery immediately; the Claimant then underwent retinal re-attachment surgery. T. at 16. There were several follow-up examinations and procedures — some of which involved needles — yet, the Claimant stated, he continued to have vision problems, including seeing double and having fluid buildup in his left eye. T. at 16-18. The Claimant stated that he underwent a second surgery and afterwards his eye felt worse. T. at 37. He was prescribed corrective lens that, the Claimant testified, did not work well and led him to fall while walking up stairs when he tried to return to work in August in 2008.[3] T. at 23.

After trying temporarily to return to work in August 2008, the Claimant did not return to longshore work full-time until January 2009. T. at 25, 47. He states that he is scared of undergoing a third surgery. T. at 21. He also testified to continued pain in his left eye if he wears his glasses too long. T. at 30. Lastly, the Claimant stated that he paid several medical bills for treatment of his left eye out-of-pocket. T. at 42.

[3] Although it is unclear sometimes from the transcript, the Claimant attempted to return to work in both August and October 2008, for less than a week each time. T. at 47.

Dr. Scannapiego (CX M)

Dr. Scannapiego testified via deposition on December 14, 2011. Counsel for both the Claimant and the Employer were present. CX M at 2. Dr. Scannapiego testified consistent with his medical report.

When asked to describe the Claimant's current condition in "layman's terms," Dr. Scannapiego responded,

> He's got a chronic left red eye. . . . It's inflamed, and chronically tears and forms mucus, et cetera. He has two small – multiple small corneal scars. . . . He's got a left iridodialysis, which means the iris, or the colored part of the eye, where it is attached to the inside of the eye in one area has become detached. . . . A left iridotomy means that there is also a hole in that iris. So he's got both of those things. Left pseudophakia merely means that his normal lens of the eye has been removed due to a cataract change, and it was replaced with a plastic implant or prosthesis. . . .
>
> The left scleral buckle is a piece of plastic that is used to put around the eye to encircle the eye, and actually indent the eye, so that a retinal detachment will have a better chance of becoming attached. And diffuse retinal scarring means during a retinal surgery and probably due to the retinal detachment that occurred, there was scarring to the retina.

CX M at 11-12. Dr. Scannapiego stated that all of these conditions, except for the left pseudophakia, resulted from the Claimant's injury of January 2008. CX M at 13. He also stressed, specifically, that the conjunctivitis suffered by the Claimant is a direct result of the retinal re-attachment procedures the Claimant underwent because of this injury. CX M at 21-22.

Dr. Scannapiego concluded that, using the American Medical Association (AMA) guidelines, there was an 85% visual disability in the left eye related to the injury, and an additional 42.5% permanent partial disability related to structural damage. CX M at 13-14.

Dr. Scannapiego also stated that he did not observe opacities in the Claimant's eyes. CX M at 14. He testified that laser surgery to dissolve an opacity

> could increase the vision to the extent that the capsule was responsible for the reduced—the reduced vision. There may be other reasons why the vision may not get better. But you would remove that. And whatever the capsule opacity was contributing to the loss in vision in general is—is alleviated.

CX M at 15-16. Dr. Scannapiego stated that the surgery does not require an in-patient stay and that the risks associated with this kind of procedure are increased pressure in the eye; development of glaucoma; retinal detachment (which is the most common and grievous risk); retinal burns; and inflammation. CX M at 16.

When asked on cross-examination if any diagnosed condition could be improved upon, Dr. Scannapiego answered, "The only thing that I can think of is the iridodialysis—meaning the separation of the iris from its peripheral attachment—could be, with great difficulty and fraught with complications, sewed back into position to possibly remove some of the double vision that he gets in that one eye." CX M at 21. He also stated that the iridotomy could contribute to the Claimant's double vision. CXM at 23-24.

Lastly, Dr. Scannapiego stated that the Claimant's uncorrected vision in his left eye was 20/200. CX M at 26.

Dr. Spitzer (EX 17)

Dr. Spitzer testified via deposition on December 15, 2011; both parties were represented by counsel. EX 17 at 1-2. Dr. Spitzer testified consistent with his medical reports.

Upon examination, Dr. Spitzer determined that the Claimant had a "best corrected visual acuity of 20/100," a posterior capsular opacity, and evidence of retinal surgery in the left eye. EX 17 at 10. Dr. Spitzer concluded that the Claimant needed further treatment:

> At that time, the examination revealed a posterior capsular opacity, which is a cloudiness of the capsule of the preexisting lens in the patient's eye, his natural lens, that was opacified, and I found and recommended that a treatment of that capsular opacity called a capsulotomy be performed to improve the vision.
>
> . . .
>
> The capsular opacity is in the front of the eye, and it was—it was noted to be severe enough that treatment with the laser would open up the capsule and facilitate light entering the eye. The only way of determining what the best vision would be ultimately is to perform the capsulotomy first, and then reevaluate the vision.

EX 17 at 11-12. Dr. Spitzer noted that at the time of his September 2009 examination of the Claimant, he graded the opacity as a "+2" on a grade pathology scale of one to four, four being the most severe. EX 17 at 15.

Dr. Spitzer concluded that the Claimant is not at maximum medical improvement, because further treatment "should be performed in order to evaluate what [the Claimant's] best corrective vision ultimately can be." EX 17 at 15. He stated that a capsulotomy is an office procedure with essentially no recovery period. EX 17 at 16-17. Dr. Spitzer stated that, in his experience, clearing the capsular opacity will improve the amount of light getting into the eye, which will improve vision. EX 17 at 17-18. When questioned about the risks associated with a capsulotomy, Dr. Spitzer testified,

> The risks of a capsulotomy are almost zero in patients who are very nearsighted, there are published statistics of retinal holes or retinal detachments after capsulotomy in the range of up to two percent, however[, for] patients who are not, what we call highly myopic, very nearsighted, the risk of that is close to zero.
>
> Of note, [the Claimant's] retinal reattachment surgery basically precludes him from getting the type of potential complication that is described. . . . Because . . . [his] scleral buckle, this belt, stops any retinal detachment from forming in the periphery, and then certainly from going towards the center.

EX 17 at 19.

When asked what the Claimant's uncorrected vision in the left eye was, Dr. Spitzer responded, "I did not note it in the chart, but a subsequent note would indicate that it's still 20/100 uncorrected, and corrected are [sic] 20/100." EX 17 at 20. Dr. Spitzer stated he used this 20/100 uncorrected visual acuity rating to determine the left eye to have a 95% disability rating under the AMA guidelines. EX 17 at 22. When the right eye with normal vision is also considered, Dr. Spitzer concluded that the overall disability is 11%. EX 17 at 22.

On cross-examination, Dr. Spitzer stated that during his last visit with the Claimant he did not note chronic conjunctivitis, but did observe left iridodialysis, left iridotomy, left pseudophakia, a left scleral buckle, and diffuse retinal scarring at that time. EX 17 at 24-25.

Summary of the Medical Evidence

In addition to the testimony of the physicians, the parties submitted the following medical opinions and reports:

Medical Records from October 2008 (CX H, I)

Dr. Syril Dorairaj's medical notes from October 4, 2008 (CX H) and Jersey City Medical Center from October 12, 2008 (CX I) indicate the Claimant was treated for conjunctivitis.

Dr. Eichler (EX 5)

Dr. Joel D. Eichler, whose letterhead indicates that he is an eye specialist, evaluated the claimant on March 13, 2008 and prepared a report, dated April 3, 2008. EX 5 at 1. At that time, he wrote:

> I believe that [the Claimant's] current medical status is quite stable as long as the residual subretinal fluid resolves as it typically will. I have not had the opportunity to reevaluate him so I cannot comment further related to that aspect of his care. He has significantly decreased vision in his left eye which may be on a refractive, that is, a glasses requirement basis. His visual acuity was quite good in advance of surgery and typically if the macula is not involved and the surgery done in a rapid fashion one should maintain good central vision. Fortunately, [the Claimant] did received the appropriate care and his visual acuity was good prior to surgery and in as much as the macula remains attached I would expect a good visual result in the 20/40 range, if not better. It is impossible for me to comment on the requirement of future treatment as I have not been able to reevaluate him. I think he will regain his maximal [sic] medical improvement once he is checked for glasses as I believe that would be the basis for the decreased vision in the left eye.

EX 5 at 2.

Dr. Lalin (EX 7, 8, 9)

Dr. Sean C. Lalin, who is Board-certified in ophthalmology, examined the Claimant on May 23, 2008 and prepared a report five days later. EX 7. Dr. Lalin wrote:

> [Regarding Posterior Segment Examination, there is a 40% gas bubble in the Vitreous OS . . . The Claimant] has Recent [sic] retinal detachment OS. The patient is doing very nicely following combined pars plana vitrectomy/scleral buckling. No further intervention is necessary at this time.

> I would recommend deferring returning to work until the bubble has further resorbed [sic], which will be approximately another 3 to 4 weeks.

EX 7 at 2.

Employer's Exhibit 8 is an additional report from Dr. Lalin stating that he examined the Claimant on June 20, 2008 and prepared the report that day. The first page of this report notes that Dr. Lalin's "Posterior Segment Examination" revealed clear vitreous in both eyes and makes no note of a "bubble," yet the second page of this report makes the same comment as his May 28, 2008 report, stating he recommended deferring returning to work "until the bubble has further reabsorbed, which will be approximately another 3 to 4 weeks."[4] EX 8.

A third report from Dr. Lalin states that he examined the Claimant on July 18, 2008 and prepared his report that same day. EX 9. Dr. Lalin stated:

> [The Claimant] has not met his MMI. I have requested that [the Claimant] follow-up for refraction and glasses to improve the vision in his left eye. After getting new glasses [the Claimant] is clear to go back to work. However, if his condition does not improve with glasses he may also benefit from a YAG capsulotomy to improve the visual clarity given the mild capsular opacification. If the monocular [illegible] persists after having new glasses, he may need a repair of the iridodyalsis.

EX 9 at 2.

<u>Dr. Cangemi</u> (EX 13)

Dr. Francis E. Cangemi, whose letterhead indicates he is a retina specialist, examined the Claimant on December 17, 2008 and wrote a report on January 8, 2009. He wrote:

> On this day, his acuity without correction and pinhole was OD 20/40 and OS 20/80. Applanation pressure was OD 14 and OS 12. ON anterior segment, increased capsular clouding was noted and healed posterior chamber pseudophakia on the left side. Moderate cataract change was noted on the right side.
> Fundus evaluation in the left eye revealed a completely reattached retina.
> [The Claimant] was told that he was stable and doing quite well from a retinal standpoint. He was also told that from our standpoint, he would be able to return to work as of the present time.

EX 13 at 1.

<u>Drs. Klein & Scannapiego</u> (CX J)

Drs. Warren M. Klein and Saveren Scannapiego, whose letterhead indicates they have specialties in ophthalmology, examined the Claimant on May 20, 2009 and wrote a report on July 1, 2009. They concluded:

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[4] I have contemplated the idea that the second page of Employer's Exhibit 8 might be a copy of the second page of Employer's Exhibit 7; however, the spelling of "reabsorbed" is correct in Employer's Exhibit 8, and therefore I find that it is not a duplicate page.

> The accident at work has cause [sic] a left chronic conjunctivitis, multiple left corneal micro-scars, left Iridodialysis, left iridotomy, left sclera buckle for retinal detachment with diffuse retinal scarring. The left pseudophakia is unrelated to the accident. There results a 86% total visual disability of the left eye based on uncorrected visual acuity as per AMA guidelines and an additional 42 ½% permanent partial total disability related to structural changes.

CX J at 2.

Dr. Spitzer (EX 12, 14, 15)

Dr. Jeffrey Alan Spitzer, a Board-certified ophthalmologist, first examined the Claimant in November of 2008. EX 12. Dr. Spitzer wrote:

> In summary, this patient has undergone cataract extraction in his left eye in 2005 before the incident. He now has a posterior capsular opacity, which is a common disorder after a cataract surgery. He then had a subsequent accident, which required retinal detachment surgery in his left eye. The subsequent retinal detachment and the reattachment surgery could have exacerbated the posterior capsular opacity of the left eye.
>
> The capsular opacity is treated with laser capsulotomy, which may improve the patient's vision. The double vision is caused by the superior iridodialysis and this is related to the accident. The double vision may be alleviated with the use of a color contact lens. If this is not adequate, then surgical correction of the iridodialysis can be attempted. At this point, the patient can be treated for the capsular opacity to improve the vision.

EX 12 at 3.

Dr. Spitzer examined the Claimant again on September 24, 2009, noting complaints of poor vision in the left eye. EX 14 at 1. Dr. Spitzer wrote:

> . . . The claimant's vision in the left eye is at least partially compromised by the posterior capsule opacity. It is premature to comment on permanency until the posterior capsule opacity is treated. This opacity is usually treated with a YAG laser. After treatment with the laser of the posterior capsule opacity the claimant can then have a postoperative refraction and permanency and impairment can then be assessed.

EX 14 at 2.

On February 24, 2010, Dr. Spitzer prepared an addendum to his September 2009 report. Dr. Spitzer added:

> The patient has a posterior capsule opacity of his left eye. He is refusing surgery. Without treatment, the condition will not improve spontaneously. Therefore, without additional treatment, the condition is permanent and the visual acuity will remain the same or worsen. The visual acuity left eye in as of the last exam is 20/100.
> As calculated by tables 12-3 (Impairment of Visual Acuity) and 12-4 (Calculation of the Acuity-Related Impairment Rating) page 284, AMA Guides to the Evaluation of Permanent Impairment, edition 5; the Acuity-Related Impairment Rating is 11%. This calculation is performed as follows: [calculations omitted] . . . Acuity-Related Impairment Rating = 100 - FAS = 11%

EX 15 at 1-2 (emphasis in original).

Summary of Other Evidence

Among the other evidence, the following are of special note:

- The Employer's First Report of Injury, dated January 29, 2008. CX A; EX 1.
- The Notice of Controversion, dated September 4, 2008. EX 10.

Injury Arising Out of Employment

The parties have stipulated that the injury in this case arose during the course of the Claimant's employment with the Employer. T at 5.

Disability

Disability under the Act is defined as "incapacity because of injury to earn wages which the employee was receiving at the time of injury in the same or any other employment." 33 U.S.C. § 902(10). Disability is an economic concept based upon a medical foundation distinguished by either the nature (permanent or temporary) or the extent (total or partial). A permanent disability is one which has continued for a lengthy period and is of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. *Care v. Wash. Metro. Area Transit Auth.*, 21 BRBS 248, 251 (1988). An injured employee's impairment may be found to have changed from temporary to permanent when the employee's condition reaches the point of maximum medical improvement (MMI). *James v. Pate Stevedoring Co.*, 22 BRBS 271, 274 (1989).

The traditional approach for determining whether an injury is permanent or temporary is to ascertain the date of maximum medical improvement (MMI). A claimant is permanently disabled if after reaching MMI, he has a residual disability. *Phillips v. Marine Concrete Structures*, 21 BRBS 233 (1988). The date that MMI is reached is to be determined by medical factors without regard to a claimant's economic situation. *Ballesteros v. Willamette W. Corp.*, 20 BRBS 184, 186 (1988). A condition is permanent if a claimant is no longer undergoing treatment with a view towards improving his condition, *Leech v. Serv. Eng'g Co.*, 15 BRBS 18, 21 (1982), or if his condition has stabilized, *Lusby v. Wash. Metro. Area Transit Auth.*, 13 BRBS 446, 447 (1981); *see also Seidel v. Gen. Dynamics Corp.*, 22 BRBS 403, 407 (1989). When a claimant's condition is continuing to improve, the claimant has not reached MMI. *Dixon v. John J. McMullen & Assoc.*, 19 BRBS 243, 245 (1986).

Alternatively, a disability will be considered permanent if the impairment has continued for a lengthy period and appears to be of a lasting or indefinite duration. *Crum v. Gen. Adjustment Bureau*, 738 F.2d 474, 480 (D.C. Cir. 1984); *see also Care v. Wash. Metro. Area Transit Auth.*, 21 BRBS 248, 251 (1988). A prognosis stating that the chances of improvement are remote is sufficient to support a finding that a disability is permanent. *Walsh v. Vappi Constr. Co.*, 13 BRBS 442, 445 (1981). However, a recommendation that a claimant receive further medical treatment may justify a finding that a claimant has not reached MMI. *Dorsey v.*

Cooper Stevedoring Co., 18 BRBS 25, 32 (1986), *pet. dismissed sub nom. Cooper Stevedoring Co. v. Dir., OWCP*, 826 F.2d 1011 (11th Cir. 1987).

The Act does not provide standards to distinguish between classifications or degrees of disability. Case law has established that in order to establish a *prima facie* case of total disability under the Act, a claimant must establish that he can no longer perform his former longshore job due to his job-related injury. *Manigault v. Stevens Shipping Co.*, 22 BRBS 332, 333 (1989); *see also Brown v. Potomac Elec. Power Co.*, 15 BRBS 337, 339 (1983).

The Claimant in this matter has returned to longshore employment. T. at 25, 47. The question remains as to whether his partial disability is permanent or temporary.

Discussion

To determine whether the Claimant's disability is permanent or temporary, I consider whether he has reached maximum medical improvement (MMI). First, I must find whether the Claimant's refusal to undergo a third eye procedure is unreasonable.

Refusal to undergo a third procedure

As a means to establish that the Claimant has not yet reached MMI, the Employer argues that, pursuant to Section 7(d)(4) of the Act, 33 U.S.C. § 907(d)(4), the Claimant's refusal to undergo the YAG laser surgery to correct a capsular opacity in his left eye is unreasonable. Employer's Brief at 8. Section 7(d)(4) provides:

> If at any time the employee unreasonably refuses to submit to medical or surgical treatment, or to an examination by a physician selected by the employer, the Secretary or administrative law judge may, by order, suspend the payment of further compensation during such time as such refusal continues, and no compensation shall be paid at any time during the period of such suspension, unless the circumstances justified the refusal.

33 U.S.C. §907(d)(4). The Employer contends the same analysis is applicable to the instant matter (i.e., the Claimant refusing to undergo additional eye surgery). Employer's Brief at 8 n.1. The Claimant failed to address this issue in his Brief.

The Benefits Review Board ("Board") has held that Section 7(d)(4) sets forth a dual test for determining whether benefits may be suspended as a result of a claimant's failure to undergo medical or surgical treatment. *See Malone v. Int'l Terminal Operating Co., Inc.*, BRB No. 94-2639, slip op. at 2-3 (BRB Aug. 30, 1995); *Hrycyk v. Bath Iron Works Corp.*, 11 BRBS 238 (1979) (Smith, S. dissenting). In *Hrycyk*, the Board held that the employer must make an initial showing that the claimant's refusal to undergo medical or surgical treatment is unreasonable; the reasonableness of a claimant's actions must be appraised in objective terms. If employer meets this burden, the burden shifts to claimant to show that the circumstances justify his or her refusal; appraisal of the justification of the claimant's actions is a subjective inquiry. *Malone*, slip op. at 3; *Hrycyk*, 11 BRBS at 241-43.

In considering the merits of the Employer's argument, I must first determine whether the Claimant's refusal to undergo surgery, specifically a YAG laser procedure, was unreasonable. The Board in *Hrycyk* described the reasonableness determination as follows:

> The first inquiry is into reasonableness. Of course, the recommended procedure or examination must be proven likely, as a matter of reasonable medical probability, to be of aid to a course of treatment designed to relieve the claimant's symptoms and restore a degree of his or her lost earning capacity without undue risk to his or her health or well-being. If this is shown, the claimant's refusal to undergo medical or surgical treatment or to submit to an examination by the employer's physician must be considered unreasonable if an ordinary reasonable person in the claimant's condition and suffering the claimant's pain and physical restrictions would consent to the recommended procedure or examination with minimal hesitation. The converse is true as well: if an ordinary reasonable person would refuse the procedure, the claimant's refusal is reasonable. Broadly stated, the inquiry is: what course would an ordinary person in the claimant's condition pursue after weighing the risks and rewards of the procedure with the alternatives of continued pain and restriction?

11 BRBS at 241-42.

In the instant case, three physicians of record commented on treating the Claimant with YAG laser surgery (also referred to as a "capsulotomy"):

<u>Dr. Lalin</u>

Dr. Lalin noted during his July 2008 examination that the Claimant may benefit from a "YAG capsulotomy" to improve visual clarity or that the iridodyalsis may need to be repaired. EX 9 at 2.

<u>Dr. Scannapiego</u>

Dr. Scannapiego stated he did not observe opacification in the Claimant's left eye. CX M at 14. He also testified that if an opacity was removed surgically, the result may not be improved vision. CX M at 15-16. Lastly, Dr. Scannapiego stated a number of risks, including retinal detachment and inflammation, could result from a YAG procedure. CX M at 16.

<u>Dr. Spitzer</u>

Dr. Spitzer testified to finding opacification in the Claimant's left eye upon examination and stated that he cannot state definitively that the Claimant is at MMI until the YAG surgery is done to remove the opacities. EX 17 at 10-12. When questioned about the risks associated with a capsulotomy, Dr. Spitzer testified that the risks are almost zero. He added:

> Of note, [the Claimant's] retinal reattachment surgery basically precludes him from getting the type of potential complication that is described. . . . Because . . . [his] scleral buckle, this belt, stops any retinal detachment from forming in the periphery, and then certainly from going towards the center.

EX 17 at 19.

I find that of these three opinions, only Dr. Spitzer unequivocally recommended the YAG procedure to improve the Claimant's condition. Moreover, following the precedent in *Hrycyk*, I find it is the Employer's burden to establish that the YAG procedure is proven likely, as a matter of reasonable medical probability, to be of aid in restoring a degree of the Claimant's lost earning capacity. *See* 11 BRBS at 241. As the Employer has made no reference to the Claimant's earning capacity in this context, and considering the Claimant has returned to work, I find the Employer has not established that the Claimant's refusal is objectively unreasonable under the *Hrycyk* standard.

The Employer additionally contends that the Claimant's refusal based on fear to undergo a capsulotomy is unjustified. Because I have determined that, under *Hrycyk*, the Claimant's decision to forgo a third surgery is not objectively unreasonable, I decline to rule on whether his subjective reasons are persuasive.

Accordingly, I find it is not unreasonable for the Claimant to decline further medical treatment for the injury to his left eye. I now must determine whether the Claimant has reached MMI.

Whether the Claimant has reached MMI

Where the medical evidence indicates that the injured worker's condition is improving and the treating physician anticipates further improvement in the future, it is not reasonable to find that maximum medical improvement has been reached. *Dixon v. John J. McMullen & Assocs.*, 19 BRBS 243, 245 (1986); *see also* Employer's Brief at 11.

When considering whether a claimant has reached MMI, treating physicians are given considerable weight initially. Treating physicians are determined by the extent of the relationship between doctor and patient. *See Am. Stevedoring Ltd. v. U.S. Dep't of Labor*, Case No. 00-4180, slip op. at 12 (2d Cir. Apr. 26, 2001). When asked at the hearing if the Claimant had a physician he saw regularly for his eye problems, he did not give a clear answer. Moreover, the only physician that states unequivocally that the Claimant needs further treatment is Dr. Spitzer. Dr. Spitzer, by his nature as an independent medical examiner, cannot be considered the Claimant's treating physician. I therefore do not consider any physician of record to be the Claimant's treating physician.

As the Claimant no longer wishes to pursue treatment in the form of a third surgery, I must now consider whether his condition has stabilized. *See Lusby v. Wash. Metro. Area Transit Auth.*, 13 BRBS 446, 447 (1981); *see also Seidel v. Gen. Dynamics Corp.*, 22 BRBS 403, 407 (1989). Regarding improvement of the Claimant's left eye condition, the physicians opined as follows:

<u>Dr. Eichler</u>

On April 3, 2008, Dr. Eichler stated that the Claimant should reach maximum medical improvement "once he is checked for glasses . . . ." EX 5 at 2.

Dr. Lalin

On July 18, 2008, Dr. Lalin stated that the Claimant had not reached MMI and suggested that if the Claimant's condition did not improve, he may benefit from additional procedures. EX 9 at 2.

Dr. Cangemi

On January 8, 2009, Dr. Cangemi wrote: "[The Claimant] was told that he was stable and doing quite well from a retinal standpoint. He was also told that from our standpoint, he would be able to return to work as of the present time." EX 13 at 1.

Dr. Spitzer

On September 24, 2009, Dr. Spitzer last examined the Claimant. EX 14 at 1. At that time, he stated it was premature to comment on permanency until the Claimant's posterior capsule opacity was treated. EX 14 at 2. In his addendum to the September 2009 report, Dr. Spitzer stated, "Without treatment, the condition will not improve spontaneously. Therefore, without additional treatment, the condition is permanent and the visual acuity will remain the same or worsen." EX 15 at 1-2.

Dr. Spitzer concluded that the Claimant is not at maximum medical improvement, because further treatment "should be performed in order to evaluate what [the Claimant's] best corrective vision ultimately can be." EX 17 at 15. On cross-examination, Dr. Spitzer stated that during his last visit with the Claimant he did not note chronic conjunctivitis, but did observe left iridodialysis, left iridotomy, left pseudophakia, a left scleral buckle, and diffuse retinal scarring at that time. EX 17 at 24-25.

Initially, I give little weight to the opinions of Drs. Eichler and Lalin because other physicians, unlike these two physicians, have examined the Claimant and opined on his condition more than a year after their reports were written. Both Dr. Cangemi and Dr. Spitzer stated the Claimant's condition was stable. Dr. Spitzer also stated, unequivocally, that the Claimant had not reached MMI. Under the Act, however, a condition is permanent if a claimant is no longer undergoing treatment with a view towards improving his condition, *Leech*, 15 BRBS at 21, *or, in the alternative,* if his condition has stabilized, *Lusby*, 13 BRBS at 447 (emphasis added); *see also Seidel*, 22 BRBS at 407. Therefore, as I have already determined the Employer has not established that the Claimant's refusal of further treatment is unreasonable, MMI may be established by showing the Claimant's condition is stable. With no evidence contradicting Dr. Cangemi and Dr. Spitzer's assertions of stability of the condition, I find that the Claimant's condition is in fact stable, and has been so since at least September 2009 (the date of Dr. Spitzer's last examination of the Claimant). The Claimant testified in September 2011, two years later, that he continues to suffer symptoms from his injury. T. at 30. Accordingly, I find the prolonged and stable nature of the Claimant's injury establishes that he has reached MMI.

Partial Permanent Disability Award

Two physicians testified extensively regarding the partial permanent disability calculations in this matter; both stated they used the American Medical Association guidelines. Dr. Scannapiego stated the Claimant had an 85% total visual disability in the left eye, and a 42.5% additional disability related to structural changes caused by the accident. CX M at 13-14. Dr. Spitzer concluded that the Claimant had a 95% disability in the left eye when vision was uncorrected and an 11%[5] total disability when the right eye was included in the calculation. EX 17 at 22. Both physicians refer to visual acuity, and not disability of the Claimant's visual field. Accordingly, I only consider the calculations involving the loss of visual acuity and structural changes to the Claimant's eye.

According to American Medical Association guidelines that both Dr. Scannapiego and Dr. Spitzer cited, a visual acuity-based impairment rating is accurately assessed when visual acuity for binocular vision, as well as the right and left eyes are combined to make a single Functional Acuity Score (FAS). The impairment rating is then calculated by subtracting the FAS from 100. LINDA COCCHIARELLA & GUNNAR B.J. ANDERSSON, GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT (Am. Med Ass'n, 5th ed. 2001).

Dr. Scannapiego's calculation of the Claimant's visual acuity-based impairment rating is incomplete: he stated that the Claimant had a 95% disability in his left eye, but failed to account for disability based on binocular vision. Dr. Spitzer, however, exhibited the application of the AMA guidelines to the Claimant's test results in his February 2010 report. Therefore, I chose to adopt Dr. Spitzer's visual acuity-based impairment rating of 11%.

Dr. Spitzer's assessment of disability is flawed, as well. He makes no mention in his reports or testimony of assigning a disability rating to the structural damage done to the Claimant's left eye. I also note that nowhere in the record does Dr. Spitzer (or any other physician) refute that damage to the surrounding structures occurred. Dr. Scannapiego assigned a 42.5% rating based on the structural changes surrounding the left eye he observed. With no evidence to the contrary, I find that the Claimant did incur structural changes to his left eye because of the accident and award him an additional compensation based on the Dr. Scannapiego's calculated loss.

In sum, I find the Claimant has a visual acuity-based impairment rating of 11%, and a structural changes-based impairment rating of 42.5%.

Temporary Total Disability Award

The Employer terminated temporary total disability benefits as of August 21, 2008, after receiving Dr. Lalin's July 2008 report which stated the Claimant could return to full duty work with corrective lenses. EX 10. The Claimant stated he returned to work in January 2009; he argues he is due temporary total disability benefits from August 21, 2008, until January 2009. In the Claimant's post-hearing brief, counsel wrote, "Furthermore, the claimant requests that the

[5] Dr. Spitzer's February 2010 report incorrectly lists the Claimant's Visual Acuity Score as "95", when it should be listed as "65" (65 x 1 = 65), however, this error did not affect the accuracy of his final calculation.

Employer provide him for the compensation for the approximately four months of work that he did not receive compensation for (the claimant's [sic] relies on his testimony on his testimony [sic] before the Court for this request)." Claimant's Brief at 11.

Case law has established that in order to establish a *prima facie* case of total disability under the Act, a claimant must establish that he can no longer perform his former longshore job due to his job-related injury. *Manigault v. Stevens Shipping Co.*, 22 BRBS 332, 333 (1989); *see also Brown v. Potomac Elec. Power Co.*, 15 BRBS 337, 339 (1983). He need not establish that he cannot return to any employment, only that he cannot return to his former employment. *Elliot v. C&P Tel. Co.*, 16 BRBS 89, 91 (1984).

Once the *prima facie* case of total disability is established, the burden shifts to the employer to establish the availability of suitable alternative employment. *Clophus v. Amoco Prod. Co.*, 21 BRBS 261, 265 (1988). Total disability becomes partial on the earliest date on which the employer establishes suitable alternative employment. *Rinaldi v. Gen. Dynamics Corp.*, 25 BRBS 128, 131 (1991). If the employer is unable to provide evidence of suitable alternate employment, a finding of total disability may be affirmed. *Clophus*, 21 BRBS at 265. Where suitable alternate employment is not established and an award of permanent total disability is made, a permanent loss of all wage-earning capacity is presupposed. *See Hoey v. Owens-Corning Fiberglass Corp.*, 23 BRBS 71, 73 (1989).

At the hearing, the Claimant testified that he was unable to work from August 2008 until January of 2009. T. at 25. The only medical evidence exhibits relevant to this time period are exam notes of Dr. Dorairaj from October 4, 2008, and records from Jersey City Medical Center from October 12, 2008. CX H, I. Neither of these exhibits, however, give any indication that the Claimant was instructed he could not return to work.

As it is the Claimant's burden to establish a *prima facie* case of total disability for this time period and he has presented no evidence supporting his testimonial assertion that he could not perform his longshore job, I find the Claimant has not proven his entitlement to additional temporary total disability benefits.

Medical Expenses

The parties have stipulated that medical expenses have been paid. The Claimant testified, however, that he paid some medical bills out of pocket. T. at 42. At the hearing, I authorized the Claimant to submit unpaid bills within 60 days. T. at 45. No evidence was received. I therefore find that no further payment for past medical expenses is due.

Attorney's Fees

Section 28 of the Act provides that an award of an attorney's fee is permitted only in cases in which the claimant is found to be entitled to benefits. 33 U.S.C. § 928.

Having successfully established his right to compensation, including entitlements to medical care and the payment of incurred medical expenses, the Claimant's attorney is entitled to

an award of fees under section 28(a) of the Act. 33 U.S.C. § 928(a); 20 CFR § 702.134(a); *Maguire v. Todd Pac. Shipyards Corp.*, 25 BRBS 299, 303 (2002).

The Claimant's attorney has not yet filed an application for attorney's fees. The Claimant's attorney is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The parties have ten days following service of the application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by the Claimant is GRANTED. I therefore ORDER:

- The Employer pay benefits for the partial permanent eye injury, based on an 11% visual acuity-impairment rating and a 42.5%-structural damage impairment rating.
- The District Director shall make all calculations necessary to carry out this Order.
- The Claimant's counsel shall have thirty (30) days to file a fully supported fee application with the Office of Administrative Law Judges, serving a copy on the Claimant and opposing counsel, who shall have ten (10) days to file any objections.

A

Ralph A. Romano
Administrative Law Judge

Cherry Hill, New Jersey