NORTH CAROLINA INDUSTRIAL COMMISSION

I.C. NO. X51195, MILTON W. NOBLES, Employee, Plaintiff v. N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTRAL REGIONAL HOSPITAL, Employer, SELF-INSURED (CCMSI, Third-Party Administrator), Defendant.

OPINION AND AWARD for the Full Commission by MYRA L. GRIFFIN, Vice-Chair.

Filed: September 29, 2021

This matter was heard by the Full Commission on June 8, 2021, upon Defendant's appeal of the January 25, 2021 Opinion and Award of Deputy Commissioner Robert J. Harris who heard this case on August 18, 2020.

A P P E A R A N C E S

Plaintiff:	Law Office of Leslie O. Wickham, Jr., Durham, North Carolina; Leslie O. Wickham, Jr., appearing.
Defendant:	North Carolina Department of Justice, Raleigh, North Carolina; Heather A. Haney, Assistant Attorney General, appearing.

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The Full Commission has reviewed the prior Opinion and Award based upon the record of the proceedings before Deputy Commissioner Harris, the Form 44 *Application for Review*, and the briefs and arguments of the parties. The Full Commission hereby enters the following Opinion and Award pursuant to N.C. Gen. Stat. § 97-85:

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The Full Commission finds as a fact and concludes as a matter of law the following, which were entered into by the parties as:

STIPULATIONS

1. All parties are properly before the Industrial Commission, and the Commission has jurisdiction of the parties and the subject matter.

2. All parties have been correctly designated, and there is no question as to misjoinder or non-joinder of parties.

3. This case is subject to the North Carolina Workers' Compensation Act.

4. An employment relationship existed between Defendant-Employer and Plaintiff on June 26, 2011.

5. Plaintiff's average weekly wage in this claim is $963.42, and his compensation rate is $642.31.

6. Plaintiff sustained an injury to his right eye on June 26, 2011, when a patient hit him in his face. Plaintiff was hit multiple times by a psychiatric patient.

7. Plaintiff has been receiving temporary total disability ("TTD") compensation since June 27, 2011.

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EXHIBITS

The following documents were accepted into evidence by the Deputy Commissioner as Stipulated Exhibits:

1. Stipulated Exhibit #1 – Pre-Trial Agreement.

2. Stipulated Exhibit #2 – Industrial Commission forms and filings, Plaintiff's medical records, discovery responses, Plaintiff's personnel file, correspondence, pharmacy ledger, and ISO claim search.

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The transcripts of the depositions of the following witnesses were admitted into evidence by the Deputy Commissioner:

DEPOSITIONS

1. Oral deposition of Chantal Boisvert, M.D., taken on September 16, 2020.

2. Oral deposition of Sabrina Butler taken on August 24, 2020.

3. Oral deposition of Manish Fozdar, M.D., taken on September 22, 2020.

4. Oral deposition of Thomas Gualtieri, M.D., taken on September 29, 2020.

5. Oral deposition of Pamela Harris taken on September 10, 2020.

6. Oral deposition of Edwin Hoeper, M.D., taken on October 30, 2020.

7. Oral deposition of Linda Nobles taken on August 24, 2020.

8. Oral deposition of Milton Nobles taken on August 24, 2020.

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The Full Commission addresses the following:

ISSUES

1. Whether any psychological conditions, including post-traumatic stress disorder and depression, are causally related to Plaintiff's June 26, 2011 injury by accident?

2. Whether Plaintiff is entitled to extended disability benefits pursuant to N.C. Gen. Stat. § 97-29(c)?

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Based upon the preponderance of the evidence in view of the entire record, and reasonable inferences flowing therefrom, the Full Commission makes the following:

FINDINGS OF FACT

1. At the time of the evidentiary hearing, Plaintiff was a fifty-three year old high school graduate. He has resided in Knightdale, North Carolina for twenty-six years. Following graduation from high school, Plaintiff obtained employment first at a pizza restaurant, followed by positions at a childcare center, a nursing home, and as a security guard. In August 1989, Plaintiff accepted a position with the State of North Carolina, working at the Caswell Center, where he helped feed, bathe, and dress mentally disabled clients, in addition to ensuring their participation in activities and programs. From October 1992 to October 1993, Plaintiff also

worked at NOVA Behavioral Health, where he taught activities of daily living and assisted in the health management of behaviorally challenged youth.

2. In July 1995, Plaintiff transferred from the Caswell Center to Dorothea Dix Hospital, where he worked as a health care technician. In his healthcare technician position, Plaintiff's duties included assisting clients attending activities in the day room, feeding clients at all mealtimes, and training clients to perform activities. In May 1996, Plaintiff requested a transfer to a forensic healthcare technician position. In this new position, Plaintiff performed similar tasks to his prior healthcare technician position; however, his clients were individuals who had been charged with committing crimes and were at Dorothea Dix Hospital for competency evaluations or had been found incompetent. Around 2008, Plaintiff was transferred to Central Regional Hospital, where he continued to work as a forensic healthcare technician.

3. On June 26, 2011, Plaintiff was working "one-on-one" with a client in Central Regional Hospital's outdoor yard. Plaintiff's position required that he stay within arm's reach of the client. Plaintiff's client began fighting with another client in the outdoor yard, which Plaintiff proceeded to terminate. After Plaintiff broke up the fight, Plaintiff's client remained upset, continuing to indicate that he wanted to fight and threatening to kill the other client. While Plaintiff was trying to calm down his client, his client struck Plaintiff in the head. The blow knocked Plaintiff to the ground and he lost consciousness.

4. Bruce Dixon, one of Plaintiff's coworkers, provided a written statement following the assault, indicating that Plaintiff's client walked up to Plaintiff and struck him in the eye and jaw, after which he fell to the ground and passed out. Mr. Dixon stated that Plaintiff's client hit and kicked Plaintiff while Plaintiff was on the ground until several Central Regional Hospital staff members intervened.

5. Plaintiff was evaluated following the assault at Central Regional Hospital's Employee Health Clinic. Plaintiff reported that a client had hit him in the right eye and mouth and that he fell onto his right shoulder. Plaintiff further reported that the client attempted to kick and hit Plaintiff while he was on the ground, but that Plaintiff "got up and had to run" to avoid being hit again. The provider assessed Plaintiff with a right eye injury with erythema, mild photophobia, and a possible mild corneal abrasion; superficial wounds to the left side of the face and mouth; and a right shoulder injury from the fall. The provider wrote Plaintiff out-of-work for the remainder of his shift, and the next two days. Additionally, Plaintiff was instructed to apply eye drops or ointment to his right eye, ice his right eye, and take ibuprofen as needed.

6. The day after the assault, Plaintiff sought treatment at WakeMed's Emergency Department complaining of a headache; pain in his right shoulder, neck, head, right eye, and forehead; swelling in his left lip; and reddening of his right eye, with blurred vision. CT scans were taken of Plaintiff's head and face, which showed no abnormalities. Additionally, a fluorescein examination, checking for corneal damage, was negative. Plaintiff was provided pain medication, discharged, and instructed to follow up with a primary care provider in two to three days.

7. On June 30, 2011, Plaintiff followed up with his primary care provider, James McCann, PA-C, reporting a headache, right hip pain, and neck pain. Following the examination, Mr. McCann diagnosed Plaintiff with a neck strain and potentially with pointer injury to the right hip, a traumatic brain injury ("TBI"), and/or post-traumatic stress disorder ("PTSD"). Plaintiff was prescribed several medications, referred to physical therapy for his right hip and neck pain, and early psychiatric evaluation was recommended.

8. On July 1, 2011, Plaintiff was seen at Rx Urgent Care North for pain in his face, right eye, shoulder, back, neck, and right hip. Plaintiff reported that he could not see out of his right eye. Based on Plaintiff's reported symptoms, the provider recommended that Plaintiff seek treatment in an emergency department. When Plaintiff arrived at the WakeMed Emergency Department later that day, he reported "slight blurred vision of the right eye" and "generalized myalgia." The provider's examination of Plaintiff's eye showed no swelling or bleeding, and Plaintiff was referred to an ophthalmologist. Additionally, a second set of CT scans of Plaintiff's head and face showed no acute abnormalities.

9. On July 6, 2011, Plaintiff was seen by Brian Kosobucki, M.D., an ophthalmologist, for his complaints of right eye blurriness. Dr. Kosobucki's examination showed no visible injury to the back of Plaintiff's right eye or optic nerve. Based on the lack of visible explanation for Plaintiff's complaints, an MRI of Plaintiff's brain was ordered to assess for a TBI, along with a referral to a neuro-ophthalmologist. Dr. Kosobucki restricted Plaintiff from driving due to Plaintiff's reported severe vision loss and wrote Plaintiff out of work until the MRI of his brain was reviewed.

10. On July 7, 2011, Plaintiff presented to Lisa Edmondson, LCSW, for evaluation related to mental health services following the assault. Plaintiff subjectively reported that he thought about the assault during the day, dreamed about the assault, and no longer felt safe at work. Plaintiff also reported that he felt depressed and was experiencing decreased ability to concentrate, crying spells two to three times a day, fatigue, feelings of hopelessness, decreased appetite, and was only able to sleep an average of three hours per night. Ms. Edmondson noted that Plaintiff was experiencing PTSD and depressive disorder and assigned a global assessment

of functioning ("GAF") score of fifty-one.[1] She recommended that Plaintiff begin undergoing outpatient therapy one to two times per week and that he obtain a psychiatric evaluation.

11. On July 12, 2011, Plaintiff's MRI of his head showed no abnormalities. There were no fractures or lesions noted within Plaintiff's brain or eyes, the blood flow to his eyes appeared appropriate, and the structural components of his eyes appeared normal.

12. On July 14, 2011, Plaintiff returned to Mr. McCann, where he reported daily headaches; complete loss of vision in his right eye; and pain in his neck, right shoulder, and left hip. However, he denied any night sweats. Mr. McCann indicated that he believed Plaintiff experienced a TBI and requested an evaluation with a neuro-psychiatrist. Additionally, Mr. McCann noted that he was unsure of the cause of Plaintiff's vision complaints, but that he did "not suspect vision loss as the patient described but possible a migraine variant secondary to his TBI."

13. On July 26, 2011, Plaintiff met with Ann Louise Barrick, Ph.D., as part of Central Regional Hospital's Staff Support Program. Dr. Barrick noted that she provided peer support, but based on Plaintiff's description to her, she thought Plaintiff "could benefit from professional services as his needs are beyond what we can provide." Dr. Barrick's note does not indicate what symptoms Plaintiff reported, the cause of any such symptoms, any potential diagnosis, or what services she recommended.

14. On August 11, 2011, Defendant filed a Form 63 *Notice to Employee of Payment of Compensation Without Prejudice (G.S. §97-18(d)) or Payment of Medical Benefits Only Without Prejudice (G.S. §97-2(19) & § 97-25)*, Section 1, related to Plaintiff's right eye, mouth, and right shoulder. According to the Form 63, Defendant began paying indemnity benefits on

[1] GAF, global assessment of functioning, is a psychological score from 0 to 100 which indicates an individual's ability to function on a day to day basis with their symptoms.

July 13, 2011. Defendant provided treatment for, and did not file any subsequent denial related to, Plaintiff's right eye, mouth, or right shoulder conditions.

15. On September 8, 2011, Plaintiff followed up with Dr. Kosobucki regarding his ongoing vision complaints. Dr. Kosobucki's exam again noted no anatomical abnormalities in Plaintiff's right eye, and his review of the MRI showed normal structure. Dr. Kosobucki noted that he "suspect[ed] non-organic contribution to degree of [vision] loss" and referred Plaintiff to a neuro-ophthalmologist. Dr. Kosobucki also wrote Plaintiff out of work.

16. On September 13, 2011, Plaintiff underwent an authorized one-time mental health evaluation with C. Thomas Gualtieri, M.D. at NC Neuropsychiatry. Dr. Gualtieri noted that Plaintiff described some symptoms that were "suggestive of an acute stress disorder, like anxiety, nightmares, avoidant behavior and difficulty sleeping, but also symptoms suggestive of the post-concussion syndrome, such as headache, neck and back pain, and forgetfulness." However, Dr. Gualtieri also noted that some of Plaintiff's other symptoms and presentation were "quite odd[,]" such as Plaintiff's report of vision loss which the ophthalmologist could not explain. Additionally, Plaintiff provided a vague report of daily headaches, including a 10/10 headache reported on the date of evaluation, which was inconsistent with Plaintiff's presentation. Specifically, Plaintiff did not "look discomfited in the least," left the facility for lunch, and completed the evaluation in "perfectly good spirits." Also, Plaintiff reported cognitive deficits to Dr. Gualtieri, but none of the subsequent testing supported Plaintiff's claims. Plaintiff left early after only completing a portion of the evaluation. Within the testing that Plaintiff did complete, Plaintiff's validity score on a CNS Vital Signs questionnaire "suggest[ed] a degree of overstatement." Dr. Gualtieri noted that Plaintiff did not appear to be experiencing the symptoms he was reporting at any point during the evaluation. Instead, based on Dr. Gualtieri's

observation, Plaintiff appeared stable and "not anxious, depressed, agitated, disorganized, or paranoid."

17. Dr. Gualtieri recorded that Plaintiff scored in the bottom one percent in ten of eleven categories on the CNS Vital Signs battery—intended to evaluate Plaintiff's cognitive capacity—which was "out of proportion to the patient's cognitive abilities" from Plaintiff's interview. Additionally, the embedded validity indicators in the test were "strongly suggestive that the patient's low level of performance is motivational in nature, rather than psychological, or neuropsychiatric." Based on the interview and partial testing, Dr. Gualtieri noted that Plaintiff "has symptoms of an acute stress disorder and also symptoms of post-concussion syndrome. The differential diagnosis however also includes somatoform disorder and malingering. We have scheduled therefore for the patient to return on October 3 to complete evaluation."

18. On October 3, 2011, Plaintiff presented to Aaron Hervey, Ph.D., to complete the evaluation begun by Dr. Gualtieri on September 13, 2011. Plaintiff related to Dr. Hervey that his recollection of the assault was unclear, but he did recall being hit on the head, attempting to escape, falling to the ground, and being struck while on the ground. Plaintiff reported that he was continuing to experience headaches three times a week, along with pain in his back, hip, and arm. Additionally, Plaintiff reported "bad dreams on a nightly basis which wake him multiple times[,]" significant distress when he had to return to Central Regional Hospital, and that he had become more forgetful. Dr. Hervey administered multiple tests including the Minnesota Multiphasic Personality Inventory ("MMPI-2"), Test of Memory Malingering ("TOMM"), Wechsler Adult Intelligence Scale – IV, and Wechsler Test of Adult Reading. After reviewing the testing, Dr. Hervey indicated that Plaintiff's results were not valid as all the embedded and standalone measures showed that Plaintiff was not putting forth appropriate effort. As such, Dr.

Hervey opined that there was "no evidence to suggest that treatment of any kind [was] warranted."

19. On October 7, 2011, Plaintiff presented to Edwin Swann, M.D., another ophthalmologist, where he related that he could not see any light with his right eye. Again, no anatomical problems were noted with Plaintiff's right eye. Dr. Swann diagnosed Plaintiff with right eye hysterical blindness. As Plaintiff's loss of right eye vision was inconsistent with clinical findings, Dr. Swann recommended that a visual evoked potential test be completed.

20. On November 22, 2011, Plaintiff underwent a visual evoked potential test. The latency for Plaintiff's left eye was normal; but his right eye latency and left-right latency difference were "abnormally prolonged." The findings were consistent with a potential lesion in the right optic nerve but noted that additional clinical evaluation was required.[2] When Dr. Swann forwarded the report to Defendant, he opined that the study showed some dysfunction of the right optic nerve, but that it confirmed "that [Plaintiff] can see better than No Light Perception which he was alleging" at the most recent appointment.

21. On February 15, 2012, Plaintiff followed up with Dr. Swann, reporting intermittent right eye pain on a daily basis and an inability to see any light with his right eye. Dr. Swann noted normal pupillary response in both eyes but indicated that Plaintiff was suffering from dry eye syndrome. Dr. Swann ordered that Plaintiff use artificial tears to address the dry eye syndrome and additional testing for Plaintiff's reported inability to see light in his right eye, including electrophysiological testing.

22. On April 17, 2012, Plaintiff was seen at Duke University Hospital's Department of Ophthalmology, again denying any light perception in his right eye. The ophthalmologist did

[2] As noted above, Plaintiff's July 12, 2011 MRI showed no such lesion.

not find any anatomical problems with the eye and diagnosed Plaintiff with functional vision loss—a complaint of vision loss that is not supported by objective findings.[3] Following the April 17, 2012 appointment, there are no records that Plaintiff sought any additional treatment for his right eye.

23. According to the testimony of Christy Wilson, a claims consultant for Defendant, Plaintiff was at maximum medical improvement ("MMI") for his right eye on May 14, 2012 based on a Medical Questionnaire completed by Dr. Swann.[4] At that time, Dr. Swann assigned an impairment rating and imposed permanent restrictions of no driving, no operating hazardous machinery, and no work on unprotected heights. There are no medical records in evidence that Plaintiff sought any additional treatment for his mouth or right shoulder. Additionally, there has been no evidence presented that he has been assigned any restrictions for either his mouth or right shoulder.

24. On May 8, 2012, Plaintiff presented to Edwin Hoeper, M.D., a psychiatrist, reporting daily flashbacks; nightmares every night; daily panic attacks; night sweats every night; constant migraine headaches; pain in his back, neck, and hips; daily muscle spasms; and damage to his optical nerve. Dr. Hoeper did not perform any psychiatric or psychological testing during the initial appointment, which lasted approximately twenty minutes. The symptoms described to Dr. Hoeper were inconsistent with symptoms previously described to other providers, as there were no references to panic attacks, muscle spasms, or night sweats in any of Plaintiff's prior medical records. Also, Plaintiff's previous medical records documented nightmares on a less than nightly basis. Dr. Hoeper's notes did not include any diagnoses but listed Plaintiff's GAF

[3] Per the deposition testimony of Chantal Boisvert, M.D., functional vision loss is synonymous with non-organic vision loss. Both conditions involve reports of vision loss that cannot be explained based on the objective examination of the eyes.
[4] The Medical Questionnaire completed by Dr. Swann on or about May 14, 2012 was not included in the record.

as thirty-five.[5] Dr. Hoeper prescribed several medications: trazodone, Klonopin, and Wellbutrin SR.

25. After his evaluation on May 8, 2012, Dr. Hoeper drafted a letter on May 17, 2012 with his assessment of Plaintiff. In the letter, Dr. Hoeper diagnosed Plaintiff with chronic PTSD, chronic major depression, migraine headaches, high blood pressure, and a TBI. Dr. Hoeper noted that Plaintiff was assaulted at Central Regional Hospital, where he was hit in the head and knocked unconscious and that "[n]o one ever came to help" him. According to the letter, Plaintiff "now has constant migraine headaches and pain in his back, neck, and hips[,]" along with daily muscle spasms and a damaged optical nerve. Dr. Hoeper also noted that Plaintiff was having nightmares and night sweats almost every night since the assault, multiple flashbacks per day, and daily panic attacks. Dr. Hoeper continued that Plaintiff "has intrusive thoughts, startles easily, is hypervigilant," does not socialize, and his memory is "severely impaired" to the point he cannot remember anything immediately after reading it. According to Dr. Hoeper, Plaintiff's "working memory is 100% impaired" and "[h]e has difficulty concentrating, making decisions, learning new information, and processing emotions in context." Dr. Hoeper additionally indicated that Plaintiff's "service connected PTSD" so "severely compromised" Plaintiff's ability to sustain relationships that Dr. Hoeper considered Plaintiff "to be permanently and totally disabled and unemployable." As such, Dr. Hoeper indicated that Plaintiff's treatment plan was medication with return appointments "every six weeks for twenty minutes for medication monitoring and cognitive behavioral psychotherapy."

26. Plaintiff attended appointments with Dr. Hoeper starting on June 7, 2012 and continuing through the date of the evidentiary hearing. Initially, Plaintiff was seen roughly every

[5]According to Dr. Hoeper, a score of thirty-five indicates that a patient would "have a hard time functioning outside the home."

two months; however, from 2014 onward, Dr. Hoeper saw Plaintiff two to three times a year. The majority of Plaintiff's appointments lasted less than twenty minutes total, and none of Dr. Hoeper's records provide any evidence that Plaintiff was receiving cognitive behavioral therapy. Dr. Hoeper's records reflect that Plaintiff reported little improvement over the six years he sought treatment with Dr. Hoeper, resulting in Dr. Hoeper changing and increasing the dosage of the medications he prescribed. During this period, Dr. Hoeper continually assigned Plaintiff a GAF score of between thirty and thirty-five.

27. Defendant did not authorize any mental health treatment for Plaintiff, including Dr. Hoeper's treatment, other than the one-time evaluation performed by Dr. Gualtieri and Dr. Hervey in the fall of 2011. Instead, Plaintiff continued to treat with Dr. Hoeper on his own until filing his request for extended benefits pursuant to N.C. Gen. Stat. § 97-29(c) on March 13, 2020.

28. Although Dr. Swann restricted Plaintiff from driving in 2012, Plaintiff returned to driving by at least 2014. On November 24, 2014, Plaintiff was cited for driving while not wearing a seat belt, and on January 2, 2016 and January 5, 2017, he was cited for speeding. During the evidentiary hearing, Plaintiff admitted that he was driving on May 30, 2014, when he was involved in a car accident in Durham. Other records indicate that Plaintiff was driving during car accidents on November 22, 2018 and January 15, 2020.

29. On March 13, 2020, after 425 weeks passed since his first date of disability, Plaintiff filed a Form 33 *Request that Claim be Assigned for Hearing* seeking extended compensation pursuant to N.C. Gen. Stat. § 97-29(c). In the March 13, 2020 Form 33, Plaintiff alleges that he sustained injuries to his head, face, right eye, back, and PTSD as a result of the assault.

30. On July 20, 2020, Plaintiff underwent an independent medical examination ("IME") with Chantal Boisvert, M.D., at Duke Eye Center Durham Neuro-Ophthalmology. Plaintiff reported that following the 2011 assault, during which he lost consciousness several times, his vision became very blurry and had gradually worsened. Additionally, he related that he immediately had pain in his right eye, but that he began experiencing pain in his left eye within three days of the assault. Dr. Boisvert, having reviewed Plaintiff's prior ophthalmological records, performed an examination of Plaintiff's eyes, which found normal baseline neuro-ophthalmic conditions, a normal right optic nerve, and no evidence of traumatic optic neuropathy. Dr. Boisvert's only diagnosis was that Plaintiff was suffering from dry eye syndrome in both eyes, for which artificial tears were recommended. She also recommended Plaintiff wear sunglasses when outside and wear goggles when swimming. Following the evaluation, with no neuro-ophthalmologic diagnoses, Dr Boisvert opined that there were no issues with Plaintiff's eyes that prevented him from returning to work without restrictions.

31. On July 28, 2020, Plaintiff underwent an IME with Manish Fozdar, M.D., at Triangle Forensic Neuropsychiatry. Dr. Fozdar noted that Plaintiff "was agitated and irritable from the start." Plaintiff reported that since his assault, he had "suffered from nightmares, flashbacks, anxiety, headaches, neck pain, back pain, hip pain, and depression. He reports that these symptoms are still frequent, occur daily, and are as intense as they were immediately after the assault." Plaintiff then indicated that Dr. Hoeper "is the only person who cares for him" and that he was taking medications but had not received any counselling. Plaintiff reported that he was unable to "do much because of the pain in his body" and because his eyes get blurry.

32. As part of the IME with Dr. Fozdar, Plaintiff was also seen by Thomas Bundick, Ph.D., a psychologist tasked with performing a psychological evaluation. Dr. Bundick indicated

that Plaintiff was hostile and uncooperative throughout his evaluation, including spending hours not completing assessments. During the Montreal Cognitive Assessment, Plaintiff did not offer a single correct answer and received a score of 0/30; whereas the average score for an Alzheimer's patient is 16/30. Plaintiff was unable to complete an MMPI in over four hours, even though it takes an average of thirty-five to fifty minutes to complete. As such, Dr. Bundick noted that "no data to support or dispute his claim of psychiatric disability could be obtained."

33. After reviewing Dr. Bundick's report, Dr. Fozdar completed his report, noting that Plaintiff's presentation at both sessions was similar. Dr. Fozdar diagnosed Plaintiff with malingering and possibly anti-social personality disorder and opined that he has "no residual psychological impairments as a result of being attacked at work in June 2011. He is able to work without any restrictions. He does not need any further psychiatric treatment related to the June 2011 assault."

34. At the evidentiary hearing, Plaintiff testified that he remembered attending the IME with Dr. Fozdar, who he perceived as arrogant, rude, and unkind to him during the appointment. Plaintiff asserted that he was anxious on the date of the IME and that Dr. Fozdar did not attempt to calm Plaintiff. Plaintiff testified that he put forward his best effort in the tests performed during his 2020 IME.

35. Plaintiff further testified that he did not feel that he could return to work in any position similar to his prior positions. When asked about his prior position at Central Regional Hospital, Plaintiff indicated that he had been diagnosed with PTSD and could not return to any work because he was terrified following his assault. Additionally, he testified that he was terrified of working with children in a daycare, with the elderly, or with animals because of his assault. During his testimony, Plaintiff did not indicate that he had any ongoing issues with his

right eye, mouth, or right shoulder that would impact his ability to return to work. Since the assault, Plaintiff has not sought any other employment.

36. Plaintiff additionally testified that while at Walmart, he was approached by Sabrina Butler while he was picking up his medications—although he claimed in discovery that he could not remember her last name. According to Plaintiff, they exchanged numbers, and afterwards, she would come over "periodically," but they never entered into a relationship. According to Dr. Hoeper's records from 2014, Plaintiff was seeing Ms. Butler almost every day, and subsequently noted anger issues Plaintiff was having toward his "girlfriend." During a subsequent deposition, Plaintiff admitted that he dated Ms. Butler for approximately one year.

37. Plaintiff also testified that he continues to "constantly" relive the assault and that he is "scared of getting hit . . . or getting around anyone that is arguing, fussing, fighting or anything." Plaintiff stated that he can only go to stores when accompanied by his sister or a friend. Shortly after the accident, Plaintiff's infirm mother moved into his home; however, Plaintiff stated that he did not help take care of his mother and that his sister had to drive to Plaintiff's house to help Plaintiff and his mother. Instead, Plaintiff indicated that he spends all of his time at his home, either gardening or spending time with his two dogs—which he denied ever walking.

38. Linda Nobles, Plaintiff's sister, testified at the evidentiary hearing that following the accident, she helped Plaintiff after the assault by regularly driving to his home to cook and clean, along with handling Plaintiff's finances until she moved away. Even though Plaintiff's mother lived with Plaintiff, Linda Nobles stated that Plaintiff did not provide his mother's care. Instead, Linda Nobles and home-health care staff came to Plaintiff's home on a regular basis to take care of her mother. Ms. Nobles stated that she still drives to Plaintiff's home three times a

month to ensure that he has food. Ms. Nobles believes that Plaintiff cannot return to work because he is forgetful and afraid of everything.

39. Dolleen Garrison, a friend of Plaintiff's family, testified at the hearing that she met Plaintiff after the assault and that she travels to Plaintiff's home several times per week to help him clean his house, run errands, and take him to appointments. She schedules appointment reminders because Plaintiff is forgetful. Ms. Garrison also indicated that she does not believe that Plaintiff could return to work because he has issues with his memory.

40. Christy Wilson, a claims consultant with CCMSI, testified that she began working on this matter when CCMSI took over from the prior third-party administrator. She testified that Defendant's records indicated that Plaintiff's last treatment for his right eye occurred in 2012, when Plaintiff was placed at MMI with permanent restrictions of no driving, no operating hazardous machinery, and no working on unprotected heights. During her review, Ms. Wilson discovered records showing that Plaintiff was actively driving following the restrictions issued in 2012. She also indicated that Plaintiff had asserted earlier in the claim that he was experiencing psychiatric issues, but that the only approved treatment provided was the evaluation completed by Dr. Gualtieri and Dr. Hervey in 2011, who did not conclude that Plaintiff was experiencing any credible psychiatric issues.

41. Following the evidentiary hearing, Sabrina Butler testified by deposition that she began dating Plaintiff in the fall of 2013. According to Ms. Butler, Plaintiff approached her in a Walmart alone and provided her with his number. Ms. Butler indicated that roughly a week later she went on a date with Plaintiff at Starbucks, and they continued to date for just shy of two years. Ms. Butler testified that she stayed at Plaintiff's home several nights a week, but that she was not present during the day while she was at work. She stated that Plaintiff took care of his

home, including washing the dishes, mowing his lawn, vacuuming, and cleaning his bathroom. Although Ms. Butler claimed that Plaintiff began taking care of his mother after his mother moved in following her discharge from the hospital, she was not present during the day when the majority of the care was rendered and did not know if it was provided by Plaintiff, home health care, or Plaintiff's sister. Additionally, Ms. Butler was not aware of Plaintiff waking up during the nights while she slept at his home and did not see him experience any anxiety attacks or instances where Plaintiff appeared especially fearful; however, she admitted that she typically slept through the night.

42. At her deposition, Dr. Boisvert, currently the chief of neuro-ophthalmology at the Duke Eye Center, was tendered as an expert in neuro-ophthalmology without objection. Dr. Boisvert testified that prior to performing the IME, she reviewed Plaintiff's medical records related to his right eye. After performing an evaluation, including of Plaintiffs visual acuity and checking for anatomical abnormalities, Dr. Boisvert opined that she did not see any abnormalities and that her only diagnosis was of dry eyes, which could be resolved with regular use of artificial tears. She explicitly stated that Plaintiff showed no signs of a prior traumatic optic neuropathy, including no evidence of any damage to the optic nerve. Additionally, she indicated that dry eyes are a normal condition that she did not associate with Plaintiff's assault. Dr. Boisvert therefore opined to a reasonable degree of medical certainty that Plaintiff did not need any further treatment for his right eye related to the assault and that she assigned no ongoing restrictions.

43. On cross-examination Dr. Boisvert testified that some post-concussive patients can experience symptoms years after the event, but rarely would such a condition last nine years. She indicated that where a patient has normal pupillary response, that patient's subjective report

vision loss is suspect, and that many of the tests performed in 2012 were subjective tests. However, Dr. Boisvert focused on Plaintiff's current condition as reflected in her IME results, which she noted showed that Plaintiff had not experienced any permanent damage to his right eye. She admitted that Plaintiff may have experienced some temporary issues with his right eye, but any such temporary condition had resolved by the time of her evaluation.

44. At his deposition, Dr. Gualtieri was tendered as an expert in neuropsychiatry without objection. Dr. Gualtieri attended medical school at Columbia University and completed a fellowship in neuropsychiatry at the University of North Carolina, where he subsequently was on faculty. He has been practicing psychiatry in North Carolina since 1973 and opened NC Neuropsychiatry in 1988.

45. Dr. Gualtieri testified that after reviewing his records from the 2011 evaluation, he recalled that that Plaintiff's test results from his evaluation were inconsistent and invalid. Additionally, as Plaintiff terminated the evaluation early, Dr. Gualtieri referred Plaintiff for a subsequent neuropsychological test battery with Dr. Hervey. Per Dr. Gualtieri's memory, Plaintiff presented as a well-spoken, appropriately groomed individual, who reported a 10/10 headache, but had no visible evidence of symptoms associated with such a headache. Dr. Gualtieri remembered that Plaintiff's physical and neurological examinations were normal, although Plaintiff reported that he could not see out of one of his eyes. He indicated that Plaintiff's subjective reporting was inconsistent, but that he complained of severe problems with sleeping; moderate problems with agoraphobia; and mild problems of anxiety, depression, fatigue, and social anxiety. Dr. Gualtieri also noted that Plaintiff was able to relate the events of the assault to Dr. Gualtieri in a normal fashion, without any of the normal indications seen with PTSD, such as blunted affect, suspiciousness, or fearfulness.

46. Dr. Gualtieri testified that Plaintiff performed poorly on the CNS Vital Signs test, which is a self-administered computerized test. Plaintiff scored in the first percentile even while reporting he did well in school and was never diagnosed with attention deficit disorder or a learning disability. Dr. Gualtieri indicated that it would be difficult for any condition to explain Plaintiff's results, as, if someone had a TBI or dementia, it would likely make it difficult to even complete the test. Additionally, the built-in validity indicators showed that Plaintiff's scores were invalid. Dr. Gualtieri noted that Plaintiff's CNS Vital Signs score meant to be synonymous with IQ was eighteen, which was out of line with Plaintiff's presentation to Dr. Gualtieri.

47. Dr. Gualtieri additionally testified that he was concerned whether Plaintiff was "completely sincere" in his presentation, as he was complaining of a severe headache with no evidence of sickness, describing a visual problem with no objective basis, performing normally during physical evaluation, and creating cognitive test results similar to or worse than dementia or Alzheimer's patients. Although Plaintiff subjectively reported symptoms consistent with PTSD or an acute stress disorder, objectively his presentation did not include the normal visible symptoms associated with such conditions. Therefore, Dr. Gualtieri requested additional testing.

48. After reviewing the results from Dr. Hervey's evaluation, Dr. Gualtieri explained that psychological testing has a number of internal measures to detect individuals who are exaggerating their symptoms or pretending to have a TBI. Dr. Gualtieri noted that the tests administered to Plaintiff in 2011 resulted in scores indicating that Plaintiff's testing was non-credible and invalid. Specifically, on the MMPI-2's internal validity scale, Plaintiff' scores "suggested intentional symptom exaggeration." Based on Dr. Gualtieri's evaluation and his review of additional testing by Dr. Hervey, Dr. Gualtieri provided his opinion to a reasonable

degree of medical certainty that Plaintiff did not show any signs of a brain injury or any psychiatric conditions to explain his reported symptoms in 2011.

49. On cross-examination, Dr. Gualtieri was asked whether it was likely that an individual who was assaulted similarly to Plaintiff would experience PTSD. Dr. Gualtieri testified that Plaintiff was specifically evaluated in 2011 for PTSD and that the objective testing and evaluation demonstrated that Plaintiff was not experiencing PTSD. Dr. Gualtieri admitted that PTSD can manifest in a variety of different ways, but that due to the different presentations, diagnostic evaluation is more important. Additionally, although a patient may subjectively report symptoms commonly associated with PTSD, the subjective reporting alone is insufficient to support a diagnosis of PTSD. Dr. Gualtieri testified that he performed an objective examination, with diagnostic testing[6], specifically to evaluate Plaintiff for the differing presentations of PTSD, but that, based on the examination, Plaintiff did not present to Dr. Gualtieri with PTSD.

50. At his deposition, Dr. Hoeper was tendered as an expert in psychiatry without objection. Dr. Hoeper attended medical school at Northwestern University, completed a residency program at the University of Wisconsin, and in 1969 he began seeing patients. Following a tour in the Air Force, Dr. Hoeper entered practice as a psychiatrist in Wisconsin and Missouri before moving to North Carolina in 1989. Roughly ninety-eight percent of Dr. Hoeper's patients are veterans, of which Dr. Hoeper indicated ninety-five percent have PTSD.

[6] Dr. Gualtieri testified that he did not perform all of the normal testing typically associated with PTSD evaluation, as Plaintiff left the appointment early. However, he testified that he administered the Hamilton Anxiety Scale, Hamilton Depression Scale, Beck Anxiety Scale, an attention deficit disorder test, a neuropsychological questionnaire, a mental state examination, physical examination, neurological examination, and cognitive testing. Dr. Gualtieri admitted that there are other tests that can be administered to evaluate a patient for PTSD, but that a diagnosis of PTSD should be based on an evaluation beyond the subjective reports of the patient.

51. Dr. Hoeper testified that he first saw Plaintiff on May 8, 2012, where he prescribed his "common starting medications [for] PTSD." He indicated that he did not review any materials and relied on Plaintiff's subjective reports at the May 8, 2012 visit. Dr. Hoeper indicated that the assault described by Plaintiff at the initial appointment was consistent with Plaintiff's hearing testimony and Mr. Dixon's written account, and that the assault was "enough of a stressor to bring on PTSD." Dr. Hoeper was then asked to go over his treatment notes, where he indicated that Plaintiff subjectively reported "nightmares, flashbacks, panic attacks, poor sleep, social isolation, poor recent memory, and high anxiety level[,]" which Dr. Hoeper associated with PTSD. Subsequently, during treatment, Plaintiff began to report auditory and visual hallucinations, increased levels of anger, and depression, along with a flat affect. Dr. Hoeper noted that Plaintiff continued to report symptoms throughout the entirety of his treatment, resulting in an increase in Plaintiff's medication dosages.[7]

52. Dr. Hoeper reported that he saw Plaintiff on October 5, 2020—after the evidentiary hearing—during which Plaintiff reported symptoms consistent with those reported throughout his treatment. Additionally, Plaintiff reported a new issue, that he could not "cook for himself because he might leave the burner on." Plaintiff also reported that he was occasionally driving, but only if someone is directing him. Dr. Hoeper indicated that he could not increase Plaintiff's medications, as Plaintiff was already receiving their maximum dosages.

53. Dr. Hoeper offered his opinion that Plaintiff continues to experience PTSD and depression from the assault in 2011 and that Plaintiff cannot return to work "[b]ecause of the

[7] According to Dr. Hoeper, if the onset of PTSD occurs before twenty-five, an individual will have to receive medication for the remainder of their lives, but if onset occurs after thirty-five, generally a patient can wean off PTSD medication in five or six years. Plaintiff was over thirty-five years old at the time of the assault. Additionally, Dr. Hoeper indicated that his patients with PTSD generally do not obtain GAF scores above forty-five and remain unable to function outside of the home.

severity and chronicity of his [PTSD]." Dr. Hoeper, relying on testing Dr. Hervey noted was invalid, proceeded to opine that Plaintiff has an IQ of sixty-three, which would place him in the 0.1 percentile, making it remarkable that Plaintiff was able to function, maintain employment, and complete school prior to the assault, and therefore, Plaintiff must be "disciplined and highly motivated."

54. When questioned about Plaintiff's medical records from other providers, Dr. Hoeper criticized Ms. Edmondson's recorded GAF score eleven days after the assault, as it was inconsistent with Plaintiff's presentation to Dr. Hoeper over eight months after the assault. Additionally, Dr. Hoeper provided no explanation for his opinion that Plaintiff is not malingering, instead stating that he disagrees with Dr. Fozdar and Dr. Gualtieri's diagnosis of malingering "[b]ecause [Plaintiff's] not." According to Dr. Hoeper, since 1989 he has treated only three patients who were malingering, who all showed indications of antisocial personality disorder—a condition for which Dr. Fozdar opined Plaintiff should be evaluated. During this time, Dr. Hoeper testified he treated roughly 3,500 individuals, the majority of whom are combat veterans.

55. Dr. Hoeper admitted on cross-examination that his treatment has been solely based on Plaintiff's subjective reporting and his observation of Plaintiff in the clinic. Dr. Hoeper indicated that no testing was performed during Plaintiff's treatment and stated that "[t]here really isn't any such thing as psychiatric [testing]." He agreed that his diagnosis of Plaintiff was just "based on [his] own expertise, judgment, and observation." On redirect, Dr. Hoeper indicated that no testing was needed "[b]ecause I'm trained as a psychiatrist. . . . I've had 31 years of experience with PTSD. . . . I could tell somebody that has PTSD across the street." He further testified that there is no cure for PTSD and that after a year PTSD is usually chronic.

56. At his deposition, Dr. Fozdar was tendered as an expert in psychiatry and neuropsychiatry. Dr. Fozdar completed residencies in psychiatry, neuropsychiatry, and behavioral neurology following medical school and is currently board certified in psychiatry and forensic psychiatry.

57. Dr. Fozdar testified that as part of the IME, he reviewed Plaintiff's medical records from the date of the assault onward, including Dr. Gualtieri and Dr. Hoeper's records. Dr. Fozdar indicated that his IME involved meeting with Plaintiff to perform an examination, followed by a referral to Dr. Bundick to complete psychological testing. Dr. Bundick administered the Montreal Cognitive Assessment, which is a cognitive screening tool, and the most recent version of the MMPI, which is a standardized personality test. Plaintiff scored a zero on the Montreal Cognitive Assessment but based on Dr. Fozdar's examination and Plaintiff's medical records, Dr. Fozdar expected a score in the normal range, above twenty-five. Dr. Fozdar testified this was the first time he had ever seen a patient score zero. Dr. Fozdar opined that the only explanation for Plaintiff's results from the testing administer during the IME was malingering.

58. Dr. Fozdar also testified that the most notable finding was Plaintiff's extremely uncooperative behavior. Plaintiff was hesitant to provide information, provided information contradicted by his prior records, and repeatedly blamed others. Dr. Fozdar opined that Plaintiff's uncooperative presentation at the examination was not correlated with PTSD. Dr. Fozdar indicated that subjective reports of symptoms are only one component of evaluating an individual for PTSD. Additionally, Dr. Fozdar noted that published clinical research has shown that most individuals with PTSD report significant improvements over time.[8] However, Plaintiff

[8] Dr. Fozdar also testified that if an individual is actually suffering from PTSD, the standard of care is that the individual receives medication management and counselling. According to Dr. Fozdar, the most important

not only continued to subjectively report severe symptoms of PTSD; he also reported that there had been no symptom improvement since the assault. Based on the IME and Plaintiff's medical records, Dr. Fozdar opined to a reasonable degree of medical certainty that Plaintiff is not suffering from PTSD and that Plaintiff should be evaluated for a personality disorder, specifically antisocial personality disorder—which would be unrelated to the assault. Dr. Fozdar further opined that Plaintiff does not need any treatment related to the assault, but that he may benefit from treatment for a personality disorder.

59. On cross-examination, Dr. Fozdar admitted that individuals react differently to trauma. However, "[t]here is a well-established . . . clinical course of anyone suffering from PTSD." According to Dr. Fozdar, treating providers must review the diagnostic criteria for PTSD, which includes a threshold of trauma, but also other factors as well. Dr. Fozdar admitted that the subjective reports of symptoms Plaintiff made to other individuals are symptoms associated with PTSD, but that Plaintiff did not report such symptoms to Dr. Fozdar and that objective testing indicated that Plaintiff's subjective reporting was not reliable.

60. Pamela Harris, a senior case manager at Carolina Case Management and Rehabilitation, testified via deposition and was tendered as an expert in vocational rehabilitation without objection. Ms. Harris has a master's degree in rehabilitation psychology, is a licensed clinical mental health counsellor, and is a certified rehabilitation counselor. Ms. Harris prepared a labor market survey in August 2020 following a review of Plaintiff's medical records from Dr. Swann, Dr. Boisvert, Dr. Fozdar, and Dr. Bundick. Based on her review of the records, Ms. Harris did not identify any active work restrictions related to Plaintiff's work injury.

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treatment for PTSD is psychotherapy. However, per Dr. Fozdar's review of Plaintiff's case, Plaintiff has never been provided psychotherapy through Dr. Hoeper, only medications prescribed based on subjective reporting without any objective evaluation of Plaintiff's symptoms.

61. Ms. Harris further testified that Plaintiff's work history provided him with transferrable skills in the healthcare field. Ms. Harris noted that Plaintiff would be qualified for nursing assistant positions or other healthcare positions dealing with patients, such as at assisted living facilities. Some of the positions Ms. Harris identified were positions that would involve Plaintiff only dealing with a single patient in an in-home environment. Ms. Harris stated that the positions she identified were just a sample of available positions for which Plaintiff is qualified. Additionally, Ms. Harris indicated that Plaintiff was a candidate to work in a childcare setting or to work in animal care, like dog walking.

62. On cross-examination, Ms. Harris was presented with Dr. Hoeper's notes indicating that Plaintiff was reporting memory issues and stating the Dr. Hoeper diagnosed Plaintiff with PTSD and considered Plaintiff unemployable. Ms. Harris opined that Dr. Hoeper's records did not alter her opinion that Plaintiff would be able to return to work. She testified that PTSD and depression do not render all individuals unemployable, and that typically providers encourage individuals with such conditions to attempt to return to work as part of treatment. Additionally, she noted that Dr. Hoeper's opinion was not based on any testing to establish Plaintiff's ability to function, only repeating Plaintiff's subjective reports. On redirect, Ms. Harris stated that Dr. Hoeper's opinion was contradicted by both Dr. Fozdar and Dr. Bundick's examinations of Plaintiff.

63. Based upon the preponderance of the evidence in view of the entire record, the Full Commission finds that Plaintiff has reached maximum medical improvement related to his right eye, mouth, and right shoulder. In reaching this finding, the Full Commission notes that Plaintiff has not sought any treatment for his right eye, mouth, or right shoulder since 2012. Additionally, pursuant to the IME performed by Dr. Boisvert, no permanent, or temporary, injury

to Plaintiff's right eye or optic nerve was present in 2020. At the time of the evidentiary hearing, Plaintiff had no work restrictions related to his right eye, mouth, or right shoulder.

64. Based on the preponderance of evidence in view of the entire record, the Full Commission finds that Plaintiff did not establish that he suffers from PTSD as a result of the 2011 assault. In reaching this finding, the Full Commission assigns greater weight to the opinions of Dr. Gualtieri and Dr. Fozdar than Dr. Hoeper, who relied solely on Plaintiff's subjective reporting without any diagnostic testing or objective findings to support his diagnosis of PTSD. Dr. Gualtieri provided a psychiatric evaluation of Plaintiff in 2011, which indicated that Plaintiff was not credible in his description of symptoms associated with PTSD or depression. Dr. Gualtieri and Dr. Fozdar considered Plaintiff's subjective reports and performed objective testing regarding his mental health conditions. The results of Dr. Gualtieri and Dr. Fozdar's objective testing and examinations assisted them in forming their psychiatric opinions that Plaintiff did not suffer from PTSD or any other mental condition related to his work injury.

65. Based on the preponderance of evidence in view of the entire record, the Full Commission finds that Plaintiff has not established that he lacks total wage-earning capacity as a result of his June 26, 2011 right eye, mouth, or right shoulder injuries. .

66. Based on the preponderance of the evidence in view of the entire record, the Full Commission finds that Plaintiff has not established that any additional medical treatment is reasonably necessary at this time to effect a cure, provide relief, or lessen the period of disability for Plaintiff's June 26, 2011 assault.

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Based upon the foregoing Stipulations and Findings of Fact, the Full Commission makes the following:

CONCLUSIONS OF LAW

1. In workers' compensation cases, Plaintiff has the burden of proving every element of compensability. As part of this burden, Plaintiff must present a preponderance of evidence in view of the entire record establishing these elements. *Whitfield v. Lab. Corp. of Am.*, 158 N.C. App. 341, 350, 581 S.E.2d 778, 784 (2003); *Harvey v. Raleigh Police Dep't*, 96 N.C. App. 28, 35, 384 S.E.2d 549, 553, *disc. rev. denied*, 325 N.C. 706, 388 S.E.2d 454 (1989). The Industrial Commission is the sole judge of the credibility of witnesses. *Adams v. AVX Corp.*, 349 N.C. 676, 680, 509 S.E.2d 411, 413 (1998).

2. On June 26, 2011, Plaintiff sustained an admittedly compensable injury by accident to his right eye, mouth, and right shoulder arising out of and in the course of his employment with Defendant which Defendant accepted by filing a Form 63 that was never subsequently denied. N.C. Gen. Stat. §§ 97-2(6), 97-18(d) (2020).

3. As of the date of the evidentiary hearing, Plaintiff had received ongoing temporary total disability benefits as a result of his compensable injury since June 27, 2011. N.C. Gen. Stat. § 97-29(b) (2020). Pursuant to N.C. Gen. Stat. § 97-29(b), an employee is limited to 500 weeks of temporary total disability benefits from his first date of disability.

4. After the 500 week period has elapsed, in order to seek additional indemnity compensation, the employee must apply to the Industrial Commission for "extended compensation." N.C. Gen. Stat. § 97-29(c) (2020). N.C. Gen. Stat. 97-29(c) establishes that the employee has the burden to show he had "sustained a total loss of wage-earning capacity." Such an application must be made more than 425 weeks after his first date of disability. *Id.* Here, Plaintiff has timely filed an application for extended compensation. *Id.*[9]

[9] On June 24, 2011, the *Protecting and Putting North Carolina Back to Work Act*, N.C. Session Law 2011-289, amended multiple sections of the Workers' Compensation Act, including N.C. Gen. Stat. § 97-29. Specifically,

5. The greater weight of the credible evidence establishes that Plaintiff has been released with no restrictions related to his admittedly compensable conditions—his right eye, mouth, and right shoulder. Dr. Boisvert released Plaintiff with no restrictions for his right eye. Additionally, there is no evidence to support that restrictions were assigned related to Plaintiff's mouth and right shoulder conditions, or that he has sought no treatment for such conditions since 2012.

6. Under N.C. Gen. Stat. § 97-82(b),[10] the *Parsons* presumption does not apply to a condition unless that condition is expressly identified on a Form 63, resulting in Plaintiff retaining the burden to establish that the condition was caused by the compensable injury unless expressly listed. N.C. Gen. Stat. § 97-82(b) (2020); *see also Parsons v. Pantry, Inc.*, 126 N.C. App. 540, 542, 485 S.E.2d 867, 869 (1997). As such, Plaintiff's mental health complaints, including but not limited to PTSD and depression, do not fall within the scope of a *Parsons* presumption and he has the burden to prove that such a condition, if it exists, was causally related to the June 26, 2011 injury by accident. N.C. Gen. Stat. § 97-82(b) (2020).

7. "[W]here the exact nature and probable genesis of a particular type of injury involves complicated medical questions far removed from the ordinary experience and knowledge of laymen, only an expert can give competent opinion evidence as to the cause of the injury." *Click v. Pilot Freight Carriers, Inc.*, 300 N.C. 164, 167, 265 S.E.2d 389, 391 (1980). "[T]he entirety of causation evidence" must "meet the reasonable degree of medical certainty

N.C. Session Law 2011-289 capped temporary total disability benefits at 500 weeks and set forth the standard to apply for extended compensation. Pursuant to N.C. Session Law 2011-289 § 23, the addition of the new standard for N.C. Gen. Stat. § 97-29 was effective upon being signed into law on June 24, 2011. Therefore, Plaintiff's claim arising from the June 26, 2011 assault is bound by the amended version of N.C. Gen. Stat. § 97-29 placing the burden on Plaintiff to prove his entitlement to extended compensation.

[10] N.C. Stat. § 97-82(b) applies "to claims accrued prior to, on, or after" N.C. Session Law 2011-287 took effect. N.C. Session Law 2017-124 § 1.(c). As Plaintiff's claim accrued after N.C. Session Law 2011-287, including the changes to N.C. Gen. Stat. § 97-29, took effect, N.C. Gen. Stat. § 97-82(b) applies to this matter.

standard necessary to establish a causal link." *Holley v. ACTS, Inc.*, 357 N.C. 228, 234, 581 S.E.2d 750, 754 (2003). Moreover, "[a]lthough expert testimony as to the *possible* cause of a medical condition is admissible if helpful to the jury, it is insufficient to prove causation, particularly 'when there is additional evidence or testimony showing the expert's opinion to be a guess or mere speculation.'" *Id*. at 233, 581 S.E.2d at 753 (citing *Young v. Hickory Bus. Furn.*, 353 N.C. 227, 233, 538 S.E.2d 912, 916 (2000)) (emphasis in original).

8. Here, the Full Commission assigns greater weight to the causation opinions of Dr. Gualtieri and Dr. Fozdar than Dr. Hoeper, who relied solely on Plaintiff's subjective reporting without any diagnostic testing or objective findings to support his diagnosis of PTSD. Thus, the Full Commission concludes that Plaintiff has failed to meet his burden to show by competent and credible medical evidence that he suffered from PTSD or depression caused by the June 26, 2011 assault.

9. Since the greater weight of evidence establishes that Plaintiff has been assigned no work restrictions related to any conditions caused by the June 26, 2011 assault, Plaintiff's alleged inability to earn wages as of the evidentiary hearing was not due to his compensable injury by accident. N.C. Gen. Stat. § 97-29(c) (2020). Therefore, Plaintiff has failed to meet his burden to establish that he sustained a total loss of wage-earning capacity because of his compensable injury, and he is not entitled to extended compensation. N.C. Gen. Stat. § 97-29(c) (2020).

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Based upon the foregoing Stipulations, Findings of Fact, and Conclusions of Law, the Full Commission enters the following:

A W A R D

1. Plaintiff's claim for medical treatment for his alleged PTSD and depression are hereby DENIED.

2. Plaintiff's claim for extended compensation pursuant to N.C. Gen. Stat. § 97-29(c) is hereby DENIED.

Commissioner GOODMAN and Deputy Commissioner HULLENDER concur.