# ALASKA WORKERS' COMPENSATION BOARD

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

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| OLGA KUZMIN,<br><br>Employee,<br>Claimant,<br><br>v.<br><br>FIRST GROUP AMERICA,<br><br>Employer,<br>and<br><br>AIU INSURANCE CO.,<br><br>Insurer,<br>Defendants. | INTERLOCUTORY<br>DECISION AND ORDER<br><br>AWCB Case No. 202402773<br><br>AWCB Decision No. 25-0079<br><br>Filed with AWCB Anchorage, Alaska<br>on November 19, 2025 |

Olga Kuzmin's (Employee) October 17, 2025 petition for a second independent medical evaluation (SIME) was heard on the written record on November 19, 2025, in Anchorage, Alaska, a date selected on October 21, 2025. The October 17, 2025 petition gave rise to this hearing. Attorney Keenan Powell represents Employee. Attorney Krista Schwarting represents First Group America and its insurer (Employer). The record closed on November 19, 2025.

## ISSUE

Employee contends that conflicting medical opinions between her attending physicians and Employer's medical evaluator (EME) warrant an SIME. She seeks an SIME.

Employer contends that any medical disputes between the physicians do not warrant an SIME. It seeks an order denying Employee's request. Alternately, if an SIME is ordered, Employer suggests a limited SIME with only an orthopedic surgeon.

**Shall this decision order an SIME?**

## FINDINGS OF FACT

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

1) On February 14, 2024, Employee slipped on ice in the parking lot at work and had right heel pain. (First Report of Injury, February 21, 2024). She also claims that on March 9, 2025, as a result of weakness and numbness in her right foot from the work injury, she fell down stairs, which caused a concussion. (Employee's SIME Hearing Brief, November 12, 2025).

2) On February 26, 2024, providers at Homer Medical Center saw Employee for "an injury that occurred at [her] place of employment" on February 14, 2026. Employee explained that she was getting into her car when she slipped and fell, bruising her right heel. The provider charted, "There is a lump on heel that wasn't previously there." Employee reported that she had right heel pain since the incident and could not walk flatfoot but had to "tiptoe." On examination, her provider found a "lump at calcaneus near insertion point of Achilles," that was laterally displaced. There was concern for a calcaneal fracture or Achilles disruption. X-rays confirmed the suspicion for a "fractured enostosis at the insertion of the Achilles tendon." The clinic referred Employee to Brent Adcox, MD, orthopedic surgeon. (Homer Medical Center record, February 26, 2024).

3) On February 26, 2024, Dr. Adcox examined Employee and stated:

> [Employee] is a very pleasant woman that is here for a fracture of a calcaneal spur. The injury occurred approximately 10 days ago. She can weight bear on her tip toes but has a hard time with complete plantar grade placement of her foot. . . .
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> Fracture of a calcaneal spur on the right calcaneus. I placed her in a fracture boot and made her non-weightbearing for the next 6 weeks. I will see her back at 6 weeks to start progressive weight bearing. . . . (Adcox report, February 26, 2024).

4) By March 25, 2024, Employee had not improved. "She has a broken osteophyte in the posterior calcaneus which is causing a significant amount of pain," despite her being not weightbearing for the previous four weeks. Her swelling had worsened and she had attempted weight-bearing on

two occasions, unsuccessfully. Dr. Adcox found a "swollen mass" at the back of her Achilles insertion into the calcaneus. (Adcox report, March 25, 2024).

5) On April 11, 2024, when Employee had still not improved, Dr. Adcox referred her to Eugene Chang, MD, orthopedic surgeon. (Adcox report, April 11, 2024).

6) On May 20, 2024, Dr. Chang opined that Employee had a work-related injury and described two work-related incidences: about a month prior she had stumbled in the parking lot and quickly thereafter developed a "bony prominence" on her right heel; thereafter, Employee may have had a small avulsion in her distal Achilles tendon and had pain while driving her bus, just from "pressure on her heel." He diagnosed a Haglund's deformity on the right foot. He charted that Employee did not have that prominence before she stumbled in the parking lot at work. "Thus, it does appear to be a work-related injury." Dr. Chang recommended a Haglund's decompression surgery and evaluation and repair of the Achilles tendon as needed. Thereafter, she would be non-weightbearing for approximately three weeks and her recovery would be roughly eight weeks. (Chang report, May 20, 2024).

7) On July 16, 2024, Dr. Chang performed an Achilles tendon debridement and repair and excised the Haglund's deformity on Employee's right heel. (Operative Report, July 16, 2024).

8) On August 5, 2024, Employee told Dr. Chang that her right foot was numb on the inside and on the dorsum aspect of her foot and ankle. He noted that she did not receive a "block" prior to surgery. She had difficulty wiggling her toes. Dr. Chang recommended progressive weight-bearing in a boot. (Chang report, August 5, 2024).

9) On August 22, 2024, following a phone visit with Employee, he attributed her numbness around the feet to "just some swelling from disuse." Employee said she "felt a little bit of a pop in the back of the heel." Dr. Chang could not assess this virtually and suggested she try physical therapy (PT) and see him in-person in two weeks. (Chang report, August 22, 2024).

10) By September, 2024, on referral from Dr. Chang, Employee began participating in PT. (PT note, September 9, 2024).

11) On September 16, 2024, Dr. Chang evaluated Employee again for numbness on her right foot and decreased sensation in the plantar aspect. He noted Employee did not have "a lot of discoloration and no real swelling," and had not gotten a popliteal block before surgery. He ascribed "disuse" as the likely cause of her subjective sense of numbness. He recommended continued PT. (Chang report, September 16, 2024).

12) On October 18, 2024, Employee told her physical therapist that when she stood up after leaving the bathtub recently she "put too much weight on the [right] foot and then fell over." She had an increase in heel pain thereafter. (PT report, October 18, 2024).

13) On November 6, 2024, Employee reported to her physical therapist that she was "kicked in the back of the right foot on Monday by a drunk person at a wedding." The therapist noted tenderness in the area where Employee reported having been kicked but no unusual masses or textures noted. (PT report, November 6, 2024).

14) On November 8, 2024, PT charted that Employee's foot the day prior was "a little swollen" because she was "moving furniture around." Her hip hurt from "putting chains on buses." (PT report, November 8, 2024).

15) On November 19, 2024, PT recorded that Employee still reported pain when stepping even while using a cane to reduce weight-bearing. Walking remained "difficult," with her foot "occasionally giving out, leading to instability and comments from others about her gait." Driving exacerbated pain in the Achilles area, an activity which Employee described as "not a good idea." (PT report, November 19, 2024).

16) On November 26, 2024, Employee reported to PT that walking and driving were still difficult and her lower back pain had been "very bad, describing it as crunching when walking and requiring her to lay down and stretch frequently." (PT report, November 26, 2024).

17) On December 11, 2024, Employee told her physical therapist that her pain felt "like the same pain as before the surgery." She had tried swimming on the previous Sunday and "it did not go well." (PT report, December 11, 2024).

18) On December 16, 2024, Timothy Borman, DO, orthopedic surgeon, saw Employee for an EME. She explained her injury and symptoms and stated she used a cane to help walking. "She also tells me that she thinks that due to her gait disturbance she is developing low back pain." Employee described right-foot numbness over most of her foot, which she thought developed following her foot surgery. She denied similar symptoms on the left foot. Employee said that when she stands a long time intermittently during the day her right foot will turn "purple." She did not feel that she had gained any pain relief since her injury. On examination with a topical thermometer, Dr. Borman found Employee's right foot and ankle were "cooler to touch than the left foot and ankle." (Borman EME report, December 16, 2024).

19) Dr. Borman diagnosed a preexisting Haglund's deformity; Achilles tendinitis; status post-surgery of the right calcaneus and Achilles tendon; peroneal nerve palsy; and possible complex regional pain syndrome (CRPS), all in the right foot and ankle. (Borman EME report, December 16, 2024).

20) Dr. Borman opined that the February 14, 2024 work injury aggravated the Haglund's deformity and caused the Achilles tendinitis and the need to operate on the Haglund's deformity. It also caused peroneal nerve palsy in the right foot and possible CRPS. Dr. Borman said the work injury was the substantial cause of the need for medical treatments Employee had to her right foot. The work injury also caused a permanent aggravation of the Haglund's deformity. Treatment to date had been appropriate but was not yet completed. Dr. Borman recommended she continue her PT and home exercises and gradually lift her weight-bearing restrictions. In his view, Employee should be encouraged to stop using her lace-up style ankle brace or ankle boot and begin weight-bearing in comfortable shoes. He also recommended a posterior relief ankle-foot orthosis. Dr. Borman opined that using her ankle-cast-boot intermittently for pain control was appropriate. He recommended a physical medicine and rehabilitation or neurology consultation regarding the numbness and weakness in the right foot and ankle. This would confirm the possible CRPS diagnosis. He also suggested electromyography and nerve conduction velocity testing. As for medications, Dr. Borman suggested Tylenol 1000 milligrams three times a day and naproxen 500 mg twice-daily. Employee's conditions were not medically stable but he anticipated they would be by July 16, 2025, one year post-surgery. He predicted Employee would eventually have the physical capacities to drive a school bus. Meanwhile, however, he restricted her to lift, carry, push and pull up to 10 pounds only and avoid weight-bearing activities that intensified her pain. She could not safely operate a school bus at the time of Dr. Borman's evaluation. (Borman EME report, December 16, 2024).

21) On January 23, 2025, Employee reported to PT that the previous Saturday she noticed her right foot was purple and the color did not dissipate with elevation. When she started massaging the foot, the color started to return. (PT report, January 23, 2025).

22) On February 5, 2025, Employee reported to PT that her toes on the right foot felt cold, particularly the little one, "which [felt] ice cold." (PT report, February 5, 2025).

23) On February 10, 2025, Dr. Chang saw Employee and administered a "very dilute" cortisone injection into the ankle. (Chang report, February 10, 2025).

24) On March 11, 2025, Anna Williams, whose credentials are not given, but who is affiliated with SPH Clinic Services, saw Employee, who reported that on March 9, 2025, she was walking down three sets of stairs and her right foot "gave out or slid out" on her. It was, "Hard to know." She previously had surgery on her right heel in July 2024 for a heel fracture and torn Achilles tendon. Employee had been using a cane to help her ambulate. Her leg was still weak and her right foot still numb. When Employee fell, she said she landed on her back. Her neck hit one step, her ribs the next one, and her hip the third step. "Everything hurts." Her neck was achy and painful to move and she thought she had a rib fracture on her left mid-back. Her right hip was tender and it was painful to lift her right leg forward. Williams stated, "[Employee] is recovering from right heel surgery 7/24 and has residual right leg weakness and right foot numbness which contributed to her fall." Williams assessed a fall from stairs or steps; a concussion syndrome causing a mild headache and irritability with trouble concentrating; neck pain; rib pain on her left side; and acute right-hip pain and spasms. She endorsed x-rays and medication. (Williams report, March 11, 2025).

25) On March 11, 2025, Employee attended her 39th PT visit. She described the March 9, 2025 slip and fall on the steps where she "missed the step" and hit her "head and thoracic spine." Employee described "another fall recently as well when her foot gave out, causing her to fall but not injure herself." She stated that having a blanket on her foot or wearing a brace and sock caused "a throbbing pain in the heel; the symptoms are worsening." (PT report, March 11, 2025).

26) On March 13, 2025, while at PT, Employee described significant neck and hip pain, a possible rib fracture and a confirmed concussion. (PT report, March 13, 2025).

27) On March 21, 2025, Employee told her physical therapist that she had been experiencing "falls and foot giving out, which she attributes to her recent concussion and whiplash." She also experienced memory loss and could not remember if she had washed the dishes the previous evening. (PT report, March 31, 2025).

28) On March 26, 2025, Dr. Chang stated Employee was issued an ankle brace on February 10, 2025, to address her ankle issue. (Chang report, March 26, 2025).

29) By March 31, 2025, Employee was reporting back and neck pain from her fall on the stairs "a few weeks ago," and headache, ringing in her ears, and memory loss from a concussion. She requested an off-work letter stating she could not return to work driving a school bus at that time. The provider assessed a right lower leg spasm; a concussion syndrome and lumbosacral

radiculopathy. She recommended x-rays and perhaps magnetic resonance imaging (MRI) and gave Employee an off-work letter. (Homer Medical Center report, March 31, 2025).

30) On April 4, 2025, Employee told her physical therapist that she still had headaches and blurred vision associated with increased activity. She still had difficulty with concentration and word-finding. Employee reported light-sensitivity with bright fluorescent lights. Her neck was doing better but was still painful and had limited motion, as well as lumbar spine pain. Employee said she had no similar symptoms before her March 9, 2025 fall on the steps. She now described right lower extremity symptoms that were not preexisting. (PT report, April 4, 2025).

31) On April 9, 2025, Employee attended her 45th PT visit and reported some improvement. However, she stated that earlier that weekend she was climbing out of the tub and fell. She was not sure if her ankle or foot "gave way" or "what happened," but she hit her left eye on the vanity. She had a blackeye and swelling. (PT report, April 9, 2025).

32) On April 10, 2025, a provider at Homer Medical Clinic evaluated Employee for her concussion and fall "last Saturday in the shower" where she hit her head on the left side. This provider recommended a computerized tomography (CT) scan to rule out abnormalities given that Employee could not recall the events leading up to the fall in the shower the previous Saturday, and because she had blurry vision in her left eye. Employee was removed from work pending the CT scan. (Homer Medical Clinic report, April 10, 2025).

33) On April 11, 2025, Employee's head CT scan was normal. (CT scan, April 11, 2025).

34) On May 2, 2025, Heath McAnally, MD, pain management, saw Employee on referral from Dr. Chang. He stated, "In brief, she apparently sustained an injury at her place of employment on February 14, 2024 comprising [of] slipping and falling on the ice and landing partially in her vehicle." Employee underwent foot surgery in July 2024. Dr. McAnally assessed a "constellation of symptoms certainly consistent with [CRPS]." Employee had numerous falls that she attributed, as did Dr. McAnally, to numbness in her foot and a lack of touch perception. He added, "she is currently unable to drive owing to unreliability of her foot/ankle." Employee had been undergoing consistent physiotherapy. Dr. McAnally prescribed among other things gabapentin. He diagnosed right-foot numbness; right-foot weakness; right peroneal-nerve neuropathy; and a fall due to slipping on ice or snow "sequela." While Dr. McAnally stated Employee "does technically meet Budapest criteria for CRPS," he added that her disproportionately profound ligament weakness in her foot also suggested an L5 radiculopathy. He recommended electrodiagnostic testing and a

CRPS-preventative regimen that included various vitamins and supplements. She was to continue PT with desensitization and "GMI" [Graded Motor Imagery] protocols should be implemented. Dr. McAnally prescribed continued gabapentin but no further interventional care by him until the electrodiagnostic results were available. (McAnally report, May 2, 2025).

35) On May 27, 2025, Eric Kussro, DO, physical medicine and rehabilitation specialist, performed electrodiagnostic studies on Employee and diagnosed right-foot paresthesia and muscle weakness in her lower extremity. He found the electrodiagnostic studies were essentially normal. There was no evidence of lumbosacral radiculopathy or any other kind of neuropathy. However, the findings suggested the presence of an accessory fibular (peroneal) nerve on the right. He referred Employee back to Dr. Chang. (Kussro report, May 27, 2025).

36) On May 30, 2025, after evaluating her, Employee's physical therapist recommended a "Bay Club" membership for a couple of months for Employee to perform her own aquatic exercises. (PT report, May 30, 2025).

37) On June 4, 2025, Employee's PT charted that she had skin sensitivity related to CRPS symptoms due to tape application. She experienced a fall while walking in the hallway without a brace or cane "as the affected area gave way." (PT report, June 4, 2025).

38) On June 6, 2025, Employee told Dr. Chang's PA-C that her electrodiagnostics revealed no nerve issues. She recommend magnetic resonance imaging (MRI). "Note given to state patient is unable to work at this time." (Tamara Brothers-McNeil, PA-C report, June 6, 2025).

39) On August 19, 2025, John Ballard, MD, orthopedic surgeon, saw Employee for an EME. He reviewed Employee's history and selected medical records. Employee's chief complaint was right-heel pain. She stated that for the most part she cannot feel her right foot, falls occasionally and feels unsteady. Employee advised that she cannot drive a motor vehicle, so she is not working. Dr. Ballard diagnosed a work-related, February 14, 2024 fracture with a Haglund's deformity and right Achilles tendinitis. He did not have an objective explanation for Employee's global numbness or subjective complaints as she had normal muscle strength in her foot. Dr. Ballard opined that her globally decreased sensation was "nonanatomic." He said, "The cause of the conditions would be the work-related exposure. I do not have any other explanation for her widespread complaints." Dr. Ballard further opined that the work injury caused the calcaneal spur to fracture, causing the Achilles tendinitis and resulting in surgery. Thus, in his view, the work injury was the substantial factor for her surgery. (Ballard report, August 19, 2025).

40) Dr. Ballard did not have an objective explanation for Employee's widespread pain complaints and her global numbness. "I cannot state objectively that her work injury is the cause of a need for any further medical treatment. I do not have an explanation for her persisting subjective symptoms." In his opinion, the work injury was an aggravation of a preexisting Haglund's deformity, which caused that deformity to fracture. "That aggravation is resolved as of today's date, August 19, 2025." Dr. Ballard opined that Employee's medical treatment had been reasonable and appropriate, but there was no further treatment that was going to make any change in her symptoms. In his view, Employee did not have signs of CRPS. Dr. Ballard stated Employee was medically stable on August 19, 2025. He opined that palliative care was not going to make any difference in her symptoms because her symptoms had not improved despite the care she had received. Dr. Ballard provided a two percent whole-person PPI rating for this injury. He did not find any physical restrictions to prevent her from being a school bus driver, and believed her restrictions were based solely on her subjective complaints, which he opined were not supported by objective findings. (Ballard report, August 19, 2025).

41) On August 29, 2025, Dr. Chang stated, "[Employee] should be off work indefinitely." (Chang Work/School Status Note, August 29, 2025).

42) On August 29, 2025, Dr. Chang also opined that while no further surgery was recommended, he prescribed lidocaine patches to help with Employee's local discomfort. (Chang report, August 29, 2025).

43) On September 22, 2025, Employee claimed permanent total disability (PTD); permanent partial impairment (PPI), and medical and related transportation benefits; an unfair or frivolous controversion; a penalty for late-paid compensation; interest; attorney fees; and costs. (Claim for Workers' Compensation Benefits, September 22, 2025).

44) On October 16, 2025, Employer denied Employee's claim for all time-loss benefits after August 19, 2025, PPI benefits over two percent and reemployment benefits. It based this denial on Dr. Ballard's August 19, 2025 EME report. (Controversion Notice, October 16, 2025).

45) On October 17, 2025, Employee requested an SIME. The disputed injuries, conditions or body parts included CRPS, a concussion and her right foot and ankle. (Petition; SIME form, October 17, 2025).

46) On October 17, 2025, Employee amended her pending claim to add denied reemployment benefits. (Claim for Workers' Compensation Benefits, October 17, 2025).

47) On November 6, 2025, Employer again denied Employee's claim on the same grounds set forth in its October 16, 2025 notice. (Controversion Notice, November 6, 2025).

48) On November 12, 2025, in her hearing brief Employee requested a three-doctor panel including an orthopedic surgeon, a neurologist and a pain specialist. She argued that the orthopedic surgeon would assess the right foot and ankle, while the pain specialist would address CRPS and the neurologist would evaluate her concussion. Employee's brief reviewed the medical history and applicable pleadings. She cited statutory and decisional law to support her SIME request. Employee argued that she suffered a concussion on March 9, 2025, when her right foot gave out and she slid or fell down on the stairs and hit her head. Employee contended that this fall was connected to her work-injury with Employer and it substantially caused a concussion syndrome, and neck, rib and hip pain as well as low-back and leg spasms. She argued that Dr. Ballard did not address the concussion at all. Employee contended this created a "causation" dispute on which her rights to any and all benefits turn. She noted that she claims PTD, PPI, and medical and related transportation benefits and reemployment benefits, which she argued are all "significant" if she prevails on her claim. (Employee's SIME Hearing Brief, November 12, 2025).

49) Employee further contended that medical care is always expensive, which makes it always significant. She argued that an impartial expert's opinion on the medical treatment and care Employee needs moving forward will significantly aid the Board in resolving this claim. Likewise, she argued that Dr. McAnally diagnosed neuropathy resulting from the fall on the stairs. By contrast, Dr. Ballard could not explain why Employee continued to have symptoms. Employee argued that there is a fundamental medical disagreement here, and an expert opinion would aid in resolving the disputes. Specifically, Dr. Chang recommended lidocaine patches and a brace, Dr. McAnally recommended additional PT, gabapentin and CRPS treatment, and the physical therapist suggested pain management. By contrast, Dr. Ballard opined Employee needed no further treatment to address her injury. Moreover, Employee's physicians diagnosed work-related CRPS, while Dr. Ballard could not explain Employee's ongoing symptoms. In Employee's view, this raised medical disputes on both "causation," and "the amount and efficacy of the continuance of or necessity of treatment." (Employee's SIME Hearing Brief, November 12, 2025).

50) Employee noted that Dr. Chang removed her from work indefinitely on August 29, 2025, less than one-week after Dr. Ballard said she could return to work as a bus driver. She contended this created a medical dispute as to her "functional capacity." Employee further argued that Dr.

Chang stated he expected her to gradually improve, and said this less than one week after Dr. Ballard stated she was already medically stable. She contended this created a medical dispute about "medical stability." (Employee's SIME Hearing Brief, November 12, 2025).

51) Alternately, Employee contended there are "gaps" in the medical evidence, as discussed above where Dr. Ballard did not offer an opinion. Furthermore, even though Dr. Ballard gave Employee a two percent PPI rating, no attending physician had yet provided a rating as many had stated she is not yet medically stable. Lastly, Dr. Chang took Employee off work indefinitely in August of this year, and one week prior to that Dr. Ballard said she could return to work as a bus driver. Employer had controverted benefits based on Dr. Ballard's opinion. This raised questions as to Employee's "ability to enter a reemployment plan." She contended an SIME opinion on her "functional capacity" and "ability to enter a reemployment plan" would assist in resolving this dispute. (Employee's SIME Hearing Brief, November 12, 2025).

52) On November 12, 2025, in its hearing brief Employer stated it initially accepted her claim and began paying Employee benefits as she sought treatment for immediate right-heel pain. Its brief reviewed the relevant medical records. Employer conceded that Dr. Ballard found Employee medically stable with no signs of CRPS, and gave her a two percent PPI rating. He released her to return to work. By contrast, Employer stated that Dr. Chang evaluated her and recommended lidocaine patches and said her discomfort would gradually improve. (Employer's Hearing Brief, November 12, 2025).

53) Employer argued that an SIME should not be ordered. Alternatively, if the Board ordered an SIME, it should be limited to only one physician. It contended there are no "gaps" in the medical record. An SIME should not be used to give Employee a PPI rating, which Employer contended she can obtain on her own from her attending physicians. Employer noted that Employee's own treating physician Dr. Chang had not recommended further treatment beyond lidocaine patches. It contended that if an orthopedic-surgeon-SIME evaluates Employee, which would be consistent with her own attending physician's specialty, the SIME physician may request further evaluations as necessary. (Employer's Hearing Brief, November 12, 2025).

54) On November 13, 2025, the Workers' Compensation Division's (Division) Reemployment Benefits Administrator's (RBA) designee referred Employee to a specialist for an eligibility evaluation. (Agency file: Reemployment, Evals, Referral Letter tabs, November 13, 2025).

55) Work injuries involving alleged CRPS and concussions, as well as surgery and chronic pain can result in significant medical expenses, disability and impairment. The Haglund's deformity and its post-surgical sequela is unfamiliar to this panel's majority. (Experience).

PRINCIPLES OF LAW

> **AS 23.30.001. Intent of the legislature and construction of chapter**. It is the intent of the legislature that
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> > 1) this chapter be interpreted . . . to ensure . . . quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers. . . .

The Board may base its decision on testimony, evidence, the Board's "experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987).

> **AS 23.30.095. Medical treatments, services, and examinations**. . . .
>
> (k) In the event of a medical dispute . . . between the employee's attending physician and the employer's independent medical evaluation, the board may require that a second independent medical evaluation be conducted by a physician or physicians selected by the board from a list established and maintained by the board. . . .

The Alaska Supreme Court in *Dwight v. Humana Hospital*, 876 P.2d 1114, 1119 (Alaska 1994) said, "The superior court correctly opined it was not the legislature's intent to require a SIME every time the Board was presented with conflicting evidence." *Dwight* further stated:

> The meaning urged upon this Court by [Dwight] would require the Board to appoint a physician at the expense of the employer every time there was disagreement in the evidence with regard to any of the issues set forth in [AS 23.30.095(k)]. According to [Dwight], this is mandated without regard to the Board's opinion as to its desirability or necessity, or any other attendant circumstance.
>
> That such exams are expensive is well understood. That this economic burden was intended by the legislature to be automatically passed to the private sector and the ultimate consumer of goods and services [via the employer] when such exam is unnecessary to the proper performance of the Board's responsibilities seems more than doubtful (bracketed material in original).

*Bah v. Trident Seafoods Corp.*, AWCAC Dec. No. 073 (February 27, 2008) addressed the Board's authority to order an SIME under §095(k). *Bah* stated in *dicta*, that before ordering an SIME it is necessary to find the medical dispute is significant or relevant to a pending claim or petition. *Bah* said when deciding whether to order an SIME, the Board considers three criteria, though the statute requires only one:

1) is there a medical dispute between Employee's physician and an EME?
2) is the dispute significant? and
3) will an SIME physician's opinion assist the Board in resolving the disputes? (*Id*.).

Wide discretion exists for fact-finders to consider any evidence in deciding to order an SIME to assist in investigating and deciding medical issues in claims, to best "protect the rights of the parties." *Bah*. An SIME's purpose is for an independent medical expert to provide an opinion. *Seybert v. Cominco Alaska Exploration*, 182 P.3d 1079, 1097 (Alaska 2008). An SIME is not a discovery tool for parties; it is an investigative tool for the Board to assist it by providing a disinterested opinion. *Olafson v. State Depart. of Transp.*, AWCAC Dec. No. 06-0301 (October 25, 2007).

> **AS 23.30.122. Credibility of witnesses.** The board has the sole power to determine the credibility of a witness. . . .

The Board's credibility finding "is binding for any review of the Board's factual findings." *Smith v. CSK Auto, Inc.*, 204 P.3d 1001, 1008 (Alaska 2009).

## ANALYSIS

**Shall this decision order an SIME?**

Employee requests an SIME based on medical disputes between her attending physician and Employer's second EME, under §.095(k). Employer contends an SIME should not be ordered. Alternatively, it suggest if one is ordered it should only be performed by one physician, an orthopedic surgeon, because Employee's primary attending physician is an orthopedic surgeon.

Under *Bah*, this decision examines the following in determining whether to order an SIME:

*1) Are there medical disputes between Employee's physician and an EME?*

The applicable statute §.095(k) lists medical disputes that could give rise to an SIME: "determinations of causation, medical stability, ability to enter a reemployment plan, degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability." At first glance, there is no medical dispute between an attending physician and an EME physician in this case regarding "degree of impairment." Employer correctly notes that Dr. Ballard gave Employee a PPI rating and her physicians have not offered one. This does not equate with a "gap" in the medical evidence; it equates with a lack of an attending physician's rating. Nothing prevents Employee from obtaining a PPI rating from her attending physician or from a physician to whom he refers her. While Employer has controverted any PPI rating exceeding two percent, it has not denied her ability to obtain a PPI evaluation, which may or may not exceed two percent. *Olafson*. Employee may be suggesting that the panel order a PPI rating simply to save time and expense under §.001(1). But there is currently no medical dispute or "gap" on the PPI issue, as Dr. Ballard has provided the only rating.

Dr. Ballard stated Employee is medically stable. Dr. Chang expects improvement in Employee's pain and Dr. McAnally prescribed GMI to address her alleged CRPS. This creates a medical dispute regarding "medical stability." Likewise, Dr. Ballard said Employee needs no further medical treatment, while Dr. Chang said she needed lidocaine patches and Dr. McAnally, and others, recommended additional PT and GMI to address CRPS. This creates a dispute about "the amount and efficacy of the continuance of or necessity of treatment."

"Causation" is not really in dispute because both EME physicians agree that the work injury is the substantial cause of not only Employee's right-lower-extremity conditions, but also her symptoms and need to treat them. As for the other post-injury conditions and symptoms Employee claims arose from various slips and falls on stairs and in the tub, which she attributes to her work-injury and its sequela, an SIME opinion will not likely assist fact-finders in resolving those. At this juncture, it is hard to see how a physician could discern why Employee had the various post-injury slips and falls she experienced. It seem more likely that a hearing panel will have to weigh Employee's credibility to determine, based on her testimony and the available medical evidence already in the file, whether she slipped or fell post-injury as a result of her work-injury with Employer, or for some other reason. AS 23.30.122; *Smith*. The panel may have to decide if she

suffered superseding intervening injuries that absolve Employer from any further liability for benefits under the Act.

Clearly, there is a medical dispute between Dr. Ballard who stated there is no objective reason why Employee could not return to work as a School Bus Driver, and Dr. Chang who withdrew her from work "indefinitely." This creates a medical dispute concerning "functional capacity."

Lastly, Employee was recently referred to a reemployment specialist for an eligibility evaluation. Therefore, while there is a current dispute over Employee's "functional capacity" to return to work as a School Bus Driver, it is premature to order an SIME on her "ability to enter a reemployment plan," because the reemployment eligibility process has just begun.

*2) Are the disputes significant?*

Employee is correct that, given the benefits she claims, if she prevails she may be entitled to additional medical treatment, disability, and a higher PPI rating. Experience shows that these benefits are expensive. *Rogers & Babler*. Therefore, the medical disputes are "significant."

*3) Will an SIME physician's opinion assist the panel in resolving the disputes?*

Some medical issues in this case are unusual in this panel's experience. *Rogers & Babler*. A Haglund's deformity is not something of which the panel's majority has any knowledge. Thus, treatment for this condition in the long-term is likewise not well understood. Similarly, GMI, with which this panel has no experience, appears to be a relatively new treatment for CRPS. Whether Employee has CRPS involves a diagnostic dispute between the physicians in this case; proper "diagnosis" is not one of the medical disputes that can be addressed in an SIME, according to the statute. Consequently, an SIME addressing only "medical stability," "functional capacity," and "the amount and efficacy of the continuance of or necessity of treatment" is likely to assist the panel in resolving these medical disputes and the case on its merits. *Seybert*.

Employer has a valid point about the SIME panel's composition and number of SIME physicians. Given the limited nature of the current medical disputes, three SIME physicians seems excessive and expensive. Since this panel has discretion to decline to order an SIME altogether, it clearly

has authority to limit the SIME's extent. *Dwight*; AS 23.30.001(1). Moreover, on the authorized SIME list there is an orthopedic surgeon with a specialty in "foot & ankle." Therefore, Employee's petition for an SIME will be granted and Division staff will be ordered to arrange for an SIME with Carol Frey, MD, orthopedic surgeon, with a specialty in foot and ankle, at Dr. Frey's earliest opportunity. If upon evaluation Dr. Frey believes Employee needs a referral to another specialist, Dr. Frey may immediately contact the Division, and the Division will arrange for another examination with a physician in the required specialty as part of the SIME process.

## CONCLUSION OF LAW

This decision will order an SIME.

## ORDER

1) Employee's October 17, 2025 petition for an SIME is granted in part.
2) An SIME will be performed by Carol Frey, MD, an orthopedic surgeon selected from the SIME list. Dr. Frey may refer Employee to a specialist if she deems it necessary.
3) The medical disputes for the SIME include: "medical stability," "functional capacity," and "the amount and efficacy of the continuance of or necessity of treatment" related to Employee's right foot and ankle symptoms, and all other issues she claims arose from her injury.
4) Along with the medical records, Employer is directed to provide the applicable job description for Employee's job at the time of injury, obtained through ONET and its "crosswalk."
5) All filings regarding the SIME must be sent to workerscomp@alaska.gov, and served concurrently on opposing parties.
6) Employer will make two copies of Employee's medical records in its possession, including medical providers' depositions, put the copies in chronological order by treatment date, starting with the first medical treatment and proceeding to the most recent medical treatment, number the pages consecutively, and put them in two binders. This must be done on or before **December 10, 2025**. Employer must serve one binder on Employee and file one with the Division, with an affidavit verifying the binders contain all medical records in its possession, by **no later than 5:00 PM Alaska time on December 10, 2025**.
7) The binders may be returned for reorganization if not properly Bates-stamped and prepared in accordance with this decision.

8) **Not later than 10-days after receipt of the binders**, Employee must review the binders to determine if they contain all Employee's medical records in her possession. If the binders are complete, Employee must file an affidavit with the Division verifying the binders contain all medical records in Employee's possession. If the binders are incomplete, Employee must make two copies of any additional medical records missing from the first binders. Each copy must be put in a separate binder (as described above). Then one set of the supplemental binders and an affidavit verifying the medical records' completeness must be filed with the Division. The remaining supplemental binder must be served upon Employer together with an affidavit verifying that it is identical to the binder filed with the Division. **Employee is directed to file the binders with the Division and serve a binder on Employer within 10 days of receipt**.

9) Any party who receives additional medical records or physicians' depositions after the binders have been prepared and filed with the Division, is directed to make two supplemental binders as described above with copies of the additional records and depositions. **Within seven days** after receiving the records or depositions, the party must file one supplemental binder with the Division, and serve one supplemental binder on Employer together with an affidavit verifying it is identical to the binder filed with the Division. All service must be made on Employer's attorney.

10) The assigned workers' compensation officer will review, prepare, and submit to the SIME physician questions in accordance with 8 AAC 45.092(h) and the next paragraph.

**11) The Division's instruction letter for Dr. Frey shall include the following: "If upon evaluation Dr. Frey believes Employee needs a referral to another specialist, Dr. Frey may immediately contact the Division, and the Division will arrange for another examination with a physician in the required specialty as part of the SIME process."**

12) The parties may review their rights under 8 AAC 45.092(j) to question an SIME physician after the parties receive the physician's report.

13) **The parties are advised that a failure to comply with the above orders timely may result in the SIME going forward notwithstanding a party's noncompliance**.

14) Long-distance travel may be required. If Employee requires travel accommodations, she must request an accommodation from Employer. The accommodation request must be accompanied by a letter from Employee's attending physician in her workers' compensation case, pursuant to and within the constraints of AS 23.30.095(a) and 8 AAC 45.082(b), detailing the necessary accommodation.

Dated in Anchorage, Alaska on November 19, 2025.

ALASKA WORKERS' COMPENSATION BOARD

/s/
William Soule, Designated Chair

/s/
Randy Beltz, Member

/s/
Pamela Cline, Member

## PETITION FOR REVIEW

A party may seek review of an interlocutory or other non-final Board decision and order by filing a petition for review with the Alaska Workers' Compensation Appeals Commission. Unless a petition for reconsideration of a Board decision or order is timely filed with the board under AS 44.62.540, a petition for review must be filed with the commission within 15 days after service of the board's decision and order. If a petition for reconsideration is timely filed with the board, a petition for review must be filed within 15 days after the board serves the reconsideration decision, or within 15 days from date the petition for reconsideration is considered denied absent Board action, whichever is earlier.

## RECONSIDERATION

A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accordance with 8 AAC 45.050. The petition requesting reconsideration must be filed with the board within 15 days after delivery or mailing of this decision.

## MODIFICATION

Within one year after the rejection of a claim, or within one year after the last payment of benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, a party may ask the board to modify this decision under AS 23.30.130 by filing a petition in accordance with 8 AAC 45.150 and 8 AAC 45.050.

## CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Interlocutory Decision and Order in the matter of Olga Kuzmin, employee / claimant v. First Group America, employer; AIU Insurance Co., insurer / defendants; Case No. 202402773; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by certified U.S. Mail, postage prepaid, on November 19, 2025.

/s/
Rochelle Comer, Workers' Compensation Technician