ALASKA WORKERS' COMPENSATION BOARD

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

LAURA B. AFANADOR, Employee, Claimant, v. ALASKA REGIONAL HOSPITAL, Employer, and ACE AMERICAN INSURANCE COMPANY, Insurer, Defendants.	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 201407245 AWCB Decision No. 17-0023 Filed with AWCB Anchorage, Alaska on February 28, 2017

Laura Afanador's (Employee) November 7, 2017 petition requesting a second independent medical evaluation was heard in Anchorage, Alaska, on February 8, 2017, a date selected on December 8, 2017. Employee appeared, testified, and represented herself. Attorney Krista Schwarting appeared and represented Alaska Regional Hospital and Ace American Insurance Company (Employer). The record closed at the hearing's conclusion on February 8, 2017.

ISSUES

Employee contends there are significant medical disputes between her attending physician and Employer's medical evaluator (EME). Employee contends there are disputes regarding reasonable and necessary medical treatment and the degree of her permanent partial impairment.

Employee requests an SIME so she can have a second opinion because she does not agree with the EME opinion.

Employer contends Employee has not demonstrated a significant medical dispute on causation, medical stability, or reasonable and necessary medical treatment. Employer contends the purpose of an SIME is to assist the board, not to give Employee a second opinion at Employer's expense. Employer contends Employee has not shown her physicians believe her spine complaints are work related and, therefore, there is not a causation or compensability dispute sufficient to warrant an SIME and Employee's request should be denied.

Should an SIME be ordered at this time?

FINDINGS OF FACT

The following facts and factual conclusions are established by a preponderance of the evidence:

1) On January 18, 2013, Employee sustained a direct blow to her right hand on a cart while working for Employer. On that same day, Bruce Welkovich, M.D., Alaska Regional Hospital's Emergency Department evaluated her. Employee's dorsal right hand had swelling, but no tingling, numbness, foreign body or skin laceration. Employee complained of moderate pain. She had not had a prior injury to her right hand. There was no injury to Employee's wrist and her neurovascular function were intact. Employee was given a splint and a prescription for 10 Vicodin and was directed to follow-up with Upshur Spencer, M.D. An x-ray showed "no signs of acute trauma or other acute disease." (Chart Note, Alaska Regional Hospital Emergency Department, January 18, 2013; X-Ray Right Hand, January 18, 2013.)

2) On January 21, 2013, Employee reported pushing a cart and hitting her hand. She did not identify if it was her right or left hand; however, Employer recorded, "Pushing cart thru doorway hit her left hand on door jam [sic]." (Report of Occupational Injury or Illness, January 21, 2013.)

3) Employee reported repetitive "passing, carrying, and moving carts" for Employer, over time, injured her back, neck, and hands. (Report of Occupational Injury or Illness, April 18, 2014.)

4) On Monday, March 24, 2014, Nurse Practitioner Eva Stassen prescribed muscle relaxants for Employee's headache and left-sided neck complaints and referred Employee for chiropractic treatment and massage therapy. Ms. Stassen did not attribute Employee's complaints, including

runny nose, swelling of face and left-sided neck pain, to Employee's work. Employee reported to NP Stassen she had had pain in her left neck since Friday, March 21, 2014. (Chart Note, NP Stassen, March 24, 2014.)

5) On March 25, 2014, as a follow-up to the March 24, 2014 appointment, NP Stassen, diagnosed acute upper respiratory infection. Employee did not complain of left-sided neck pain. (Chart Note, NP Stassen, March 25, 2014.)

6) On March 26, 2014, Employee contacted NP Stassen's office and reported she did not go to work because she was "still feeling bad and really stuffed up." Employee requested a note to return to work on March 27, 2014. NP Stassen instructed Employee to return if she was not feeling better by March 27, 2014, and faxed the requested note to Employer. (Telephone Encounter, Christi Andrews, March 26, 2014.)

7) On March 27, 2014, Employer terminated Employee. (Progress Notes, Gerald Manning, PA, May 8, 2014.)

8) On March 29, 2014, Employee went to the Alaska Regional Hospital Emergency Department with neck, left shoulder and low back pain complaints. Her history indicates the pain's onset was Thursday, March 27, 2014. Employee said she ran a cart accidentally into the operating room door while at work, and although it did not hurt at first, it became increasingly stiff and sore. Employee reported morning bilateral hand numbness and tingling, 8/10 pain, and she "always had a bad back." (Chart Note, Alaska Regional Hospital Emergency Department, March 29, 2014.)

9) On May 8, 2014, Employee complained of neck pain, primarily on the left, with radiation into the left arm and hand. PA-C Manning took Employee's report and recorded, "She was pushing a large cart, while working Alaska Regional Hospital, when the cart, unexpectedly, hit a raised area on the floor, stopping the cart suddenly. She was jerked forward, in this process, and felt discomfort in her neck, following this incident." A cervical spine x-ray revealed mild levocurvature secondary to muscle spasms, and evidence of mild degenerative disc disease. PA-C Manning diagnosed cervical strain. He prescribed Zoloft and hoped Employee's neck pain would diminish once her depressive symptoms resolved. PA-C Manning did not attribute Employee's left-sided neck pain to Employee's work for Employer. (Progress Notes, PA-C Manning, May 8, 2014; C-spine X-ray Report, Kamran Janjua, M.D., May 9, 2014.)

10) On May 19, 2014, PA-C Manning referred Employee to Alaska, Back and Spine for a more definitive evaluation and treatment. (Progress Notes, PA-C Manning, May 19, 2014.)

11) On May 22, 2014, PA-C Manning stated, "Due to medical reasons, I feel Laura is unable to work until she is seen and released by the referred orthopedic surgeon." (Letter To Whom it May Concern, PA Manning, May 22, 2014.)

12) On May 28, 2014, Employee reported she was pushing a cart through a doorway on April 17, 2014, and crashed with an impact causing acute onset of neck pain with left greater than right numbness, tingling, and radicular pain. Employee had slightly decreased sensation on the left; however, she had no reflex change, or strength or sensation loss. She had experienced pain for a few weeks with no improvement and said her condition was getting worse. Employee reported severe pain of eight on a 0-to-10 scale. Erik Olson, D.O., noted Employer terminated Employee. He thought if she was able to get back to work with Employer "that will help with the overall rehabilitation process; if not, we may be able to consider a work hardening program once we get her pain levels down to a more manageable level." A positive Spurling test and increased numbness and tingling led Dr. Olson to suspect Employee may have spinal stenosis in the lower left half of her cervical spine. Dr. Olson referred Employee to physical therapy and ordered magnetic resonance imaging (MRI). He directed Employee to continue her current medications to manage pain but advised her to avoid taking hydrocodone and acetaminophen on a regular basis. (Letter to Edward Manning, PA-C, from Dr. Olson, May 28, 2014.)

13) On June 16, 2014, Dr. Olson noted Employee's nerve conduction studies were normal; Employee's left upper extremity had no electrodiagnostic evidence of cervical radiculopathy, brachial plexopathy, polyneuropathy, mononeuropathy or myopathy. He recommended physical therapy, including splinting exercises for the carpal tunnel symptoms in the Employee's left wrist, and an interlaminar epidural steroid injection at C7-Tl. (Chart Note, Dr. Olson, June 16, 2014.)

14) On July 2, 2014, Employer's medical examiner (EME) Donald Schroeder, M.D., evaluated Employee. Dr. Schroeder diagnosed cervical strain, by history, related to the March 21, 2014 work injury; mild cervical spine degenerative disc disease, C3-4, C4-5, and C5-6, pre-existing and unrelated to work; and bilateral carpal tunnel syndrome, pre-existing and unrelated to work. Dr. Schroeder opined Employee's cervical strain is the substantial cause of and the most significant cause contributing to her "medical problem." He indicated the treatment Employee

received thus far was medically reasonable and necessary, and recommended she continue physical therapy for the next month. After that, no further treatment would be reasonable or necessary. He anticipated Employee would be medical stable by August 1, 2014. Employee would have no ratable permanent partial impairment from the March 21, 2014 injury, and could perform her normal work once she completed physical therapy on August 1, 2014. In the meantime, Employee could perform light duty work. Dr. Schroeder found no radiculopathy, nor objective proof to support Employee's subjective complaints. Dr. Schroeder commented Employee "has a bilateral mildly symptomatic carpal tunnel syndrome that preexisted the March 21, 2014 injury." He considered this unrelated to the March 21, 2014 injury. (EME Report, Dr. Schroeder, July 2, 2014.)

15) On July 14, 2014, Dr. Olson noted Employee continued to have neck pain and intermittent left upper extremity pain greater than right, with numbness and tingling. The cervical MRI showed mild degenerative changes at C3-4 and C4-5. Dr. Olson stated this may be the source of Employee's pain; however, "some of her physical exam is consistent with facet mediated pain, and she does have a small facet cyst seen on the left at C3 – C4." Dr. Olson did not attribute Employee's mild degenerative changes or her facet cyst to her work for Employer. (Chart Note, Dr. Olson, July 14, 2014.)

16) On July 22, 2014, Dr. Schroeder provided an addendum to his July 2, 2014 EME report. He apologized for the confusion and indicated there were three separate issues. He reported Employee "failed to mention she had filed a claim for repetitive motion injury, nor did she mention anything about a fall that occurred prior to her April 17, 2012 [sic] . . . emergency room visit for an allergic reaction. (Employee's emergency room treatment for an allergic reaction to Nair was on April 17, 2013.) Dr. Schroeder stated:

> I presume she is basing her claim for repetitive motion on the fact that she had numbness and tingling in her hands. Her entire history during my interview and physical examination focused on the "art event" that occurred on March 21, 2014. This presumably resulted in her cervical strain.
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> I found it interesting that she cannot recall that she ever had an EMG/nerve conduction test that was recommended by Dr. Olson. The test which involves probing needles is not a comfortable experience and usually one that patients vividly remember.

> In conclusion, I found no evidence of repetitive strain injury though she may have a mild carpal tunnel syndrome that is considered unrelated. There is no indication that the fall that was noted in the medical record occurred on the job.
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> The focus of her history and physical examination, again, was related to the cart event on March 27, 2014. I anticipate medical stability by August 1, 2014, with no permanent impairment.

(EME Addendum Report, Dr. Schroeder, July 22, 2013 [sic]; Clinical Report – Physicians / Mid Levels, April 17, 2013.)

17) On July 29, 2014, during a physical therapy evaluation, Employee reported a March 2014 work injury caused left-sided neck pain. Employee also reported she had bilateral carpal tunnel and hand numbness for the last year with intermittently decreased grip strength, which was worse in the morning, and her "hand numbness has not worsened since her neck injury in March." (Alaska Physical Therapy Specialists, P.C., PT Initial Evaluation Report, July 29, 2014.)

18) On August 5, 2014, Employer controverted all benefits effective August 1, 2014. Employer relied on Dr. Schroeder's July 2, 2014 opinion Employee was medically stable on August 1, 2014, required no further medical treatment, and had no ratable permanent partial impairment. (Controversion Notice, August 5, 2014.)

19) On November 11, 2014, Dr. Olson found Employee's neck pain to be secondary to underlying disk protrusions and cervical strain, but her overall symptoms improved to a significant extent. Employee's most prominent issue was carpal tunnel syndrome, which he did not believe was originating from her cervical spine. He noted the nerve conduction studies in June did not show any evidence of medial neuropathy at Employee's wrist, although, Employee noted numbness and tingling in her hands had become significantly worse in the past couple of months. He prescribed rigid wrist splints. Dr. Olson stated:

> In regard to cervical spine, it probably is reasonable that she has reached medical stability. With the wrist issue, we will see what the IME report opinion is. I certainly think it would be reasonable for her to start working on treatment for carpal tunnel syndrome. Whether this is indeed a true work-related injury or not. The symptoms have been getting pretty severe. I think she is in need of treatment for this issue.

(Chart Note, Dr. Olson, November 11, 2014.)

20) On December 18, 2014, Employee reported to Dr. Olson she discontinued Percocet, Flexeril, and Voltaren Gel because her cervical spine pain symptoms had improved. She took them only occasionally if there was a flare-up in her symptoms. Dr. Olson provided the following history:

> Ms. Afanador is a 51-year-old female who I have been seeing for neck pain issues, which had been aggravated after a reported injury at work on April 17, 2014 when she was going about her typical activities at work as an OR supply tech, she was pushing a case cart through a set of doorways and apparently the door was closed on her resulting in the cart crashing into door and she had a sudden and abrupt impact. Ever since that time, she has reported issues with neck pain with periodic pains radiating into the upper extremities.
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> She has had an MRI of the cervical spine, which revealed minimal disc bulging at C3-C4 and C4-C5, neither level has any significant amount of central or foraminal stenosis. She has been through an extensive course of treatment including physical therapies and development of an independent exercise program. She also tried multiple different medications to try to help reduce some of the muscle spasm and pain in the region. She has periodically had radicular symptoms described in the upper extremities; however, this was not consistently verified on various physical exams performed. She has had chronic pain in the axial cervical spine, pretty consistently through all of her visits. Therefore, the diagnosis for the injury she suffered at work is the cervical strain injury with continued chronic neck pain and inconsistent and non-verifiable radicular symptoms. Again, she has been through a full course of treatment and has reached medical stability. I do not anticipate any changes to her treatment regimen at this time. She may periodically have aggravations of her symptoms, which may require some additional treatments, but barring that no additional changes to her treatment regimen anticipated.

Dr. Olson, utilizing the American Medical Association Guides to the Evaluation of Permanent Impairment, Sixth Edition, gave Employee a two percent whole person impairment rating for cervical strain with non-verifiable continued neck pain and upper extremity symptoms and inconsistent radiculopathy. (Permanent Partial Impairment Rating Report, Dr. Olson, December 18, 2014.)

21) On October 19, 2015, Employee had been working as a personal care attendant for Comfort Keepers for one to two weeks. (Providence Alaska Medical Center ED Notes, Adm: October 19, 2015, D/C: October 20, 2015.)

22) On October 30, 2015, a cervical MRI showed no new evidence of a disc herniation or central canal stenosis. It did show mild bilateral foraminal stenosis at C3-4, C4-5, C5-6, and disc

herniation with a possible extruded fragment at T2-3. (Chart Note, Diagnostic Studies History, Algone Center, November 4, 2015.)

23) On November 4, 2015, Matthew Peterson, M.D., evaluated Employee upon referral for chronic opioid management. Employee reported she was in the hospital on October 19, 2015, because she blacked out and reported since that incident, her headaches are a new issue. Employee described her pain as severe with an onset following trauma when a "big cart" fell on her at work. Employee reported the pain had been occurring for two years; the average pain intensity is eight out of 10, at best it is seven out of 10, and at its worst 10 out of 10. Dr. Peterson noted secondary gains include a workers' compensation claim. (Encounter #1 Report, Algone Center, Dr. Peterson, November 4, 2015.)

24) On November 23, 2015, Kelly Powers, MD., compared Employee's cervical spine x-ray with the October 30, 2015 cervical spine MRI. Employee's cervical vertebral bodies were anatomically aligned, vertebral body heights and intervertebral disc spaces were normal, and there were no fractures. There was uncovertebral joint hypertrophy at C4-5, left greater than right. There was no evidence of osseous central spinal canal or neural foraminal stenosis. Employee's prevertebral soft tissues appeared normal. The impression was degenerative changes at C4-5. (XR C Spine Report, Dr. Powers, November 23, 2015.)

25) On December 2, 2015, the source of Employee's neck pain was uncertain. MRI findings noted by PA-C Harrell were multiple levels of degenerative disc disease with minimal disc bulges, the most severe at T2-3 with posterior disk extrusion, but minimal stenosis. PA-C Harrell opined Employee would benefit from a cervical epidural steroid injection. She gave Employee permission to pay cash for her medication because Employee did not have Medicaid approval for December. PA-C Harrell counseled Employee "on self-increasing her medications" and made her aware that she is not allowed to self-increase her medications, "this would be a one-time early, courtesy fill" and about taking medications as directed. PA-C Harrell noted Employee "ran out of medications early. Did not contact us. No permission was given to self-increase." (Encounter #2 Report, Algone Center, PA-C Harrell, December 2, 2015.)

26) On December 22, 2015, Employee returned to Algone Center to receive a partial narcotic medication refill to last until her appointment on January 6, 2016. Again, Algone Center permitted Employee to pay with cash. Again, Employee ran out of medications early. Employee did not contact Algone Center, nor was she given permission to self-increase her medication.

Employee was again counseled about taking medications as directed. (Encounter #3 Report, Algone Center, PA-C, Cheryl Fitzgerald, December 22, 2015.)

27) On December 22, 2015, Employee received a C7-T1 interlaminar cervical epidural steroid injection for cervical radicular pain into the left upper extremity, chronic cervical spine pain, and extruded disc fragment at T1-2. (Operative Report, Dr. Peterson, December 22, 2015.)

28) On January 6, 2016, Employee denied any improvement in her pain after the cervical epidural steroid injection, and asserted her current regimen including an oral non-opioid nonsteroidal anti-inflammatory drug, Mobic 15 mg one QD, and a short acting oral opioid, Oxycodone–APAP 10-325 TID, was ineffective. (Encounter #4 Report, Algone Center, Dr. Peterson, January 6, 2016.)

29) On January 8, 2016, Dr. Peterson restarted Employee on Oxycodone-Acetaminophen 10-325 mg, one table BID. He indicated the source of Employee's neck pain was uncertain and that MRI findings showed multiple levels of degenerative disc disease with minimal disc bulges, most severe at T2-3 with posterior disk extrusion, but minimal stenosis. (Encounter #5 Report, Algone Center, Dr. Peterson, January 8, 2016.)

30) On January 12, 2016, an x-ray of Employee's thoracic spine showed broad-based dextroconvex thoracic scoliosis. Employee's thoracic spine was otherwise normally aligned and demonstrated no fracture or focal osseous abnormality. Small, marginal osteophytes were present throughout the mid-thoracic spine without significant disk space narrowing. (XR T Spine Report, Scott Naspinsky, M.D., January 12, 2016.)

31) On January 19, 2016, Employee received another C7-T1 interlaminar cervical epidural steroid injection for cervical radicular pain, upper thoracic pain, and upper thoracic disc herniation. (Operative Report, Dr. Peterson, January 19, 2016.)

32) On January 20, 2015, Employer controverted the two percent permanent partial impairment rating given Employee by Dr. Olson. Employer relied upon Dr. Schroeder's July 2, 2014 opinion Employee's work injury did not cause her to have a ratable permanent partial impairment. (Controversion Notice, January 20, 2015.)

33) On January 28, 2016, Employee, treated for thoracic back pain and neck pain, reported her current regimen was adequate and she had minimal pain since the epidural steroid injection "done on 12/22/2015." The source of Employee's neck pain continued to be uncertain. PA-C Harrell recommended a thoracic facet joint medial branch nerve block, and, if successful, a

radiofrequency neurotomy would follow. (Encounter #7 Report, Algone Center, PA-C Harrell, January 28, 2016.)

34) On February 12, 2016, PA-C Harrell reported Employee was stable on her current medication regimen; however, she started Employee on Percocet, a new prescription, one tablet every six hours as needed for pain. (Encounter #8, Algone Center, PA-C Harrell, February 15, 2016.)

35) On March 1, 2016, Employee received a bilateral T8 and T9 medial branch nerve block for diagnostic purposes. The indication for the procedure was Employee's chronic mid-thoracic spine pain. (Operative report, Dr. Peterson, March 1, 2016.)

36) On March 7, 2016, Employee reported greater than 80 percent pain reduction for one hour after receiving the thoracic medial branch block. Therefore, PA-C Harrell recommended a second cervical facet joint medial branch nerve block. (Encounter #9, Algone Center, PA-C Harrell, March 7, 2016.)

37) On April 14, 2016, Employee filed a workers' compensation claim seeking temporary total disability (TTD), temporary partial disability (TPD), permanent total disability (PTD), and permanent partial impairment (PPI) benefits from April 17, 2014 through April 14, 2016. In addition, she sought transportation costs and a compensation rate adjustment. Employee described how the injury or illness happened as: "carpet [sic] tunnal [sic] hand over time, neck pushing cart in door jam [sic], back over time lifting." (Workers' Compensation Claim, April 14, 2016.)

38) On May 3, 2016, Employee requested Fentanyl be again prescribed. PA-C Harrell informed Employee she would not re-prescribe a medication Employee had failed due to reported adverse reactions. PA-C Harrell further discussed with Employee:

> [T]hat the medication is not a long-term solution, the patient should attend all scheduled procedures as she is already trying to cancel her upcoming procedure. Each time that I have seen this patient, there has been an issue of noncompliance. . . . We are both in agreement that medication is a short-tern solution and she should follow through with the plan of care for longer lasting management of pain. Patient has self-medicated on multiple occasions without permission to increase medications. I am no longer filling her medications early nor adding additional analgesics, as she needs to take responsibility for following through with set and recommended plan of care.

(Encounter #12, Algone Center, PA-C Harrell, May 5, 2016.)

39) On May 10, 2016, Employee received a left T4 medial branch nerve block for diagnostic purposes for chronic upper thoracic mechanical nociceptive spine pain, thoracic kyphosis, and thoracic spondylosis with facet joint arthropathy. Dr. Peterson aborted the procedure due to Employee's discomfort despite sedation. Dr. Peterson determined it unlikely Employee would accommodate a radiofrequency procedure given the difficulty with placement of the one needle during the procedure. (Operative Report, Dr. Peterson, May 10, 2016.)

40) On May 12, 2016, William Gardner, M.D., evaluated Employee for bilateral carpal tunnel syndrome. Employee reported Dr. Olson saw her for neck problems and he thought she had carpal tunnel, but "she never had anything done with it." She stated, for the last two years it seemed to be getting worse; right hand more affected than the left. Dr. Gardner planned to review the electrodiagnostic studies done under Dr. Olson's care. (Chart Note, Dr. Gardner, May 12, 2016.)

41) On June 27, 2016, Erik Kussro, D.O., saw Employee on referral for an electrodiagnostic medicine consultation. Employee's chief complaint was neck pain, present since 2014, that radiates into her thoracic spine, and is worse with activity. Nerve conduction studies demonstrated normal median and ulnar values bilaterally. There was electrodiagnostic evidence of a very mild right median neuropathy at Employee's wrist, which is carpal tunnel syndrome. There was no clear electrodiagnostic evidence of a left median neuropathy at Employee's wrist. An EMG needle study was attempted but Employee could not tolerate examination of even one muscle and requested the study discontinue. (Chart Note, Dr. Kussro, June 27, 2016.)

42) On September 7, 2016, an x-ray of Employee's cervical spine was compared with one taken on November 23, 2015. Employee's vertebral body heights were well-maintained and levels relatively well preserved. Degenerative changes were most notable at C4-5. (XR C Spine Report, Kelly Powers, M.D., September 7, 2016.)

43) On September 13, 2016, an x-ray of Employee's thoracic spine compared with one taken on January 12, 2016 showed Employee's mild dextroscoliosis was unchanged. Alignment was otherwise normal. Mild osteophytes remained present diffusely at the thoracic disc margins, unchanged from January 12, 2016, and no other change was present. (XR T Spine Report, Leonard Sisk, M.D., September 13, 2016.)

44) On September 13, 2016, to evaluate Employee's complaints of low back pain at multiple sites, a lumbar spine x-ray revealed mild levoscoliosis and facet joint degenerative joint disease

with L4-5 grade 1 degenerative spondylolisthesis. (XR L-S Spine Report, Dr. Sisk, September 13, 2016.)

45) On September 19, 2016, a lumbar spine MRI compared with the September 13, 2016 x-rays to evaluate Employee's chronic low back pain, revealed degenerative changes primarily at L4-5 where there was mild spinal stenosis and mild bilateral neural foraminal stenosis. (MRI Lumbar Spine Report, Dr. Naspinsky, M.D., September 19, 2016.)

46) On September 20, 2016, EME Amit Sahasrabudhe, M.D., examined Employee, and found no significant objective abnormal findings to explain Employee's ongoing subjective complaints with regard to either her neck, back, upper extremities, or lower extremities. Dr. Sahasrabudhe found no orthopedic explanation for Employee's random lower extremity numbness or for leg numbness when she goes to the bathroom. Dr. Sahasrabudhe opined Employee had no objective evidence of carpal tunnel syndrome bilaterally; he found no thenar atrophy and negative carpal Tinel's, Phalen's, and Durkan's testing. He noted Dr. Schroeder had these same findings in July 2014. Because Employee's electrodiagnostic studies at most revealed evidence of mild carpal tunnel syndrome, and because this was an incomplete study, Dr. Sahasrabudhe determined Employee's subjective complaints outweighed the objective findings on exam. Dr. Sahasrabudhe stated, "It is additionally noteworthy that she has been a one pack a day smoker for 30 years. Smokers are known to have poorer pain patterns and pain tolerance." Dr. Sahasrabudhe opined the work injury caused a cervical strain superimposed on Employee's pre-existing degenerative condition and the work injury was no longer the substantial cause of Employee's "condition" or need for medical treatment. Dr. Sahasrabudhe agreed with Dr. Schroeder's opinion Employee was medically stable on August 1, 2014, and no further medical treatment was needed for Employee's work-related cervical strain, to include pain management treatment. Dr. Sahasrabudhe noted the treatment rendered by pain management had not given Employee any significant relief and, in fact, addicted her to pain medications. Dr. Sahasrabudhe indicated Employee should continue weaning off the methadone on a nonindustrial basis. Dr. Sahasrabudhe was unable to identify an orthopedic explanation for Employee's medical complaints. The only two explanations he could provide for Employee's ongoing complaints were psychological and Employee's smoking history. (EME report, Dr. Sahasrabudhe, September 20, 2016.)

47) On September 22, 2016, an MRI of Employee's cervical spine compared with one taken October 30, 2015, showed multilevel degenerative disc and joint changes. Significant motion artifacts limited the evaluation; however, there was no central spinal canal stenosis at any level but mild to moderate bilateral neural foraminal narrowing at C4-5 and C5-6. (MRI Cervical Spine Report, Gerald York, M.D., September 22, 2016.)

48) On September 22, 2016, an MRI of Employee's thoracic spine revealed a small T2-3 disc protrusion without resultant stenosis. Otherwise, Employee's thoracic spine was normal. (MRI Thoracic Spine Report, Dr. Naspinsky, M.D., September 22, 2016.)

49) On October 17, 2016, Luke Liu, M.D., gave Employee a cervical epidural steroid injection. (Operative Report, Dr. Liu, October 17, 2016.)

50) On October 31, 2016, Employer controverted time loss benefits after August 1, 2014, PPI benefits, further medical treatment, and reemployment benefits. Employer relied upon Dr. Schroeder's July 2, 2014 EME report and his addendum to that report, and Dr. Sahasrabudhe's September 20, 2016 EME report. (Controversion Notice, October 31, 2016.)

51) On November 7, 2016, Employee filed a petition for an SIME. Her reason for the petition is, "My doctor secon [sic] opinion I don't agree with IME." (Petition, November 7, 2016.)

52) On November 7, 2016, PA-C Darcie Sorenson evaluated Employee for progressive neck and lower back pain with intermittent radicular symptoms into her lower extremities bilaterally. Employee had recently undergone a cervical epidural steroid injection, which significantly helped her neck pain and left upper extremity paresthesias. Employee continued to experience numbness in her right hand with associated weakness. PA-C Sorenson reported electrodiagnostic studies revealed right carpal tunnel syndrome and referred Employee to Dr. Kralick for a right carpal tunnel release. PA-C Sorenson reviewed the lumbar MRI, which revealed facet arthropathy at L4-5 where there is mild spinal stenosis and mild bilateral neural foraminal stenosis. She recommended L4-5 facet blocks bilaterally to determine if Employee was a surgical candidate for an L4-5 posterior decompression and fusion. (Chart Note, PA-C Sorenson, November 7, 2016.)

53) On December 6, 2016, PA-C Jason Collins opined Employee was not a surgical candidate. PA-C Collins offered no opinion regarding the substantial cause of Employee's need for medical treatment. (Letter To Whom It May Concern, PA-C Collins, December 6, 2016.)

54) On November 22, 2016, Employer answered Employee's petition for an SIME. Because Employee had not completed an SIME form or identified the disputes and issues to submit to an SIME physician, Employer was unwilling to stipulate to an SIME based only upon Employee's disagreement with the EME physician's opinions and Employee's desire for a second opinion. Employer contended there was no evidence from any of Employee's physicians disagreeing with the EME. (Answer, November 22, 2016.)

55) On January 10, 2017, PA-C Kacie Tempel wrote a letter "To Whom It May Concern," acknowledged Anchorage Neurosurgical Associates saw Employee for carpel tunnel syndrome and stated, "Her right wrist pain and hand numbness she reports is secondary to her work as a sterile processor for numerous years prior. She is currently undergoing further diagnostic testing for evaluation." (Letter To Whom It May Concern, PA-C Tempel, January 10, 2017.)

56) On January 12, 2017, Employee filed an SIME form. She contends disputes exist regarding treatment and degree of impairment. The form does not identify disputes regarding causation or medical stability. (SIME Form, January 12, 2017.)

57) Employee testified at hearing neither Dr. Olson, nor any of her other providers reviewed Dr. Schroeder's or Dr. Sahasrabudhe's EME reports. (Afanador.)

PRINCIPLES OF LAW

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

The board may base its decision on not only direct testimony and other tangible evidence, but also on the board's "experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987).

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

> **AS 23.30.095. Medical treatments, services, and examinations**. (a) . . . When medical care is required, the injured employee may designate a licensed physician to provide all medical and related benefits. The employee may not make more than one change in the employee's choice of attending physician without the written consent of the employer. Referral to a specialist by the employee's attending physician is not considered a change in physicians. Upon procuring the services of a physician, the injured employee shall give proper notification of the selection to the employer within a reasonable time after first being treated. Notice of a change in the attending physician shall be given before the change.
> . . . .
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> (k) In the event of a medical dispute regarding determinations of causation, medical stability . . . degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's independent medical evaluation, the board may require that a second independent medical evaluation be conducted by a physician or physicians selected by the board from a list established and maintained by the board. The cost of an examination and medical report shall be paid by the employer. The report of an independent medical examiner shall be furnished to the board and to the parties within 14 days after the examination is concluded. . . .
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> **AS 23.30.110. Procedures on Claims.**
> . . . .
> (g) An injured employee claiming or entitled to compensation shall submit to the physical examination by a duly qualified physician, which the board may require. The place or places shall be reasonably convenient for the employee. . . .

The Alaska Workers' Compensation Appeals Commission (AWCAC) in *Bah v. Trident Seafoods Corp.*, AWCAC Decision No. 073 (February 27, 2008) addressed the board's authority to order an SIME under §095(k) and §110(c). Under either section, the commission noted the purpose of an SIME is to assist the board, not an employee or an employer. The AWCAC referred to its decision in *Smith v. Anchorage School District,* AWCAC Decision No. 050 (January 25, 2007), and referencing AS 23.30.095(k) said:

> [t]he statute clearly conditions the employee's right to an SIME . . . upon the existence of a medical dispute between the physicians for the employee and the employer.

The commission in *Bah* stated when deciding whether to order an SIME, the board typically considers the following criteria, though the statute does not require it:

1) Is there a medical dispute between 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?

It also stated when there is a significant gap in the medical or scientific evidence and an opinion by an SIME physician will assist in resolving the issue, an SIME may be ordered under AS 23.30.110(g).

> Ordering an SIME is not proper if it serves no purpose to the board by advancing its understanding of the medical evidence or by filling in gaps in the medical evidence, where that gap in the evidence, or lack of understanding of the medical evidence, prevents the board from ascertaining the rights of the parties in the dispute before the board.

Bah at 5.

> **8 AAC 45.082. Medical treatment.**
> . . . .
>
> (b) A physician may be changed as follows:
> . . . .
>
> (2) except as otherwise provided in this subsection, an employee injured on or after July 1, 1988, designates an attending physician by getting treatment, advice, an opinion, or any type of service from a physician for the injury; if an employee gets service from a physician at a clinic, all the physicians in the same clinic who provide service to the employee are considered the employee's attending physician; an employee does not designate a physician as an attending physician if the employee gets service
>
> (A) at a hospital or an emergency care facility;
>
> (B) from a physician
>
> (i) whose name was given to the employee by the employer and the employee does not designate that physician as the attending physician;
>
> (ii) whom the employer directed the employee to see and the employee does not designate that physician as the attending physician; or

> (iii) whose appointment was set, scheduled, or arranged by the employer, and the employee does not designate that physician as the attending physician
>
> . . . .
>
> (4) regardless of an employee's date of injury, the following is not a change of an attending physician:
>
> (A) the employee moves a distance of 50 miles or more from the attending physician and the employee does not get services from the attending physician after moving; the first physician providing services to the employee after the employee moves is a substitution of physicians and not a change of attending physicians;
>
> (B) the attending physician dies, moves the physician's practice 50 miles or more from the employee, or refuses to provide services to the employee; the first physician providing services to the employer thereafter is a substitution of physicians and not a change of attending physicians;
>
> (C) the employer suggests, directs, or schedules an appointment with a physician other than the attending physician, the other physician provides services to the employee, and the employee does not designate in writing that physician as the attending physician;
>
> (D) the employee requests in writing that the employer consent to a change of attending physicians, the employer does not give written consent or denial to the employee within 14 days after receiving the request, and thereafter the employee gets services from another physician.

Richard v. Fireman's Fund, 384 P.2d 445 (Alaska 1963), was a civil tort case primarily about the insurer's duty to arrange for medical care for an injured worker, as opposed to simply paying for the care pursuant to the Act once the injured employee made his own arrangements.

> We hold to the view that a workmen's compensation board or commission owes to every applicant for compensation that duty of fully advising him as to all the real facts which bear upon his condition and his right to compensation, so far as it may know them, and of instructing him on how to pursue that right under the law.

Id. at 449.

ANALYSIS

Should an SIME be ordered at this time?

The purpose of an SIME is not to assist either an employee or an employer. *Bah*. When there is a medical dispute in any one of seven enumerated areas, between an injured worker's attending physician and an EME physician, an SIME may be ordered. AS 23.30.095(k). Absent an attending physician's testimony at hearing, the question whether a medical dispute exists is resolved by reviewing medical records or depositions.

Employee's medical records neither expressly, nor implicitly, offer any opinions concerning causation of Employee's disability or need for medical treatment after Employee's attending physician Dr. Olson's December 18, 2014 opinion. Dr. Olson and Dr. Schroeder agree work was the substantial cause of Employee's cervical strain injury. In fact, Dr. Olson on December 18, 2014, stated Employee has been through an extensive treatment course and tried multiple medications all to reduce her pain and that her complaints of radicular symptoms could not consistently be verified on multiple physical exams. He noted Employee had chronic pain regularly throughout her treatment course. Dr. Olson noted an independent exercise program had been developed for Employee and he did not anticipate any changes to her treatment regimen. Dr. Olson did not indicate Employee needed palliative care for chronic pain.

Dr. Schroeder and Dr. Olson agreed physical therapy was reasonable and necessary medical treatment for Employee's work-related cervical strain. Through Employee's course of physical therapy, an independent exercise program was developed. A medical dispute regarding medical treatment for Employee's work-related cervical strain does not exist. A disagreement between Dr. Olson and Dr. Schroeder regarding the date physical therapy was complete and Employee was medically stable exists. Dr. Schroeder opined employee would be medically stable on August 1, 2014, and no further treatment after that date was reasonable or necessary. Dr. Olson determined Employee was medically stable on November 11, 2014, and her independent exercise program was the only reasonable and necessary medical treatment. There is sufficient evidence in the current record and this dispute can be resolved without an SIME. *Bah*; *Smith*; *Rogers & Babler*.

Employee correctly contends there is a dispute between Dr. Olson and Dr. Schroeder regarding her PPI rating. Dr. Schroeder predicted she would not have a ratable PPI when she was medically stable, and Dr. Olson gave her a two percent PPI rating when he determined she was medically stable. There is sufficient evidence in the record to make a determination regarding this PPI dispute and an SIME is not necessary. *Id.*

If there are gaps in the medical or scientific evidence, an SIME can be ordered. AS 23.30.110(g); *Bah.* Dr. Olson determined Employee was medically stable on November 11, 2014. This was Dr. Olson's first appointment with Employee after she completed physical therapy at the end of July 2014. It was also his first appointment with Employee after Employer's controversion. Dr. Olson agreed with Dr. Schroeder that Employee's cervical strain was medically stable. Overall, Employee's symptoms had improved to a significant extent and Dr. Olson determined Employee's work related cervical strain was medically stable. The difference in time between Dr. Schroeder's declaration of Employee's medical stability for her work related cervical strain and Dr. Olson's constitutes a dispute. This does not qualify as a gap in the medical evidence, nor will an SIME assist to determine when Employee was medically stable for her work related cervical strain. *Bah*; *Smith*; *Rogers & Babler.*

There is also no dispute or gap in the medical evidence with regard to causation. Dr. Olson and Dr. Schroeder agreed work was the substantial cause of Employee's cervical strain. Dr. Olson determined Employee's underlying disc protrusions and cervical strain caused her neck pain. He diagnosed her work injury as a cervical strain. Dr. Olson and Dr. Sahasrabudhe agree Employee's work injury caused a cervical strain superimposed on Employee's pre-existing degenerative condition.

Dr. Olson offered no opinion regarding causation of Employee's carpal tunnel syndrome. He deferred the causation determination to the EME physician's opinion, but stated, "whether this is indeed a true work-related injury or not" it was reasonable for her to treat for carpal tunnel syndrome. Dr. Kussro performed electrodiagnostic studies to evaluate Employee's wrist pain complaints. He found electrodiagnostic evidence of a very mild right median neuropathy at

Employee's wrist, which is carpal tunnel syndrome. There was no clear electrodiagnostic evidence of a left median neuropathy at Employee's wrist. An EMG needle study was attempted but Employee could not tolerate the examination and requested the study discontinue. Dr. Kussro did not offer an opinion regarding the cause of Employee's very mild right carpel tunnel syndrome. Dr. Sahasrabudhe opined Employee had no objective evidence of carpal tunnel syndrome bilaterally; he found no thenar atrophy and negative carpal Tinel's, Phalen's, and Durkan's testing. Dr. Schroeder made these same findings in July 2014. Employee's electrodiagnostic studies at most revealed evidence of very mild right carpal tunnel syndrome, and because this was an incomplete study, Dr. Sahasrabudhe determined Employee's subjective complaints outweighed the objective findings on exam. He did not attribute Employee's very mild right carpel tunnel syndrome to Employee's work for Employer. Employee offers PA-C Kacie Tempel's January 10, 2017 letter not for causation, but as an opinion for treatment. PA-C Tempel's letter merely states Employee reports her carpal tunnel syndrome is secondary to her work for Employer.

No conflicting or disputed opinions regarding causation of Employee's very mild right carpal tunnel syndrome exist between Employee's attending physicians and Employer's EME physicians. Employee seeks a second opinion because she does not like the EME physicians' opinions. It is inappropriate to order an SIME when the sole purpose is to provide Employee with an additional opinion at Employer's expense. *Bah.*

An SIME is discretionary and is appropriate only when it will assist in deciding the parties' disputes. AS 23.30.095(k). An SIME will not assist in ascertaining the parties' rights or making determinations regarding the parties' disputes. Disputes exist in the record; however, there is sufficient evidence regarding causation, treatment, medical stability, and Employee's degree of impairment to ascertain the parties' rights and make determinations regarding Employee's claims. *Rogers & Babler.*

Employee has received considerable treatment since Dr. Olson determined her medically stable. As the record currently stands, there is no affirmative statement in any medical record suggesting any medical recommendations or treatment provided are necessitated by, or in any way

connected to, Employee's work injury. The current record demonstrates no medical disputes warranting an SIME, and Employee's request will be denied. *Bah*; *Smith.*

However, this does not mean Employee cannot still develop evidence justifying an SIME. To ensure quick, efficient, and fair delivery of benefits to Employee if she is entitled to them, at a reasonable cost to Employer, and to make this process as summary and simple as possible, Employee is advised to take Dr. Schroeder's and Dr. Sahasrabudhe's EME reports to her attending physician and ask her physician to review the medical opinions set forth therein. AS 23.30.001(1); AS 23.30.005(h). Employee should ask her attending physician to prepare a report stating the physician either agrees or disagrees with the EME physicians' opinions. It may be helpful for Employee to show this decision to her attending physician. If Employee's attending physician agrees with the EME physicians, there will again be no medical disputes warranting an SIME. If Employee's attending physician disagrees in writing with one or more expressed EME physicians' opinions, there may be a basis for a medical dispute, and the parties can either stipulate to an SIME or bring the issue back for an additional hearing. *Richard*. Employee is cautioned to avoid making an "unlawful change of physician," as this may result in the bill for the unlawful physician's services going unpaid and the report not being considered as evidence for any purpose. *Richard*; AS 23.30.095(a); 8 AAC 45.082(c). If Employee has any questions, she may contact a Workers' Compensation Technician for additional information.

CONCLUSIONS OF LAW

An SIME will not be ordered at this time.

ORDER

Employee's November 7, 2016 SIME petition is denied without prejudice, meaning she is free to file a subsequent petition requesting an SIME should she obtain relevant medical evidence.

Dated in Anchorage, Alaska on February 28, 2017.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Janel Wright, Designated Chair

/s/
David Ellis, Member

/s/
Rick Traini, Member

PETITION FOR REVIEW

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

RECONSIDERATION

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

MODIFICATION

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

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Interlocutory Decision and Order in the matter of LAURA B. AFANADOR, employee / claimant v. ALASKA REGIONAL HOSPITAL, employer; ACE AMERICAN INSURANCE COMPANY, insurer / defendants; Case No. 201407245; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on February 28, 2017.

/s/
Nenita Farmer, Office Assistant