ALASKA WORKERS' COMPENSATION BOARD

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

SCHAD SCHWEITZER, Employee, Claimant, v. ASRC ENERGY SERVICES, Employer, and ARCTIC SLOPE REGIONAL CORP., Insurer, Defendants.	)	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 201410856 AWCB Decision No. 17-0037 Filed with AWCB Fairbanks, Alaska on March 29, 2017

Schad Schweitzer's December 30, 2015 claim was heard in Fairbanks, Alaska on January 19, 2017, a date selected on January 10, 2017. Attorney Tasha Porcello appeared and represented Schad Schweitzer (Employee), who appeared and testified on his own behalf. Attorney Robert Bredesen appeared and represented ASRC Energy Services (Employer). Katie Weimer, Employer's adjuster, and Don Handley, Employer's general foreman, both testified telephonically on Employer's behalf. The record closed at the conclusion of deliberations on February 28, 2017.

ISSUE

Employee contends he suffered a compensable injury and seeks additional medical and indemnity benefits. He relies on the opinions of his treating chiropractor, Peter Quartarolo, D.C., his pain management specialist, Michael Tran, M.D., and the second independent medical evaluator, Judy Silverman, M.D.

Employer points to discrepancies in the record concerning Employee's reporting of his injury, as well as his reporting of symptoms to his treating provider, and alternatively contends either an injury event never occurred, or if one did, it resulted in a strain that resolved within 30 days of the injury. It contends no further benefits are due Employee and relies on the opinions of its medical evaluator, Patrick Radecki, M.D.

Is Employee's June 4, 2014 injury the substantial cause of his disability or need for medical treatment?

FINDINGS OF FACT

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

1) On January 23, 2009, Employee sought treatment from Peter Quartarolo, D.C., in Lakeport California for tightness and soreness in his lower back. He explained he was experiencing a "clicking" in his back that preventing him from getting up from a laying position. Employee could not recall any specific activity that precipitated his symptoms. Dr. Quartarolo diagnosed chronic lumbar strain and instructed Employee to return for further evaluation, soft tissue work and manipulation. (Quartarolo report, January 23, 2009; Confidential Health History, January 23, 2009).

2) Employee never followed-up with Dr. Quartarolo to address his January 23, 2009 complaints. (Record).

3) On May 11, 2011, Employee completed a health questionnaire indicating he never treated for muscular strain or a back injury. (Employment Health Questionnaire, May 11, 2011).

4) On April 5, 2012, Employee completed an occupational history questionnaire for Employer indicating he had never treated with a physician or chiropractor for back, neck or muscle problems. (Post-Offer General and Occupational History Questionnaire, April 5, 2012).

5) On June 30, 2011, April 17, 2012, and May 25, 2014, Employee completed respirator history questionnaires indicating he had never had a back injury or musculoskeletal problems. (Respirator History Questionnaires, June 30, 2011, April 17, 2012; May 25, 2014).

6) On October 29, 2012, Employee saw Dr. Quartarolo for mild tightness and soreness in his lower back and reported he had been working in Alaska during the past year, which required a great deal of heavy lifting. Dr. Quartarolo diagnosed "[c]hronic mild lumbar, thoracic and

cervical sprain," performed manual manipulation to reduce joint dysfunction and ordered Employee to follow-up with him on an as needed basis. (Quartarolo chart noted, October 29, 2012).

7) On June 4, 2014, Employee sought treatment at the North Slope medical clinic for low back pain. He reported he woke up that day with more soreness than usual, but could not recall a specific injury or strain while working. Employee denied numbness, tingling or weakness, and was examined by Marianne Hoosier, PA-C, who found Employee to have a full range of motion in his back and no palpable tenderness. PA Hoosier prescribed ice, rest and over the counter ibuprofen and instructed Employee to follow-up with her the next day. PA Hoosier noted Employee was going home the next day for R&R. (Initial Report of Injury/Illness, June 4, 2014; Hoosier report, June 4, 2014).

8) On June 4, 2014, Employee completed a soft-tissue injury interview with Brian Charbonneau, during which Employee reported the gradual onset of pain that started out as general soreness and throbbing with occasional spikes in intensity resulting from body position. (Interview for Soft Tissue Injuries, June 4, 2016). Employee later identified Brian Charbonneau as Employer's safety specialist. (Employee dep., June 14, 2015).

9) On June 4, 2014, Employee completed an employee statement describing the incident that caused his back pain. He explained he had typical body soreness towards the end of the previous day, but woke up with more soreness than usual. Employee wrote, "Can not [sic] pinpoint a daily task that caused it, but typical soreness and more in the morning." (Employee Statement, June 4, 2014).

10) On June 5, 2014, Employee followed-up with PA Hoosier, who noted minor tenderness over the left lumbar region. Employee denied radiating pain or numbness and was unable to flex or extend his back due to pain. PA Hoosier ordered continued Motrin and ice, and gave Employee some heating patches for his flight home. She also instructed Employee to follow-up with his primary care physician as soon as he got home. (Hoosier report, June 5, 2014).

11) On June 9, 2014, Employee saw Dr. Quartarolo for acute lower back pain that started while Employee was working in Alaska a week prior. Employee reported he had been moving heavy scaffolding materials in deep snow. Employee was not experiencing leg pain. Dr. Quartarolo found Employee's gross mobility in his lumbar spine was reduced 50 percent and diagnosed

acute lumbar strain. He treated Employee with tissue mobilization, manual manipulation and electrical stimulation. (Quartarolo chart notes, June 9, 2014).

12) On June 11, 2014, Employee returned to Dr. Quartarolo with continuing lower back pain, though he reported a mild reduction in pain and tightness. Employee was not experiencing leg pain. Dr. Quartarolo found Employee's gross mobility in his lumbar spine was reduced 25 percent and treated Employee with soft tissue mobilization, manual manipulation and electrical stimulation. (Quartarolo chart notes, June 11, 2014).

13) On June 13, 2014, Employee saw Dr. Quartarolo for continuing lower back pain, which was worse in the afternoon and when sitting. Employee was not experiencing leg pain. Dr. Quartarolo found Employee's gross mobility in his lumbar spine was reduced 25 percent and treated Employee with soft tissue mobilization, manual manipulation and electrical stimulation. (Quartarolo chart notes, June 13, 2014).

14) On June 16, 2014, Employee returned to Dr. Quartarolo for continuing lower back pain, which was worse in the afternoon and when sitting. Employee was exercising sporadically and did not have leg pain. Dr. Quartarolo found Employee's gross mobility in his lumbar spine was reduced 25 percent and treated Employee with soft tissue mobilization, manual manipulation and ultrasound. He also advised Employee to use lumbar support during the day and reviewed extension exercises with Employee. (Quartarolo chart notes, June 16, 2014).

15) On June 18, 2014, Employee saw Dr. Quartarolo and reported continued improvement with his lower back pain and tightness. He was increasing his activities, exercising more consistently and was not experiencing leg pain. Dr. Quartarolo found Employee's gross mobility in his lumbar spine was reduced 25 percent and treated Employee with soft tissue mobilization, manual manipulation and ultrasound. (Quartarolo chart notes, June 18, 2014).

16) On June 20, 2014, Employee returned to Dr. Quartarolo and reported continued improvement with the pain and tightness in his lower back. He was increasing his activities and exercising more consistently and was not experiencing leg pain. Dr. Quartarolo found Employee's gross mobility in his lumbar spine was reduced 10 percent and treated Employee with soft tissue mobilization and manual manipulation. Dr. Quartarolo wrote, Employee was also "[g]iven bridging exercises today." (Quartarolo chart notes, June 20, 2014).

17) On June 23, 2014, Employee saw Dr. Quartarolo and reported "much reduced" pain and tightness in his lower back. He was not experiencing leg pain. Dr. Quartarolo found

Employee's gross mobility in his lumbar spine normal and noted his acute lumbar strain was nearly resolved. He treated Employee with soft tissue mobilization and instructed Employee to continue exercises at home. Dr. Quartarolo thought Employee could return to all normal work activities and advised Employee on using proper body mechanics for the next two weeks. Dr. Quartarolo instructed Employee to return him on an as needed basis. (Quartarolo report, June 23, 2014).

18) On June 23, 2014, Dr. Quartarolo faxed a message summarizing his treatment of Employee and stating he had released Employee to his normal work duties without restrictions. It is presumed the message recipient, David E. Bitterman, is affiliated with Employer. (Quartarolo fax, June 23, 2014; experience, judgment and inferences drawn therefrom).

19) On June 25, 2014, Employee returned to Dr. Quartarolo and continued to report "much reduced" pain and tightness in his lower back. Though he was not having leg pain, Employee reported he had done light yard work the previous day and had been experiencing "some tingling" in the ball of his left foot since that morning. Dr. Quartarolo found Employee's gross mobility in his lumbar spine normal and noted his acute lumbar strain was nearly resolved. Employee requested an additional week off work, which Dr. Quartarolo granted. Dr. Quartarolo opined Employee should be able to return to all normal work duties following his additional week off work, and planned to see Employee in one week. (Quartarolo chart notes, June 25, 2014).

20) On June 25, 2014, Dr. Quartarolo faxed a message to David E. Bitterman, which stated "Latest update on [Employee]. He will need to be off work an additional 7 days to ensure that he can return to his full work duties without restrictions after next week." It is presumed the message recipient, David E. Bitterman, is affiliated with Employer. (Quartarolo fax, June 25, 2014; experience, judgment and inferences drawn therefrom).

21) On July 1, 2014, Employee followed up with Dr. Quartarolo and reported a "mild" reduction of pain and tightness in his lower back, along with "sharp pain" in his centerline lower back, which varied in intensity. Employee also reported he "avoids any activity that precipitates this as in bending and occasionally getting up from sitting" and "is still very cautious." Dr. Quartarolo found Employee's gross mobility in his lumbar spine was reduced 25 percent only in extension, advised Employee to walk longer distances on flat ground, and requested lower back x-rays to rule out any underlying abnormalities. (Quartarolo chart notes, July 1, 2014).

22) On July 1, 2014, Dr. Quartarolo authored a progress report for Employer in which he requested two additional office visits and lumbar spine x-rays for Employee. He also took Employee off work for two additional weeks. (Progress Report, July 1, 2014; Quartarolo fax, July 1, 2014).

23) On July 9, 2014, Dr. Quartarolo faxed a completed preauthorization medical treatment form to Employer requesting lumbar x-rays and opining Employee's work injury involving heavy lifting was the substantial cause of his disability and need for medical treatment. (Preauthorization, undated; fax confirmation, July 9, 2014).

24) On July 11, 2014, Employee underwent lumbar spine x-rays, which were interpreted to show mild, early, lumbar spine spondylosis with no acute lumbar spine fracture or dislocation, as well as "calcific density" over the left kidney, for which further work up, including urine analysis and ultrasound, was suggested. (X-ray report, July 11, 2014).

25) On July 12, 2014, Dr. Quartarolo faxed Employer informing it Employee's x-rays showed a renal stone in his left kidney, which he thought might explain Employee's residual symptomology. He took Employee off work for two weeks for further evaluation. (Quartarolo fax, July 12, 2014).

26) On July 21, 2014, Employee applied for short-term medical disability benefits through Employer's disability insurer, Unum. Dr. Quartarolo anticipated Employee's "condition" might last until August 19, 2014, and indicated he would like to have Employee evaluated by Michael Tran, M.D., a pain specialist. (Unum Claim Form, July 21, 2014).

27) On July 22, 2014, Employee saw Dr. Quartarolo and reported he continued to experience sharp pain of varying intensities in the centerline of his lower back when raising from a seated position and bending at the waist. Dr. Quartarolo found Employee's gross mobility in his lumbar spine was reduced 25 percent only in extension. Employee requested a referral to either a spine, or a pain, specialist. Dr. Quartarolo referred Employee to Dr. Tran and instructed Employee to follow-up with himself as needed. (Quartarolo chart notes, July 22, 2014).

28) On July 23, 2014, Dr. Quartarolo updated Employer on Employee's referral to Dr. Tran and took Employee off work for four weeks to allow for Dr. Tran's evaluation. He also attributed Employee's work restrictions to his work injury and predicted Employee would become medically stable by August 19, 2014. (Quartarolo fax, July 23, 2014; Quartarolo responses, July 23, 2014).

29) On August 14, 2014, Patrick Radecki, M.D., performed an employer's medical evaluation (EME). "The mechanism of the onset of symptoms relative to his lower back . . . was in his words: He was working on June 3, 2014 and felt something. The next day on June 4, 2014, he awoke with pain . . . ." Employee reported to Dr. Radecki he would leave Dr. Quartarolo's office after chiropractic treatments feeling worse than he did when he went in. During his records review, Dr. Radecki observed, "There is a note and some information in the medical record that Mr. Schweitzer has left low back pain that seems to be related to lifting." He further noted, "A chiropractic note by Dr. Quartarolo mentions acute low back pain on June 1 [sic], 2014, moving heavy scaffolding in deep snow." Upon physical examination, Dr. Radecki recorded the following observations and findings:

> [Employee] did display a fair amount of pain behavior: Getting up and down gingerly from the table, getting up and down, just walking somewhat gingerly across the room.
>
> . . . . He can only squat 20 percent before he says he gets low back pain, even though he is holding onto the table and that is non-physiologic.
>
> The maneuvers for nonphysiologic reactions include: Compression on the shoulders said to increase pain, although the compression is just mild; traction upward on the elbows also is said to cause low back pain and that is very non-physiologic; and rotation of the pelvis to the right is said to give him low back pain greater that rotation to the left, although the pelvis and the shoulders are moving all as one unit and there should be no pain with that.
>
> When he is lying down prone on his abdomen and when one brings his foot upward bending the knee, he says that gives him low back pain at 60 degrees right and 45 degrees left, although that does not stretch the sciatic nerve and should not cause back pain and yet he said it did.
>
> Even checking his reflexes, he said that gave him pain even though his reflexes are 2 at the knee and 2 at the ankles. So he has low back pain with multiple maneuvers that should not cause back pain.
>
> When supine on his back, internal rotation rolling his thighs internally, which would internally rotate the hip, is said to aggravate his low back pain as well right and left. He cannot do a cross-leg maneuver with him saying that gives him low back pain at about 25 degrees on both sides.

> His sitting straight leg raise on the left is 70 degrees and right 75 degrees with some discomfort at most. . . . When both legs are lifted simultaneously, he again has no pain, but cannot sit forward in that position to touch his toes.
>
> His supine straight leg raise is much, much different than his sitting straight leg raise with him saying a 12 degree straight leg raise on the right and 15 degrees on the left was giving him significant low back pain so that was stopped. However, that is a great disparity on the right 12 degrees supine versus 75 degrees sitting, much non-physiologic pointing to something nonphysical. The sciatic nerve cannot possibly be tight at just 12 degrees on the right and yet he is complaining of low back pain there. . . .
>
> With him lying down supine, pulling gently on his legs gives him some discomfort in the right low back greater than left and pushing upward is also said to give him low back pain and both of those would be nonphysiologic [sic] production of pain since just pulling and pushing gently on the legs and thighs while the claimant is supine does not move the sciatic nerve in any way whatsoever. . . .
>
> The claimant had widespread tenderness to palpation, which is also nonphysiologic [sic] with his midline being tender at L1, L2, and L3 over the spinous process mildly and he had moderate midline tenderness at L4 and L5 . . . . The paraspinal muscles were mildly to moderately tender as well bilaterally at all levels L1 through S1. The SI joint was moderately painful on the right, mildly left, and the greater trochanter was slightly tender on the right and the right upper buttock was diffusely tender on the right.

Dr. Radecki's impressions were:

> 1) Possible but no clearly documented lumbar strain: there was no specific incident noted by the claimant. He said he was working and felt something. This is not an injury per se; 2) Known minimal osteophytic changes reported at L4 and L5 spine levels with minimal loss of disc height at L5-S1, consistent with early lower lumbar degenerative disc disease; 3) Coincidental calcific density over the left kidney; a kidney stone that does not seem to be in any way whatsoever related to his midline symptoms; and 4) Much nonphysiologic [sic] presentation and pain behavior.

Dr. Radecki repeatedly concluded there was "no specific injury," "no verifiable injury," and "no definite injury." He further opined, if Employee did suffer a work related lumbar strain, it was now resolved, and pointed to Employee's improvement documented in Dr. Quartarolo's chart notes to support his opinion. Instead, Dr. Radecki thought Employee's non-physiologic pain behavior was psychosocial in nature and additional medical care would "just feed into the

psychosocial factors that are causing [Employee's] pain behaviors." (Radecki report, August 14, 2014).

30) On August 22, 2014, Employer controverted all benefits on the basis of Dr. Radecki's August 14, 2014 report. It served similar controversions on November 13, 2014 and January 25, 2016. On December 16, 2016, Employer denied TTD from August 15, 2014 to October 12, 2015, and TPD from October 13, 2015 continuing. (Controversions, August 22, 2014; November 13, 2014, January 25, 2016; December 16, 2016).

31) On August 18, 2014, Employee saw Dr. Tran, who found, "Tenderness and tightness across the lumbosacral area, L4-5, L5-S1 level, with flexion up to 20 degrees and extension barely beyond neutral. Negative straight leg raise. Patrick's was not applicable due to pain." Dr. Tran assessed: 1) mild degenerative disc disease at L5-S1; 2) Possible lumbar facet osteoarthritis; 3) Lumbar sprain and strain; and 4) Remote bilateral sacroiliitis. Dr. Tran thought Employee might benefit from a bilateral L4-L5 and L5-S1facet injection and a lumbar spine magnetic resonance imaging (MRI) study to assess the significance of degenerative disc disease. (Tran report, August 18, 2014).

32) On August 26, 2014, Dr. Quartarolo faxed Employer informing it he has released Employee form his care for the reported work injury. He also wrote, "Taking into consideration the report of Dr. Radecki and the findings at my last visit with [Employee], he should be able to return to normal work duties as of 08/14/2014." He also wrote Employee and explained, "After submitting [the August 14, 2014 return to work authorization] to [Employer] I do not think it is possible for me at this point [sic] retract my statements in attempt to reopen your case. (Quartarolo fax, August 26, 2014; Quartarolo letter, September 10, 2014).

33) On October 7, 2014, Employee attended a fit-for-duty evaluation for Employer, which was terminated "for safety reasons" due to Employee's pain complaints. Employee was referred for a medical release. (Fitness for Duty report, October 7, 2014).

34) On October 16, 2014, Employee filed a pro se claim seeking unspecified TTD, and medical and transportation costs. (Claim, September 3, 2014).

35) On October 29, 2014, after receiving Dr. Radecki's EME report, Dr. Tran wrote Employer, recounting his August 16, 2014 examination of Employee and his treatment recommendations, and opining Employee did suffer an industrial injury that required additional treatment. He also

wrote, "This patient should also be totally temporarily disabled at this time." (Tran letter, October 29, 2014).

36) On November 25, 2014, Employee underwent a lumbar spine MRI, which was interpreted to show: 1) Straightening of the normal lordosis of the lumbar spine; 2) mild diffuse disc bulges at L4-5 with ligamentous hypertrophy producing mild central canal stenosis; 3) Neural foraminal stenosis at L4-5, L3-4 and L5-S1; 4) Acute to subacute formation of a Schmorl's node along the inferior plate of L4; 5) Mild chronic degenerative changes at L5-S1; 3) Mild retrolisthesis of L4 and L5 probably due to degenerative disc and facet changes; and 7) Small synovial cyst associated with the right-sided facet joint art L4-5 and a more complex-appearing structure associated with the right-sided facet joint at L2-3 that could be a synovial cyst with synovitis or hemorrhage. (MRI report, November 25, 2014).

37) Following Employee's November 25, 2014 MRI, there is a gap in the medical record of Employee receiving any treatment until he resumed treating on February 8, 2016. (Record).

38) On March 17, 2015, Judy Silverman conducted a second independent medical evaluation (SIME). Upon physical examination, Dr. Silverman found Employee to have a hesitant gate pattern and to move very slowly. Lumbar flexion was full with pain at about 50 percent upon returning to upright and extension was approximately 50 percent with pain complaints. She also noted decreased sensation to light touch on the lateral aspect of Employee's left foot. Straight leg raise was 50 percent bilaterally with complaints of pain. Internal and external hip rotation was full without complaints of pain. During prone knee bending, Employee brought his heels nine inches to his buttock bilaterally without nerve stretch signs. Employee's deep tendon reflexes were grade 2 with pain complaints. Dr. Silverman found Employee non-tender upon palpation over his spinous processes, but he did have "some tenderness" at the paraspinal muscles and facet joints. She also wrote:

> Note: [Employee] had reported pain in transitioning from sit [sic] to supine as well as pain rotating into prone. In performing physical maneuvers, he did acknowledge that he was afraid that these maneuvers were going to cause a sharp stabbing pain in his back, and he did acknowledge that he was fearful of this pain occurring. It would be noted that in discussing the maneuvers of the physical examination and breaking the maneuvers into smaller elements, he did allow further increase in mobility and ability to be examined, therefore adding a

> component of fear of moving or kinesiophobia[1] being a component of his global condition.

Dr. Silverman, diagnosed: 1) Lumbosacral strain/sprain related to lifting and carrying heavy scaffolding in deep snow; 2) Low back pain with pain pattern consistent and imaging suggestive of facet arthropathy; 3) Lumbar ligamentous facet hypertrophy L4-5 seen on MRI; and 4) Chronic pain with kinesiophobia (fear of movement) and associated deconditioning. When asked if work aggravated, accelerated of combined with a pre-existing condition to cause Employee's disability or need for medical treatment, Dr. Silverman answered: "I do feel that the underlying ligamentous and facet hypertrophy . . . was pre-existing but asymptomatic. I do feel that walking in knee-deep snow carrying a 50-pound plank on one side of the body could aggravate and initiate symptoms relating to the pre-existing degenerative change." In response to the question of whether the work injury combined with a pre-existing condition to produce a temporary or permanent change in a pre-existing condition, she wrote, "I do know that it has hopefully, temporarily, aggravated the underlying condition . . . ." When asked to evaluate the relative contributions of the different causes of Employee's disability or need for medical treatment, Dr. Silverman answered she was "concerned" Employee's kinesiophobia, or fear of movement, and how that diagnosis "may be" contributing to his deconditioning. Dr. Silverman did not discuss other potential causes in her answer. Upon being sked to identify "the substantial cause" of Employee's disability or need for treatment, Dr. Silverman listed degenerative changes combining with lifting and carrying in deep snow, the "more passive nature of [Employee's] treatment and his pain," Employee's fear of movement, Employee's reluctance to use medication and a chiropractor's inability to prescribe medicine as "the substantial cause." Dr. Silverman did not think Employee was medically stable, and opined additional medical treatment should include "trying" to improve the quality of pain control, which "may be possible" with more consistent use of oral non-steroidal anti-inflammatories, but "may also need to include a trail of facet injections as suggested by Dr. Tran." She also recommended more consistent physical therapy. The only question of potential difficulty in Dr. Silverman's opinion, was whether Employee could overcome his fear of movement. If not, she thought supportive psychotherapy or a work-hardening program might be appropriate, as well. Dr. Silverman initially stated she

[1] The spelling appears as both "kinesiophobia" and "kinesophobia" throughout the medical record.

was "uncertain" as to specific work restrictions for Employee, but did "know" he could not repetitively lift, bend, carry up to 50 pounds, climb and do over-shoulder-height work at that time. In responses to other questions, Dr. Silverman thought "[Employee's] report of the facts of 6/14/2014 and his subsequent treatment [were] not fully consistent with the medical record," and she acknowledged Employee's treatment and his responses to it were "discrepant from the medical record." However, Dr. Silverman went on to opine Employee was "limiting information to Dr. Quartarolo about his response to treatment." (Silverman report, March 17, 2015).

39) On July 14, 2015, the parties deposed Employee, who testified as follows: He was born in Soldotna, Alaska and has lived at his current address in Lakeport, California for the last eight years. (Schweitzer depo. at 5-6). Employee has been married ten years and he has two children, ages 10 and five. (*Id*. at 7-8). He is pursuing a master's degree in marriage and family therapy, and is a 150 question, multiple-choice test away from receiving his degree. (*Id*. at 8-9). Employee has taken the required 150 question, multiple-choice test three times previously. (*Id*. at 10). Prior to his work injury, he was "a regular" at the gym, and would work out three to five times per week. (*Id*. at 14). Employee also played football in college, and two-years' of professional football in Europe. His last day of work for Employer was June 5, 2014, and he has been looking for work. Employee was offered work as a substitute custodian, but he declined that employment because he did not think he could perform the required duties. (*Id*. at 20). He has also applied for social work positions, other jobs with Employer, a job with a school district, and for a campus director position with Yuba College. (*Id*. at 24). Employee worked as a scaffold builder, and had also worked as an insulator for Employer at Kuparuk. (*Id*. at 26, 29). Prior to working for Employer, he worked as a program coordinator for the Lake County Resource Center, and as a part-time football coach for the Lakeport Unified School District. (*Id*. at 31). His previous employment also includes work as family liaison, mentoring foster children and as a juvenile corrections officer. (*Id*. at 33-36). Employee described first injuring his left knee in 1994 while playing football, and again later while playing basketball. (*Id*. at 40-41). He recovered from both knee injuries. (*Id*.). Employee eventually underwent an ACL repair, and his knee was never the same after that. (*Id*. at 43). He described his duties as a scaffold builder and identified Dave Darrow as his supervisor and Brian Charbonneau as the safety person. Employee had concerns about "being let go" and "[h]aving a mark on your record" if he reported

to Employer's medical clinic. (*Id*. at 49). He described his employment environment as follows:

> It was kind of a scared place, where you didn't want to get hurt, you didn't want to have an incident, you didn't want to cause an accident, all that kind of stuff. It was a very "Don't mess up" kind of thing, or else you will lose your job.

(*Id*). Prior to his work injury, Employee's back was not bothering him. (*Id*. at 57). When asked whether he preferred work as a counselor of working on the Slope, he answered, "My preference was the best providing for my family; and at that time it was the slope. Great money." (*Id*. at 58). Employee was injured when he was walking in deep snow with an eight-foot metal plank and felt a sharp pain in his lower back. (*Id*. at 65-66). He had never had pain like that before. (*Id*. at 68). Since the job was almost done, Employee kept working with pain. (*Id*.). He is not sure if he mentioned his injury to anyone that day, and did not go to the clinic because he was scared. (*Id*.). That night, Employee's injury worsened and became very painful. (*Id*. at 74). The next morning he was having trouble getting out of bed and he knew "it was serious." (*Id*.). Employee called his supervisor, told him about the incident the previous day, and said he needed to go to the medic. (*Id*.). His supervisor asked in to talk to the general foreman, Don Henley, about it. (*Id*. at 74-75). After the "tool box" meeting, Employee's supervisor and the general foreman brought Employee into the hallway, where Employee described the previous day's incident, but the general foreman instructed Employee to say he woke that way. Employee "knew what he was getting at." (*Id*. at 75). He next reported to the medic and met with "the safety guy." (*Id*. at 78). June 5, 2014 was Employee's scheduled departure date and his flight home was "rough." (*Id*. at 86-87). When treating with Dr. Quartarolo, Employee would leave his office "in more pain," but just assumed he was going to hurt for a while after an adjustment. (*Id*. at 89-90). He does not think Dr. Quartarolo was aware of how he was feeling because Employee never told him. (*Id*. at 90). Employee brought his wife to one appointment with Dr. Quartarolo to "make sure that I was saying what needed to be said," and his wife "let [Dr. Quartarolo] know how [he] was feeling at home and stuff like that." (*Id*.). Even though his back was still "very sore," he asked Dr. Quartarolo to release him back to work because Employee was not authorized to receive any more medical treatment and Employee needed "to make an income for his family." (*Id*. at 93). After Dr. Quartarolo released Employee back to work,

Employee asked to Dr. Quartarolo to take him off work for another week because Employee was worried about reinjuring himself. (*Id*. at 92). He acknowledge he "became emotional" during his appointment with Dr. Silverman, and she "tried to calm [him] down." (*Id*. at 104). He also applied for, and received, disability benefits from an insurer, Unum. (*Id*.). Employee had discussed knee replacement surgery with the physician who was treating his knee. (*Id*. at 108-09). While employed by Employer, Employee turned down job offers "in [his] field" because he "[n]eeded to provide for [his] family and the money in Alaska was better." (*Id*. at 110). He also explained he provided a "no" response on Employer's post-hire occupational questionnaire in response to a question concerning previous chiropractic treatment because his previous chiropractic treatment did not consist of multiple treatments, but rather was a "one-time deal." Employee applied for the custodian position because he had lost his job with Employer and wanted "to be able to support his family." (*Id*. at 112). He acknowledged he has anxiety and is concerned about his ability to support his family. (*Id*. at 114).

40) On July 14, 2015, the parties deposed Dr. Quartarolo, who testified as follows: He briefly discussed Employee's treatment in 2009 and 2012. When Dr. Quartarolo treated Employee in 2014, Employee "appeared to improve at a fairly good progression," and "we were prepared to send him back to work," but on June 25, 2014, Employee wanted to wait another week. (Quartarolo depo. at 10-11). Dr. Quartarolo explained Employee was indicating he had pain and was also "nervous" about returning to work and not being able to perform his duties, or experiencing a worsening of his back symptoms. (*Id*. at 16). In Dr. Quartarolo's experience, "some people think if they are hurting and you do things and it hurts, then you are causing further and further damage, so they avoid that." (*Id*.). However, at the time, Dr. Quartarolo thought Employee's hypomobility or "vertebral problems" had cleared up, and Employee had no evidence of neurologic impairment. (*Id*.). Next, Employee's condition started "to go in the other direction." X-rays showed "some" degenerative changes in Employee's lower back, "but that is a longstanding thing," and "certainly not an acute process there." (*Id*. at 18). Employee's kidney stone was ruled out as an active problem causing his pain. (*Id*.). With respect to his August 26, 2014 fax, Dr. Quartarolo explained,

> [Employee] . . . was symptomatic . . . from what he has been telling me. But . . . Dr. Radecki was an orthopedic specialist. He went through everything and basically didn't find anything to substantiate it, felt he was able to return to work.

> . . . So if he thinks he's strong enough and physically capable of going back to work, then I agreed with that, based on the limited amount of material that I had clinically.

(*Id*. at 20). Dr. Quartarolo though Employee's MRI, showing L4 endplate marrow edema, was a "real good tip-off" Employee might have suffered an acute injury. (*Id*. at 23). However, he does not have a specific opinion as to why Employee continues to report back pain. (*Id*. at 28). "Kinesiophobia" is not a term Dr. Quartarolo is familiar with, but he "know[s] what [Dr. Silverman] is talking about." In California, they call it "pain avoidance behavior." Dr. Silverman's exam findings represented a worsening of Employee's condition in terms of range of motion loss and loss of sensation in his left foot, according to Dr. Quartarolo. (*Id*. at 30-31). He also recalls Employee's wife telling him "how uncomfortable [Employee] was, to the extent she thought [Employee] was uncomfortable," because Employee complained more at home than Employee's wife thought he did when he was seeing Dr. Quartarolo. (*Id*. at 35-36). If Employee's MRI, Dr. Tran's reports and Dr. Silverman's report were available to Dr. Quartarolo, he would not have released Employee to work. He also thought Employee's MRI was consistent with a traumatic injury to Employee's low back in June of 2014, but he "wouldn't say in all probability" that carrying scaffolding through snow would cause trauma in the form of marrow edema shown on Employee's MRI. (*Id*. at 40).

41) On September 28, 2015, the parties deposed Dr. Silverman, who testified as follows: If she sees a patient very quickly after the onset of symptoms, the potential for that patient's history to be accurate is greater than if she evaluates a patient who had an onset of symptoms several years before. (Silverman depo. at 10). Upon her physical examination, she found it "interesting" Employee had pain at 50 percent of flexion, but continued to go "further than that." (*Id*. at 25-26). When asked to compare Employee's presentation with respect to flexion and extension upon her physical examination versus when Employee was treating with Dr. Quartarolo, she explained:

> I think that -- I -- so I think the first honest statement has to be I really don't know. I can only come up with a theory.
>
> I think that -- my gut sense is I think [Employee's] global mobility and his reluctance to move and fear of moving is much bigger when I saw him compared to last summer.

> The other thing that comes across from the dep – from my evaluation of him that also comes out in [Employee's] deposition – which I reviewed . . . is there's a lot of fear, and if we come back to the International Association for the Study of Pain, their definition of pain is that pain is both the physical and emotional response to tissue damage or the threat of tissue damage.
>
> . . . [W]hat I really like about that definition is it does talk about the emotional stuff, and it describes the concept of the threat of tissue damage, and to me, that really gets to this component of fear. Fear of getting hurt, fear of having pain.
>
> In my note, he did talk about being afraid because of the safety issues, that he was afraid of [sic] would lose his job because of an injury, and that's an issue that comes up in his deposition, as well.

(*Id*. at 32-33). Dr. Silverman also thought Employee's imaging studies showed a tear and tear process, which more indicative of chronic issues rather than acute issues. (*Id*. at 33). However, she also thinks the "emotional stuff" has to be treated or "people don't get better." (*Id*.). The "crux" of Employee's problem, according to Dr. Silverman, is Employee does not want to move. (*Id*. at 33-34). When comparing her diagnosis to Dr. Radecki's, she thinks Dr. Radecki's "non-physiologic" pain behavior language is the equivalent of saying a person is "malingering and there's not anything wrong with them." (*Id*. at 38). Dr. Silverman doers not use the term "non-physiologic pain behavior" in her practice, because she comes from a "bio-psycho-social model," which means she does not think you can fix all pain by looking for a pain generator. (*Id*. at 39-40). She thinks people's "emotional place" determines how much suffering their going to have for their pain.

> [T]he classic example is the little kid who – goes down the slide and lands hard and is fine until they see mom or dad, and them they start crying. Right? And so the real statement is how . . . badly are they hurt? How much are they just shocked and scared?

(*Id*. at 40-41). Dr. Silverman thinks Employee suffered a sprain/strain as a result of the work injury, but the sprain/strain should be resolved. (*Id*. at 47). Instead, she thinks Employee's chronic pain is explained by her kinesiophobia diagnosis. (*Id*.). Dr. Silverman opined Employee needs to build strength, but he is afraid to move. (*Id*. at 49). When asked how she would help Employee "get over" his fear, she stated, "it's a "dynamic process," and would consider physical therapy, aqua-therapy, anti-inflammatories, "adjuvant" medications, anti-depressants, cognitive

behavioral therapy, medical and surgical treatment for his knees. Dr. Silverman opined Employee's knees may be playing a huge role, a factor she did not "adequately evaluate." (*Id*. at 50). She explained the use of anti-anxiety medications would help Employee with "catastrophizing" something like a "little catch" in his back. She explained catastrophizing as, "It's like - you know if you get a little paper cut and you think that your arm is going to be amputated." (*Id*. at 49-51). Dr. Silverman also acknowledged her concerns regarding inconsistencies between Employee's reporting of events and his medical treatment. (*Id*. at 53). With respect to Dr. Quartarolo's recording of Employee's symptoms, Dr. Silverman recalls Employee's wife questioning whether Employee was actually doing as well as he was telling Dr. Quartarolo he was doing, so the medical record is "unclear," because Dr. Quartarolo "kept documenting improvement, but then all of a sudden he turned around and kept [Employee] off work for another week." (*Id*. at 54). When asked about Employee's work restrictions, Dr. Silverman stated, "That's hard to answer" because of the "fear stuff." (*Id*. at 57). Dr. Silverman explained she is "psychologically aware," but acknowledged she is not a formally trained Ph.D. psychologist or psychiatrist or MST or anything," and was "out of her element" when asked to explain the causes of Employee's kinesiophobia. (*Id*. at 60-62). She further explained, "I have to trust my gut about [Employee's kinesiophobia], and to me, that's a gut thing that, you know, is not completely objective, which isn't what you want from me as an evaluator." (*Id*. at 63). When Dr. Silverman talks about people who are going to catastrophize, there are "other issues that come into play" that she cannot fully identify. (*Id*.). She did not know whether a delay in treatment contributed to the development of Employee's kinesiophobia, (*id*.), and thought it was "interesting" Employee developed kinesiophobia with "around his back" and not his knees, (*id*. at 69). Employee is experiencing the threat of tissue damage, as opposed ongoing tissue damage, according to Dr. Silverman. (*Id*. at 73).

42) On January 4, 2016, Employee's attorney filled a claim on his behalf seeking TTD from August 15, 2014 to October 12, 2015, TPD from October 13, 2015 continuing, medical and transportation costs, compensation rate adjustment, penalty, interest and attorney's fees and costs. (Claim, December 30, 2015).

43) On February 8, 2016, Employee saw Shanna Thompson, FNP, of the Mendocino Health Clinic to establish care and reported he had previously been diagnosed with anxiety and has noticed he is getting more anxious in the evenings. NP Thompson prescribed lorazepam for

Employee's anxiety and referred Employee to physical therapy and chiropractic care, and ordered a transcutaneous electrical nerve stimulation (TENS) unit to address his bilateral low back pain with sciatica. (Thompson report, February 8, 2016).

44) Between February 17, 2016 and May 25, 2016, Employee underwent a course of treatment with Javier Arroryo, D.C., who administered spinal manipulations. At Employee's last visit, Dr. Arroryo noted, "Chiro care has offered temporary relief at times but overall pt had had no overall improvement." Dr. Arroryo referred Employee back to his primary care physician to discuss further care options. (February 17, 2016; March 9, 2016; March 30, 2016; April 13, 2016; April 27, 2016; May 11, 2016; May 25, 2016).

45) On May 5, 2016, Dr. Radecki performed a second EME, at which point Employee described the mechanism of injury as is reflected elsewhere in the medical record. Employee also reported he had been working as a night watchman at a residential home for wayward children for about seven months. Dr. Radecki reviewed additional medical records that were not available to him at the time of his first EME. Upon physical examination, Dr. Radecki again noted numerous "non-physiologic" and "grossly non-physiologic" behaviors. "Employee's hip flexion supine was a maximum of 80 degrees on the right, and 60 left, beyond which he could not tolerate because of low back pain and yet he can sit at 90 degrees of flexion, so there is an inconsistency." "The straight leg raise, supine, raising left foot and leg at 15-20 degrees, he had great complaints in the low back, so much so that I put exclamation points next to his response." Upon Employee's sitting straight leg raise, Dr. Radecki found "a remarkable difference on the left of course between the sitting straight leg raise of 60 to 70 for back pain production compared to the supine . . . at 15 to 20, he had exclamation point marks." "Palpation revealed widespread discomfort along the spine . . . ." Dr. Radecki diagnosed, "[p]ossible, but no clearly documented lumbar strain," and "[m]uch non-physiologic presentation and pain behavior." Dr. Radecki continued to doubt an occurrence of back strain, and wrote, "Today he said he was carrying a plank, 8 feet long in his right hand when he felt a sudden jab/stab. There are other discussions [in the medical record] about the onset of symptoms and as we know there is no consistent description of a specific incident or occurrence." When asked whether "non-physiologic pain behavior" and "kinesophobia" are generally accepted terms within the medical community, Dr. Radecki responded:

> Non-physiologic as a phrase put into Google gives over 27 million results. It is an obviously generally accepted medical community term. Dr. Silverman makes a diagnosis of kinesophobia. Putting that term into Google, it gives 41,000 results. So I would say that in the medical community and the community at large, non-physiologic pain behavior is extremely generally accepted. . . . I would say the term kinesophobia is not a generally accepted term in the medical community.

Dr. Radecki pointed out Dr. Quartarolo documented Employee doing light yard work "just 21 days after the claimed 'injury,' which "certainly dispelled the notion" Employee had some abnormal fear of re-injuring himself. Instead, Dr. Radecki thinks Dr. Silverman "came up with [her kinesiophobia diagnosis] on her own," and points to Employee's improvement documented in Dr. Quartarolo's chart notes as evidence Employee had recovered from his "alleged 'injury.'" He also disagreed with Dr. Silverman, and stated non-physiologic pain behaviors do not require malingering as a component. Dr. Radecki opined Employee had recovered from his work injury by June of 2014, "if there was an injury." Employee's non-physiologic presentation and pain behavior was not due to work, but rather "a psychological condition, psychosocial in nature[,] due to his personal factors," in Dr. Radecki's opinion. Although Dr. Radecki did not think these personal factors were work related, he did think a psychologist who is well-trained in the evaluation and treatment of psychological conditions of chronic pain might benefits the claimant. In Dr. Radecki's opinion, Employee lost his "coping ability" sometime between July 2014 and August 2014 due to psychosocial factors, and proposed treatments, such as facet joint injections would be "contraindicated and harmful since they merely reinforce psychosocially derived pain behaviors. . . . You do not treat psychosocial factors with lumbar injections and pain medications." Dr. Radecki summarized his opinion:

> Psychosocial factors can be simple things at times such as how much someone might earn. If you earn $100,000 in Alaska, but you just make $30,000 working in California, that is a psychosocial factor. It adds stress to the claimant's psyche. Stress affects psyche. That's just one of the potential psychosocial factors.

He repeatedly pointed to Dr. Quartarolo's documentation of Employee returning to a full range of motion in support of his opinions. (Radecki report, May 5, 2016).

46) Between April 25, 2016 and June 10, 2016, Employee participated in a six-week physical therapy program. On his initial visit, Employee reported his lumbar pain as "9" at its worst, "4" at its best and was currently at "6." Also on his initial visit, he reported his posterior left leg pain

as "10" at its worst, "4" at its best and was currently at "6." On his last visit, Employee's reports of lumbar pain and posterior left leg pain had improved to "4" at their worst, "0" at their best, and were currently "2" for both types of pain. On his last visit, Employee also reported a new, mid-back strain and stated his intention to follow-up with his primary care physician. (Physical Therapy around the Lake reports, April 25, 2016; May 9, 2016; May 13, 2016; May 16, 2016; May 20, 2016; May 25, 2016; May 27, 2016; June 1, 2016; June 3, 2016; June 8, 2016; and June 10, 2016).

47) On June 8, 2016, Employee followed-up with FNP Thompson and reported Dr. Arroryo had decided his back pain was progressively getting worse and Dr. Arroryo would like to have him referred to a neurologist for his back pain. He also reported he had been leaving physical therapy appointments with his left leg feeling numb. FNP Thompson ordered a lumbar spine MRI and lumbar spine x-rays. She also referred Employee to a neurosurgeon and to Dr. Tran for pain management. (Thompson report, June 8, 2016).

48) On June 8, 2016, lumbar spine x-rays were interpreted to show: 1) Loss of normal lordosis; 2) Minimal degenerative disc disease involving preferentially the mid lumbar levels; and 3) Suspect renal stone unchanged from the previous study. (X-ray report, June 8, 2016).

49) Between July 22, 2016 and August 5, 2016, Employee underwent additional physical therapy. Upon resuming physical therapy, Employee reported continued improved lumbar mobility with less pain. He also had not experienced any leg numbness for several weeks. At his last visit, he reported mild lumbar pain after walking three miles, and rated his lumbar pain as "3" at its worst, "0" at its best and was currently at "3," At his last visit, Employee also rated his posterior left leg pain as "2" at its worst, "0" at it was currently "0." (Physical Therapy around the Lake reports, July 22, 2016; July 26, 2016; August 1, 2016; August 5, 2016).

50) On July 27, 2016, Employee saw Dr. Tran and complained of excessive lower back pain, which was now radiating into his posterior thigh. Because Employee had not been working for several years, he was reportedly destitute and on MediCal insurance, although Employee also reported he was working part-time as a night watchman and campus supervisor. Dr. Tran assessed an "obvious" work-related injury involving Employee's lumbar spine, for which "he has not been treated adequately through his work injury company," and recommended a follow-up lumbar spine MRI, lumbar epidural steroid injection at L5-S1, bilateral L4-5/L5-S1 medial branch facet diagnostic injections, and a possible functional capacity evaluation because

Employee "is still interested in returning to work in Alaska, where he can earn a significantly better living to support his family." (Tran report, July 27, 2016).

51) On August 2, 2016, a lumbar spine MRI was interpreted to show, 1) Broad-based posterior disc protrusion with borderline stenosis at L4-5, 2) Broad-based posterior disc protrusion with mild bilateral foraminal stenosis at L5-S1. (MRI report, August 2, 2016).

52) On August 18, 2016, Employee attended physical therapy and demonstrated "functional and asymptomatic lumbar mobility," and was discharged from physical therapy on August 23, 2016 because he "appeared to be progressing well with improved lumbar mobility without leg pain." (Daily Note, August 18, 2016; Discharge Note, August 23, 2016).

53) On August 23, 2016, Dr. Tran administered an L5-S1 epidural steroid injection. (Tran report, August 23, 2016).

54) On September 7, 2016, Employee followed up with Jim Williams, a physician's assistant to Dr. Tran, and reported a resolution to his radiculopathy and a 50 percent reduction in his back pain following the lumbar epidural steroid injection. His range of motion was increased. PA Williams requested medial branch facet blocks at L4-5 and L5-S1. (Williams report, September 7, 2016).

55) On October 4, 2016, Dr. Tran administered bilateral L4-5 and L5-S1 medial branch facet injections. (Operative Report, October 4, 2016).

56) On October 17, 2016, neurosurgeon Scott Collins Berta, M.D. evaluated Employee, who reported the epidural steroid and facet injections "helped" his lower back pain, but physical therapy and electrical stimulation did not. On physical examination, Dr. Berta found mild tenderness to low back palpation and no pain on external rotation of the hips. He interpreted an unspecified MRI to show a mild herniated nucleus pulposi at L4-5 and L5-S1. Dr. Berta assessed "LBP with left leg pain / radiculopathy however, [t]he L5-S1 foramen show only mild to moderate foraminal stenosis without obvious nerve root compression." He ordered and electromyogram (EMG) and nerve conduction velocity (NCV) studies to assess for peripheral neuropathy and continued pain management. (Berta report, October 17, 2016).

57) On November 16, 2016, the parties deposed Dr. Radecki, who testified consistent with his EME reports. Regarding Dr. Silverman's kinesiophobia diagnosis, he stated:

> That's kind of like a hypotthesis on her part, apparently. No other physician or treating medical provider in this case has come up in that diagnosis. Two

> chiropractors did not make this diagnosis; Dr. Cornelius who saw this patient did not make that diagnosis. A person who had a doctorate in physical therapy did not make that diagnosis, and I did not make that diagnosis.

(Radecki depo at 26-27). When questioned on his psychiatric expertise, Dr. Radecki answered, "My brother is a psychiatrist." (*Id*. at 49). He also explained he had received two months psychiatric training as part of his residency, and has attended lectures by psychologists to learn the five steps of grieving. (*Id*.). Dr. Radecki also cited his work at various pain centers, which included "a team approach," as a basis for his psychiatric background. (*Id*. at 49-50). Dr. Radecki agreed with Dr. Silverman's opinion that the earliest patient histories are usually the best. (*Id*. at 56). Orthopedists do not spend a lot of time with their patients, according to Dr. Radecki, and they "don't do provocative maneuvers that look for non-physiologic pain." (*Id*. at 60).

58) At hearing, Employee testified consistent with his deposition, including his description of the work injury and feeling a sharp pain in his back. According to him, the "trade-offs" of working on the Slope included being away from home and family, but a "plus" was the money he earned. Employee was looking for work in California at the time of injury because he is "always looking for a way to better [himself]" and provide for his family. Upon being asked if he was honest with Dr. Quartarolo during treatment, he explained he is stubborn and hardheaded, and did not want to lose his job, so he was "probably not honest" because he wanted to go back to work. Employee described financial stresses in his life. After he was controverted, he withdraw money from 401(k) accounts and borrowed money from family to pay income taxes and make the house payment. He attended to October 7, 2014 fit-for-duty examination, but could not complete it because he was in too much pain. Employer terminated Employee's employment following the fit-for-duty examination. Regarding Dr. Silverman's kinesiophobia diagnosis, Employee explained he is not afraid of all movement, just movement that causes him sharp pain. He is not afraid all potential jobs will cause pain, just physical jobs. Employee testified concerning FNP Thompson's chiropractic, physical therapy, pain management and neurosurgical referrals. He feels physical therapy and injections have helped him. Employee described the effects of injections as "night and day." He is a lot better now, but still has some bad days. Employee would be willing to try work on the Slope again. He also feels he can now work fulltime in his field in California. On cross-examination Employee explained he "played

possum" when completing his June 4, 2014 employee statement, where he indicated he could not pinpoint a daily task that caused his pain, because he was scared and confused. He acknowledged providing inaccurate information at the Slope medical clinic and to Dr. Quartarolo. During Dr. Silverman's EME evaluation, he "broke down and cried." Employee does not "think much" of Dr. Silverman's recommendation for psychotherapy, and he does not need to see a counsellor. He acknowledged he had approximately doubled his income, from 16 dollars per hour to roughly, 70,000 dollars per year, by working on the Slope. (Employee).

59) Though credible on direct examination, on cross-examination, Employee's testimony became evasive, with frequent answers such as "I don't know," "I don't remember," "I don't recall," "I don't know all the details," and "I'm not good with dates." Employee's testimony during cross-examination raised concerns as to his credibility. (*Id*.; experience, judgment, observations and inferences drawn therefrom).

60) At hearing, Employer's adjuster, Katie Weimer, testified regarding her background as an adjuster and acknowledged issuing a check to Employee last week. Ms. Weimer did not issue the check to Employee following Dr. Radecki's deposition, where he testified he would have taken Employee off work for three weeks following the injury, because "somehow we missed it." Ms. Weimer calculated Employee's compensation rate from his 2013 W-2s. (Weimer).

61) At hearing, Employer's general foreman, Don Hanley, testified concerning Employer's incident reporting policy, including "near loss" reports and actual injuries, as well as the types of investigations that follow such reports. On the day of Employee's injury report, he wanted to go the camp medic because he woke up with pain. Mr. Haley asked him questions, such as when, why, at what time, and at what location did the injury occur, but Employee did not give him anything "tangible to use." Mr. Hanley denied Employee was instructed to report he woke up with pain that day, but rather explained he just wanted to make sure Employee knew that was what he was going to write down. (Hanley).

62) The parties agree Employee returned to gainful employment on October 21, 2015, so any TPD award would commence from that date. (Employee's Hearing Brief, January 11, 2017; Employer's Hearing Brief, January 11, 2017).

63) Although Employer does not expressly contend Employee was looking for work in California at the time of his injury because his knee was not holding up to work on the Slope, it strongly suggest as much. (Employee deposition, July 14, 2015; Employer's Hearing Brief,

January 11, 2017; Employee hearing testimony, January 19, 2017; and inferences taken therefrom).

PRINCIPLES OF LAW

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

> **AS 23.30.001. 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 the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to . . . employers . . . .
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> **AS 23.30.010. Coverage**. Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability . . . or the need for medical treatment of an Employee if the disability . . . or the Employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability . . . or the need for medical treatment arose out of and in the course of the employment, the Employee must establish a causal link between the employment and the disability . . . or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the . . . disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the . . . disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability . . . or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability . . . or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability . . . or need for medical treatment. . . .
>
> (b) Compensation and benefits under this chapter are not payable for mental injury caused by mental stress . . . .
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> **AS 23.30.095. Medical treatments, services, and examinations**. (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years

> from and after the date of injury to the employee. . . . The board may authorize continued treatment or care or both as the process of recovery may require.
> . . . .
>
> (k) In the event of a medical dispute regarding determinations of causation, medical stability, ability to enter a reemployment plan, degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's independent medical evaluation, the board may require that a second independent medical evaluation be conducted by a physician or physicians selected by the board from a list established and maintained by the board. . . .
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> **AS 23.30.110. Procedure on Claims.** (a) . . . the board may hear and determine all questions in respect to the claim.
> . . . .
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> (c) Before a hearing is scheduled, the party seeking a hearing shall file a request for a hearing together with an affidavit stating that the party has completed necessary discovery, obtained necessary evidence, and is prepared for the hearing.
> . . .
>
> (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 physician or physicians as the employee, employer, or carrier may select and pay for may participate in an examination if the employee, employer, or carrier so requests. Proceedings shall be suspended and no compensation may be payable for a period during which the employee refuses to submit to examination. . . .

The regulation at 8 AAC 45.090(b) provides for orders requiring an employer to pay for an employee's examination pursuant to AS 23.30.095(k) or §110(g). Section 095(k) and §110(g) are procedural in nature, not substantive, for the reasons outlined in *Deal v. Municipality of Anchorage*, AWCB Decision No. 97-0165 (July 23, 1997), at 3; *see also Harvey v. Cook Inlet Pipe Line Co.*, AWCB Decision No. 98-0076 (March 26, 1998). Considering §135(a) and §155(h), wide discretion exists under AS 23.30.110(g) to consider any evidence available when deciding whether to order an SIME to assist in investigating and deciding medical issues in contested claims, to best "protect the rights of the parties."

The Alaska Workers' Compensation Appeals Commission (Commission) 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(g). With regard to §095(k), the Commission referred to its decision in *Smith v. Anchorage School District*, AWCAC Decision No. 050 (January 25, 2007), at 8, in which it confirmed:

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

The Commission further stated in *dicta*, before ordering an SIME it is necessary to find the medical dispute is significant or relevant to a pending claim or petition and the SIME will assist the board in resolving the dispute. *Bah* at 4.

The Commission outlined the board's authority to order an SIME under §110(g), as follows:

> [T]he board has discretion to order an SIME when there is a significant gap in the medical or scientific evidence and an opinion by an independent medical examiner or other scientific examination will help the board in resolving the issue before it. . . . 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 evidence, or lack of understanding of the medical evidence, prevents the board from ascertaining the rights of the parties.

Id. at 5.

Under either §095(k) or §110(g), the Commission noted the purpose of ordering an SIME is to assist the board, and the SIME is not intended to give employees an additional medical opinion at the expense of employers when employees disagree with their own physician's opinion. *Id.* When deciding whether to order an SIME, the board typically considers the following criteria, though the statute does not require it:

1) Is there a medical dispute between 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?

Deal at 3. *See also, Schmidt v. Beeson Plumbing and Heating*, AWCB Decision No. 91-0128 (May 2, 1991). Accordingly, an SIME pursuant to §095(k) may be ordered when there is a

medical dispute, or under §110(g) when there is a significant gap in the medical or scientific evidence. Further, the Commission held an SIME may be ordered when, because of a lack of understanding of the medical evidence, the parties' rights cannot be ascertained. It stated:

> 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 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 8.

The decision to order an SIME rests in the discretion of the board, even if jointly requested by the parties. *Olafson v. State Department of Transportation*, AWCAC Decision No. 06-0301 (October 25, 2007), at 6. Although a party has a right to request an SIME, a party does not have a right to an SIME if the board decides an SIME is not necessary for the board's purposes. *Id*. at 8. A party does not have "veto" rights over the board's choice of physician. *Id*. at 10. An SIME is not a discovery tool exercised by the parties; it is an investigative tool exercised by the board to assist it by providing disinterested information. *Id*. at 15.

> **AS 23.30.120. Presumptions**. (a) In a proceeding for the enforcement of a claim for compensation under this chapter it is presumed, in the absence of substantial evidence to the contrary, that
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> (1) the claim comes within the provisions of this chapter . . . .
>
> (c) The presumption of compensability established in (a) of this section does not apply to a mental injury resulting from work-related stress.

"The text of AS 23.30.120(a)(1) indicates that the presumption of compensability is applicable to *any* claim for compensation under the workers' compensation statute." *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996) (emphasis in original). Medical benefits, including continuing care, are covered by the AS 23.30.120(a) presumption of compensability. *Municipality of Anchorage v. Carter*, 818 P.2d 661, 664-65 (Alaska 1991). The Alaska Supreme Court in *Sokolowski v. Best Western Golden Lion*, 813 P.2d 286, 292 (Alaska 1991) held a claimant "is entitled to the presumption of compensability as to each evidentiary question."

The presumption's application involves a three-step analysis. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381 (Alaska 1991). First, an employee must establish a "preliminary link" between the "claim" and her employment. In less complex cases, lay evidence may be sufficiently probative to make the link. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Whether or not medical evidence is required depends on the probative value of available lay evidence and the complexity of the medical facts involved. *Id.* An employee need only adduce "some," minimal relevant evidence, *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987), establishing a "preliminary link" between the "claim" and the employment, *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). Witness credibility is not examined at this first step. *Excursion Inlet Packing Co. v. Ugale*, 92 P.3d 413, 417 (Alaska 2004).

Second, once an employee attached the presumption, the employer must rebut it with "substantial" evidence that either, (1) provides an alternative explanation excluding work-related factors as a substantial cause of the disability ("affirmative-evidence"), or (2) directly eliminates any reasonable possibility that employment was a factor in causing the disability ("negative-evidence"). *Huit v. Ashwater Burns, Inc.*, 372 P.3d 904; 919 (Alaska 2016). "Substantial evidence" is the amount of relevant evidence a reasonable mind might accept as adequate to support a conclusion. *Miller v. ITT Arctic Services*, 577 P.2d 1044, 1046 (Alaska 1978). The mere possibility of another injury is not "substantial" evidence sufficient to rebut the presumption. *Huit* at 920, 921. The employer's evidence is viewed in isolation, without regard to an employee's evidence. *Miller* at 1055. Therefore, credibility questions and weight accorded the employer's evidence are deferred until after it is decided if the employer produced a sufficient quantum of evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Compensation Board*, 880 P.2d 1051, 1054 (Alaska 1994); *citing Big K Grocery v. Gibson*, 836 P.2d 941 (Alaska 1992).

For claims arising after November 7, 2005, employment must be the substantial cause of the disability or need for medical treatment. *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 (March 25, 2011) (reversed on other grounds by *Huit*). If an employer produces substantial evidence work is not the substantial cause, the presumption drops out and the employee

must prove all elements of the "claim" by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1381 (*citing Miller v. ITT Services*, 577 P 2d. 1044, 1046). The party with the burden of proving asserted facts by a preponderance of the evidence must "induce a belief" in the fact-finders' minds the asserted facts are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

To determine whether the presumption of compensability applies, work-related mental injuries are divided into three different categories: mental stimulus that causes a physical injury, or "mental-physical" cases; physical injury that causes a mental disorder, or "physical-mental" cases; and mental stimulus that causes a mental disorder, or "mental-mental" cases. *Kelly v. State of Alaska, Dept. of Corrections*, 218 P.3d 291; 298 (Alaska 2009). Where a work-related physical injury results in a mental disorder, such as depression, the presumption is applied. *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249; fn 36 (citing *Williams v. Abood*, 53 P.3d 134 (Alaska 2002)). However, where work-related stress results in a mental injury, such as posttraumatic stress disorder, a claimant is required to prove each element of the test for mental injury by a preponderance of the evidence, without the benefit of the presumption of compensability. *Kelly* at 297 (discussing the former AS 23.30.395(17)).

> **AS 23.30.122. Credibility of witnesses**. The board has the sole power to determine the credibility of a witness. A finding by the board concerning the weight to be accorded a witness's testimony, including medical testimony and reports, is conclusive even if the evidence is conflicting or susceptible to contrary conclusions. The findings of the board are subject to the same standard of review as a jury's finding in a civil action.

The legislative history of AS 23.30.122 states the intent was "to restore to the Board the decision making power granted by the Legislature when it enacted the Alaska Workers' Compensation Act." *DeRosario v. Chenega Lodging*, 297 P.3d 139, 146 (Alaska 2013). The Alaska Workers' Compensation Appeals Commission is required to accept the board's credibility determinations. *Id.* The Alaska Supreme Court defers to board's credibility determinations. *Id.* If the board is faced with two or more conflicting medical opinions, each of which constitutes substantial evidence, it may rely on one opinion and not the other. *Id.* at 147. The board may also choose not to rely on its own expert. *Id.*

> **AS 23.30.135. Procedure before the board.** (a) In making an investigation or inquiry or conducting a hearing the board is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by this chapter. The board may make its investigation or inquiry or conduct its hearing in the manner by which it may best ascertain the rights of the parties. . . .
>
> **AS 23.30.155. Payment of compensation.**
> . . . .
>
> (h) The board may upon its own initiative at any time in a case in which payments are being made with or without an award, where right to compensation is controverted . . . make the investigations, cause the medical examinations to be made, or hold the hearings, and take the further action which it considers will properly protect the rights of all parties.
>
> **AS 23.30.394. Definitions.**
> . . . .
>
> (24) "injury" means accidental injury or death arising out of and in the course of employment, and an occupational disease or infection that arises naturally out of the employment or that naturally or unavoidably results from an accidental injury
> . . . .

ANALYSIS

For compensation or benefits to be due Employee, his employment must be "the substantial cause" of his disability or need for medical treatment. AS 23.30.110(a). The issue of compensability raises a factual dispute to which the statutory presumption of compensability applies. *Meek.* Employee attaches the presumption with his own deposition and hearing testimony, where he describes the work injury and feeling a sharp pain in his back. *Cheeks*. Employer rebuts the presumption with Dr. Radecki's opinions that, either an injury never occurred, or if one did, it resulted in a back strain that was resolved by the end of June 2014. *Miller*. Employee must now prove, by a preponderance of the evidence, that his injury with Employer is the substantial cause of his disability and need for medical treatment. *Koons.*

Employee decidedly has credibility problems. One might accept his explanation - he had not engaged Dr. Quartarolo in *ongoing* treatment prior to his work injury, to excuse his inaccurate responses on several employment health questionnaires, which indicated he had never treated for

muscle strain or a back injury, or with a chiropractor for back or muscle problems. One might also accept his explanation - he feared losing his job because of an intense, safety-oriented, work culture on the Slope, to excuse his inaccurate reporting of the injury, where he initially stated he woke up with back pain and could not pinpoint a specific activity that caused the pain. However, it becomes increasingly more difficult with each successive occurrence to continue excusing his numerous other inconsistencies in the record, such as him now contending he was misrepresenting the extent of his improvement while treating with Dr. Quartarolo immediately following the work injury.

As another example, Employee repeatedly emphasized the importance to him of supporting his family, and he repeatedly testified he appreciated the income he was able to earn while working on the Slope. Thus, while "always looking for a way to better [oneself]" is a laudable goal, it remains entirely unclear why Employee was looking for counselling-type work in California at the time of his injury, work that historically has paid but a fraction of what he was earning on the Slope, given Employee's oft-stated priority of supporting his family. Although Employer does not expressly contend Employee was looking for alternative employment because his knee was not holding up to physically demanding work on the Slope, it strongly suggests as much, and there is evidence in the record that would support such a theory. Employee's cursory and quizzical explanation for seeking work in California once again calls his credibility into question. Employee's obvious evasiveness during cross-examination at hearing is a further concern. For these reasons, Employee's testimony is afforded little weight. However, this does not all mean that Employee has necessarily failed to carry his burden, as there are concerns throughout the entirety of the current medical record, as well.

Dr. Radecki's dramatic EME reports both stand out, and stand alone, in the medical record. No other medical provider, including Dr. Quartarolo, Dr. Tran, Dr. Silverman, Dr. Arroryo, Dr. Berta, FNP Thompson, or Employee's physical therapy providers documented the multitude of "non-physiologic" and "grossly non-physiologic" pain behaviors Dr. Radecki observed. Given the sensational nature of Employee's described behaviors, it is difficult to understand why such astonishing findings would not have been noted elsewhere in the medical record. Equally concerning are Radecki's repeated conclusions of "no specific injury," "no verifiable injury" and

"no definite injury," notwithstanding his own notation of Employee's June 9, 2014 description of the work injury to Dr. Quartarolo, made while performing his records review in advance the first EME. Even after Employee cleared up the misunderstanding between him and Dr. Radecki regarding the mechanism of injury at the second EME, Dr. Radecki still maintained there was "no clearly documented lumbar strain," and continued to refer to Employee's "claimed 'injury,'" and his "alleged 'injury,'" "if there was an injury." These references might well be indicative of an animus where Dr. Radecki was unwilling to entertain the notion Employee was injured at work in the first place, and might further suggest he did not approach his evaluations with any degree of objectivity and arrived at a results-oriented outcome. Given Dr. Radecki's unique observations and stubborn skepticisms, his opinions are afforded little weight.

Meanwhile, the concerns with Dr. Silverman's SIME opinions are legion. When asked if work aggravated, accelerated or combined with a pre-existing condition to cause Employee's disability or need for medical treatment, she merely suggested the possibility walking in knee-deep snow carrying a 50-pound plank on one side of the body *could* have aggravated Employee's symptoms, but she did not state that it did so. In fact, almost all of Dr. Silverman's opinions are quite tentative and couched in indecisive terms such as "hopefully," and "trying to," "my gut sense is," and "I can only come up with a theory." She initially wrote she was "uncertain" of Employee's work restrictions and later stated, "That's hard to answer." Upon being asked to identify "the substantial cause" of Employee's disability or need for medical treatment, she provided no less than six different potential causes. When asked to evaluate the different causes of Employee's disability or need for medical treatment, she undertook no such analysis, but rather pointed to a single cause – Employee's kinesiophobia. Later, at her deposition, Dr. Silverman was unable to identify potential causes of kinesiophobia.

Dr. Silverman's "kinesiophobia" diagnosis is troublesome.[2] Dr. Radecki is not familiar with that term, Dr. Quartarolo is not familiar with that term, and the experienced members of this panel are not familiar with that term. Dr. Silverman clearly struggled during her deposition to explain

[2] Also troublesome, when Dr. Radecki was asked whether "kinesiophobia" is a generally accepted term within the medical community, instead of consulting scientific studies or citing scholarly publications, or even basing his answer on his own experience, he performed an ordinary Google search and based his answer on the number of search results.

the term herself, using descriptors such as "emotional stuff" and "fear stuff." Dr. Silverman also struggled with how to treat Employee's kinesiophobia and explained, "it's a dynamic process," then stated she would consider using physical therapy, aqua-therapy, anti-inflammatories, "adjuvant" medications, anti-depressants, cognitive behavioral therapy, and even *medical and surgical treatment for Employee's knees*, though Employee is not claiming a knee injury. Most importantly, nowhere does Dr. Silverman relate Employee's need for treatment of his kinesiophobia or lumbar ligamentous hypertrophy to his employment, yet she recommends treatment for both. The relevance of Dr. Silverman's kinesiophobia diagnosis to the work injury is suspect, and her other opinions provide little, if any, probative value in ascertaining the parties rights.

The opinions of Dr. Quartarolo, Employee's treating chiropractor, do not fare any better under this analysis. As of the date of his deposition, he did not have a specific opinion as to why Employee continues to report back pain, and he "wouldn't say in all probability" that carrying scaffolding through snow would cause trauma in the form of marrow edema shown on Employee's MRI. Following Employee's injury, Dr. Quartarolo documented a complete recovery of Employee's gross lumbar mobility, and then released Employee back to work without restrictions. He next took Employee back off work a mere two days later, first because Employee requested it, and then again later to evaluate the potential contributions of Employee's kidney stone to his symptoms. It was during these latter off-work periods when Dr. Quartarolo authored two reports for Employer in which he attributed Employee's need for medical treatment to his work. Next, after reviewing Dr. Radecki's first EME report, Dr. Quartarolo reversed course yet again, and on August 26, 2014, faxed Employer what is essentially a retraction of his previously stated opinions, where he also seems to indicate agreement with Dr. Radecki's opinions and releases Employee back to work. Curiously enough, Dr. Quartarolo cites his "findings at [his] last visit with [Employee]" as a basis for his August 26, 2014 retraction. At his last visit with Employee, Dr. Quartarolo had found Employee was continuing to complain of sharp pains of varying intensities in the centerline of his lower back, found Employee's gross lumbar mobility had regressed 25 percent, had taken Employee off work for an additional four weeks to afford him an opportunity to be evaluated by Dr. Tran. Yet, on August 26, 2014, Dr. Quartarolo inexplicably saw this same visit as a basis to return Employee to work, rather than

keeping him off work. Now, Dr. Quartarolo once again opines Employee requires work-related medical treatment. Of course, he also now explains, if Employee's MRI, Dr. Trans', and Dr. Silverman's reports were available to him at the time, he would not have released Employee back to work on August 26, 2014. Nevertheless, he did release Employee back to work on that date, without any additional requests for further diagnostic studies or evaluations beyond the previously made referral to Dr. Tran. Because it is not known which of Dr. Quartarolo's constantly vacillating medical opinions should be relied upon, they are afforded little weight.

So far as can be discerned from the medical record, Employee's treating pain management specialist, Dr. Tran, evaluated Employee twice over the course of as many years, and he administered epidural steroid injections on a couple of subsequent occasions. There is no evidence Dr. Tran has evaluated the entire medical record in this case, yet he nevertheless opines Employee continues to suffer from an "obvious" work-related injury, for which "he has not been treated adequately through his work injury company." He provides no basis for these opinions. If Employee continues to suffer from an obvious work-related injury, this fact is only "obvious" to Dr. Tran alone. For these reasons, his opinions are afforded little weight.

This decision does not yet reject, in their entirety, the opinions of any physician, and neither does it make any credibility determinations with respect to Employee, other than those previously stated in the findings of fact. In summary, the evidence in the record to date is so suspect, it cannot be relied upon as substantial evidence to decide Employee's claim. *Miller*. An SIME may be ordered under a variety of circumstances, such as when there is disputed opinions between physicians for the employee and the employer. AS 23.30.095(k); *Bah*. As there was at the time of Dr. Radecki's first EME, disputes of opinions remain between Drs. Quartarolo and Radecki, as well as disputed opinions between Dr. Tran and Dr. Radecki. Not only was Dr. Silverman's SIME report of little assistance in resolving the parties' disputes, it only served to muddy the waters further. An SIME may be ordered when there is a gap in the medical evidence. AS 23.30.110(g); *Bah*. Because Employee was controverted and lost his job, he was unable to treat between August 18, 2014, and February 8, 2016, a gap of nearly a year-and-a-half. An SIME may be ordered when it would assist in understanding of the medical evidence. *Id*. It is unknown, what significance, if any, Employee's treatment records from 2016 would

have in understanding earlier medical evidence and ascertaining the parties rights. In addition, it is still not understood whether "kinesiophobia" is a generally accepted term in the medical community, or why Dr. Radecki alone made findings on Employee's dramatic, non-physiological pain behaviors. For each of the above-stated reasons, an additional SIME will be ordered.

Whether it is Dr. Radecki's "psychosocial factors," or Dr. Silverman's "kinesiophobia" diagnosis, both physicians opine there is a psychological component to Employee's disability and need for medical treatment, which may, or may not, be work-related. Dr. Silverman readily acknowledges she was "out of her element" when asked to explain the causes of kinesiophobia, and further testified there are elements, which she cannot fully identify, that come into play when a patient "catastrophizes" pain. However, unlike Dr. Silverman, no such acknowledgments were forthcoming from Dr. Radecki. Instead, Dr. Radecki touts a two-month psychiatric rotation during his residency, his attendance at lectures where he learned about the five steps of grieving, his brother being a psychiatrist, and working with psychologists as his psychological credentials. Given an agreed-upon psychological component to Employee's disability, Employee's history of anxiety, which has been treated with prescription medications, and Dr. Silverman's multi-disciplinary treatment recommendations for Employee's kinesiophobia, including the use of prescription medications, psychiatrist, Walter Ling, M.D., will be appointed to evaluate Employee. So that the opinions of physiatrists Drs. Radecki and Silverman can be further examined and better understood, Marvin Zwerin, D.O., also a physiatrist, will also be appointed to serve on the SIME panel.

CONCLUSIONS OF LAW

Substantial evidence does not exist in the current record upon which to determine whether Employee's June 4, 2014 injury is the substantial cause of his disability or need for medical treatment.

ORDERS

1) A panel SIME is ordered as set forth above.

2) The parties are instructed to request a prehearing conference, to be held on a date mutually convenient for the parties, within 15 days if this decision. The purpose of the prehearing conference will be to arrange for SIME binder exchange deadlines.

3) The SIME record will include the transcripts of Employee's, Dr. Quartarolo's, Dr. Radecki's and Dr. Silverman's depositions.

4) In addition to the board's standard SIME questions, both SIME physicians will be asked the following questions:

a. Are "non-physiologic pain behavior" and "psychosocial factors" generally accepted terms within the medical community?

b. Do you share Dr. Radecki's opinion, Employee's demonstrates non-physiologic pain behaviors that are caused by psychosocial factors? Please cite to relevant portions of the medical record, scholarly publications, or reference your own experience to support your answer.

c. Is the term "kinesiophobia" (or "kinesophobia") a generally accepted term within the medical community?

d. Do you agree with Dr. Silverman's kinesiophobia diagnosis? Please cite to relevant portions of the medical record, scholarly publications, or reference your own experience to support your answer.

Dated in Fairbanks, Alaska on March 28, 2017.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Robert Vollmer, Designated Chair

/s/
Lake Williams, 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 SCHAD SCHWEITZER, employee / claimant; v. ASRC ENERGY SERVICES, employer; ARCTIC SLOPE REGIONAL CORP., insurer / defendants; Case No. 201410856; dated and filed in the Alaska Workers' Compensation Board's office in Fairbanks, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on March 29, 2017.

/s/
Alyssa Kerr, Office Assistant