ALASKA WORKERS' COMPENSATION BOARD

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

THOMAS R. O'CONNELL, Employee, Claimant, v. CHEVRON CORPORATION, Self-Insured Employer, Defendant.	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 201014260 AWCB Decision No. 15-0108 Filed with AWCB Anchorage, Alaska on August 28, 2015

Thomas O'Connell (Employee) and Chevron Corporation's (Employer) July 21, 2015 stipulation was heard on the written record in Anchorage, Alaska, on July 29, 2015, a date selected on June 16, 2015. The matter was heard by a two-member panel, a quorum under AS 23.30.005(f). Attorney Eric Croft represented Employee. Attorney Robert McLaughlin represented Employer. The record re-opened on August 18, 2014, to obtain the parties' input on how Employee came to be seen by three Employer's medical evaluators and whether in the future there would be a potential issue regarding a possible excessive change of physician. The record closed upon receiving Mr. McLaughlin and Mr. Croft's input on August 19, 2015.

ISSUE

Employee petitioned for a second independent medical evaluation (SIME) on February 5, 2015. The petition was withdrawn on May 19, 2015. The parties stipulated an SIME is not needed but acknowledged a dispute exists and a SIME may be ordered under AS 23.30.095(k). The parties agreed to a hearing on the written record to determine if an SIME will be required prior to the case going to hearing on the merits on September 29, 2015.

Should an SIME be ordered before deciding this matter on its merits?

FINDINGS OF FACT

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

1) On April 7, 2010, Employee was working as an oil well services field supervisor for Employer and injured his right shoulder during fire training. He was donning gear, reached behind his back to grab a strap and felt a popping sensation and pain in his right arm. (Report of Occupational Injury or Illness, April 7, 2010.)

2) On September 8, 2012, at Employer's request, Keith Holley, M.D., evaluated Employee. (EME Report, Dr. Trumble, December 12, 2012.)

3) On December 12, 2012, Thomas Trumble, M.D., performed an evaluation on Employer's behalf (EME). Dr. Trumble found the two surgeries Employee received for his work related right shoulder injury were reasonable, but no additional medical treatment was necessary and actually may be harmful to Employee's function and symptoms. He noted, "It is unfortunate that he has had to have two surgeries for this condition, which again is somewhat unusual for an individual without a severe full thickness and retracted rotator cuff tear." Employee was found medically stable. Dr. Trumble imposed no restrictions "given the excellent quality of the surgery that was performed." (EME Report, Dr. Trumble, December 12, 2012.)

4) On December 2, 2012, Employee returned to work. (ICERS, Injuries Screen, Accident Site Information.)

5) Employee required three surgical procedures on his right shoulder due to his work injury, the last being a right shoulder arthroscopy with mini open biceps tenodesis on April 4, 2013. The third procedure was performed after Employee treated with an extensive course of nonsurgical interventions, including multiple courses of physical therapy and a corticosteroid injection in his bicipital sheath. All treatments were provided to address Employee's chronic right shoulder pain and limited strength and mobility. (Operative Note, Henry Krull, M.D., April 4, 2013.)

6) On July 17, 2013, Employer controverted temporary total disability benefits, permanent partial impairment benefits greater than three percent, and medical benefits based upon Dr. Trumble's December 15, 2012 opinion Employee's April 7, 2010 injury is not the substantial

cause of Employee's ongoing disability or need for medical treatment. (Controversion Notice, July 17, 2013.)

7) On August 6, 2013, Jason Doppelt, M.D., evaluated Employee's right shoulder. He was aware Employee had extensive problems with his right shoulder and had undergone three surgical procedures. The first was a superior labral repair, which failed. In 2012, the second surgery was revision of the superior labral repair. Employee's most recent surgery was in 2013, which was a mini open biceps tenodesis. Employee reported "persistent pain since his last surgery in April of 2013." Dr. Doppelt found Employee's right shoulder's range of motion severely compromised. Radiographs of Employee's shoulder showed a "lucency in the proximal humerus likely consistent with placement of interference screw for biceps tenodesis in the intertubercular groove." There was no degenerative change in the glenohumeral joint, but there was evidence of prior partial distal clavicle excision with some remaining bone, with the most superiorly along the joint. Dr. Doppelt diagnosed right shoulder stiffness and pain, status post biceps tenodesis. The main pain generator was determined to be Employee's shoulder stiffness, for which Dr. Doppelt ordered Employee to work on range of motion for two months with physical therapy. If physical therapy did not work, Dr. Doppelt would consider injections or surgery. Because Employee had three previous surgeries, Dr. Doppelt stated there is a chance additional surgery is not in Employee's best interest and Employee may not have pathology that can be corrected with surgery. Therefore, non-operative pain management was the recommended course of treatment. (Chart Note, Dr. Doppelt, August 7, 2013.)

8) On October 8, 2013, Employee's range of motion had improved a small degree; although his pain had not. Dr. Doppelt did not advocate injections because in the past Employee received no more than three days' relief. The treatment options discussed were physical therapy and injections, neither of which resolved Employee's pain, and revision surgery. Employee was going to think about his options and "get back" to Dr. Doppelt. (Chart Note, Dr. Doppelt, October 11, 2013.)

9) On November 26, 2013, Employee continued to have persistent pain in his right shoulder, and was interested in an injection. Dr. Doppelt was not certain an injection would be beneficial if Employee's pain was generated at his tenodesis site. If Employee did poorly in the future, the next step would be open exploration of his biceps tenodesis site with debridement and biceps tendon release. (Chart Note, Dr. Doppelt, November 29, 2013.)

10) Employee had physical therapy from February 20, 2014 to April 24, 2015. (Northern Michigan Physical Therapy Daily Notes / Billing Sheets, David Columb, DPT, OCS, MT (ASCP), February 20, 2014 through April 24, 2015.)

11) On May 7, 2014, Employer controverted medical treatment, including physical therapy services. Employer relied upon Dr. Trumble's December 15, 2012 opinion work is not the substantial cause of Employee's current condition or need for medical treatment. (Controversion Notice, May 5, 2014.)

12) On January 20, 2015, considering Employee's multiple previous surgeries and cardiac condition, Dr. Doppelt recommended continued non-operative management for Employee's right shoulder pain. Employee was "interested in another round of physical therapy" and finding it a reasonable option, Dr. Doppelt ordered continued physical therapy. (Chart Note, Dr. Doppelt, January 21, 2015.)

13) On January 22, 2015, during physical therapy, Employee complained of continuing shoulder pain, which increased with activity. Employee noted improved mobility and overall function continued to progress. Physical Therapist Columb noted Employee tolerated treatment "fairly well with decreased frequency and intensity of exacerbations;" however, despite Employee's persistent pain and limitations, he continued to progress with improved mobility, increase strength and function, and improved quality of life. Employee's problems, which physical therapy intended to address, included pain, tenderness, and increased muscle tension; decreased glenohumeral joint mobility and range of motion; decreased strength and stability of the shoulder girdle; and difficulty with activities of daily living including bathing, grooming, dressing, sleeping and lifting. The treatment plan provided for therapy one to two times a week for 12 to 16 months and included therapeutic exercises for range of motion, strength, endurance, and stability; therapeutic activities specific to activities of daily living; neuromuscular rehabilitation to reeducate muscles and improve coordination; manual therapy; iontophoresis; and patient education to teach a home exercise program and postural training. (Physical Therapy Recertification Note, Columb, January 22, 2015.)

14) On February 5, 2015, Employee filed a claim for medical treatment recommended by Dr. Doppelt, medical costs, transportation costs, and attorney fees and costs. He also filed a petition for an SIME. (Workers' Compensation Claim, February 5, 2015; Petition for SIME, February 5, 2015.)

15) On April 2, 2015, therapist Columb opined continued physical therapy is reasonable and necessary for Employee's recovery. Employee's treatment plan included right shoulder strengthening and stabilization, joint mobility and range of motion to improve function with activities of daily living to include modalities as needed for symptom management. Treatment would be one time per week, up to six months, and it is unreasonable to limit Employee's treatment to one visit per month. Mr. Columb indicated the physical therapy Employee had received improved and was likely to continue to improve his condition. (Responses to Mr. Croft's Questions, David Columb, April 2, 2015.)

16) On May 5, 2015, Dr. Doppelt concurred with physical therapist Columb's opinions that physical therapy once a week for up to six months is reasonable and likely to improve Employee's condition, and agreed it is unreasonable to limit Employee's physical therapy to one visit per month. (Responses to Mr. Croft's Questions, Dr. Doppelt, May 5, 2015.)

17) On April 6, 2015, at Employer's request, Amit Sahasrabudhe, M.D., evaluated Employee (EME). Dr. Sahasrabudhe noted Employee has had three separate surgeries to the right shoulder and none have helped in any significant manner. Employee complained of pain in the same location he did when injured in 2010, the anterior aspect of the right shoulder. Dr. Sahasrabudhe reported, "therapy is helping with his pain, as well as helping him sleep." Dr. Sahasrabudhe described Employee's current symptoms to include Employee cannot lift his right arm above shoulder level and has aching pain in the right shoulder.

> He states that he has no difficulty carrying a shopping bag or briefcase, using a knife to cut food, or doing social activities. He has mild difficulty with work/activities of daily living. He has moderate difficulty opening a tight or new jar, washing his back, and sleeping because of his shoulder pain. He has severe difficulty doing recreational activities. He is unable to do heavy household chores. He states he is unable to do his job as an offshore oil platform operator. He has no difficulty playing a guitar. He notes that his pain level is decreasing but made worse by pushing, pulling, and lifting. On average, his pain is a 3.5/10, at its best 2/10, and at its worst 7/10.

Dr. Sahasrabudhe chronicled Employee's medical history acknowledging he sustained a work-related injury on April 7, 2010, and, as a result, was diagnosed about one year later with a SLAP tear and has undergone three separate surgeries; the first, a SLAP repair; the second, a revision SLAP repair along with a subacromial decompression and distal clavicle resection; and, the third, a mini-open biceps tenodesis. Employee reported none of the surgeries helped him and he

continues to experience anterior right shoulder pain and limited function, including range of motion. Dr. Sahasrabudhe noted a discrepancy between Employee's range-of-motion ability described in physical therapy progress notes, and exhibited upon Dr. Sahasrabudhe examination. Dr. Sahasrabudhe found Employee's persistent symptoms could have been predicted considering the following:

> The orthopedic literature does not support SLAP repairs in individuals generally over the age of 40. It could have therefore been predicted by Mr. O'Connell's age alone that a SLAP repair, let alone a revision SLAP repair, would not have been successful.
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> Furthermore, Mr. O'Connell has a history of chronic tobacco use, which increases the likelihood of soft tissue not healing. In other words, it again could have been predicted that a SLAP repair would have failed not once but twice in Mr. O'Connell because of his history of smoking. Nonetheless, he somehow underwent two separate work related SLAP repairs. Thereafter, Dr. Trumble indicated, during the Independent Medical Examination of December 15, 2012, that the mechanism of injury of a single reaching activity would not be expected to cause the constellation of symptoms that Mr. O'Connell presented with. He further indicates that it is unfortunate that Mr. O'Connell has had to have two surgeries for a condition, which is somewhat unusual for an individual without a severe full thickness and retracted rotator cuff tear. Additional surgery would be noted to cause further disability and would be unlikely to improve Mr. O'Connell's symptoms and function, which clearly appears to be the case. No further surgical intervention is being recommended at this time for Mr. O'Connell. Physical therapy is being recommended by Dr. Doppelt.

Dr. Sahasrabudhe concluded Employee's right shoulder complaints are related to subjective pain and inability to do overhead activities, which outweigh objective findings on physical examination. Despite Employee's three separate right shoulder surgeries, Dr. Sahasrabudhe found no evidence of right upper extremity or shoulder girdle muscle atrophy when compared to Employee's left side. Additionally, Dr. Sahasrabudhe found normal symmetric biceps contour. He found no significant objective abnormal finding on physical examination that correlates with Employee's subjective complaints. Dr. Sahasrabudhe identified the following causes of Employee's right shoulder pain: (1) age and degenerative joint disease; (2) April 7, 2010 work-related incident; and (3) history of smoking. Dr. Sahasrabudhe opined the most likely substantial cause of Employee's right shoulder symptoms are Employee's age, degenerative changes, and history of smoking. Dr. Sahasrabudhe noted "smokers tend to have poorer pain patterns

compared to the non-smoking population." Dr. Sahasrabudhe opined the treatment Employee "has received to date was not necessarily completely reasonable or necessary." Dr. Sahasrabudhe rationalizes his opinion based upon orthopedic literature, which does not support SLAP repairs in individuals over 40 years old, and finds no further treatment for Employee's right shoulder reasonable or necessary. Dr. Sahasrabudhe stated:

> None of the three surgeries have helped him in any way. It would be difficult to conclude that going to physical therapy now, five years after the original injury, status post three surgeries, status post multiple physical therapy sessions after each surgery, would in some way benefit Mr. O'Connell today. He has had ample opportunity during multiple courses of physical therapy over the past five years to learn a home exercise program, which he can maintain on his own. There is no orthopedic indication for further active treatment regarding Mr. O'Connell's right shoulder/work related incident of April 7, 2010.
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> In my opinion, to a reasonable degree of medical probability, there are alternatives available for ongoing treatment recommendations. Specifically, I recommend a self-directed home exercise program. (EME Report, Dr. Sahasrabudhe, April 6, 2015.)

18) On April 28, 2015, Dr. Doppelt responded to Employer's April 22, 2015 inquiry. Dr. Doppelt reviewed Dr. Sahasrabudhe's April 6, 2015 EME report, and agreed with some of the findings. He agreed no additional intervention is presently needed and an unsupervised home physical therapy regimen is a reasonable next step. He stated, "unfortunately," no additional orthopedic interventions especially from surgical standpoint will be beneficial. Dr. Doppelt disagreed with Dr. Sahasrabudhe's opinion the initial round of surgery was unnecessary and a failure. Dr. Doppelt acknowledged success rates are decreased in the over 40 population; however, if tissue quality allows, repair is indicated. He did not think surgery was absolutely contraindicated in the over 40 population. Had Dr. Doppelt been Employee's treating physician, the second surgery would have been a biceps tenodesis after the failed SLAP repair. Dr. Doppelt found Employee has done poorly. (Response to Mr. McLaughlin's April 22, 2015 Note, Dr. Doppelt, April 28, 2015.)

19) On May 19, 2015, Employee withdrew his petition for an SIME and reserved his right to request an SIME at any time in the future pursuant to AS 23.30.095(k). (Withdrawal of Petition for SIME, May 19, 2015.)

20) On August 21, 2015, the parties filed a stipulation. They agreed and stipulated as follows:

> 1. A dispute regarding the compensability of physical therapy treatment exists between the employee's attending physician and the employer's IME physician.
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> 2. The dispute referenced above, concerns the compensability of ongoing physical therapy treatment under AS 23.30.095.
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> 3. The employee's claim for additional medical treatment is set for hearing on September 29, 2015. The parties recognize that should a second IME be scheduled, the hearing in late September will be postponed pending conclusion of the SIME process.
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> 4. The parties recognize that a dispute exists that might trigger a Board ordered SIME under AS 23.30.095(k). The dispute notwithstanding, the parties request that a second IME not be ordered so that this matter can proceed to hearing on the compensability issues set forth above.
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> 5. The parties knowingly waive their right to have a second IME under AS 23.30.095(k), regarding the disputed physical therapy services. (Stipulation, July 21, 2015.)

21) On August 19, 2015, Robert McLaughlin asserted he believed Employer's change of EME physician from Dr. Holley to Dr. Trumble was based on a referral. Eric Croft, on behalf of Employee, stated even if Employer's change of physician from Dr. Trumble to Dr. Sahasrabudhe is an excessive change of physician, Employee waives any objection he may have to an excessive change of physician and Dr. Sahasrabudhe's April 6, 2015 EME report can be considered and Employee will not request the report be excluded from the record. (Record.)

PRINCIPLES OF LAW

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

> (2) workers' compensation cases shall be decided on their merits. . . .
> . . . .
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> (4) hearings . . . shall be impartial and fair to all parties . . . and all parties shall be afforded due process and an opportunity to be heard and for their arguments and evidence to be fairly considered.

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

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 23.30.010. Coverage.** (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee 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 death 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 death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or 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 death or 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 death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.

Effective November 7, 2005, the legal "causation" definition changed to narrow the Act's coverage. For injuries occurring on or after November 7, 2005, the board must evaluate the relative contribution of all causes of disability and need for medical treatment and will award benefits if employment is, in relation to all other causes, "the substantial cause" of the disability

or need for medical treatment. *City of Seward v. Hanson*, AWCAC Decision No. 146 at 10 (January 21, 2011).

> **AS 23.30.095. Medical treatments, services, and examinations**. . . .
> . . . .
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> (k) In the event of a medical dispute regarding determinations of causation, medical stability, . . . functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's independent medical evaluation, the board may require that a second independent medical evaluation be conducted by a physician or physicians selected by the board from a list established and maintained by the board. The cost of an examination and medical report shall be paid by the employer. The report of an independent medical examiner shall be furnished to the board and to the parties within 14 days after the examination is concluded.
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> **AS 23.30.110. Procedure on claims**. . . .
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> (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 Alaska Workers' Compensation Appeals Commission (AWCAC) in *Bah v. Trident Seafoods Corp.*, AWCAC Decision No. 073 (February 27, 2008) addressed the board's authority to order an "SIME" under AS 23.30.095(k) and AS 23.30.110(g). With regard to §095(k), the AWCAC referred to its decision in *Smith v. Anchorage School District,* AWCAC Decision No. 050 (January 25, 2007), at 8:

> [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 AWCAC 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 would assist the board in resolving the dispute. *Bah* at 4.

The AWCAC further 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. (*Id.* at 5).

Under either §095(k) or §110(g), the AWCAC noted the purpose of ordering an SIME is to assist the board, and 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 v. Municipality of Anchorage (ATU), AWCB Decision No. 97-0165 at 3 (July 23, 1997). *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.

> **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 in 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. . . .

Considering the broad procedural discretion granted in AS 23.30.135(a), wide discretion exists under AS 23.30.095(k) and AS 23.30.110(g) to consider any evidence available when deciding whether to order an SIME or other medical evaluation to assist in investigating and deciding medical issues in contested claims, to best "protect the rights of the parties."

AS 23.30.155. Payment of compensation. . . .

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(h) The board may upon its own initiative at any time . . . where right to compensation is controverted, or where payments of compensation have been increased, reduced, terminated, changed, or suspended . . . 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.

8 AAC 45.082. Medical Treatment. . . .

. . . .

(f) If an injury occurs on or after July 1, 1988, and requires continuing and multiple treatments of a similar nature, the standards for payment for frequency of outpatient treatment for the injury will be as follows. Except as provided in (h) of this section, payment for a course of treatment for the injury may not exceed more than three treatments per week for the first month, two treatments per week for the second and third months, one treatment per week for the fourth and fifth months, and one treatment per month for the sixth through twelfth months. Upon request, and in accordance with AS 23.30.095(c), the board will, in its discretion, approve payment for more frequent treatments.

(g) The board will, in its discretion, require the employer to pay for treatments that exceed the frequency standards in (f) of this section only if the board finds that

(1) the written treatment plan was given to the employer and employee within 14 days after treatments began;

(2) the treatments improved or are likely to improve the employee's conditions; and

(3) a preponderance of the medical evidence supports a conclusion that the board's frequency standards are unreasonable considering the nature of the employee's injury.

8 AAC 45.090. Additional examination. . . .

. . . .

(b) Except as provided in (g) of this section, regardless of the date of an employee's injury, the board will require the employer to pay for the cost of an examination under AS 23.30.095(k), AS 23.30.110(g), or this section.

Such examinations 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).

ANALYSIS

Should an SIME be ordered before deciding this matter on its merits?

Employee seeks medical benefits for his right shoulder, injured while working for Employer in 2010. The parties agree a medical dispute exists; however, they have requested an SIME not be ordered so their dispute can proceed to hearing on compensability of past medical treatment and continuing, future physical therapy. Acknowledging the panel's authority to order an SIME if a significant medical dispute exists and would assist in resolving the parties' dispute, the parties requested the hearing to proceed. Prior to a hearing on the merits to determine if past medical treatment was reasonable and necessary, if continued physical therapy is reasonable and necessary and, if so, is it unreasonable to limit physical therapy treatment to the permissible treatment under the frequency standards, the parties request it be determined if an SIME will be ordered.

Employee experiences persistent shoulder pain due to shoulder stiffness. Dr. Doppelt ordered non-operative management and continued physical therapy. Physical therapist Columb developed a treatment plan on January 22, 2015, which called for physical therapy one to two times per week for 12 to 16 months. In addition to many other therapy modalities, the plan included patient education to teach Employee a home exercise program and postural training.

Dr. Sahasrabudhe, Employer's medical evaluator, identified three causes for Employee's right shoulder pain: age and degenerative joint disease; April 7, 2010 work incident; and Employee's smoking history. Of these three causes, he opined "the most likely" substantial cause of Employee's right shoulder symptoms are Employee's age, degenerative changes, and history of smoking. However, Dr. Sahasrabudhe opined Employee needed no further physical therapy except, perhaps, a self-directed home exercise program. Dr. Sahasrabudhe felt Employee had ample time and opportunity during multiple courses of physical therapy since 2010 to learn a home exercise program Employee could maintain on his own.

Employee's treating physician Dr. Doppelt ordered several rounds of physical therapy, the last being on January 20, 2015, after Employee expressed interest in undergoing additional physical therapy. On April 2, 2015, Dr. Doppelt stated treatment has improved Employee's condition, is likely to continue to improve it, and it is unreasonable to limit treatment to one visit per month. On April 29, 2015, Dr. Doppelt did, however, agree with Dr. Sahasrabudhe that no additional medical intervention is presently needed and an unsupervised home physical therapy program is a reasonable next step for Employee's treatment.

Employee's treating physician and the EME dispute the need for past physical therapy services provided by Employee pursuant to Dr. Doppelt's order. However, they do not dispute reasonable and necessary future treatment for Employee. Although Dr. Doppelt does not agree with all Dr. Sahasrabudhe's findings, he agrees an unsupervised home physical therapy regimen is reasonable and necessary medical treatment. Dr. Sahasrabudhe asserts Employee had ample opportunity during multiple courses of physical therapy over the past five years to learn a home exercise program, which he can maintain on his own. As of January 22, 2015, patient education to teach a home exercise program and postural training was a therapy modality included in Employee's treatment plan. Whether or not Employee has been sufficiently educated to carry through with a self-directed home exercise program is a factual finding to be determined at hearing. Although this is a gap in the medical evidence, it is not necessary to order an SIME to fill this evidence gap. (*Bah.*)

The record contains sufficient evidence to determine if past medical treatment provided and recommended by Dr. Doppelt was reasonable and necessary. There is not a medical dispute regarding continuing or future physical therapy, and therefore an SIME opinion will not assist in reaching a determination on the case's merits. (*Deal*; *Schmidt*; *Harvey.*) Accordingly, an SIME will not be ordered.

CONCLUSION OF LAW

An SIME should not be ordered before deciding this matter on its merits.

ORDER

1) An SIME will not be ordered under AS 23.30.095(k) or AS 23.30.110(g).
2) This matter will proceed to hearing on September 29, 2015.

Dated in Anchorage, Alaska on August 28, 2015.

ALASKA WORKERS' COMPENSATION BOARD

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Janel Wright, Designated Chair

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Donna Phillips, Member

PETITION FOR REVIEW

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

RECONSIDERATION

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

MODIFICATION

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

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Interlocutory Decision and Order in the matter of Thomas R. Oconnell, employee / claimant v. Chevron Corporation, employer; , insurer / defendants; Case No. 201014260; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on August 28, 2015.

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Pamela Murray, Office Assistant