ALASKA WORKERS' COMPENSATION BOARD

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

KEVIN L. SERFLING, Employee, Claimant, v. HAGEN BUILDERS, INC., Employer, and LIBERTY NORTHWEST INSURANCE CORPORATION, Insurer, Defendants.	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 200320725 AWCB Decision No. 15-0109 Filed with AWCB Fairbanks, Alaska on August 31, 2015

Kevin Serfling's (Employee) March 25, 2015 claim was heard on August 27, 2015, in Fairbanks, Alaska, a date selected on May 12, 2015. Attorney Eric Croft appeared and represented Employee. Attorney Rebecca Holdiman-Miller appeared and represented Hagen Builders, Inc., and its insurer (Employer). Employer wanted its July 20, 2015 petition and its August 12, 2015 amended petition requesting a second independent medical evaluation (SIME) heard before Employee's claim. Employee objected. The panel issued an oral order finding unusual and extenuating circumstances to consider the SIME issue, which had not been set for hearing. After arguments on the SIME petitions, the panel issued an oral order granting the petitions, ordering an SIME and continuing the merits hearing pending the SIME. This decision examines the oral orders and sets forth the SIME process and the parties' other stipulations. Employee was the only witness. The record closed at the hearing's conclusion on August 27, 2015.

ISSUE

As a preliminary matter, Employer contended a decision should be made on its pending SIME petitions before a decision is rendered on Employee's claim. Employer contended as a medical dispute exists between its employer's medical evaluation (EME) physician, and Employee's attending physician, an SIME should be ordered so the panel can consider the SIME physician's opinion before it decides Employee's claim on its merits.

Employee contended the parties agreed at a May 12, 2015 prehearing conference to set only his March 25, 2015 claim on for hearing on August 20, 2015. He contended his claim on its merits should not be delayed by Employer's belated SIME request. Employee contended the designee was correct at the August 24, 2015 prehearing conference to decline Employer's request to add the SIME petition on for hearing on August 27, 2015. An oral order at the August 27, 2015 hearing granted Employer's petitions and continued the hearing.

Were the oral orders adding the SIME issue at hearing, granting Employer's petitions for an SIME and continuing the hearing correct?

FINDINGS OF FACT

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

1) On September 22, 2003, at approximately 4:00 PM, Employee was standing on a plank between two ladders when the plank snapped in the middle and he fell while working as a carpenter for Employer. Employer stated it knew about the injury on September 22, 2003, as Chris Hagen, company president, was a witness. Employee reported "both wrists [were] broken" in the fall. (Report of Occupational Injury or Illness, September 23, 2003).

2) On November 11, 2004, Aaron Lautenschlager, OTR, reported Employee had successfully completed a work hardening program approximately one year post-injury. Employee demonstrated an ability to work safely at medium to heavy physical demands, *i.e.*, up to 75 pounds on an occasional basis, which met his job classification as a carpenter. Lautenschlager recorded Employee "had a short stent [sic] of right shoulder pain during work hardening program, which was resolved by the end of the program." (Lautenschlager report, November 11, 2004).

3) On October 14, 2008, Jimmy Tamai, M.D., saw Employee for right wrist and left elbow pain. Employee reported about two weeks earlier, he was turning the steering wheel on his car when he felt immediate pain in his left elbow. Employee had difficulty flexing or extending the elbow for several days but had since regained some motion. Dr. Tamai diagnosed a ruptured left distal bicipital tendon and a recurrent right "TFCC tear." (Tamai report, October 14, 2008).

4) On June 13, 2012, while attending physical therapy for his right shoulder, Employee told Lindsay Costello, PT, his left shoulder hurt while performing exercises. (Costello report, June 13, 2012).

5) On June 20, 2012, Employee told Edward Axman, PT, he continued to have left shoulder discomfort, especially during bilateral shoulder exercises. Therapist Axman recorded though Employee's right upper extremity was improving, he continued with left shoulder problems. Employee first complained of dropping a weight on April 24, 2012, when performing bilateral shoulder girdle strengthening. Therapist Axman reported Employee complained from his first therapy visit about left shoulder symptoms. Employee was scheduled for a left shoulder MRI scan and Axman would determine what to do about the left shoulder following the results. (Axman report, June 20, 2012).

6) On June 20, 2012, Employee saw Dr. Tamai, reporting he had "sustained injury" to his left shoulder while performing exercises at physical therapy. Employee said he reported this immediately to the therapist who included progress for the left shoulder in Employee's physical therapy records. The therapist told Employee to report this to Dr. Tamai. Dr. Tamai performed a physical examination and diagnosed an acute, left shoulder rotator cuff injury. Dr. Tamai referred him for a magnetic resonance imaging (MRI) scan. (Tamai report, June 20, 2012).

7) On June 21, 2012, Employee had a left shoulder MRI without contrast. The radiologist did not find a full thickness tear, but found a variable grade partial thickness tear in the left rotator cuff. There was no fracture or dislocation, but Employee had a complex tear involving the glenoid labrum. The radiologist found bone marrow edema of the glenoid of uncertain etiology which may be related to bone contusion, degenerative changes, or both. (MRI report, June 21, 2012).

8) On July 5, 2012, Dr. Tamai reviewed the MRI results with Employee, and recommended surgical intervention to repair a full thickness rotator cuff tear and torn labrum. (Tamai report, July 5, 2012).

9) On August 28, 2012, Employee told therapist Axman he had been out of town since his prior visit and "he used both shoulders working on a project and believes he injured L shoulder further." (Axman report, August 28, 2012).

10) On January 14, 2013, Dr. Tamai reiterated his suggestion for Employee to have left shoulder surgery for a known rotator cuff tear. Employee said he would like to proceed. (Tamai report, January 14, 2013).

11) On or about March 20, 2013, Dr. Tamai responded to a questionnaire from Employee's lawyer's office. Dr. Tamai stated the work injury with Employer was a substantial factor in Employee's need for left shoulder surgery. Dr. Tamai said the injury Employee incurred during physical therapy was a significant factor in his resulting condition and need for treatment. He again recommended surgical repair. (Tamai questionnaire responses, March 20, 2013).

12) On or about April 23, 2013, Dr. Tamai responded to questions from Employer's attorney. Dr. Tamai stated Employee's left shoulder had an MRI-confirmed large rotator cuff tear. He provided CPT codes for his recommended surgery, but did not comment on what was "the most significant factor" in the need for surgery. Dr. Tamai estimated Employee would need physical therapy for three months post-surgery and would experience maximum recovery about six months post-surgery. Employee would be medically stable approximately eight months following left shoulder surgery. (Tamai questionnaire responses, April 23, 2013).

13) On May 9, 2013, Dr. Tamai diagnosed Employee with a left shoulder rotator cuff tear, long-term impingement, biceps tendon rupture, glenohumeral chondromalacia with chondral fracture involving a large surface of the glenoid, abundant synovitis and labral tear involving the anterior labrum and a Hill-Sachs lesion of the humeral head. On the same day, Dr. Tamai performed on Employee a left shoulder arthroscopically assisted debridement, open rotator cuff repair involving the supraspinatus and infraspinatus, open decompression acromioplasty and an open distal clavicle excision and Mumford procedure. Dr. Tamai recorded the history arising from a fall at work several years earlier, with progressively worsening symptoms thereafter. (Operative Report, May 9, 2013).

14) On May 13, 2013, Employee testified at deposition. He had taken Percocet off and on for 10 years following his work injury with Employer. Employee had also taken Lexapro for about eight years. Following his work injury with Employer, Employee attended training in Bremerton, Washington, to obtain certificates in fire damage restoration and structural drying.

However, as of this deposition, since the work injury with Employer, other than for on-the-job training in his reemployment program Employee had not returned to work for anyone. Employee recalled having had a shoulder injury while working for L&H in 1998, though Employee could not recall with whom be treated. Employee missed one week of work, had no surgery and made a complete recovery. Employee described his pre-injury health as "A-1, top notch, excellent." Describing his work injury, Employee said he hurt his hands and the back of his head when he fell and suffered a concussion. When asked if he had any shoulder pain immediately after he woke up, Employee said, "At that time all I could feel was my hands on fire." Employee said his hands were numb from the beginning of his injury. He also had short- and long-term memory loss immediately following his fall at work, but his short-term memory had returned. As for his right shoulder pain, Employee stated he had always had right shoulder pain and it began right after his hands and elbows were surgically repaired. Clarifying, Employee said he always had pain in his bilateral upper extremities since he fell on the job, but the pain was never to the point that he needed medical treatment until he had difficulty raising his arms. Employee also had anger issues since his head injury. Employee retrained in the small engine repair field for several months, and finished the program, but could not do the work because it was too repetitive, given his symptoms. His hands would go numb and he could not perform his job duties. Once Employee started his retraining work, everything began "going haywire" and he started noticing new symptoms he had not noticed before. Employee recalled telling his doctor in 2007 that his left elbow hurt after snow shoveling. Employee's doctor told him to try doing "little things" but not overdo it to test his limitations. Employee recalled getting into a fist fight, perhaps in May 2007, and having a chest injury. He did not injure his hands or shoulders noting he "got stomped on." Employee explained he always had symptoms in his right shoulder since his fall. While in physical therapy in April or May 2012 for his right shoulder, Employee was lying on his stomach lifting two pound weights and heard a "swishing" sound in his left shoulder and dropped the weight from his left hand. Employee had experienced left shoulder weakness and it was "kind of mushy" before that, and he could not lift heavy weights. But, on the particular day in physical therapy, Employee noticed the swishing sound and he could not pick anything up thereafter. Employee could not recall having any shoulder symptoms during his physical capacity evaluation several years earlier. In July 2011, Employee got into a "fist fight" with his neighbor, though all he did was kick the individual with his foot. Employee

suffered no shoulder injury, but did injure his knee and required knee surgery. A few months later, Employee had his first right shoulder MRI and subsequently had right shoulder surgery. Employee believes his shoulder symptoms were "masked" by his other symptoms and as one body part was fixed, he would notice another body part hurt. Employee did not have any new injury while working at Rod's Saw Shop during his reemployment training, but had difficulty removing spark plugs and using a chain hoist. (Employee deposition, May 13, 2013).

15) On May 14, 2013, Employer sent Employee to an EME with Steven Groman, M.D., orthopedic surgeon, and S. David Glass, M.D., psychiatrist. Employee's chief complaint was pain in both shoulders and in this left wrist. Employee expressed difficulty recalling pre-injury problems. Employee told Dr. Groman: He recalled a 1998 work injury where he injured his right shoulder while rolling up an air hose at a construction company. Employee recalled he had right shoulder pain for one to two weeks and no subsequent symptoms since then. On September 22, 2003, Employee was standing on a board suspended between two ladders when the board broke and he fell headfirst to the ground landing on both hands and striking his forehead. Someone told Employee he was unconscious for about eight or nine minutes. In the emergency room, Employee did not recall having any shoulder or elbow pain. Several days later, Employee had surgery to repair a left wrist scaphoid fracture. His right wrist was casted. The left wrist did not heal properly and Employee had revision surgery in April 2004. Contrary to Dr. Groman's review of Employee's medical records, Employee stated his hands had been numb from the time he fell. Several months later, a physician diagnosed bilateral carpal tunnel syndrome, and in January 2005, Employee had a left carpal tunnel release, followed by right carpal tunnel release in April 2005. Employee reported having left ulnar nerve surgery in 2006, followed by right ulnar nerve symptoms while retraining to do small engine mechanic work in 2007. He had right ulnar nerve surgery later in 2007. Employee recalled after his elbow surgeries his shoulders began to hurt. However, Employee received no shoulder treatment until 2012 when he started physical therapy. Employee recalled having his right carpal tunnel re-operated in 2009. His left wrist continued to hurt particularly while doing physical therapy for his shoulders. In November 2011, Employee said he saw a surge in right shoulder pain, and an MRI scan found a rotator cuff tear in the shoulder Employee just had repaired. While continuing physical therapy followed this surgery, Employee said he noticed left shoulder pain while doing therapy for his right shoulder. In 2012, a left shoulder MRI showed a rotator cuff tear. His physician scheduled left shoulder

surgery, but the insurance company denied payment. Nonetheless, Employee reported his surgeon proceeded with left shoulder rotator cuff repair on May 9, 2013. Employee reported having worked in "on-the-job training" since his work injury with Employer. Dr. Groman performed a physical examination and reviewed Employee's medical records and radiographic studies. Dr. Groman diagnosed: 1) left wrist scaphoid fracture secondary to the work injury, but medically stable following internal fixation in September 2003 and April 2004; 2) right wrist triquetral avulsion fracture and extensor carpi ulnaris tendon instability secondary to the work injury, medically stable following surgical stabilization in April 2005; 3) bilateral carpal tunnel syndrome unrelated to the work injury; 4) bilateral preexisting ulnar nerve subluxation with symptoms unrelated to the work injury; 5) remote right anterior shoulder dislocation with residual instability, unrelated to the work injury because Employee never mentioned it; 6) right shoulder rotator cuff tear, likely related to the episode causing the shoulder dislocation, and unrelated to the work injury; 7) left rotator cuff partial thickness tears, unrelated to the work injury; 8) early Dupuytren's right palm, idiopathic and unrelated to the work injury; and 9) early arthritis in the right glenohumeral joint unrelated to the work injury but possibly related to chronic right shoulder instability. Dr. Groman opined it was unlikely Employee developed carpal tunnel syndrome as a result of his fall at work because he had no numbness or tingling symptoms and had normal neurological examinations until January 2005. In Dr. Groman's view, Employee would have had symptoms within one year of his injury. He further opined Employee's May 2005 elbow symptoms were not work-related because there was no evidence his elbows sustained any injury in the fall sufficient to sublux the ulnar nerves. As for the 2008 recurrence of right wrist symptoms, Dr. Groman thought the etiology was "unclear" and may be related to a "history of altercations" arising out of "non-work events." In respect to Employee's right shoulder pain and weakness, Dr. Groman noted no medical record mentioned shoulder weakness before November 2011, and Employee mentioned shoulder pain only once since his injury, in 2004. Dr. Groman opined the right shoulder demonstrated early osteoarthritis, which, in his opinion, was due to multidirectional and chronic instability. The etiology for these abnormalities "is not fully explained." According to Dr. Groman, Employee has no recorded shoulder dislocation history and no shoulder instability was noted as far back as May 2005. Since Employee's May 2005 shoulder examinations were normal, "it is likely," in Dr. Groman's opinion, "some intervening trauma had resulted sometime after the work event of 09/22/03 to

account for the abnormalities noted on the MRI." To support this, Dr. Groman points to an episode where Employee was kicked and punched by four people and seen in an emergency room on May 23, 2007. He further notes a July 20, 2007 psychology note in which Employee revealed he had been in a bar fight in January 2007. Given these events, Dr. Groman opined this "history of altercations raises suspicions that his right shoulder condition, likely a dislocation, arose from some injury other than the work injury of 09/22/03." Dr. Groman noted Employee, on examination, had an unstable right shoulder. In summary, Dr. Groman opined had Employee injured his right shoulder in the September 22, 2003 fall, he would have had some symptoms and findings in his shoulder before 2011, and the 2005 right shoulder examination would not have been normal. Therefore, Dr. Groman concluded Employee's right shoulder instability is "a result of at least an additional unreported injury to the right shoulder, resulting in an anterior shoulder dislocation" causing the current medical findings and presumably the need for treatment, all unrelated to the work injury. As for the left shoulder, Dr. Groman found no evidence in the physical therapy records to support Employee's contention he hurt his left shoulder while performing physical therapy for his right shoulder. Dr. Groman opined the two to three pound weights Employee was using in therapy could not have caused the left shoulder injury. Given Employee had no left shoulder complaints before June 2012, in Dr. Groman's view the exact etiology is unknown, but imaging studies suggest "age-related, attritional change" unlikely due to the work injury. (Groman EME report, May 14, 2013).

16) On June 11, 2014, Employee underwent a right shoulder MRI with contrast, which the radiologist compared to prior studies. The radiologist diagnosed: 1) a high-grade, partial-thickness, delaminating interstitial tearing of the distal supraspinatus and infraspinatus tendons. He also suspected a small, full-thickness tear; 2) an interval increase in the degree of synovial hypertrophy, which may be related to an infection or inflammatory process; 3) an interval development of prominent bony erosions and chondromalacia of the humeral head and glenoid fossa probably related to the same process affecting the synovium, such as gout; 4) a complex labral tear; 5) a longitudinal split tear of the long head of the biceps tendon without complete rupture; and 6) borderline prominent axillary lymph nodes. (MRI report, June 11, 2014).

17) On June 23, 2014, Employee saw Dr. Tamai again and complained about recurring left wrist pain. Dr. Tamai reviewed the recent MRI results from the right shoulder. Dr. Tamai

referred Employee back to Dr. Trumble for his left wrist and suggested arthroscopic surgery for the right shoulder. (Tamai report, June, 23 2014).

18) On July 7, 2015, Employee had a right shoulder MRI with contrast, which the radiologist compared to prior studies. The radiologist diagnosed: 1) thinning, heterogeneity and areas of low to moderate grade partial-thickness tearing of the rotator cuff tendons without a full-thickness tear; 2) interval development of severe degenerative changes in the glenohumeral joint with new bony erosions involving the humeral head. Given the degree of interval change from previous studies, these findings were suspicious for an infectious or inflammatory process given the osseous erosions and prominent synovial hypertrophy that have developed in the interim; 3) new extensive degenerative tearing in the glenoid labrum; 5) [sic] full thickness tear of the long head of the biceps tendon; 6) [sic] probable subtle areas of ligamentous perforation involving the posterior aspect of the inferior glenohumeral ligament; and 7) [sic] post-surgical changes of the rotator cuff and acromioclavicular joint. (MRI report, July 7, 2015).

19) On February 10, 2015, Dr. Groman saw Employee for a follow-up EME. Dr. Groman reviewed his previous report and incorporated his previous medical record review and updated it. Dr. Groman also performed another physical examination and gave an opinion very similar to his previous EME report. (Groman report, February 10, 2015).

20) On or about March 17, 2015, Dr. Tamai responded to Employee's attorney's questionnaire. Dr. Tamai opined the September 22, 2003 work injury was a substantial factor in Employee's need for right and left shoulder surgery, bilateral carpal tunnel syndrome surgery, bilateral ulnar nerve surgery and a closed head injury with residual neurological defect. Dr. Tamai recommended left shoulder arthroscopic surgery. (Tamai questionnaire response, March 17, 2015).

21) On July 15, 2015, Dr. Tamai testified at deposition. Dr. Tamai agreed with Dr. Groman's opinion that Employee's wrists and elbows do not require interventional care at this time. As to the shoulders, Dr. Tamai suspects Employee will "very likely" need replacement arthroplasty in both shoulders. As to how Employee injured his shoulders when he fell on the job, Dr. Tamai said this falls into the category "of polytrauma." He gave an example of a person injured in an automobile accident and brought into the emergency room on a "sponge board." All the medical attention is directed to what appears to be the most serious injury. "You don't determine the full extent of all the injuries until the -- quote, the dust settles." Dr. Tamai opined that people with

head injuries such as Employee, often cannot adequately and accurately describe the mechanism of their injury or how they landed or what they struck on the ground. Dr. Tamai agreed Employee injured his left shoulder in physical therapy in May 2012. Regardless of the weight involved, Dr. Tamai stated something was going on in the shoulder prior to the incident that caused the damage when Employee was performing physical therapy. Dr. Tamai opined Employee may have directly injured his wrist causing carpal tunnel syndrome when he fell, but subsequent treatment he received to address his multiple conditions also contributed "significantly." Dr. Tamai disagreed with Dr. Groman about the elbow conditions. He did not think they were idiopathic conditions and noted Dr. Groman did not see the bruises and "ecchymosis and deformities" around Employee's upper forearms and elbows after he fell. Dr. Tamai was "not so certain" left shoulder arthroscopy was still required because the definitive treatment is shoulder replacement. He proposed another MRI to further illuminate the situation. (Tamai deposition, July 15, 2015).

22) On August 24, 2015, the parties attended a prehearing conference where Employer tried to add its SIME request as an issue for the August 27, 2015 hearing. The designee declined to add the SIME as an issue. (Prehearing Conference Summary, August 24, 2015).

23) At hearing on August 27, 2015, Employee said he had an appointment with his physician for a new left shoulder MRI. He said Dr. Tamai would review the MRI and decide the appropriate course to take. (Employee).

24) At hearing, Employer argued there were unusual and extenuating circumstances to justify the board considering its SIME petitions, even though these were not previously set for hearing at the controlling prehearing conference. (Employer's hearing arguments).

25) At hearing, Employee argued there was nothing unusual or extenuating about Employer's situation to merit the panel going beyond hearing the sole issue set for hearing in the controlling prehearing conference summary. Employee contended Employer had ample time to file its SIME petitions and its belated filings and failure to prosecute the petitions should not delay Employee's right to a hearing on his claim's merits, given his current, dire need for additional left shoulder surgery. (Employee's hearing arguments).

26) At hearing, the panel issued an oral order finding unusual and extenuating circumstances existed sufficient to justify considering Employer's SIME petitions before considering Employee's case on its merits. Most notably, the panel noted Dr. Tamai had originally

recommended left shoulder arthroscopic surgery for Employee, but in his more recent deposition, Dr. Tamai stated he no longer believed arthroscopic surgery was necessary as Employee might need a shoulder arthroplasty, in which case interim arthroscopic surgery would be pointless. Given this change, the panel determined arguments on whether or not an SIME should be ordered made sense, as it would be inefficient to go forward with a hearing on the merits only to find, shortly thereafter, that an SIME should have been ordered given existing medical disputes. The panel issued an order so stating and invited the parties to present arguments on the SIME petitions. (Record).

27) At hearing while offering arguments on the SIME petitions, both Employer and Employee agreed there was a medical dispute between EME Dr. Groman and attending physician Dr. Tamai at least as to causation of the need for treatment to Employee's bilateral shoulders. They further agreed the dispute was significant and that an SIME may well assist the board in resolving this case. However, Employee contended Employer's petitions were belatedly filed, and the merits hearing should not be delayed because Employer simply did not file its SIME petitions and pursue them more promptly. (Parties' hearing arguments).

28) At hearing, and after deliberation, the panel issued an oral order granting the SIME petitions. The panel found there was a medical dispute between EME Dr. Groman and attending physician Dr. Tamai. It further found the dispute significant because bilateral, total shoulder replacements were being recommended as a treatment possibility. The panel reasoned that if Employer was found liable for Employee's bilateral shoulders, it would be responsible to pay for at least one bilateral shoulder replacement and perhaps more, costing possibly hundreds of thousands of dollars in medical costs with attendant temporary disability and possible permanent impairment over Employee's lifetime. Further, the panel said, given Dr. Tamai's recent deposition, there was no actual recommendation currently pending for left or right shoulder treatment. Therefore the panel was unclear as to what "need for medical treatment" the panel could address at a merits hearing. Consequently, though the panel did not enter its order lightly, the panel issued an oral order granting Employer's SIME petitions and ordered an SIME. (Record).

29) To expedite the SIME, the parties stipulated at hearing as follows: Employer's attorney's office will prepare the SIME binders and send them to Employee's attorney along with the appropriate affidavit no later than September 9, 2015; Employee's attorney's office will review

the SIME binders and send them to the board, along with the appropriate affidavit no later than September 15, 2015; the parties agreed to an orthopedic surgeon to perform the SIME; they tentatively stipulated to Peter E. Diamond, M.D., or another orthopedic surgeon from Dr. Diamond's clinic also on the boards SIME list, pending Employer's final approval; the SIME physician will address causation of the need for treatment to Employee's shoulders and appropriate medical treatment for Employee's shoulders. (Parties' hearing stipulation).

30) At hearing, Employee also contended the SIME order should not affect Employee's pending claim for medical care unrelated to his shoulders. Specifically, Employee testified he had been refused "head injury medication," because his "prescription card" at the local pharmacy had repeatedly not been honored and he could not afford to pay $400 in advance and then seek reimbursement from Employer. "Head injury" medications at issue include Lexapro, Zyprexa and Tylenol III. After some discussion, the parties entered into another stipulation: Employer stipulated its insurer, Liberty Mutual, will pay for these medications and will ensure the "prescription card," or Employee's ability to otherwise obtain pharmaceutical preauthorization for the above three medications, works at Employee's pharmacy. Employer's attorney stipulated to immediately follow-up on this with her clients. Employer directed Employee to attempt to use his pharmaceutical privileges later on the hearing date, and if he was unsuccessful, to contact his attorney, who would contact Employer's attorney, who would resolve any remaining issue over the prescriptions immediately. Employer agreed to pay for these three medications without further difficulty. (Employee; Employer's hearing stipulations).

PRINCIPLES OF LAW

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

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

> **AS 23.30.005. Alaska Workers' Compensation Board**. . . .
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> (h) . . . Process and procedure under this chapter shall be as summary and simple as possible. . . .
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> **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 . . . degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's independent medical evaluation, the board may require that a second independent medical evaluation be conducted by a physician or physicians selected by the board from a list established and maintained by the board. The cost of an examination and medical report shall be paid by the employer. The report of an independent medical examiner shall be furnished to the board and to the parties within 14 days after the examination is concluded. . . .

The Alaska Workers' Compensation Appeals Commission (AWCAC) in *Bah v. Trident Seafoods Corp.*, AWCAC Decision No. 073 (February 27, 2008) addressed the board's authority to order an SIME under §095(k). The AWCAC said, referring to AS 23.30.095(k):

> [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*. Under §095(k), the AWCAC noted the purpose of an SIME is to assist the board. (*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?

> **AS 23.30.110. Procedure on claims.** (a) Subject to the provisions of AS 23.30.105, a claim for compensation may be filed with the board in

> accordance with its regulations at any time after the first seven days of disability . . . and the board may hear and determine all questions in respect to the claim. . . .

The language "all questions" is limited to questions raised by the parties or by the agency upon notice duly given to parties. *Simon v. Alaska Wood Products*, 633 P.2d 252, 256 (Alaska 1981).

> **8 AAC 45.050. Pleadings**. . . .
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> (f) **Stipulations.**
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> (2) Stipulations between the parties may be made at any time in writing before the close of the record, or may be made orally in the course of a hearing or a prehearing.
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> (3) Stipulations of fact or to procedures are binding upon the parties to the stipulation and have the effect of an order unless the board, for good cause, relieves a party from the terms of the stipulation. . . .
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> **8 AAC 45.065. Prehearings**. (a) After a claim or petition has been filed, a party may file a written request for a prehearing, and the board or designee will schedule a prehearing. . . . At the prehearing, the board or designee will exercise discretion in making determinations on
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> (1) identifying and simplifying the issues. . . .
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> (c) After a prehearing the board or designee will issue a summary of the actions taken at the prehearing, the amendments to the pleadings, and the agreements made by the parties or their representatives. The summary will limit the issues for hearing to those that are in dispute at the end of the prehearing. Unless modified, the summary governs the issues and the course of the hearing. . . .
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> **8 AAC 45.070. Hearings**. (a) Hearings will be held at the time and place fixed by notice served by the board. . . . A hearing may be adjourned, postponed, or continued from time to time and from place to place at the direction of the board or its designee, and in accordance with this chapter.
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> (g) Except when the board or its designee determines that unusual and extenuating circumstances exist, a prehearing summary, if a pre-hearing was conducted and, if applicable, governs the issues and the course of the hearing. . . .

> **8 AAC 45.074. Continuances and cancellations.** (a) A party may request the continuance or cancellation of a hearing by filing a
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> (1) petition with the board and serving a copy upon the opposing party. . . . . . .
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> (2) stipulation signed by all the parties requesting a continuance or cancellation together with evidence of good cause for the request.
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> (b) Continuances or cancellations are not favored by the board and will not be routinely granted. A hearing may be continued or cancelled only for good cause and in accordance with this section. For purposes of this subsection,
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> (1) good cause exists only when
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> (F) a second independent medical evaluation is required under AS 23.30.095(k). . . .

ANALYSIS

Were the oral orders adding the SIME issue at hearing, granting Employer's petitions for an SIME and continuing the hearing correct?

Employer filed two petitions requesting an SIME, claiming a medical dispute between its EME physician and Employee's attending doctor. AS 23.30.095(k). At hearing, Employer contended its SIME petitions should be heard before Employee's case is heard on its merits. Employer conceded if granted, its petitions necessarily would also require a hearing continuance. 8 AAC 45.074(b)(1)(F). Employee objected to this procedure and contended the designee was correct when, at the August 24, 2015 prehearing conference, he refused to add the SIME petitions as an issue for the August 27, 2015 hearing. Employee contended by statute, regulation and case law the hearing was limited to Employee's claim on its merits. AS 23.30.110(a); *Simon*; 8 AAC 45.065(c); 8 AAC 45.070(g).

Employer contended "timing" was an unusual extenuating circumstance in this case justifying adding the SIME petitions as an issue for the August 27, 2015 hearing. 8 AAC 45.070(g). Employer contended it was not delaying Employee's claim; it simply wanted an SIME because there was a significant medical dispute between EME Dr. Groman and attending physician Dr. Tamai, and because an SIME report would assist the factfinders in resolving the claim. Further,

Employer contended Dr. Tamai had originally recommended left shoulder arthroscopy, but over time and as of his deposition, no longer believed arthroscopic surgery was necessary and opined Employee might need a total shoulder arthroplasty. Employee contended these factors did not arise to unusual and extenuating circumstances to go beyond the prehearing conference summary issues set for hearing, without adequate notice. AS 23.30.110(a); *Simon*.

This case presents important, countervailing positions on both sides. Employee has the right to adequate notice of issues set for hearing. AS 23.30.110(a); *Simon*. The SIME petitions were not set for hearing. Employee is anxious to get recommended medical treatment, which in this case will require a decision and order addressing causation. He is entitled to have his claim decided and benefits delivered quickly, efficiently, fairly and predictably and to have a summary and simple hearing process. AS 23.30.001(1); AS 23.30.005(h). On the other hand, Employer has a right to at least request an SIME before Employee's case is heard on the merits to provide a quick, efficient, predictable outcome at a reasonable cost to Employer, to make procedures as summary and simple as possible and to avoid multiple hearings. (*Id.*).

Experience shows SIME issues are not difficult to derive from medical evidence or to argue at hearing. *Rogers & Babler*. Without oral argument on the SIME issue, the panel could not have known whether an SIME "is required," thus providing "good cause" to continue the hearing. 8 AAC 45.074(b)(1)(F). If the hearing had gone forward without hearing Employer's SIME petitions, Employer could have asked for another hearing on its SIME petitions, obtained one quickly, and may have convinced the panel to order an SIME even though a decisive opinion might have already been issued addressing Employee's claim on its merits. Such a procedure would have required Employer to file a hearing request on its pending petitions and to file one or more petitions for reconsideration or modification of an already issued a decision on the merits and may have required it to file an appeal. This practice would not have been quick or efficient or a reasonable cost to Employer, and would have been something other than summary and simple. AS 23.30.001(1); AS 23.30.005(h). Therefore, the oral order allowing the parties to argue Employer's SIME petitions was correct. AS 23.30.001(1).

Once the parties had cleared this procedural hurdle, they agreed there was a medical dispute between Employer's EME and Employee's attending physician about causation of Employee's need for medical care for his shoulders, and agreed the dispute was significant. The parties further agreed an SIME would probably assist the factfinders deciding this case though Employee maintained his contention that Employer's request was belated. Finding it agreed with the parties' *Bah* assessment, the panel issued an oral order granting Employer's SIME petitions. The SIME must be completed before Employee's case is heard on its merits. Therefore, the oral orders granting Employer's SIME petitions and continuing the hearing were correct. AS 23.30.001(1); AS 23.30.095(k); *Bah*; 8 AAC 45.074(b)(1)(F).

Once the panel had ordered the SIME, the parties stipulated as follows: Employer's attorney will provide SIME binders to Employee's lawyer with the necessary affidavit by no later than September 9, 2015. Employee's attorney will review the binders and file them along with the appropriate affidavit and any supplementary medical records by no later than September 15, 2015. The parties stipulated to an orthopedic surgeon from the approved SIME list to perform the SIME. They tentatively stipulated to Dr. Diamond if he is willing and available or another orthopedic surgeon in his clinic from the approved SIME list, pending Employer's final confirmation to use Dr. Diamond or his clinic from the insurer. The parties stipulated to the SIME physician addressing "causation" of Employee's need for bilateral shoulder treatment and "the amount and efficacy of the continuance of or necessity of treatment" for Employee's shoulders. It will be so ordered. AS 23.30.095(k); 8 AAC 45.050(f)(2), (3). The parties may add additional SIME or non-SIME issues before the SIME occurs, should they so stipulate.

At hearing Employee also contended the SIME should not defeat his present right to a hearing on his ongoing need for non-shoulder-related medical care. Specifically, Employee said he had been unable to obtain his "head injury" medications from his local pharmacy, as the "prescription card" the insurer provided was not adequate authorization. He could not afford to pay $400 for the medications each month, and then submit a receipt to the insurer for reimbursement. Rather than go forward with a hearing on this limited issue, Employer stipulated it would pay for Employee's Lexapro, Zyprexa and Tylenol III without further difficulty. Employer stipulated it would ensure the "prescription card" worked properly or, if an actual card

was not involved, Employee would nonetheless be able to obtain his pre-authorized "head injury" medications without further delay. Employer's attorney directed Employee to attempt to obtain the medications and if he was still unsuccessful, to contact his attorney, who would contact her, and she would resolve the issue immediately. It will be so ordered and the order will remain in effect unless and until Employer petitions for relief. 8 AAC 45.050(f)(2), (3).

CONCLUSION OF LAW

The oral orders adding the SIME issue, granting Employer's petitions for an SIME and continuing the hearing were correct.

ORDER

1) Employer's July 20, 2015 and August 12, 2015 petitions for an SIME are granted.
2) As stipulated to at hearing by the parties, an SIME with an orthopedic surgeon is ordered.
3) The parties may stipulate to any orthopedic surgeon on the approved SIME list, including Dr. Diamond or another physician his clinic on the approved SIME list.
4) If the parties do not stipulate to a specific orthopedic surgeon, the designee will select the next available orthopedic surgeon on the list in accordance with division policy and procedure.
5) As stipulated to at hearing by the parties, Employer's lawyer will provide the SIME binders to Employee's attorney, with the appropriate affidavit by no later than September 9, 2015. Employee's attorney will file the SIME binders along with filing and serving the appropriate affidavit and any supplemental medical records no later than September 15, 2015. All filing and service for the SIME will be done in accordance with the applicable administrative regulations.
6) The SIME physician will address "causation" of Employee's need for shoulder treatment and the "the amount and efficacy of the continuance of or necessity of treatment," for Employee's shoulders. The parties may agree to add additional SIME or non-SIME issues at their discretion before the SIME occurs.
7) As stipulated to at h9999999earing by Employer, Employer is ordered to pay for Employee's Lexapro, Zyprexa and Tylenol III by ensuring his "prescription card" or other preauthorization for these medications at Employee's local pharmacy is functioning and adequate for him to obtain the medications without first purchasing them himself. This order remains in effect unless and until Employer petitions for relief to controvert Employee's right to these medications.

Dated in Fairbanks, Alaska on August 31, 2015.

ALASKA WORKERS' COMPENSATION BOARD

/s/_____
William Soule, Designated Chair

/s/_____
Robert C. Weel, Member

Unavailable For Signature _____
Rick Traini, Member

PETITION FOR REVIEW

A party may seek review of an interlocutory of 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 Final Decision and Order in the matter of Kevin L. Serfling, employee / claimant v. Hagen Builders, Inc., employer; Liberty Northwest Insurance Corporation, insurer / defendants; Case No. 200320725; 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 August 31, 2015.

/s/_____
Jennifer Desrosiers, Office Assistant II