ALASKA WORKERS' COMPENSATION BOARD

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

MARK A. CHASE,	)	
	)	INTERLOCUTORY
Employee,	)	DECISION AND ORDER
Respondent,	)	
	)	AWCB Case No. 201112328
v.	)	
	)	AWCB Decision No. 16-0122
UNIVERSITY OF ALASKA,	)	
	)	Filed with AWCB Anchorage, Alaska
Self-Insured Employer,	)	on December 7, 2016
Petitioner.	)	
	)	

University of Alaska's (Employer) September 15, 2016 petition for a second independent medical evaluation (SIME) was heard in Anchorage, Alaska, on November 22, 2016, a date selected on September 15, 2016. Attorney Joseph Kalamarides appeared and represented Mark A. Chase (Employee). Attorney Colby Smith appeared and represented Employer. The record closed at the hearing's conclusion on November 22, 2016.

ISSUES

Employer contends significant medical disputes exist between Employee's attending physicians and Employer's medical experts (EME). Employer contends an SIME under either AS 23.30.095(k) or AS 23.30.110(g) will help resolve the disputes in Employee's workers' compensation claim for palliative care.

Employee contends there are sufficient opinions in the record to rely upon to resolve his claim for palliative care and the case is capable of being resolved without any SIME opinions.

Shall an SIME be ordered?

FINDINGS OF FACT

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

1) On August 9, 2011, while performing work as an industrial plumber for Employer, Employee lifted a pump assembly and injured his neck and back. (Report of Occupational Injury or Illness, August 11, 2011; Corrected Report of Occupational Injury or Illness, August 25, 2011.)

2) Employee treated with Lawrence Stinson, M.D., prior to the August 9, 2011 work injury. On August 11, 2011, Dr. Stinson, diagnosed right lower extremity radiculitis and exacerbated cervical, thoracic, and lumbar axial pain while placing a pump assembly at work. (Progress Note, Dr. Stinson, August 11, 2011.)

3) On August 15, 2011, a cervical magnetic resonance image (MRI) scan showed mild disc degeneration most pronounced at C3-4 with a small broad disc osteophyte complex and mild neural foraminal stenosis at C3-4, C4-5, and C5-6 bilaterally due to uncovertebral spurring and early facet arthropathy. A thoracic spine MRI scan was negative for acute findings and showed diffuse degenerative changes, but with no significant abnormalities. A lumbar spine MRI scan showed mild multilevel disc degeneration; small annular fissures at L3-4, L4-5, and L5-6; a small broad disc extrusion at L5-6 narrowing the left lateral recess and contributing to mild left neural foraminal stenosis; and six lumbar type vertebral bodies. Dr. Stinson diagnosed cervicalgia with cervical spondylosis and C3-4 disc displacement with central spinal canal stenosis; diffuse thoracic spondylosis; and lumbar degenerative disc disease with spondylosis. Employee was referred to neurosurgeon Louis Kralick, M.D. (Cervical, Thoracic MRI, and Lumbar MRI Reports, August 15, 2011; Progress Note, Dr. Stinson, August 15, 2011.)

4) On August 23, 2011, Dr. Kralick recommended a C3-4 anterior cervical discectomy and fusion because Employee was at significant risk for neurologic deterioration, especially if he were to sustain any type trauma or additional injury, given his severe central canal stenosis and spinal cord impingement from the C3-4 disc protrusion, which caused C4 radiculopathy. Dr. Kralick indicated work was the substantial cause of Employee's need for cervical discectomy and fusion. The recommended procedure was performed on September 14, 2011. (Outpatient Consultation Report, August 23, 2011, Dr. Kralick; Letter, Dr. Kralick, September 9, 2011; Operative Report, September 15, 2011, Dr. Kralick.)

5) On May 5, 2012, EME Keith Holley, M.D., related Employee's cervical and lumbar strains to the August 9, 2011 work injury. Dr. Holley diagnosed cervical spondylosis and degenerative

disc disease, most severe at C3-4 with corresponding cervical stenosis, pre-existing but permanently aggravated by the August 9, 2011 work injury. He related the C3-4 anterior cervical discectomy and fusion to the August 9, 2011 work injury and determined Employee's lumbar spondylosis and degenerative disc disease were pre-existing but temporarily aggravated by the August 9, 2011 work injury causing corresponding left lower extremity radiculitis. Dr. Holley opined the work injury was still the substantial cause of Employee's cervical and lumbar conditions. The work injury aggravated and combined with Employee's pre-existing condition and caused a permanent aggravation requiring cervical discectomy and fusion at C3-4. The work injury was also, in Dr. Holley's opinion, the substantial cause of Employee's need for medical treatment for his lumbar spine. Dr. Holley acknowledged nonsurgical treatment and epidural steroid injections failed to relieve the aggravation to Employee's lumbar spine and made Employee a candidate for discectomy and decompression to relieve his ongoing left lower extremity radicular symptoms. (EME Report, Dr. Holley, May 5, 2012.)

6) On June 26, 2012, Dr. Kralick performed a lumbar fusion at Employee's L4-5 level. (Operative Report, Dr. Kralick, June 26, 2012.)

7) On September 12, 2012, Dr. Kralick performed an L5-6 posterior laminectomy with spinal canal and nerve root decompression, and an interbody and lateral mass fusion with segmental instrumentation. (Operative Report, Dr. Kralick, September 12, 2012; Admission Report, Dr. Kralick, June 28, 2016.)

8) On February 19, 2013 Dr. Kralick noted Employee was making slow progress after his L4-5 lumbar fusion. Dr. Kralick thought it unlikely Employee would be able to return to his prior job activity level as a plumber and recommended a physical capacity evaluation to determine Employee's ability to return to work. Dr. Kralick supported continued physical therapy and a TENS unit trial. (Follow-Up Evaluation Report, Dr. Kralick, February 19, 2013.)

9) On April 13, 2013, Dr. Holley stated the work injury aggravated Employee's lumbar spine, which would have reached medical stability in early July 2012. However, he stated, "the underlying lumbar spine condition was thereafter irrevocably altered with the occurrence of surgery in September 2012." Dr. Holley opined there was no further medical treatment necessary for the "process of recovery" from Employee's work injury. He related ongoing treatment to Employee's pre-existing degenerative lumbar spine condition and subsequent lumbar fusion surgery. He did not believe a TENS unit, physical therapy, massage therapy, or

pool therapy was reasonable or necessary. He rated Employee's lumbar spine with a 12 percent permanent partial impairment and stated Employee should be retrained to a light or sedentary position. (EME Report, Dr. Holley, April 13, 2013.)

10) Employee continued to have back and leg pain complaints secondary to lumbar spondylosis with disc degeneration and canal and nerve root involvement at L4-5. On June 28, 2013, Dr. Kralick again performed an L4-5 laminectomy, decompression, interbody and lateral mass fusion. Employee's fusion was extended to include L5-6 segments and involved instrumentation from L4-6. Employee's lumbar spine has been fused at three levels. (Operative Report, Dr. Kralick, June 28, 2013; Discharge Summary, Dr. Kralick, June 30, 2016.)

11) On September 10, 2013, Dr. Kralick noted Employee continued physical therapy and was progressing with improved mobility and decreased pain complaints. Employee reported chiropractic adjustment and massage therapy helps calm things down in his neck and he had discontinued OxyContin and was only using Percocet occasionally during the day and sometimes at night as well as nighttime Valium. Employee continued to have low back pain and numbness in both legs. (Follow-up Evaluation Report, Dr. Kralick, September 10, 2013.)

12) On December 11, 2013, Dr. Kralick stated it was unlikely Employee would be able to return to his plumber position. (Follow-Up Evaluation Report, Dr. Kralick, December 11, 2013.)

13) On January 28, 2014, Dr. Kralick opined Employee's function level would make no further improvement and determined Employee was medically stable. He stated Employee could not be retrained, was permanently totally disabled, and may need additional cervical spine surgery and medical care. (Follow-up Evaluation Report, Dr. Kralick, January 28, 2014.)

14) On March 10, 2014, EME neurosurgeon Richard Polin, M.D., opined Employee's work injury was resolved after three months. Dr. Polin stated the work injury was not the substantial cause of Employee's need for either the cervical or lumbar spine surgeries or any further care three months after the injury. It was unclear to Dr. Polin whether the C3-4 surgery was indicated and, if it was, whether work was the substantial cause of the need for the C3-4 fusion. Dr. Polin opined work was not the substantial cause of Employee's need for treatment beyond a three-month period of appropriate conservative care and the substantial cause of any further treatment was Employee's underlying extensive and long-standing degenerative disease process. Dr. Polin opined Employee's post laminectomy syndrome, also known as failed back syndrome, of both the cervical and lumbar spine were unrelated to the August 9, 2011 work injury. Reasonable and

necessary treatment, according to Dr. Polin, was only to treat a cervical and lumbar strain conservatively for three months after the August 9, 2011 work injury. He stated, "Any further care outside of three-month period, therefore, any care outside of November 9, 2011, would be based upon the other issues, namely lumbar spondylosis, cervical spondylosis, post laminectomy syndrome of the cervical and lumbar spine as a consequence of those two conditions and functional overlay and would not be related to the initial work injury." Dr. Polin opined the following treatments were not reasonable or necessary: pain medications, including Lidoderm patches and Senokot; TENS unit; physical therapy; massage therapy; pool therapy; acupuncture; chiropractic treatment; nor a treadmill. Dr. Polin acknowledged:

> Unfortunately, the claimant had a poorly timed cervical spine surgery, which was likely not indicated and likely performed for cervical strain, rather than cervical disc herniation, and had the claimant been given an appropriate three-month time of conservative care, his cervical strain would have resolved and that surgery would have not been indicated. The cervical spine surgery unfortunately set up a chain of events of postlaminectomy syndrome resulting in persistent pain in both the cervical and lumbar spines.
> . . . .
>
> All further care would be palliative and continued physical therapy, pool therapy, massage therapy, TENS unit, acupuncture, chiropractic, and prescription medicines are palliative treatments designed to treat these underlying conditions of cervical and lumbar spondylosis and postlaminectomy syndrome related to what in my opinion were an unnecessary cervical and two unnecessary lumbar surgeries.

(EME Report, Dr. Polin, March 10, 2014.)

15) On March 18, 2014, Employee's prescription medications were Norco 5, 325 mg as needed, Lidoderm patches 1 to 2 times daily, diazepam daily, Neurontin 600 mg daily, Senokot 1 to 2 times daily as needed, and Percocet as needed. (Follow-up Evaluation Report, Dr. Kralick, March 18, 2014.)

16) On August 27, 2014, SIME neurosurgeon Bruce McCormack, M.D., found Employee's pre-existing lumbar degeneration aggravated by his August 9, 2011 work injury. Employee's cervical disc disease had not been symptomatic for years prior to the August 9, 2011 incident, which "caused the neck strain and probable nonspecific aggravation of degenerative changes with axial neck pain." Dr. McCormack stated:

> By virtue of the surgery done to treat the flare of pain after 8/9/11, a permanent change in the pre-existing condition. The timing and wisdom of a surgical program can be questioned and I am in agreement with much of what Dr. Polin said in his report 3/10/14, except on causation issues.
>
> I cannot rule out that the 8/9/11 incident caused only a temporary strain of his neck. His symptoms were nonspecific and could have been a muscle strain or temporary aggravation of spondylosis (age-related findings). Dr. Kralick's notes indicate a normal neurologic examination and symptoms of numbness and weakness was denied. A C4 radiculopathy was diagnosed, but I don't find much evidence for this and agree with Dr. Polin's opinions. Mr. Chase had immediate C3-4 fusion for what turned out to be a spur and stenosis at surgery which is age-related.
>
> His low back pain was getting worse prior to 8/9/11 and then got worse still in a delayed fashion in 2012 when he returned to his job tasks. Radicular symptoms indicate pain was discogenic and more than a strain. Three epidurals did not resolve his pain. However, he never had a documented disc herniation after the work injury and MRI only showed chronic degenerative change. We sometimes see patients' back pain get worse after trauma without an obvious structural lesion aside from chronic degenerative changes.

The relative contributions of different causes of Employee's disability and need for medical treatment for his neck and low-back were evaluated and Dr. McCormack apportioned 80 percent of Employee's disability and need for cervical medical treatment to the work injury and 20 percent to pre-existing degenerative changes. Seventy percent of Employee's disability and need for lumbar spine treatment was apportioned to the work injury and 30 percent to his pre-existing degenerative condition. Dr. McCormack noted indications for lumbar fusion were, at best, controversial, not of benefit, and vastly complicated Employee's future care. Dr. McCormack stated Employee had been over treated with three spine surgeries and greater than 200 physical therapy and chiropractic appointments. Pain medication and, perhaps, a functional restoration program were recommended to see if Employee's current condition could be improved so Employee could reenter the workforce. Dr. McCormack stated a psychological evaluation may also help. He did not believe more therapy or chiropractic would help Employee "recover." He stated, "It was excessive and there hasn't been any documented improvement beyond a day or so to justify more." Dr. McCormack stated medication use will relieve Employee's chronic debilitating pain. In responding to the question, "Will the treatment provide recovery from individual episodes of pain caused by a chronic condition?" Dr. McCormack responded, "His

future care has been complicated by the neck and back fusions. His condition has progressed past the point where chiropractic could make a meaningful difference." Dr. McCormack opined Employee's course of care, including multiple treatments, would not limit or reduce Employee's permanent impairment or enable Employee to return to work. Dr. McCormack stated Employee would benefit from treatment for chronic pain; however, he opined, TENS unit, further physical therapy, massage therapy, acupuncture, chiropractic treatment, and treadmills were not reasonable, necessary, or likely to relieve Employee's pain. He did endorse Employee's pain medication, the Lidoderm patches and Senokot, and a functional restoration program as reasonable and necessary treatment for Employee's injury. (SIME Report, Dr. McCormack, August 27, 2014.)

17) On December 10, 2014, Dr. McCormack testified Employee had over 100 physical therapy sessions and he saw no role for physical therapy prior to Employee being managed medically with medication and follow up with a pain doctor. At that point, physical therapy may be reasonable. Dr. McCormack noted Employee had "quite a number of invasive procedures" but found no evidence Employee had done particularly well with them. Dr. McCormack did not believe physical therapy or chiropractic care qualified as palliative care because he found no documentation it alleviated Employee's pain. However, he also stated, "I'm open to medical evidence. If he saw a chiropractor for three months and reduced his Norco prescription and all the other prescriptions, and you could say: well, look, this reduces pain burden. I'm open to that, but there is nothing been presented like that." (Deposition of Bruce McCormack, M.D., December 10, 2014.)

18) On March 25, 2015, Employee was evaluated after undergoing a cervical epidural steroid injection and specific physical therapy for his head and neck. Employee felt 25 percent better and the sharp burning pain in both his neck and down his arms had resolved. He was no longer experiencing severe headaches, but still had paresthetic sensation extending to his bilateral hands and fingers. Employee's medications prescribed by Dr. Stinson were:

Diazepam, 5 mg, 1 at bedtime
Gabapentin, 300 mg, twice per day
Hydrocodone-Acetaminophen 10-325 mg, three times per day as needed for pain
Lidoderm 5% Patch, applied to affected area 12 hours on, 12 hours off
Neurontin, 300 mg, once per day
Norco 5-325 mg, 2 tablets every 4 to 6 hours

Valium, 5 mg, 1 at bedtime

Dr. Stinson added Endocet, 10-325 mg, and directed Employee to take one every four to six hours for breakthrough pain while traveling, in addition to hydrocodone. (Chart Note, Dr. Stinson, March 25, 2015.)

19) On May 11, 2015, Employee's active problems were brachial neuritis, cervical spondylosis, lumbago, lumbosacral neuritis, lumbosacral spondylosis, non-allopathic cervical lesions, and lumbar postlaminectomy syndrome. Dr. Stinson noted Employee received benefit from a cervical epidural steroid injection. Employee's headache was gone and certain aspects of his cervicalgia had improved while others remained. Employee's grip was "a bit better." Employee requested a referral to massage therapy and asked for guidance regarding the EME opinion stating no further care was reasonable or necessary. Dr. Stinson stated:

> We discussed in detail that with his surgery and degenerative changes, he is going to require additional treatment from time to time to maintain function as well as controlling his symptoms to a tolerable level. This will include massage therapy, physical therapy, medications, and occasionally injection therapy on a lifelong basis. This is typical for patients with his type of postoperative, spinal conditions.

Medications Dr. Stinson prescribed were:

Diazepam, 5 mg, 1 at bedtime
Endocet, 10-325 mg, one every 4 to 6 hours for breakthrough pain while traveling in addition to hydrocodone
Gabapentin, 300 mg, twice per day
Lidoderm 5% Patch, applied to affected area 12 hours on, 12 hours off
Norco 5-325 mg, 2 tablets every 4 to 6 hours.
Valium, 5 mg, 1 at bedtime

Dr. Stinson did not refill Neurontin or hydrocodone with acetaminophen. (Chart Note, Dr. Stinson, May 11, 2015.)

20) On June 19, 2015, Employee filed a claim for medical costs incurred and continuing and transportation costs for denied medical treatment, and attorney fees and costs. (Workers' Compensation Claim, June 18, 2015.)

21) On July 13, 2015, Employee reported the opioid medication was no longer strong enough or lasting long enough to effectively relieve his symptoms. Employee had become "tolerant" of the medication, though he still had significant neck, upper extremity, low back, and lower extremity

pain. Dr. Stinson added Meloxicam, 7.5 mg, twice per day as needed for pain, and directed Employee to continue to take Gabapentin twice per day, added one to two Gabapentin at bedtime. Dr. Stinson discussed with Employee the multiple aspects of long-term opioid management and planned to taper Employee off hydrocodone and hoped to establish better pain control, sleep, and relief of Employee's radiculitis symptoms. Dr. Stinson gave Employee a prescription for massage therapy and active release, one time per week, for palliative care and chronic pain management. (Chart Note, Dr. Stinson, July 13, 2015.)

22) On July 13, 2015, and September 11, 2015, relying on Dr. McCormack's August 27, 2014 SIME report, Employer controverted physical therapy, pool therapy, massage therapy, TENS unit, acupuncture, and chiropractic treatment. (Controversion Notices, July 13, 2015 and September 11, 2015.)

23) On August 19, 2015, Dr. Stinson noted:

> Mark returns to the evaluation. He has tapered off of his hydrocodone. He did have to stop the Meloxicam due to an outbreak of a rash. After he discontinues the Meloxicam the widespread dermatologic lesions resolved within 3 days. He would like to go back on Naprelan which he has used in the past effectively for pain. He would also like to have a refill of his Lidoderm patches but brand-name only. The generic ones, "always come off". The brand name "sticks on for the whole time". He has been less active after tapering off the hydrocodone July 27 and with the discontinuation of the Meloxicam. He is hoping to increase his activities with the Naprelan and Lidoderm patches. He would also like to continue with other therapies such as massage and physical therapy.

Dr. Stinson discontinued hydrocodone and gave Employee prescriptions for Naprelan and Lidoderm patches. Dr. Stinson refilled Diazepam and directed Employee to continue physical therapy, "which does help his overall ability to function." (Chart Note, Dr. Stinson, August 19, 2015.)

24) On September 25, 2015, Employee filed a claim for permanent total disability (PTD) benefits from April 1, 2013 and continuing, a compensation rate adjustment, and attorney fees and costs. This claim has not been controverted. (Workers' Compensation Claim, September 18, 2015; Record.)

25) On October 15 2015, Employer served its October 14, 2015 answer to Employee's September 25, 2015 claim upon Employee. Employer's answer is not contained in the record. However, Employer asserted Employee's claim for PTD benefits is moot because Employer

continues to pay Employee PTD benefits. Employer denied Employee's claim for a compensation rate adjustment and attorney fees and costs. (Employee's Brief Exhibit 4: Answer, October 14, 2015.)

26) On March 28, 2016, Dr. Stinson assessed cervical spondylosis with bilateral upper extremity radiculitis that had been "progressive" for several weeks and was significantly inhibiting Employee's ability to function. Dr. Stinson stated, "Need to reinstitute physical therapy for his overall general functioning. He is demonstrating significant deterioration in his level of functioning since he was last seen." Dr. Stinson referred Employee to physical therapy "as it is necessary to intervene with his overall physical deterioration." Dr. Stinson believed physical therapy was needed to improve and maintain Employee's function. If Employee did not improve with a combination of injection therapy and physical therapy, Dr. Stinson planned to refer him to Dr. Kralick for evaluation and possible imaging. (Chart Note, Dr. Stinson, March 28, 2016.)

27) On June 20, 2016, Dr. Stinson summarized the recommendations he has made for Employee's ongoing postsurgical care.

> As a Pain Management physician I am qualified to prescribe the course of treatment that is typical for patients with Mr. Chase's postoperative, spinal conditions. As a stated in my 5/11/15 chart note, Mr. Chase will require additional treatment from time to time to maintain function as well as controlling his pain symptoms to a tolerable level. This will include massage therapy, physical therapy, medications and occasional injection therapy on a lifelong basis. Again, this is typical to manage pain for patients with this type of postoperative, spinal conditions.
>
> My assessment of 3/28/16 noted that Mr. Chase is 'demonstrating significant deterioration in his level of function since he was last seen' (8/9/15) and 'need to reinstitute physical therapy for his overall general functioning.' Mr. Chase stated that since Worker's Comp had controverted physical therapy (and other treatments that I have stated are typical and necessary) as a result of Dr. McCormack's August SIME he had not had any treatment since approximately May 2015.
>
> Neurosurgeons such as Dr. McCormack are not typically involved in long-tern post-operative care of patients. Long-term post-operative care is typically handled by a specialist in Pain Management such as myself. I have followed Mr. Chase's condition since his injury, therefore, I am the most qualified to prescribe what treatment is necessary to maintain his function and control his pain symptoms. A clear decline of functioning was observed when my prescribed treatment plan was not followed. When Mr. Chase resumed Physical Therapy in

> April 2016, management of his pain and decline of function improved, clearly demonstrating the importance of Physical Therapy as a part of his life-long medical care for his 8/9/11 injury.

(Memorandum, Dr. Stinson, June 20, 2016.)

28) After receiving physical therapy two to three times per week for eight weeks, Employee was "doing better" with a combination of physical therapy and a home traction unit, which helped decrease his cervicalgia and his upper extremity radiculitis symptoms. Although both were still present, it was to a lesser degree. Employee wanted refills of Gabapentin and Naprelan, as both had been helpful to control his symptoms. Employee also wanted to continue with physical therapy on an intermittent basis because it helped his symptoms and activity level. Employee's current medications were Gabapentin, Lidoderm patches, and Naprelan. Dr. Stinson stated physical therapy would be continued because it "clearly benefited" Employee and "controlling his symptoms makes it much less likely that additional surgical intervention may be necessary." Dr. Stinson noted physical therapy was a key modality to control Employee's symptoms and maintain function. (Chart Note, Dr. Stinson, June 20, 2016.)

ANALYSIS

Shall an SIME be ordered?

Hewing v. Peter Kiewit & Sons, 586 P.2d 182 (Alaska 1978), highlights the Alaska Workers' Compensation Act's intent to provide a simple and inexpensive remedy with speedy and informal procedures, later codified in AS 23.30.001, which provides:

> It is the intent of the legislature that
>
> 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. . . .

To meet this end, under AS 23.30.135(a), investigations or inquiries may be made in the manner by which the parties' rights may best be ascertained. AS 23.30.135(a). If necessary to protect the parties' rights, investigations, including medical examinations may be ordered. AS 23.20.155(h). An SIME may be ordered under AS 23.30.095 or AS 23.30.110(g), which provide:

AS 23.30.095. Medical treatments, services, and examinations.

. . . .

(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. . . .

. . . .

(o) Notwithstanding (a) of this section, an employer is not liable for palliative care after the date of medical stability unless the palliative care is reasonable and necessary (1) to enable the employee to continue in the employee's employment at the time of treatment, (2) to enable the employee to continue to participate in an approved reemployment plan, or (3) to relieve chronic debilitating pain. A claim for palliative care is not valid and enforceable unless it is accompanied by a certification of the attending physician that the palliative care meets the requirements of (c)-(n) of this section. If a claim for palliative care is controverted by the employer, the board may require an evaluation under (k) of this section regarding the disputed palliative care. A claim for palliative care may be heard by the board under AS 23.30.110.

AS 23.30.110. Procedure on claims.

. . . .

(g) An injured employee claiming or entitled to compensation shall submit to the physical examination by a duly qualified physician which the board may require. The place or places shall be reasonably convenient for the employee. The 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.

Considering the broad procedural discretion granted in AS 23.30.135(a) and AS 23.30.155(h), great latitude 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 to assist in investigating and deciding medical issues in contested claims, to best "protect the rights of the parties." *Hanson v. Municipality of Anchorage*, AWCB Decision No. 10-0175 at 18 (October 29, 2010).

The Alaska Workers' Compensation Appeals Commission (AWCAC) in *Bah v. Trident Seafoods Corp.,* AWCAC Decision No. 073 (February 27, 2008) addressed authority to order an SIME under AS 23.30.095(k) and AS 23.30.110(g). The AWCAC referred to its decision in *Smith v. Anchorage School District,* AWCAC Decision No. 050 (January 25, 2007), and 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 commission noted "the purpose of ordering an SIME under either AS 23.30.095(k) or AS 23.30.110(g) is to assist the board, not to give employees an additional medical opinion at the expense of the employer when they disagree with their own physicians." *Bah.* Under AS 23.30.110(g), panels have discretion to order an SIME when there is a significant gap in the medical evidence, or a lack of understanding of the medical or scientific evidence prevents the factfinders from ascertaining the parties' rights and an opinion would help the panel. *Id.*

When deciding whether to order an SIME, the following criteria are typically considered, 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 panel in resolving the disputes?

Id. "[T]he SIME physician is the board's expert," not either parties' expert. *Olafson v. State, Dep't of Trans. & Pub. Facilities,* AWCAC Decision No. 061, (October 25, 2007).

Employee and Employer agree there is a medical dispute between Employee's physician, Dr. Stinson, and Employer's EME physician, Dr. Polin regarding whether work is the substantial cause of Employee's need for palliative care. The issue, however, is whether palliative care is compensable under AS 23.30.095(o), and specifically, whether palliative care will relieve Employee's chronic debilitating pain. Employer petitioned for an SIME and contends an SIME will assist to resolve whether Employee is entitled to palliative care. Employee contends there

are enough medical opinions to resolve his claim for palliative care and the panel is capable of determining which opinion is entitled to the greatest weight, and an SIME is not necessary.

Drs. Polin and Stinson agree Employee has cervical and lumbar spine post laminectomy syndrome caused by the cervical and lumbar fusions. Despite all surgeries being found reasonable and necessary due to the work injury by Drs. Kralick and Holley, Dr. Polin does not attribute the post laminectomy syndrome to Employee's August 9, 2011 work injury because, in his opinion, conservative treatment for cervical and lumbar strains for three months after the work injury was the only reasonable and necessary treatment for the August 9, 2011 work injury. He stated, "Any further care outside of three-month period, therefore, any care outside of November 9, 2011, would be based upon the other issues, namely lumbar spondylosis, cervical spondylosis, post laminectomy syndrome of the cervical and lumbar spine as a consequence of those two conditions and functional overlay and would not be related to the initial work injury."

Dr. Polin's opinion disregards a uniform holding in workers' compensation cases that aggravation of a primary injury by medical or surgical treatment is compensable. A. Larson & L. Larson, *Larson's Workers' Compensation Law* §10.09 Aggravation by Treatment, at 10-22 (2008). Despite Dr. Polin's opinion Employee's work related injury required no more than three months conservative treatment, Employee's work injury had been treated with three surgical fusion procedures, resulting in post laminectomy syndrome. Dr. Polin stated physical therapy, pool therapy, massage therapy, a TENS unit, acupuncture, chiropractic treatment, and prescription medicines are palliative treatments designed to treat Employee's underlying cervical and lumbar spondylosis and postlaminectomy syndrome, related to what in his opinion "were an unnecessary cervical and two unnecessary lumbar surgeries." Because he attributed Employee's palliative care needs to the cervical and lumbar surgeries he found "unnecessary," Dr. Polin did not respond to Employer's request to provide an opinion regarding whether or not physical therapy, pool therapy, massage therapy, a TENS unit, acupuncture, chiropractic treatment, and prescription medicines were reasonable and necessary and met the criteria for palliative care to treat Employee's chronic debilitating pain. *Bah* noted an SIME's purpose is not to give employees an additional opinion when they are dissatisfied with their own physician's opinion. Presumably, *Bah*'s rationale is also applicable to employers' SIME requests. Dr. Polin's opinion

does not create a dispute with Dr. Stinson's opinion and does not serve as the basis for an SIME under AS 23.30.095(k).

Dr. Holley last evaluated Employee on April 13, 2013, and opined neither a TENS unit, physical therapy, massage therapy, nor pool therapy were reasonable or necessary treatments for the process of recovery. Dr. Holley related ongoing treatment to employee's pre-existing degenerative lumbar spine condition and subsequent lumbar fusion surgery. Dr. Holley has not offered an opinion regarding whether the palliative care recommended by Dr. Stinson is reasonable and necessary to relieve Employee's pain.

To treat Employee's pain, SIME physician Dr. McCormack recommended only pain medication, and "perhaps" a functional restoration program. He also thought a psychological evaluation may help. Dr. McCormack did not believe additional physical therapy or chiropractic would help Employee "recover" because the medical record did not reveal any improvement beyond a day or two after physical therapy or chiropractic treatment. Dr. McCormack affirmed Employee's future care has been complicated by his neck and back fusions, but stated his condition has progressed beyond where chiropractic care would make a "meaningful difference." The only treatment Dr. McCormack found reasonable and necessary to alleviate Employee's pain is prescription medication. In Dr. McCormack's opinion, neither physical therapy nor chiropractic care qualify as palliative care because there was no documentation either alleviated Employee's pain. However, if Employee saw a chiropractor for three months and reduced his prescription medications because chiropractic treatment reduced his pain burden, Dr. McCormack said he was "open" to considering chiropractic treatment as reasonable and necessary palliative care.

AS 23.30.095(k) conditions the right to an SIME upon a medical dispute between the Employee's and Employer's physician. A dispute between Dr. McCormack, an SIME physician, and Dr. Stinson does not meet the dispute condition to order an SIME under AS 23.30.095(k).

Employee received extensive treatment to relieve pain and maintain function. Dr. McCormack's deposition testimony states prescription medications are the only reasonable and necessary treatment. His opinion could change if Employee received three months of chiropractic

treatment and his pain burden was reduced, evidenced by a decrease in Employee's pain medications. To properly protect all parties' rights, further investigation is necessary. AS 23.30.155(h). Over two years have passed since the SIME with Dr. McCormack and two years have passed since his deposition. On May 11, 2015, Dr. Stinson discontinued Neurontin and hydrocodone with acetaminophen, but added Endocet. Employee's medications have changed and an opinion is necessary to determine if pain medications have decreased as a result of chiropractic or any other therapy modality. Employee has received chiropractic and other palliative care intermittently under his personal health insurance policy. A review of the palliative care he has received, whether it has been effective to relieve Employee's pain burden, and the effects upon Employee's pain burden when he is without palliative care will assist to determine if palliative care is reasonable and necessary to relieve chronic debilitating pain and to best ascertain all parties' rights. AS 23.30.135. An SIME ordered under AS 23.30.110(g) is necessary.

No physician is currently recommending any additional surgical treatment. Therefore, the appropriate SIME specialty is pain management. There are two physicians on the SIME list with a pain management specialty: Judy Silverman, M.D., and Marvin B. Zwerin, D.O. The parties can stipulate to one of these two physicians and if unable to reach agreement, the appropriate workers' compensation officer will select one of these physicians.

CONCLUSION OF LAW

An SIME will be ordered.

ORDER

1) Employer's September 15, 2016 petition for an SIME is granted.

2) An SIME will be performed by a pain management specialist. The parties may stipulate to either Dr. Zwerin or Dr. Silverman. If the parties are unable to stipulate, the appropriate workers' compensation officer will select either Dr. Zwerin or Dr. Silverman in accordance with the Act, regulations, and normal internal processes and procedures.

3) The SIME will be provided the following information and directed to answer the following questions:

1. "Chronic debilitating pain" is "pain that is of more than six months duration and that is of sufficient severity that it significantly restricts the patient's ability to perform activities of daily living."

    a. Does Employee have chronic debilitating pain?

    b. If so, what is the substantial cause of the need to treat Employee's chronic debilitating pain?

    c. Is there any way to measure a reduced pain burden and relief from chronic debilitating pain? If so, please describe.

2. If Employee has chronic debilitating pain, is palliative care reasonable and necessary to relieve his chronic debilitating pain?

3. Through the course of Employee's palliative care treatment, including physical therapy, chiropractic care, massage therapy, and pool therapy, was Employee's pain burden relieved? And, if so, please describe how it was relieved.

4. Through the course of Employee's palliative care treatment, if Employee's pain burden was relieved, was it evidenced by a decrease in his need for prescription pain medication?

4) Employer is directed to make two copies of all medical records since Employee was determined medically stable by Dr. Kralick on January 28, 2014, including Dr. Kralick's January 28, 2014 report and medical providers' depositions, regarding Employee in Employer's possession, put the copies in chronological order by date of treatment with the initial report on top and the most recent report at the end, number the copies consecutively, and put the copies in two separate binders.

5) Employer is directed to serve the two medical record binders upon Employee together with an affidavit verifying the binders contain copies of all medical reports relating to Employee in Employer's possession, no later than December 21, 2016.

6) Employee is directed to review the medical records to determine if the binders contain all of Employee's medical records in Employee's possession. Employee is directed to file the two binders within 10 days of receipt.

7) If the binders are incomplete, Employee must file the two binders together with two supplemental binders with copies of the medical records in Employee's possession that were missing from the binders and an affidavit verifying the binders contain copies of all medical records in Employee's possession, within 10 days of receipt.

8) Any party who receives additional medical records after the two binders have been prepared and filed is directed to make three copies of the additional medical records, put the copies in three separate binders in chronological order by date of treatment, and number the copies consecutively. Within seven days after receiving the medical records, the party must file two of the additional binders, and serve one of the additional binders on the opposing party, together with an affidavit stating the binder is identical to the binders that were filed.

9) The parties are encouraged to stipulate to SIME questions. Within 10 days after a party's filing of verification the binders are complete, if the parties can stipulate to questions, they may file up to six questions. If they cannot stipulate to questions, within 10 days after a party's filing of verification the binders are complete, each party may file and serve up to three questions for the SIME physician.

10) The appropriate workers' compensation officer will review, prepare and submit to the SIME physician questions in accordance with 8 AAC 45.092(h)(5).

11) If any party objects to any question submitted to the SIME physician, that party shall file and serve a petition within 10 days after receipt of the questions. The objection will be preserved in the record for consideration at a hearing on the claim's merits, or upon the petition of any party objecting to the questions, at the next available procedural hearing date. Failure by a party to file and serve an objection does not result in waiver of that party's right to later argue the questions were improper, inadequate, or otherwise ineffective.

Dated in Anchorage, Alaska on December 7, 2016.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Janel Wright, Designated Chair

/s/
Mark Talbert, Member

/s/
Ron Nalikak, 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 MARK A. CHASE, employee / respondent v. UNIVERSITY OF ALASKA, self-insured employer / petitioner; Case No. 201112328; 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 December 7, 2016.

/s/
Pamela Hardy, Office Assistant