ALASKA WORKERS' COMPENSATION BOARD

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

MICHAEL FAY, Employee, Claimant, v. COEUR D'ALENE MINE CORPORATION, Employer, and ZURICH AMERICAN INSURANCE COMPANY OF ILLINOIS, Insurer, Defendants.	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 201713548 AWCB Decision No. 18-0051 Filed with AWCB Juneau, Alaska on May 29, 2018

Coeur D'Alene Mine Corporation and Zurich American Insurance Company Of Illinois's (Employer) April 3, 2018, April 18, 2018, and April 20, 2018 petitions for a continuance and April 2, 2018 petition for a second independent medical evaluation (SIME) and Michael Fay's (Employee) January 19, 2018 claim were heard on May 1, 2018 in Juneau, Alaska. The hearing date was selected on March 22, 2018. Attorney Elliot Dennis appeared and represented Michael Fay (Employee), who appeared in person. Attorney Rebecca Holdiman Miller appeared and represented Employer. The record closed at the hearing's conclusion on May 1, 2018.

ISSUES

Employer contends there are disputes between Employee's treating physician and the employer medical examiner (EME) concerning causation, treatment, degree of impairment, functional capacity, and medical stability warranting an SIME. Employer contends an SIME would provide clarity as to whether fusion surgery is necessary for Employee's preexisting structural conditions or for a work-related lumbar strain. Employer seeks an order granting its petition for an SIME with an orthopedic surgeon or neurosurgeon.

Employee contends an SIME is not necessary as his case is not complex and an SIME is not going to provide any additional information. Employee seeks an order denying Employer's petition for an SIME. An oral order issued denying Employer's request for an SIME.

1) **Was the oral order denying Employer's petition for an SIME correct?**

Employer objects to this case being heard on its merits at this time. Employer contends an SIME is necessary. Employer contends there are outstanding discovery requests and it received additional medical records after the deadline for submission of evidence. Employer contends additional discovery is necessary to avoid prejudice and irreparable harm.

Employee contends an SIME is not necessary and there are adequate medical records to make a decision. Employee contends a continuance will harm him irreparably because he needs surgery which Employer denied. Employee would like to proceed on a hearing in his claim and proposed keeping the record open two weeks after a merits hearing to allow Employer to submit additional medical evidence received after the deadline for submission of evidence. An oral order issued granting Employer's request for a continuance.

2) **Was the oral order continuing the hearing correct?**

FINDINGS OF FACT

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

1) On September 10, 2011, Employee visited John C. Steinmann, D.O., and reported experiencing lower back pain for six months which was aggravated by lifting heavy objects. Employee denied any numbness or tingling and stated the pain was alleviated by medication and did not radiate into his leg. Dr. Steinmann noted "AP pelvis and 3 views" of Employee's lumbar

spine were taken in his office. He diagnosed grade I spondylolisthesis at L5-S1. They discussed pursuing an MRI scan in contemplation of surgery and Employee would notify Dr. Steinmann if he wanted the MRI. Employee's work status was listed as "regular duty." (Steinmann, Chart Note, September 10, 2011).

2) On April 20, 2013, Employee visited Dr. Steinmann and stated he injured his back on April 8, 2013 while working in his backyard. Employee reported frequent sharp pain in his low back aggravated by walking, standing, and lifting. Employee stated lying down alleviated the pain. Dr. Steinmann noted three "views" of Employee's lumbar spine were taken today in his office and they demonstrated "grade I spondylolisthesis at L4-5 and S-1, unchanged from 2011." He stated if Employee's pain remained unacceptable, he recommended an MRI and consideration of surgery. (Steinmann, April 20, 2013).

3) On February 15, 2017, Employee visited Pedro Perez, M.D., for a complete health workup. Employee experienced discomfort on the lumbosacral and sacroiliac joint and he informed Dr. Perez that was where he was told some of his vertebra were displaced forward. (Perez, Chart Note, February 15, 2017).

4) On February 16, 2017, an x-ray of Employee's lumbar spine revealed an L5-S1 grade I anterolisthesis with associated pars defects and focal degenerative change. (X-Ray Report, February 16, 2017).

5) On March 7, 2017, Employee visited Dr. Perez. Employee completed exercises Dr. Perez recommended for his lower back. Afterward, his lower back was good for the first day but then it was very uncomfortable. Dr. Perez requested an MRI of Employee's lumbosacral spine. (Perez, Chart Note, March 7, 2017).

6) On March 8, 2017, Employee visited Koob Chiropractic for his neck, shoulders, and low back. The remainder of the notes for this visit are illegibly hand written. (Koob Chiropractic Notes, March 8, 2017; Observations).

7) On May 11, 2017, Employee saw Dr. Perez. Employee's lumbar area and sacroiliac joint was uncomfortable. Dr. Perez noted Employee "has been presenting some occasional tingling" on both of his legs. (Perez, May 11, 2017).

8) On July 7, 2017, Employee visited Koob Chiropractic for his back. The remainder of the notes for this visit are illegibly hand written. (Koob Chiropractic Notes, July 8, 2017; Observations).

9) On September 18, 2017, Employee went to the emergency room for center low back pain radiating to his left buttocks and down to his left posterior knee and tingling on the left last three toes. Employee reported the back pain began yesterday when he was running a loader and hit pot holes because the loader's suspension was not working well. Employee stated he had similar "milder occasional pain" previously. James Sexton, PA-C diagnosed an acute lumbar strain and instructed Employee to apply ice and limit his lifting. He prescribed Employee Norco, ibuprofen and Flexeril. (James Sexton, PA-C, Emergency Room Medical Report, September 18, 2017).

10) On September 20, 2017, Employer filed an employer first report of occupational injury (FROI) stating Employee injured his lower back while running a load of rock down to port in a loader on September 18, 2017. (Employer FROI, September 20, 2017).

11) On September 27, 2017, Employee reported low back pain from an injury at work on September 18, 2017 to Dr. Perez. He complained of left leg neuropathy going down the back of his left leg. Dr. Perez diagnosed lumbosacral pain and left leg neuropathy. Dr. Perez recommended an MRI and prescribed Flexeril and Vicoprofen. He referred Employee to Arctic Spine in Anchorage and took Employee off work from September 27, 2017 through October 9, 2017. (Perez, Chart Note, September 27, 2017; Perez, Work Status and Referral Report, September 27, 2017).

12) On October 9, 2017, Employee visited Marius Maxwell, M.D., and reported he injured himself on September 17, 2017 while operating a loader. Employee stated the boom suspension on the loader had gone out and he experienced bad jarring while operating the loader for eight miles. Afterwards, Employee developed sudden onset of low back pain and left leg pain with numbness and weakness. His current pain was excruciating and constant and any movement exacerbated it. Dr. Maxwell opined Employee likely ruptured a lumbar disc herniation. (Maxwell, October 9, 2017).

13) On October 9, 2017, Employee saw Dr. Perez for persistent and chronic low back pain. Dr. Perez diagnosed acute and persistent low back pain, lumbar spine degenerative disease, discogenic disease, and neuropathy. He prescribed a lumbosacral support belt to help Employee's mobility and Vicoprofen for pain and inflammation. He took Employee off work for a month and referred him to Central Peninsula Spine Center. (Perez, Chart Note, October 9, 2017; Perez, Work Status and Referral Report, October 9, 2017).

14) On October 12, 2017, an MRI demonstrated a grade I spondylolisthesis and disc desiccation at L5-S1, posterolateral annular tear and subligamentous herniation extending into the left neural foramen. (MRI Report, October 12, 2017).

15) On October 12, 2017, an x-ray demonstrated mild anterior subluxation of L5 on S1, associated bilateral L5 pars defects, no significant translational instability between flexion and extension, mild disc space narrowing at L5-S1, and mild left lumbar scoliotic curve. (X-Ray Report, October 12, 2017).

16) On October 12, 2017, Employee saw Dr. Maxwell and reported excruciating and constant pain in his low back and tingling, numbness and weakness in the left leg. Any movement exacerbates his pain and 95 percent of Employee's pain is low back pain and 5 percent is left leg pain, numbness, and weakness. Dr. Maxwell opined there was a foraminal stenosis on the left with impingement of the exiting left L5 nerve, disc degeneration, a posterolateral annular tear, and a subligamentous disc herniation extending into the left neural foraminal. He recommended a left L5-S1 transforaminal epidural steroid injection and functional anesthetic discogram to alleviate Employee's symptoms and identify the pain generator. (Maxwell, Chart Note, October 12, 2017).

17) On October 13, 2017, Dr. Maxwell performed a left L5-S1 transforaminal epidural steroid injection and functional anesthetic discogram. He described the following procedure:

> Using a 3.5 inch 22-gauge needle I was able to access the disc with some difficulty. Negative aspiration was performed before all injections. An injection of 0.5 mL of Omnipaque 300 revealed a very degenerative disc matter within the anterolisthesis at L5-S1. This was followed by the injection of 0.6 mL of 1.25% Marcaine and Kenalog 40 mg mix. The needle was withdrawn to the foramen. Another injection of another 0.5 mL of Omnipaque 300 revealed the foraminal architecture and this was followed by another injection of 0.6 mL of 0.25% Marcaine and Kenalog 40 mg mix. (Maxwell, Operative Report, October 12, 2017).

18) On October 16, 2017, Employee informed Dr. Maxwell he initially had total relief of his lower back pain after the left L5-S1 transforaminal epidural steroid injection and functional anesthetic discogram but his pain returned that morning. Dr. Maxwell opined the block confirmed the pain generator as the L5-S1 spondylolisthesis and recommended an L5-S1 posterior lumbar interbody fusion. (Maxwell, Chart Note, October 16, 2017).

19) On October 20, 2017, Dr. Maxwell performed a left L4-5 transforaminal epidural steroid injection and functional anesthetic discogram. He described the following procedure:

> A 3.5-inch 22-gauge needle was advanced into the disc without difficulty. Negative aspiration preceded all injections. I then injected 0.3 mL of Omnipaque 300 which revealed a severed degenerated discogram pattern with intermittent fluoroscopy. This was followed by the injection of 0.5 L of 0.25% Marcaine and Kenalog 40 mg mix. The needle was withdrawn to the foramen. I then injected another 0.2 mL of Omnipaque 300 delineating the foraminal architecture and this was followed by another injection of 0.5 mL of 0.25% Marcaine and Kenalog 40 mg mix after negative aspiration. The need was withdrawn. (Maxwell, Operative Report, October 20, 2017).

20) On October 23, 2017, Jim Price, M.D., prescribed Employee a tens unit and a walking cane. (Price, Chart Note, October 23, 2017).

21) On November 7, 2017, Rebecca Byerley, PT, evaluated Employee upon referral by Dr. Price She treated Employee with electrical muscle stimulation and a cold pack for 20 minutes in the lumbar-sacral region. PT Byerley discussed using a can and, TENS unit and positioning during rest or sleep with pillows between his knees when lying on his side and provided Employee a cold pack for home use. (Byerley, Chart Note, November 7, 2017).

22) On November 8, 2017, PT Byerley treated Employee with electrical muscle stimulation and a cold pack for 20 minutes in the lumbar-sacral region. (Byerley, Chart Note, November 8, 2017).

23) On November 9, 2017, James R. Schwartz, M.D., an orthopedic surgeon, evaluated Employee for an EME. After reviewing the October 12, 2017 MRI, Dr. Schwartz stated he agreed with the radiologist that there are some subtle findings of a posterolateral annular tear but he did not see any extension into the left neural foramen of any significance. He diagnosed spondylolisthesis at L5 with listhesis at L5-S1 not substantially caused by the September 2017 work injury and lumbosacral strain substantially caused by the September 2017 work injury. He opined the substantial cause of the need for medical treatment is Employee's September 2017 injury and recommended conservative treatment, including physical therapy, lumbar epidural steroid blocks, and prescriptions for muscle relaxers and pain medication. However, the treatment for the September 2017 injury does not include surgery as Dr. Schwartz further opined, "the recommendation for surgery is on a structural basis only and that is a preexisting condition" and Employee has no clear-cut radiculopathy. He stated "at the present time, he may not return to work." Dr. Schwartz opined Employee was not medically stable, he had inadequate treatment,

and significant improvement was expected when adequately treated conservatively. He expected a permanent partial impairment (PPI) only if Employee is operated on but conservative treatment was expected to improve Employee to a point he would not have an impairment related to his injury. (Schwartz, EME Report, November 9, 2017).

24) On November 27, 2017, Employee visited Dr. Price and described stabbing pain as 6/10 with Percocet. Employee has increased constant sciatic pain, numbness below the left knee radiating from his hips, and numbness of his last three toes. He has an antalgic gait and used a cane and was unable to heel-toe walk. (Price, Chart Note, November 27, 2017).

25) On December 4, 2017, Mark Flanum, M.D., evaluated Employee's low back pain and left leg pain. After examining Employee and reviewing the October 12, 2017 x-rays and MRI, he diagnosed spondylolisthesis at L5-S1, lumbar radiculopathy, lumbosacral disc degeneration, spina bifida occulta at L5, and chronic back pain. Dr. Flanum recommended Employee participate in physical therapy for six to eight weeks in order to determine its efficacy before considering a L5-S1 posterior interbody fusion. (Flanum, Medical Report, December 4, 2017).

26) On December 4, 2017, Dr. Flanum wrote a letter to Dr. Perez thanking him for the referral for a second opinion. He recommended a course of physical therapy. Dr. Flanum said if Employee was unable to tolerate physical therapy or if it failed to ameliorate his pain, consideration of an L5-S1 posterior interbody fusion would be appropriate. (Flanum Letter, December 4, 2017).

27) On December 15, 2017, Employer controverted surgery for spondylolisthesis at L5 with listhesis at L5-S1 based on Dr. Schwartz's November 9, 2017 EME report. (Controversion Notice, December 15, 2017).

28) On January 4, 2018, Dr. Maxwell performed a left L5-S1 transforaminal epidural steroid injection and functional anesthetic discogram. He described the following procedure:

> Then using a 3.5-inch 22-gauge needle I was able to access the disc with not too much difficulty. Negative aspiration proceeded all injections. At that time the anesthesiologist told me that the patient was experiencing some respiratory difficulty and therefore the procedure was speeded up while the bed was brought into the room so that he could be rolled supine. I then quickly injected 0.4 mL of 0.25% bupivacaine Kenalog 40 mg mix. I rapidly withdrew the needle to the foramen. AP and lateral x-rays confirmed position in both places and I injected another 0.2 mL of 0.25% bupivacaine Kenalog 40 mg mix. The needle was withdrawn. A bandage was applied. The patient was rolled supine and Dr. Price

> took over the management for suspected aspiration with ventilator support. . . . (Maxwell, Operative Report, January 4, 2018).

29) On January 11, 2018, Employee went to the Central Peninsula Hospital for worsening chronic lower back pain and fevers starting in that morning. He was admitted for sepsis and started on intravenous fluids, clindamycin, and levofloxacin. After he underwent an MRI, Employee became hypotensive and somnolent. Employee eventually disclosed he took his home prescription medications prior to his blood pressure reading which demonstrated hypotension. Employee left the hospital after discussing locking up his prescription medications with medical personnel. Later, Employee returned and declined admission but was prescribed clindamycin to treat his aspiration pneumonia. (Joelle Rosser, M.D., Central Peninsula Hospital Chart Note, January 11, 2018).

30) On January 18, 2018, Dr. Maxwell opined Employee needs a left L5-S1 lumbar microdiscectomy as soon as possible because a delay would likely cause a long term and chronic radiculopathy. (Maxwell, Chart Note, January 18, 2018).

31) On January 19, 2018, Employee claimed medical costs, transportation costs, PPI, interest, unfair or frivolous controversion and attorney fees and costs. (Claim, January 19, 2018).

32) On February 9, 2018, in response to a letter from the rehabilitation specialist, Dr. Price opined Employee will not have the physical capacities to perform the physical demands for his job at the time of injury or other jobs he held within 10 years before the injury after reviewing the job descriptions and Employee will incur a PPI. (Price Response, February 9, 2018).

33) On February 15, 2018, Employee requested a hearing on his January 19, 2018 claim. (ARH, February 15, 2018).

34) On February 23, 2018, in response to a letter from the rehabilitation specialist, Dr. Price indicated his February 9, 2018 opinions are solely attributable to the September 2017 injury. (Price Response, February 23, 2018). Dr. Price also wrote a letter to the rehabilitation specialist opining Employee will not improve without surgery and he is 100 percent disabled from not receiving definitive treatment. (Price Letter, February 23, 2018).

35) On February 21, 2018, Dr. Schwartz issued an addendum EME report. Dr. Schwartz opined the substantial cause of Employee's need for medical treatment and disability is not the September 2017 work injury. He stated "any indication for surgery" is for the "underlying" L5-S1spondylolisthesis. Dr. Schwartz stated Employee has apparently refused physical therapy

multiple times which indicates he is unwilling to do any conservative treatment and there is substantial indication of significant drug seeking behavior. He released Employee to work without restrictions as of the date of the November 9, 2017 EME report. Dr. Schwartz opined Employee reached medical stability for the September 2017 work injury and he did not anticipate any PPI as a result of the work injury. He recommended obtaining additional medical records from Arctic Spine and Koob Chiropractic. (Schwartz, Addendum EME Report, February 21, 2018).

36) On February 22, 2018, Employer opposed Employee's ARH contending additional time was necessary to complete discovery, including gathering medical records and obtaining testimony of employee's treating physician and the EME at deposition. (Opposition to ARH, February 22, 2018).

37) On March 2, 2018, Dr. Maxwell performed a left L5-S1 transforaminal epidural steroid injection and functional anesthetic discogram. He described the following procedure:

> Using a 3.5-inch 22-gauge needle with some difficulty I was able to access the lateral subannular subforaminal portion of the L5-S1 disc. Negative aspiration preceded all injections. I injected 0.2 mL of Omnipaque 300 which revealed a lateral subannular degenerative patter. I then injected 0.3 mL of 0.25% Marcaine and Kenalog 40 mg mix. The needle was withdrawn to the foramen. I injected another 0.3 mL of Omnipaque 300 delineating the foraminal architecture and existing nerve root. This was followed by another injection of 0.45 mL of 0.25% Marcaine and Kenalog 40 mg mix. The need was withdrawn. (Maxwell, Operative Report, March 2, 2018).

38) On March 13, 2018, Employer controverted temporary total disability (TTD), temporary partial disability (TPD), medical costs, transportation costs, PPI, reemployment benefits, interest, unfair or frivolous controversion and attorney fees and costs based upon Dr. Schwartz's EME reports. (Controversion Notice, March 13, 2018).

39) On March 22, 2018, the parties attended a prehearing conference. Employer objected to scheduling a hearing on Employee's claim on May 1, 2018. The board designee scheduled an oral hearing in Juneau, Alaska on May 1, 2018, on Employee's January 19, 2018 claim. (Prehearing Conference Summary, March 22, 2018).

40) On March 22, 2018, Dr. Maxwell responded to questions in a letter from the claims adjuster. He opined the September 2017 work injury is the substantial cause of Employee's need for treatment and disability after reviewing Dr. Steinman's September 10, 2011 and April 20, 2013

medical records. Dr. Maxwell stated Employee needs further treatment related to the September 2017 injury and specified Employee requires a left L5-S1 lumbar microdiscectomy and may need a posterior lumbar fusion. Dr. Maxwell said Employee is not released to work and he cannot return to modified work. He opined Employee has not reached medical stability for the September 2017 work injury. (Maxwell, Response, March 22, 2018).

41) On March 26, 2018, Employee testified at deposition he has lived in Beaumont and Banning, California and Kenai and Soldotna, Alaska in the last ten years. (Employee Deposition at 6, March 26, 2018). Employee filled out a health questionnaire and had a physical when he began employment with Employer and he could not remember if he included any preexisting conditions on the questionnaire. (*Id*. at 90). Dr. Steinman took x-rays of Employee's back. (*Id*. at 92). Employee stated he did not remember if he treated prior to March 2017 with a chiropractor. (*Id*. at 94). When asked when he first remembered seeking treatment for his back, Employee stated the first time he remembered experiencing back pain was around the time when he was an ironworker and he saw Dr. Steinman. (*Id*. at 96). Employee stated the first time he had any kind of sensation into his left leg was on September 17, 2017. (*Id*. at 98-99).

42) On April 2, 2018, Employer requested an SIME and filed an unsigned SIME form. Employer indicated disputes between Dr. Maxwell and Dr. Schwartz regarding causation, treatment, degree of impairment, functional capacity, and medical stability and the medical specialty required for the SIME as an orthopedic surgeon or neurosurgeon. Employer attached copies of Dr. Maxwell's March 22, 2018 response and January 18, 2018 chart note and Dr. Schwartz's February 21, 2018 EME addendum to the SIME form. (Petition, April 2, 2018; SIME form, April 2, 2018).

43) On April 2, 2018, Dr. Flanum responded to questions in a letter from Employer's attorney's office. He opined Employee's L5-S1 spondylolisthesis predated the work place injury and the nerve root irritation and disc displacement may be the result of the September 2017 injury. He stated nerve irritation is never seen on an MRI but Employee's MRI reveals the L5 nerve root is in contact with the disc. Dr. Flanum opined nerve conduction studies are not needed to determine if surgery is reasonable and necessary. However, they may be useful if they show L5 radiculopathy. (Flanum Response, April 2, 2018).

44) On April 3, 2018, Employer requested a continuance of the May 1, 2018 hearing. Employer contends good cause exists for a continuance under 8 AAC 45.074(b)(1)(F) because an SIME is necessary. (Petition, April 3, 2018).

45) On April 4, 2018, Employee opposed Employer's April 2, 2018 petition for an SIME and April 3, 2018 petition for a continuance. Employee acknowledged there is a significant dispute between Dr. Maxwell and Dr. Schwartz regarding medical treatment, medical stability, and whether Employee is released to work without restrictions. Employee contended an SIME is not necessary to resolve the dispute because the medical opinions are not uncommon or overly complex and the three physicians in this case will be deposed. Employee contended an SIME would result in a six to twelve month delay of the case which would contravene the legislature's intent to ensure the quick, efficient, fair, and predictable delivery of benefits to employee's at a reasonable cost to employers. Employee contended an SIME would delay the medical treatment necessary for Employee to recover from the work injury and reenter the job market. Employee contended an SIME would increase the costs of the case dramatically because of the SIME costs, both attorneys would have to prepare for another hearing on the merits, Employee still requires medical care while awaiting surgery, and delaying medical care may increase the likelihood Employee will become a chronic pain patient. (Opposition, April 4, 2018).

46) On April 5, 2018, the parties attended a prehearing conference and stipulated to changing the deadline to submit evidence for hearing to April 20, 2018. The board designee set the following issues for an oral hearing in Juneau, Alaska, on May 1, 2018:

- Employer's March 30, 2018 petition for an SIME,
- Employer's April 3, 2018 petition for a continuance,
- TTD,
- PPI,
- medical and transportation coasts,
- interest,
- unfair or frivolous controversion, and
- attorney fees and costs. (Prehearing Summary, April 5, 2018).

47) On April 16, 2018, Dr. Flanum testified at deposition he is a board certified orthopedic surgeon and he saw Employee on December 4, 2017. (Flanum Deposition at 4, April 16, 2018). After reviewing Employee's October 12, 2017 and January 11, 2018 MRIs, Dr. Flanum diagnosed a long standing pars defect at L5 with grade I anterolisthesis of L5 on S1 and a subligamentous herniation on the left adjacent to the nerve root. (*Id*. at 9). Dr. Flanum opined

Employee's MRIs reveal mild nerve compression. (*Id*. at 19). He does not recommend discograms because they do not provide much useful data and have been shown to cause disc degeneration in patients. (*Id*. at 20-21). Dr. Flanum opined the January 4, 2018 operative report by Dr. Maxwell was not a discogram, only an epidural steroid injection because a discogram requires putting a needle into disc space, recording the opening pressure, and pressurizing it to try to recreate the pain and Dr. Maxwell did not do that. (*Id*. at 21-22). Dr. Flanum opined the October 13, 2017 epidural steroid injection was more therapeutic than diagnostic. (*Id*. at 52-53). He explained the October 13, 2017 epidural steroid injection was not diagnostic because it numbed up the disc, the ends plates of the vertebrae, and the nerve and you cannot identify if the pain generator is the disc herniation. (*Id*.). He opined the pain generator is the non-congenital L5-S1 spondylolisthesis caused by a stress fracture that did not heal when Employee was a little boy. He noted Employee has congenital spina bifida occulta. (*Id*. at 27). Dr. Flanum recommended physical therapy. (*Id*. at 29). He stated there are three indicators for surgery – mechanical instability, neurological instability, and persistent pain. (*Id*. at 28-29). Employee had some suggestion of mechanical instability because he has spondylolisthesis and some neurological instability, depending on whose report you look at. (*Id*.). He recommended the L5-S1 posterior interbody fusion and stated he would not do a microdiscectomy prior to a fusion because he does not believe the disc is the primary pain generator. (*Id*. at 29). The fusion is needed to fix the L5-S1 spondylolisthesis. (*Id*. at 32). He stated if a person was completely asymptomatic before a work injury and then had an onset of debilitating pain or objectively documented neurologic deficit, then the work place injury is the cause of the need for the fusion. (*Id*.). If there was any evidence Employee had left leg symptoms before the work injury, that could affect his opinion on whether the injury was work related; but Employee might have had some nerve root irritation that got better and then he exacerbated it. (*Id*. at 38-39). If a patient had left leg symptoms in the same pattern months before the work injury, he would conclude it was a chronic process. (*Id*. at 39). Dr. Flanum said nerve irritation is never shown on an MRI; however Employee's left L5 nerve is in contact with the disc. (*Id*.). Dr. Flanum stated he does not know when the disc herniation occurred. (*Id*. at 45). He opined he cannot determine what "the most substantial cause" of Employee's need for a fusion. (*Id*. at 46). Dr. Flanum would perform surgery for patients with significant pain if the patient could not undergo physical therapy. (*Id*. at 48). He stated bouncing up and down on a potholed road is a mechanism that

can cause a herniated disc. (*Id*. at 49). Dr. Flanum stated Employee's left leg radiculopathy could be caused by his disc herniation or spondylolisthesis at L5-S1. (*Id*. at 59).

48) On April 16, 2018, Dr. Maxwell testified at deposition he is a board-certified neurosurgeon and has been treating Employee since October 9, 2017. (Maxwell Deposition at 6-7, April 20, 2018). Dr. Maxwell opined the September 2017 injury is the substantial cause of Employee's disability and need for medical treatment. (*Id*. at 16). He recommended a left L5-S1 lumbar microdiscectomy and a possible posterior lateral fusion depending on whether he finds instability during surgery. (*Id*. at 18-19). Dr. Maxwell stated at this stage, physical therapy would not do anything for Employee and Employee's radiculopathy is so severe he did not think Employee would be able to tolerate it. (*Id*. at 21). He anticipated Employee having a disability rating greater than zero. (*Id*. at 22). After reviewing Dr. Perez's February 15, 2017 and March 7, 2017 chart notes, Dr. Maxwell would still conclude the work injury caused Employee's need for medical treatment as Employee's symptoms qualitatively and quantitatively changed on the date of the work injury. (*Id*. at 32-38). He was not aware Employee had treated in 2011 and 2013 for low back pain and surgery had been recommended in 2013. (*Id*. at 45-46). The recommended surgery is for a structural condition and a secondary disc herniation which is impinging on a nerve. (*Id*. at 49-50). Employee's need for the recommended surgery is due to the disc herniation. (*Id*. at 50). Dr. Maxwell identified the pain generator as the L5-S1 disc with a nerve block and discogram. (*Id*. at 52). After reviewing Employee's October 12, 2017 and January 11, 2018 MRIs, Dr. Maxwell opined Employee's anterolisthesis is preexisting and the disc herniation is new. (*Id*. at 54-55). He did not believe EMG or nerve conduction studies would help because it is a painful study and it may be normal when someone has clinically clear radiculopathy. (*Id*. at 66). Dr. Maxwell agrees with Dr. Price's opinion that Employee will not improve without surgery and he is 100 percent disabled from not receiving treatment. (*Id*. at 80-81).

49) On April 18, 2018, Employer requested a continuance of the May 1, 2018 hearing for good cause under 8 AAC 45.074(b)(1)(k) for new medical evidence. (Petition, April 18, 2018). Employer contended it received new medical records on April 17, 2018 for an appointment with Dr. Perez on May 11, 2017 and that record warrants additional time for discovery and cross examination. Employer contended it would be irreparably harmed if additional time for discovery was not provided. Employer attached a letter dated February 28, 2018 to Dr. Perez's

office requesting medical records with a medical release signed by Employee on February 8, 2018. (Memorandum, April 18, 2018).

50) On April 20, 2018, Employer requested a continuance of the May 1, 2018 hearing because Dr. Flanum is unavailable to testify at hearing and his transcribed deposition was not yet available. Employer contended Dr. Flanum's live testimony is necessary due to discovery of the May 11, 2017 chart note after his deposition. (Petition, April 20, 2018).

51) On April 23, 2018, Employer filed transcripts for Dr. Flanum's April 16, 2018 deposition and Employee's March 26, 2018 deposition. (Dr. Flanum Deposition, April 23, 2018; Employee Deposition, April 23, 2018).

52) Employer contended it first received signed releases from Employee on February 8, 2018 to conduct discovery. Employer contends Employee's deposition occurred on March 26, 2018 and afterwards, it received supplementary signed releases from Employee on March 28, 2018. Employer served discovery requests on several medical providers on April 3, 2018 and is waiting for responses. Employer contends it received x-ray records of Employee's back from a medical provider in California on April 27, 2018 after requesting records on April 3, 2018 and a chiropractor in California provided a response on April 30, 2018. Employer contends leaving the record open after a merits hearing is unreasonable because the physicians that provided opinions in the record would not have reviewed the additional medical records. Employer contends Employee's opposition to Employer's petition for an SIME is a tactic intended to prevent discovery. (Employer's hearing arguments, May 1, 2018).

53) Employee contended he does not know of any relevant medical evidence that is not in the record. Employee contended there is adequate medical evidence in the record for a decision on the merits. Employee contended Employer's petition for an SIME is a tactic intended to delay the case and "starve Employee out." (Employee's hearing arguments, May 1, 2018).

54) After the oral orders were issued, the parties stipulated to a prehearing conference on May 29, 2018 at 1:30 p.m. Alaska time and to an oral hearing date on June 19, 2018 to hear Employee's January 18, 2018 claim. (Record).

PRINCIPLES OF LAW

> **AS 23.30.001. Intent of the legislature and construction of chapter.** It is the intent of the legislature that

> (1) this chapter be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter.
>
> (2) workers' compensation cases shall be decided on their merits except where otherwise provided by statute;
>
> (3) this chapter may not be construed by the courts in favor of a party;
>
> (4) hearings in workers' compensation cases shall be impartial and fair to all parties and that all parties shall be afforded due process and an opportunity to be heard and for their arguments and evidence to be fairly considered.

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

> **AS 23.30.095. Medical treatments, services, and examinations.**
> . . . .
>
> (k) In the event of a medical dispute regarding determinations of causation, medical stability, ability to enter a reemployment plan, degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's independent medical evaluation, the board may require that a second independent medical evaluation be conducted by a physician or physicians selected by the board from a list established and maintained by the board. . . .

The following general criteria are typically considered when ordering an SIME, though the statute does not expressly so require:

> 1) Is there a medical dispute between the employee's physician and the employer's medical examiner?
>
> 2) Is the dispute significant?
>
> 3) Will an SIME physician's opinion assist the Board in resolving the disputes?

DiGangi v. Northwest Airlines, AWCB Decision No. 10-0028 at 13 (February 9, 2010). AS 23.30.095(k) is procedural and not substantive for the reasons outlined in *Deal v. Municipality of Anchorage*, AWCB Decision No. 97-0165 at 3 (July 23, 1997). AS 23.30.135 provides the

Board with wide discretion under AS 23.30.095(k) to consider any evidence available when the board decides whether to order an SIME to assist in investigating and deciding medical issues in contested claims. *Bah v. Trident Seafoods Corp.*, AWCAC Decision No. 073 (February 27, 2008) addressed the Board's authority to order an SIME under AS 23.30.095(k) and AS 23.30.110(g). *Bah* stated, 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. *Id.*

> **AS 23.30.135. Procedure before the board**. (a) In making an investigation or inquiry or conducting a hearing the board is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by this chapter. The board may make its investigation or inquiry or conduct its hearing in the manner by which it may best ascertain the rights of the parties. . . .
>
> **AS 23.30.155. Payment of compensation.**
> . . . .
>
> (h) The board may upon its own initiative at any time in a case . . . where right to compensation is controverted . . . make the investigations, cause the medical examinations to be made, or hold the hearings, and take the further action which it considers will properly protect the rights of all parties.
>
> **8 AAC 45.070. Hearings.** (a) Hearings will be held at the time and place fixed by notice served by the board under 8 AAC 45.060(e). A hearing may be adjourned, postponed, or continued from time to time and from place to place at the discretion of the board or its designee, and in accordance with this chapter.
> . . . .
>
> (j) If the hearing is not completed on the scheduled hearing date and the board determines that good cause exists to continue the hearing for further evidence, legal memoranda, or oral arguments, the board will set a date for the completion of the hearing.
>
> **8 AAC 45.074. Continuances and cancellations.**
> . . . .
>
> (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,
>
> (1) good cause exists only when
> . . . .

> (F) a second independent medical evaluation is required under AS 23.30.095(k).
>
> . . . .
>
> (K) the board determines that despite a party's due diligence in completing discovery before requesting a hearing and despite a party's good faith belief that the party was fully prepared for the hearing, evidence was obtained by the opposing party after the request for hearing was filed which is or will be offered at the hearing, and due process required the party requesting the hearing be given an opportunity to obtain rebuttal evidence;
>
> (L) the board determines at a scheduled hearing that, due to surprise, excusable neglect, or the board's inquiry at the hearing, additional evidence or arguments are necessary to complete the hearing;
>
> . . . .
>
> (N) the board determines that despite a party's due diligence, irreparable harm may result from a failure to grant the requested continuance or cancel the hearing;

Employers have a constitutional right to defend against liability claims. *Granus v. Fell*, AWCB Decision No. 99-0016 at 6 (January 20, 1999), citing Alaska Const., art. I sec. 7. Employers also have a statutory duty to adjust workers' compensation claims promptly, fairly and equitably. *Granus* at 5, citing AS 21.36.120 and 3 AAC 26.010 - 300. The board has long recognized a thorough investigation of workers' compensation claims allows employers to verify information provided by the claimant, properly administer claims, effectively litigate disputed claims, and detect fraud. *Granus* at 6, *citing Cooper v. Boatel, Inc.*, AWCB Decision No. 87-0108 (May 4, 1987).

ANALYSIS

1) Was the oral order denying Employer's petition for an SIME correct?

An SIME may be ordered when there is a significant medical dispute between the employee's attending physician and an EME. AS 23.30.095(k); *Diangi*; *Bah*. Wide discretion exists when

deciding whether to order an SIME. AS 23.30.135(a); AS 23.30.155(h). The disputes in this case are significant regarding causation, treatment, degree of impairment, functional capacity, and medical stability. The existence of a medical dispute alone does not require an SIME. AS 23.30.095(k); *Diangi*; *Bah*. Employer contended an SIME would provide clarity as to whether fusion surgery is necessary for the preexisting structural condition or for a work-related lumbar strain. There is an adequate amount of medical opinions from Dr. Flanum, Dr. Maxwell, Dr. Flanum, and Dr. Schwartz to decide whether the work injury is the substantial cause of Employee's need for L5-S1 posterior interbody fusion and the other issues in this case. *Rogers & Babler*. Employer's petition is denied. The oral order denying Employer's April 2, 2018 petition for an SIME was correct

2) Was the oral order continuing the hearing correct?

Hearing continuances are not favored and will not be routinely granted. 8 AAC 45.070(a); 8 AAC 45.074(b). Continuances are granted for good cause only. 8 AAC 45.074(b). Employer's April 3, 2018 petition for a continuance based upon its contention an SIME is required under AS 23.30.095(k) is denied because Employer's April 2, 2018 petition for an SIME was denied above. 8 AAC 45.074(b)(1)(F).

A continuance may be appropriate under 8 AAC 45.074(b)(1)(K) or (L) when a party seeks additional time to present evidence. A continuance may also be appropriate under 8 AAC 45.074(b)(1)(N) if the board determines that despite a party's due diligence, irreparable harm may result from a failure to grant the requested continuance. Employer contended it served discovery requests on medical providers on April 3, 2018 and it received additional medical records after the deadline for submission of evidence. A principal dispute in this case is whether the work injury was the substantial cause of Employee's disability and need for medical treatment, specifically a L5-S1 posterior interbody fusion. *Rogers & Babler*.

Employer contends a preexisting lumbar condition is the substantial cause of Employee's disability and need for treatment. At hearing, Employer indicated it received an x-ray and chiropractic records predating the work injury after the deadline for submission of evidence.

Employee testified he recalled getting back x-rays while treating with Dr. Steinman in California, the first physician in the record to contemplate surgery for Employee's grade I spondylolisthesis at L5-S1, and he could not remember whether he received chiropractic treatment prior to March 2017. The new medical evidence is relevant to and may support either parties' contention regarding an issue in dispute. The medical record is incomplete.

AS 23.30.001(4) requires hearings to be fair and that parties have the opportunity to present their evidence. A reasonable opportunity to gather evidence is implicit in the opportunity to present evidence. Employer has a right to investigate Employee's claim. *Granus*. Employee proposed keeping the record open for two weeks after a merits hearing to allow Employer to submit new medical evidence. Failing to grant the requested continuance may result in irreparable harm to one or both parties, as due process requires both parties have reasonable opportunity to review and evaluate the evidence and to present arguments at hearing. Submitting the new medical evidence after a hearing on the merits does not ensure due process to both parties because, as stated previously, the new medical evidence may support either parties' contention regarding an issue in dispute. It may be necessary for either party to obtain rebuttal evidence and for either party to depose Dr. Flanum, or Dr. Schwartz or re-depose Dr. Maxwell or Dr. Price based upon the new evidence.

Finally, there is no evidence Employer has not diligently pursued discovery since Employee's January 11, 2018 claim. After Employer received signed releases from Employee, it requested medical records from medical providers, followed up with Dr. Schwartz for his opinion upon receiving additional medical records, and deposed Employee, Dr. Flanum and Dr. Maxwell. At deposition on March 26, 2018, Employee testified he lived in two cities in California and Alaska in the last 10 years, he remembered medical treatment not in the record, and he could not remember whether he received chiropractic care prior to March 2017 for his preexisting lower back injury. It was reasonable for Employer to serve additional discovery requests based on Employee's testimony on medical providers on April 3, 2018 after Employee's deposition.

Employee's contention a continuance would deny him a quick remedy is well taken. After balancing Employee's right to quick delivery of benefits and the right of both parties to have the

opportunity to gather and present their evidence, it would be reasonable (1) to provide Employer a reasonable time period to receive and submit any new medical evidence received in response to Employer's April 3, 2018 discovery requests and (2) to provide both parties a reasonable time period to evaluate new medical evidence and obtain rebuttal evidence if necessary. *Rogers & Babler*. Therefore, a continuance is granted and a new hearing date will be set. AS 23.30.001(1)-(4); 8 AAC 45.070(j); 8 AAC 45.074(b)(1)(K), (L), (N). The parties agreed to an oral hearing on June 19, 2018 to hear Employee's January 18, 2018 claim. The board properly exercised its discretion in continuing the hearing to allow the board and the parties an opportunity to review the additional evidence. The oral order to continue the hearing was correct.

CONCLUSIONS OF LAW

1) The oral order denying Employer's petition for an SIME was correct.
2) The oral order continuing the hearing was correct.

ORDER

1) The oral order denying Employer's petition for an SIME was correct.
2) Employer's April 2, 2018 petition for an SIME is denied.
3) Employer's April 3, 2018 and April 20, 2018 petitions for a continuance are denied.
4) Employer's April 18, 2018 petition for a continuance is granted.
5) The May 1, 2018 hearing on Employee's January 19, 2018 claim is continued to June 19, 2018.

Dated in Juneau, Alaska on May 29, 2018.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Kathryn Setzer, Designated Chair

/s/
Bradley Austin, 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 MICHAEL FAY, employee / claimant; v. COEUR D'ALENE MINE CORPOTATION, employer; ZURICH AMERICAN INSURANCE COMPANY OF ILL, insurer / defendants; Case No. 201713548; dated and filed in the Alaska Workers' Compensation Board's office in Juneau, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on May 29, 2018.

/s/
Dani Byers, Technician