ALASKA WORKERS' COMPENSATION BOARD

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

ANGELEE J. WOOD,	)	
	)	INTERLOCUTORY DECISION AND ORDER
Employee, Respondent,	)	
	)	AWCB Case No. 201509544
v.	)	
	)	AWCB Decision No. 18-0131
STATE OF ALASKA,	)	
	)	Filed with AWCB Anchorage, Alaska on December 28, 2018
Self-Insured Employer, Petitioner.	)	

State of Alaska's (Employer) December 11, 2018 petition for review of a board designee (designee) order denying Employer's October 3, 2018 and October 11, 2018 petitions was heard on the written record on December 18, 2018, in Anchorage, Alaska, a date selected on December 11, 2018. Employer's December 11, 2018 petition gave rise to this hearing. Attorney John Franich represents Angelee Wood (Employee). Assistant Attorney General Daniel Cadra represents Employer. *Wood v. State of Alaska*, AWCB Decision No. 18-0014 (February 14, 2018), denied Employee's request for a protective order against attending a neuropsychological examination with neuropsychological testing. (*Wood I*). The record closed at the hearing's conclusion on December 18, 2018.

ISSUE

Employer contends the designee abused his discretion when he denied Employer's petitions to strike records from the second independent medical evaluation (SIME) binders.

Employee opposed Employer's petitions to strike records from the SIME binders and contends the designee did not abuse his discretion, and denial of Employer's petitions should be affirmed.

Did the designee abuse his discretion when he denied Employer's petition to strike records from the SIME binder?

FINDINGS OF FACT

A preponderance of the evidence establishes the following facts and factual conclusions:

1) The parties stipulated in *Woods I* as follows: Employee was assaulted by an inmate at Highland Mountain Correctional Facility on June 16, 2015, during the course of her employment as a correctional officer; the inmate who assaulted Employee was wearing a cast and broke Employee's nose; this is an extremely complex medical case; Employer commenced workers' compensation benefits and those benefits have continuously been paid since the injury date; Employer originally scheduled a psychiatric and neuropsychological panel employer's medical evaluation (EME) in August 2017, rescheduled it at Employee's request, accommodated her numerous scheduling conflicts, and rescheduled the EME for October 3 and 4, 2017, with Paul Craig, Ph.D.; Employee is eligible for reemployment benefits and reemployment plan development has been suspended. Employee received treatment from a naturopath, chiropractor and psychiatrist. (*Woods I.*)

2) On August 16, 2017, Employee underwent a neuropsychological assessment with Thomas Bergquist, Ph.D., LP. He made "behavioral observations" including Employee had a clear stutter throughout the evaluation and understood most directions but needed directions repeatedly clarified. Occasionally, she seemed unable to concentrate for extended periods. She displayed a good attitude and established and maintained good rapport throughout the evaluation. Employee warned Dr. Bergquist she has difficulty controlling her temper and is easily frustrated mainly due to 'how high functioning' she used to be compared to how much difficulty she has now. Despite this warning, Employee was calm and pleasant throughout testing and handled even the difficult tests well. Dr. Bergquist felt Employee put forth good effort but, at the same time, noted she performed quite poorly. He stated she performed "well below the chance level on a measure of performance validity testing" and in certain other instances seemed to give effort that was much less than optimal. Dr. Bergquist emphasized Employee "refused to guess on items of the TOMM, a forced choice measure of performance

validity testing, and gave a 'don't know' response despite significant prompting from the examiner on the majority of items on that particular measure. On those items which she did give response, she was correct in all but one instance." Dr. Bergquist determined Employee's evaluation results were of questionable validity, and as a result the data's integrity was questionable. He nonetheless interpreted the results with this factor in mind. Employee performed poorly on the vast majority of the evaluation's measures, including her basic measured intelligence, on which her overall performance was in the first percentile, a "clearly impaired range." Dr. Bergquist's impressions were:

> The results of neurological testing are positive, but interpretation of the results is complicated by much less than expected, in fact less than chance, level of performance on performance validity testing measures. As a consequence, I am unable to confidently interpret the true significance of these results in terms of their representation of level of underlying cognitive dysfunction and even more so to the degree to which they represent underlying brain injury. They do represent that Mrs. Wood is having difficulties with functioning at this time. She essentially shows poor and impaired performances in the vast majority of measures given as part of this evaluation, with her performances varying from at, or even in some cases, above the average range to in other cases being clearly, even markedly, impaired. This includes her performance of measured intelligence which are markedly below expectation and are at the 1st percentile.
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> Also elevated are scores on measures of both anxiety and depression which are significantly elevated in both instances. In fact, her score in both measures are at or near the ceiling level including endorsement of suicidal ideation, though she denies any specific plan or intent. She also performs markedly poorly and well within the impaired range on measures of both motor speed and motor functioning bilaterally in both hands.
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> Thus in summary, these results, while not useful for determining the actual degree and nature and pattern of neurocognitive impairment, do represent a means to degree to which Mrs. Wood feels she is having difficulty and essentially can be considered almost a 'cry for help.' The fact that her performance is not only poor, but well below the chance level, on performance validity testing suggests some degree of an attempt to present to the examiner in such a way that she is trying to show how much difficulty she is having and the degree to which she is impaired.
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> She likely can benefit from the brain rehabilitation services including among other things cognitive rehabilitation, but these are really secondary to the need to address emotional, psychological factors and perhaps, most importantly, her own perception of her current situation. Also, related to this are the circumstances

> surrounding her injury and her job history in which she was involved in regular levels of stress on the job as a corrections officer.

(Mayo Clinic Neuropsychological Assessment, Dr. Bergquist, August 16, 2017.)

3) On September 20, 2017, Aryeh Levenson, M.D., sent an email to claims administrator Penser because he became aware Employer had scheduled a neuropsychological evaluation with Paul Craig, Ph.D. Dr. Levenson stated to maintain validity of neuropsychological testing the tests cannot be repeated within the same year; otherwise, recognition of the test invalidates the test scoring. It was unclear to Dr. Levenson what further information a retest would provide when the Mayo Clinic, "one of the nation's foremost institutions with expertise in head injuries" performed the initial test. Finally, Dr. Levenson asserted, "Ms. Wood's brain injury and juxtaposed PTSD have left sufficiently limited cognitive and emotional reserve that such frequent evaluations and reevaluation severely impact her emotional, cognitive, and psychiatric well-being." Dr. Levenson stated Employee's extensive evaluation history and treatment records document her strengths, limitations, and disabilities and further evaluations were unnecessary. Dr. Levenson concluded his email to Penser stating, "I do not feel comfortable discussing the details of her case or specific psychiatric, cognitive, and functional limitations further via email. However, I would like to discuss this case review so to avoid requiring additional unnecessary evaluations that inadvertently lead to further compromise of her mental and cognitive states." (Email from Dr. Levenson to Penser, September 20, 2017, SIME Number 2551.)

4) On November 29, 2017, Adam Grove, CBIS, ND, wrote to Assistant District Attorney (ADA) Lawrence Monsma, prosecutor from the Alaska Department of Law's Criminal Division responsible for prosecuting the inmate who broke Employee's nose. Dr. Grove was concerned the litigation of charges against Employee's assailant was causing Employee's "medical status" to degrade. Dr. Grove considered Employee at high risk to harm herself and "medically unstable in part due to the stress of the litigation." He stated she was much worse than she was immediately following the assault, was suffering from PTSD, had recently been hospitalized for suicidal ideation and all gains she achieved from out-of-state treatment in 2017 were lost. Dr. Grove said after a traumatic brain injury (TBI), individuals are "often more stress sensitive." He attributed this sensitivity to numerous factors, including diminished cognitive abilities, increased light, sound and smells sensitivity, "increased responses to threats" and poor emotional control. According to Dr. Grove, "studies have shown that recovery time for people with TBI involved in

litigation is longer and can be less complete compared to those who are not involved in litigation." He asked Monsma to do his best to minimize Employee's exposure to litigation stress and recommended strategies to use when working with her. (Letter from Dr. Grove to Monsma, November 29, 2017, SIME Numbers 2554 and 2555.)

5) Employee began treating with Dr. Grove in 2015. He provides her naturopathy, counseling and physical therapy services. (Record.)

6) On February 14, 2018, *Woods I* considered Dr. Levenson's September 20, 2017 email to Penser asserting a neuropsychological evaluation was unnecessary and would invalidate the previous evaluation's scoring. Dr. Levenson's email was not relied upon or given weight to determine if Employee's petition for a protective order would be granted or denied. (*Woods I.*)

7) On March 28, 2018, EME Dr. Craig conducted a neuropsychological evaluation on referral from Objective Medical Assessments, Employer's EME. Dr. Craig diagnosed malingering and stated, Employee "made a statistical confession of malingering in her objective test performances." She answered six of 24 items correctly in a series of 24 forced-choice responses after Employee was shown the correct answer and then shown two possible answers and asked to select the one that matched. Dr. Craig said, because Employee got only six of 24 answers correct, "it can be stated with 98.9% certainty that she deliberately - and consciously - chose the wrong answers" and "an individual with very significant memory impairment can perform much better than 12 out of 24 on this visual recognition task that was designed to measure performance validity." He said the task does not measure memory even though it may appear like a memory task and individuals with significant memory problems can perform relatively well if they attempt to put forth their best effort. He opined Employee deliberately opted to select wrong answers to achieve this error level. Dr. Craig said Employee "has been reinforced by healthcare providers into believing she suffers from a traumatic brain injury. However, there is absolutely no biomedical evidence in any record that she ever incurred a traumatic brain injury." He said:

> Her pattern of slowly developing more and more symptoms after the assault is consistent with one or more of the psychiatric diagnoses described below, but certainly does not point toward traumatic brain injury or post-concussion syndrome. Ms. Wood's nose was broken. Her brain was not damaged.

Dr. Craig diagnosed posttraumatic stress disorder (PTSD) and found the June 16, 2015 assault is the substantial cause of Employee's PTSD diagnosis. Employee's psychiatric symptoms began

emerging shortly after the work assault and when she began to address return to work issues, her psychiatric symptoms accelerated. Dr. Craig said her psychiatric symptoms were misinterpreted as post-concussional symptoms, which "has led to an increasingly debilitated presentation."

> On 05/23/17 Dr. Grove wrote: "Basically, I see Angelee as being very symptomatic -- almost as if she is only weeks from her injury rather than two years. I think this is because she is not getting proper treatment." The current examiner agrees with Dr. Grove in this regard. Treating PTSD as if it is a TBI is not proper treatment and has only served to reinforce and accelerate Ms. Wood's disability behaviors.

Dr. Craig also diagnosed Employee with conversion disorder (functional neurological symptom disorder) with attacks or seizures. He noted she "developed a variety of functional neurological symptoms over time, including the pseudo-seizures diagnosed in the medical record, stuttering, tremor, and movement disorder." Dr. Craig does not believe Employee's functional neurological symptom disorder is a result of malingering and he elaborated:

> The substantial cause is thought to be the assault on the job and the misattribution of her post-traumatic stress disorder symptoms to a nonexistent traumatic brain injury. Again, Ms. Wood did not suffer from a traumatic brain injury. The delayed emergence of functional neurological symptoms is consistent with the conversion disorder diagnosis. The emergence of the symptoms is reinforced both by healthcare providers as well as by the fact that Ms. Wood was reinforced for presenting with the symptoms insofar as the symptoms allowed her to avoid returning to work as a correctional officer -- the work environment in which she experienced the assault leading to her post-traumatic stress disorder. Although her objective test findings necessitate a diagnosis of malingering of neurocognitive deficits, on a more probable than not basis her conversion disorder is not thought to be conscious or deliberate. Rather, it is a psychological coping mechanism that has emerged over time -- most likely at a subconscious level.
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> [T]he functional neurological symptoms are psychogenic in origin rather than neurological in origin. The primary support for this diagnosis is based upon the complete absence of any biomedical data supporting a conclusion of a traumatic brain injury, and the fact that her symptoms emerged during the weeks, months, and years following the acute injury. These emerging symptoms grew worse over time rather than improving as would be the case if there was a neurological explanation for her symptoms. Likewise, if there was a neurological explanation for her symptoms and these symptoms were caused by a brain injury, the symptoms would have been evidenced immediately after the injury rather than evolving slowly overtime as reflected in the healthcare records. There is

> absolutely no reason to suspect a neurological explanation for any of these psychiatrically related symptoms, based upon a thorough review of all of the records, as well as a review of all of the current neuropsychological evaluation objective test results.

Dr. Craig said there are no known treatments for malingering. The neurocognitive services Employee received, although well intended, were treating the wrong condition. Dr. Craig said it was not surprising Employee slipped back into the full spectrum of psychiatric symptoms manifested before treatment when she returned home. Dr. Craig stated:

> Specifically, focusing on the nonexistent traumatic brain injury as the cause of her problems was a doomed enterprise from the beginning. Had the focus been exclusively on her psychiatric issues and management of her PTSD, it is probable that a much better outcome would have been achieved. In summary, the treatment focused on TBI has not been reasonable, necessary, or helpful. Admittedly, the care providers wanted to be helpful. Unfortunately, absent the correct diagnosis for her symptoms, the care provided was palliative at best, and harmful to the extent it has contributed to her misunderstanding of her psychiatric condition and exacerbation over time of her conversion disorder.
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> With regard to treatment of the PTSD, Ms. Wood has been correctly diagnosed and has received some treatment for PTSD. Unfortunately, her psychiatrist, Dr. Levenson, has stated repetitively in his records that he believes her primary problem was caused by "neuro-circuitry" problems, suggesting that he was attributing the primary cause of her problem to a traumatic brain injury. Defining Ms. Wood's problems in this context has not been helpful to her with regard to successful treatment of her PTSD.

Dr. Craig said medical treatment for Employee's conversion disorder has been nonexistent to the extent no one has looked at Employee's entire clinical profile and biomedical history to determine a traumatic brain injury never occurred during the assault. He found no indication in the record that any provider has considered her "pseudo-seizures" diagnosis, the emergence of stuttering when stressed, and her presentation with other functional neurological symptoms to arrive at a correct differential diagnosis; namely, conversion disorder. Dr. Craig noted the emergency department records "clearly indicate that no brain injury occurred" and "symptoms of a brain injury do not emerge over time." He concluded Employee's presentation is consistent with a psychogenic explanation for her conversion disorder, first expressed as symptoms of post-concussive syndrome and now expressed as ever-increasing symptoms of a severe traumatic brain injury, "a condition that does not exist in the case of Ms. Wood." Dr. Craig indicated

Employee will benefit from an independent psychiatric evaluation to determine the nature and extent of necessary psychiatric treatment. He said:

> Ms. Wood must be disabused of the myth that she suffered from a traumatic brain injury during the assault if she is going to make any progress with respect to resolving her conversion disorder symptoms -- and desisting from ongoing malingering of neurocognitive impairment. Likewise, she is going to need to be disabused of any notion of having suffered from a traumatic brain injury before she can develop a rudimentary understanding that post-traumatic stress disorder is her primary diagnosis. If she and her current and future healthcare providers adopt the correct diagnosis, it is conceivable that she will be able to begin making the behavioral changes required in order to improve her psychosocial adjustment.

Dr. Craig recommended future treatment, provided by one psychiatrist and one psychotherapist working collaboratively, be exclusively psychiatric in nature because her disorder is psychiatric rather than neurological. He said, "Continuing to misattribute Ms. Wood's problems to a nonexistent traumatic brain injury will not result in any improvement in symptoms over time. The fact that she has not improved over time despite all of the treatment for her 'TBI' should speak volumes to her existing care providers." Dr. Craig deferred to an independent psychiatrist to make a more definitive statement regarding frequency and length of reasonable and necessary psychiatric treatment, but confirmed Employee's "work injury is the substantial cause of the need for the recommended psychiatric treatment for PTSD, conversion disorder, and malingering." Employee is not medically stable for any of the psychiatric diagnoses. Dr. Craig said Employee's psychiatric disorders are real and actively interfering with her ability to return to work. As long as her return-to-work plan has anything to do with working in a prison setting, Employee will evidence variable levels of psychiatric complaints and symptoms. He concluded Employee will not improve if pressured to return to work in a prison setting and he suspects both her PTSD symptoms and her functional neurological symptoms will accelerate dramatically. Therefore, from a practical perspective, it is reasonable to identify a return-to-work plan that does not involve interaction with inmates or work in a prison setting. Employee cannot currently engage in any form of gainful employment; however, she may return to non-prison-related employment within the next 12 months with aggressive and appropriate treatment of Employee's PTSD, conversion disorder and malingering diagnoses. Dr. Craig noted Dr. Levenson and Ms. Bowman are compassionate providers and the extent to which either or both have become

Employee's advocates is an issue each must review for himself and herself. (EME Report, Dr. Craig, March 28, 2018.)

8) On March 28, 2018, M. Sean Green, M.D., neurologist, evaluated Employee on Employer's behalf. Of the nine diagnoses he gave, the only one he relates to Employee's work injury is nasal fracture. The others, which he states are preexisting and unrelated are:

1. Malingering.
2. Rule out somatic symptom disorder. This may be an alternative explanation to the more probable malingering, or may be comorbid with malingering.
3. Probable Grave's disease, status post thyroid ablation, recent iatrogenic hyperthyroidism (resolved), current proptosis.
4. Status post cardiac electrophysiologic ablation for ectopic atrial foci.
5. Psychogenic non-epileptic seizures (PNES, pseudoseizure). This condition is strongly associated with other somatic symptom disorders and may be a part of #2, above. PNES has implications regarding abuse, #7 below.
6. Possible depression and/or anxiety. A reliable diagnosis cannot be made in the face of diagnoses #1 and #2; but these conditions are common in the general population and may be present here.
7. Possible childhood or adolescence sexual or physical abuse; possible adult abusive relationship or family dysfunction. These circumstances occur in 50 to 90% of women with PNES (#5 above) and merit consideration, as psychiatric and medical treatment may be altered.
8. Clinically significant behavioral signs at today's examination.

Dr. Green did not provide a diagnoses for Employee's "myriad non-specific and sometimes bizarre symptoms." He considers these an expression of malingering or somatic symptom disorder rather than "independent medical conditions." Dr. Green used "malingering" to describe Employee's conscious intentional misrepresentation about her health state or symptoms and to identify "the most probable cause of otherwise medically inexplicable symptoms and signs." Dr. Green found "zero evidence" Employee had a traumatic brain injury. He said, "Invalid responding is further evidence of either serious psychiatric disease or -- as is more probable in this case -- malingering." Dr. Green deferred to Dr. Craig for a detailed analysis. (EME Report, Dr. Green, March 28, 2018.)

9) On May 16, 2018, in reliance on Drs. Green's and Craig's opinions, Employer denied further medical benefits for traumatic brain injury. (Controversion Notice, May 16, 2018.)

10) On May 29, 2018, Employee petitioned for a SIME. Employer signed the SIME form. The disputed issues are: causation, treatment, degree of impairment, functional capacity, and medical stability. (SIME Form: John Franich, May 29, 2018 and Daniel Cadra, May 30, 2018.)

11) On August 31, 2018, Dr. Levenson conducted what he called a "forensic evaluation." The first paragraph of his report states:

> Prior to discussing Mrs. Wood's case, I will provide some information on my relevant professional background, how I came to treatment [sic] Mrs. Wood, issues involved in the fact that I have a dual relationship with her, and my rationale for taking up this case.

Dr. Levenson discusses his experience as a board-certified psychiatrist in general, child and adolescent psychiatry, his decade of experience working in clinical psychiatry, neuropsychiatry and forensic practice. He shared, "As important as one's experience is one's reputation and if you have any questions regarding my clinical or forensic reputation; I can give you a list of dozens of local providers and attorney's [sic] and judges." Dr. Levenson stated he is not a "hired gun." He emphasized he has a busy private clinical practice through which he has "a reputation in the community for having the background and experience to treat individuals with an array of brain injuries. Based on this reputation a colleague of mine asked me if I would be willing to see Mrs. Wood." In describing his observations and treatment of Employee, Dr. Levenson said:

> Over the 20 plus visits I have had with Mrs. Wood, what I have consistently seen is an individual who is hyper-verbal, lacks interpersonal sensitivity, is impulsive in speech, and lacks the typical front inhibitory controls regarding emotions, speech, and judgment. This, along with a lack of awareness of the context results in periodic odd behavior. Her deficits in judgment and impulsivity has made treatment progression very difficult. She forgets and becomes confused over medication doses, she often interprets different somatic symptoms as being the result of medications and stops them abruptly, tends to feel paranoid about the motivations of those in her treatment team and at times conflates the intentions of those trying to help her (e.g. her therapist) with those who are trying to evaluate her for disability. In fact, she carries a subtle belief that her disability carrier is deliberately trying to drive her crazy (figuratively kill her) to avoid paying for her medical treatments. It became clear, as will be noted below, that these symptoms/perceptions were the result of her traumatic brain injury and not related to pre-injury conditions.

> From a symptoms standpoint she has consistently shown significant deficits in the ability to plan and anticipate, tends not to screen out thoughts whether appropriate or not, struggles with executive functioning, memory, learning, attention, visuo-spatial regulation, language and behavioral-affective modulation, abstract reasoning and working memory and personality change with disinhibited and inappropriate behavior.

Dr. Levenson reviewed Employee's independent medical evaluations and stated what they "witnessed was exactly the same symptom constellation that her other providers and I had seen and what the independent medical evaluators perceived as malingering was in fact a misinterpretation of her symptoms." Dr. Levenson believes this "misunderstanding" led to a malingering diagnosis for symptoms with a "clear" neuropsychiatric component. He said:

> [I]ndividuals who see her only once or twice and review her records would not be able to effectively understand the complexity of her case or issues involved.
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> As such, I decided to consider entering into a dual agency role with Mrs. Wood -- that of a treatment provider and that of a forensic evaluator. This created a difficult position, as my role as medical provider is to act in Mrs. Wood's best interests and my role as forensic evaluator is to provide an opinion regarding her Workmans' [sic] Compensation case. My duty in this case would be towards developing a clinical opinion on the issues at hand and present this information to her legal team including providing information that may not be supportive to her case. After personally considering the risks involved I decided that what was at stake in this case warranted my offering to take on this role.
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> In short, while it is true that I am writing this report as Mrs. Wood's advocate, my assessment stemmed from my in depth evaluation during which time I was using principals of medical and forensic science to come to an objective conclusion. The goal was not based on advocacy but scientific, clinical and medical accuracy. As such it may include information that is both favorable and unfavorable for Mrs. Wood's case.

Dr. Levenson provided "scientific background," a "brief clinical and treatment history" and his "assessment." He opined Employee has damage to the circuitry that connects the frontal lobe to the cerebellum and has lost elements of her frontal inhibition and lacks regulatory control over her memory access and cognitive control over her emotions. This impacts Employee's "capacity to inhibit her emotions and interpret past experiences in a manner that helps her regulate emotions." He said there is a significant psychiatric overlay, including depression and anxiety,

PTSD, and major depressive disorder with severe periods characterized as quasi-psychotic. Dr. Levenson noted, "An important aspect of life is engagement in meaningful work. It follows Freud's view that a definition of psychic health is to be able to love well and work well. I am a firm believer of this." Dr. Levenson's prognosis is Employee is permanently disabled from performing correctional officer duties. Employee suffers from multiple deficits that render her unemployable on the open job market and were she to obtain a job, her deficits render her "unable to manifest the perseverance, sustained focus, ability to multi-task or handle stress or fatigue for her to maintain employment." Dr. Levenson believes further evaluations add to the stress that overwhelms Employee and that there is no value in further evaluations. He acknowledges Employee is over three years post-injury and has seen numerous providers in many specialty areas. If additional evaluations are necessary, Dr. Levenson said:

> Given that I have had a dual relationship with Mrs. Wood, were one to wish to further obtain an independent medical exam by a psychiatrist, it will be critical that this be provided by a neuropsychiatrist, as most psychiatrists have little to no training in the various manifestations of traumatic brain injuries. Moreover, for this to be independent; it would be crucial that this be done by an individual who does not have access to the reports of the other independent medical exams done by physicians who have worked with OMAC.

Dr. Levenson recommends ongoing rehabilitation from a mental health provider to address PTSD, depression and adjustment issues, a psychiatrist to address and monitor neuro-cognitive symptoms and provide medication management for Employee's mood and trauma related symptoms, a neuro ophthalmologist or optometrist, physical therapy providers to address her vestibular issues and cognitive rehabilitation service providers to treat cerebellar cognitive affective syndrome.
Dr. Levenson said while Employee's "brain injury is stable in terms of neuro-physiological functions; she will need require such services over time to prevent decline in functioning, maximize her limited problem solving and coping abilities and provide rehabilitative training to deal with the ongoing vicissitudes of life that will tap her limited neuro-cognitive functions." (Forensic Evaluation Report, Dr. Levenson, August 31, 2018.)

12) On October 3, 2018, Employer petitioned to strike and objected to inclusion of Dr. Grove's November 29, 2017 letter to AAG Monsma in the SIME binder. Employer also petitioned to strike and objected to inclusion of Dr. Levenson's September 20, 2017 email in the SIME binder

for several reasons. Employer contends neither of the records authored by Dr. Levenson are medical records prepared in the ordinary course of business or to provide a medical diagnosis or treatment to Employee, are not relevant to any issue before the SIME panel and are unduly repetitious. Employer also contends the email is Dr. Levenson's attempt to insert himself in Employee's workers' compensation litigation and it is not "ordinary" for a treating physician to interject himself into litigation between a patient and a third-party. Employer contends Dr. Levenson's report is advocacy, is more prejudicial than probative on the SIME medical issues, is repetitive, redundant and cumulative and there is an inherent conflict-of-interest when a treating psychiatrist becomes a litigation advocate for his patient. Employer argues, "Allowing Levenson's report into SIME binders sets a dangerous precedent in that any treating physician of any specialty may then abandon their role as treating physician and generate expert reports (to which, presumably, Employers' IME physicians may respond to) reducing the SIME process to a platform by advocacy through physicians. If Dr. Levenson's report is permitted in the SIME binders, Employer contends the SIME process will be reduced to a platform for attorney advocacy through "so-called" experts and creates an inherent conflict of interest. Such a conflict, Employer contends, poses therapeutic risks to Employee but also risks inaccuracy and inserts lack of objectivity into the litigation process. Employer contends Dr. Grove's letter to Monsma was not generated to diagnose or treat Employee, was not produced in response to an October, 2017 records request to Head to Toe Holistic Care and is not a medical record. (Petition, October 3, 2018; Employer's Hearing Brief on Employer's Petitions to: (1) Strike Levenson Email to Insurance Adjuster and Grove Correspondence to ADA Monsma from SIME Binders and (2) Strike "Forensic Evaluation" of Treating Physician Levenson from SIME Binders, November 9, 2018.)

13) On October 10, 2018, Employee opposed Employer's petition to strike records from the SIME binder and filed a "recently received" additional record, which was Dr. Levenson's August 31, 2018 forensic evaluation report. Employee anticipated Employer would also object to inclusion of Dr. Levenson's report and agreed another hearing issue is whether the forensic report should be included in the SIME binders. Employee contended wide discretion exists to consider any available evidence other than medical records a SIME physician should review to assist in deciding disputed medical issues. She contended records Employer wants to strike from the binders are medical records but even if it is found they are not "medical records" that does

not bar the records' inclusion in the binders unless it is irrelevant, duplicative or both. (Employee's Opposition to Petition to Strike Records from SIME Binders, October 10, 2018.)

14) On October 11, 2018, Employer petitioned to strike Employee's October 10, 2018 medical summary, which contained Dr. Levenson's forensic report. Employer contended the report is not a medical record. (Petition, October 11, 2018.)

15) On October 11, 2018, Employee opposed Employer's petition to strike Dr. Levenson's forensic report. Employee contends the report is a medical record; that it should be included in the SIME binders because it is relevant to the issues the SIME physician will address and is not cumulative. Employee noted the SIME physician should have an opportunity to consider Dr. Levenson's report and offer criticism, if warranted, because he has assumed a dual role as a medical provider acting in Employee's best interest and a forensic evaluator. (Employee's Opposition to Defendants' October 11, 2018 Petition in Opposition to Inclusion of Forensic Evaluation Report of Dr. Levenson in SIME Binders, October 11, 2018.)

16) On December 10, 2018, the designee denied Employer's petitions:

> As argued by EE, the Board favors broad inclusion of medical records in SIME binders, so the SIME physicians have all relevant evidence, even the SIME records that might contain information that the Board may not be permitted to consider at Hearing.
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> In addition, EE has offered a credible explanation why Dr. Levenson's "forensic report" dated 8/31/2018 may be relevant and ER has offered no argument countering that argument; merely they argued that this report was not a "medical record." Therefore, the report will not be excluded from the 10/10/2018 medical summary.

(Prehearing Conference Summary, December 10, 2018.)

17) On December 11, 2018, Employer appealed the designee's order denying Employer's petitions to strike documents from the SIME binders. (Petition, December 11, 2018.)

PRINCIPLES OF LAW

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

> a reasonable cost to the employers who are subject to the provisions of this chapter;

The board may base its decision not only on direct testimony and other tangible evidence, but also on the board's "experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987). Liberal and wide-ranging discovery is favored. *Schwab v. Hooper Elec.,* AWCB Decision No. 87-0322 (December 11, 1987).

Coverage under the Act is established by work connection, and the work connection test is, if accidental injury is connected with any of the incidents of one's employment, then the injury both would "arise out of" and be "in the course of" employment. *Northern Corp. v. Saari*, 409 P.2d 845 (Alaska 1966).

> **AS 23.30.095. Medical treatments, services, and examinations.**
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> (k) In the event of a medical dispute regarding determinations of causation . . . or compensability between the employee's attending physician and the employer's independent medical evaluation, the board may require that a second independent medical evaluation be conducted by a physician or physicians selected by the board from a list established and maintained by the board. . . .
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> **AS 23.30.110. Procedure on claims.**
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> (g) An injured employee claiming or entitled to compensation shall submit to the physical examination by a duly qualified physician, which the board may require. The place or places shall be reasonably convenient for the employee. . . .

The Alaska Workers' Compensation Appeals Commission (commission) in *Bah v. Trident Seafoods Corp.*, AWCAC Decision No. 073 (February 27, 2008), addressed the board's authority to order an SIME under AS 23.30.095(k) and AS 23.30.110(g). With respect to AS 23.30.095(k), and referring to its decision in *Smith v. Anchorage School District,* AWCAC Decision No. 073 (February 27, 2008), the commission affirmed an SIME's purpose is to assist the board in resolving a significant medical dispute. "[T]he SIME physician is the board's expert." *Bah,* at 5.

> **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. . . .
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> **AS 23.30.155. Payment of compensation.**
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> (h) The board may upon its own initiative at any time in a case in which payments are being made with or without an award, where right to compensation is controverted, or where payments of compensation have been increased, reduced, terminated, changed, or suspended, upon receipt of notice from a person entitled to compensation, or from the employer, that the right to compensation is controverted, or that payments of compensation have been increased, reduced, terminated, changed, or suspended, make the investigations, cause the medical examinations to be made, or hold the hearings, and take the further action which it considers will properly protect the rights of all parties.

Considering the broad procedural discretion granted in AS 23.30.135(a) and AS 23.30.155(h), wide discretion exists under AS 23.30.110(g) to consider any evidence available when deciding whether to order an SIME or other medical examination and to determine evidence other than medical records an SIME physician should review to assist in investigating and deciding medical issues in contested claims, to best protect the parties' rights. *Perry v. Mappa, Inc.*, AWCB Decision No. 13-0016 (February 22, 2013).

> **8 AAC 45.092. Selection of an independent medical examiner**. (a) The board will maintain a list of physicians' names for second independent medical evaluations. The names will be listed in categories based on the physician's designation of his or her specialty or particular type of practice and the geographic location of the physician's practice. . . .
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> (h) If the board requires an evaluation under AS 23.30.095(k), the board will, in its discretion, direct
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> > (1) a party to make two copies of all medical records, including medical providers' depositions, regarding the employee in the party'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;

> (2) the party making the copies to serve the two binders of medical records upon the opposing party together with an affidavit verifying that the binders contain copies of all the medical reports relating to the employee in the party's possession;
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> (3) the party served with the binders to review the copies of the medical records to determine if the binders contain copies of all the employee's medical records in that party's possession. The party served with the binders must file the two binders with the board within 10 days of receipt and, if the binders are
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>> (A) complete, the party served with the binders must file the two sets of binders upon the board together with an affidavit verifying that the binders contain copies of all the employee's medical records in the party's possession; or
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>> (B) incomplete, the party served with the binders must file the two binders upon the board together with two supplemental binders with copies of the medical records in that party's possession that were missing from the binders and an affidavit verifying that the binders contain copies of all medical records in the party's possession. The copies of the medical records in the supplemental binders must be placed in chronological order by date of treatment and numbered consecutively. The party must also serve the party who prepared the first set of binders with a copy of the supplemental binder together with an affidavit verifying that the binder is identical to the supplemental binders filed with the board;
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> (4) the party, who receives additional medical records after the two binders have been prepared and filed with the board, 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. The party must file two of the additional binders with the board within seven days after receiving the medical records. The party must serve one of the additional binders on the opposing party, together with an affidavit stating the binder is identical to the binders filed with the board, within seven days after receiving the medical records.

As defined in *Mitchell v. United Parcel Service,* AWCB Decision No. 15-0040 (April 9, 2015), citing *Wilson v. Eastside Carpet Co.*, AWCB Decision No. 09-0029 (February 10, 2009), "medical records" for SIME purposes are "records maintained in the regular course of business by a physician or other medical provider" which "the medical provider has prepared," or which have "been generated at the direction of the physician or other medical provider, for the purpose

of providing medical diagnosis or treatment on behalf of the patient." *Wilson*, at 5, specifically stated, "while requiring the inclusion of 'all medical records, including medical providers' depositions' in the SIME binder, 8 AAC 45.092(h) does not prohibit the inclusion of 'non-medical' records." Nor does 8 AAC 45.092(h) require inclusion of non-medical records not relevant to the parties' disputes. *Wright v. Saltwater, Inc.*, AWCB Decision No. 18-0067 (July 9, 2018).

> **8 AAC 45.120. Evidence**.
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> (e) Technical rules relating to evidence and witnesses do not apply in board proceedings, except as provided in this chapter. Any relevant evidence is admissible if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil actions. Hearsay evidence may be used for the purpose of supplementing or explaining any direct evidence, but it is not sufficient in itself to support a finding of fact unless it would be admissible over objection in civil actions. The rules of privilege apply to the same extent as in civil actions. Irrelevant or unduly repetitious evidence may be excluded on those grounds. Irrelevant or repetitious evidence may be excluded on those grounds.

ANALYSIS

Did the designee abuse his discretion when he denied Employer's petitions to strike records from the SIME binder?

Alaska workers' compensation statutes and case law strongly favor development of an inclusive medical record to be considered when deciding a claim's merits. *Schwab*. Investigation and inquiry is permitted in the manner that will enable the parties' rights to be best ascertained when there is a dispute. AS 23.30.135(a); AS 23.30.155(h). All medical records, including medical providers' depositions must be included in SIME binders. 8 AAC 45.092(h)(1). This requirement does not bar inclusion of additional documents if an SIME physician's review will assist in ascertaining parties' rights. AS 23.30.001; AS 23.30.135(a); *Wilson*; *Wright*; *Perry*.

An inmate wearing a cast struck Employee in the face with the cast. The assault broke her nose. Additionally, she developed behaviors including stuttering, seizures, tremors and a movement disorder. Dr. Levenson attributes Employee's disability and need for medical treatment to a

traumatic brain injury and PTSD. Dr. Craig on the other hand has determined Employee does not have a traumatic brain injury and concluded Employee's debilitated presentation was caused because her psychiatric symptoms were misdiagnosed as post-concussive symptoms. Both Drs. Craig and Grove agree Employee is not getting appropriate treatment. According to Dr. Craig, treating PTSD as if it is a traumatic brain injury is not proper treatment and has only served to reinforce and accelerate Employee's disability behaviors. Dr. Craig diagnosed PTSD, conversion disorder and malingering and determined work is the substantial cause of Employee's disability and need for medical treatment for these three diagnoses.

Employee's case involves a complex physical-mental injury. Coverage for a work-related injury is established by a work connection. *Saari*. Employee's case involves conflicting opinions regarding the proper diagnoses and necessary treatment. These opinions scan a wide spectrum. Dr. Green opines the only injury connected to Employee's work was a nasal fracture. He determined, among six other diagnoses, Employee is malingering or has somatic symptoms disorder, either of which account for Employee's numerous "non-specific" and "bizarre" symptoms. Of all eight diagnoses, Dr. Green related none to Employee's work injury. Dr. Levenson opines Employee has a traumatic brain injury, cerebellar cognitive affective syndrome, PTSD, anxiety, depression and adjustment disorders all substantially caused by Employee's work injury. Dr. Craig's opinions and diagnoses fall somewhere in the middle.

These are significant medical disputes that must be resolved and several questions need to be answered by the SIME physicians. AS 23.30.095(k); *Smith*. Foremost is whether Employee has a traumatic brain injury caused by the June 16, 2015 work incident. Whether she does or does not will dictate reasonable and necessary treatment. Whether Employee has a cognitive impairment must be determined and, if she does, if it is medically stable or if additional reasonable and necessary medical treatment will lead to improvements. These are just a few of the issues the SIME physicians must address to assist in resolving the parties' disputes. *Id.*

Employer wants three records stricken from the SIME binders. Records from Dr. Levenson and Dr. Grove will be analyzed separately.

A) August 31, 2018 Levenson forensic evaluation and September 20, 2017 Levenson email to Penser.

Dr. Levenson's "forensic report" was written with the acknowledgment he entered into a "dual agency role" with Employee. Dr. Levenson goes to great lengths to provide details about himself, including board certifications, expertise and experience as an expert witness conducting forensic evaluations. He acknowledges he wrote the report as Employee's advocate, and then bolsters his forensic conclusions as objective and based on scientific, clinical and medical accuracy. His report is a medical record. *Wilson*; *Mitchell*. It is similar to other reports written by injured workers' treating physicians to respond to EME and SIME reports in anticipation and preparation for litigation. *Rogers & Babler*. Injured workers are often advised to ask their treating physicians to review an EME or SIME report and obtain an opinion from their doctor addressing their injury's compensability. Treating physicians, unlike EME and SIME physicians, are frequently not familiar with medical-legal terminology addressing if work is the substantial cause of disability or need for medical treatment. *Id*. Thus, giving them an opportunity to review EME and SIME reports provides the applicable compensability standards, which treating physicians can apply in conducting their assessments. *Id.*

For Employee to receive appropriate medical treatment, a correct diagnosis is needed. Dr. Levenson's forensic report contrasted against Drs. Green's and Craig's reports highlights the gulf among the opinions. Employee's presentation is complex and providers and EME physicians disagree regarding diagnoses and whether work is the substantial cause of her disability and need for medical treatment. SIME physicians' opinions will assist to determine these issues. Moreover, to best ascertain the parties' rights, SIME physicians' opinions regarding Dr. Levenson's "dual agency role" and its effect, if any, on Employee's diagnoses, causation and appropriate treatment will assist the panel in deciding these issues. *Bah*. SIME physicians' opinions that consider Dr. Levenson's forensic evaluation will also assist in determining the proper weight to be given his opinions. *Id.* The designee did not abuse his discretion when he denied Employer's petition to strike Dr. Levenson's forensic report, which is a medical record. AS 23.30.110(g); AS 23.30.135(a); AS 23.30.155(h); 8 AAC 45.092(h)(1).

Dr. Levenson's email to Penser was written to dissuade Penser from requiring Employee to attend an EME neuropsychological evaluation with Dr. Craig. Typically, if an employee does not wish to attend an EME, the employee will file a petition for a protective order, which Employee eventually did but not until after Dr. Levenson sent his email to Penser. Rarely does a treating psychiatrist make a plea to an adjuster to cancel an EME appointment. *Rogers & Babler.* However, Dr. Levenson did and asserted that to maintain the validity of neuropsychological testing, tests cannot be repeated within the same year; otherwise, Employee's recognition of the test would invalidate the test scoring. Dr. Levenson's email said it was unclear to him what further information a retest would provide considering the initial neuropsychological testing was performed by the Mayo Clinic. He concluded his email stating he did not feel comfortable discussing details of Employee's case or specific psychiatric, cognitive and functional limitations with Penser further via email. He wanted to speak with Penser to further plead Employee should not be required to undergo additional evaluations and asserted they would lead to further compromise of Employee's "mental and cognitive states."

Dr. Levenson's email remains a part of Employee's record. *Woods I* did not rely on his opinion or recommendation, gave Dr. Craig's opinions regarding retesting validity great weight and denied Employee's petition for a protective order. Dr. Levenson's forensic report, like the email to Penser, asserts further evaluations of Employee are of no value. The designee abused his discretion when he denied Employer's petition to strike this record. *Woods I* choose not to rely on this email, it contains the same opinions regarding further evaluations as the forensic report, is therefore unduly repetitious and will be stricken from the SIME binders. AS 23.30.135(a); AS 23.30.155(h); 8 AAC 45.120(e).

B) November 29, 2017 Grove letter to ADA Monsma.

Dr. Grove's letter to Monsma is a medical record. It was maintained in the regular course of Dr. Grove's treatment of Employee. *Mitchell*; *Wilson*. His letter was written to suggest Monsma utilize certain strategies to minimize Employee's exposure to stress when he worked with her to prosecute her assailant. *Id*.

The designee did not abuse his discretion and Dr. Grove's November 29, 2017 letter to Monsma will be included in the SIME binders. AS 23.30.135(a); AS 23.30.155(h).

CONCLUSION OF LAW

The board designee abused his discretion in part when he denied Employer's petition to strike records from the SIME binder.

ORDER

1) Employer's petition to strike Dr. Levenson's September 20, 2017 email to Penser is granted. This email will not be included in the SIME binders.
2) Employer's petition to strike Dr. Levenson's August 31, 2018 forensic report is denied. This report will be included in the SIME binders.
3) Employer's petition to strike Dr. Grove's November 29, 2017 letter to ADA Monsma is denied. This letter will be included in the SIME binders.

Dated in Anchorage, Alaska on December 28, 2018.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Janel Wright, Designated Chair

/s/
Rick Traini, 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 Angelee J. Wood, employee / respondent v. State of Alaska, self-insured employer, petititioner; Case No. 201509544; 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 28, 2018.

/s/
Charlotte Corriveau, Office Assistant