ALASKA WORKERS' COMPENSATION BOARD

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

JAMES SPAULDING,	)	
	)	
Employee,	)	
Claimant,	)	INTERLOCUTORY
	)	DECISION AND ORDER
v.	)	
	)	AWCB Case No. 201507256
ASRC ENERGY SERVICES,	)	
	)	AWCB Decision No. 20-0111
Employer,	)	
and	)	Filed with AWCB Fairbanks, Alaska
	)	on December 10, 2020
ARCTIC SLOPE REGIONAL CORPORATION,	)	
	)	
Insurer,	)	
Defendants.	)	

James Spaulding's December 9, 2019 petition seeking an SIME was heard on the written record in Fairbanks, Alaska on August 20, 2020, a date selected on July 24, 2020. An affidavit of readiness gave rise to this hearing. Attorney Rene Gonzalez represented James Spaulding (Employee). Attorney Timothy McKeever represented ASRC Energy Services and Arctic Slope Regional Corporation (Employer). The record closed at the hearing's conclusion on August 20, 2020.

ISSUES

Employer opposes Employee's petition for an SIME and contends Employee waived his right to an SIME since his petition was untimely filed.

Employee cites the Alaska Rules of Civil Procedure in defense of his petition and contends Employer waived its right to assert an affirmative defense since its assertion was also untimely. He also contends the panel can still order an SIME independent of his petition.

1) Does an untimely filed petition preclude an SIME?

Employee contends a number of differing medical opinions have been offered concerning additional treatment for his right shoulder, and whether or not his right shoulder is medically stable, so an SIME should be ordered.

Employer opposes Employee's petition and contends the disputes listed on Employee's SIME form do not meet the criteria for an SIME. It contends some listed disputes involve Employer's nurse case manager, who is not a physician, so her opinions cannot form the basis for an SIME, while other disputed opinions are between its own medical evaluators, and not a treating physician, so they cannot form the basis for an SIME, either. Employer further contends other disputes are based on outdated medical reports and, since Employee's medical conditions have changed over the years, any medical opinions forming the basis of an SIME should be roughly contemporaneous.

2) Should an SIME be ordered?

FINDINGS OF FACT

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

1) On May 26, 2007, Employee fell on stairs while working as an equipment operator. (Initial Report of Injury or Illness, May 29, 2007; Cross chart notes, May 29, 2007). Imaging studies showed a right shoulder humoral head fracture and a partial high-grade supraspinatus tendon tear. (Levine chart notes, May 30, 2007). He treated conservatively with physical therapy and was released back to work on a trial basis. (Serie chart notes, June 1, 2007; Moore chart notes, January 3, 2008).

2) On April 22, 2015, Employee was working for Employer as an operating engineer when he caught his left foot on carpet while descending stairs, which caused him to trip and fall down three or four stairs. He tried to catch his fall with his right hand and injured his right shoulder. Employee

reported he also strained his right wrist and neck as a result of the work injury. (First Report of Injury (FROI), May 8, 2015; Claim, January 6, 2016).

3) On April 27, 2015, a magnetic resonance imaging (MRI) study showed a full-thickness tear of the supraspinatus tendon, which had retracted medially four centimeters to the glenoid level, as well as a 50 percent tear of the infraspinatus tendon and a superior labrum tear not involving the long head of the biceps tendon. (MRI report, April 27, 2015).

4) On May 20, 2015, Employee underwent surgery with Gregory Schumacher, M.D., who performed labral debridement, arthroscopic subacromial decompression, arthroscopic distal clavicle resection and an open rotator cuff repair. (Operative Report, May 20, 2015).

5) On June 11, 2015, Employee reported his right shoulder "feels great," but his left hand had been going numb, which was keeping him from sleeping. (Physical therapy chart notes, June 11, 2015).

6) On June 18, 2015, Employee reported new hand numbness and neck pain, which Dr. Schumacher planned on evaluating during subsequent follow-up visits. (Schumacher chart notes, June 18, 2015).

7) Employer initially accepted the compensability of right shoulder treatment, but controverted cervical spine and carpal tunnel treatment. (Prehearing Conference Summary, May 10, 2017; Controversion Notice, September 29, 2015; Controversion Notice, January 6, 2016).

8) On August 20, 2015, Employee demonstrated excellent motion and reasonable strength in his right shoulder and was "slightly advanced" in his recovery from what Dr. Schumacher would expect, though persistent left arm paresthesias remained a problem. (Schumacher chart notes, August 20, 2015).

9) On August 26, 2015, a cervical MRI showed a disc protrusion resulting in severe left foraminal stenosis at C5. (MRI report, August 26, 2015).

10) On September 18, 2015, neurologist Lynne Bell, M.D., performed an employer's medical evaluation (EME) and opined the work injury was the substantial cause of Employee's right shoulder rotator cuff tear and the subsequent surgical repair. She also thought Employee had preexisting bilateral severe median entrapment neuropathies, and although Employee reported he was asymptomatic on his right side, opined "it is possible" his left-sided carpal tunnel syndrome had become symptomatic after the work injury due to an increase in left upper extremity use as a result of the immobilization of his right upper extremity. Dr. Bell later clarified, she believed Employee's altered use of his upper left extremity "caused him to transition from an asymptomatic

entrapment neuropathy to symptomatic left carpal tunnel syndrome." She also diagnosed Employee with cervical spondylosis, which she thought preexisted the work injury. Dr. Bell recommended a referral to a hand surgeon to treat Employee's left carpal tunnel syndrome and she deferred to Employee's treating surgeon for additional right shoulder treatment recommendations. (Bell report, September 18, 2015).

11) On October 13, 2015, Employer terminated Employee's employment after he had worked for Employer for 11 years. (Nurse Case Manager report, April 1, 2016).

12) On October 14, 2015, Kurt Mentzer, M.D., performed a left wrist endoscopic carpal tunnel release. (Operative report, October 14, 2015).

13) On November 12, 2015, Dr. Schumacher administered a steroid injection because Employee was experiencing increasing soreness in his right shoulder. Dr. Schumacher also planned to refer Employee back to Dr. Mentzer because of worsening right hand symptoms. (Schumacher chart notes, November 12, 2015).

14) On November 17, 2015, Dr. Mentzer planned to perform a right carpal tunnel release surgery. While Dr. Mentzer thought Employee's left carpal tunnel release surgery was work related, he did not think the right one was. (Mentzer chart notes, November 17, 2015).

15) On December 27, 2015, Dr. Bell reviewed additional records and concluded Employee's right carpal tunnel syndrome did not result from trauma, but rather was the natural progression of Employee's right median entrapment neuropathy. (Bell addendum, December 27, 2015).

16) On December 28, 2015, Dr. Schumacher thought Employee's right hand condition "seems to have come on as a result of this trauma." (Schumacher chart notes, December 28, 2015).

17) On January 21, 2016, Dr. Mentzer thought Employee had achieved a "good surgical result" from his left carpal tunnel release surgery. He planned on ordering an MRI to evaluate worsening swelling on the dorsum of Employee's left wrist. (Mentzer chart notes, January 21, 2016).

18) On January 29, 2016, a left wrist MRI showed a ganglion cyst in the superficial tissues at the dorsal aspect of Employee's wrist. (MRI report, January 29, 2016).

19) On March 11, 2016, Dr. Bell examined Employee and opined left wrist ganglion cyst was not related to trauma, but rather arose spontaneously. (Bell report, March 11, 2016).

20) On March 24, 2016, Employee was complaining of increasing right shoulder pain and was concerned his recovery was stalling. He demonstrated poor overhead motion and significant wincing as he tried to come past 90 degrees of forward flexion or abduction. Dr. Schumacher did

not think further surgical intervention was appropriate and was skeptical of performing another steroid injection. He and Employee discussed the possible need for job retraining. (Schumacher chart notes, March 24, 2016).

21) On April 6, 2016, Employee sought a finding of unfair or frivolous controversion, citing Employer's controversion of right carpal tunnel treatment, which Employee thought was related to the work injury. (Claim, January 6, 2016).

22) On April 15, 2016, orthopedic surgeon Douglas Bald, M.D., performed an EME and opined the work injury "has been and continues to be the 'substantial cause' of Employee's right shoulder condition, including the surgical repair performed by Dr. Schumacher on May 20, 2015." He recommended a repeat right shoulder MRI and specific treatment directed at Employee's adhesive capsulitis, including a fluoroscopy guided corticosteroid injection of the glenohumeral joint followed by a "fairly vigorous" regimen of stretching and physical therapy. Dr. Bald did not think Employee had the physical capacities to return to work as an equipment operator. (Bald report, April 15, 2016).

23) On May 9, 2016, after returning from Dr. Bald's EME, Employee had an "unequivocally clear intent of getting an MRI of the right shoulder." Dr. Schumacher "immediately complied with [Employee's] demands," and promised to "help [Employee] understand the outcome." (Schumacher chart notes, May 9, 2016).

24) On May 16, 2016, a right shoulder MRI showed show a high grade, full thickness tear of the anterior aspect of the supraspinatus tendon without retraction. Harold Cable, M.D., noted, "The patient did have extreme difficulty remaining motionless for this sturdy and many of the images are degraded by patient motion." (Cable report, May 16, 2016).

25) On May 17, 2016, Employee continued to experience persistent pain and swelling in his left wrist and hand. Dr. Mentzer thought Employee's report of no significant improvement overall was "concerning." He ordered a repeat electrodiagnostic study to evaluate Employee's response to surgical intervention. (Mentzer chart notes, May 17, 2016).

26) On May 25, 2016, an electrodiagnostic study showed ongoing severe left carpal tunnel syndrome. (Levine report, May 25, 2016).

27) On June 6, 2016, Dr. Schumacher reviewed Employee's May 16, 2016 MRI study and thought it exhibited "motion artifact and is grainy." He initially disagreed with Dr. Cable's interpretation and opined the study showed "near complete healing of the tear," but also observed

"there was a high signal there" and it was not clear to him whether that demonstrated a complete failure or new tearing. Dr. Schumacher ordered a nerve conduction study and referred Employee for a cervical spine evaluation. (Schumacher chart notes, June 6, 2016).

28) On June 14, 2016, an electrodiagnostic study showed severe right carpal tunnel syndrome. (Levine report, June 14, 2016).

29) On June 21, 2016, Employee reported unrelenting pain and swelling in both wrists and left hand pain was keeping him up at night. Dr. Mentzer's findings on physical examination suggested probable bilateral inflammation of the dorsal tenosynovium and he planned on performing an open left carpal tunnel release surgery. (Metzer chart notes, June 21, 2016).

30) On July 7, 2016, Dr. Schumacher observed Employee "was about to undergo a lot of work on his hands," which "will take a month or two." Afterwards, if Employee's right shoulder was still bothering him, Dr. Schumacher would consider performing revision arthroscopic surgery, however he made it "abundantly clear" to Employee the overall healing in his shoulder was "quite good, and any improvement might not be as much as [Employee] is hoping for, even if performed perfectly." (Schumacher chart notes, July 7, 2016).

31) On July 18, 2016, Employee was referred for allergy testing to determine if he was allergic to either long-acting steroids or the anesthetic he was given for his right shoulder. (Levine letters, July 18, 2016; November 9, 2016).

32) On November 3, 2016, Employee's physiatrist, Larry Levine, M.D., thought Employee should not return to work until it was known whether he would undergo repeat shoulder surgery. Dr. Levine also opined Employee would "certainly" have a permanent impairment as a result of his shoulder injury and was "not sure" whether Employee could return to his previous employment. (Levine chart notes, November 3, 2016).

33) On January 9, 2017, dermatologist Patricia Norris, M.D., performed an EME to evaluate Employee for potential allergies to steroids and anesthetics. Employee reported a history of anaphylaxis to an anesthetic, "possibly and likely," lidocaine. Because of the risk of anaphylaxis, Dr. Norris decided to forgo testing for anesthetic allergies. She did administer patch testing for steroid screening allergens and concluded Employee had mild reactions to Class B steroids and Class D2 steroids, as well as sodium methylcellulose, which is a preservative in Kenalog 10. Dr. Norris recommended Employee avoid all steroids in these two classes. (Norris report, January 9, 2017).

34) On January 23, 2017, Dr. Levine reviewed Dr. Norris's report and had "little to offer in relation to [Employee's] overall situation." He was "at a loss as to what to recommend next." Employee thought he would best benefit from decompression of the carpal tunnel so he could get hand function back before undergoing shoulder surgery. With respect to Employee's shoulder, Dr. Levine thought it best to get Employee's adhesive capsulitis under control before doing an open procedure. One consideration was doing Employee's shoulder surgery with manipulation under anesthesia. Dr. Levine planned on referring Employee to Michael McNamara, M.D., for his hand surgery. (Levine chart notes, January 23, 2017).

35) On February 16, 2017, Dr. McNamara saw Employee on a "very complex second opinion referral from Dr. Larry Levine." Dr. McNamara assessed a high-grade partial scapholunate ligament tear, which had caused a moderate amount of symptoms, swelling, dorsal tenosynovitis and probably contributed to Employee's severe left carpal tunnel syndrome. Given that Employee's carpal tunnel symptoms did not resolve after an endoscopic carpal tunnel release suggested an incomplete release to Dr. McNamara. A "re-release" surgery was planned, at which point Dr. McNamara would also evaluate Employee's scapholunate ligament and switch to an open repair with temporary screw fixation. (McNamara chart notes, February 16, 2017).

36) On March 31, 2017, Dr. McNamara performed left wrist arthroscopic surgery with triangular fibrocartilage complex debridement, open carpal tunnel release and open scapholunate ligament repair. Dr. McNamara observed permanent pathology of the tenosynovium, which he thought could be of rheumatologic etiology. (Operative Report, March 31, 2017).

37) On April 3, 2017, biopsy specimens were found to be benign fibrous connective tissue consistent with a ganglion cyst. (Pathology report, April 3, 2017).

38) On April 11, 2017, Employee's incision site was clean, dry and well healed without any signs of infection. His sutures were removed with no wound dehiscence; however, he had a moderate soft tissue edema so he was placed in a well-padded thumb spica split instead of a cast. (Thomas chart notes, April 11, 2017).

39) On May 9, 2017, Employee was having "quite a bit of pain." He reported, if he rests his arm on a table, it feels like "'his joint is pulling apart,'" shooting pain from his fingertips up into his forearm. Chronic regional pain syndrome (CRPS) was considered as a potential assessment. (Thomas chart notes, May 9, 2017).

40) On June 27, 2017, Employee's rheumatologic workup was negative and he was still experiencing sharp, throbbing pain in his left wrist, which Dr. McNamara suspected could have been the result of an inflammatory process. He planned on referring Employee in order to get a formal diagnosis of Employee's continued swelling and pain and decided to keep Employee off work for another eight weeks. (McNamara chart notes, June 27, 2017; referral letter, July 21, 2017).

41) On August 31, 2017, Employee underwent a left wrist dexamethasone and lidocaine injection (Davis report, April 18, 2018).

42) On September 26, 2017, Employee's left wrist swelling was markedly improved, but he had developed a rash and was itching constantly. Dr. McNamara noted Employee had been injected with lidocaine, Marcaine and dexamethasone to reduce swelling and unfortunately later found out Employee had a "cain [sic] and steroid prior workup with an allergy to that." He suspected seronegative rheumatoid arthritis despite Employee's negative rheumatologic lab results. (McNamara chart notes, September 26, 2017).

43) On October 12, 2017, rheumatologist Summer Engler, M.D., evaluated Employee on referral from Dr. McNamara. She thought the etiology of Employee's left wrist swelling and tenosynovitis was "unclear." She considered, and ruled out, differential diagnosis, including, insidious infection; underlying spondyloarthropathy or other rheumatologic conditions predisposing to tenosynovitis, and inflammatory arthritis such as rheumatoid or psoriatic arthritis; monosodium urate and calcium pyrophosphate crystal gout. Dr. Engler opined complex regional pain syndrome might be considered as a diagnosis and ordered a tri-phase bone scan to rule it out. She also ordered an HLA-B27 lab test to check for a genetic predisposition for tenosynovitis and additional x-rays of the hands, wrists and feet to rule out inflammatory arthritis, gout and pseudogout. (Engler chart notes, October 12, 2017).

44) On October 31, 2017, Bryan Winn, M.D. interpreted a bilateral hand tri-phase bone scan to not show a typical pattern for complex regional pain syndrome but rather a pattern for hardware infection, hardware loosening, inflammatory arthropathy, and osteonecrosis. (Winn report, October 31, 2017). On that same date, Dr. McNamara assessed "left wrist inflammatory versus rheumatologic inflammatory arthritis of the wrist, now at seven months, with an almost unusable wrist." He was planning on awaiting Dr. Engler's "rheumatologic med trial" to see if that would improve Employee's left wrist. He thought this would be "the last chance" of getting Employee

better with medicinal treatment, and if that failed, he would recommend a full wrist fusion, which he thought would get Employee back to work the fastest and improve his function. (McNamara chart notes, October 31, 2017).

45) On November 21, 2017, Dr. McNamara reviewed Employee's October 31, 2017 bone scan and concluded it did not show signs of an infection. He also noted Dr. Engler "felt that there was nothing that she could offer [Employee] at this time." Dr. McNamara thought Employee might have to have his left wrist fused if he continued to have pain and encouraged a referral to a hand surgeon for another opinion. (Thomas chart notes, November 21, 2017).

46) On January 11, 2018, Employee had developed a pruritic rash, which started at his surgical sight and went straight up his arm to his shoulder. He stated the rash started on September 1, 2017, following a steroid injection of his wrist on August 31, 2017, but it had only recently become pronounced. Employee was very hesitant to start any systemic arthritis therapy unless he had a confirmed diagnosis of an inflammatory arthritis. Dr. Engler noted the tri-phase bone scan indicated hardware infection, hardware loosening and osteonecrosis. She thought it might be useful to obtain an additional MRI to evaluate tenosynovitis in the bilateral wrists. Dr. Engler planned on referring Employee to a dermatologist, who accepts workers' compensation patients, for his rash. Dr. Engler also planned on discussing Employee's x-rays with Dr. McNamara. (Engle chart notes, January 11, 2018).

47) On January 18, 2018, Dr. Levine thought the only treatment that would improve Employee's wrist was a fusion, but Employee's rash should be treated first because of infection risks with surgery. He also though referral for another opinion on Employee's wrist was appropriate. (McNamara chart notes, January 18, 2018).

48) On February 19, 2018, a left wrist MRI showed mild marrow edema in the lunate, capitate and the distal aspect of the scaphoid bone, and nonspecific inflammation around the wrist. A small perforation of the triangular fibrocartilage complex (TFCC) at its attachment to the ulnar styloid was also observed. (MRI report, February 19, 2018).

49) On March 20, 2018, Dr. Norris performed an EME and diagnosed staphylococcus capitis infection and dermatitis, which appeared to be in a dermatomal distribution. She suggested Employee might undergo a course of antibiotics, even though staphylococcus capitis was a rare prosthetic joint infection. Dr. Norris noted Employee had previously had a mild test reaction to Class B steroids, and triamcinolone, a Class B steroid, had been injected the day before the onset

of the rash. However, she did not think Employee's rash was consistent with contact dermatitis because in was not pruritic and because Employee's biopsy indicated otherwise. In her analysis, Dr. Norris characterized Employee's rash as "unusual," and postulated, "it is possible that the injection triggered [an allergic] reaction," but she "[could] not explain why the rash moved up the arm unless it became secondarily infected with the Staphylococcus capitis." She concluded Employee's need for treatment was substantially caused by the work injury and Employee's injection had aggravated the rash. Dr. Norris recommended an antibiotic trial and a topical steroid to see if the rash would clear. She further opined Employee's rash was delaying his recovery. (Norris report, March 20, 2018).

50) On March 20, 2018, rheumatologist Peter Bonafede, M.D., performed an EME and assessed Employee as having "complex musculoskeletal / neurological problems." He thought Employee's right rotator cuff tear and left carpal tunnel syndrome were related to the work injury, but his right carpal tunnel syndrome and cervical spondylosis were not. He further opined Employee's dermatological condition or allergies had delayed additional surgical procedures on his left wrist. Dr. Bonafede questioned Employee's previous tenosynovitis diagnosis since his histology showed benign fibrous material instead of inflammatory tissue. He deferred to Employee's dermatologist for further evaluation of his skin condition and its impact on his care. Dr. Bonafede opined Employee's right shoulder lifting restrictions were permanent and the result of the work injury, while his left wrist activity restrictions, though work related, would depend on the results of any future surgery. He recommended ongoing rehabilitation of Employee's right shoulder until it reached a plateau, and possible further surgery on his left wrist, and thought neither condition had reached medical stability. (Bonafede report, March 20, 2018).

51) On March 21, 2018, orthopedic surgeon Kathryn Hanna, M.D., performed an EME, and assessed preexisting right shoulder rotator cuff tendinitis, preexisting right greater tuberosity fracture, preexisting cervical spondylosis with degenerative changes, preexisting left wrist inflammation and degeneration, and preexisting right carpal tunnel syndrome, none of which were aggravated by the work injury, in her opinion. Dr. Hanna also assessed right shoulder rotator cuff repair, which was caused by the work injury and preexisting left carpal tunnel syndrome that became symptomatic because Employee did not have use of his right upper extremity. Both of these conditions had reached maximum medical improvement. A potential allergic reaction to cortisone was not related to the work injury but it was slowing Employee's recovery. Employee's

work restrictions included no overhead lifting and a seven percent right upper extremity PPI was assessed, both resulting from the work injury. (Hanna report, March 21, 2018).

52) On April 17, 2018, Dr. McNamara referred Employee to the Mayo Clinic for a "bizarre" dermatologic rash following a steroid injection that had not resolved after eight months and unresolving dorsal tenosynovitis effusion. (Referral form, April 17, 2018; Davis email, April 18, 2018). Although Dr. Bonafede had advised Employee he did not think the rash was the result of a rheumatologic process, Dr. McNamara stated, "I'm not so sure about that." (Davis report, April 18, 2018).

53) On July 2, 2018, Dr. Hanna opined Employee's right shoulder and left wrist were medically stable and required no further treatment, though she thought Employee would not have the physical capacities to return to work as a Station Mechanic. (Hanna addendum, July 2, 2018). On that same date, Dr. Bonafede also opined Employee did not have an inflammatory rheumatic disease and thought Employee's left carpal tunnel syndrome was no longer the cause his disability. Dr. Bonafede attributed 80 percent of Employee's carpal tunnel syndrome to "underlying reasons" and 20 percent as an aggravation from the work injury. He thought additional surgery on Employee's right shoulder might be necessary but no additional treatment was necessary for Employee's carpal tunnel syndrome. (Bonafede addendum, July 2, 2018).

54) On July 9, 2018, Dr. Norris no longer thought Employee's rash was delaying his recovery from other conditions. (Norris letter, July 9, 2018).

55) On August 7, 2018, Employee was evaluated by a panel of physicians at the Mayo Clinic on referral from Dr. McNamara. Rheumatologist Thomas Osborn, M.D., did not think Employee was suffering from an ongoing rheumatologic illness, nor did he think additional rheumatologic or autoimmune testing was indicated. (Osborne chart notes, August 7, 2018). On that same date, dermatologist Sartori Valinotti, M.D., opined Employee did not suffer from contact dermatitis but assessed lichen simplex chronicus instead, which Dr. Valinotti did not think should preclude surgery because there were no signs of a concerning infectious process. (Valinotti chart notes, August 7, 2018). Also on August 7, 2018, after reviewing additional imaging and performing nerve blocks, orthopedic surgeon, Louis Poppler, M.D., thought Employee's surgical screw was "almost certainly loose," and since it stood "slightly proud" to the scaphoid articular surface, which he opined, was an ongoing cause of Employee's pain. Dr. Poppler thought Employee's best option

was removal of the screw with concomitant nerve neurectomies. (Poppler chart notes, August 7, 2018).

56) On October 10, 2018, Employee was still complaining of right shoulder and left wrist pain and was frustrated with his overall situation. He "just want[ed] his life back in relation to his limbs working the way their [sic] supposed to." Dr. Levine noted "discrepancies" of opinions between orthopedic hand surgeons, one of which thinks the cortical bone screws going into the joint are causing Employee's problem and should be removed, and another who thinks Employee's left wrist should be fused. Dr. Levine thought the "minimal procedure" of hardware removal "makes more sense" than fusion surgery, which Employee could undergo later. He thought it was reasonable to obtain additional opinions on treatment options for Employee's left wrist and "[c]ertainly" did not think Employee's right shoulder rotator cuff tear with adhesive capsulitis was medically stable. Both Employee's shoulder and wrist injuries were preventing his ability to return to work as equipment operator, in Dr. Levine's opinion. Employee was interested in pursuing surgical intervention at the Mayo Clinic, which in Dr. Levine's opinion, would "go a long way . . . towards optimizing the chances of a good outcome and recovery." (Levine chart notes, October 10, 2018).

57) On October 24, 2018, Employer controverted right shoulder medical treatment based on Dr. Hanna's medical stability opinion. (October 24, 2018).

58) On November 19, 2018, Dr. McNamara removed Employee's scapholunate screw, though he remained "very adamant" that a wrist fusion would improve Employee's likelihood of returning to gainful employment. (Operative Report, November 19, 2018).

59) On April 2, 2019, Employee reported his wrist strength was improving and the pain was much better than before surgery, though he was still experiencing numbness and tingling on the dorsal side of his wrist. He was "very happy" with how his wrist was doing and wanted to undertake job retraining to perform safety engineer inspection work. Dr. McNamara opined Employee's left wrist was medically stable and planned to refer him to Dr. Levine for a PPI rating, but still thought Employee would require a wrist fusion in the future. (McNamara chart notes, April 2, 2019).

60) On April 18, 2019, Employee sought medical and indemnity benefits for his work injury. (Claim, April 18, 2019).

61) On May 7, 2019, Dr. Levine rated Employee with an 11 percent whole person impairment. (Levine chart notes, May 7, 2019).

62) On December 9, 2019, Employee sought an SIME for alleged right shoulder medical disputes. (Employee's petition, December 9, 2019). His SIME form lists purported disputes between Employer's nurse case manager and one of Employee's treating physicians, as well as between Employer's nurse case manager and one of Employer's own medical evaluators. Other purported disputes are based on differing opinions between 2016 and 2018. Employee's SIME form also cited a March 21, 2018, right shoulder medical stability opinion of Dr. Hanna, where she opined Employee's right shoulder was medically stable, and an October 10, 2018 right shoulder medical stability opinion of Dr. Levine, where he opined Employee's right shoulder was not medically stable. (Employee's SIME Form, December 9, 2019).

63) The record is unclear as to when Employer served Employee with Dr. Hanna's March 21, 2018 report; however, Employee filed it with an April 19, 2019 medical summary. (Observations; Employee's Medical Summary April 19, 2019).

64) On December 20, 2019, physiatrist Patrick Radecki, M.D., performed an EME and opined Employee's left wrist required no further medical treatment and was medically stable in April 2019. He also thought Employee's right shoulder was medically stable by definition, given the lack of objectively measurable improvement for 45 days, but the issue of further right shoulder medical treatment was a "complex" question, which should be directed at an orthopedic surgeon. (Radecki report, December 20, 2019). Dr. Radecki also opined Employee could not work as a safety inspector. (Radecki reply, January 23, 2020).

65) On February 14, 2020, orthopedic surgeon John Ballard, M.D., performed an EME and diagnosed Employee with right rotator cuff tear, status post labral debridement, sub-acromial decompression, distal clavicle resection, and mini open rotator cuff repair, as well as chronic right shoulder pain of "unknown etiology." He could not provide an objective explanation for Employee's significantly restricted range of motion and right shoulder pain. Dr. Ballard wrote:

> There is no measurable improvement in [Employee's] right shoulder with my physical exam, compared to Dr. Hanna and Dr. Levine. In fact[,] there is significant deterioration. There is no indication that any further improvement will occur with additional medical care treatment [sic]. There is no objective explanation for such a deterioration in his shoulder. His symptoms are based upon subjective complaints

> without an objective basis. I do agree that he has reached medical stability. He would have been medically stationary by March 21, 2018.

He concluded no further treatment "will make any difference in [Employee's] current subjective complaints. . . ." (Ballard report, February 14, 2020).

66) At a July 24, 2020 prehearing conference, Employee's December 9, 2019 petition was set as the sole issue for hearing. (Prehearing Conference Summary, July 24, 2020).

67) Employer first raised the issue of Employee's petition being untimely filed in its hearing briefs, where he contended Employee received the medical reports, which he claims evidences medical disputes, more than 60 days prior to his December 9, 2019 petition. (Employer's hearing briefs, August 6, 2020; August 13, 2020). In his reply brief, Employee cited the Alaska Civil Rule 8 and 12 in defense of his petition and contends Employer waived its right to assert an affirmative defense since its assertion was also untimely. (Employee reply brief, August 13, 2020). Employee also contended the panel could still order an SIME independent of his petition. (*Id.*).

PRINCIPLES OF LAW

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**. (a) The employer shall furnish medical, surgical, and other attendance or treatment . . . for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. . . . It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require. . . .
>
> (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. . . .

> **AS 23.30.110. Procedure on Claims.** (a) . . . the board may hear and determine all questions in respect to the claim.
> . . . .
>
> (g) An injured employee claiming or entitled to compensation shall submit to the physical examination by a duly qualified physician which the board may require. The place or places shall be reasonably convenient for the employee. The physician or physicians as the employee, employer, or carrier may select and pay for may participate in an examination if the employee, employer, or carrier so requests. Proceedings shall be suspended and no compensation may be payable for a period during which the employee refuses to submit to examination.
> . . . .

Considering the broad procedural discretion granted in AS 23.30.135(a) and AS 23.30.155(h), wide discretion exists under AS 23.30.095(k) and AS 23.30.110(g) to consider any evidence available when deciding to order an SIME in order to "properly protect the rights of all parties."

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 §095(k) and §110(g). With regard to §095(k), the Commission referred to its decision in *Smith v. Anchorage School District,* AWCAC Decision No. 050 (January 25, 2007), at 8, in which it confirmed:

> [t]he statute clearly conditions the employee's right to an SIME . . . upon the existence of a medical dispute between the physicians for the employee and the employer.

The Commission further stated in *dicta*, before ordering an SIME it is necessary to find the medical dispute is significant or relevant to a pending claim or petition and the SIME will assist the board in resolving the dispute. *Bah* at 4.

The Commission outlined the board's authority to order an SIME under §110(g), as follows:

> [T]he board has discretion to order an SIME when there is a significant gap in the medical or scientific evidence and an opinion by an independent medical examiner or other scientific examination will help the board in resolving the issue before it. . . . Ordering an SIME is not proper if it serves no purpose to the board by advancing its understanding of the medical evidence or by filling in gaps in the medical evidence, where that gap in evidence, or lack of understanding of the medical evidence, prevents the board from ascertaining the rights of the parties.

Id. at 5. Accordingly, an SIME pursuant to §095(k) may be ordered when there is a medical dispute, or under §110(g) when there is a significant gap in the medical evidence or a lack of understanding of the medical evidence.

> **AS 23.30.135. Procedure before the board.** (a) In making an investigation or inquiry or conducting a hearing the board is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided 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. . . .

The board has broad statutory authority in conducting its investigations and hearings. *Tolson v. City of Petersburg*, AWCB Decision No. 08-0149 (August 22, 2008); *De Rosario v. Chenenga Lodging*, AWCB Decision No. 10-0123 (July 16, 2010).

> **AS 23.30.155. Payment of compensation.**
> . . . .
>
> (h) The board may, upon its own initiative and 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.

> **AS 23.30.395. Definitions.**
> . . . .
>
> (28) "medical stability" means the date after which further objectively measurable improvement from the effects of the compensable injury is not reasonably expected to result from additional medical care or treatment, notwithstanding the possible need for additional medical care or the possibility of improvement or deterioration resulting from the passage of time; medical stability shall be presumed in the absence of objectively measurable improvement for a period of 45 days; this presumption may be rebutted by clear and convincing evidence;
> . . . .
>
> (32) "physician" includes doctors of medicine, surgeons, chiropractors, osteopaths, dentists, and optometrists;

. . . .

8 AAC 45.092. Second independent medical evaluation.
. . . .

(g) If there exists a medical dispute under AS 23.30.095 (k),
. . . .

(2) a party may petition the board to order an evaluation; the petition must be filed within 60 days after the party received the medical reports reflecting a dispute, or the party's right to request an evaluation under AS 23.30.095 (k) is waived;
. . . .

(3) the board will, in its discretion, order an evaluation under AS 23.30.095 (k) even if no party timely requested an evaluation under (2) of this subsection if
. . . .

(B) the board on its own motion determines an evaluation is necessary.

ANALYSIS

1) Does an untimely filed petition preclude an SIME?

Employer correctly observes a regulation requires a party to petition for an SIME within 60 days of receiving the medical reports giving rise to a dispute or its right to request an SIME is waived. 8 AAC 45.092(g)(2). In defense of his petition, Employee cites the Alaska Rules of Civil Procedure and contends Employer waived its right to assert an affirmative defense since its assertion was also untimely. His contention in this regard is unpersuasive, given that workers' compensation proceedings are not governed by the Civil Rules. AS 23.30.135(a). However, Employee also correctly points towards another regulation that is directly on point, which provides a panel can order an SIME even if a party did not timely request one. 8 AAC 45.092(g)(3). Moreover, in addition to having the independent authority to order an SIME based on disputed medical opinions, a panel has further authority to order an SIME when there are gaps in the medical evidence that would prevent a panel from ascertaining the parties' rights, or where an SIME will facilitate a panel's understanding of the medical evidence. AS 23.30.155(g); *Bah*. Therefore, an untimely filed petition does not necessarily preclude an SIME.

2) Should an SIME be ordered?

Employee's SIME form lists purported disputes between Employer's nurse case manager and one of Employee's treating physicians, as well as disputes between Employer's nurse case manager and one of Employer's own medical evaluators. Other purported disputes listed on Employee's SIME form are based on differing opinions offered in 2016 and 2018. Under AS 23.30.095(k), an SIME is conditioned upon there being a dispute between Employee's treating physician and Employer's medical evaluator. *Bah*. Therefore, Employer's contentions that qualifying disputes cannot be based on its nurse case manager opinions, 23.30.095(e); AS 23.30.095(32), and cannot be based on disputes between its own medical evaluators, AS 23.30.095(k), are well-taken. So too is its contention that any medical opinions forming the basis of an SIME should be roughly contemporaneous because, as the medical record plainly shows, Employee's conditions have significantly changed over time since his 2015 injury. *Rodgers & Babler*. Nevertheless, Employee's SIME form sets forth another dispute. On March 21, 2018, Employer's medical evaluator, Dr. Hanna, opined Employee's right shoulder was medically stable, an opinion she reiterated on July 2, 2018, which is in opposition to Employee's treating physician, Dr. Levine's, October 10, 2018, right shoulder medical stability opinion. Therefore, even after certain purported medical disputes on Employee's SIME form are eliminated from consideration, Employee's form still sets forth a qualified dispute meriting an SIME. *Bah*.

In addition to ordering an SIME based on disputed medical opinions under AS 23.30.095(k), an SIME is also appropriate under AS 23.30.110(g) when there is a gap in the medical evidence that prevents a panel from ascertaining the parties' rights. *Bah*. On July 7, 2016, Employee's orthopedic surgeon, Dr. Schumacher observed Employee "was about to undergo a lot of work on his hands," and if Employee's shoulder was still bothering him following that treatment, Dr. Schumacher would consider performing right shoulder revision arthroscopic surgery. Similarly, on January 23, 2017, Dr. Levine noted Employee thought he would benefit from carpal tunnel decompression surgery so he could get hand function back before undergoing additional shoulder surgery. However, Employee's left hand treatment was significantly delayed while a multitude of both Employee's physicians, including Drs. McNamara, Levine, Osborn, Valinotti, and Poppler; as well as Employer's medical evaluators, including Drs. Norris, Engler, and Bonafede, sought to

diagnose and treat Employee's left upper extremity rash and his continuing left hand symptoms. It was not until April 2, 2019, and only after an additional surgery was undertaken to remove a scapholunate screw, that Dr. McNamara finally declared Employee's left wrist medically stable.

The prolonged course of treatment for Employee's left hand prevented Drs. Schumacher and Levine from ever revisiting the subject of potential revision surgery to Employee's right shoulder, even though, on October 10, 2018, Dr. Levine continued to think it was not medically stable. At about that same time, Dr. Bonafede also thought Employee might require additional shoulder surgery. Only much later, and following Employee's SIME petition, did Employer's newest medical evaluators, Drs. Radecki and Ballard, opine Employee's right shoulder was medically stable. Significantly, their medical stability opinions were mere presumptions under AS 23.30.395(28) based solely on a lack of objectively measurable improvement for 45 days. Given, that Employee's right shoulder had not received any medical attention for over four years while he pursued left hand treatment, it is hardly surprising that it had not recently improved. *Rogers & Babler*.

Under these circumstances, a four-year gap in the evaluation and treatment of Employee's right shoulder is significant because Employee might well be entitled to further right shoulder treatment. *Id*.; AS 23.30.095(a). However, based on the current medical record, this determination cannot be made. Since an SIME will assist the panel in ascertaining the parties' rights, one should be ordered; and since the most recent treatment contemplated by Employee's treating physicians was arthroscopic shoulder surgery, an orthopedic surgeon should perform it. *Bah*.

CONCLUSIONS OF LAW

1) An untimely filed petition does not necessarily preclude an SIME.
2) An SIME should be ordered.

ORDERS

1) Employee's December 9, 2019 petition seeking an SIME is granted.
2) An SIME shall be undertaken by an orthopedic surgeon.

Dated in Fairbanks, Alaska on December 10, 2020.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Robert Vollmer, Designated Chair

/s/
Sarah Lefebvre, Member

/s/
Lake Williams, 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 JAMES SPAULDING, employee / claimant v. ASRC ENERGY SERVICES, employer; ARCTIC SLOPE REGIONAL CORPORATION, insurer / defendants; Case No. 201507256; dated and filed in the Alaska Workers' Compensation Board's office in Fairbanks, Alaska, and served on the parties by certified U.S. Mail, postage prepaid, on December 10, 2020.

/s/
Ronald C. Heselton, Office Assistant II