ALASKA WORKERS' COMPENSATION BOARD

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

ERNEST REAGAN, Employee, Claimant, v. KENWORTH NORTHWEST, INC., Employer, and ALASKA NATIONAL INSURANCE, Insurer, Defendants.	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 201513964 AWCB Decision No. 24-0050 Filed with AWCB Fairbanks, Alaska on September 9, 2024.

Ernest Reagan's (Employee) July 25, 2024 petition for a second independent medical evaluation (SIME) was heard on the written record on August 22, 2024 in Fairbanks, Alaska, a date selected on August 8, 2024. The July 25, 2024 petition gave rise to this hearing. Attorney Robert Bredesen represented Employee. Attorney Vicki Paddock represented Kenworth Northwest, Inc. and Alaska National Insurance (Employer). The record closed at the hearing's conclusion on August 22, 2024.

ISSUE

Employee contends there is a significant medical dispute between Employee's attending physician and an employer's medical evaluator (EME) warranting an SIME. He also contends a psychiatric SIME was recommended by an SIME physician warranting an SIME under AS 23.30.110(g).

Employer contends there is no significant medical dispute in this case and an SIME is not necessary. It contends the request for an SIME should be denied.

Shall this decision order an SIME?

FINDINGS OF FACT

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

1) On August 25, 2015, Employee reported he injured his back, knee and arm on August 21, 2015, while working as a mechanic for Employer when the torque wrench he was using to tighten a wheel bearing slipped and he fell forward on his knee and scraped his arm on a mud flap. (Report of Occupational Injury or Illness, August 25, 2015).

2) On November 24, 2015, Employee reported a history of agoraphobia beginning around 1995 but his symptoms did well after he got married. Employee described being very particular about the condition of his home and becoming short tempered if things were out of place. He stated his fear of public places had made it difficult for him to leave home, his sleep was impaired, he cleaned before and after work and he was "picking at" and yelling at his family members. Employee requested Xanax because it worked in the past and Klonopin was not "scratching the surface" of his symptoms. Zachary Werle, DO, prescribed Xanax and referred Employee for counseling. (Werle Chart Note, November 24, 2015).

3) On December 2, 2015, Employee saw Angela Brown, LPC, upon referral for counseling. He reported struggles with stress, aggression, sleeping and obsessive-compulsive disorder-like tendencies with cleaning. Brown assessed risk factors including symptoms of depression, medical concerns, increased anger and unemployment. She diagnosed adjustment disorder with depressed mood. Employee stated he did not feel he needed to attend therapy and would call if further sessions were needed. (Brown Psychiatric Diagnostic Evaluation, December 2, 2015).

4) On December 9, 2015, Employee followed up regarding his lower back injury. He reported having a lot more anxiety and agitation now than he had in the past; he had been "more short" with everyone and wanted help with anxiety. Employee was prescribed Celexa and Ativan for adjustment disorder with depressed mood. (Luke Hawes, DO, and Eric Schneider, DO, Chart Notes, December 9, 2015).

5) On December 18, 2015, Employee stated his lower back pain was not controlled and he had a disagreement with his pain management physician earlier that week. He complained of increasing anxiety and agitation, Celexa was making him "loopy" and Ativan was not helping. He asked for 90 days of Xanax. Dr. Haws told Employee Xanax was not the correct medication and continued Celexa and referred Employee to a psychiatrist. (Haws Chart Note, December 18, 2015).

6) On January 8, 2016, Dr. Haws predicted Employee will not have the physical capabilities to perform the physical demands of diesel mechanic and small-engine mechanic. (Haws Job Analysis, January 8, 2016).

7) On January 8, 2016, Ronald Teed, MD, orthopedist, evaluated Employee for an EME. Dr. Teed diagnosed a work-related L5-S1 disc protrusion with left-sided L5 radiculopathy and non-work-related spondylosis of the lumbar spine. He recommended Employee lift no greater than or equal to 25 pounds secondary to the August 2015 work injury. He stated, "a neurology evaluation, and possible nerve tests, may be helpful in determining the presence of radiculopathy and thus treatment thereof." (Teed EME Report, January 8, 2016).

8) On January 20, 2016, Employee said he was trying to see a psychiatrist at Fairbanks Neurological, Psychiatric Associates but was turned down. Peter S. Jiang, MD, performed a left S1 transforaminal epidural steroid injection under fluoroscopy. (Jiang Operative Note, January 20, 2016).

9) On January 25, 2016, Employee followed up with Dr. Haws regarding lower back pain and agitation. He was still experiencing agitation and felt it could be due to steroid injections for his lower back and wondered if it was worse because he was not working; Employee requested he be prescribed Xanax. Dr. Haws referred Employee to psychiatry, continued prescribing Celexa but would not prescribe Xanax without Employee seeing a psychiatrist. (Haws Chart Note, January 25, 2016).

10) On February 5, 2016, Employee informed Dr. Haws he stopped taking Celexa and was feeling well. (Haws Chart Note, February 5, 2016).

11) On February 17, 2016, Dr. Haws predicted Employee will not have the physical capabilities to perform the physical demands of kitchen helper. (Haws Job Analysis, February 17, 2016).

12) On March 3, 2016, John Lopez, MD, performed a laminotomy and disc excision on the left at L5-S1. He diagnosed a left L5-S1 herniated disc with S1 radiculopathy. (Lopez Operative Report, March 3, 2016).

13) On March 17, 2016, the Reemployment Benefits Administrator (RBA) designee found Employee eligible for reemployment benefits. (RBA Letter, March 17, 2016).

14) On April 1, 2016, Employer requested review of the RBA's eligibility determination and asked for a hearing. (Employer Petition, April 1, 2016; Affidavit of Readiness for Hearing, April 1, 2016).

15) On April 9, 2016, Yong Han Kim, MD, performed a lumbar wound exploration, a revision of the L5-S1 laminectomy on the left, a partial facetectomy on the left, and an S1-2 foraminotomy for intractable back pain after surgery. (Kim Operative Report, April 9, 2016).

16) On April 25, 2016, Jens Chapman, MD, performed a revision laminectomy at L5-S1 and irrigated and debrided the disc at L5-S1. He diagnosed discitis, an epidural abscess with no dural deficiency, and a left pars defect after laminectomy. (Chapman Operative Report, April 25, 2016).

17) On July 11, 2016, Employee reported increased stress and sadness over the last months, increased medical struggles since surgery in April and distrust and nervousness for future operations. Brown recommended weekly psychotherapy session to process emotions and struggles with adjusting to life after medical issues. (Brown Psychotherapy Note, July 11, 2016).

18) On July 18 and August 2 and 9, 2016, Employee attended psychotherapy sessions with Brown. (Brown Psychotherapy Notes, July 18 and August 2 and 9, 2016).

19) On September 15, 2016, Gary Olbrich, MD, an internal medicine specialist, evaluated Employee for an EME to provide a pain management, addictive disease and internal medicine assessment. He diagnosed Employee with preexisting addictive disease and chronic pain disease. Dr. Olbrich opined Employee's August 2015 work injury is not the substantial cause of Employee's addictive disease and chronic pain. (Olbrich EME Report, September 15, 2016).

20) On September 16, 2016, S. David Glass, MD, a psychiatrist, performed an EME. He diagnosed preexisting opioid, anxiolytic, cannabis, and nicotine dependence and pain disorder associated with both psychological factors and a general medical disorder. Dr. Glass specified the psychological factors included a pain disorder associated with psychological factors; a pain disorder with both psychological factors and a general medical disorder; or a conversion disorder. Dr. Glass opined Employee's psychiatric disorders are not caused by the August 2015 work injury and Employee's chemical dependency requires indefinite abstinence from addictive drugs. He also stated there were no specific work restrictions from a "psychiatric standpoint." (Glass EME Report, September 16, 2016).

21) On September 21, 2016, Employer denied a prescription for Chantix, gym membership referral and first-class and a travel companion for EME appointments. (Controversion Notice, September 21, 2016).

22) On October 19, 2016, Banner Health Physicians Alaska, LLC, claimed medical costs. (Workers' Compensation Claim, October 19, 2016).

23) On November 15, 16 and 22, 2016, Employee attended psychotherapy sessions with Brown for emotional intensity and struggling with coping skills. (Brown Psychotherapy Notes, November 15, 16 and 22, 2016).

24) On November 23, 2016, Employee stated he "blows up" and had "explosive anger" and at times was very "low." He reported Clonazepam was helpful. Dr. Haws "discussed the importance of managing his mood and depression and anxiety in the setting of his back pain and inability to work" and prescribed Prozac for adjustment disorder with depressed mood. (Haws Chart Note, November 23, 2016).

25) On December 14, 2016, Employer denied medical and travel benefits, temporary total disability (TTD), temporary partial disability (TPD) and permanent partial impairment (PPI) benefits greater than six percent relating to Employee's hernia condition, travel accommodations, a prescription for Chantix and home modification based on EME reports dated September 16 and 17, 2016. (Controversion Notice, December 14, 2016).

26) On December 14, 2016, Tanya Nguyen, ARNP, FNP-BC, for Dr. Chapman, conducted a long-term post-operative assessment of Employee. NP Nguyen recommended Employee attend physical therapy, including traction; a low-resistance exercise program including 30 minutes of light cardio and 30 minutes of low weight, high repetition weightlifting; cessation of nicotine products; and bilateral foraminal injections at L5-S1 after a clear nicotine screen. (Nguyen Chart Notes, December 14, 2016).

27) On March 25, 2017, Employee followed up with Dr. Jiang for treatment for post-laminectomy syndrome with bilateral axial back pain and more left leg symptoms. Employee contemplated fusion surgery with Dr. Chapman. Dr. Jiang recommended continuing physical therapy and use of a TENS unit. (Jiang Chart Note, March 25, 2017).

28) On March 28, 2017, Employer denied medical treatment for dermatitis as there was substantial evidence Employee's need for medical treatment is not work related. (Controversion Notice, March 28, 2017).

29) On June 26, 2017, Tanana Valley Clinic claimed medical costs. (Workers' Compensation Claim, June 26, 2017).

30) On July 11, 2017, John W. Swanson MD, an orthopedic surgeon, performed an EME. He diagnosed preexisting lumbar spondylosis with arthritis in the facet joints and intervertebral disc degeneration; aggravation of a preexisting L5-S1 disc protrusion on the left with radicular symptoms; wound infection and secondary osteomyelitis following left L5-S1 laminotomy and disc excision; opioid, benzodiazepine, and marijuana dependence due to addictive disease per Dr. Olbrich; a history of a pain disorder, dependence on opioids, anxiolytics, marijuana, and nicotine, with abnormal personality psychodynamics per Dr. Glass; and behavioral signs with possible secondary gain. Dr. Swanson opined the only condition caused by the August 2015 work injury was the aggravation of Employee's "preexisting lumbar spondylosis with arthritis in the facet joints and intervertebral disc degeneration at L5-S1 with the work activity aggravating the disc protrusion on the left producing radicular symptoms." He stated all treatment had been completed as it relates to the August 2015 work injury and a fusion at L5-S1 was not indicated because the flexion and extension x-rays on July 20, 2016, did not demonstrate instability. Dr. Swanson recommended Employee work in the light to medium category with no lifting over 35 pounds occasionally or 20 pounds repetitiously. He determined Employee was medically stable and provided a six percent PPI rating for Employee's August 2015 work injury. Dr. Swanson found Employee did not have the physical capabilities to perform his regular job duties but Employee's August 2015 work injury was not the substantial cause of Employee's inability to perform his regular job duties. (Swanson EME Report, July 11, 2017).

31) On July 11, 2017, Dr. Olbrich performed an EME. He diagnosed Employee with preexisting addictive disease, specifically opioid, benzodiazepine, cannabis and nicotine dependence; exaggerated, subjective chronic pain symptoms not supported by the underlying pathology demonstrated by imaging or objective clinical examinations; and significant psychological and psychological issues, as defined by Dr. Glass. He opined Employee's August 2015 work injury was "not a substantial factor in the activation or reactivation of Employee's preexisting addictive disease, rather its origin is genetic and psychosocial (developmental) grounds." Dr. Olbrich opined that without treatment for Employee's addictive disease and cessation of the use of all benzodiazepines, opiates, and/or partial opiate, Employee would potentially be a threat to himself and others. He stated Employee is in a state of active addictive disease and "will continue to

present with complaints of pain, anxiety, and other forms of alleged disability as long as those complaints provide him with a continued source of his addictive drugs." (Olbrich EME report, July 11, 2017).

32) On July 12, 2017, Lara Kierlin, MD, a psychiatrist, performed an EME. Dr. Kierlin diagnosed preexisting opioid, sedative, hypnotic, anxiolytic, cannabis and tobacco use disorders and chronic pain disease. She opined the chemical dependency diagnoses are preexisting conditions and were not caused or worsened by Employee's August 2015 work injury. Dr. Kierlin related Employee's chemical dependency to developmental, constitutional, and genetic factors, all preexisting Employee's August 2015 work injury. She recommended Employee avoid addictive medication and use active exercise and "positive expectation setting" as helpful treatments. Dr. Kierlin stated Employee "did not sustain [a] DSM-V mental health diagnosis" as a result of the work injury and had capacity to perform his regular job duties "from a mental health perspective." (Kierlin EME Report, July 12, 2017).

33) On July 20, 2017, Dr. Jiang prescribed Employee a transcutaneous electrical nerve stimulation (TENS) unit. (Jiang Order, July 20, 2017).

34) On July 27, 2017, Dr. Jiang referred Employee to Larry Parker, MD, for a consultation for post-laminectomy syndrome and lumbar radiculopathy. (Jiang Order, July 27, 2017).

35) On August 8, 2017, Employer denied permanent total disability (PTD), TTD, TPD and PPI benefits greater than six percent, and medical benefits based on the July 11, 2017 and July 12, 2017 EME reports. (Controversion Notice, August 8, 2017).

36) On August 8, 2017, Employer denied medical benefits for counseling contending it was unrelated to Employee's August 2015 work injury. (Controversion Notice, August 8, 2017).

37) On August 16, 2017, Dr. Jiang assessed Employee with post-laminectomy pain syndrome, chronic pain, and lumbar radiculopathy in the left L5-S1 dermatomal distribution. He noted Employee was doing well with the TENS unit and medication treatment. Dr. Jiang provided Employee two referrals: one to Dr. Parker and another to the Barolat Institute of Denver, Colorado for a second surgical opinion in terms of the feasibility of fusion versus spinal cord stimulation. (Jiang, Chart Note, August 16, 2017).

38) On September 21, 2017, Employee requested an SIME. (Employee Petition, September 21, 2017).

39) On October 10, 2017, Employer objected to Employee's SIME request. It contended Employee failed to identify any medical disputes and failed to file an SIME form or any supporting medical records. Employer also contended Employee failed to file a petition within 60 days after receiving the EME report. (Answer, October 10, 2017).

40) On December 8, 2017, Dr. Jiang testified he is a practicing anesthesiologist specializing in pain management and has been Employee's attending physician. (Jiang deposition, December 8, 2017, at 5). He began treating Employee for chronic pain. (*Id*. at 7). There are three components of pain: a mechanical component such as disc herniation, osteomyelitis, and bone spur; a chemical component such as nerve inflammation; and an electrical component such as the electrical signal a nerve sends the brain and the brain's response to stress and anxiety. (*Id*. at 34-35). Employee is using a TENS unit, which sends an electrical signal to the dermis to create a vibratory sense through the spinal cord. (*Id*. at 38-39). Dr. Jiang's goal is to maximize Employee's function, productivity and quality of life and minimize the chronic abuse of medications. (*Id*. at 39). He is also considering prescribing a spinal cord stimulator (SCS), which he described as a "salvage procedure," when all other treatments fail. (*Id*. at 40-41). An SCS is "sort of like the TENS unit device except it is more deeply implanted near the spine." (*Id*. at 40). Dr. Jiang agreed with Dr. Swanson's 25-to-30-pound weight restriction for bending, lifting, carrying, pushing and pulling but would add avoiding crouching in tight spaces, crawling and "basically things that are more postural-related, not necessarily lifting-related." (*Id*. at 41). He disagreed with Dr. Swanson's conclusion that all treatment has been completed as it relates to the August 2015 work injury. (*Id*. at 42-43). Dr. Jiang disagreed with Dr. Swanson's opinion that no surgical recommendation is necessary regarding Employee's L5-S1 fusion because Employee did not exhibit any instability on the flexion and extension film. (*Id*. at 43-44). He stated the lack of instability on the flexion and extension film does not "mean an instability will not be found in the future date, in which case it might open the new opportunity of even a surgical treatment option in the future." (*Id*. at 44). Dr. Jiang opined either supervised or self-directed physical therapy; pain medications while Employee is gradually weaned off narcotics as conditions justify; and anti-inflammatory pain medications, muscle relaxer, non-narcotic and non-addictive pain medications should continue. (*Id*. at 44-45). He agrees Employee has a preexisting addictive behavior disorder. (*Id*. at 48). However, Dr. Jiang disagrees with Dr. Olbrich and opined "an individual can have a preexisting substance abuse issue and a pain issue." He does not "believe we should put off our treatment

options for a medical or underlying physical or medical or chemical component of pain because of the preexisting condition." (*Id*. at 46-49). On cross-examination, Dr. Jiang confirmed he referred Employee to a neurosurgeon for pain management and consideration of an SCS. (*Id*. at 62-63). He also acknowledged an SCS would require a psychological evaluation to determine its appropriateness. (*Id*. at 65-66).

41) On January 31, 2018, the parties had agreed to conduct an SIME but disagreed as to the physician specialties. Employee contended an orthopedic surgeon specializing in lumbar spine issues and a physician specializing in neurology, psychiatry and substance abuse should evaluate him. Employer did not oppose the orthopedic surgeon but contended a pain management and physical rehabilitation physician should be on the panel. *Reagan v. Kenworth Northwest Inc.*, AWCB Dec. No. 18-0010 (January 31, 2018) (*Reagan I*), ordered an SIME panel consisting of an orthopedic surgeon experienced in spinal surgery, a physician specializing in pain management and physical medicine and rehabilitation, and a neurologist based upon Dr. Jiang's explanation that there are three components of pain. (*Reagan I*).

42) On June 6, 2018, Jonathan A. Schleimer, MD, a neurologist, examined Employee for an SIME. He diagnosed (1) "Industrial lower back injury 08/21/15 resulting in lateral disc protrusion, secondary radiculopathy"; (2) "Postlaminectomy failed back syndrome with chronic back and radiculopathy symptoms"; and (3) "Sleep and mood disturbance with anxiety and depression." Dr. Schleimer opined the cause of Employee's disability and need for medical treatment was the work injury, even though there was some underlying lumbar spondylosis, as the work injury caused the lateral disc herniation. He recommended a psychiatric SIME evaluation regarding the psychiatric conditions. Dr. Schleimer stated Employee was still disabled due to the work injury and "suggested a second opinion neurosurgical evaluation with repeat imaging studies to determine if a) the patient requires any additional surgery and, if not, b) a spinal cord stimulator." He suggested a chronic pain management and consideration of a temporary SCS "to see if it would effectively improve his pain condition." Dr. Schleimer suggested updated imaging studies include computer tomography (CT) myelogram and said Employee would be limited to semi-sedentary to sedentary work should it be determined that no additional intervention such as surgery or an SCS should be provided. (Schleimer SIME Report, June 6, 2018).

43) On June 8, 2018, Marvin Zwerin, DO, a physical medication and rehabilitation a pain management specialist, examined Employee for an SIME. He diagnosed (1) lumbar degenerative

disc disease at L4-5 and L5-S1, (2) grade I L4 on L5 spondylolisthesis, (3) a herniated nucleus pulposus at L5-S1, (4) status post lumbar osteomyelitis, (5) lumbar radiculopathy L5, S1 left and (6) post-laminectomy syndrome. Dr. Zwerin stated the work injury, surgical treatment to address the herniated nucleus pulposus leading to post-op osteomyelitis and discitis and long-term residuals of both, including chronic pain syndrome, opioid dependence, and possibility of additional spinal surgery and/or invasive procedures, are the causes of Employee's disability or need for medical treatment. He said early imaging studies revealed minor degenerative changes in Employee's lumbar spine but they "paled in comparison to the effect of the 8/21/15 injury that subsumed combined with them to cause his need for treatment and ultimate disability." Dr. Zwerin opined the work injury was the substantial cause of Employee's disability or need for medical treatment. Employee's disability continued and he reached medical stability with Dr. Jiang's March 6, 2018 agreement with the retraining plan. When asked what additional treatment he recommended for the work injury or its consequences, Dr. Zwerin answered there were few reasonably viable alternatives going forward. None of the possible alternatives alone or together would cure Employee's problem, and there are varying degrees of risk associated with some of the alternatives making choosing how to proceed difficult and subject to medical disagreement. He debated the surgical options:

> 1. Revisiting the surgical site to remove scar tissue – least likely to have a good outcome
> 2. Fusion at L4-S1 (stabilize the L4-5 listhesis to eliminate a preexisting issue) – probably will improve his low back pain but may lead to accelerated degeneration at L3-4 or L4-5 if only L5-S1 is fused. – more likely than #1 to benefit. BUT, he has been unable to cease smoking and is more likely to have a bad outcome on that basis.
> 3. Ongoing use of LESI – short term benefit. Risk of infection is low. – Reward is low.
> 4. Spinal Cord Stimulator – a crap shoot – may work or may not. Trial required prior to any permanent implant. Likely long-term benefit 40% or less after 1 year. – Variable results.

Dr. Zwerin discussed the nonsurgical options:

> 1. PT – TIW x 6-9 weeks of progressive reconditioning and progressing from stretching to more arduous back stabilization program
> 2. Self-directed HEP (home exercise program) following instruction & supervision during PT

> 3. Functional restoration program at a facility solely dedicated to this activity
> 4. NSAIDs (if no surgery),
> 5. Opioids – ongoing & judicious use of relatively low risk Tramadol.
> 6. Adjunctive Medications including Lyrica, Cymbalta Lidoderm patch Salonpas patch
> 7. TENS/Muscle Stim - Trial and Rx if provides >25% improvement in pain and increased function (all subjective) with ongoing refills of pads, leads batteries, ad-infinitum.
> 8. Acupuncture - may or may not offer any benefit. A 6 session trial is sufficient to know if it will provide relief. If not, stop. If yes, continue x 2-3 months at TIW.

He stated Employee would never be able to work at his normal occupation at the time of injury and restricted Employee from more than occasional bending, stooping; climbing ladders or stairs or working at unprotected heights; lifting or carrying greater than 20 pounds, 10 pounds occasionally or five pounds intermittently; working above shoulder level; performing work requiring trunk extension; squatting or kneeling; and that Employee should spend the workday alternating sitting or standing "ad-lib." Dr. Zwerin believed Employee could work at the sedentary level. He rated Employee with a 31 percent whole body PPI. He disagreed with Dr. Olbrich's conclusions for three reasons:

> First, the underlying need for opioids was mediated by his disc herniation and subsequent back surgery. Second, his overuse thereof was fed by the post-op infection and lastly he has developed an iatrogenic habituation to opioids. He is not now and never was an addict, other than to cigarettes. Given that Mr. Reagan is clearly no longer abusing his medications and given that absent the industrial injury he would only be "addicted" to cigarettes, I find Dr. Olbrich's conclusions to be incorrect. There is no reason to delay treatment for the issues of having an "addition"[sic] to cigarettes and/or a low dose of opioid medication. To do so is simply punitive and pointless four years after his injury. (Zwerin SIME Report, June 8, 2018).

44) On June 17, 2018, Sidney Levine, MD, orthopedic surgeon, examined Employee for an SIME. He diagnosed (1) status post L5-S1 microdiscectomy performed on March 3, 2016, (2) status post exploration of wound and revision of laminectomy on April l9, 2016, (3) status post revision laminectomy with washing of the disc space on April 26, 2016, (4) history of discitis and osteomyelitis, and (5) chronic pain. Dr. Levine opined the work injury is the substantial cause of Employee's need for medical treatment and Employee became medically stable on June 7, 2018, but is disabled from the work injury. He recommended medical treatment for chronic pain, including a weight reduction program, a home exercise program and nonnarcotic analgesics and

anti-inflammatory medication and gabapentin. After reviewing the job description, Dr. Levine stated Employee is not able to work at his normal occupation and precluded him from prolonged standing, repetitive bending, stooping, pushing, or pulling and lifting in excess of 35 pounds. He related the restrictions to the work injury. Dr. Levine rated Employee with a 17 percent whole body PPI rating. He did not recommend any additional studies, tests or specialist evaluations. (Levine SIME Report, June 17, 2018).

45) On August 6, 2018, Employee sought TTD, TPD and PTD benefits, transportation costs, interest and attorney fees and costs for a low-back work injury, "To overturn current controversions." (Claim for Workers' Compensation Benefits, August 6, 2018).

46) On October 9, 2018, Employee's attorney sent a letter to Dr. Schleimer stating:

> I look forward to meeting you at the deposition scheduled to occur on October 16th. You may be aware that you were one of three SIME physicians to evaluate Mr. Reagan last June. He was also seen by Dr. Marvin Zwerin (Physiatry and Pain Management) and Dr. Sidney Levine (Orthopedic Surgeon). Copies of their reports are enclosed, in hopes that you may have an opportunity to review them prior to the deposition. (Letter, October 9, 2018).

47) On October 11, 2018, Dr. Schleimer issued an addendum SIME report stated he reviewed Dr. Levine's and Dr. Zwerin's SIME reports. (Schleimer SIME Addendum SIME Report, October 11, 2018).

48) On October 16, 2018, Dr. Schleimer testified at deposition and noted Dr. Levine's PPI rating rated only low-back "as opposed to other factors such as chronic pain or -- and the whole other issue of anxiety, depression, sleep disturbance could fit into the mood disturbance category." (Deposition of Jonathan A. Schleimer, MD, October 16, 2018, at 43). He recommended a trial, temporary SCS and treatment by a pain management person, including medications and possibly additional physical therapy. (*Id*. at 44.). When asked if he intended to comment upon whether Employee "would be able to return to work on a 40-hours-a-week basis for an indefinite period of in light of the anxiety, depression and mood disorder et cetera condition," Dr. Schleimer responded:

> Yeah, I hadn't really gotten to that point because I really stated I felt I hadn't gotten to the is-he-MMI point. So I don't think I didn't go that far in terms of I didn't specifically give you a rating, you know. I'm saying I have not yet looked at the 6th Edition. The other issue is when you start to put in what does the psychiatrist

> say in terms of mood, memory -- well, mood and depression, I haven't gotten that far. So I have not gone into -- I said sedentary, semi sedentary is the likely finding, but I haven't gone into the number of hours per week. Because I thought, well does he -- if you can reduce his pain with a spinal cord stimulator, okay. So, again, I wouldn't change the semi sedentary or sedentary, but, again, with reduction of pain, assuming his psychiatrist says, you know, he's not severely depressed, then, you know, perhaps he could be a 40-hour week. But you have not specified one way or the other. I vaguely left that out. (*Id*. at 45-46).

He recommended Employee see a psychologist, "But if he has a mood disturbance that's industrial further -- either -- it either should be done industrial or non industrial, he needs treatment for anxiety and depression." (*Id*.). When asked about his experience making psychiatric or psychological diagnostic impression, Dr. Schleimer stated:

> . . . we neurologists we're actually board certified by the American Board of Psychiatry and Neurology. However, I'm a neurologist. During our training we do extra time of psychiatry. So certainly we neurologists see and treat or at least diagnose many patients with depression and anxiety. Sometimes that can be the primary problem. I mean, if you look at the constellation of trouble sleeping, headaches, fatigue, trouble concentrating, depression is very common. As far as then, you know, I think we all agree that Mr. Reagan has depression, he says he has sleep disturbance, he has anxiety. That's also very common in chronic pain patients. Where I don't go is into getting more detailed as to specific causation and/or psychiatric disability. So in this particular case he definitely has anxiety, depression, you know, based upon the symptoms he has, his treaters, the other experts, okay. What I recommend would be an SIME or independent psychiatric evaluation to see more into causation and/or disability factors or need for treatment. As opposed to I'm not going to turn around and say his anxiety and depression are all a hundred percent work related. . . . (*Id*. at 48-49).

49) On October 23, 2018, rehabilitation specialist Tommie Hutto reported Employee completed the reemployment plan for radiographer. (Hutto Status Report, October 23, 2018).

50) On March 12, 2019, a stipulation was approved stating:

> The following medical treatment is currently reasonable and necessary to treat Employee's work injuries on an ongoing basis: treatment with Dr. Jiang to include prescription medications (including Chantix through the date of surgery and post-surgery recovery is recommended by Dr. Chapman), referrals for physical therapy, a membership at the Alaska Club upon submission of receipts and attendance logs, evaluation for depression related to the work injury, and a TENS unit.
>
> Employer shall also authorize currently recommended surgical evaluation and testing, and then surgery if it is recommended by Dr. Chapman, the surgery itself.

> If the surgery is not recommended, then a trial spinal cord stimulator is authorized. Then if the trial spinal cord stimulator is deemed effective by Mr. Reagan's physician, and Employee is determined to be a candidate for a permanent device through appropriate evaluations (presumably common neurologic and psychiatric), then a permanent spinal cord stimulator is authorized.
>
> Employer shall process and pay medical bills controverted on March 20, 2017 (dermatitis) and August 1, 2017 (counseling visit) under the Alaska fee schedule.
>
> Mr. Reagan's past medical treatment to date has been reasonable and necessary to treat his work injuries. Employers shall reimburse the pharmacy and other out-of-pocket medical expenses incurred by Mr. Reagan, as documented in the recent evidence filing.
>
> Employer reserved the right to raise defenses to future benefits based on new evidence received after the data stipulation. Employee reserves the right to file additional claims should a dispute arise. (Stipulated Order Awarding Benefits, March 12, 2019).

51) On January 21, 2021, Employee asked for a referral to a psychiatrist:

> Recently moved back after being displaced by the wildfire, but they are living in a camper in someones backyard. He reports the yard is full of junk and stinks but they have no where to go. His wife works, and he feels helpless that he can't help support his family and that he does not have anything to do. His pain has slightly improved since getting injections in his back, but he has mood swings and wondering if he can start prozac or something.

Lynn Gower, DO, assessed mixed anxiety and depressive disorder, prescribed Prozac and referred Employee to psychiatry. (Gower Encounter Note, January 21, 2021).

52) On February 10, 2021, Poly Chen, MD, diagnosed pain disorder with related psychological factors and provided Employee access to a HIPAA-compliant software program to provide "mindfulness activities, patient education materials pertaining to the patients psychosocial status and diagnosis, along with crisis resource information." (Chen progress note, February 10, 2021).

53) On March 13, 2021, Mary Storm, MD, examined Employee for a Social Security disability assessment and noted his primary complaints were depression and back pain that began on August 2, 2015. The depression symptoms began in 2016 and include "unsocial, lost contacts with family, anxiety, do not want to be around people" and are worsened by staying at home. Dr. Storm noted Employee had an "odd affect, psychomotor agitation" with "very pressured speech" and he told her "[Y]ou got me in a panic situation." He felt sad after his wife cheated on him and left but

stated he did not have depression and "has never had a psychiatric need in his life." Dr. Storm noted Employee had "severely poor concentration and short term memory" upon a "mini mental health exam" and opined Employee would benefit from psychiatric care or counseling. She limited Employee to lifting and carrying less than 20 pounds occasionally and less than 10 pounds frequently due to "balance and LSS [lumbar spinal stenosis]." (Storm Chart Note, March 13, 2021).

54) On February 2, 2022, Stalia Soliday, ARNP, filled out an Amazon Healthcare Provider Questionnaire for Employee Accommodation Request indicating Employee had a permanent impairment that may prevent him from performing job duties. She wrote Employee was unable to stand, bend, lift for more than eight hours or more than two hours without a break. Soliday recommended limiting daily work hours to eight or less and to limit standing, bending, lifting to two hours, and then have a break. (Soliday Amazon Healthcare Provider Questionnaire for Employee Accommodation Request, February 2, 2022). She attributed the restrictions to the work injury and complications with the lumbar surgery. (Amazon Healthcare Provider Request for Information (RFI) Form, February 2, 2022).

55) On October 7, 2022, Employee sought TTD, TPD, and PTD benefits, medical and transportation costs, a finding of unfair or frivolous controversion, interest and attorney fees and costs for a low-back work injury because "Insurer has failed to authorize treatment." (Claim for Workers' Compensation Benefits, October 7, 2022).

56) On October 27, 2022, Employer denied TTD, TPD, and PTD benefits, attorney fees and costs, interest and a finding of unfair or frivolous controversion, contending Employee did not produce any medical evidence supporting a current disability and Employer "is without evidence to support that the Employee is permanently and totally disabled from work." It contended Employee was medically stable based upon Dr. Zwerin's June 8, 2018 SIME report. Employer stated Employee's "medical benefits have not been denied and the carrier approved Employee's medications on September 22, 2022." (Controversion Notice and Answer, October 27, 2022). It admitted to reasonable and necessary medical benefits and transportation costs related to the work injury. (Answer, October 27, 2022).

57) On January 19, 2023, Employee visited Chad Mongrain, DO, for back pain:

> Pt states that he has really been having a hard time as of late.

> Pt recounts his hx w/ his pain, states that his pain has really affected his ability to get along with others.
> Pt states that he is "mad" b/c of all the pain that he is in, states that he feels like sx to remove hardware was not performed appropriately and he feels that this is a big part of his pain. Pt states that his pain does prevent him from getting work, he will often become upset w/ the people at work, disrupting his environment.
> Thinks that he needs to see a counselor to deal w/ his mood.
> Pt has been told in the past that nothing can be done w/ his back since he has had prior infection. Pt has not seen a neurosx here locally and he would like to get opinion about having revision of the spinal fusion.
> Would like to consider changing pain meds-wonders if he can inc his gabapentin or lyrica.
> Pt states that he has been on a mood stabilizer in the past-these have not been helpful. Pt does not believe that he has bipolar-he has not been given this dx in the past.

Dr. Mongrain referred Employee to behavioral health for a "mood problem." (Mongrain, Progress Note, January 19, 2023).

58) On April 20, 2023, Employee reported struggling with people and was often irritable and short with them. He said he had trouble with anger and denied depression but endorsed having anxiety and being stressed. Karen Keith, a mental health therapist, diagnosed generalized anxiety and recommended Employee to follow up as needed. (Keith progress note, April 20, 2023).

59) On May 2, 2023, Employee reported "difficulty getting along with people" that began after his work injury. Keith noted Employee's "affective and emotional state appeared mainly unhappy, sad, dysphoric, rather distressed, moderately depressed, moderately anxious and labile" and the "main themes" of the session were "working through interpersonal/family experiences; exploration of relationships with friends; expression of stressful experiences; exploration of health concerns and illness; and exploration of life experiences and self-understanding." (Keith Progress Notes, May 2, 2023).

60) On May 4, 2023, Employee followed up with Dr. Mongrain regarding his back pain. He reported having a real hard time with relationships and struggling due to back pain and he did not want to be on medications because they have not been helpful to him in the past. Employee wanted help relating with others because he gets so easily upset with others. Dr. Mongrain diagnosed depression, anxiety and mood problem. Employee was to return in two weeks after labs to consider starting medication. (Mongrain Progress Note, May 4, 2023).

61) On May 19, 2023, Employee followed up for depression and anxiety and reported having a lot of fatigue. He stated he recently found out he may need to move in the near future because the house he is living in has been sold and he did not know what he is going to do. Dr. Mongrain prescribed Duloxetine for depression and anxiety. (Mongrain Progress Notes, May 19, 2023).

62) On June 21, 2023, Dr. Chapman stated there were no clinical or radiographic findings warranting surgical intervention at that time. He recommended Employee complete a lumbar spine and pelvic Tc-99 bone scan to evaluate the abnormal arthritic appearance of his sacroiliac joints, a lumbar spine CT myelogram to better visualize the bony and neural anatomy and an electrolmyology (EMG) of his bilateral lower extremities to determine between peripheral neuropathy or radiculopathy, seek podiatric help and use Voltaren gel for his right foot plantar fasciitis and engage in a home exercise plan with a recumbent stationary bike at least 30 minutes daily. Dr. Chapman said there were no restrictions to Employee's activity levels. (Chapman Progress Notes, June 21, 2023).

63) On June 27, 2023, Employee stated he thought the Duloxetine was helpful and he felt much better. (Mongrain Progress Note, June 27, 2023).

64) On February 22, 2024, Chad Mongrain, MD, wrote a letter to the claims adjuster:

> I am writing today to aak [sic] you to approve a functional capacity exam for my patient noted above for his present work-related injury sustained in August 2015. An FCE [functional capacities evaluation] that has extensive review of his complex case (and involvement of appropriate medical subspecialties) could facilitate appropriate planning and getting patient back to work, or allowing him to receive appropriate job training. I do believe that any FCE will need to incorporate appropriate psychiatric evaluation as I do believe he has some psychiatric condition (possibly due in part to the work-related injury) that could contribute to his ability (or inability) to return to work. (Mongrain Letter, February 22, 2024).

65) On March 7, 2024, Employee followed up about back pain. He stated he was moving to Arizona later that month and was having more pain because of all the packing he was doing. Dr. Mongrain prescribed oxycodone and told Employee he would have to get a new provider in Arizona to prescribe medication after the current prescription was used. He also refilled the Duloxetine prescription for depression and anxiety. (Mongrain progress notes, March 7, 2024).

66) On July 25, 2024, Employee sought TTD, TPD and PTD benefits, medical and transportation costs, interest, a finding of unfair or frivolous controvert and attorney fees and costs for a lower-

back injury stating, "Insurer has failed to authorize treatment, and Employee is disabled due to injury." (Claim for Workers' Compensation Benefits, July 25, 2024).

67) On July 25, 2024, Employee requested an SIME under AS 23.30.095(k) and AS 23.30.110(g). (Petition, July 25, 2024). He contended there is a dispute regarding causation between Dr. Mongrain's February 22, 2024 letter and Dr. Kierlin's July 12, 2017 EME report. Employee included the following under "Non-SIME Issue(s) (AS 23.30.110(g) request: "Note: in his 10/16/18 depo, SIME Schleimer recommended a psychiatric SIME, at page 44." He requested a psychiatrist perform the SIME. (SIME Form, July 25, 2024).

68) On August 12, 2024, Employer admitted reasonable and necessary medical benefits and transportation costs related to the work injury. (Answer, August 12, 2024). It denied TTD, TPD and PTD benefits, interest, a finding of unfair or frivolous controversion and attorney fees and costs contending:

> The employee has not produced any medical evidence to support current disability. On 6/21/23, the employee's physician, Dr. Chapman, noted that there are no restrictions at any activity level. The employer is without evidence to support that the employee is permanently and totally disabled from work. Per the 6/8/18 SIME of Dr. Zwerin, the employee is medically stable.
>
> The employee's medical benefits have not been denied. The carrier has provided authorization for treatment and prescriptions as received. (Controversion Notice and August 12, 2024).

69) On August 14, 2024, Employer opposed Employee's July 25, 2024 petition for an SIME, contending, "The facts of this case do not support than an SIME under AS 23.30.11(g) [sic] is warranted." (Answer to Employee's Petition for an SIME, August 14, 2024).

70) On August 15, 2024, Employee filed a hearing brief, contending the SIME opinions support Employee's claim that he sustained a work-related mental injury and recommended further psychiatric evaluation to evaluate whether it disables him. He contended his work-related mental injuries preclude him from returning to work. Employee contended there is a dispute between Drs. Kierlin and Mongrain, and a psychiatric SIME would assist the factfinders. He contended a psychiatric SIME should have been ordered in 2018 and both Drs. Schleimer and Mongrain "call for serious further evaluation of [Employee's] disability and the causes for it by a psychiatrist" to give "the parties and the Board a meaningful explanation for [Employee's] anxiety, depression and mood issues" and to "discern how disabling those conditions may be." Employee did not care

whether the evaluation is ordered under AS 23.30.095(k) or AS 23.30.110(g). (Employee's Hearing Brief, August 15, 2024).

71) On August 15, 2024, Employer filed a hearing brief, contending mental health and psychiatric care related to the work injury are not denied. It contended it has not been contacted by a provider requesting authorization for the FCE Dr. Mongrain recommended. Employer contended there is no current dispute between any of Employee's and Employer's physicians regarding the need for mental health or psychiatric care. Thus, Employer contends an SIME under AS 23.30.110(g) is not warranted. (Employer's Brief for 8/22/24 Hearing, August 15, 2024).

PRINCIPLES OF LAW

> **AS 23.30.001. Legislative intent.** It is the intent of the legislature that
>
> (1) this chapter be interpreted so as to ensure . . . quick, efficient, fair, and predictable delivery of . . . benefits to injured workers at a reasonable cost to . . . employers; . . .

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

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

The Alaska Workers' Compensation Appeals Commission in *Bah v. Trident Seafoods Corp.,* AWCAC Dec. No. 073 (February 27, 2008) addressed the Board's authority to order an SIME under §095(k). *Bah* stated in *dicta*, that before ordering an SIME it is necessary to find the medical dispute is significant or relevant to a pending claim or petition. *Bah* said when deciding whether to order an SIME, the Board considers three criteria, though the statute requires only one:

1) Is there a medical dispute between Employee's physician and an EME?
2) Is the dispute significant? and
3) Will an SIME physician's opinion assist the Board in resolving the disputes? (*Id*.).

AS 23.30.110. Procedure on claims. . . .

(g) An injured employee claiming or entitled to compensation shall submit to the physical examination by a duly qualified physician which the board may require.

AS 23.30.135. Procedure before the board. (a) . . . The board may make its investigation or inquiry or conduct its hearing in the manner by which it may best ascertain the rights of the parties. . . .

AS 23.30.155. Payment of compensation. . . .

(h) The board may upon its own initiative at any time in a case 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.

Section 095(k) and §110(g) are procedural in nature, not substantive, for the reasons outlined in *Deal v. Municipality of Anchorage*, AWCB Dec. No. 97-0165 (July 23, 1997). Under §135(a) and §155(h), wide discretion exists to consider any evidence available when deciding whether to order an SIME to assist in investigating and deciding medical issues in claims, to best "protect the rights of the parties." Under §110(g) the Board may order an SIME when there is a significant "gap" in the medical evidence, or a lack of understanding of the medical or scientific evidence prevents the Board from ascertaining the rights of the parties and an SIME opinion would help. *Bah*. Under either AS 23.30.095(k) or AS 23.30.110(g), the Commission noted an SIME's purpose is to assist the Board in resolving a significant medical dispute; it is not intended to give Employee an additional medical opinion at Employer's expense when Employee disagrees with his own physician's opinion. *Id*.

An SIME's purpose is to have an independent medical expert provide an opinion about a contested issue. *Seybert v. Cominco Alaska Exploration*, 182 P.3d 1079, 1097 (Alaska 2008). The decision to

order an SIME rests in the discretion of the Board, even if jointly requested by the parties. *Olafson v. State Department of Transportation*, AWCAC Dec. No. 06-0301 (October 25, 2007). Although a party has a right to request an SIME, a party does not have a right to an SIME if the Board decides one is not necessary for the Board's purposes. *Id*. at 8. An SIME is not a discovery tool exercised by the parties; it is an investigative tool exercised by the Board to assist it by providing a disinterested opinion. *Id*. at 15.

> **8 AAC 45.090. Additional examination.** . . . .
>
> (b) Except as provided in (g) of this section, . . ., the board will require the employer to pay for the cost of an examination AS 23.30.095(k), AS 23.30.110(g), or this section.

Roberge v. ASRC Construction Holding Company, AWCAC Dec. No. 269 (September 24, 2019) held a neurological SIME had not been completed and a final report had not been provided by the SIME physician when the SIME physician included numerous references to the need for an EMG and a nerve conduction study in his report to clarify the employee's diagnosis as his opinions were based upon an "incomplete data base."

ANALYSIS

Shall this decision order an SIME?

Employee contended there is a significant medical dispute between Dr. Mongrain's February 22, 2024 letter and Dr. Kierlin's July 12, 2017 EME report regarding the substantial cause of Employee's disability and need for medical treatment. Employer contends there is no current significant medical dispute. Employee's July 25, 2024 claim seeks disability benefits and medical costs for a work-related mental injury. He contends he sustained a work-related mental injury and "Insurer has failed to authorize treatment, and Employee is disabled due to injury." Employer's August 12, 2024 controversion and answer admitted reasonable and necessary medical benefits related to the work injury and denied disability benefits. It contends mental health and psychiatric care related to the work injury are not denied and it has not been contacted by a provider requesting authorization for the FCE Dr. Mongrain recommended in the February 22, 2024 letter. Based on these pleadings, there is a clear dispute between the parties on whether Employee's work injury is

the substantial cause of any work-related psychiatric disability. But more than a dispute between parties is needed to order an SIME.

If a significant medical dispute exists between Employee's attending physician and the EME physician and an SIME would assist in resolving the dispute, a party's SIME petition may be granted or one may be ordered on the panel's own motion. AS 23.30.095(k); 8 AAC 45.092(g)(2); and (3)(B); *Bah*. Dr. Kierlin's July 12, 2017 EME report stated Employee had the capacity to perform his regular job duties "from a mental health perspective." Dr. Mongrain's February 22, 2024 letter recommended an FCE and stated Employee has a psychiatric condition that could possibly be due in part to the work injury and which could contribute to his ability or inability to return to work. He had previously diagnosed Employee with a mood problem, depression and anxiety on January 19 and May 4, 2023. A possible cause that could contribute means the work injury may or may not be a cause. Thus, Dr. Mongrain failed to make an individual determination on causation. Therefore, there is no significant medical dispute between Drs. Mongrain and Kierlin on causation. *Bah*; *Rogers & Babler*.

In the absence of a significant medical dispute, an SIME may be ordered if there is a significant gap in the medical or scientific evidence or a lack of understanding of that evidence and the opinion of an independent medical examiner will assist the panel in resolving the issues. AS 23.30.110(g); *Bah*. Employee contended an SIME is warranted because Dr. Schleimer recommended a psychiatric SIME, which has not been completed. Dr. Schleimer performed a neurological SIME as ordered in *Reagan I*, which declined to order a psychiatric SIME. Dr. Schleimer diagnosed "sleep and mood disturbance with anxiety and depression" in his SIME report and explained at his deposition that as a neurologist he sees, treats and diagnoses patients with psychiatric conditions; however, he does not evaluate causation for psychiatric diagnoses. He recommended a psychiatric SIME to "see more into causation and/or disability factors or need for treatment." Additional testing or evaluations may be ordered as part of an incomplete SIME if the SIME physician states it is necessary to complete their evaluation and their opinion depends on the results of the additional testing or evaluations. *Roberge*. Dr. Schleimer's SIME report was complete because determining causation of psychiatric diagnoses and treatment is outside his area of specialty and he provided his opinion as a neurologist on the disputed issues. *Id*. A psychiatric SIME should

not be ordered simply because Dr. Schleimer recommends it to "see more into causation" of psychiatric diagnoses.

Employee's physicians have provided psychiatric diagnoses over the years, including an adjustment disorder with depressed mood, anxiety, depression and a mood problem, and recommended psychiatric treatment and prescribed medications. But none of them have issued opinions regarding causation for psychiatric disability, nor have they issued work restrictions for psychiatric conditions. Dr. Mongrain referred Employee to behavioral health and recommended an FCE take his psychiatric condition under consideration as Employee's psychiatric condition "could" be due to the work injury and "could" contribute to his ability or inability to return to work. Both Drs. Glass and Kierlin issued medical opinions that the work injury is not the substantial cause of Employee's need for psychiatric treatment and Employee had no work restrictions for a mental health diagnosis. The only gap in the medical record or in the scientific evidence is the lack of a psychiatric opinion indicating the work injury is the substantial cause of Employee's work-related mental health disability and the uncompleted FCE recommended by Dr. Mongrain.

A lack of a favorable opinion does not constitute a gap in medical or scientific evidence necessitating an SIME. AS 23.30.110(g); *Bah*. An SIME is not intended to give Employee an opinion when his own physician failed to make an individual determination on causation or to give Employee an evaluation recommended by his own physician. *Bah*; *Olafson*; *Seybert*. Given the clear and understandable medical evidence, the lack of a gap in the medical record of scientific evidence and a lack of a significate medical dispute between Employee's treating physician and Employer's medical evaluator on causation, an SIME will not be ordered. AS 23.30.095(k); AS 23.30.110(g).

CONCLUSION OF LAW

This decision shall not order an SIME.

ORDER

Employee's July 25, 2024 petition for an SIME is denied, without prejudice.

Dated in Fairbanks, Alaska on September 9, 2024.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Kathryn Setzer, Designated Chair

/s/
Lake Williams, Member

PETITION FOR REVIEW

A party may seek review of an interlocutory or 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 Ernest Reagan, employee / claimant v. Kenworth Northwest, Inc., employer; Alaska National Insurance, insurer / defendants; Case No. 201513964; 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 September 9, 2024.

/s/
Suzanne Schmidt, Workers' Compensation Technician