ALASKA WORKERS' COMPENSATION BOARD

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

KATHARINE RUEB, Employee, Claimant, v. HOST HEALTHCARE, INC., Employer, and ARCH INDEMNITY INSURANCE COMPANY, Insurer, Defendants.	)	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 202401878 AWCB Decision No. 25-0037 Filed with AWCB Anchorage, Alaska on June 23, 2025.

Host Healthcare, Inc.'s and Arch Indemnity Insurance Company's (Employer) March 14, 2025, petition seeking a second independent medical evaluation (SIME) was heard on the written record in Anchorage, Alaska on April 23, 2025, a date selected on April 10, 2025. An April 7, 2025, affidavit of readiness for hearing (ARH) gave rise to this hearing. Katharine Rueb (Employee) represented herself. Attorney Colby Smith represented Employer. The record closed at the conclusion of deliberations on April 24, 2025, and was reopened on May 8, 2025, to receive missing medical records and closed again on June 2, 2025.

ISSUE

Employer contends there are medical disputes between its medical evaluators and Employee's treating physicians such that an SIME by an orthopedic surgeon should be ordered.

Employee objects to an SIME for many reasons. She contends she received insufficient notice of this hearing so she was unable to file documents that she thinks should be considered. Employee contends because this is a hearing on the written record she is being deprived of her ability to testify to matters, she thinks should be considered. She further contends Employer's petition should be denied because it was untimely filed under the regulations. Employee contends Employer's petition should be denied because its medical evaluators' reports are "legally insufficient to overcome the presumption of compensability," and because ordering an SIME would give Employer another 'bite at the apple' to obtain favorable medical evidence. She contends ordering an SIME will unreasonably and unfairly delay resolution of her claim. Employee contends Employer provided its medical evaluators with altered medical records, the medical records of other people, and medical records that were improperly obtained, so there is an absence of reliable evidence of a medical dispute that would support an SIME. She objects to an SIME because of the "failure and refusal" of a designee to timely schedule a hearing on her claim in accordance with statutory and regulatory mandates, and because of the "failure and refusal" of a designee to rule on her various petitions to compel discovery and petitions for protective orders. Employee objects an SIME because she contends, she was confused by a Board letter and did not file an answer to Employer's SIME petition.

Should an SIME be ordered?

FINDINGS OF FACT

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

1) On January 31, 2024, Employee slipped and fell on ice going to work as a nurse. (First Report of Injury (FROI), February 9, 2024). She worked that day but later that night her left wrist began to hurt and she sought medical treatment the next day. (Renteria chart notes, February 1, 2024; Loss Report Summary Form, February 5, 2024).

2) On February 1, 2024, Employe sought treatment at an urgent care clinic for left wrist pain. She reported "a little numbness" in her fingers, but her elbow and shoulder were unaffected. Left wrist x-rays showed no acute fracture or subluxation. Employee also reported hitting her left buttocks area and having a large bruise. Left wrist sprain was assessed and the plan was to splint Employee's wrist and put her arm in a sling, but Employee refused the sling. She requested pain

medication, which was provided. (Renteria chart notes, February 1, 2024; X-ray report, February 1, 2024).

3) On February 2, 2024, Employee followed up at an outpatient clinic with Samantha Hawkins, NP, and reported worsening lower left back pain. She was also "concerned for the negative x-ray of her left wrist as she has a history of having a missed fracture on her right wrist initially that was later found by an MRI [magnetic resonance imaging study] that was performed three weeks after the initial injury and required surgery." A "[s]ignificant dark purple bruise" was noted on Employee's lower left back. The plan of care included repeat x-rays of the left wrist in one week "given [Employee's] history of missed fracture needing surgery on her right wrist," and sacrum/coccyx x-rays "given the severity of her bruising on exam and worsening pain." (Hawkins chart notes, February 2, 2024).

4) On February 2, 2024, sacrum coccyx x-rays showed a "rare fraction of the left ischium possibly reflecting presence of a bone lesion" and no evidence of fracture. There was also "posterior angulation of the coccyx with widening of the typical interval between the sacrum and coccyx possibly indicating injury although no definite soft tissue swelling is seen." The report concludes, "Depending on degree of clinical suspicion, MRI would probably be most useful in assessing this area in the left ischial lesion." (X-ray report, February 2, 2024).

5) On February 8, 2024, left wrist x-rays showed intact bones with no fractures and normal alignment. Soft tissues were "unremarkable." (X-ray report, February 8, 2024). A pelvic MRI study performed that same day showed three "homogenously enhancing bone lesions" within the pelvis. It further states, "Osseous metastatic disease cannot be excluded on this study. If the patient has a history of cancer, a biopsy would be recommended. If there is no cancer history, short interval follow-up and whole-body nuclear medicine bone scan would be recommended." (MRI report, February 8, 2024).

6) On February 9, 2024, Employee followed up with Melinda Noble, FNP-C, her primary care provider. FNP Noble's chart notes state:

> Patient is a histrionic 54YO F here today for several issues. She recently returned to Anchorage from position in Juneau as a travel nurse. She has left her contract prematurely. She states she was dismayed to find that after taking the position, people in several position[s] adjacent to her own were let go. She states she did not lose her job, but intimates that her work environment was not ideal. She is here today for workman comp claim per patient record. . . . She states that when she was

> seen. [sic] She had XR completed of her hand and wrist and MRI of pelvis. She states the first hand and wrist XR showed no injury. She states she has them redo this as she has previously had an XR that did not show a fracture that was later only found on MRI. I am able to find the results of this second XR as well and it is likewise negative for issues. She insists however that there is something more wrong than soreness following her fall – MRI of hand and wrist sent to further evaluate. . . . Patient feels she would benefit from cryotherapy for home treatment, a pressure relieving seat pad with a relief for coccyx, XL back support brace and a wrist wrap with an ice pack. She has found these items on Amazon and states that if she buys them for treatment of her injuries the cost will be refunded to her with her workman comp claim. She asks that I include this in my note for reimbursement purposes. . . . After the appointment, the patient does call back to the clinic to ask for a work note. [sic] Which I do agree to give. Patient is released to work without restriction tomorrow as she has no obvious injuries. She can however, continue to wear her wrist brace for comfort and stability.

(Noble chart notes, February 9, 2024). FNP Noble signed a form releasing Employee to return to work without restrictions on February 12, 2024. That same day, NP Hawkins wrote a letter stating, "It is my professional medical opinion that [Employee] remain our [sic] of work from February 2nd until February 9th." (Hawkins letter, February 9, 2024).

7) On February 15, 2024, Employee treated with Nicholas Jason, DC, whose assessment stated:

> Due to patient's current amount of deterioration of their state of health and condition upon examination, at this time I expect a partial recovery of the patient's symptoms and their functional deficits. Because of this I expect the case to possibly extend longer than usual due to a slower than usual recovery period.

(Jason chart notes, February 15, 2024).

8) Employee treated extensively following the January 31, 2024, work injury. (Observations; experience). Between February 23, 2024, and December 9, 2024, treatments not separately set forth in these factual findings include, chiropractic, trigger point injections, massage therapy, physical therapy, occupational therapy, stellate ganglion blocks, and medial branch blocks. (Craig report, September 23, 2024; Olamikan chart notes, December 9, 2024). Employee also participated in counselling with Lynda Freeman, PhD. (Freeman notes, June 24, 2024; July 8, 2024; July 15, 2024; July 22, 2024; July 29, 2024; August 5, 2024; August 12, 2024). At least 1,932 pages of medical records have been filed relating to Employee's January 31, 2024, fall. (Observations).

9) On March 5, 2024, Employee saw Johannes Gruenwald, MD, an orthopedist, who wrote, "Patient is well known to our clinic, presents after another fall late in January. She has been seen many times by several other providers who have requested several exams. Only some of them are available to me at this point." Dr. Gruenwald assessed "[s]ignificant trauma pain," and wrote, "Point tenderness at the 'snuff box' is obvious and almost diagnostic in my humble opinion to establish a scaphoid pathology." He reviewed x-rays "done about a week after the injury" and thought two views were "suggestive of possible undisplaced scaphoid fracture." Dr. Gruenwald ordered a left wrist computed tomography (CT) scan and thought Employee might benefit from trigger point injections due to "significant upper extremity muscle tension." (Gruenwald chart notes, March 5, 2024). CT scan impressions included "[h]igh suspicion for a tiny nondisplaced fracture of the dorsal aspect of the triquetrum," and "[s]uspect a small wrist joint effusion." (CT report, March 5, 2024).

10) On March 7, 2024, Employee returned to Dr. Gruenwald, who thought the March 5, 2024, CT showed "an undisplaced but healing fracture of the scaphoid." He wrote, "Swelling in the snuffbox and point tenderness at the dorsal aspect of the wrist joint at the triquetrum and in the snuffbox itself are indicative of the correctness of this diagnosis." (Gruenwald chart notes, March 7, 2024). The following day, Employee again saw Gruenwald, who thought "[Employee] now has all the hallmarks of developing an early onset RSD [reflex sympathetic dystrophy]." (Gruenwald chart notes, March 8, 2024).

11) On April 3, 2024, Employee returned to Dr. Gruenwald, who wrote, "[Employee] still has clear evidence of reflex sympathetic dystrophy affecting the distal two-thirds of the left forearm." He observed that Employee's fingers were swollen and red and noted, "I do believe we already see changing hair growth in this area." Dr. Gruenwald wanted to follow Employee's "point tenderness about the snuffbox" with x-rays and ordered additional x-rays that day. He interpreted them to show "the fracture line to be persistently visible" with no additional resorption and "several areas where cross fracture line bridging appears to be happening." He administered trigger point injections and recommended that Employee remove her hand from the brace and start finger exercises. Dr. Gruenwald also had a discussion with Employer's adjuster about referring Employee to a pain management specialist. He later authored an addendum to his chart notes:

> After additional review of x-rays, I finally got access to the server directly. Undisplaced fracture line in the distal radius becomes obvious. This fracture is

> clearly associated with the original injury, longitudinal fracture that was undisplaced and therefore unnoticed up to this point, but as now resorption sets in several weeks after the injury, these fracture lines become visible. So, an additional diagnosis has been established today, distal radius fracture.

(Gruenwald chart notes, April 3, 2024). X-rays taken that day were interpreted by the radiologist to show "No acute fracture or dislocation." (X-ray report, April 3, 2024).

12) On April 4, 2024, Dr. Gruenwald excused Employee from work from April 4, 2024 through May 3, 2024. (Authorization for Absence, April 4, 2024).

13) On May 13, 2024, Dr. Gruenwald referred Employee to the Alaska Fracture and Orthopedic Clinic for evaluation and treatment. (Patient Referral, May 13, 2024).

14) On May 14, 2024, Employee was prescribed a transcutaneous electrical nerve stimulation (TENS) unit for lower back and left wrist pain. (Prescription, May 14, 2024). The signature of the prescriber is illegible. (Observations).

15) On May 15, 2024, Daniel Cepela, MD, evaluated Employee at the Alaska Fracture and Orthopedic Clinic. He found Employee in "mild distress" and observed that she was "heavily guarding her whole upper extremity." Employee demonstrated "minimal" range of motion at the fingers and wrist, and "very hesitant" range of motion at the elbow. Employee was also "very sensitive to touch even in the fingers." Dr. Cepela found no significant warmth, mild swelling and no allodynia. He wrote, "I think at this point she has developed CRPS in her left upper extremity. She is certainly catastrophizing the injury and is guarding heavily." Dr. Cepela thought it "extremely important" that Employee undertake hand therapy and planned to refer her for evaluation for stellate ganglion blacks. He also noted that Employee has a history of developing CRPS in her right upper extremity following right wrist surgery and thought Employee might benefit from a pain psychologist. (Cepela chart notes, May 15, 2024). Dr. Cepela released Employee from work "till cleared by medical provider." (Return to Work / School, May 15, 2024).

16) On June 3, 2024, Oluwasola Olamikan, MD, evaluated Employee at Advanced Pain Centers of Alaska on referral from Dr. Cepela. Employee described her pain as aching, exhausting, gnawing, miserable, nagging, penetrating, pressure, sharp, shooting, stabbing, tender, throbbing, tiring, twisting, unbearable, and burning. Her pain is worsened by sitting, standing, heat, cold, walking, exercise, sex, tough, stress, and movement. It is elevated by distraction, ignoring it, medications and TENS. Dr. Olamikan thought Employee met the diagnostic criteria for CPRS type I of the upper left extremity "as elaborated in the Budapest criteria," and recommended

"multimodal, multidisciplinary treatment algorithms," including stellate ganglion blocks. He also recommended "appropriate mental health interventions" and wrote, "the presence of mental health challenges in this patient does not obviate the authenticity of his [sic] pain presentation." Dr. Olamikan's other recommendations included the use of neurotropic medications and psychotropic medications and anti-inflammatories. (Olamikan chart notes, June 3, 2024).

17) On June 5, 2024, a left wrist magnetic resonance imaging (MRI) study showed:

> No acute or subacute fracture. No dislocation. No abnormal widening of the scapholunate interval. No abnormal rotation of the lunate. Large intraosseous ganglion within the capitata. Mild-to-moderate osteoarthritis of the triscaphe and first carpometacarpal joints. There may be very mild bone marrow edema within the carpal bones (most notably within the proximal row) as well as the base of the first metacarpal. This does not have the classic appearance of complex regional pain syndrome (robust subcortical bone marrow edema).

(MRI report, June 5, 2024).

18) On June 19, 2024, Dr. Cepela discussed recent MRI results with Employee. He wrote,

> I do not see any evidence of a fracture dislocation or malalignment of bones. She has no ligamentous injury. . . . I do not see any surgical indication. . . . She currently is incapable of doing her job or doing any significant work with her left hand.

Dr. Cepela thought it was appropriate for Employee to see a counsellor for pain management strategies. (Cepela chart notes, June 19, 2024).

19) On July 10, 2024, Employee followed up with Dr. Cepela, whose assessment states:

> I again had a lengthy discussion with [Employee] who has made significant improvement since [our] visit and quite dramatic improvement since her initial visit both with objective evaluation of her left upper extremity as well as her overall outlook and mood. She is attempting to treat CRPS on multiple fronts. She is seeing a counselor Lynn Freeman who specializes in CRPS and she has found helpful. She is seeing Dr. Alamakahn [sic] for pain management and trigger point injections. Will also send a referral to him for evaluation and treatment for back pain. She is seeing Arctic [C]hiropractic for massage. She is attempting to see Dr. Oster Bauer [sic] and neurology for further evaluation of her CRPS. We discussed slowly weaning out of the brace which she is only using when out of the house at this point as well as reintegrating more normal use of her left upper extremity as she continues to improve. For the time being she is still symptomatic enough that she is unable to work. I recommend she continue treating CRPS on all fronts. I am optimistic at this point she will make a full recovery, but this could take a significant amount of time. She is [sic] attempted to do more driving still finds this

> significantly painful and irritating to her left wrist. Will include a driving restriction in her work restrictions.

(Cepela chart notes, July 10, 2024).

20) On August 1, 2024, Dr. Cepela responded to questions posed by Employee's vocation rehabilitation specialist and opined that Employee would incur a ratable permanent impairment greater than zero and would not have the permanent physical capacities to perform the physical demands of a General Duty Nurse; Nurse Supervisor; or Nurse Supervisor, Community Health Nursing. (Cepela responses, August 1, 2024).

21) On August 20, 2024, Employee claimed temporary total disability (TTD), permanent total disability (PTD), permanent partial impairment (PPI), and medical and transportation benefits. She also sought penalty, interest and a finding of unfair or frivolous controversion. (Claim for Workers' Compensation Benefits, August 20, 2024).

22) On September 9, 2024, Employer answered Employee's August 20, 2024, claim, stating that Employee's claimed benefits were either being paid, or medical documentation supporting those benefits had not been received. (Answer, September 9, 2024).

23) At a September 18, 2024, prehearing conference, Employee clarified she is seeking benefits arising from injuries to her left upper extremity, left hand, left buttock, back, neck, right shoulder, pelvis and coccyx. (Prehearing Conference Summary, September 18, 2024).

24) In September 2024, two EMEs evaluated Employee: Paul Craig, PhD, and Dennis Chong, MD. Dr. Craig's report is dated September 23, 2024, and Dr. Chong's report is dated "September 24, 2024 – October 17, 2024." However, since Dr. Craig's report summarizes and quotes from Dr. Chong's report in the medical records review section, the latter would have preceded the former. (Craig report, September 23, 2024; Chong report, September 24 – October 17, 2024; observations, inferences drawn therefrom). Employer later explained, "On September 23, 2024[,] and September 24, 2024, the employer had an Independent Medical Evaluation conducted by Dr. Paul Craig and Dr. Dennis Choing." It further explained that it received Dr. Chong's report on October 18, 2024, and it received Dr. Craig's report on November 25, 2024. (Affidavit Regarding Due Diligence, December 2, 2024).

25) Between September 24 and October 17, 2024, Dr. Chong, a physical medicine and rehabilitation specialist, undertook an EME. Employee's chief complaints included symptoms in her cervicodorsal spine, global left upper limb, left low back, and all her toes feeling cold. She

also reported unintentional weight gain in the past two months secondary to stress, which she attributed to attorneys and workers' compensation causing a 'cortisol' response. Employee stated her daily routine typically involves being awoken by nocturnal pain and her day commencing in the morning with a home exercise program or going to therapies. Her afternoons are spent doing administrative work and documenting workers' compensation Health Insurance Portability and Accountability Act (HIPAA) violations. On physical examination, Dr. Chong observed Employee "postures her left upper limb in a guarded manner, with elbow flexed at 90 degrees and internally rotated 45 degrees," and "[w]hen arising from sit to stand, it is supported in that position by the right hand." He further noted, during the examination, "While moving her left hand volitionally, she lets out a loud "ow" and reports that with all this activity her left wrist is now swelling." Dr. Chong then wrote, "This calls into question what home exercise program she does in that there has been minimal activity engaged thus far during the examination." Following the physical examination and his review of available medical records, Dr. Chong provided 13 diagnoses, including:

> 10. Notation by [Employee's] primary care at Family Health Center of "histrionic" personality. This is corroborated in the clinical records of extensive reports by the examinee of fractures, in the absence thereof, as well as ligamentous injuries, again in the absence thereof.
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> 11. . . . . Left FOOSH [fall on outstretched hand] without initial symptoms. This is related to the index industrial event. Symptoms evolved with prolonged immobilization with a wrist brace. CT scan circa April/May 2024 of left wrist. *(Examiner's Note: I do not have this report available for review, and this should be obtained).*
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> [Employee] was informed by Dr. Gruenwald of having five fractures and ligamentous disruption by Dr. Cepela.
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> Subsequent MRI wrist on June 5, 2024, without evidence of either and furthermore, no objective findings of CRPS. Notation by Dr. Cepela of no surgical indication. Nevertheless, [Employee] insists today that she is being evaluated by Dr. Cepela for wrist surgery when the CRPS subsides.
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> 12. There is no objective finding consistent with the Budapest Criteria for CRPS. There may be some fullness of the left wrist, but this is consistent with dependent positioning. Notably, there is no atrophy to the left upper limb, indicative of continued use.

> If this diagnosis had been present, it has resolved from today's evaluation. . . .

Dr. Chong's diagnosis for Employee's "current condition(s)" was "subjective report of left-hand pain, without objective findings for pathological diagnosis." He did not think the work injury was the substantial cause of Employee's "extensive symptoms including global pain of the entire left upper limb" and went on to point out that there were "substantial missing clinical records" related to ongoing treatment for cervicodorsal spine and low back, including 2023 MRIs following a motor vehicle accident. Dr. Chong opined Employee's ongoing treatment for the wrist and low back was excessive and medically unnecessary, including stellate ganglion blocks or trigger point injections, surgical treatment, diagnostic testing, pain medications and anti-inflammatories, passive manual therapies, interventional pain management, and stimulation devices, but past medical treatment had been reasonable and necessary "in the absence of diagnostic clarity." He did not offer an opinion on the reasonableness and necessity of continued counselling since he did not have any counselling notes to review. Dr. Chong saw no objective basis for work restrictions and thought Employee had the physical capacities to return to her previously held jobs. In response to a question about an alternative explanation for Employee's medical complaints, he stated:

> There is a history that is strongly suggestive of psychologic overlay. This is as noted in the graphic descriptions to different providers of fractures and ligamentous injures, in the objective absence of such. This is also reflected in the physical examination today whereby light touch for sensory testing was described by [Employee] as 'hitting' and 'punching.' This correlates with the descriptor of 'histrionic,' as used by her primary care nurse practitioner.

Dr. Chong opined Employee was medically stable "in that there has been no objective measurable improvement from the most recent available notes." He concluded his report by writing, "[Employee] appears to have had prolonged immobilization of the left wrist for alleged multiple fractures. It would be instructive to obtain all the x-rays, CT scans, and MRIs of the left wrist and have these independently reviewed by a radiologist, to verify if these truly exist." (Chong report, September 24 – October 17, 2024).

26) Between September 23, 2024, and November 25, 2024, Dr. Craig, a neuropsychologist, performed an EME. During his cursory review of records provided, he noted some of the records from recent months referred to mental health referrals for Employee. However, when passing

through all the records, no mental health records were observed. Dr. Craig recorded Employee's current physical complaints:

> [Employee] complained of ongoing pain in the left wrist, left elbow, and left upper arm into the shoulder and neck. She complained of ongoing pain in the thoracic and cervical spine. She complained of sacral and coccyx pain. She denied pain in her lumbar spine but reported pain everywhere else in her spinal column. She stated that the left side of her pelvis hurst more than the right side. She reported to the current examiner that she has intermittent numbness in the left hip. She denied any pain in the lower extremities, including her feet. She stated that her right shoulder and right upper extremity are also sore. She explained the pain in her right shoulder and right upper extremity is the result of compensating for the problems with the left side of her body.

He then undertook a clinical interview that spans over 11 typewritten, single-spaced pages, a medical records review and he administered psychological assessment testing. Dr. Craig diagnosed 1) somatic symptom disorder, with predominant pain, persistent; 2) post-traumatic stress disorder; 3) major depressive disorder, recurrent, severe; and 4) generalized anxiety disorder. He opined all four of these psychiatric disorders were the substantial cause of Employee's "current condition," and none of the disorders were caused by work injury, since they all predated the work injury. Dr. Craig did not think Employee was a good candidate for traditional insight-oriented psychotherapy, but treatment might include time-limited, behaviorally oriented, pain management treatment program focused on increasing her physical activity, social engagement and work hardening. However, he cautioned that even with behaviorally oriented treatment, Employee's somatic symptom disorder was so chronic and persistent that she may be unable or unwilling to meaningfully participate. Dr. Craig opined it was highly probable that Employee would reject participating in such a program because she believes her problems are exclusively medical rather than psychological and behavioral. He thought work was not the substantial cause of Employee's need for psychological and behavioral treatment, and such treatment should not be provided. However, Dr. Craig did think Employee might benefit from being under the care of a psychiatrist who understands somatic symptom disorder and her other psychiatric diagnoses, and such treatment might include medications to treat her PTSD, depression and anxiety. When asked whether Employee's treatment had been medically reasonable, necessary, and related to the January 31, 2024 work injury, he replied:

> The current examiner defers to the independent medical evaluator to determine the medical necessity of the medical treatments she has received . . . . Although the current examiner is reluctant to opine about the specific medical necessity for any of these treatments, the current examiner can point out that [Employee] does not appear to have benefited from these treatments, insofar as she continues to present with the same subjective complaints and concerns over time . . . . The treatment records repetitively refer to improvement and gains she is making during each treatment session. Despite records of improvement, her subjective symptoms persist at a similar level month after month. Hence, it appears that the treatment she has been receiving has been primarily palliative.
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> [Employee] has built her life around her complaints of chronic pain, and spends her days attending various healthcare appointments, with no evidence of significant improvement consequent to those treatments. It is very doubtful she will improve by simply doing more of the same with respect to treatment. [Employee's] primary problems are psychogenic rather than medical or physical. Obviously, this conclusion stands in stark contrast to [Employee's] self-image and subjective complaints. The conclusion that her problems are primarily psychogenic will undoubtedly elicit a hostile response from [Employee], consistent with the findings contained in the computer-generated psychological reports. Despite [Employee's] preference to define her problems as medical and physical, there is ample evidence to suggest the opposite - namely, a longstanding psychogenic causation for chronic pain complaints that appear to be far in excess of what would be predicted following one or more injuries.

Dr. Craig would not place any psychological work restrictions on Employee, but opined, "She would undoubtedly display behavioral difficulties if she were to return to work immediately based on symptoms, she evidences consequent to her somatic symptom disorder, depression, anxiety, and post-traumatic stress disorder." In response to a question about an alternative explanation for Employee's medical complaints, he cited examples from the medical records and his clinical interview and concluded that Employee's psychiatric disorders were substantially caused by "a plethora of traumatic events and stressors dating back more than two decades." (Craig report, September 23, 2024 [sic]).

27) On October 3, 2024, Dr. Cepela authored a "To whom it may concern" letter and explained Employee's "conditions" included CRPS of the left upper extremity, which involved the "entire upper extremity." Her CRPS symptoms were "classic," according to Dr. Cepela, and included hypersensitivity, swelling, stiffness, pain, and reactive skin changes. He thought the work injury was the substantial cause of Employee's CRPS and her need for treatment, and that Employee did not have a preexisting condition in her left upper extremity. Dr. Cepela opined Employee would

require a few more months of therapy with multiple modalities including massage and chiropractic. He did not think Employee's CRPS had reached maximum medical improvement and thought Employee had been unable to engage in full-time gainful employment since January 31, 2024, as a result of her CRPS. However, Dr. Cepela also opined that "it is most likely [Employee] will be able to return to full-time employment in the future." He explained Employee's current work restrictions "involve limiting aggravation and worsening of her CRPS," and included activities involving repetitive use, lifting and fine motor tasks. (Cepela letter, October 3, 2024).

28) On October 4, 2024, Employee filed an unsigned affidavit of readiness for hearing (ARH) on her August 20, 2024 claim, which was "not processed" because of the missing signature. (ARH, October 4, 2024; Incident Claims and Expense Reporting System (ICERS) Comments, October 4, 2024).

29) On October 7, 2024, Employee filed a signed ARH on her August 20, 2024, claim. (ARH, October 7, 2024).

30) On October 9, 2024, Employer opposed Employee's October 7, 2024, ARH on the basis a prehearing should be scheduled, at which the parties could "select a mutually agreeable hearing date." (Opposition, October 9, 2024).

31) On October 9, 2024, Jared Kirkham, MD, evaluated Employee on referral from Dr. Cepela for chronic neck pain and left upper extremity pain, as well as chronic low back and left buttock pain after the January 31, 2024 work injury. During the physical exam, he recorded, "[Employee] remains quite anxious and perseverates on her symptoms. She remains heavily guarded, especially in her left upper extremity. . . . She walks slowly and cautiously. . . . She is intermittently wincing and grimacing." Dr. Kirkham's "[p]roblem list" for Employee included the following:

> 1. Chronic neck pain and diffuse upper extremity pain after work injury in [sic] January 31, 2024: The cause of this is unclear. There are no concerning neurological deficits on exam. There is no objective evidence of complex regional pain syndrome. Her symptoms are out of proportion to objective findings.
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> 2. History of left wrist triquetral avulsion fracture from work injury on January 31, 2024, resolved per MRI of the left wrist from June 5, 2024.
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> 3. Chronic low back and left buttock pain after the work injury on January 31, 2024: The cause of her pain is unclear. She did sustain a contusion based upon the picture she showed me . . . but it is unclear to me why her pain has persisted for ten months. Her physical exam and imaging studies are reassuring.

> 4. Prominent psychosocial contribution to her degree of pain and disability. She is very anxious regarding her symptoms. She perseverates on her pain complaints. She is quite guarded. She has poor expectations for improvement. She demonstrates catastrophic thinking, reporting that she sustained multiple fractures of her left hand and wrist.
>
> 5. History of migraines, anxiety, and PTSD.

He explained to Employee that her physical exam and extensive imaging studies were reassuring. Employee asked about interventional procedures, but Dr. Kirkham was concerned interventional procedures would worsen her symptoms "in context of nervous system hypersensitivity and a prominent psychosocial component to her symptoms." He recommended Employee gradually return to all her normal activities, including exercise and work activities, with no formal restrictions on her activities. (Kirkham chart notes, October 9, 2024).

32) On November 18, 2024, Employee followed up with Dr. Cepela. "The decision was made to perform a left first extensor compartment steroid injection." Dr. Cepela administered the injection and now thought Employee's exam was most consistent with a triangular fibrocartilage complex tear [TFCC] tear. He added that Employee "did have a partial-thickness degenerative tear" on a previous MRI and further thought Employee's examine is "consistent with de Quervians tenosynovitis." If Employee had a significant inflammatory response or loss of progress with her CRPS therapy from the injection, Dr. Cepela did not think she was "ready for surgery." (Cepela chart notes, November 18, 2024).

33) On December 2, 2024, Employee saw Dr. Cepela, who thought Employee's response to the steroid injection was "promising." Dr. Cepela discussed the possibility of de Quervain's release surgery and the risk of "flare" to Employee's CRPS. He also administered a foveal injection. (Cepela chart notes, December 2, 2024).

34) On December 2, 2024, Employer controverted TTD and temporary partial disability (TPD) benefits after November 25, 2024; medical and related transportation benefits; retraining and stipend benefits; and PPI benefits based on Drs. Chong's and Craig's EME reports. (Controversion Notice, December 2, 2024).

35) On December 9, 2024, Employee filed a petition for an SIME along with three SIME forms setting forth disputes between her physicians and Dr. Chong. She did not indicate a medical

specialty for the SIME on the forms. Employee signed the forms, but Employer did not. (Petition, December 9, 2024; SIME forms, December 8, 2024).

36) On December 18, 2024, Employer answered Employee's December 9, 2024, petition for an SIME, stating it did not object to Employee's request for an SIME. (Answer, December 18, 2024).

37) On January 15, 2025, Dr. Cepela performed a left De Quervain's release with left wrist arthroscopy and debridement. (Procedure Note, January 15, 2025).

38) On March 10, 2025, Employer filed a petition to dismiss Employee's August 20, 2024, claim based on her continued refusal to sign its medical release as ordered at a December 20, 2024, prehearing conference and based on her revocation of previously signed releases. (Employer petition, March 10, 2025).

39) On March 10, 2025, Employee filed a petition to withdraw her December 9, 2024, petition for an SIME. (Employee petition, March 10, 2025).

40) On March 14, 2025, Employer filed a petition "reasserting" Employee's December 9, 2024, request for an SIME, along with an SIME form listing disputes between Dr. Chong and Employee's physicians. Its SIME form requested an evaluation by an "orthopedic." Employer's attorney signed the form, but Employee did not. (Petition, March 14, 2025; SIME form, March 14, 2025).

41) On April 7, 2025, Employer requested a hearing on its March 14, 2025, petition for an SIME. (Affidavit of Readiness for Hearing, April 7, 2025).

42) On April 10, 2025, Employee's March 10, 2025, petition to withdraw her December 9, 2025, petition for an SIME, and Employer's March 14, 2025, petition for an SIME were scheduled for an April 23, 2025, written records hearing. (Prehearing Conference Summary, April 10, 2025).

43) On April 14, 2025, Employee opposed a hearing on Employer's March 14, 2025, SIME petition on numerous bases. (Affidavit of Opposition, April 14, 2025).

44) On May 8, 2025, the panel wrote to the parties to request additional documents that appeared to be missing from the medical record. The hearing record was reopened until June 2, 2025. (Vollmer letter, May 8, 2025).

45) On May 15, 2025, Employer filed additional documents pursuant to the panel's May 8, 2025, request. (Medical Summary, May 15, 2025).

46) On May 22, 2025, Employee's August 24, 2024, claim was scheduled for an October 21, 2025, hearing on its merits. (Prehearing Conference Summary, May 22, 2025).

PRINCIPLES OF LAW

> **AS 23.30.001**. **Intent of the legislature and construction of chapter.** It is the intent of the legislature that
>
> (1) this chapter be interpreted . . . to ensure . . . the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to . . . employers . . . .
>
> (4) hearings in workers' compensation cases shall be impartial and fair to all parties and that all parties shall be afforded due process and an opportunity to be heard and for their arguments and evidence to be fairly considered.
>
> **AS 23.30.005. Alaska Workers' Compensation Board.**
> . . . .
>
> (h) . . . . Process and procedure under this chapter shall be as summary and simple as possible. . . .

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

> **AS 23.30.095. Medical treatments, services, and examinations**. . . .
>
> (k) In the event of a medical dispute regarding . . . 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. . . .

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 to "properly protect the rights of all parties."

The Alaska Workers' Compensation Appeals Commission in *Bah v. Trident Seafoods Corp.*, AWCAC Decision No. 073 (February 27, 2008) addressed the board's authority to order an SIME under AS 23.30.095(k) and AS 23.30.110(g). Regarding AS 23.30.095(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 AS 23.30.110(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 AS 23.30.095(k) may be ordered when there is a medical dispute, or under AS 23.30.110(g) when there is a significant gap in the medical evidence or a lack of understanding of the medical evidence.

> **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) In making an investigation or inquiry or conducting a hearing the board is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by this chapter. The board may make its investigation or inquiry or conduct its hearing in the manner by which it may best ascertain the rights of the parties. . . .
>
> **AS 23.30.155. Payment of compensation**. . . .

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

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 45.052. Medical Summary.**
> . . . .
>
> (c) . . . a party filing an affidavit of readiness for hearing must attach an updated medical summary . . . if any new medical reports have been obtained since the last medical summary was filed.
>
> > (1) If the party filing an affidavit of readiness for hearing wants the opportunity to cross-examine the author of a medical report listed on the medical summaries that have been filed, the party must file with the board, and serve upon all parties, a request for cross-examination . . . .

(d) After a claim or petition is filed, all parties must file with the board an updated medical summary form within five days after getting an additional medical report. A copy of the medical summary form, together with copies of the medical reports listed on the form, must be served upon all parties at the time the medical summary is filed with the board.

8 AAC 45.070. Hearings.

. . . .

(b) . . . a hearing will not be scheduled unless a claim or petition has been filed, and an affidavit of readiness for hearing has been filed . . . .

(1) A hearing is requested by using the following procedures:

. . . .

(F) To resolve a medical dispute under AS 23.30.095(k) or to request the board order a physical examination under AS 23.30.110(g), a party shall file with the division and serve on opposing parties a petition asking the board to order a second independent medical evaluation, a completed second independent medical evaluation form signed by the party that filed the petition, and medical records reflecting the medical disputes; if the parties do not stipulate to the second independent medical evaluation within 20 days of service of the documents, the board or its designee will schedule a hearing, the board will hold a hearing on the written record with briefs, and the board will issue its decision and order within 60 days of the date the documents were filed with the division and served on the opposing party; an affidavit of readiness for hearing form is not required.

8 AAC 45.092. Second independent medical evaluation.

. . . .

(h) In an evaluation under AS 23.30.095(k), the board or the board's designee will identify the medical disputes at issue and prepare and submit questions addressing the medical disputes to the medical examiners selected under this section. The board may direct

(1) a party to make a copy of all medical records, including medical providers' depositions, regarding the employee in the party's possession, put the copy in chronological order by date of treatment with the initial report on top, number the records consecutively, and put the records in a binder;

(2) the party making the copy to serve the binder of medical records upon the opposing party together with an affidavit verifying that the binder contains

> copies of all the medical reports relating to the employee in the party's possession;
>
> (3) the party served with the binder to review the copies of the medical records to determine if the binder contains copies of all the employee's medical records in that party's possession; the party served with the binder must file the binder with the board not later than 10 days after receipt and, if the binder is
>
> > (A) complete, the party served with the binder must file the binder upon the board together with an affidavit verifying that the binder contains copies of all the employee's medical records in the party's possession; or
> >
> > (B) incomplete, the party served with the binder must file the binder upon the board together with a supplemental binder with copies of the medical records in that party's possession that were missing from the binder and an affidavit verifying that the binders contain copies of all medical records in the party's possession; the copies of the medical records in the supplemental binder must be placed in chronological order by date of treatment, with the initial report on top, and numbered consecutively; the party must also serve the party who prepared the first binder with a copy of the supplemental binder together with an affidavit verifying that the binder is identical to the supplemental binder filed with the board;
>
> (4) the party, who receives additional medical records after the binder has been prepared and filed with the board, to make two copies of the additional medical records, put the copies in two separate binders in chronological order by date of treatment, with the initial report on top, and number the copies consecutively; the party must file one binder with the board not later than seven days after receiving the medical records; the party must serve the other additional binder on the opposing party, together with an affidavit stating the binder is identical to the binder filed with the board, not later than seven days after receiving the medical records;

Betts v. Greenling Enterprises, LLC, AWCAC Appeal No. 22-013, Order on Petition for Review (November 30, 2022), addressed an employee's petition for review from a Board order granting an employer's request for an SIME. The Board had found a medical dispute, "especially as to the kind and nature of proposed medical treatment." *Id*. at 9. Addressing the employee's argument, *Betts* said "even if the EMEs' opinions did not rebut the presumption of compensability, there remained a substantial and significant question as to future medical treatment." *Id*. *Betts* explained:

> Ms. Betts' position that the EMEs do not rebut the presumption of compensability is a legal issue to be addressed by the Board at a hearing on the merits. The procedure is that the Board, at that time, will decide if Ms. Betts raised the presumption, then

> whether Greenling rebutted it and, if so, then Ms. Betts must prove her claim by a preponderance of the evidence. However, a hearing on the issue of whether to order an SIME is not a hearing on the merits and the issue of sufficiency and credibility of the EME reports is not addressed. Among the concerns addressed by the Board at the hearing on the SIME is whether an SIME will be of assistance to the Board in resolving the issues of the claim at a hearing on the merits. The Board has a right to order an SIME to assist it in understanding the medical issues involved in the claim and this right is independent of the issue of the presumption of compensability. . . .
> . . . .
>
> This right to require an SIME arises prior to a hearing on the merits. The presumption analysis is not relevant where the Board is making a determination as to whether an SIME would assist it. . . .
>
> The Board's ordering of the SIME does not impair a legal right of Ms. Betts, because the Board has its own right to order an SIME. The Board is entitled to have a full understanding of the medical issues it is deciding, as are the parties to the claim.
>
> Furthermore, there is no unnecessary expense for Ms. Betts because the examination is paid, per statute, by the employer. While there is delay in the Board holding a hearing on the merits, it is better for the delay to occur prior to that hearing than to occur part-way through such a hearing. If the Board were to find it necessary to halt the proceedings in order to exercise its right to order an SIME to help this decision-making process, the cost of the parties would be substantially greater. That is, at hearing the parties usually have one or more medical experts lined up to testify. If the Board stays the hearing to conduct an SIME, there is greater expense due to the need for the experts to be called again to testify after the SIME.
> . . . .
>
> . . . Ms. Betts contends that the EME reports do not rebut the presumption of compensability and, therefore, should not be a basis for ordering an SIME. However, the issue of the presumption of compensability comes into play at hearing on the merits. To decide this issue when deciding whether to order an SIME deprives the parties of a full and fair hearing because not all evidence will be heard or considered at the preliminary hearing on the issue of the SIME. The question Ms. Betts raises as to whether the EME reports are sufficient to rebut the presumption of compensability is an important question, but it is a question for the board at a hearing on the merits of her claim. . . .

See also Phillips v. Vend. Inc., AWCB Dec. No. 24-0038 (June 28, 2024).

> **8 AAC 45.095. Release of information.**
> . . . .

> (b) If after a prehearing the board or its designee determines that information sought from the employee is not relevant to the injury that is the subject of the claim, a protective order will be issued.
>
> **8 AAC 45.120. Evidence.**
> . . . .
>
> (k) The board favors the production of medical evidence in the form of written reports.

ANALYSIS

Should an SIME be ordered?

Although Employe opposes an SIME because she withdrew her December 9, 2024, petition requesting one, and even though she contends Employer's March 14, 2025, petition for an SIME is untimely, an SIME may be ordered on the Board's own initiative at any time where the right to compensation is controverted, as Employee's benefits are here. AS 23.30.155(h). Medical disputes between Employee's and Employer's physicians are a basis for an SIME and, in this case, such disputes are plentiful. *Bah*; AS 23.30.095(k). Medical disputes are most readily found in Dr. Chong's September 24, 2024, EME report and Dr. Cepela's October 3, 2024 "To whom it may concern" letter. In his report, Dr. Chong opined the work injury was not the substantial cause of Employee's symptoms; Employee's medical treatment had been excessive and medically unnecessary; there were no objective bases for work restrictions and Employee had the physical capacities to return to her previously held jobs; and Employee was medically stable in the absence of objectively measurable improvement. On the other hand, in his letter, Dr. Cepela opined the opposite on each of these issues. He thought the work injury was the substantial cause of Employee's CRPS and her need for treatment; Employee was not medically stable and would require additional therapy with multiple modalities; and Employee had been unable to engage in gainful employment because of the work injury. Thus, there are medical disputes regarding causation, medical treatment, medical stability and functional capacity. These disputes are significant because their resolution will determine Employee's entitlement to, and Employer's liability for, valuable benefits Employee has claimed. *Bah*.

Other medical disputes involve whether Employee sustained a wrist fracture because of the work injury and whether she subsequently developed CRPS from such a fracture. On February 1, 2024, left wrist x-rays taken at an urgent care clinic were interpreted to show no fracture, left wrist x-rays taken on February 8, 2024, were also interpreted to show no fracture, and on June 5, 2024, a left wrist MRI was interpreted to show no fracture. However, on March 5, 2024, Dr. Gruenwald thought the February 8, 2024, x-rays were "suggestive of possible undisplaced scaphoid fracture," and on April 3, 2024, he thought unspecified x-rays showed an "obvious" distal radius fracture that was "clearly associated with the original injury." Meanwhile, Dr. Chong was openly skeptical of Employee's "alleged multiple fractures" in his EME report and he thought that all left wrist x-rays, CT scans and MRIs should be further reviewed. Whether or not Employee developed CRPS is also disputed. Dr. Olamikan thinks Employee meets the Budapest criteria for CRPS; Dr. Chong thinks she does not. This panel finds these disputes confounding and an SIME will facilitate the fact finders' understanding of the medical evidence. AS 23.30.110(g). Given the musculoskeletal nature of Employee's left wrist and sacrum/coccyx injuries, and because of Dr. Cepela's ultimate decision to perform left wrist surgery, an orthopedic surgeon is the appropriate medical specialist to conduct the SIME.

In response to her many objections to an SIME, Employee is advised that the Board favors the production of medical evidence in the form of written reports, 8 AAC 45.120(k), and all medical reports are required to be filed with the Board. 8 AAC 45.052(d). Since SIME petitions are decided on these medical reports, additional documents or testimony would not be material to this decision. *Bah*. Additionally, the regulations provide that a written records hearing will be held to decide petitions seeking an SIME. 8 AAC 45.070(b)(1)(F). At these hearings, the parties' positions and arguments are heard and fairly considered through their hearing briefs, as they now are here. 8 AAC 45.114; 23.30.001(4). Employee further advised that a hearing on the merits of her August 24, 2024, claim is scheduled for October 21, 2025, and it is unlikely that this SIME will delay the hearing on the merits of her claim. *Rogers & Babler*. She is also advised that an SIME is not a discovery tool to give Employer another 'bite of the apple' to obtain favorable medical evidence; it is an investigative tool exercised by the Board to assist it by providing a disinterested opinion. *Olafson*. Employee is encouraged to seek the assistance of a workers' compensation technician in completing requests for cross-examination of the EME physicians so she may explore

any concerns she may have with the bases of their reports. 8 AAC 45.052(c)(1). She is additionally assured that she will be given an opportunity to verify medical records before they are sent to the SIME physician, 8 AAC 45.092(h)(3), so she can still object to the inclusion of any medical records that have not been subject to the designee's prior rulings. 8 AAC 45.095(b).

Finally, Employee objects to an SIME and asserts Employer's petition should be denied because its EME reports do not rebut the presumption of compensability. This agreement has been rejected by the Appeals Commission and the Board in previous cases. The issue of whether Employer's EMEs' opinions rebut the presumption is decoded at a hearing on the merits, not when deciding whether to order an SIME. *Betts*; *Phillips*.

CONCLUSION OF LAW

An SIME should be ordered.

ORDERS

1) Employer's March 14, 2025, petition for an SIME is granted.
2) An SIME will be performed by an orthopedic surgeon. An SIME physician from the board's list will be selected to perform the examination. If, at the time of processing, the board's designee determines that no physician on the board's list is available and/or qualified to perform the examination under 8 AAC 45.092(e), the board's designee will notify the parties and request that they provide the names, addresses, and curriculum vitae of physicians in accordance with 8 AAC 45.092(f).
3) The medical disputes are causation, medical treatment, medical stability and functional capacity arising from Employee's left wrist and sacrum/coccyx injuries.
4) All filings regarding the SIME must be sent to workerscomp@alaska.gov and served on opposing parties.
5) Employer will make two copies of all employee's medical records in its possession, including medical providers' depositions, a written job description or the written physical demands of the employee's job as described in the United States Department of Labor's *Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles*, put the copies in chronological

order by treatment date, starting with the first medical treatment and proceeding to the most recent medical treatment, number the pages consecutively, put the copies in two binders. This must be done on or before July 7, 2025. Employer must serve one binder on Employee and one with the Division, with an affidavit verifying the binders contain copies of all medical records in his/her possession no later than 5:00 PM on July 7, 2025.

6) The binders may be returned for reorganization if not properly Bates stamped and prepared in accordance with this prehearing summary.

7) Not later than 10 days after receipt of the binders, Employee must review the binder to determine if it contains all Employee's medical records in Employee's possession. If the binder is complete, Employee must file an affidavit with the Division verifying the binder contains copies of all medical records in Employee's possession. If the binder is incomplete, Employee must make two copies of the additional medical records missing from the first set of binders. Each copy must be put in a separate binder (as described above). Then one supplemental binder, and an affidavit verifying the medical records completeness, must be filed with the Board. The remaining supplemental binder must be served upon Employer together with an affidavit verifying that it is identical to the binder filed with the Board. Employee is directed to file with the Division and serve the binders on opposing parties within 10 days of receipt.

8) Any party who receives additional medical records or physicians' depositions after the binders have been prepared and filed with the Division, is directed to make two supplemental binders as described above with copies of the additional records and depositions. Within seven days after receiving the records or depositions, the party must file one supplemental binder with the Division, and serve one supplemental binder on opposing party, together with an affidavit verifying that it is identical to the binder filed with the Division.

9) A complete set of the board's SIME questions shall be sent to the SIME physician.

10) The parties may review their rights under 8 AAC 45.092(j) to question an SIME physician after the parties receive the physician's report.

11) The parties are advised that a failure to comply with the above orders may result in the SIME going forward notwithstanding a party's noncompliance.

12) SIME physicians are often located outside of Alaska and long-distance travel may be required. If Employee requires travel accommodations, she must request an accommodation from the Employer. The accommodation request must be accompanied by a letter from Employee's

attending physician in their workers' compensation case, pursuant to and within the constraints of AS 23.30.095(a) and 8 AAC 45.082(b), detailing the necessary accommodation.

Dated in Anchorage, Alaska on June 23, 2025.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Robert Vollmer, Designated Chair

/s/
Sara Faulkner, 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 KATHARINE RUEB, employee / claimant v. HOST HEALTHCARE, INC., employer; ARCH INDEMNITY INSURANCE COMPANY, insurer / defendants; Case No. 202401878; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by certified U.S. Mail, postage prepaid, on June 23, 2025.

/s/ Rochelle Comer
Rochelle Comer, Workers' Compensation Technician