ALASKA WORKERS' COMPENSATION BOARD

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

HUGH DUNCAN, Employee, Claimant, v. ASI SERVICES, Employer, and BERKSHIRE HATHAWAY HOMESTATE INSURANCE CO., Insurer, Defendants.	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 202311936 AWCB Decision No. 25-0053 Filed with AWCB Anchorage, Alaska on August 21, 2025

Hugh Duncan's (Employee) June 17, 2025 petition for a second independent medical evaluation (SIME) was heard on the written-record on August 20, 2025, in Anchorage, Alaska, a date selected on July 24, 2025. The June 17, 2025 petition gave rise to this hearing. Attorney Adam Franklin represents Employee. Attorney Krista Schwarting represents ASI Services and its insurer (Employer). The record closed at the hearing's conclusion on August 20, 2025.

ISSUE

Employee contends a significant medical dispute between Employee's attending physicians and an employer's medical evaluator (EME) warrants an SIME.

Employer contends while it does not object to an SIME *per se*, it argues that one should not be ordered right now. If an SIME is ordered, Employer suggests it include additional issues.

Shall this decision order an SIME?

FINDINGS OF FACT

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

1) On August 26, 2023, Employee injured his right shoulder while working for Employer as a mechanic. (First Report of Injury, September 1, 2023). Employee is right-handed. (Jason Gray, MD, report, January 24, 2025).

2) On September 5, 2023, right-shoulder x-rays showed degenerative changes of the glenohumeral joint and acromioclavicular joints. (X-ray report, September 5, 2023).

3) On September 6, 2023, a right-shoulder magnetic resonance imaging (MRI) showed a full-thickness tear of the infraspinatus tendon and the posterior fibers of the supraspinatus tendon with associated tendon retraction. Edema within the rotator cuff musculature showed a moderate-grade muscular strain. The radiologist also found severe degenerative changes of the acromioclavicular joint, and osteophytes. There were also other indications suggesting a partial-thickness tear of the biceps tendon with tendinopathy. (MRI report, September 6, 2023).

4) On September 21, 2023, Dr Gray, orthopedic surgeon, performed right-shoulder surgery on Employee to address his work injury. (Operative Report, September 21, 2023).

5) Unfortunately, by November 29, 2023, Employee developed a right-shoulder infection, which required admission to the hospital, and surgery the following day to remove loose anchors and to surgically manage his septic right shoulder. (Hospital reports, November 29-30, 2023).

6) On February 21, 2024, Dr. Gray evaluated Employee's right shoulder and found right-shoulder dysfunction consistent with "pseudo-paralytic shoulder." He was not improving and Dr. Gray stated Employee would continue to fail to have functional improvement without further intervention. He opined Employee may require a rotator cuff repair versus a reverse total shoulder arthroplasty. (Gray report, February 21, 2024).

7) On May 20, 2024, Dr. Gray opined that if Employee who has diabetes could improve his hemoglobin A1c to 7, he would be a surgical candidate. (Gray report, February 21, 2024).

8) On October 8, 2024, Dr. Gray answered the adjuster's question, "If further treatment is necessary" what he would recommend. He stated, "possible reverse total shoulder" and recognized Employe had a high risk of recurrent infection. (Gray response, October 8, 2024).

9) On October 22, 2024, Employee said his status was the same; he "would like to discuss potentially moving forward with surgical options." His A1c was down to 9.2. "Work status at this time is no release based on the patient's shoulder dysfunction and the intense nature of the activities of his job." (Eric Page, PA-C, report, October 22, 2024).

10) On November 23, 2024, Darren Thomas, MD, orthopedic surgeon, saw Employee for an EME and noted Employee's right-shoulder rotator cuff repair on September 21, 2023, with a postoperative infection treated with irrigation, debridement, and hardware removal, and take-down of his rotator cuff tendon repair, which occurred on November 30, 2023. Employee had been on maintenance amoxicillin since mid-December. He told Dr. Thomas that he will likely require life-long suppression antibiotics. (Thomas report, November 23, 2024).

11) Employee also told Dr. Thomas he was not able to work and had difficulties with many activities of daily living. (Thomas report, November 23, 2024).

12) After reviewing 176 pages of medical records and examining Employee, Dr. Thomas diagnosed a right-shoulder rotator cuff tendon tear with labral tear and biceps tendinitis, postoperative right-shoulder infection status post-surgical debridement and removal of implants. He added, "This is substantially caused by the August 26, 2023, work event." Dr. Thomas also independently reviewed the right-shoulder September 6, 2023 MRI. He opined, "The supraspinatus tendon is torn by about 90 percent of its entire footprint; the vast majority of posterior aspect of the supraspinatus footprint is torn and retracted. The entirety of the infraspinatus footprint appears to be torn and retracted to the level of the articular margin." These findings were "acute." (Thomas report, November 23, 2024).

13) Dr. Thomas added, "At this time, his current condition is considered compensable consequence of treatment rendered for the original condition substantially caused by the work injury in question. He does have insulin-dependent diabetes, and this certainly is considered a contributing factor to increase the risk of postoperative infection; however, the postoperative infection is inextricably intertwined with the original compensable surgery as such to support a compensable consequence of the original work event." In Dr. Thomas' opinion, the employment injury is the substantial cause of any current and ongoing disability or need for treatment. Dr.

Thomas stated, Employee "would not likely have developed an infection if he had not undergone a surgery." He further opined the work injury had not resolved. Employee still had a functional deficit in his right shoulder consistent with a deficient rotator cuff. Dr. Thomas added:

> However, his rotator cuff deficiency, while it more likely than not will lead to rotator cuff arthroplasty, is complicated by his underlying postoperative infection for which he has been treated with suppression lifelong antibiotics. This precludes a safe hygienic revision surgery, particularly in the form of an implant surgery. It is my opinion that further invasive treatment, while [it] may be indicated for his condition in the absence of poorly-controlled insulin-dependent diabetes with chronically suppressed infection, the presence of poorly-controlled diabetes with a chronically suppressed infection precludes safe arthroplasty surgery for the shoulder in my medical opinion.

Dr. Thomas did not recommend any further invasive medical treatment for Employee's right shoulder. Employee will require lifelong suppression antibiotics and physical therapy as palliative maintenance to relieve debilitating pain. (Thomas report, November 23, 2024).

14) Dr. Thomas opined about reasonableness and necessity of Dr. Gray's proposed surgery:

> In my opinion, the reverse total shoulder arthroplasty recommended by Dr. Gray is not considered medically reasonable, although it is considered an acceptable treatment option. It is considered medically reasonable for the process of recovery for the underlying pathology in the absence of insulin-dependent diabetes with postoperative infection requiring suppression antibiotics. It is not considered acceptable given the facts of the case of his insulin-dependent diabetes and post-operative infection with lifelong suppressive antibiotics. If the claimant were to undergo a reverse total shoulder arthroplasty, there would be an enormous certainty that he would develop a postoperative shoulder arthroplasty infection requiring resection arthroplasty and thus, worsen his disability. Thus, it is my opinion that the reverse total shoulder arthroplasty treatment is not indicated in this case from a do no harm perspective as well as from the perspective of not worsening his disability or worsen his functional deficits.

He stated Employee was medically stable, effective November 23, 2024, and provided a seven percent whole-person permanent partial impairment (PPI) rating. Dt. Thomas limited him to no lifting, pulling, pushing or carrying over 20 pounds with his right arm and no lifting overhead with it. He could not work as a mechanic in the future. Dr. Thomas opined Employee could return to gainful employment at the sedentary level. (Thomas report, November 23, 2024).

15) On January 10, 2025, Employer denied Employee's right to: Temporary total disability (TTD) and temporary partial disability (TPD) benefits, and payment for a reverse total shoulder

arthroplasty. Employer relied on Dr. Thomas' November 23, 2024 report where he opined that Employee became medically stable effective November 23, 2024. Dr. Thomas also stated Employee needed no further formal invasive medical treatment for his right shoulder. Employer stated, "Reverse total shoulder arthroplasty is not considered medically reasonable and not considered acceptable given the facts of his insulin-dependent diabetes and post-operative infection with lifelong suppressive antibiotics." (Controversion Notice, January 10, 2025).

16) On January 27, 2025, Dr. Gray released Employee to light-duty work with no lifting over five pounds with his right upper-extremity above shoulder-level, and no activity at or above shoulder-level. (Work Status, January 27, 2025).

17) On January 29, 2025, Employee claimed TTD, permanent total disability (PTD), PPI and medical benefits, medical transportation costs, a penalty for late-paid compensation, interest, attorney fees and costs. (Claim for Workers' Compensation Benefits, January 29, 2025).

18) On February 27, 2025, Dr. Gray wrote:

> I agree with Dr. Thomas' opinion that patient has extremely high risk of postoperative infection primarily given his poorly controlled insulin-dependent diabetes.
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> However, given patient's shoulder dysfunction [it] is not unreasonable, if patient can maintain appropriate diabetic control for a prolonged pre-op window, to proceed with reverse total shoulder arthroplasty in light of a prior infection. This assumes Infectious Disease involvement and likely lifelong antibiotic suppressants. This is [sic] already been discussed in depth with patient's Infectious Disease physician, Dr. Megan Clancy. (Gray letter, February 27, 2025).

Dr. Gray released Employee to light-duty work, limited to five pounds in his right upper-extremity below shoulder level and no activity above that level. (Work Status, February 27, 2025).

19) On February 28, 2025, Employer denied Employee's claim for: TTD, TPD or PTD benefits after November 23, 2024; PPI benefits over seven percent of the whole-person; any further invasive medical treatment; and reemployment benefits. It based these denials on Dr. Thomas' EME report. (Controversion Notice, February 28, 2025).

20) On June 25, 2025, Dr. Clancy, infectious disease specialist, wrote:

> Question posed: "whether a reverse total shoulder is medically reasonable?" Response: I am unqualified to comment on the anatomic and functional pros/cons of a reverse total shoulder. However the patient has done quite well when on oral antibiotic suppression without evidence of recurrence. He may be on oral antibiotic suppression the rest of his life, regardless of further procedures, so this should NOT be a reason to deny him the procedure. Certainly optimizing diabetes management will be crucial prior to any further elective surgeries. . . . (Clancy letter, June 25, 2025) (emphasis in original).

21) On July 17, 2025, Employee petitioned for an SIME based on medical disputes between his attending physicians and Employer's physician. (Petition, July 17, 2025).

22) On July 29, 2025, Dr. Gray responded to a question from Employee's attorney and stated that he did not predict Employee would have permanent physical capacities to perform physical demands of Small-Engine Mechanic, as described on a Dictionary of Occupational Titles form. (Gray questionnaire response, July 29, 2025).

23) On August 7, 2025, Employee reiterated that a medical dispute regarding medical care exists between his attending physicians Drs. Gray and Clancy and EME physician Dr. Thomas. Dr. Gray recommended a reverse total shoulder arthroplasty, and Employee's infectious disease specialist Dr. Clancy stated the shoulder procedure was reasonable with appropriate control of Employee's diabetes and ongoing antibiotic suppressants, which he had to take anyway given his first infection. By contrast, Dr. Thomas opined that the recommended surgery was not medically reasonable, with "enormous certainty" Employee would develop a postoperative infection, which would require additional resection arthroplasty, and worsen Employee's disability. Employee noted that "on July 17, 2025, [he] petitioned for [an SIME] regarding his entitlement to the recommended reverse arthroplasty procedure and related benefits." He further stated that he had been unable to work and has significant disability in his right shoulder. Employee's brief then analyzed the SIME request pursuant to *Bah* and related cases. He requested an SIME and had no objection to Employer's request to include additional issues. (Employee Hearing Brief regarding Employee's Petition for an SIME, August 7, 2025).

24) On August 12, 2025, Employer stated it only objected to the SIME because it may not be necessary and because Employee's SIME form failed to include other SIME issues such as "causation/compensability, medical stability, degree of impairment and potentially functional capacity." Employer also applied *Bah* and other opinions to analyze the SIME issue. It concluded, "While the employer is not opposed to an SIME *per se*, it asserts that the process

should not be used to shore up the employee's claim." Employer suggested Employee wants the SIME to assist in his pending petition for reconsideration of the Reemployment Benefits Administrator's (RBA) decision finding him not eligible for reemployment benefits. It also objected to the Board considering opinion letters from Employee's attending physicians, which were all "subject to cross-examination, which has not yet been provided." If the Board decides to order an SIME, Employer asked that it include "causation/compensability, medical stability, PPI, and functional capacity." However, Employer argued that the Board should find an SIME is not needed at this time. (Employer's Hearing Brief, August 12, 2025).

25) Shoulder surgery especially when there is a risk of infection can be expensive for an employer and insurer and may result in more benefits payable to a worker. (Experience).

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 testimony, evidence, the Board's "experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987).

> **AS 23.30.095. Medical treatments, services, and examinations**. (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. . . . It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require. . . .
> . . . .
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> (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 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*.).

Geister v. Kid's Corps, Inc., AWCAC Dec. No. 045 (June 6, 2007) involved a Board decision denying a requested SIME. *Geister* stated why a panel may choose not to order an SIME:

> Based on the commission's experience of the workers' compensation system, there are reasons why a board panel may exercise its discretion not to grant a request for an SIME, even when there is a medical dispute. After weighing the expense of the evaluation, delay, . . . significance of the medical dispute to the material and contested issues in the claim, quantity of medical evidence already in the record, [and] likelihood of new and useful information, . . . the board may decide that it is "more doubtful" that an SIME would assist . . . in reaching a decision on the material and contested issues before it and therefore it will not grant a request for an SIME. *Id*. at 7.
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> . . . If the board *weighed* and chose to rely on Dr. Klassen over Dr. Dramov in deciding a dispute did not exist, instead of merely comparing competing opinions to identify conflicts, or if the board did not consider Dr. Dramov's letters because they were the subject of an unsatisfied request for cross-examination, then we believe the board erred. It is enough that the parties present evidence of a medical dispute to request an SIME. The board is not asked to decide which physician's opinion is more persuasive when deciding if there is a qualifying conflict in opinions -- it will only do that when deciding the merits of the claim. The parties are not offering competing opinions to persuade the board of the truth of their substance; the opinions are offered solely to establish that a difference of medical or scientific expert opinion exists. Therefore, the documents containing the opinions are not hearsay evidence (emphasis in original). *Id*. at 9.

Section .095(k) is procedural, not substantive. *Deal v. Municipality of Anchorage*, AWCB Dec. No. 97-0165 (July 23, 1997). Wide Board discretion exists to consider any evidence available in

deciding to order an SIME to assist in investigating and deciding medical issues in claims, to best "protect the rights of the parties." *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 Board's discretion even if the parties jointly request one. 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 its purposes. An SIME is not a discovery tool for parties; it is an investigative tool for the Board to assist it by providing a disinterested opinion. *Olafson v. State Depart. of Transp.*, AWCAC Dec. No. 06-0301 (October 25, 2007).

Philip Weidner & Associates, Inc. v. Hibdon, 989 P.2d 727, 731-33 (Alaska 1999) set the Board's limits when reviewing recommended medical care made within two years post-injury:

> Under Alaska's Workers' Compensation Act, an employer shall furnish an employee injured at work any medical treatment "which the nature of the injury or process of recovery requires" within the first two years of the injury. The medical treatment must be reasonable and necessitated by the work-related injury. Thus, when the Board reviews an injured employee's claim for medical treatment made within two years of an injury that is undisputably work-related, its review is limited to whether the treatment sought is reasonable and necessary.
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> In the present case, Hibdon filed an injury report for the June 24, 1993 incident on July 1, 1993. Weidner and Alaska National conceded the injury was work-related, but controverted Hibdon's claim for back surgery. She then filed an application in April 1995 for an adjustment of her claim. This was within two years of the date of the injury. Therefore, her claim may be reviewed only to determine whether the treatment she sought in her claim was reasonable and necessary.
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> Weidner and Alaska National mistakenly argue that because Hibdon is seeking medical treatment beyond two years from the date of injury, the Board has greater latitude in its determination. This confusion is understandable as the treatment sought, if approved, would have occurred outside the initial two-year period due to the time required for the Board's adjudicative process to run its course. However, Hibdon sought and was ready to undergo this treatment by April 1995 at the latest -- well within two years of the date of injury. She did not go forward because Weidner and Alaska National controverted her claim. It would be unjust to allow an employer to avoid the more stringent benefit requirements owed to injured employees in the first two years following an injury by simply

controverting a claim and delaying the employee's medical treatment beyond the two years. Accordingly, we hold that a claim for medical treatment is to be reviewed according to the date the treatment was sought and the claim was filed with the Board. Because Hibdon's claim was filed within two years of the date of injury, we must determine whether the treatment she sought was reasonable and necessary.

. . . .

According to Professor Larson's treatise on workers' compensation, where a claimant receives conflicting medical advice, the claimant may choose to follow his or her own doctor's advice, so long as the choice of treatment is reasonable. The question of reasonableness is "a complex fact judgment involving a multitude of variables." However, where the claimant presents credible, competent evidence from his or her treating physician that the treatment undergone or sought is reasonably effective and necessary for the process of recovery, and the evidence is corroborated by other medical experts, and the treatment falls within the realm of medically accepted options, it is generally considered reasonable. If the employee makes this showing, the employer is faced with a heavy burden -- the employer must demonstrate to the Board that the treatment is neither reasonable and necessary, nor within the realm of acceptable medical options under the particular facts. It is not the Board's function to choose between reasonable, yet competing, medically acceptable treatments. Rather, the Board must determine whether the actual treatment sought by the injured employee is reasonable.

In the present case, Hibdon presented ample evidence that the surgery she sought was a reasonable medical procedure necessary for her recovery process. Her treating physician, Dr. Garner, came to his recommendation to perform surgery after extensive testing, including bone scans, two MRI's, and x-rays. Hibdon was also seen twice by Dr. Peterson, an orthopedic surgeon and colleague of Dr. Garner's. Finally, Dr. Garner sought the advice of Dr. Benson, a spine specialist from the University of California at Davis. All three of these doctors came to the conclusion that the persistent and debilitating pain experienced by Hibdon could be alleviated by a surgical procedure involving a fusion to the L-4 vertebral segment of her spine. Moreover, Drs. Keane and White both admitted under cross examination that fusion surgery often makes sense for patients with a Pars defect, that surgery could potentially benefit Hibdon, and that Dr. Garner's recommended course of treatment was "within the realm of medically accepted options."

. . . .

In sum, we conclude that the testimonial evidence presented by Dr. Garner, which was corroborated by Drs. Peterson and Benson, in addition to the admissions of Drs. Keane and White, were sufficient to establish that the treatment Hibdon sought was reasonable and necessary for her process of recovery. Neither Drs. Keane nor White disputed Hibdon's diagnosis, nor the efficacy of the surgical procedure generally in treating such defects. Rather, they argued that additional

> tests needed to be performed to isolate the pain generators, that Hibdon was unfit for the procedure, that if surgery was performed a more extensive procedure would be required, and that in light of the risks a conservative treatment regimen was the best option. Such evidence is insufficient to support a conclusion that Hibdon was not entitled to the surgery. Choices between reasonable medical options and the risks entailed should be left to the patient and his or her physician. The superior court correctly stated that the Board should not have overridden the consensus reached in the physician-patient decision-making process. We therefore hold that Hibdon proved her claim by a preponderance of the evidence. . . .

ANALYSIS

Shall this decision order an SIME?

Employee requested an SIME under §.095(k) and Employer objected. The SIME request is the only issue being decided here; this decision does not reach Employee's claims on their merits. The Alaska Workers' Compensation Act under §.001(1) must be interpreted to ensure quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to employers. Employee's SIME petition and related medical records contain differing opinions and thus create medical disputes between Employee's treating physicians Drs. Gray and Clancy and Employer's EME physician Dr. Thomas on several points. That Drs. Gray's and Clancy's opinions may be subject to a request for cross-examination, that has not yet been satisfied, is irrelevant to the SIME issue. *Geister*. Applying *Bah*:

(1) Are there medical disputes between Employee's physicians and the EME? Dr. Gray opined that Employee needs a reverse total shoulder arthroplasty to relieve his symptoms and related disability. Dr. Clancy stated if Employee can get his diabetes under control preoperatively, that the risk of lifelong antibiotics would not prevent the recommended surgery from occurring. She noted that Employee already takes lifelong antibiotics because of his previous work-related shoulder infection. By contrast, EME Dr. Thomas plainly disagreed with Dr. Gray's opinion and opined there was an "enormous certainty" that if Employee has the recommended shoulder surgery, he will get another infection, which may require additional surgery and disability and may result in his condition worsening. This creates a medical dispute on "the amount and efficacy of the continuance of or necessity of treatment." Moreover, it also creates a dispute concerning "medical stability," because Dr. Thomas said Employee is

medically stable while Dr. Gray's recommended surgical treatment, if accepted by the factfinders, would render him not medically stable until treatment is completed. The surgery Dr. Gray recommended may create a higher or lower PPI rating, thus creating a medical dispute on "degree of impairment." Depending upon the surgical results, there may also be a dispute over "functional capacity" under §.095(k). In other words, the surgery may make Employee's situation better, or it may make it worse.

(2) Are the medical disputes significant? Drs. Gray and Thomas agree that Employee may need additional right-shoulder evaluation and treatment. There is no dispute about causation, and experience teaches that shoulder surgery and the potential for an infection and related disability and impairment may create significant medical costs and require Employer to pay Employee more benefits. AS 23.30.095(a); *Rogers & Babler*. Significant benefits are at stake. *Seybert*.

(3) Will an SIME physician's opinion assist the factfinders to resolve the disputes? An SIME may be ordered if it will assist factfinders in determining the parties' rights when there is a significant dispute between attending physicians and an EME. *Deal*; *Bah*; *Olafson*. However, wide discretion is accorded to order or not order an SIME. *Bah*. An SIME's purpose is to have an independent medical expert provide an opinion about a contested issue. *Seybert*. But the decision to order an SIME rests in the factfinders' discretion even if the parties jointly requested one. *Olafson.* Although Employee has a right to request an SIME, he does not have a right to one if the factfinders decide one is not necessary for their purposes. *Id*. He currently claims TTD, PTD, PPI and medical benefits, and ancillary benefits. Drs. Gray and Clancy and Dr. Thomas disagree over risks associated with Dr. Gray's recommended shoulder surgery. Given the issues in Employee's pending claim and the *Hibdon* decision, an SIME is not needed at this time as there is sufficient evidence in the agency file to decide Employee's claim. It is "more doubtful" that an SIME would assist the factfinders in this matter. *Geister*. Moreover, not ordering an SIME under this case's facts will help ensure quick, efficient, fair, and predictable delivery of benefits to Employee if he is entitled to them at a reasonable cost to Employer under §001(1). His SIME request will be denied.

CONCLUSION OF LAW

This decision shall not order an SIME.

ORDER

Employee's July 17, 2025 petition for an SIME is denied.

Dated in Anchorage, Alaska on August 21, 2025.

ALASKA WORKERS' COMPENSATION BOARD

/s/
William Soule, Designated Chair

/s/
Sara Faulkner, Member

/s/
Brian Zematis, 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 Hugh Duncan, employee / claimant v. ASI Services, employer; Berkshire Hathaway Homestate Insurance Co., insurer / defendants; Case No. 202311936; 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 August 21, 2025.

/s/
Trisha Palmer, Workers' Compensation Technician