ALASKA WORKERS' COMPENSATION BOARD

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

SALUALO APAISA,	)	
	)	
Employee,	)	
Claimant,	)	
	)	FINAL DECISION AND ORDER
v.	)	
	)	AWCB Case No. 202204156
L&M MOTORS, INC.,	)	
	)	AWCB Decision No. 26-0027
Employer,	)	
and	)	Filed with AWCB Anchorage, Alaska
	)	on April 2, 2026
EMPLOYERS PREFERRED INSURANCE COMPANY,	)	
	)	
Insurer,	)	
Defendants.	)	

Salualo Apaisa's (Employee) April 21, 2023 claim and L&M Motors, Inc.'s (Employer) March 5, 2026 petition for a Social Security disability (SSD) offset was heard in Anchorage, Alaska on February 3, 2026, and on March 11, 2026; the February 3, 2026 date was selected on November 25, 2025. A May 25, 2025 hearing request gave rise to this hearing. Attorney Michael Flanigan appeared and represented Employee, who appeared and testified. Attorney Michelle Meshke appeared and represented L&M Motors, Inc. (Employer). Witnesses included Eunice Apaisa (Eunice), Ian Bramsted, DPT, and Edward Barrington, DC, who testified on Employee's behalf, and Mark Koenen, MD, Scott Coronado, and Dennis Chong, MD, who testified on behalf of Employer. The record closed on March 11, 2026.

ISSUES

Employee objected to consideration of the video of his September 6, 2023 deposition. He contended Employer filed it late under 8 AAC 45.120(f) because Employer did not file an evidence list at least 20 days before the hearing and that he did not have enough time to review it with his attorney prior to hearing. Employee requested an order that it cannot be considered.

Employer contended 8 AAC 45.120(a) requires the filing of deposition transcripts and videos two days before the hearing. It contended the videotape of Employee's deposition was filed more than two days before the hearing and 8 AAC 45.120(f) does not require the parties to file an evidence list 20 days before the hearing. Employer requested Employee's objection be overruled. An oral order overruled Employee's objection.

1) Was the oral order overruling Employee's objection to consideration of the video of his deposition correct?

Employee objected to consideration of Michael Villanueva's, Psy.D., ABBPP-CN, October 23, 2025 deposition. He contended his attorney was ill and unable to attend the deposition, Employer's attorney was so informed at the deposition, and the deposition was held without him or his attorney. Employee contended it was a violation of his due process right to consider it because he did not cross-examine Dr. Villanueva and he requested cross-examination of Dr. Villanueva when he requested a hearing. Employee contended the Alaska Workers' Compensation Act (Act) places the onus on Employer to reschedule when a "Smallwood" request for cross-examination of the employer's medical evaluator (EME) cannot occur due to a party's representative's illness. He requested an order that Dr. Villanueva's October 23, 2025 deposition cannot be considered. Alternatively, Employee did not oppose taking Dr. Villanueva's deposition on March 3, 2026.

Employer contended Employee failed to object to taking Dr. Villanueva's deposition prior to deposition and at the deposition, and he failed to file a petition for a continuance or an order requiring it be rescheduled. It contended depositions are taken according to the Alaska Rules of Civil Procedure and the onus is on Employee to file a petition. Employer contends Employee waived his right to cross-examine Dr. Villanueva by failing to file a petition. It requested an

order overruling Employee's objection to consideration of Dr. Villanueva's deposition. Alternatively, Employer proposed taking Dr. Villanueva's testimony on March 3, 2026. An oral order keeping the record open to take Dr. Villanueva's testimony on March 3, 2026 issued.

2) Was the oral order keeping the record open to take Dr. Villanueva's testimony on March 3, 2026 correct?

Employee objected to consideration of deposition transcripts for the depositions of Mark Flanum, MD, Employee, R. David Bauer, MD, Bruce McCormack, MD, and Dr. Villanueva. He contended the prehearing conference summary ordered the parties to file all evidence, including deposition transcripts, at least 20 days before hearing and Employer filed them after the prehearing conference summary deadline. Employee requested an oral order that the deposition transcripts cannot be considered.

Employer contended the prehearing conference summary directed the parties to file documentary evidence at least 20 days before the hearing and did not provide a date to file deposition transcripts. It contended 8 AAC 45.120(a) requires the filing of deposition transcripts two days before the hearing and it filed them seven days before the hearing. Employer requested an order overruling Employee's objection. An oral order issued overruling Employee's objection.

3) Was the oral order overruling Employee's objection to consideration of deposition transcripts correct?

Employer objects to consideration of Employee's October 23, 2025 hearing brief, contending it was filed late. It requests orders sustaining its objection, and that it cannot be considered.

Employee contends his attorney was very ill, as evidenced by a letter from his physician. He contends Employer agreed to a hearing continuance due to this illness and his hearing brief was filed late due to the same illness and it should be accepted. Employee requests an order overruling Employer's objection and that his October 22, 2025 hearing brief can be considered.

4) Should Employer's objection to Employee's October 22, 2025 hearing brief be sustained?

Employer requested Member Ladd be disqualified for questions and comments he made during Employee's and Dr. Koenen's hearing testimony. It contended his questions and comments showed bias and prejudgment.

Employee objected to Employer's request to disqualify Member Ladd. He contended the questions and comments did not show bias or prejudgment. An oral order denied Employer's request.

5) Was the oral order denying Employer's request to disqualify Member Ladd correct?

Employer objects to Employee's evidence, including a letter from his bank and the second page of a subsequent report of injury (SROI), and Employee's and Eunice's testimony regarding a stopped temporary total disability (TTD) benefit check, contending the evidence was irrelevant. It contends the evidence "is only intended to illicit bias against the insurer" and requests its objection be sustained.

Employee contends the stop payment letter and Employee's and Eunice's testimony are relevant to the credibility of Employee and Eunice and to his request for a finding of unfair or frivolous controversion. He requests Employer's objection be overruled.

6) Should Employer's objection to Employee's evidence and testimony regarding a stopped TTD benefit check be sustained?

Employee contends the work injury is the substantial cause of his need for medical treatment and disability for his neck, low back, fractured wrist, and concussion after October 12 2022. He requests an order awarding medical benefits and related transportation costs and TTD benefits from October 12, 2022 and continuing.

Employer contends Employee sustained a lumbar and cervical sprain/strain and a mild concussion as a result of the work injury, which have resolved, and his non-work-related cervical and lumbar multilevel degenerative disease with stenosis and his preexisting anxiety and

depression is the substantial cause of his need for medical treatment and disability after October 12, 2022. It requests an order denying Employee's claim.

7) Is Employee entitled to medical and transportation costs and additional TTD benefits?

Employee contends permanent partial impairment (PPI) benefits are not yet due because he is not medically stable. Alternatively, he contends he is entitled to PPI benefits based upon Dr. Barrington's and McCormack's PPI rating.

Employer contends Employee is not entitled to PPI benefits because Drs. Chong, Bauer, and Villanueva and Mark Kimmel, PhD, opined he had no ratable impairment related to the work injury and his medical providers assessed no ratable impairment related to the work injury. It contends Dr. McCormack's PPI rating should be given less weight because Employee's left trigger finger is not related to the work injury and Dr. Barrington's PPI rating should be given no weight because it was incorrectly calculated. Employer requests an order denying PPI benefits.

8) Is Employee entitled to PPI benefits?

Employer contends Employer's controversion notices were unfair or frivolous. He also contends Employer's stop of a TTD benefit check was an "illegal claw back" and constituted an unfair or frivolous controversion. Employee requests an order and referral to the Division of Insurance.

Employer contends its controversion notices were supported by substantial medical opinions. It contends its stop payment did not constitute an unfair or frivolous controversion because it was a duplicate payment. Employer requests an order denying a finding of unfair or frivolous controversion.

9) Did Employer unfairly or frivolously controvert benefits?

Employee contends he is entitled to a penalty and interest on all benefits awarded.

Employer contends Employee is not entitled to interest and penalty as he is not entitled to any additional benefits.

10) Is Employee entitled to interest and a penalty?

Employer contends it is entitled to a SSD offset because Employee was paid SSD benefits for the work injury for which he filed a claim. It requests that any lump-sum award be reduced by the full value of the overpayment and that any TTD benefits awarded as a result of the work injury be reduced by the offset.

Employee agrees Employer is entitled to a SSD offset and did not object to recoupment against future benefits awarded.

11) Is Employee entitled to a Social Security disability offset?

Employee contends he is entitled to attorney fees under AS 23.30.145(a) for obtaining additional benefits.

Employer contends Employee is not entitled to attorney fees because he is not entitled to additional benefits.

12) Is Employee entitled to attorney fees and costs?

FINDINGS OF FACT

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

1) On August 28 and September 11 and 24, 2018, Employee was treated for gout. (Rebecca Bingham, MD, records, August 28 and September 11 and 24, 2018).

2) On December 13, 2019, Employee complained of high blood pressure, it was 169/150 at work. He had a headache during "this event." Employee's coworker gave him nitroglycerine, and his blood pressure went down to 133/81. His blood pressure was 168/100 and he weighed 330 pounds. He experienced mild confusion when symptoms started. Employee underwent an electrocardiogram (EKG) and was sent to the emergency department for further evaluation and treatment. (Rebecca Bingham, MD, record, December 13, 2019).

3) On December 13, 2019, Employee went to the emergency room and was diagnosed with chest pain, non-intractable headache, and hypertension. Employee was directed to follow up with his primary doctor and take a low-dose aspirin. (Emergency room record, December 13, 2019).

4) On December 19, 2019, Employee followed up with Je'Dette Green, NP, for chest pain and hypertension. His blood pressure had been 169/105 at work and he had a headache; he weighed 330 pounds. Employee's supervisor gave him nitroglycerin, he went to urgent care, and then he went to the emergency room. He reported "[h]igher anxiety over teh [sic] past 2 years," "muscle aches, arthralgias/joint pain, back pain, limited motion," and "depression and restless sleep" but no suicidal thoughts. Employee was diagnosed with chest pain, essential hypertension, low-back pain, headache, neck pain, and obesity. He was prescribed propranolol and medical massage for low-back pain, one to two times per week for 20 weeks. (Green record, December 19, 2019).

5) On January 3, 2020, Employee reported bilateral shoulder and thoracic-spine pain. The spine pain had been going on for about a year; it came on and was higher in the evening after work. It was dull and generally mild to moderate. Employee had tenderness and decreased range of motion in both shoulders and tenderness in his cervical, thoracic, and lumbar spine. He was diagnosed with shoulder pain and treated with myofascial release and myofascial trigger point therapy. (Green record, January 3, 2020).

6) On April 15, 2021, Employee reported left back pain, left front lower groin pain that was "better when he pushes it back in to body" and felt "like a bag." He also reported swelling in the right groin, sleep disturbances, restless sleep, and anxiety. NP Green diagnosed right inguinal hernia and thoracic back pain. She referred Employee for chiropractic care for thoracic spine pain and an ultrasound for left and right groin areas. (Green record and Referral Order, April 15, 2021).

7) On May 6, 2021, Employee filled out a Patient Intake Form at Pairmore & Young: Synergy Chiropractic, LLC, and stated the reason for the visit was for bilateral lower back discomfort. He rated his current pain level as 8/10, his average pain level as 6/10, and at the worst it was 10/10. Sleeping, standing, and lifting were aggravating factors; rest and massage relieved the pain. Employee could not lift items at work that were more than 30 pounds and could not walk more than half a mile without increasing pain. Pain also prevented him from lifting heavy

weights off the floor, but he could lift them if they were conveniently placed. (Patient Intake Form, May 6, 2021).

8) On May 7, 2021, Employee reported tolerable frequent dull and aching tightness and stiffness at a level four out of ten in his cervical and thoracic spine "caused by insidious onset" and severe constant dull and aching pain, tightness, and stiffness at level eight out of ten in his lumbar and sacral spine, radiating to his right and left legs, also "caused by "insidious onset." X-rays were taken of his cervical, thoracic, and lumbar spine. He weighed 310 pounds. Employee was diagnosed with low back pain, segmental and somatic dysfunction of the lumbar, thoracic, and cervical region and lower extremity, and back muscle spasm. He underwent chiropractic manipulative therapy, spinal traction, myofascial release, and electromuscle stimulation. (Rizaldy Ortiz, DC, record, May 7, 2021).

9) On May 7, 2021, an abdominal ultrasound found a fat-containing left inguinal hernia. (US abdomen report, May 7, 2021).

10) On May 11, 18, 20, and 27 and June 11 and 18, 2021, Employee underwent chiropractic care for his cervical, thoracic, and lumbar spine. (Ortiz records, May 11, 18, 20, and 27 and June 11 and 18, 2021).

11) On June 6, 2021, Employee underwent an open repair of left Spigelian hernia with resection of subcutaneous lipoma. (Madhu Prasad, MD, operative report, June 6, 2021).

12) On September 2, 2021, Employee's chief compliant was "obesity"; he reported he gained 40 pounds. He weighed 320 pounds and said he was at the highest weight ever. He had been on metformin but stopped due to the recall, nausea, and diarrhea. Employee recovered well from hernia surgery and was back at work for three weeks. His anxiety was much better using propranolol. (Green record, September 2, 2021).

13) On February 22, 2022, Employee slipped on the ice when he was going to move a car while working for Employer. (First Report of Injury, March 14, 2022).

14) On February 23, 2022, Employee visited urgent care for the fall on February 22, 2022; he weighed 332.2 pounds. He said he was helping a customer when he fell, hitting the back of his head on the ground and losing consciousness at about 9:30 am. Employee laid on the ground after waking up and coworkers were unable to lift him due to his size, and he got up on his own after three minutes or so. He left work by 10 am. Employee was experiencing nausea, vomiting, shortness of breath, difficulty swallowing, dizziness, confusion and memory loss, neck pain,

light-headedness, upper and lower back pain, and a "pins and needles" sensation in his left wrist. His neck concerned him the most because he could not turn his head at all. Employee described the neck pain as a constant throbbing stiffness that radiated to his shoulders and to his upper back. The side of his neck emitted a tingling sensation that worsened when touched and radiated to his chest. Employee's lower back emitted a sharp pain that radiated to both of his thighs when transitioning from sitting to standing or when he straightened his spine. He took an extra strength Tylenol the prior night for pain. Employee had a history of head trauma as a football and rugby player about 15 years ago. He moved his head "within a limited ROM freely. Employee was observed doing head rotation approx[.] 60 degrees to right without distress when existing the clinic. On the exam table, he comfortably moved only about 15 degrees left and right." Employee had significant spinous process tenderness at C5-7. Employee was recommended to go to the emergency room as he "may have significant neck injury and should have high level eval. This is discussed as well as potential neck fracture and complications that occur." (John Quimby, DO, record, February 23, 2022).

15) On February 23, 2022, Employee went to the emergency room for neck and back pain after a fall. He reported that the day before, he was outside when he slipped backwards on ice and fell, striking his upper back and the back of his head. Employee thought he lost consciousness for about one minute. Afterwards, he felt foggy and pain in the back of the head without vision change or double vision. Employee did not have any associated numbness, tingling, weakness, or loss of bowel or bladder control. He took Tylenol without significant relief. Employee had some discomfort in his left wrist. After a left wrist and chest x-ray and head and cervical computed tomography (CT), he was diagnosed with a left wrist closed, nondisplaced hamate fracture, neck muscle strain, and concussion with loss of consciousness of 30 minutes or less. He was provided with a splint, recommended to follow up with an orthopedic hand surgeon, and advised to use Tylenol and ibuprofen as needed for pain. (Tyler Berliner, MD, record, February 23, 2022).

16) On March 2, 2022, a left hand CT scan found no evidence of hamate fracture or hamate body fracture; no fracture was found in the hand or wrist. (CT report, March 2, 2022).

17) On March 2, 2022, Employee followed up with Jessie Janowski, MD, for the left wrist fracture; he weighed 336 pounds. He had pain and swelling in his left wrist. Dr. Janowski noted, "We discussed the treatment options for a left wrist fracture. We discussed operative and

nonoperative management. Due to CT confirmed minimal displacement I would recommend a cast. He will be placed in a short arm cast today." (Janowski record, March 2, 2022).

18) On March 24, 2022, Employee complained of "headache anteriorly and posteriorly" after falling at work in the parking lot. He thought he lost consciousness for a few seconds. Employee had trouble sleeping, stating "his neck pain will keep him up," and he felt off balance, but he denied double vision. He weighed 339 pounds. Employee was assessed with traumatic brain injury (TBI) without loss of consciousness and vertigo with no evidence of rotational nystagmus. Employee was prescribed amitriptyline and was found to be totally incapacitated but he would be reevaluated in two weeks. (Eric Miknich, MD, record and Provider's Return to Work Recommendations, March 24, 2022).

19) On April 7, 2022, Employee followed up with Andrea Frangiosa, PA-C, for his left wrist, complaining of pain over the ulnar aspect of the wrist. He completed six weeks of immobilization in a cast. PA-C Frangiosa recommended Employee use a removable fracture brace at all times, except for doing personal hygiene, and that Employee remain non-weightbearing on that side. She stated Employee was totally incapacitated and would be reevaluated in two weeks. (Frangiosa record and Provider's Return to Work Recommendations, April 7, 2022).

20) On April 11, 2022, Employee weighed 340 pounds. He reported his neck pain persisted, but his sleep improved. Overall Employee felt better but he still felt dizzy and forgetful at times and could not focus. He started to get nightmares on the amitriptyline but continued to take it because it helped with sleep. Employee was diagnosed with TBI without loss of consciousness, not enough improved to return to his work duties. The amitriptyline dosage was increased. (Miknich record, April 11, 2022).

21) On April 21, 2022, Employee said his left wrist pain was drastically reduced and that he was experiencing left middle finger trigger finger. PA-C Frangiosa recommended Employee wear the removable fracture brace any time he slept or doing any high-risk activities; otherwise he was to take if off and use it like normal. He was also advised to wear a splint for his trigger finger at all times for four to six weeks. PA-C Frangiosa ordered physical therapy for left-hand pain. She restricted him to sedentary work. (Frangiosa records and Providers Return to Work Recommendations, April 22, 2022).

22) On April 29, 2022, Employee reported headaches, vision changes, vertigo, and neck and back pain. He had some trouble word finding and relied on his workers' compensation nurse to assist with his memory. The symptom that bothered him the most was headaches and eye pain; he felt like his eye was "pushing out." Employee also had "12/10 low back pain." He denied any numbness tingling or weakness of the legs. He weighed 348.9 pounds. Hale Loofbourrow, MD, diagnosed TBI without loss of consciousness, vertigo, back pain due to injury, frequent headaches, neck pain, and neurological disorder of eye movements. He referred Employee to neurology and ophthalmology, as Employee was "unable to look to the right and got nystagmus when trying to do so as well as vertigo," and ordered a brain and lumbar and cervical spine magnetic resonance imaging (MRI). (Loofbourrow record, April 29, 2022).

23) On May 14, 2022, a brain MRI was normal. (Brain MRI report, May 14, 2022). A lumbar spine MRI showed moderate degenerative disc disease and a small broad, broad posterior disc bulge and mild facet osteoarthritis at L4-5 superimposed on congenitally short pedicle, which resulted in severe central canal stenosis with residual AP canal diameter of just under five millimeters and mild bilateral neural foraminal stenosis. (Lumbar spine MRI report, May 14, 2022). A cervical spine MRI showed mild cervical spondylosis resulting in multilevel moderate and severe neural foraminal stenosis at C2-3, C4-5, and C5-6. (Cervical spine MRI report, May 14, 2022).

24) On May 26, 2022, Employee reported persistent occipital headaches, light sensitivity, right posterior neck pain, and diffuse low-back pain. He said his walking tolerance was limited to no more than 20 yards secondary to recurrent low-back pain, rating his pain level as ten out of ten when walking and easing to four out of ten when sitting and reclined. Employee's head, neck, and back hurt equally. He weighed 335 pounds. Michael Dyches, PA-C, assessed probable TBI, diffuse cervical spondylosis with persistent right posterior neck pain without signs of radiculopathy or myelopathy, lumbar spondylosis with severe central stenosis at L4-5 and probably annular tear. He recommended physical therapy for Employee's cervical and lumbar spine, a trial of cervical traction, and a bilateral L4-5 transforaminal epidural steroid injection (ESI) and consideration of a C7-T1 interlaminar ESI. Employee was referred for a neurological evaluation and prescribed ibuprofen and Flexeril. PA-C Dyches restricted Employee from returning to work until follow up after the ESI. (Dyches record, May 26, 2022).

25) On June 2, 2022, Employee reported the headaches had gotten worse and he developed vision problems. When his headaches start, his right eye "deviated laterally" and he felt like he was being "physically pulled back." Employee said he had trouble seeing with his right eye because the right eyelid came down and said it felt like his eye was going to pop out of his head. He was light sensitive during the headaches and continuously. Employee's headaches felt better after two to three hours, and after another hour it was gone; he was getting headaches about three times per week. He had an appointment for his eye the next month. Employee had short-term memory problems, which were becoming more severe. He sometimes could not find his car keys or other things, and he misplaced things a lot; he also has trouble finding the right word. Employee reported he was giving a talk to his congregation from his iPad and he could not read it at one point; another time he could not remember his wife's name. He developed anxiety and depression. Employee's wife took a couple videos of him; in one video he had lost his temper and was yelling at his wife and daughter. He had no recollection of it until he was shown the video; "that was so unlike him that he deleted the video." When Employee stood up, sometimes he briefly lost his balance. His wife told him he had something she called a seizure, but Employee could not recall it. While he was sleeping, he "was just kind of thrashing around." Employee was prescribed Lexapro for depression by his primary physician, but he had not picked it up yet. With some severe headaches, he had some suicidal ideation, thinking his wife and daughter would be better off without him. "He has not had any sort of plan, although I had to ask the question about three different ways to actually get him to answer that specific question. . . ." Standford Downs, MD, a neurologist, noted Employee tended to be "extremely inattentive"; he answered questions slowly and the answers "not infrequently" were not really very closely related to the question. He had to ask the same question three or four times with increasing emphasis to actually get that question addressed in some way in an answer, such as when he asked about suicidal ideation. Employee had trouble with memory but "it could be easily explained by his inattention." Dr. Downs thought Employee's slow speech was related to his mood. He diagnosed Employee with chronic post-traumatic headache and reactive depression. Dr. Downs believed Employee activated a migraine with the head trauma, and prescribed Neurontin and Maxalt. He told Employee to start Lexapro and referred him to a psychiatrist. (Downs record, June 2, 2022).

26) On June 7, 2022, Employee followed up with PA-C Frangiosa for his left-wrist fracture. He stated he did not have any wrist pain and the clicking and locking of his left long finger greatly improved with splinting. Employee continued to wear the splint anytime he was out of the house. He weighed 332.8 pounds. PA-C Frangiosa said Employee made a full recovery from the left hamate and triquetrum fracture and had no restrictions for his wrist. Employee declined a steroid injection for his finger and wanted to continue to wear the split because it was helping him. PA-C Frangiosa ordered physical therapy. (Frangiosa record, June 7, 2022).

27) On June 29, 2022, Employee followed up with PA-C Dyches for low back pain; he weighed 342.2 pounds. He had elected to not proceed with the ESI. PA-C Dyches assessed L4-5 stenosis with associated low-back pain and recommended the ESI "for both diagnostic as well as therapeutic purposes. I informed him that the worst thing we could do would be a surgery that did not make him better. This is the reason I would like to have him undergo the injection." Employee agreed to the bilateral transforaminal ESI. (Dyches record, June 29, 2022).

28) On July 1, 2022, Employee reported he fell at work on February 22, 2022, striking the back of his head and breaking his left wrist. He lost consciousness, first noting it was "just a few seconds" but thought it "may have been up to a minute or so." Employee did not "recall much about the trauma itself." He said he "collapses during the day, such as watching TV, not remembering what occurred" and that he "was found apparently down and unresponsible by his wife one time." Employee continued to be photosensitive and sound sensitive. He was taking amitriptyline 25 mg at night and initially it helped but then stopped working. Employee felt it gave him nightmares. He had "flashbacks, almost post-traumatic, often reliving what happened when he fell." Employee's gait was normal and he walked with no aids; he weighed 340 pounds. Scot Hines, MD, ordered an electroencephalogram (EEG) but did not believe Employee had any injury catastrophic enough to cause epilepsy. "It is possible these are physical manifestations of stress." As he was four months out from the injury and had normal findings otherwise, Dr. Hines had a "hard time explaining a lot of the residual symptomology. He has good reason to have some myofascial pain, etc., but I do not believe the nervous system is significantly damaged, at least on the basis of the exam, which is normal except for some enhancement of some features of the examination as outlined." (Hines record, July 1, 2022).

29) On July 5, 2022, Employee saw Eileen Myers, MD, an ophthalmologist, for evaluation of double vision upon referral. Since he fell and hit his head in February, he has had frequent

headaches and double vision; the symptoms started about one week after the fall. Employee stated he saw "an image with 'graffiti shad' under it" that goes away when he closes his eyes. He has been unable to read due to double vision and pain. Employee felt pressure and felt like he eye was about to "pop out." Under "Plan", Dr. Myers wrote:

> Referral reviewed. Patient with decreased vision OD. Does correct somewhat with glasses. Unable to perform HVF OD but had full field OS. Normal exam for age. Unsure of cause of decreased vision OD, ? pathologic vs. functional. Patient has bene seen at Makar in the past, will obtain records to see if he has a history of amblyopia OD. Providence records reviewed – CT scan of brain on 2/23/202 was normal. MRI brain without contrast on 05/14/22 was also normal. Referral was also for abnormal eye movement, patient did not exhibit any abnormal eye movement in office today. He does complain of pain when moving eye to right, but does have full movement without nystagmus.

She assessed bilateral age-related nuclear cataract and recommended follow-up in one to two months. (Myers record, July 5, 2022).

30) On July 13, 2022, Eric Olson, DO, performed a right and left L4-5 transforaminal ESI. (Olson record, July 13, 2022).

31) On July 26, 2022, Employee had made a full recovery from the left hamate and triquetrum fracture and was back to full range of motion. He had "no restrictions in regards to the wrist." Employee was still wearing the left middle finger splint, stating it helped him. He declined a steroid injection and wanted to continue with splinting and hand occupational therapy as his left hand was weak and he did not feel he could go back to work. Zachary Hartmann, PA-C, referred Employee to six weeks of physical therapy for trigger finger. (Hartmann record, July 26, 2022).

32) On July 28, 2022, Employee's EEG was normal -- awake and drowsy. "On a few occasions there were quick 'jerks' noted around the head in the shoulders, with associated muscle artifact, but no distinct myoclonic activity was noted." (EEG report, July 28, 2022).

33) On August 10, 2022, Employee reported neck and back pain at the time of his slip and fall on the ice at work on February 22, 2022 and denied previous similar symptoms. His "#1 pain" was his low back, but he also reported substantial neck symptoms. Employee had no clear radicular symptoms upon evaluation. He denied any bowel or bladder dysfunction. Employee endorsed issues with balance, coordination, headaches, and difficulty with fine motor skills. His low back hurt while standing, lying down, and walking. Employee's ESI in July "resulted in substantial improvement of his symptoms" but the relief had abated. He had a walking tolerance of about

20 yards, stopping secondary to back pain, and endorsed a sense of weakness, particularly in his lower left extremity, numbness, and tingling. He was not using an assistive devise for ambulation and his gait was normal; he weighed 352.2 pounds. Employee's x-rays and cervical spine MRI showed "no sequential cord compression or stenosis" with "some degenerative changes with some right-sided neural foraminal stenosis at C4-5." He had congenital stenosis in his lower back, exacerbated by a small disc protrusion at L4-5, resulting in significant spinal stenosis. Dr. Flanum diagnosed back pain due to injury, cervical spondylosis without active myelopathy or radiculopathy, and lumbar spinal stenosis "in the setting of degenerative spinal stenosis and lumbar disc herniation." He referred Employee to physical therapy and noted he may be a candidate for an L4-5 decompression to treat his severe spinal stenosis. (Flanum record, August 10, 2022). Dr. Flanum restricted Employee to light duty work until October 5, 2022, when he would be reevaluated, and indicated the restrictions are due to the work incident. (Providers Return to Work Recommendations, August 10, 2022).

34) On August 10, 2022, Dr. Flanum reviewed Employee's cervical spine MRI and said there was no disc herniation or fracture or anything concerning. (Transcript of Meeting Between Mark Flanum, MD, and Salualo Apaisa, August 10, 2022, at 2). "[T]here is a little wear and tear throughout here, but I don't -- I -- I can't attribute anything to the accident that I go, oh, yeah, that's something that you need surgery. So I would just leave your neck well enough alone. I mean, there's a little narrowing on the right at C5-6, but I -- if anything, I would just do an injection there. I wouldn't offer you surgery because you're a young guy to be talking about surgery." (*Id.*). Dr. Flanum stated many people born in American Samoa, like Employee, are born with a little bit smaller spinal canal. (*Id.* at 3). He reviewed Employee's lumbar spine MRI and stated, "here's L5, 4, 3, 2, 1. All these disks are totally normal, but this one has bulged out a little bit, and it did bulge some. And you were born with a big spinal canal you'd just be like, yeah, my back's a little achy, it's not causing you big problems. But because you started with a pretty small spinal canal compared to some people, here's the spinal canal, when we get down to L4-5 you are pretty darn narrow there, and it's something that a surgery can help. Now, I can't say -- again, we just have to assume that that disk herniation at L4-5 --." (*Id.*). Dr. Flanum noted Employee returned to back to where he was after the injection, and recommended physical therapy. (*Id.* at 4). If Employee was still symptomatic after physical therapy, "we can talk about surgery," an L4-5 laminectomy. (*Id.* at 4-5). "I'm only going to do surgery if it's bothering you.

We see people who have functional stenosis just like that and they're just like, no, I don't have any pain. Because you had some stenosis before. With your workplace injury it just became symptomatic." (*Id*. at 5).

35) On September 7, 2022, Employee reported he had been doing physical therapy and using a transcutaneous electrical nerve stimulation (TENS) unit but continued to experience substantial pain, rating it twelve out of ten. He had a walking tolerance of only 20 yards. Dr. Flanum appreciated no new deficits upon testing Employee's strength and sensation. He was able to rise from a seated position and ambulate, using a single-point cane, and he had moderate tenderness with palpation of the low back. Employee weighed 326.8 pounds. Dr. Flanum diagnosed left-hand pain and lumbar stenosis with neurogenic claudication, "Spinal stenosis status post a workplace injury." He recommended an L4-5 laminectomy and decompression with removal of the midline elements because of his congenital stenosis. Dr. Flanum stated Employee was totally incapacitated at this time and would be reevaluated on "surgery date TBD." (Flanum record and Provider's Return to Work Recommendations, September 7, 2022).

36) On September 29, 2022, Employee followed up Hale Hoofbourrow, MD, a family medicine specialist, and reported his pain was almost entirely eliminated with the recent ESI, but the effects wore off. He was back to his original pain, and he was worried that it may cause him to lose his ability to walk. Employee rated his pain as twelve out of ten and said he had a tingling sensation going up his spine starting in the mid low back when he laid down flat on his back that got better when he stood or laid down on his belly. He reported no peripheral neuropathic changes and his "vertigo, diplopia" were "more or less unchanged." Employee was sleeping six hours per night after increasing Ambien and his headaches were much better and his mood improved. Dr. Hoofbourrow diagnosed TBI, without loss of consciousness, with symptoms ongoing for six months, vertigo, back pain due to injury, frequent headaches, neck pain, neurologic disorder of eye movements, primary insomnia, and current moderate episode of major depressive disorder without prior episode. (Hoofbourrow record, September 29, 2022).

37) On September 30, 2022, Employee followed up with Dr. Hines regarding his TBI. He still experienced chronic photosensitivity and was wearing dark glasses with polarized filters, "which probably helps." Employee still "zones out now and then, this must be a function of his response to pain." He has been depressed and stressed, which was completely understandable and expected as a consequence of not progressing as well as he hoped. Dr. Hines noted it would

slow down and diminish his recovery, which Employee was aware of, and Employee was interested in pursuing mental health treatment with a psychiatrist. Employee's EEG was normal. Dr. Hines diagnosed history of TBI, post-traumatic stress disorder, and "[r]ecent history of unusual 'spells' of memory lapses and possible convulsion." He stated Employee's chronic photosensitivity, diffuse pain, myalgias were "beyond what I can explain on the basis of TBI. Stress and anxiety likely play a role." Dr. Hines explained:

> I do not find evidence of residual TBI of significance. He is not having seizures, etc. in my opinion. I would hold off on more in the way of neurologic workup. I think his major impairment cognitively relates to the stress and depression, which is natural complement of chronic pain, loss of job, etc. It is to his credit that he recognizes this and is interested in seeking treatment. So, I will go ahead and make referral to Providence Behavioral Health, or any other institute that could see him a little sooner. I think this would not only enhance his quality of life in terms of mood, but enable him to recover more quickly.
> Hopefully, he will do well with his spine surgery, etc. In terms of his TBI, etc.[,] I told him I would be happy to see him back if I could be of further assistance, but this does not seem to be a significant issue at this state. (Hines record, September 30, 2022).

Dr. Hines responded to questions from Kristin Foster, PN, medical case manager, and indicated Employee was able to return to work with no neurological restriction, he reached medical stability for "neurologic only," he will not incur a PPI as a result of the work injury, "Not neurologic," and he was released from care for the work injury. (Hines response, September 30, 2022).

38) On October 5, 2022, Employee said his standing tolerance was less than five minutes and he was aware of increasing weakness in his lower extremities. Dr. Flanum noted Employee's imaging showed "disc displacement in the setting of congenital stenosis causing about only 5 mm of space available for the cauda equina at the L4-5 level." He recommended an L4-5 decompression; he did not think additional physical therapy or injections were going to fix Employee's severe spinal stenosis. "Our agreement is that we are going to wait until the IME gets done next week and then proceed accordingly." (Flanum record, October 5, 2022).

39) On October 12, 2022, Dr. Bauer, an orthopedic surgeon, examined Employee for an EME. Employee was wearing sunglasses and a hat and brought a cane, but he did not use it during the examination; he was also wearing a brace on his left arm and on the middle finger of his left hand. Dr. Bauer diagnosed fall from a standing height, closed head injury, contusion to his back,

congenital spinal stenosis without any aggravation, acceleration, or change caused by the work injury, symptom exaggeration, no evidence of a hand or wrist fracture, and left-hand trigger finger unrelated to the work injury. He said Employee's subjective complaints were widespread and out of proportion to any objective physical findings and to the length of the time since the work injury that cannot be explained by any physiologic findings. Dr. Bauer deferred to a neurological EME but noted "that the neuropsychiatric complaints proffered by Mr. Apaisa are often consistent with malingering." He found a great deal of symptom magnification as the objective findings were minimal and degenerative. When asked to state the substantial cause of each complaint, Dr. Bauer stated:

> The following question was the substantial cause of the contusion to his back. Based on the history this is the only objective diagnosis that can be made.
>
> The cervical spondylosis and congenital spinal stenosis are normal physiologic findings, brought about by age and time and are not substantially caused by the incident in question.
>
> The objective imaging did not demonstrate any fracture-the reviewing radiologist ruled out any fractures to the carpal bone.
>
> The trigger finger is in idiopathic medical condition not caused by trauma. Flexor tendon entrapment of the digits is a disorder characterized by snapping or locking of the thumb or fingers (with or without pain).
>
> Most cases are secondary to thickening of the digit's Al pulley, but other pathogeneses include tendon abnormalities at the level of the carpal tunnel, thickening of other pulleys, and abnormalities of the metacarpal-phalangeal joint.
>
> There is no significant evidence in the literature that increased grip or highly repetitive work increases the risk of trigger digits. In most cases, the cause of stenosing tenosynovitis or trigger finger is not known.
>
> Trigger finger is a mechanical problem with many etiological factors such as diabetes mellitus and carpal tunnel syndrome. It is known that the type of incident described as not cause a trigger finger.
>
> Cervical spondylosis refers to spectrum of conditions that are manifested secondary to age-related degenerative changes in the spine.
>
> These changes can manifest as three types of complaints: axial neck pain, upper extremity radiculopathy (secondary to compression of a nerve) or myelopathy

> (secondary to compression of the spinal cord) or some combination of these. Individuals with spondylotic changes, however, can be symptom free.
>
> The vast majority of patients with cervical radiculopathy caused by spondylosis reported that they either awoke with symptoms or symptoms began without a memorable event; the severity of an inciting event is not likely to proportional to the chances of inducing cervical radiculopathy. Incidents such as described here do not cause or accelerate degenerative change.
>
> On a more probable than not basis, the lumbar discs did not bulge, deform, or herniate from this incident.
>
> This mechanism of injury (either landing on his feet or on his buttock) would not cause a disc herniation. Compression forces are mainly absorbed by the vertebral body.
>
> The nucleus pulposus, being liquid, is incompressible. The tense annulus bulges very little. The bone is brittle, much like a pretzel, while the disc is like a marshmallow that will rebound after being squeezed.
>
> As axial pressure continues to be applied (for example in this fall) the vertebral endplate will fracture before the disc herniates.
>
> This has been demonstrated in multiple scientific studies, as well as experience with pilots who have ejected from aircraft. Sudden or traumatic disc prolapse has been produced in lumbar spinal specimens only when the vertebrae were first placed simultaneously in hyperflexion (beyond physiological limits), and then suddenly loaded by a compressive force.
>
> Within physiologically reasonable ranges of motion of the spine, disc bulges without adjacent bony damage were produced experimentally only through repetitive compressive loading for thousands of cycles.
>
> The findings in the lumbar spine, likewise, are due to aging and not substantially caused by this incident. Degenerative changes in the neck and lower back often occur in tandem. Severe degeneration disease is routinely identified in otherwise asymptomatic individuals.

When asked if treatment to date had been appropriate, Dr. Bauer said:

> It is my medical opinion that there are no objective or physiologic findings that arose from this incident. Continued treatment has furthered Mr. Apaisa's conviction that he has been grievously injured when the objective facts do not support that assertion.

> Symptom Magnification refers to the conscious or sub-conscious tendency of an individual to under-rate their abilities and/or overstate his or her limitations.
>
> The nonorganic findings and excessive symptoms arc closely correlated with psychological distress and abnormal illness behavior.
>
> Illness behavior refers to the ways in which given symptoms may be perceived, evaluated, and acted on by different persons and can be conscious or unconscious (the latter means unnoticeable and refers to mental processes and content that arc significant in determining behavior but of which the person is unaware).
>
> Illness behavior is not an impairing condition according to the AMA Guides to the Evaluation of Permanent Impairment. Any deficit can be exaggerated, including neuropsychological deficits, pain, and loss of sensation.
>
> Medically unexplained symptoms (MUPS) are defined as "... physical symptoms persisting for more than several weeks and for which adequate medical examination has not revealed a condition that adequately explains the symptoms."
>
> A disturbance of normal neurological and/or psychological processes underlying symptoms production, perception and experience, which cannot be explained better by another clearly defined physical or psychiatric illness. The most common unexplained symptoms arc in the area of musculoskeletal pain.
>
> This leads to ineffective treatment because the treating provider makes a diagnosis and offers treatment even though symptoms cannot reasonably be unexplained by a known disease. A diagnostic label is important to the patient and family to demonstrate that the doctor is taking the problem seriously and accepts the complaints as real. Most doctors are somatically focused due to our training, in the familiar territory of physical symptoms/organic pathology.
>
> In this case the attending has clearly overlooked the psychological aspects of the examinee's illness and has apparently not considered that the cause of the pain may be mainly or entirely psychological.
>
> "A medicalizing doctor & a somatizing patient are a bad combination". Somatization is the unconscious expression of mental phenomena, especially distress, as physical (somatic) symptoms.
>
> People have mixed reactions to both physiological and psychological explanations of disproportionate pain. If minor slips and falls led frequently in "normal" people to chronic disabling spinal pain, society would long ago have banned football, soccer, hockey, rugby, wrestling, etc.

Dr. Bauer found Employee "medically stationary" on July 1, 2022, as "Dr. Hines did not identify any organic pathology, nor have other providers." He found no objective conditions or

physiologic orthopedic findings that prevented Employee from returning to work "without restrictions or limitations immediately." Further medical treatment was not likely to yield any subjective or physiologic improvement and Employee's prognosis for any improvement was extremely poor, "Spine surgical intervention would not be of any benefits to Mr. Apaisa and would likely reinforce his sense of impairment disability and would preclude any attempt at return to work. Surgery for predominant axial pain complaints will not lead to success and a prudent surgeon would not proceed just on imaging findings." Dr. Bauer assessed a zero percent PPI rating. (Bauer EME report, October 12, 2022).

40) On October 13, 2022, Employee said his eyes hurt when he had a migraine and he had to close them. He had some light sensitivity and balance issues and felt like his eyes closed involuntarily. Employee felt his vision was about the same as the last visit three months prior. His right temple seemed numb on the left side of his head. Dr. Myers performed an eye exam and said it was normal, and his vision was better than the prior visit: "He feels a pulling sensation in vision and also has some discomfort and light sensitivity, which is more neurological than ocular in nature. He has not sought care for migraine/headache treatment. He was referred to a psychiatrist, which I agree with. No further treatment or testing from my standpoint." (Myers record, October 13, 2022).

41) On October 19, 2022, Dr. Chong, a physical medicine and rehabilitation specialist, examined Employee for an EME. Employee said on the date of injury, he was walking towards a car where two coworkers were waiting for further instruction from him. He was holding an aluminum shovel, when he slipped on ice and fell. His next recollection was seeing a while cloud above in the morning light. Employee heard his coworkers calling to check on him, but he did not see anyone "somehow" and the two coworkers pulled him to a standing position. He felt disoriented but walked to the workshop and waited to regain his composure. Employee developed a posterior headache that felt like a migraine he had experienced in the past, low back pain, and left-hand pain. He noticed a mark like the handle of the shovel on the palm of his hand. Employee told his supervisor he did not feel well and went home to sleep. He awoke later that night with total body aches and took Extra Strength Tylenol; he sought medical attention the next day. Employee stated he has constant low back pain, which increased with fixed postures, activity, or positional changes. He also had a constant occipital headache, worsened by sound or depression; two weeks earlier he started feeling a sense of numbness in his left temporoparietal

area. Employee never had low back pain or headaches before the work injury. He also had intermittent neck pain, "paroxysmal with positional changes." Employee reported numbness to all four limbs, beginning one month before, which was now constant; it worsened when his back pain increased. Dr. Chong diagnosed:

> 1. Predating emergency department visit [in] 2019 for severe headache, with CT scan head;
> 2. Predating insidious onset low back pain since 2021, with referral to bilateral lower limbs. This was treated by chiropractic adjustments without resolution and recommendation for continued treatment.
> 3. Predating morbid obesity, progressively increasing to a four-point BMI gain in half a year. This exerts tremendous compressive forces to the spine.
> 4. Slip on ice and fall on back with questionable loss of consciousness. Subsequent symptomatic complaints inconsistent with the natural history of a concussion.
> 5. Slip and fall on ice, landing on back, while holding onto aluminum hand shovel, and left palm pain. Subsequent treatment for presumptive left hamate fracture diagnosed by x-ray, although no fracture detectable on CT scan left hand.
> 6. Proximate emergency department diagnosis of cervical sprain/strain. This has long since resolved.
> 7. Presentation to primary care for low back pain at two months subsequent to the industrial event. This was not proximate to, and not contemporaneous with the industrial event. This is not related to, and not substantially caused by the industrial event.
> 8. Presentation to the primary care for vertiginous symptoms at two months subsequent to the industrial event. This is unrelated to, not caused by, and not aggravated by the industrial event.
> 9. Left middle finger trigger finger. This did not present proximate to, and not contemporaneous to the industrial event. This is unrelated to, not caused by, and not aggravated by the industrial event.
> 10. Preexisting cervical spine multilevel degenerative disease and spondylosis, with neural foraminal stenosis, unrelated to, not caused by, and not aggravated by the industrial event.
> 11. Preexisting lumbar multilevel degenerative disease and spondylosis, with spinal stenosis. This is unrelated to, not caused by, and not aggravated by the industrial event.
> 12. Profound symptom magnification, with numerous inconsistencies in history, physical examination, and emotional behavior inconsistent with the PHQ-9 and GAD-7 screening scores.
>
> Review of activities of daily living noted with difficulty to all self-care activities. This is reflective of profound disability that is incongruent with the examinee's actual impairment.

Dr. Chong stated Employee denied "any prior or intervening injuries or conditions. This is contradicted by the medical record." He found extensive inconsistencies in the history, physical examination, and screening instruments. Despite Employee's "report of inability to execute any intentional tasks," he was "sufficiently cognizant to undertake a surreptitious audio recording of the evaluation which was not detected" until the conclusion of the exam. Dr. Chong opined treatment had been appropriate with the exception of the lumbar spine interventional spinal injection because Employee had "not demonstrated a clear radiculopathy." The work injury was not the substantial cause of Employee's current disability and need for medical care:

> There is currently a plethora of symptoms, disparate without a unifying diagnosis. There is emergence of symptoms that are not proximate, and not contemporaneous to the industrial event.
>
> This is in particular the lumbar spine, which was a preexisting condition in 2021, treatment by chiropractic adjustments without resolution, and without findings until more than two months subsequent to the industrial event.

Dr. Chong released Employee to return to his job as an Automotive Technician without restrictions. He recommended Employee be referred to a psychiatric or neuropsychological EME to ascertain the validity of the behavioral screening instruments which are marked showing severe anxiety and severe depression. Employee was medically stable by the end of July 2022, when the final related diagnostic evaluation of an EEG confirmed there were no true seizures for the alleged convulsion like behavior, with no impairment. (Chong EME report, October 19, 2022).

42) On November 2, 2022, Employer denied all benefits after the October 12 and 19, 2022 EMEs, contending the substantial cause of Employee's need for medical care and disability was not the work injury and Employee was medically stable with no PPI and that Dr. Chong stated there were "extensive inconsistencies in the history, physical examination, and screening instruments." It contended Employee recorded the EME with Dr. Chong which was not discovered by Dr. Chong until the conclusion of the evaluation. (Controversion Notice, November 2, 2022).

43) On November 28, 2022, Employer reported a "880 - Voided Indemnity Benefit Check Recovery in the amount of $1,251.56 on page two and that TTD benefits were paid from

February 23, 2022 through October 11, 2022 for 33 weeks in the weekly amount of $625.78, totaling $20,650.74. (SROI, November 28, 2022).,

44) On December 12, 2022, Dr. Flanum stated he reviewed and did not concur with Dr. Chong's October 19, 2022 EME report. He wrote, "Lumbar ESI was done for lumbar radiculopathy. Patient has severe stenosis at L4-5 with disc displacement. Timing of disc displacement is unknown but should be treated." (Flanum letter, December 12, 2022).

45) On February 1, 2023, Employee saw NP Green to discuss ongoing pain and headaches, he weighed 328 pounds:

> . . . .
> Lots of push back from WC. They are stating that the migraines (started when he had his initial injury at work 2/22/22) are related to neck, which they are denying fault for. Stating that his low back pain is preexisting, although he has to use a cane for ambulation which was never the case prior to injury. He did NOT have mood swing prior to his concussion at work. He did NOT suffer from migraines, photophobia, phonophobia, loss of sensation to his face, neck pain, loss of sensation down his legs, neurogenic bowel/bladder/erectile dysfunction, or dysphagia prior to this accident. I will attest to this, as my primary care precedes this injury.

Employee reported a weight gain of 40 pounds. He was on metformin for a while but stopped due to the recall, nausea, and diarrhea. NP Green assessed, "Traumatic brain injury, S06.9X4A: Unspecified intercranial injury with loss of consciousness of 6 hours to 24 hours, initial encounter," mood disorder, postconcussion syndrome, and type II diabetes. (Green record, February 1, 2023).

46) On February 28, 2023, NP Green wrote a letter "To Whom It May Concern" stating:

> This letter is in regards to the above referenced patient and his continued difficulty accessing appropriate medical care through Worker's [sic] Compensation (WC). It is my understanding that he has been denied coverage through WC for a witnessed accident while at work, doing work duties, and clearly related to an OSHA infraction on his employers part. I would like to take this opportunity to outline very clearly the health implications from his on-site work injury (2/22/22), and to refute the discrepancies laid out in the Worker's [sic] Compensation Controversion report dated 11/2/22.
>
> I have been caring for Mr. Apaisa since 2019. Since the date of this work related injury on 2/22/22, I have professionally witnessed a dramatic decline in his functional status (both physically and cognitively), an increase in his lumbar

back/head/neck/and global pain, and a new onset of multiple neurological sequelae. These neurological changes include chronic daily migraines with photophobia/phonophonia, new onset tonic-clonic "events" with concurrent loss of cognitive awareness, new nystagmus, new hyper-reflexive DTR's to all extremities, new anisocoria, new aphasia and delayed response time, and new sensory deficits to his cranium and face. He now walks with a cane, no longer can work due to daily chronic head pain, dizziness and lumbar pain due to disc rupture, experiences difficulty finding his words, is overwhelmed with all sensory input including processing new information, and now has cognitive short term memory deficits. Each one of these symptoms started the day of his work injury (occipital head blow following a slip and fall due to ground surface at the company warehouse), which are clinically very typical in presentation with a recent TBI. Let me make myself very clear:

1) He did NOT experience lumbar pain to the point of requiring a cane to ambulate on a daily basis, experience pain or extreme vertigo in any position but laying flat, or urinary retention due to his lumbar nerve compression prior to his work accident. He did occasionally have flares of lumbar pain that followed a very typical pattern of lumbago with self-resolution within 4-6 weeks, however he never required a cane to walk, was nauseated and had vertigo, or experienced difficulty with peroneal nerve function then resulting in difficulty urinating (amngst [sic] other urogenital nerve loss) for a year following one of these flares.
2) He did NOT experience chronic daily migraines to the point of severe vertigo/vomiting and debilitating pain, photophobia, or phonophobia prior to his work accident, He did have occasional migraines, including one that was severe enough for cause of an ER visit in 2019, This did not last an entire year, nor did it cause him to lose his ability to engage with his wife and/or continue his employment. The onset of this year-long migraine started on 2/22/22 and has not stopped since.
3) He did NOT experience any neurological deficits such as facial numbness and partial paralysis, tonic-clonic like events, loss of grip and arm strength, aphasia, anisorcia, hyperreflexive DTRs globally, short term memory deficits, or neurogenic bladder prior to his work related accident. These measurable abnormalities are all signs of severe neurological damage and Traumatic Brain Injury. This is very basic assessment based on clear clinical indicators in Neurology. In an Armchair consult with a local Neurologist on a "hypothetical" patient exhibiting Mr. Apaisa's signs and symptoms, he assessed immediately that the patient had a Traumatic Brain Injury.

The Controversion of the Worker's [sic] Compensation claim on this particular patient is unbelievably unethical, especially since he has been within the first critical year of healing after a Traumatic Brain Injury through this grueling process. The assessment done through Dr. Chong was clearly inept, witholding [sic] of proper neurological evaluations that would have revealed these manifestations, and incorrect in its conclusion that Mr. Apaisa had the above medical conditions prior to his work related injury. Moreover, the delay in his

> medical coverage, and thereby medical care, left him without the proper treatment and has now caused permanent damage to his brain and nervous system. Ms. Molly Friess (Senior Claim Examiner) and Dr. Chong (Independent Medical Examiner) have manipulated a vulnerable and disabled man (TBI is a disabiling [sic] condition under American Disabilities Act) during the most critical timeframe in his life, now resulting in a devastating and permanent loss of function. Due to the egregiousness of manipulation and deceptive behavior by Ms. Friess and Dr. Chong, as well as the seriousness of Mr. Apaisa's permanently resulting medical deficits, legal counsel has been initiated.
>
> The above statements are medical facts, which I will uphold in any court of law.
>
> Lastly, I would like to point out the questionable character and medical competency [sic] of Dr. Chong. In an 2019 legal brief by Keenan Powell, Attorney here in Anchorage, Dr. Chong has a longstanding reputation of incestuous relationships with the insurance companies. In Mr. Powell's article, he outlines 4 specific cases in which the Alaska State Workers' Compensation Board "rejected Dr. Chong's opinions because he didn't rely on the legal standard for causation in his opinions". I am expressing my grave concern that Mr. Chong has used his position to manipulate this WC claim outcome for his own personal gain, and now Mr. Apaisa will suffer the consequences for the remainder of his life.
>
> For more on this article, please feel free to reference at https://www.keenanpowell.com/blog/2019/04/29/gang-of-seven-episode-iii-dennis-chong-md-career-insurance-doctor/.
>
> This claim will not be Controverted, and Ms. Friess and Dr. Chong have manipulated and ruined the lives of far too many individuals. I will not allow this to continue. (Green Letter, February 28, 2023).

47) On March 29, 2023, Employee visited Luke Liu, MD, upon referral from NP Green for evaluation of neck pain, migraines, and post-traumatic stress order (PTSD); she reported he had a history of severe post-concussive syndrome with anger, irritability, and PTSD from a workers' compensation injury in February 2022 when Employee slipped on ice. Employee stated he had constant, sharp stabbing neck pain, radiating down his shoulders and occipital region of his dead. He also reported progressive neuropathy in his finger, forearms and bilateral lower extremities, significant weakness in his bilateral lower extremities, facial numbness, photosensitivity, motor function deficits, vision spotting and blurring, tinnitus, and sleep disturbances. Employee experienced minimal relief from extra strength Tylenol, Lyrica, and cyclobenzaprine. Dr. Liu diagnosed Complex Regional Pain Syndrome Type 1 of both upper extremities, left hand carpal

tunnel syndrome and cubital syndrome, and cervical radiculitis. He recommended right and left stellate ganglion blocks. (Liu records, March 29, 2023).

48) On May 15, 2023, Dr. Liu performed a right stellate ganglion block. (Liu record, May 15, 2023).

49) On May 30, 2023, Dr. Liu performed a left stellate ganglion block. (Liu record, May 30, 2023).

50) On May 31, 2023, Zurlini Guzman from Dr. Liu's office called Employee and asked how he was doing. Employee said he was "good" and rated his pain at eight out of ten and that he had relief of his pain. (Guzman record, May 31, 2023).

51) On April 12, 2023, Employee saw Dr. Flanum and under "History of Present Illness", Dr. Flanum wrote:

> Mr. Apaisa returns to Orthopedic Clinic in follow up. He has known, significant lumbar stenosis. He has been controverted at work. We have discussed in the past that he would benefit from surgical decompression. He has elected not to proceed. He says that he has continued to be painful. He is ambulating with the use of a cane. He denies any frank incontinence, but says he is constipated and spends a lot of time having a bowel movement. He has no frank bladder incontinence.

He diagnosed lumbar stenosis with neurogenic claudication and under "Plan" stated:

> The patient has severely-limited walking tolerance. He reports ongoing pain. We have discussed many times the treatment would be surgical decompression. He has elected not to proceed. I have discussed that he is certainly welcome to get opinions from my partner, see if they have a different strategy with him. We will set him up with one of my spine colleagues to offer their opinion. I do not need to see the patient in the clinic again unless he is interested in proceeding with surgical treatment, as I do not think that there is any role for injections or further physical therapy at this point in time. This was explained to the patient in detail. (Flanum record, April 12, 2023).

52) On April 21, 2023, Keenan Powell entered her appearance on behalf of Employee. (Entry of Appearance, April 21, 2023).

53) On April 21, 2023, Employee sought TTD and PPI benefits, medical and transportation costs, a finding of an unfair or frivolous controversion, a penalty for late-paid compensation, interest and attorney fees and costs for "Slip and fall resulting in injuries to neck, back, fractured wrist,

and concussion." The reason provided for filing the claim was the November 2, 2022 controversion. (Claim for Workers' Compensation Benefits, April 21, 2023).

54) On May 15, 2023, Employer controverted all disability and medical benefits for orthopedic conditions after October 12, 2022, all benefits for any other condition after October 19, 2022, an unfair or frivolous controversion finding, attorney fees and costs, a penalty, and interest, relying on Drs. Bauer's and Chong's EME reports. It contended it relied on Drs. Bauer's and Chong's EME reports in good faith. (Controversion Notice, May 15, 2023; Answer to Employee's Workers' Compensation Claim, May 15, 2023).

55) On August 14, 2023, Dr. Flanum referred Employee to Samuel Waller, MD, for "second opinion for lumbar spine surgery." (Flanum referral order, August 14, 2023).

56) On September 6, 2023, Employee testified he is married and has a two-and-a-half-year-old daughter that lives with him and his wife. (Videotaped Deposition of Salualo Apaisa, September 6, 2023, at 8). He was born in and grew up in American Samoa. (*Id*. at 9). Employee graduated from high school. (*Id*.). He moved to Anchorage in 2011 for job opportunities. (*Id*. at 9-10). Employee obtained automotive training in Sydney, Australia. (*Id*. at 10). When he first came to Alaska, he worked in Kodiak for Trident Seafood as an automotive technician for less than a year. (*Id*. at 13-14). Afterwards, he preached through the Jehovah's Witness church at homes and in a correctional facility as a volunteer for three years while his wife worked. (*Id*. at 14). Employee did not have a job from 2011 to 2016. (*Id*.). He began working for Employer in 2016; prior to that he worked for a cleaning company part-time in Anchorage and cleaned the Carrs grocery store. (*Id*. at 11-12). While working for Employer he worked 7:30 to 5:30 Monday through Friday and was paid on commission. (*Id*. at 18). Employee could not remember if he had "ever gone to a doctor to say, 'Oh, my back hurts,' or something of that sort." (*Id*. at 22-23). Prior to the work injury he had gout and hernia surgery. (*Id*. at 23-25). Sometime after Employee moved to Alaska, he was in a car accident, and he went to the chiropractor as he was sent there by the insurance company for whiplash. (*Id*. at 26-29). He could not remember the December 19, 2019 medical report that stated he has had anxiety since 2017; he was never treated with a mental health provider, had not been hospitalized for psychiatric or mental reasons before 2022, and never had any type of counseling by any type of medical professional prior to 2022. (*Id*. at 30-31). Employee was referred to a psychiatrist or psychologist by Dr. Hines after the work injury but did not see anyone because, "They're not taking in any new patients." (*Id*. at

31). He could not remember who he tried to see. (*Id.*). Employee said he was helping a technician pull out a stuck vehicle for a new customer in the morning, he had a shovel in his left hand, and he slipped and fell and landed on his back and head. (*Id.* at 32-22). The ground was covered in ice. (*Id.*). Employee's back hit the ground first, but he could not remember the fall because it happened so fast. (*Id.* at 33-34). The first thing he remembered after falling was left wrist pain. (*Id.* at 34). Employee believed he was unconscious for a period of time because his coworker told him. (*Id.* at 35). His head also hurt; he had a bad headache. (*Id.*). Employee went into the shop after he fell and talked to another technician, and he told him to go home and to go to the hospital. (*Id.* at 35-26). He went home and took a shower and Extra Strength Tylenol to try to "sleep it off." (*Id.* at 36). Employee slept until the evening and woke up with a really bad migraine, so he took another Extra Strength Tylenol. (*Id.* at 36-27). The next day he sought medical care at Alpine Urgent Care. (*Id.* at 37). Employee saw Dr. Liu at Neurovision for pain management for injections in his neck. (*Id.* at 42-43). When asked which body parts he was claiming are related to the work injury, he stated his head, neck, back, and left wrist. (*Id.* at 44). Employee could not remember if he had any complaints of headaches prior to the work injury. (*Id.*). When he sees a bright light, it gives him a headache, and he wears dark sunglasses when he leaves his house in daylight. (*Id.* at 45). Employee uses a cane when he leaves his house to ease the pain in his neck and back. (*Id.* at 45-46). Prior to the work injury, his physical ability to "exert himself" was not limited by pain. (*Id.* at 46). Employee does not go to the grocery store, his wife does, and he does not carry grocery bags; he can drive his truck. (*Id.* at 47). He has shooting pain in his left wrist. (*Id.* at 48). Employee treated at Pairmore & Young before the work injury for a basic adjustment and massage; he could not remember if he was unable to lift heavy weights from the floor. (*Id.* at 49). Employee was able to walk three miles before the work injury; he cannot take out the garbage or check the mail due to back pain. (*Id.* at 49-50). He can bend over but not all the way to the ground. (*Id.* at 50). In the last two months, his condition has gotten worse with shoulder pain shooting through his arms and back pain shooting through his legs, and he started having an issue with his left hip. (*Id.* at 51). Employee complained of cognitive and memory problems due to the work injury and a shortened temper. (*Id.* at 52). He can sit in a recliner for about 30 minutes, and his butt gets numb and has pain in his legs. (*Id.* at 54). Employee can walk about five yards without the cane. (*Id.* at 55). His wife helps him put his shoes on and he dresses himself. (*Id.*).

57) On September 25, 2023, Employee followed after his left and right stellate ganglion blocks. He said he had good improvement in symptoms for about an hour or two. Dr. Flanum told Employee he had nothing left to offer him, so Employee is going to see Susanne Fix, MD, for a second opinion. Gregory Gootee, PA-C, recommended an IV ketamine infusion as he thought Employee could "derive significant relief of pain" given his pain and overall discouragement with quality of life and the few hours of improvement with the blocks. (Gootee record, September 25, 2023).

58) On September 28, 2023, Employee followed up with NP Green about ongoing pain and headaches. His neck pain was eight out of ten and his back pain was a ten. Employee had been experiencing vertigo episodes; the previous night was the worst ever. His EEG was normal. Employee had very severe migraines at least two times per week, and he noticed clear fluid coming out of his left ear about an hour after the most severe headache. He had tested positive for COVID two weeks earlier and his photophobia had been amplified. Dr. Flanum recommended an MRI, which was denied by Medicaid, and a second opinion, as Dr. Flanum would not see Employee and refused to refer him to Dr. Fix or Coastal. "They were told the second opinion was because [Employee] 'did not want to pursue surgery,' however he and his wife were in the appointment and both clearly remember that he wanted to pursue surgery." Employee had severe dysphagia which started immediately after the accident and the right side of his face felt numb. He felt like he was on a roller coaster, awakes with severe head pain, and was very light sensitive. Employee's back pain was terrible, and he used gabapentin without relief. His back had a constant stabbing pain. Employee's anxiety was much better using propranolol, but his depression was much worse. Employee was unable to pick up medications and see some providers for his depression as his insurance was in limbo and he was waiting for a neuropsychiatrist evaluation. NP Green stated:

> Lots of push back from WC. They are stating that the migraines (started when he had his initial injury at work 2/22/22) are related to neck, which they are denying fault for. Stating that his low back pain is pre-existing, although he has to use a cane for ambulation which was never the case prior to injury. He did NOT have mood swing prior to his concussion at work. He did NOT suffer from migraines, photophobia, phonophobia, loss of sensation to his face, neck pain, loss of sensation down his legs, neurogenic bowel/bladder/erectile dysfunction, or dysphagia prior to this accident. I will attest to this, as my primary care precedes this injury. (Green record, September 28, 2023).

59) On October 6, 2023, Employee saw Dr. Fix for a new patient visit:

> Mr. Apaisa is a 42 year old man that fell on the ice striking his back and head in February of 2022. He was referred to physical therapy which didn't help him much. He subsequently saw Dr. Flanum who recommended injections which helped for a about a week or two. He also injured his left hand/wrist in the fall and remains in a splint/brace for that. He had daily back pain with referred pain to both legs but his left leg is worse. He feels the leg is weak. He also has groin pain. He has not been able to work since the injury. He denies bowel and bladder problems. He also has some numbness in his hands and both legs. He does not take any vitamins or supplements. Any activity worsens his pain. He also complains of problems with his memory and vision since the fall.

Dr. Fix diagnosed congenital spinal stenosis with lower lumbar disc protrusion causing moderate increase in stenosis, history of TBI, depression, and chronic pain. She recommended blood work as he had physical findings suggestive of a deficiency state which would make him more symptomatic in the setting of spinal stenosis. Employee was a candidate for lumbar decompression, but Dr. Fix wanted him to address any deficiencies first; she recommended he take turmeric and magnesium. (Fix record, October 6, 2023).

60) On October 15, 2023, NP Green wrote a letter Dr. Flanum:

> This letter is in regards to the above referenced patient. He was referred to OPA by Molly Friess (Broadspire Worker's Compensation) for severe Lumbar stenosis 2nd to a fall and head/back/neck injury at work and to consult for surgical options. He sought care SPECIFICALLY for surgical intervention options, which he repeatedly voiced as his goal to multiple providers.
>
> In reviewing notes from Dr. Flanum, he indicate that Mr. Apaisa refused surgical Intervention. This is incorrect and needs correction in the chart.
>
> At his first visit with OPA (5/26/22, Michale Dykes) he was told that he had spinal stenosis between L4-L5, and that his neck was a pre-existing condition with a congenital narrowing of his C-Spine, however he failed to do a comparison against Mr. Apaisa's MRI at Paramoire [sic] and Young from 2021. His recommendation was to do a Laminectomy and decompression (possibly fusion) and to avoid injections. Mr. Apaisa concurred with this recommendation.
>
> At his 2nd appointment on June 29, 2022 Mr. Apaisa discussed radiating shoulder pain from his neck with Dr. Flanum, who recommended an injection (in anticipation the disc ball would heal over time) and PT. He underwent the nerve

injection on July 13, 2022. The injection relief brought his pain level from a 10/10 to a 7/10 for 1 week.

At his 3rd visit on August 10, 2022 with Dr. Flanum, it was noted that he had nerve damage and stenosis that was progressively symptomatic and he recommended Physical Therapy.

Mr. Apaisa was referred to Daniel Oiulette, who upon first visit refused to proceed with PT due to concerns about further nerve injury.

At his 4th visit on September 7, 2022 he was seen by Dr. Dykes to follow up on the injection and PT. He was told that his weight was the cause of his increasing pain, however he had lost 20 pounds in between this visit and 8/10/22. He was told that the focus needed to be on the lumbar spine and was advised to do surgery that would last 4 hours and he would have a 2 week recovery. Mr. Apaisa was called by OPA on October 5, 2022 and told that the workman's [sic] comp adjuster, Molly, stopped the approval for the surgery, and that he needed an Independent Medical Evaluation (IME).

Mr. Apaisa underwent an IME on 10/12/22 (Dr. David Power, orthopedic), and a second one on 10/19/22 (Dr. Dennis Chong, physical and rehabilitation). OF SIGNIFICANT NOTE, HIS IME DECISION WAS BASED ON AN MRI DONE AT PARAMOIRE AND YOUNG IN 2021 PRIOR TO HIS INJURY. His case was controverted on 11/7/22.

At his 5th and last visit on 4/20/23, Dr. Flanum recommended an updated MRI and a second opinion by Dr. Foke. When Mr. Apaisa questioned the need for a second opinion, he was told that "even after surgery (he) would not improve." Mr. Apaisa reported that since his accident he has experienced severe urinary incontinence/retention and constipation which was not addressed. During this visit, Mr. Flanum's demeanor changed from being inquisitive to gruff irritation, refusing to give him eye contact and did not perform a full physical exam. Mr. Apaisa was reprimanded by the CMA for asking questions. He left without answers, and felt "disregarded and personally hurt." Mr. Apaisa states to me today that he felt as if he could trust Dr. Flanum initially, with a rapport around Pacific Island common experiences, and that at this visit Dr. Flanum was very defensive. In reviewing Mr. Apaisa's voice recording, it appears that Dr. Flanum was prompting Mr. Apaisa in an attempt to admit his symptoms were pre-existing.

He was scheduled to follow up with Dr. Flanum on 8/28/23, and then was contacted by OPA to reschedule with Dr. Foke on 8/15/23. Mr. Apaisa requested a referral be sent to Dr. Suzzane Fix for a second opinion, however the referral was sent to Dr. Waller. Mr. Apaisa contacted OPA to have the referral corrected, however this request was denied.

> I need a written explanation for the above noted events and corrections made to his chart. Once this has been completed, I am requesting a copy of the Addended clinic visit notes.
>
> Following each of his visits Mr. Apaisa took detailed voice recorded notes for his records. He also took voice recordings during each appointment so he could share the information with his wife at home with their infant child. I caution you to be forethcoming [sic] and honest in your response to this letter. (Green letter, October 15, 2023).

61) On November 7, 2023, Dr. Koenen, a psychiatrist, examined Employee for an EME "via a two-way audio-video" and diagnosed panic disorder, agoraphobia, mild major depressive disorder, and "Rule out other specified somatoform disorder." Employee said he was born and raised an American Samoa. His father was an electrician, and his mother was a school principal. Employee was the middle of his parents seven children, and he had a "strict Christian upbringing." Employee was the black sheep of his family because he liked to do things like go off and play video games with his cousins. Employee denied any serious disciplinary problems and did not feel like he was abused. After high school, Employee began working as a mechanic. In 2011, Employee and his wife moved to Alaska from American Samoa together. He had one child. Prior to the work injury, he was active in his church. After the work injury, he became much more isolated, he preaches from time to time but is generally inactive. Employee spent most of his time at home and his wife had to take over many responsibilities that he is unable to do, and he felt guilty about not helping out as much as he would like. He used to enjoy cooking, but he does not do it much anymore. Employee described a situation where he attempted to cook and accidentally left food on the stove, fell asleep, and the food was burned. He stated one of the main reasons he does not go out and socialize with others is because he has anxiety about being around groups of people since the work injury. Employee said he lost consciousness for "a minute or two" when he fell at work and his coworkers helped him up. He said he became anxious after the fall and described periods of heightened anxiety that sometimes lasted a few minutes but sometimes lasted as long as an hour, including symptoms of palpitations, dyspnea, and diaphoresis. Employee stated he has been feeling depressed for much of the last year, he felt guilty for not supporting his family and felt worthless, that his family would be better off without him. Dr. Koenen concluded, "There is likely no relationship between Employee's reported psychiatric conditions and a slip and fall accident at work in early 2022." He stated:

Mr. Apaisa has claimed to have a number of psychiatric conditions. The relationship of these conditions to his industrial injury and the validity of his claims will be analyzed using the methodology of psychiatric causation analysis are laid out in the *AMA Guides to the Evaluation of Disease and Injury Causation, 2nd Edition*.

Mr. Apaisa has a history of anxiety symptoms. The examinee was generally dismissive about having any psychiatric history. As will be discussed below, this may not be reliable. He appears to have had panic attacks in the past. The medical records suggested this was a problem for a longer period of time than he disclosed during the evaluation.

Mr. Apaisa described symptoms consistent with panic disorder at the present time. He described the acute onset of extreme anxiety, palpitations, diaphoresis, and dyspnea. He states that being aware of palpitations was a trigger for his panic symptoms. The examinee also complains of vertigo which may actually be a panic symptom even though he states the vertigo often precedes the panic attacks.

Mr. Apaisa also appears to meet the criteria for major depressive disorder. He reports that he feels depressed most of the time. He has difficulties with insomnia, low energy, difficulties with focus and concentration, feelings of guilt, and occasionally hopelessness.

The examinee also meets criteria for agoraphobia. Mr. Apaisa states that he has isolated himself at home over the last few years. He attributes much of this behavior to anxiety about going out because of his anxiety. The examinee also states that one of the reasons he does not go out is because of his numerous physical problems although what physical problems he has appear to be minor and/or unrelated to his fall.

Generalized anxiety disorder is part of his differential diagnosis. This condition is often comorbid with panic disorder and major depressive disorder. Mr. Apaisa describes vague anxiety symptoms outside of the panic episodes and states that he often has issues with insomnia. He states he often worries about his health and his financial situation. These symptoms come and go. He did not appear to be anxious during the evaluation.

The examinee was diagnosed with a concussion. However, given that his head injury comprised a fall from a standing height with perhaps 30 seconds of unconsciousness. As it is unlikely that his reported neurological symptoms are related to his fall. The diagnostic possibilities to explain the symptoms attributed to his concussion are psychiatric conditions or malingering.

Somatoform disorders refer to psychiatric conditions presenting as physical symptoms. Somatoform disorders are often comorbid with other psychiatric

conditions such as mood and anxiety disorders. However, it is unclear if his reported physical conditions represent a genuine experience or are being fabricated for secondary gain given the context in which they are being reported. Therefore, this can only be considered a possible diagnosis.

Major depressive disorder is a common psychiatric condition with a lifetime prevalence of 13-16% and a 12-month prevalence 6.6% of the population.

There is no scientific evidence that major depressive disorder is "caused" by adult life stressors. The known risk factors for mood and anxiety disorders are genetics, prenatal insults, and adverse events during childhood. Thus, if the examinee meets criteria for major depressive disorder, there is no evidence that this condition would be related to his fall.

Panic disorder is also a common psychiatric condition. The National Comorbidity Survey found the prevalence rates of this condition in the 30-44- year-old age group is 5.4%. Panic disorder is often comorbid with other psychiatric conditions including major depressive disorder.

Panic disorder is a chronic, recurrent illness. The examinee has a history of an anxiety disorder in the past and may have previously met criteria for this condition. There is some research suggesting that an increase in interpersonal stressors can be associated with the onset of panic symptoms. Research on the topic is mixed with other studies finding no clear relationship between stressors and panic attacks. Others have pointed out that the research that purports to show a causal relationship is methodologically flawed. Whether a concussion with symptoms that would have resolved within weeks and a self-limited hand injury would count as such a stressor is questionable.
The examinee also claims to have a number of neurological symptoms that he claims are the result of his concussion. While there are some who argue that persistent cognitive deficits can occur following mild traumatic brain injuries, the research underlying such claims is flawed. Specifically, studies involving pre-injury testing, the use of control groups, and controlling for the effects of litigation show that complete resolution of mild traumatic brain injury symptoms within a short period of time is the norm. While concussions can be associated with symptoms or irritability and increased anxiety, these symptoms are usually transient, whereas the examinee's reports of anxiety to his medical began after such symptoms would likely have resolved. The examinee's ever-expanding claims of neurological symptoms are not credibly associated with the symptoms that would be expected form a head injury of this nature.

As noted above, somatic symptom disorder is a possibility. If he does have such a condition, it would not be related to his industrial injury. There is no evidence that somatoform disorders are caused by adult life stressors. Other diagnostic possibilities to explain the examinee's symptoms include factitious disorder or malingering.

The examinee was dismissive of having any significant psychiatric pathology prior to his injury. Descriptions of the timing of symptoms and premorbid functioning among patients tend to be inaccurate, especially among those involved in litigation. If the examinee was experiencing more mood and or anxiety symptoms than he contends at the present time prior to his injury, he may not have sought treatment. There is often a significant time lag between the onset of symptoms and seeking mental health care.

Other factors may be influencing Mr. Apaisa's myriad post-accident pain complaints. As is discussed in the *AMS's Guides to the Evaluation of Permanent Impairment, Fifth Edition*, "a variety of factors strongly influence" presentations of pain. Some of the factors specifically discussed include:

- Beliefs, expectations, rewards, attention, and training.
- Social and environmental factors.
- Spouse solicitousness.
- Financial compensation, receipt of work-related sickness benefits, and compensation-related litigation.
- Tendencies to be preoccupied with one's body and symptoms.
- Depression and daily hassles at work.

Thus, a variety of issues unrelated to the examinee's injury may be contributing to his chronic pain complaints.

Psychiatric factors may underlie the examinee's myriad pain complaints. It is common for individuals with psychiatric problems to complain of a variety of physical symptoms, often without evidence of physical pathology to explain these complaints.

The fact that Mr. Apaisa has a compensable injury claim may also be playing a role in his presentation. Research has shown that the primary risk factor for complaining of chronic pain following minor back injuries is the availability of compensation. Other studies have shown that involvement in litigation and the availability of compensation often result in symptom prolongation. There is also research that shows that when the availability of compensation is eliminated, claims of physical and emotional distress tend to resolve.

Malingering is a strong possibility in this case. Exaggeration and outright fabrication of symptoms common in compensable injury claims. Research finds evidence of malingering in 30-50 percent of industrial injury cases. Given the profound symptom exaggeration and magnification present in this case as evidenced by his ever-growing litany of physical and pseudo-neurological complaints, malingering must be taken into consideration.

Dr. Koenen stated Employee was medically stable with regard to his psychiatric conditions as they related to his claim as he might have experienced some symptoms related to his concussion but those would have been resolved in a few weeks and he never had any psychiatric condition related to the work injury. None of Employee's ten percent impairment was attributable to the work injury. Dr. Koenen recommended an antidepressant for Employee's unrelated psychiatric conditions and psychotherapy to address his unrelated mood and anxiety symptoms, comprised of cognitive behavioral therapy or a similar modality for six months. Such treatment may facilitate Employee's return to work, but it was unrelated to the work injury. Dr. Koenen stated Employee had no psychiatric work restrictions related to the work injury. (Koenen EME report, November 7, 2023).

62) On November 9, 2023, Dr. Villanueva, a neuropsychologist, conducted a clinical interview and administered standardized testing of Employee for an EME. Employee said he may have lost consciousness for a few seconds, and his coworkers were not able to get him off the ground due to body habitus. He denied feeling depressed "at this time," denied "any feelings of anxiety," and denied thoughts of hopelessness and suicidal ideation. Employee indicated he did not notice cognitive symptoms until about two or three weeks after the work injury. He said it was hard to concentrate; for example, he noted that he was trying to put away sockets but put them where wrenches were supposed to go. Employee said his concentration was getting worse over time. Employee noted he forgot his wife's name a couple of times. He said he was gaining weight largely due to diet choices. Employee was raised in American Samoa and spoke Samoan at home with his family. In school, he spoke, read, and wrote in English. He has been married since 2011; he met his wife in Alaska. Employee denied any history of childhood adversity. Employee typically does the driving and usually drives short distances. His wife helps him get into the shower, but he is able to independently dress himself. Employee did not participate in household chores and was not cooking because he almost burned the house down after he forgot something on the stove. His wife took over household finances after the work injury. Employee said only took propranolol for about a month before the work injury and then restarted it after the work injury. Dr. Villanueva performed neuropsychological testing:

> On the WMT, he scored well below cutoff levels on immediate recall, delayed recall, and consistency. Cutoff scores are based upon individuals with known moderate to severe brain injuries, in other words, brain injuries that were much

more severe than suffered by the claimant. The scores, then, that fall below the cutoff indicate a lack of credible effort. Once lack of credible effort is definitively noted on a performance validity measure, one is not able to interpret clinical measures that fall below average as being representative of acquired neurocognitive deficit. Further, and providing even greater confidence in the performance validity finding, one notes that clinical measures of memory suggested adequate recall, using, for example, long-term retention percentage and recognition percent correct. Also, delayed recall for visually presented material was within normal limits. There is no explanation, then, for the finding on the word memory test of recall being at a random level, given that other measures demonstrate normal retention percentage, and given clinical history, which suggests that at most, a mild head injury occurred.

Other performance validity measures include the TOMM, with trial one scored just one point above the cutoff. The DCT was within acceptable limits, as was RDS. AVLT recognition was within acceptable limits.

For reasons just discussed, scores that fall below average cannot be interpreted. Those scores that are average and represent normal function include visuospatial reasoning skills. He also demonstrated normal executive function as assessed by complex sequencing and as assessed by inhibition of response.

His language was normal as assessed by fluency tasks and confrontation naming.

Because of the brace on the nondominant extremity, we did not assess fine motor speed/control with the left hand. With the dominant hand, fine motor speed/control was normal.

As noted above, his verbal memory for a word list, using recognition percent correct, was normal. His retention percentage for verbally presented information in paragraph form was normal. His delayed recall and retention percentage for visually presented material was normal.

Mr. Apaisa was administered the MMPI-2-RF. This measure indicates modest difficulties with responding in an internally consistent fashion. The degree of inconsistency does not invalidate the scale, but does suggest either a modestly careless approach or some difficulties reading items.

The rest of the validity scales indicate an invalid approach. There is a marked elevation on F-r, T97. This indicates a tendency to endorse highly atypical psychiatric symptoms. There is also a marked elevation on Fs-T115, indicating a tendency to endorse highly atypical somatic/physical symptoms, rarely endorsed even by those with serious medical illnesses. There is also an elevation on FBS-r, which suggests a tendency to overfocus/overreport on a combination of somatic and cognitive symptoms, and to do so in such a way as to overemphasize limitations. Individuals with such an elevation will often report physical and

> cognitive symptoms in a manner that cannot be objectively verified or is unexpected, given the clinical history.

Dr. Villanueva found no evidence of a neuropsychological diagnosis and no indications that Employee had a cognitive or neuropsychologically related disability or symptoms:

> From a neuropsychological standpoint, the worker's injury was quite mild. By his report, there was limited, if any, RTA, and very limited PTA, with possible alteration of consciousness. His GCS would have been 15, since he was able to leave the situation, drive home, and then drive to the urgent care clinic the next day. The injury was also mild given that imaging in the aftermath of the injury was negative. One would not anticipate neuropsychological symptoms beyond several weeks to three months, at the most, following such an incident.
>
> There is report in the record available for review of psychological symptoms that have been attributed to the mild head injury. Psychological symptoms such as depression and anxiety are an unlikely outcome from a mild concussion. There is no outcome research available that would support the presence of psychological symptoms following such an injury. Also, the claimant, at this time, is without complaint in regard to depression and anxiety.
>
> This examination does not support the presence of enduring neurocognitive impairment. There are multiple normal findings. Those findings that fall below average cannot be interpreted as representing acquired neurocognitive deficit given performance validity concerns, as I outlined under Findings.

Dr. Villanueva opined the first three months, on a more likely than not basis, substantially contributed to neuropsychological symptoms and related disability, which may have been due to the direct blow to the head, sleep disruption, headaches, and other complicating conditions. But the work injury was no longer the substantial cause of the need for treatment from a neuropsychological standpoint after three months. Dr. Villanueva stated there were no indications for a PPI, no current indication of neuropsychological related symptoms or need for treatment, and no restrictions from a neuropsychological standpoint. (Villanueva EME report, November 9, 2023).

63) On November 15, 2023, Employee followed up with Dr. Fix after neuropathy labs. He reported his pain eased after taking magnesium and turmeric but was still present. His sleeping issue worsened; he had neck pain, dizziness, and persistent back pain. Dr. Fix diagnosed low B vitamin levels, vitamin D deficiency, and suboptimal B12 level. She suggested melatonin for

insomnia, continuing magnesium and turmeric for neuropathic pain, and supplements for his multiple vitamin deficiencies. (Fix record, November 15, 2023).

64) On January 11, 2024, the parties agreed to conduct second independent medical evaluations (SIME) with Ryan Davis, MD, Dr. McCormack, and Mark Kimmel, PhD. (SIME form, January 11, 2024).

65) On January 23, 2024, Employee continued to report shooting neck pain at six out of 10, radiating with numbness in his upper extremities. He also reported nine to 10 migraine episodes a month, intermittent left sciatic episodes worse at night when laying down in bed, and difficulty getting in and out of bed. PA-C Gootee diagnosed lumbar and cervical radiculitis, sympathetic pain and right and left upper extremity complex regional pain syndrome type one. He recommended a left transforaminal ESI targeting the L4-5 canal stenosis. Employee wanted to proceed with his cervical spondylosis and stenosis first. (Gootee record, January 23, 2024).

66) On February 7, 2024, Employee's vitamin D levels had improved but remained below optimal level. Further supplementation was needed for B3 and B12. He was not a surgical candidate due to his vitamin deficiencies and required ongoing pain management. Employee was referred to Dr. Liu for ongoing nerve pain and reported tolerating the increased Lyrica at night. Dr. Fix re-sent the referral to Dr. Liu to expediate his pain management referral. (Fix record, February 7, 2024).

67) On February 14, 2024, Employee had confusion regarding the need to put off surgery until his deficiency states resolved. Dr. Fix explained that his vitamin D levels must approach 40 before surgical intervention can be considered due to risks of infection and complications. Employee explained a history of pre-diabetes and recent concerns regarding memory loss; he expressed willingness to undergo further neurological evaluation and testing. Employee said he was unable to establish with Dr. Liu's office for pain management. Dr. Fix referred Employee to Dr. Liu's office again to expedite his pain management referral and referred him to Dr. Hines for memory loss evaluation. (Fix record, February 14, 2024).

68) On March 1, 2024, Employee continued to have neck and back pain. His neck pain caused radicular pain down his arms, and he felt it was the generator for his migraines. Employee was wearing sunglasses. He had radiative pain down the posterolateral aspect of his bilateral lower extremities and urinary incontinence for a year. Employee felt his medications were not as effective as they once were and he was interested in injections. PA-C Gootee ordered bilateral

cervical medial branch blocks for two levels and recommended a cervical interlaminar ESI targeting the C7-T1 if the medial branch blocks were unsuccessful in alleviating pain. (Gootee record, March 1, 2024).

69) On April 3, 2024, Dr. Liu performed bilateral cervical mediation branch blocks at C4 and 5. (Liu record, April 3, 2024).

70) On April 4, 2024, Guzman called Employee to see how he was doing after the procedure. Employee said he was okay and rated his pain as a level four. He felt he had no relief of his pain. (Guzman record, April 4, 2024).

71) On April 17, 2024, Employee reported no improvement in his neck pain after the bilateral cervical mediation branch blocks. His neck pain continued to radiate down both arms to the small fingers. PA-C Gootee recommended updating the neck MRI and discussed cervical ESIs that targeted the "C7 VIII nerve roots." (Gootee record, April 17, 2024).

72) On April 23, 2024, Employee ambulated with a cane due to poor balance and associated vertigo. He reported continued neck pain radiating down his arms, lower back pain, and bilateral numbness with sciatica on the left lower extremity. Employee denied bowel or bladder incontinence. PA-C Gootee prescribed hydromorphone and reserved Butrans patches for long-term pain should no surgical intervention be required. (Gootee record, April 23, 2024).

73) On April 29, 2024, Dr. Hines evaluated Employee's cognitive impairment and multiple somatic complaints:

> The patient is a 43-year-old gentleman who was in good neurological health until a couple years ago. He apparently had a "slip and fall" at work, he has never been the same since. Apparently, he was workers' comp at first, the claim has been settled. However, he has never really been able to get back to his baseline. He particularly worries because he has cognitive issues. He had trouble concentrating and focusing. He has chronic ongoing complaints including diffuse pain, particularly around the neck and shoulders, chronic headaches, chronic imbalance, anxiety, "short temper," dizziness, and many other complaints. He is cautious when he drives, has difficulty in bright sunshine, he wears polarized lenses. He is considering getting tinted glass.
>
> He was found to be low in his vitamins, but since had B vitamins which are very good, though vitamin D3 is low. He is getting replacement. He had had neurosurgical evaluation and is first of all getting conservative pain management. He has some cervical injections but thus far have not been beneficial. Also, the pain appears to be in the neck, radiating down into the left arm around the fourth

> and fifth finger. He has chronic low back pain, and spasms going out through his entire body.

Dr. Hines stated:

> Employee had "severe, longstanding pain and anxiety, and this interferes with his ability to focus and concentrate, being perceived as memory deficit. The major way to address this will be to address the pain itself. Perhaps going up on duloxetine will help. He found this gives him some benefits, has good antidepressant/anti-anxiety properties, and maybe he can "get over the hump," he can heal a little faster. I suggest going up from 60 mg daily to twice daily.
>
> He should continue to get pain management, if necessary, even surgical intervention. If, however, these measures do not give him benefit, he may wish to consider neuropsychological testing and management. However, he has already tried to get neuropsychological testing, is frustrated, and thus far we have had trouble finding a provider.
>
> If these measures do not work, I would be happy to see him again. At this stage, it is not clear that I can offer him a lot neurologically. (Hines record, April 29, 2024).

74) On June 3, 2024, Dr. Davis, a psychiatrist, evaluated Employee for an SIME. He reviewed 721 pages of records and performed psychiatric testing. Employee said two coworkers came to his assistance after he fell and told him he was "out" and "lost consciousness there for a minute." He said at some point he did not recognize his wife and did not remember her name, which happens "frequently, sometimes we conversate (sic) and then sometimes I look at her and I don't recognize her, and she says the same with me too." Employee "acknowledged" "a seizure disorder." On one occasion he woke up with a sore heel and his wife told him he kicked the corner of his daughter's crib. On another occasion, Employee was sitting in a recliner watching a show and had a different seizure episode, which his wife recorded but he was so embarrassed he deleted the video from her phone. He estimated having about four seizures to date which stopped after taking Lamotrigine "about six months ago." Employee said he was born and raised in American Samoa by both parents and seven siblings. He became tearful, stating he loved it there and did not "even think of moving, but with war and famine we didn't have choice but to go." Employee stated he married his wife in American Samoa, and the wages were really low in 2011, then the couple moved to Alaska that same year "looking for an opportunity." He denied any prior sporting injuries. Employee said his concentration was poor and that he forgot chicken

on the grill and it burned. He denied a history of hypertension but reported being treating for high blood pressure before the injury and he denied any diabetes. Employee reported suicidal ideation at times, thinking he does not deserve to be here. Dr. Davis performed the Minnesota Multiphasic Personality Inventory (MMPI)-3 and reported, "[Employee] provided an unusual combination of responses that is associated with non-credible memory complaints. This combination of responses may occur in individuals with significant emotional dysfunction who report credible symptoms, but it could also reflect exaggeration. The score on the Cognitive Complaints (COG) scale should be interpreted in light of his caution." He found Employee to be "a grossly credible historian, whose account was easily corroborated with information contained in the records provided for my review." Dr. Davis stated:

> Based on the information currently available to me, including Mr. Apaisa's history, review of the medical file, results of psychological testing and my clinical impressions, my primary Axis I disorder is that of an Adjustment Disorder with Mixed Anxiety and Depressed Mood, Chronic which arose in direct response to the fall at work on February 22, 2022. The essential feature of an Adjustment Disorder is the development of clinically significant symptoms in response to an identifiable stress or stressors. The modifier "Chronic" is used to indicate the persistence of symptoms for six months or longer, in response to a chronic stressor or to a stressor with enduring consequences. In this instance those stressors are musculoskeletal pain, physical limitations, restricted lifestyle, and uncertain occupational future. In response, Mr. Apaisa experienced the emergence of a variety of symptoms that have interfered with his ability to function.

Dr. Davis further stated:

> Causation is 10% to preexisting anxiety as mentioned in the records but there was no clear psychiatric or psychological treatment out-lined prior to the industrial event of 2022. 70% is due to a consequence of the musculoskeletal/orthopedic pain and disability presumed due to the slip and fall at work on February 22, 2022 but this is deferred to the appropriate orthopedic specialist. 20% is due to the neurocognitive symptoms (headache and cognitive issues) also presumed due to the February 22, 2022 slip and fall but deferred to the appropriate neurologic specialist.

The work injury aggravated and accelerated any preexisting condition to cause disability and need for treatment and combined with the preexisting condition to produce a permanent change in the preexisting condition. Dr. Davis opined the substantial cause of Employee's psychiatric

condition is the work injury. Employee was never disabled based on a purely psychiatric basis, but he is not medically stable. Dr. Davis estimated Employee would become medically stable after six months of psychotherapy and psychotropic medication management. The treatment would assist in relieving the psychiatric conditions and reduce permanent impairment on a psychiatric basis. Employee is able to work on a psychiatric basis; however, "The psychiatric treatment could also assist in a return to work for his musculoskeletal complaints due to the overlap of pain and his psychiatric conditions." All treatment to date "appears to have been reasonable and necessary." (Davis SIME report, June 3, 2024).

75) On June 5, 2024, Dr. McCormack, a neurosurgeon, evaluated Employee for an SIME. Employee wore dark sunglasses, moved slowly, and had a painful, depressed demeanor. Staff had to help him dress and undress, "which he appeared based on a musculoskeletal exam of being capable of doing." He ambulated with a cane in his right hand and wore a left wrist split and trigger splint on his left middle finger. Dr. McCormack included four causes of Employee's disability and need for medical treatment, including:

> Mechanical fall 2/22/22 with neck and back muscle strains.
> Minor head injury 2/22/22 with post traumatic headache and delayed expansion of concussion type symptoms inconsistent with natural history of head injury.
> Chronic pain syndrome since the 2/22/22 fall. I defer causation to pain specialist.
> Congenital lumbar stenosis worse left L4-5 but bilateral lateral gutter stenosis at L5-S1 unrelated to the 2/22/22 fall.
> Cervical disc disease unrelated to the 2/22/22 fall.

Dr. McCormack stated the accident caused neck and back strains anticipated to resolve in three to four months, by June 2022. The head injury was minor and anticipated to resolve in three months. Employee had a preexisting spinal condition and had seen a chiropractor for cervical, thoracic and low back with insidious onset on May 6, 2021, or eight months earlier; his low back was rated 8/10 and cervical thoracic was rated four out of 10 and bilateral leg radiation was noted. At the end of eight visits until June 18, he had four out of 10 low back and two out of ten cervical thoracic. Employee told Dr. McCormack he would get a massage once a year with his wife from a chiropractor and had no prior spinal complaints but Dr. McCormack knew that was not accurate based on record review. Employee's MRI findings are all chronic and age related, with congenital stenosis in the lumbar spine worse on left L4-5 but radicular symptoms were not in the records until April 12, 2023. Dr. McCormack opined the lumbar radiculopathy and need

for any decompression surgery is not tied to the work injury, and the cervical disc disease is degenerative, age appropriate and not caused or aggravated by the work injury. The post traumatic headache was anticipated to resolve in six weeks. The chronic pain was temporally connected to the work injury. "Medical evidence indicate chronic pain is associated with early life experiences, unemployment, anxiety[,] and depression. I would defer to a pain specialist." Dr. McCormack said there was "a lot of functional overlay and [Employee] presents himself as completely disabled. Staff had to dress and undress him, which is disproportionate disability compared to his neurologic exam and MRI findings. I can't account for his urinary issues. I find Waddell signs and some inconsistencies. His disability appears to expand over time." When asked which of the different causes is the substantial cause of Employee's disability and need for medical treatment, Dr. McCormack responded:

> In evaluating a claimed head injury, facts established in the first few days are the most important. What is reported to doctors at a later point, is much less significant, particularly if doctors did not review index medical records. Medical records closest to the date of injury 2/22 indicate a minor head injury. GCS was not recorded indicating a significant head injury was not even on the radar. Given initial records I would anticipate some post traumatic headache only 6 weeks to 2-3 months. After head injury, symptoms should be worse around date of injury and improve over time not withstanding some recalcitrant symptoms. His head injury symptoms expand over time. Pscyh [sic] issues have a lot of overlap with concussion type symptoms.
>
> His cervical MRI shows age-appropriate degeneration. Lumbar MRI shows congenital spinal stenosis, worse left L4-5. I don't see any leg radicular symptoms documented until 4/12/23. He also had pre-accident complaints with leg radiation. I don't believe the lumbar stenosis was caused or aggravated by the subject incident.

Employee reached medical stability within three to four months after the work injury. Dr. McCormack did not recommend any additional treatment for the work injury. "Any spine surgery is beyond the scope of the 2/22/22 incident." Employee is not a candidate for neck or back surgery, and injections will not help his neck or his back. Surgery or shots will "only complicate his management." Dr. McCormack recommended Employee lose weight, continue pain management "with focus on psychological barriers to recovery," and complete a functional restoration program, "which would only be worthwhile if he showed an interest in getting better." He was not sure Employee was interested in getting better "as he told me he has applied

for social security disability." Dr. McCormack stated, "If I discount subjective complaints and based on his spinal and brain MRI structural issues, [Employee] is capable of working as an auto technician." Employee gained weight and was out of shape and "he will have to do some reconditioning to return to his prior job." Dr. McCormack provided a zero percent impairment for Employee's spine and minor head injury. (McCormack SIME report, June 5, 2024).

76) On June 18, 2024, Employee saw Eric Page, PA-C, upon referred from NP Green for left wrist pain. He reported he slipped and fell on February 22, 2022, and he still had sharp pain in his wrist and his pinky finger was numb. Employee was wearing a splint for trigger finger that he received in 2022. His current pain was four out of ten, highest was eight out of ten. Employee used buprenorphine patches and tramadol from his pain doctor to manage his symptoms. PA-C Page diagnosed left long finger trigger finger, left cubital tunnel syndrome, and chronic left hand pain and said, "The patient's persistent hand pain is likely caused by his continued use of the splint and stiffness in the wrist and carpal bones." He recommended conservative management of the trigger finger and cubital tunnel syndrome in the form of nonsteroidal anti-inflammatories, wrist splinting, and night splinting and referred Employee for hand therapy. (Page record, June 18, 2024).

77) On June 28, 2024, Employee followed up with NP Green:

> Here to follow up post SIMEs. Showed up on time, dressed appropriately, with all paper work completed. The IME doctor made many comments about his race, ethnicity, size, etc. During the neurological exam he was injured Dr. McCormack lifted his left foot abruptly and being forced to lay flat-the doctor asked him to lay back and he held the left leg while Sal got onto the exam room table and the doctor threw his left foot up onto the bed--resulting in lower back sharp pain that has persisted since. The doctor had him turn his head to the left and he pounded with force to the top of his head with significant force. Mr. Apaisa told him that "there is a shocking pain from [my] neck to lower back, and radiates into the left leg to ankle as well as right". The doctor had him turn his head to the left and repeat the blunt force jab to the top of his head again, amplifying the pain that the doctor started with the first jab. Since then on he had a sensation of nerve shock, white sparkles in his field of vision, Increased neck pain, increased sciatica, and headaches. The force was severe enough Felt as if he was being tortured, as if the doctor did not know the background. Wonders if the CT was the image reviewed and not the MRI. The doctor told him to jump with both legs and hop on each foot-he attempted as instructed, although stating to the doctor that "it hurts" to do this. IME results returned unfavorable. He felt as if the IME doctor was intimidating him.

> His goal is to be able to provide for his family. His SSI application was prompted by his WC attny. He is becoming more and more depressed not being able to go outdoors, not able to fish, camping, biking-things he historically loved to do. (Green record, June 28, 2024).

78) On July 22, 2024, Dr. McCormack responded to questions from Employer's attorney. He stated there is an impairment rating for Employee's left wrist and left middle finger. Dr. McCormack assessed a three percent whole person impairment for Employee's left wrist and middle finger and said the work injury is the substantial cause of the impairment rating. He stated, "Hand and wrist trauma can aggravate tenosynovitis to cause trigger finger. He had full middle finger extension but lacked full flexion. It is not clear to me how much of this effort related since there was a large functional component to his examination." (McCormack addendum SIME report, July 22, 2024).

79) On August 26, 2024, Dr. Kimmel, a licensed psychologist, evaluated Employee for an SIME. He performed neuropsychological testing and reviewed 606 pages of medical records. Employee said he was born in Samoa, and he became interested in auto repair in his sophomore year after his father died. He continued to live in his family's house until 2011, when he and his wife moved to Alaska to seek a better opportunity as wages were low in Samoa. Employee said he has trouble concentrating, focusing, and remembering family names and that he is easily distractable, slower in thinking and has difficulty prioritizing tasks. He denied a history of closed head injuries or loss of consciousness and said he was never prescribed psychiatric medicines. Dr. Kimmel diagnosed "Conversion Disorder (Functional Neurological Symptom Disorder)" and "Other Specified Depressive Disorder with Anxious Distress." He opined:

> In my opinion, the 02/22/22 injury likely activated a dormant psychiatric syndrome. Dr. Koenen had noted prior psychiatric symptoms, which were likely activated by the injury. It appears that he had only a minor concussion and his delayed recovery can only be understood as an activation of a dormant psychiatric syndrome or malingering. I do not believe that Mr. Apaisa is a malingerer, however. Unfortunately, he did not receive prompt counseling or neuropsychological rehabilitation. He would have disabused of the notion that he had a serious neurocognitive disorder. Nonetheless, this injury occurred two-and-a-half years ago. The need to respond to counseling is questionable.

Dr. Kimmel stated the work injury resulted in permanent change. "What began as delayed recovery has now become entrenched in a variety of physiological, emotional, and cognitive symptoms." The substantial cause of Employee's disability and need for medical treatment is his

preexisting, non-industrial psychiatric vulnerability to the expression of the conversion disorder. "His conversion disorder was dormant, although the fragility of his coping repertoire has left him vulnerable for the expression of emotional and psychological needs as well as the sensitivity to subtle changes in his health status." When asked to evaluate the relative contribution of the different causes of Employee's disability and need for medical treatment, Dr. Kimmel stated,

> It is my opinion that pre-existing factors account for 60% of Mr. Apaisa's disability. Of that 70%, I would note a vulnerability to depression and anxiety, personality style characterized as having a rudimentary coping repertoire which leaves him vulnerable to the expression of somatic complaints. The industrial factors of disability (30%) include sleep disturbance, pain, and mood states. He is also reporting ongoing physiological symptoms, which may be a combination of both industrial and nonindustrial factors.

He opined Employee continued to be disabled from the work injury "due to a combination of industrial and nonindustrial factors." Employee was medically stable because "his symptoms persisted for two-and-a-half years without any appreciable change." He should have reached medical stability 90 days after the work injury "given the nature of his injury, which in all likelihood was a mild concussion" on May 22, 2022. Dr. Kimmel recommended 12 to 15 sessions of cognitive behavioral therapy from a pain psychologist "geared towards disabusing him of many of his negative beliefs regarding his problems." The treatment would not allow him to fully recover from the injury but it "*could* be helpful," help reduce the pain Employee is experiencing, may promote recovery, and will probably reduce permanent impairment. It is likely Employee will require some work restrictions "exclusively related to orthopedic and pain issues." Treatment may enable him to participate in an approved reemployment plan. Dr. Kimmel assessed a five percent PPI rating:

> He displayed mild impaired working memory, processing speed, and inconsistent word learning. In other respects, he had mild abnormalities on neuropsychological testing. It is this examiner's opinion that he is able to resume all usual roles and perform ADLs. His presentation indicates that he has a greater level of neurocognitive disability that [sic] he has. Unfortunately, he has not had appropriate psychological counseling. I would not that during the clinical interview, Mr. Apaisa stated that he is motivated to return to work. In this regard, I do not believe that he needs vocational rehabilitation or an approved re-employment plan. (Kimmel SIME report, August 26, 2024).

80) On November 25, 2024, Powell withdrew as counsel for Employee. (Notice of Withdrawal of Counsel, November 25, 2024). She filed a lien with a detailed list of fees and costs for $37,141.50 in attorney fees and $185.98 in costs. (Notice of Attorney Lien, November 25, 2024).

81) On December 2, 2024, Employee saw NP Green and she noted:

> Insomnia: Lunesta takes a long time to work, and he wants to know if he can double the dose.
>
> . . . .
>
> Right knee pain has been high. He has been struggling with mobility due to his gait dysfunction. Sciatic pain in the right leg. He has been losing his balance, nearly falling, severe urinary incontinence and progressive lack of sensation. He has now been experiencing an increase in urinary retention which has nearly taken him to the ER the past week. Sudden on sent [sic] of bowel incontinence. Totally unaware of bowel movements. Foot numbness is getting worse. Strength to thighs and calves is worse. Right leg weakness > left. Using his right leg for the majority of his ambulation. Cannot bear weight on the left leg unassisted, toe drag and now unable to lift his left foot to clear stairs. (Green record, December 2, 2024).

82) On February 26, 2025, David Graham filed a notice of limited appearance, petition, and memorandum requesting approval of a limited entry of appearance. (Notice of Limited Appearance, Petition, and Memorandum in Support of Petition to Accept and Approve Limited Entry of Appearance, February 26, 2025).

83) On March 18, 2025, Employer filed a limited opposition to the February 26, 2025 petition. (Limited Opposition to Petition to Allow Limited Appearance and Request for Clarification, March 18, 2025).

84) On April 1, 2025, Employee saw Edward Barrington, DC, on a referral from Dr. Hines for evaluation and treatment of "cognitive changes." He reported neck and back pain and stiffness with migraine and post-concussive syndrome. Employee brought multiple CDs of imaging studies. Dr. Barrington did not formally examine Employee because he was unclear if he was requesting treatment or impairment advice. (Barrington record, April 1, 2025).

85) On April 4, 2025, Employee's primary complaints were photophobia, dizziness, and egocentric vertigo when getting up out of a chair or out of bed suddenly. He was unable to drive; when riding as a passenger watching cars and other objects made him dizzy; he had trouble

finding words, and tinnitus. Employee walked with a cane in his left hand and wore dark glasses. He described his neck pain as tenderness with occasional sharp pain, radiating down into his shoulders. Employee had an occasional sharp pain in his left wrist when pressing down on the palm of his hand. His primary spinal complaint was his lower back, which was occasionally sore with burning pain and leg pain on the left side into his foot described as tingling and not constant. Dr. Barrington assessed concussion injury of brain, concussion without loss of consciousness, sacroiliac joint pain, sacrococcygeal disorders, lumbar spine pain, vertebrogenic low back pain, thoracic spine pain, and stiff neck cervicalgia. He explained he would probably only be able to provide limited relief of symptoms as Employee had tried treatment in the past including chiropractic care. (Barrington record, April 4, 2025).

86) On April 14, 2025, Employee reported intermittent episodes of bowel upset including diarrhea, which had occurred last week and was why he did not keep his second appointment. He wore adult diapers when necessary. He complained of stiffness and pain in his neck and upper back, lower back, and posterior left leg along with headache and dizziness. Employee felt better after the initial treatment and said the home exercises were uncomfortable. (Barrington record, April 14, 2025).

87) On April 21, 2025, Dr. Barrington reviewed the plan to start him on the interactive metronome exercises once he was able to maintain gaze holding. (Barrington record, April 21, 2025).

88) On May 7, 2025, Employee said he has daily back pain with referred pain to both legs, his left leg was worse and weak. He also had groin pain and numbness in his hands and both legs. Employee denied bowel and bladder problems. He was very photosensitive and wore dark glasses; he ambulated with a cane. Dr. Fix diagnosed congenital spinal stenosis with lumbar disc herniation at L4-5 with moderately severe stenosis, history of TBI, depression, and chronic pain. She recommended a lumbar decompression and partial discectomy at L4-5. (Fix record, May 7, 2025).

89) On May 20, 2025, Employee requested cross-examination of Dr. Villanueva. (Request for Cross-Examination, May 20, 2025). He also filed an unnotarized ARH dated May 19, 2025 stating, “A notary is not reasonably available” and requesting an oral hearing on his April 21, 2023 claim “For medical and related benefits only.” Employee failed to serve Employer with the ARH. (ARH, May 20, 2025).

90) On May 20, 2025, Employee filed an unnotarized ARH dated May 19, 2025 stating, "A notary is not reasonably available" and requesting an oral hearing on his April 21, 2023 claim "For medical and related benefits only." He served it on Employer. (ARH, May 20, 2025).

91) On May 30, 2025, Employer opposed Employee's ARH, contending a prehearing conference was needed "to arrange a mutually convenient hearing date." (Affidavit of Limited Opposition to Affidavit of Readiness, May 30, 2025).

92) On June 3, 2025, Dr. Fix performed an L4-5 lumbar decompression. She noted the disc was "fairly firm" and she did not think it warranted discectomy. (Operative Note, June 3, 2025).

93) On June 18, 2025, Employee said all of his shooting pain was resolved, "He is ecstatic with this result as he had gotten used to living with constant pain." He still had some discomfort in his buttocks when he sat for too long but changing position resolved it. Susan Hartmann, PA-C, recommended Employee continue with a 10-pound weightlifting limit, and avoid overly strenuous activities; walk for exercise. (Hartman record, June 18, 2025).

94) On July 17, 2025, Employee said he had excellent relief of the shooting pain down his legs and some numbness from time to time in his buttocks and at the bottoms of his feet. Stephen Poggi, PA-C, referred him to physical therapy. (Poggi record, July 17, 2025).

95) On July 22, 2025, the designee scheduled the October 29, 2025 hearing on Employee's April 21, 2023 claim on TTD, PPI, medical and transportation costs, an unfair or frivolous controvert, interest, penalty, and attorney fees and costs. He ordered the parties to file and serve evidence by October 8, 2025 and witness lists and hearing briefs by October 22, 2025. (Prehearing Conference Summary, July 22, 2025).

96) On July 23, 2025, Employee said the decompression surgery immediately reduced symptoms in his lower spine; the sharp pain resolved almost immediately but he continued to experience numbness in both buttocks and tingling in his feet. "Postconcussion syndrome symptoms are primary for him today, with the patient reporting fatigue, photophobia, dizziness, sensitivity to sound, reduced concentration, short tempered and dizziness." Employee also had head and neck pain. Dr. Barrington referred Employee to physical therapy at Reger Physical Therapy because Dr. Fix released him for physical therapy and his office did not have the appropriate equipment for lumbar rehabilitation. He recommended Employee attend physical therapy two to three times per week for six weeks. (Barrington record, July 23, 2025).

97) On August 20, 2025, Dr. Bauer testified he is a board-certified orthopedic surgeon, fellowship trained at the University of California in San Diego by the Departments of Orthopedics and Neurosurgery, and he practiced orthopedics with a specialty in spinal injuries and diseases. (Zoom Deposition of R. David Bauer, MD, August 20, 2025, at 8). Since his examination of Employee, Dr. Bauer reviewed Dr. McCormack's SIME report, a July 2025 MRI, and an investigation surveillance report. (*Id*. at 9). Employee's use of a cane was not consistent with his presentation or claimed injuries. (*Id*.). Dr. Bauer found inconsistencies in Employee's physical examination; for example, Employee wore sunglasses and asked him to turn off the light but was facing a window directly and had no problems throughout the examination; he also documented non-physiological signs in his exam report. (*Id*.). Employee's cervical spondylosis and congenital spine stenosis were brought on by age and time and were not substantially caused by the work injury. (*Id*. at 10). When asked what the cause of Employee's need for spinal surgery was, Dr. Bauer stated:

> [Employee] is genetically predisposed to have a small spine. People whose -- what we call the AP length, the anterior posterior length of the pedicle, which is what separates the front of the spine from the back of the spine, people who have congenital stenosis and have a decreased AP length are much more prone to need surgery at an earlier age. The type of impact that he had falling onto his back does not accelerate the need for surgery. It does not change the anatomy of the congenital stenosis. (*Id*. at 11).

The back pain mentioned in the April 15, 2021 note was a very nondescript note, "I wouldn't use it to say he was not having pain in his back in April of 2021. It's very common for individuals to have recurrence of their back pain, especially when they're obese." (*Id*. at 17). It could have been back pain, it could have been hernia, it could have been totally unrelated. (*Id*.). On September 2, 2021, NP Green also treated Employee for anxiety, "which is highly correlated with subjective complaints of back pain." (*Id*.). The May 7, 2021 lumbar spine x-ray had no significant findings because Employee's stenosis is measurable only on a CT scan or an MRI; his cervical spine x-rays reported loss of cervical lordosis, multi-level degenerative changes with spurs, and loss of disc space height. (*Id*. at 18-19). The emergency room did not measure Employee's Glascow Coma Score on admission, "indicating very low suspicion for a closed head injury." (*Id*. at 23). The CT scan did not rule out a concussion but "it puts it in the -- in the lowest grade of head trauma possible." (*Id*. at 24). The diagnosis of a nondisplaced hamate

fracture in the emergency department was factually incorrect because a March 2, 2022 CT scan showed the hamate was intact. (*Id*.). Dr. Bauer stated the radiologist for the March 2, 2022 CT scan was more likely to be correct than PA Frangiosa in her April 7, 2022 record. (*Id*.). The May 14, 2022 cervical spine showed small, broad posterior disc bulges at C3-4, C4-5, C5-6, but not at C6-7, which are consistent with degenerative changes and not by the type of trauma Employee sustained. (*Id*. at 25). Disc bulges cannot be caused by trauma. (*Id*.). The May 14, 2022 MRI noted cauda equina nerve root clumping above the level of L4-L5 is "consistent with the congenital spinal stenosis having been present for a significant period of time. If you squeeze the nerves at L4-5, what will happen is that there will be inflammation above it. It's not something that would occur between the dates of February 22 and May 14. Ninety days is not enough to cause that to happen. That's something that happens over years of time." (*Id*. at 25-26). Employee indicated his pain was 10 out of 10 and his symptom diagram showed pain throughout his body, which is "inconsistent with any known physiologic process that could have arisen from the ground level fall." (*Id*. at 28). Dr. Bauer stated it has been scientifically shown by an award-winning extensive five year study by Dr. Carragee in 2006 of thousands of patients with preexisting degenerative disease who had falls of greater than 30 feet, motor vehicle accidents of greater than 60 miles per hour, and lifting incidents, and by Matsumoto in Japan in a study of the neck comparing individuals with severe flexion extension injuries to the neck in very high speed motor vehicle accidents compared to the general population, and none of them, except those involved in workers' compensation claims, had long term or short aggravation; the clinical courses were the same in the non-secondary gain population and the degree of symptoms were higher in the litigious population but the objective findings were exactly the same. (*Id*. at 31-34). Dr. Fix's finding of "sensation intact bilaterally throughout upper and lower extremity with the exception of right C8 distribution and left C7 distribution and right L5, S1 distribution, an entire left leg which has decreased light touch and pinprick" in 2023 would not be "subjective findings" if they included Employee's entire left leg because it would be a "non-physiologic finding." (*Id*. at 35). Dr. Bauer noted the examination occurred months after his examination and would be consistent with the natural progression of a degenerative condition that would have occurred regardless of his ground level fall at work. (*Id*.). When asked if those were objective findings or not, Dr. Bauer stated, "If someone other than Dr. Fix noted that, then yes. It was not noted in my examination. And to the best of my knowledge, it was not noted on the SIME. (*Id*.

at 35-36). Dr. Fix's noted absent left Achilles reflex would be an objective finding "if there was pathology at L5-S1, but there's not. I've seen a lot of patients that have seen Dr. Fix, and her exam always seems to be more severe than any other physician." (*Id*. at 36). When asked if Dr. Bauer doubted Dr. Fix's ability to do a general examination, Dr. Bauer stated:

> What I'm saying to the Board is a physical examination, a diagnosis, is like a jigsaw puzzle, and you get a lot of pieces, some of which don't fit the objective findings. So if the pathology was at L4-5, which could affect either the L4 or the L5 nerve root, and there's a diminished reflex at S1, it doesn't fit. So whether it's there or it doesn't -- and it isn't there, and we'll leave Dr. Fix's abilities out of this, it still doesn't fit. It's an objective, irrelevant finding. (*Id*. at 36-37).

Dr. Fix's diagnoses of congenital spinal stenosis and lower lumbar disc protrusion causing moderate increase in stenosis was "the same thing" because a small protrusion occurring with aging in people with congenital stenosis further diminishes the diameter of the bony canal and leads to earlier symptoms, which would have occurred regardless of the work injury. (*Id*. at 37). Dr. Bauer stated ESI have very little efficacy in congenital spinal stenosis and if there is a lack of response, it is not diagnostic. (*Id*. at 38). The continued splinting of Employee's left hand after the CT scan showed no break or soft tissue swelling was unnecessary and increased Employee's belief that he had an objective, significant injury when he did not. (*Id*. at 39). Dr. Janowski found minimal displacement but that was not found by the radiologist, and he would "take" the neutral neurologist opinion every time. (*Id*. at 43). If there had been a minimal displacement, a short-term cast would have been reasonable. (*Id*.). The trigger finger diagnosed on April 21, 2022 is not consistent with the fall because edema on the back or dorsal aspect of his hand would indicate he struck his hand on the ground and the A-1 pulley is on the palmar surface of the hand and a nodule takes a long time to develop. (*Id*. at 44-45). Reversal of cervical lordosis is an indication of degenerative disc disease in the neck or positioning in the x-ray; it is not reflective of an injury as spasm due to an injury would cause the lordosis to increase. (*Id*. at 45-46). Employee's decreased lordosis is "a part of the puzzle that points to his preexisting degenerative changes and not any effects of the ground level fall." (*Id*. at 47). Dr. Bauer agreed with Dr. McCormack's report in "that the disability would end within three to four months of the incident, that there was no evidence of severe closed head injury, that the cervical MRI showed age-appropriate degeneration, that there was no requirement for spinal surgery as a result of the work injury." (*Id*. at 55-56).

98) On August 22, 2025, Employee reported significant improvement in pain following the L4-5 decompression surgery, "describing it as night and day change" at Reger Physical Therapy (Reger) . He noted he still got numbness and tingling in his lower extremities though.

> **Comments** Musculoskeletal:
> Lumbar flexion: fingertips to patella with mild tightness.
> Lumbar extension: stiffness noted.
> Left side bend: tightness about 6 fingerbreadths above patella.
> Right side bend: stiffness about 5 fingerbreadths from patella.
> Incision site appears well-healed.
> Tenderness on left paraspinals, more than right.
> Tenderness of bilateral quadratus lumborum.
> Neurological:
> Left: great toe and tibialis anterior 3/5.
> Right great toe 5/5, tibialis anterior 4/5.
> Left glute medius strength 3/5.
> Right glute medius strength 4/5.
> Left hamstring: pain.
> Right hamstring strength 4/5.
> Left hip flexor: pain
> Right hip flexor strength 4/5.
> Left quad strength 3+/5.
> Right quad strength 4+/5.
> Sensation diminished L2, L3, L4, L5, S1, S2 on left.
> Left Achilles tendon reflex diminished.
> Left patella tendon reflex diminished.
> Right patella and achilles reflex intact.
>
> The patient presents with low back pain with mobility deficits. Clinical examination reveals limitations in lumbar AROM, diminished sensation in LE, weakness in LE, and absent reflexes. Functional limitations include difficulty with ending forward during ADLs, limitations in bed mobility and limitations with leisure activities. The patient tolerated treatment well with improved pain free lumbar AROM and decreased palpable pain and without adverse events. The patient is expected to benefit from skilled physical therapy services to address impairments, restore function, and promote independence. (Reger records, August 22, 2025).

99) On August 25, September 11 and 17, and October 1 and 8, 2025, Employee attended physical therapy. (Reger records, August 25, September 11 and 17, and October 1 and 8, 2025).

100) On August 28, 2025, Employee told Dr. Fix he had excellent relief of the shooting pain down his legs. He had numbness from time to time in his buttocks and at the bottoms of his feet. It was not constant and was possibly related to activity. Employee weighed 340 pounds and felt

his strength was back to normal. He wanted to discuss options for his neck as he had daily neck pain and wanted to consider more permanent options for it. Employee walked with a normal station and gait. Dr. Fix said Employee could follow up after physical therapy was completed to discuss options for his cervical spine, he "may be a good candidate for cervical laminoplasty." (Fix record, August 28, 2025).

101) On October 9, 2025, Employer filed a Notice of Intent to Rely with a surveillance report written by Scott Coronado from Denali Investigations of Alaska and two surveillance videos. The surveillance report is not dated. It states Coronado conducted surveillance of Employee on October 19 - 23, 2022. He concluded:

> Denali Investigations had concluded, over the course of several day's surveillance of Mr. Apaisa, he presented as favoring an injury and used a cane to walk, while at his medical evaluation appointment, however, the day's following his medical appointment, Mr. Apaisa walked, leaned/bent over, drove, obtained mail from the neighborhood mailbox and carried items to/from his truck, showing no signs of being hindered by an injury. Mr. Apaisa talked with neighbors in his driveway, where he fist-bumped, smiled, laughed[,] and walked about the driveway in a normal manner. Mr. Apaisa, in the days following his medical evaluation, did not use a cane to walk. (Notice of Intent to Rely, November 9, 2025; Coronado Investigative Surveillance Report, November 9, 2025).

The surveillance video shows Employee used a cane in his right hand while walking slow in a parking lot from the passenger side of his truck to a building and then back to the passenger side of his truck on October 19, 2022; Employee walked without a cane and sunglasses and "fist bumped" and spoke with other men for over 10 minutes while standing in his driveway without a cane and sunglasses outside his home, he carried an item from his home to his truck without a cane or sunglasses, and he drove his truck on October 20, 2022; Employee did not use a cane or wear sunglasses outside his home on October 21, 2022; Employee bent over to reach a mail box above his knees without sunglasses or a cane, drove thru the drive thru at KFC, and did not use a cane or sunglasses to walk outside his home on October 22, 2022, Employee did not wear sunglasses or use a cane to walk outside his home while carrying items from his truck to his home and Eunice lifted their child from the truck and carried her into their home on October 23, 2022. (Surveillance Videos, October 19-23, 2022).

102) On October 9, 2025, Dr. McCormack testified he is a neurosurgeon and he performs about 200 spinal surgeries a year; he has been on the Board's SIME list for over 20 years. (Deposition

of Bruce McCormack, MD, October 9, 2025 at 8). When asked if there was anything that stood out to him as significant "in terms of his findings," Dr. McCormack noted Employee had a lot of symptoms and was extremely limited in what he could do. (*Id.* at 9). Employee had breakaway weakness, his nurse had to help Employee get dressed, and he thought Employee had the capacity to dress himself. (*Id.*). Employee declined to squat, kneel, and hop; he was wearing sunglasses, wrist, and hand splints, and ambulated with a cane. (*Id.*). He winced and had a lot of pain complaints and Dr. McCormack's examination was very limited as he could not get Employee to lay flat on the table. (Id. at 9-10). Dr. McCormack thought there were some inconsistencies. (Id. at 10). He read NP Green's June 28, 2024 record and it was not accurate with his recollection of his examination of Employee as Employee never laid flat; he laid in a three-quarter prone position on the exam table, so he could not perform a straight leg raising test. (*Id.* at 10-11). Dr. McCormack did not recall anything like the pounding with force on the top of Employee's head, "That's not something we would do." (*Id.* at 11). Wadell signs involves putting your hand on the top of the head and seeing if it caused low back pain, "It's a sign of -- it's a non-physiologic finding." (*Id.*). I reported it was positive with axial compression, so Dr. McCormack was certain he put his hand on Employee's head. (*Id.*). He did not pound on the top of Employee's head with force, "I mean, the idea of the test is light pressure or light touch on the top of the head doesn't provide enough weight that it should cause low back pain. And if someone reports that putting your hand on the top of the head is worsening their low back pain, it just means the symptoms are not anatomic or physiologically based. (*Id.*). Employee's complaint of shocking pain from his neck to his lower back, radiating down into his left leg to ankle is a positive Wadell sign and does not make sense in terms of anatomy or physiology. (*Id.* at 11-12). Dr. McCormack did not recall Employee reporting to him it felt like he was being tortured and he would note that if someone told him that. (*Id.* at 12). Employee did not inform Dr. McCormack that he was injured during the course of his examination. (*Id.* at 13). The spinal MRI findings were degenerative related, and the narrowing of the nerve channel has a congenital component. (*Id.* at 14). Persons from the South Pacific have a higher incident of congenital spinal stenosis, "It's a hereditary risk factor for a smaller nerve channel, more likely to develop nerve symptoms later in life." (*Id.* at 14-15). Dr. McCormack thought the decompressive surgery "would set [Employee] on a bad path," it was not indicated, and it was not due to the work injury. (*Id.* at 15). He did not think Employee was a candidate for neck or back surgery, "I

just thought that there's no pains that can't be made worse with surgery. He does have some findings on his MRIs, but I think surgery would -- would lead him on a bad path based on his exam, his reported symptoms, the duration of symptoms, and the disc-associated disability." (*Id.* at 15-16). When asked if knowing Employee had an "L4-5 decompression surgery on June 3, 2025" changed his opinion, Dr. McCormack stated, no because if you aggravate spinal stenosis, it should cause radicular symptoms pretty quickly and there was no documented left leg radicular symptoms until a year later on April 12, 2023. (*Id.* at 16). He does not think the surgery is related to the work injury. (*Id.*). Employee's use of a cane on August 22, 2025, in Dr. Barrington's record is not typical for somebody who is more than two and a half months post-surgery. (*Id.*). Dr. McCormack reviewed Dr. Kimmel's report, and he agreed that there was a large functional component, so he agreed with the diagnosis of conversion disorder. (*Id.* at 17-18). He does not usually diagnosis it, but he is familiar with what it is. (*Id.* at 18). Dr. McCormack felt that there was something going on that was not musculoskeletal; he thought that there might be a psychiatric or psychological component. (*Id.*). He would defer to psychiatric or psychological providers for hose diagnosis. (*Id.*). Dr. McCormack was not provided with Dr. Fix's records. (*Id.* at 20-21). His opinion of the surgery is based upon his review of records provided for and the examination of Employee over a year ago. (*Id.* at 21). It is not beyond the possibility that radicular symptoms can show up later after an injury. (*Id.* at 23). The ESI was not diagnostic, "for therapeutics, but the problem is when you inject people with steroids, there's a stress hormone, and you feel good afterwards. And you know, the benefit may not be from resolution or radicular symptoms. It may be there -- there's some systemic effect. So it's not a perfect diagnostic test. I mean, ideally, it's a nerve root block with an anesthetic for pain relief for the duration of the anesthetic." (*Id.* at 24-25). Dr. McCormack believed the work injury caused a temporary aggravation, sprains, and strain but it did not cause the left leg sciatica so surgery for it is unrelated to the work injury. (*Id.* at 26). When asked if he "had no opinion" that the decompression surgery was inappropriate, Dr. McCormack answered, "No." (*Id.* at 26-27). He did not know if the decompression "was an appropriate thing to do," "I mean, he had a lot -- he had a lot -- a lot of symptoms when I saw him. And even when there's stenosis, surgery may not be a good path. At the time I saw him, I didn't think he was an appropriate candidate for surgery. Now, that was a year ago, and I didn't see the connection of stenosis surgery to the incident." (*Id.* at 27). Dr. McCormack was not criticizing the physician for doing the surgery

and he hoped it was successful and provided relief. (*Id.*). If it provided relief, Dr. McCormack agreed it was a good thing to do. (*Id.*). If Employee got benefit from the surgery, it would indicate that the stenosis was a contributing factor to his symptoms. (*Id.* at 30).

103) On October 15, 2025, Employee attended physical therapy and the record noted "this will have to be his last session until his attorney gets his work comp situation figured out." (Reger record, October 15, 2025).

104) On August 19, 2025, Flanigan entered his appearance on behalf of Employee. (Entry of Appearance, August 19, 2025).

105) On October 22, 2025, at 3:55 p.m. Alaska Time, Employer filed a hearing brief by email contending the substantial cause of Employee's orthopedic complaints, his preexisting and degenerative congenital spinal stenosis and the cause of head injury and concussion complaints is his preexisting psychological issues based upon Drs. Bauer's, Chong's, Villanueva's, Kimmel's, and McCormack's opinions. It also contended Employee's head injury and concussion complaints are not supported by objective findings. Employer contended Dr. Flanum opined Employee had a congenitally narrow spinal canal and the timing of the disc bulge was unknown and he would not attribute the neck symptoms to the work injury. It contended Dr. Fix did not review Employee's entire medical record and there was no indication she had any knowledge of his medical history. Employer contended Employee is an unreliable and a poor historian, denying prior symptoms when there is medical evidence showing otherwise. Employer contended Employee failed to present any opinion showing the work injury is the substantial cause of his need for low back surgery or ongoing neck pain. It contended Employee is not entitled to PPI benefits because Drs. Chong, Bauer, Villanueva, and Kimmel opined he had no ratable impairment related to the work injury and his medical providers assessed no ratable impairment related to the work injury. Employer contended Employee was found medically stable for his left wrist on June 7, 2022, and the trigger finger is not related to the work injury. It contended Dr. McCormack's three percent PPI rating should be given less weight than the other providers because his specialty is the spine. Employer contended its controversions are based upon substantial medical evidence and were filed in good faith. It contended Employee is not entitled to penalty or interest because no benefits are due. Employer contended Employee failed to prove his claim by a preponderance of the evidence and requested his claim be denied. (Employer's Hearing Brief, October 22, 2025).

106) On October 22, 2025, at 6:14 p.m. Alaska Time, Employee filed a hearing brief by email and served Employer with the hearing brief with the same email. He contended the October 29, 2025 hearing was premature because it was scheduled before his attorney entered the case and Employee was not medically stable as he is still treating and making progress on his neck and it would be more appropriate to have a hearing when he reaches medical stability in the opinion of his medical providers, which may occur in in a few months. Employee also contended Employer would not be prejudiced by a delay because benefits are controverted. Alternatively, he requested benefits be awarded if the panel decides to go forward with the hearing. Employee requested orders awarding TTD and medical benefits from the date of the controversion forward. He contended Dr. Barrington's PPI rating was premature because his medical treatment was ongoing. Employee requested minimum attorney fees be awarded under AS 23.30.145(a). He contended he was able to work for seven years before the work injury before the work injury and was only unable to work following the work injury. Employee contended the medical record and Employee's steady work history "supports the reasonable conclusion" that the work injury caused the bulging disc which caused pain symptoms due to a preexisting stenosis. He contended that his pain symptoms diminishing after Dr. Fix performed a surgical decompression with a partial discectomy further supports the bulge was work related. Because Employee only needs to prove that "but for" the subsequent trauma he would not have suffered disability at this time, or in this way, or to this degree under *Traugott*, he should prevail on his claims. (Email, October 22, 2025; Employee's Hearing Brief, October 22, 2025).

107) On October 23, 2025, Dr. Barrington assessed a four percent whole person PPI rating under the *AMA's Guide to the Evaluation of Permanent Impairment*, Sixth Edition, 2024:

> The MRI study on March 3, 2025 of his lumbar spine showed severe stenosis at L4-5 partially due to short pedicles, a congenital condition, but also showed a small to moderate disc bulge resulting in severe central canal stenosis. This is concurrent with the findings from the CT on March 14, 2022. It is my opinion that although the patient had lumbar stenosis, it was not activated until after he had his fall and subsequent disc bulge. The August 17, 2024, MRI report of the cervical spine showed mild canal stenosis at C6-7 and the multiple level of IVF stenosis at C4-5 on the right and C5-6 on the left. His Pain Disability Questionnaire score is 130/150.
>
> . . . .

> Single level lumbar stenosis with symptoms of bilateral hip pain with radiating pain into the buttocks. 17-20-10, Class D: 4% Whole Person Impairment.
>
> Mr. Apaisa has pre-existing DJD with canal and IVF stenosis which was aggravated by his fall but has resolved with residual symptoms of stiffness and pain: 0% Whole Person Impairment. (Barrington record, October 23, 2025).

108) On October 23, 2025, Meshke "put a couple of things on the record" before taking Dr. Villanueva's deposition:

> Mr. Flanigan is not present. Before we went on the record, both Leslie Marshall, the paralegal for Mr. Flanigan, and Mr. Apaisa were logged into the Zoom call.· Les- -- Ms. Marshall, the paralegal, came -- advised that Mr. Flanigan is -- has pneumonia and is en route to the hospital. She did not make any request specifically, other than to relay that she was instructed to log off and would not be participating. She also instructed Mr. Apaisa to log off. I advise at this time, this is the time set for the deposition of Dr. Villanueva pursuant to Mr. Apaisa's request for cross-examination. In light of the fact that we have hearing going -- a hearing scheduled for October 29th, we're going to go ahead and move forward with the deposition.· And I don't believe there was any – any further requests or anything by Ms. Marshall before she disconnected from the line. (Videotaped Videoconference Deposition of Michael R. Villanueva, PsyD., October 23, 2025 at 5).

Dr. Villanueva testified he is a board-certified neuropsychologist and a member of the American Academy of Neuropsychology. (*Id*. at 6). He earned his doctorate at Baylor University, with a subsequent internship at the Portland VA Medical Center and postdoctoral fellowship at the Oregon Health Sciences and University. (*Id*. at 7). Employee told him he may have lost consciousness for a few seconds when he slipped and fell. (*Id*.). Employee told Dr. Villanueva he noticed cognitive symptoms two or three weeks after the work injury. (*Id*. at 8). Such a delay is unusual because, "If a person has a true concussion, there's a period of confusion and difficulties with attention, et cetera, in the immediate aftermath of the blow to the head. The history that is expected from then is that there's gradual improvement, not onset two weeks post. (*Id*. at 8-9). Employee indicated his complaints got worse with time, "which is also a typical and unexpected." (*Id*. at 9). When asked about the normal course of recovery after a head injury like Employee sustained, Dr. Villanueva answered, "So his -- his head injury from parameters that are important in terms of estimating outcomes was -- was very mild. So one might anticipate some confusion and problems with attention in the hours or weeks after the event. No study

using meta-analytic methods has demonstrated difficulties beyond three months following such an injury." (*Id.*). There was no indication from an objective standpoint of any significant TBI based on the head CT and brain MRI; imaging was always characterized as normal or unremarkable. (*Id.* at 10). When asked to summarize his findings, Dr. Villanueva stated,

> Performance validity testing is a way that neuropsychologists assess whether or not a person is trying their best on testing. And so if there is definitive evidence on performance - on any aspect of performance validity testing of less than full effort, then you are not able to interpret scores that fall below average as being indicative of acquired deficit. So in other words, a score that falls at the10th percentile in your test battery does not -- you can't interpret that as being evidence of a neurological syndrome, because it could very well be explained by effort, and you've already established with the performance validity testing that effort was not always full. In our testing, it was very definitive on one sensitive measure of performance validity that he was not trying his best. And so that way -- given that, we were only able to interpret scores that fall within the average range as being indicative of at least average abilities. So what we do know is that his visual memory, for example, was completely normal. We know that his language was normal, as assessed by fluency tasks and confrontation naming. He demonstrated normal executive function in terms of complex sequencing and inhibition of response. So there were multiple measures that were within normal limits, which is what one would expect, given the nature of the injury. (*Id.* at 10-12).

Employee reported he forgot his wife's name a couple times and that is not a neurological symptom. Except in the most catastrophic injuries where the person is "essentially comatose for many months" the person does not "forget that type of over-learned material." (*Id.* at 12). The performance validity Dr. Villanueva performed on Employee indicated "he was not always trying his best on testing." (*Id.* at 13). Dr. Villanueva did not find Employee credible that he had forgotten his wife's name. (*Id.*). When asked to explain "RTA" and "PTA," he stated:

> So if you have a -- a blow to the head from, you know, a slip and fall or even from a very severe injury, whatever that may be, so you have the point of time when you have the blow to the head. Then you have the period of time prior to hitting your head. That's -- remembering that is retrograde amnesia -- or not remembering that is retrograde amnesia. And then after the blow to the head, there's a period of time for some people where they don't remember information. Well, that's posttraumatic amnesia. So it's retrograde amnesia, point imta -- point of impact, and then posttraumatic amnesia. In a true, significant brain injury, the person can't remember the event itself, and they also can't remember a period of time prior to the event and a period of time after the event. (*Id.* at 14-15).

In this case, it indicated to Dr. Villanueva the injury was mild. (*Id*. at 15). The Glasgow Coma Scale (GCS) would have been 15 because Employee was able to get himself off the ground, to remember conversations he had, and to drive himself home. (*Id*.). Studies looking at people who have had mild traumatic brain injuries who later report psychological conditions generally demonstrate that there are preexisting psychological factors or other stressors, other explanations besides mild TBI. (*Id*. at 16). People who have much more severe traumatic brain injuries actually report less psychological distress than the people who have lingering subjective symptoms following the concussion suggesting it is not the head injury active in those cases. (*Id*.). Dr. Villanueva expected the mild head injury in this case to result in neuropsychological symptoms no more than weeks to three months at most. (*Id*. at 16-17). He was not able to confirm any evidence of neurocognitive impairment based upon his direct examination of Employee. (*Id*. at 17). Dr. Villanueva said there was no reason for Employee to have neuropsychological symptoms this long after the work injury. (*Id*. at 18). For a mild head injury, the anticipation is symptoms, if any very early on, then complete recovery to baseline. (*Id*. at 19). Employee's light sensitivity is a "nonspecific complaint" and "it is not necessarily meaningful from an objective neuropsychological sense." (*Id*. at 19-20). Dr. Villanueva would defer to ophthalmology regarding credibility of the light sensitivity Employee reported and said, "I would say that in my experience with many individuals who've had much more severe brain injuries than suffered by this gentleman, it's very unlikely." (*Id*. at 20). He reviewed Dr. Kimmel's SIME report and agreed that was not evidence of a neurocognitive disorder associated with the work injury, although he found his report to be contradictory at times regarding Employee's effort being okay and then in the next paragraph saying there was some evidence of poor effort. (*Id*. at 22-23). Dr. Villanueva also agreed that the greater than 50 percent associated with nonindustrial factors as the substantial cause of Employee's disability and Employee's preexisting psychiatric issues are the substantial cause of his disability and need for medical treatment. (*Id*. at 23). He did not agree with Dr. Kimmel's five percent PPI rating because Dr. Kimmel was again being internally inconsistent in saying that Employee displayed mildly impaired working memory, processing speed, and inconsistent work learning but also indicated there was evidence of poor effort when he assessed verbal memory. (*Id*. at 25). Dr. Villanueva would not find any indications for impairment at any percentage related to the work injury. (*Id*.).

109) On October 24, 2025, Employee requested a continuance of the October 29, 2025 hearing, contending his attorney was sick with double pneumonia and could not present Employee's claim as "Any amount of talking brings on severe coughing and it hurts to breathe." He attached an October 24, 2025 letter. (Petition, October 24, 2025).

110) On October 24, 2025, Charles Sather, NP-C, authored a letter "To Whom It May Concern" stating, "Mr. Michael Flanigan was seen in the VA ER on 10/23/2025 and diagnosed with pneumonia to bilateral lungs. Please excuse from work from 10/23/2025 through 11/02/2025. Veteran may return to work on 11/03/2025 without restrictions." (Sather letter, October 24, 2025).

111) On October 27, 2025, Employer stipulated per 8 AAC 45.074(b)(1)(C) that the standard of good cause has been met. (Employer email, October 27, 2025).

112) On November 5, 2025, Employee reported dull and aching lower back pain, with burning sensation into his buttocks. It persisted since surgery but was overall improving. He had stiffness between his shoulder blades and upper back with cervical range of motion restriction in all planes. Employee had no pain radiating into his upper extremities and said his headaches occurred randomly in his temporal area. He used a cane on his right mostly for balance and wore dark glasses. Employee performed pre-long-form assessment with the interactive metronome, successfully completing all 14 exercises. Dr. Barrington recommended a 15 session training with the goal of reducing frequency and intensity of headaches and improvement of thought processes including finding words. (Barrington record, November 5, 2025).

113) On November 25, 2025, the parties agreed to schedule an oral hearing on February 3, 2026, and the issues for hearing included "Employee's April 21, 2023, WCC for TTD and PPI benefits, Medical and transportation costs, Unfair controversion, Interest, Penalty, and Attorney fees/costs." The designee directed the parties to serve upon all parties and file with the Board witness lists and hearing briefs by 5:00 p.m. Alaska Time on January 27, 2026, and exhibits or other documentary evidence by 5:00 p.m. Alaska Time on January 14, 2026. (Prehearing Conference Summary, November 25, 2025).

114) On December 9, 2025, Employee reported improvement in cervical pain and restriction after the last treatment, and not having any more sharp shooting pain. His lower back pain improved significantly since surgery although he still had numbness across his hips and buttocks. Employee was able to walk more and occasionally go to the mall and shop with his wife. He

was able to read with his daughter more often and for longer periods without stopping due to pain. Dr. Barrington provided cervical traction therapy. (Barrington record, December 9, 2025).

115) On December 16, 2025, Employee reported reduction in intensity of headache, although it was "still at the back of his head and uncomfortable thoracic pain which has been accompanied by a sensation of gas." Dr. Barrington provided cervical traction therapy. (Barrington record, December 16, 2025).

116) On January 21, 2026, Employer filed a notice of intent to rely with deposition transcripts for Dr. Flanum's August 10, 2022 medical appointment, Employee's September 6, 2023 deposition, Dr. Bauer's August 20, 2025 deposition, Dr. McCormack's September 10, 2025 deposition, and Dr. Villanueva's October 23, 2025 deposition. (Notice of Intent to Rely, January 21, 2026).

117) On January 27, 2026, Employer filed a thumb driving with the September 6, 2026 videotaped deposition of Employee. The certificate of service shows it was served upon the Board by United States Postal Service and on Employee's attorney by email on January 27, 2026. Employee wore dark sunglasses and a suit and tie with a hat to his deposition. (Notice of Intent to Rely, January 27, 2026; Recording; September 6, 2026).

118) On January 27, 2026, Employee objected to consideration of the video-taped deposition of Employee, contending it was filed late, after the evidence deadline in the November 25, 2025 Prehearing Conference Summary. He contended the certificate of service stated it was served on Employee to an address in Sparks, Nevada on January 27, 2026, "which is almost guaranteed to not show up before the hearing." Employee contended the late filing did not give his attorney sufficient time to review it, compare it to the deposition, and go over it with Employee in preparation for his testimony at hearing. He contended it would violate his due process rights. Employee requested his video-taped deposition be excluded. (Notice of Employee's Objection to the Use of the Employee's Video Taped Deposition at the 2/3/2026 hearing, January 27, 2026).

119) On January 27, 2026, Employee objected to consideration of the deposition transcript of Dr. Villanueva, contending his attorney could not attend the deposition because he was on his way to the hospital with a medical emergency. He contended Employer continued with the deposition after it was provided notice Employee's attorney could not attend. Employee contended it would violate his due process right to use it as evidence because he was deprived of

his right to cross-examine Dr. Villanueva. He contended Employer had sufficient time to reschedule Dr. Villaneuva's deposition and failed to do so. (Notice of Employee's Objection to the Use of the Deposition Transcript of Dr. Villanueva's Deposition at the 2/3/2026 Hearing, January 27, 2026).

120) On January 27, 2026, Employee objected to consideration of the deposition transcripts filed by Employer on January 21, 2026, contending Employer failed to file them by the deadline in the November 25, 2025 Prehearing Conference Summary. He argued that the November 25, 2025 prehearing conference set the date for filing and service a list and copies of evidence to be relied on for the February 3, 2026 hearing by no later than January 14, 2026, and Employer filed the Notice of Intent to Rely after the deadlines, on January 21, 2026. Employee requested an order excluding the deposition transcripts from consideration. (Notice of Employee's Objection to the Use of Evidence Submitted by the Employer After 1/14/2025 Date Set in 11/25/2025 Prehearing Conference, January 27, 2026).

121) On January 27, 2026, Employee filed a hearing brief contending he provided sufficient evidence to entitle him "to a presumption of coverage." He contended Dr. Flanum diagnosed his back symptoms as related to a disc injury pressing on nerve roots on September 7 and October 5, 2022, and she recommended a L4-5 laminectomy for the stenosis to relieve the pressure the disc bulge created. Employee contended the partial discectomy Dr. Fix performed relieved the pressure on Employee's nerve roots which caused cessation of leg pain with only minor numbness remaining, which may reduce overtime. He contended this proves his disabling back symptoms were caused by a bulging disc caused by the work injury and not the preexisting stenosis. Employee contended the stenosis made him more susceptible to back pain if he injured a disc and the cause of the bulging disc was the work injury because there is no evidence he had a bulging disc prior to the work injury. He contended that while Dr. McCormack's opinions were not entirely consistent with Dr. Fix's, Dr. McCormack testified at deposition that people with congenital spinal stenosis would be more at risk for the need for spinal surgery because they already have a narrowed space in their vertebrae for the spinal cord, spinal injuries can worsen over time and that it was not beyond possibility that radicular symptoms show up later after an injury, there is nothing surprising about getting depressed and suffering from depression and similar mental problems if you are in pain for years, he was not criticizing the physicians for performing the surgery and he hoped it provided relief, and if it did provide relief, that was a

good thing to do. Employee contended that if he only suffered a temporary strain from the work injury, that it would not be expected to cause a disc bulge and to cause years of pain. He contended he was not receiving benefits during most the period, "so he had no financial incentive to not go back to work." Employee reiterated his arguments from his October 22, 2026 hearing brief. He requested orders awarding TTD benefits from the date of the controversion forward, requiring Employer to pay for Employee's medical treatment from the date of the controversion forward, awarding him the four percent PPI rating from Dr. Barrington, interest on TTD and PPI benefits awarded, unpaid medical expenses, and the 10 percent minimum attorney fees under AS 23.30.145(a) for all benefits paid, plus paralegal fees based on the hourly rate of $120. (Employee's Hearing Brief, January 27, 2026).

122) On January 27, 2026, Employee filed an affidavit by paralegal Leslie Marshall itemizing 50 hours of paralegal work from August 19, 2025 to January 24, 2026. (Affidavit of Leslie Marshall, January 27, 2026).

123) On January 27, 2026, Employer filed a hearing brief incorporating its October 22, 2025 hearing brief. It contended Employee filed his October 22, 2026 hearing brief late and objected to its consideration. Employer contended Drs. Flanum's and Barrington's opinions are not credible because they are based upon Employee's representations that he had not had symptomatic back pain prior to the work injury. It contended Employee has no documented cognitive disorder, raising substantial credibility issues. Employer contended there was no objective evidence corroborating Employee's continued use of dark sunglasses and a cane. It contended Employee's lack of credibility should apply to him relating all back pain to his work injury when there is medical evidence that it was a symptomatic preexisting condition. (Employer's Supplemental Hearing Brief, January 27, 2026).

124) On February 3, 2026, Employee filed with an email dated February 2, 2026 at 6:10 p.m., a Social Security Administration Retirement, Survivors and Disability Insurance Notice of Award letter dated December 14, 2025, stating they found he became disabled under their rules on February 22, 2022, the first month he became entitled to benefits was August 2022, with the following benefit amount before deductions or rounding down to the nearest dollar $1,294.70; and he would begin receiving $1,145 for December 2025. (Email, February 2, 2026; Social Security Administration Retirement, Survivors and Disability Insurance notice of award letter, December 14, 2025).

125) On February 2, 2026, Employer filed a notice stating Employer would be taking Dr. Villanueva's continued deposition on March 3, 2026. (Notice of Taking Continued Videotaped Deposition of Michael R. Villanueva, Psy.D, February 2, 2026).

126) On February 3, 2026, Dr. Fix testified she is a board-certified neurosurgeon. She first saw Employee as a new patient in October 2023; he complained of weakness in his right arm and both leg and hand numbness. She diagnosed pretty severe spinal stenosis at L4-5, which is narrowing in the spine, and a disc protrusion that made the narrowing worse. Dr. Fix removed tissue and bone to make more room for Employee's nerve in the June 3, 2025 surgery. Employee's symptoms improved after surgery as his leg and back pain were much better and the nerve pain in his legs was better. Dr. Fix believes the work injury is the cause of Employee's need for surgery based upon his ability to work for six years prior to the work injury and his inability to work afterwards due to his severe symptoms. After physical therapy is completed for Employee's back, she was going to discuss possible treatment of Employee's cervical spine with him. Employee clearly needed surgery because the stenosis in his back was pretty severe and did not allow him to carry on with normal activities. Had the surgery been completed sooner, it would have allowed for an easier recovery. The surgery was reasonable and necessary. Dr. Fix believed Employee was referred to her but could not recall specifics about the referral. She did not recall whether Employee informed her he experienced back pain prior to the work injury or whether she asked him about it; but it is very likely she did and sometimes she notes it in her records if she believes it is significant. She cannot say how or when the disc protrusion occurred or changed due to the work injury without imaging prior to the work injury; the history and the patient's activities is more important. If he was not working after the injury, you assume something happened. Employee has congenital stenosis, which many people have but do not necessarily have symptoms. But when Employee developed radicular pain or pain that prevents him from performing normal functions, the assumption is something changed. All it takes is a minor change in the disc protrusion to trigger impingement on the nerve roots because the space is small. It is typically an acute event that triggers symptoms in patients with that type of anatomy. The presumption is that the fall changed something in that disc that brought him in for treatment. Dr. Fix "had no doubt that he had preexisting disease" and he could have had some radiculopathy at some point in his life, but part of Employee's history told her that he had done pretty heavy work before the work injury without any difficulty. A disc bulge is less severe than

a disc herniation. Chronic protrusions or herniations do not necessarily cause symptoms. It is an acute change that often triggers the need for treatment; it is physically triggered by an event. Employee's ability to work before the work injury and his inability to work after the work injury strongly suggests that there was a trigger for the progression of symptoms and then he had physical findings to go along with that, which he did not describe as a chronic condition to her, such as numbness and inability to use his leg. Dr. Fix did not recall reviewing anyone else's records about Employee, including Dr. McCormack's report. She last saw Employee in August 2025; she referred Employee for post operative physical therapy. Dr. Fix did not recall whether she referred Employee to Dr. Barrington for a PPI rating. She did not know why she had not seen Employee since August 2025 and did not know if there was an appointment scheduled in the future; she assumed Employee was going to follow up with her because they were going to discuss other insurance. Dr. Fix did not recall seeing any documentation from Dr. Flanum about Employee's neck. She would have to see Employee again before additional treatment, but they had discussed the possibility of a cervical laminoplasty to improve his canal diameter in his cervical spine due to his neck symptoms and the congenital stenosis. Repeat imaging would most likely be performed because his images are several years old; he had moderately severe mid-cervical spine narrowing. She could not answer whether Employee had any protrusions in his cervical spine without looking at the imaging. Dr. Fix would need to reevaluate Employee to say whether the cervical spine treatment was related to the work injury but "would assume so." (Fix).

127) On February 3, 2026, Dr. Barrington testified that he graduated from the University of Alaska Anchorage with a bachelor's degree, attended chiropractic school in Davenport, Iowa, graduated in 1983, and has been a chiropractic physician in Anchorage since that time. He first met with Employee on April 1, 2025, when he came in for a consultation and brought some imaging discs. Dr. Barrington scheduled him for a formal evaluation on April 4, 2025, when Employee provided a history of a slip and fall outside of his workplace, he fell on slippery ground onto his back and struck his head in February 2022. Employee's symptoms included photophobia, dizziness, egocentric vertigo when getting up out of a chair or bed suddenly, he was unable to drive, neck and upper back tenderness with radiation into his shoulder, occasional sharp pain in his left wrist, constant soreness and burning in his lower back with tingling pain occasionally going into his left leg to his foot, and increased pain with coughing and sneezing.

Dr. Barrington had gotten a referral for cognitive issues from Dr. Hines, so he assumed he was to treat Employee for his head injury. He practices functional neurology, including standard neurological testing for balance, eye movements, and other indicators to tell if a person has had either an injury or some type of deficit. Employee walked with a cane and was wearing dark glasses. He was able to stand erect, but when he closed his eyes, he lurched backwards. When Dr. Barrington pressed on Employee's head, he had pain in his neck and his upper back, but it did not radiate into his arms or hands. Spurling's maneuver, with a light tap on the top of the head, caused a shocking pain to travel through Employee's spine. He measured his neck range of motion. Employee's reflexes appeared normal in the upper and lower extremities. He had a negative straight leg test, fixation in his lumbar spine, and torsion in his hips. Employee's eye movements were fairly normal, although he did have dysmetria with difficulty standing erect and finding his nose accurately. He could not focus while looking to the left without his eyes starting to react to that. Dr. Barrington told Employee he was only going to be able to provide limited relief of symptoms because he had already had chiropractic treatment and pain management treatment, including injection therapy. He provided a spinal adjustment to reduce the pelvic torsion and gave him some eye exercises to stabilize his ocular mobility. Employee could not stand without support and move his arms and legs without restrictions, so he was not ready for interactive metronome treatment for ocular mobility. Dr. Barrington only treated Employee a few times because his lower back pain was beyond his scope of treatment as he was seeing a surgeon. He began treatment of Employee again in October after Employee was dismissed from all of his therapies. Employee was able to stand and move his arms better ,so Dr. Barrington thought he could possibly be more successful in treatment for his concussion. He examined Employee for deficits to begin interactive metronome treatment, and Employee began interactive metronome treatment. It became apparent that Employee would have break-throughs in his ability to respond to the signaling. Dr. Barrington stopped interactive metronome treatment after it became apparent Employee's head pain was interfering with his ability to perform the exercises. He put Employee on a course of neck traction to see if it would improve everything. Employee regained considerable cervical range of motion and headaches diminished. He plateaued last month. Employee recovered nicely but not completely from the effects of the concussion. Dr. Barrington recommended a home cervical traction devise because he showed enough improvement with traction. He believed the surgery was quite successful because

Employee's leg pain and his ability ambulate improved afterwards. Employee still had burning pain across his lower back. Employee's back and neck MRI findings and x-rays indicated he had premature aging to his chronological age. A slip and fall to someone like him would probably be more devastating than a person without degenerative changes. Dr. Barrington believed the disc more than likely caused Employee to be unable to work from back pain. Employee's headaches are also very restrictive to his ability to work. Dr. Barrington performed a PPI rating and used the 6th Guide 2024 Edition. It was based upon congenital central canal stenosis exacerbated by disc bulging, which likely occurred when Employee fell. Employee had a single level lumbar stenosis caused by preexisting short pedicles but exacerbated and made symptomatic by a disc bulge. Dr. Barrington arrived at a four percent whole person impairment. He reviewed one medical record from Dr. Hines. Dr. Barrington did not ask Employee whether he had any symptoms before the work injury and was not aware of any spinal medical treatment before the work injury. If Dr. Flanum wrote that the time of the disc bulge was unknown, it was probably correct. It is very difficult to age them using imaging unless you have pre- and post-images for comparison. Employee continued to use a cane for balance and wear dark sunglasses throughout treatment into January 2026; he does not have a limp. Dr. Barrington was not aware that Dr. Hines found Employee medically stable without a PPI rating for neurological issues on September 30, 2022. He deferred any PPI rating for post-concussion issues to a neuropsychologist, psychiatrist, or psychologist per the *Guides*. Dr. Barrington performed the PPI rating when he was out of town based upon electronic records that he could get; "Class D" in his rating does not sound correct. He may need to correct his PPI rating; he would have to refer to the *Guides* to see what his reasoning was for that. Employee is medically stable as of his last examination in January 2026, for his lower back. Dr. Barrington was not aware Employee reported chronic headaches in 2019, radiculopathy in 2021, and cervical and thoracic pain in 2021 but he was aware neck and back pain was reported in 2019. The lower back was a new injury that exacerbated preexisting conditions. Because Employee was working before the work injury and was not able to work after the work injury, the work injury caused his inability to work. (Barrington).

128) On February 3, 2026, Employee testified he became serious about being a mechanic in junior year in high school. He has been an auto mechanic ever since. Employee is American Samoan and moved to Alaska in late 2011. He began working for Employer in 2016. Employee

suffered from a hernia while working for Employer and did not file a claim. On the day of the work injury, he grabbed a shovel to help the new guy and slipped and fell on ice, striking his head. Afterwards, Employee felt confused and had a migraine. He went to the doctor the next day. Employee had vertigo as he felt a spinning feeling, his left hand fingers were numb and weak, he had shoulder and neck pain, and buttock numbness. He had tingling in his feet, and he dragged his left leg. Employee relied on workers' compensation benefits to pay his rent. Employer cancelled checks after they were deposited. He was the single provider for his wife and one year old daughter. In 2024, Employee exhausted his savings and credit cards; he was evicted from his apartment because he could not pay rent. His family was homeless, they lived in his truck, slept in parking lots overnight, and camped. The work injury caused Employee to lose being the father his family looked up to. He experienced anxiety and then depression, it "took the best" of him. The surgery really helped Employee's symptoms. He is able to get around the house better and is able to spend more time with his family. Employee is now able to go grocery shopping; before the surgery he could not walk long distances. He got an adjustable bed to help him get up. Employee still has headaches and neck pain after treatment. He has shooting pain in his neck and shoulders, but it is duller. Employee's migraines are controllable and not as bad. Employee's wife works from home, and they got a section eight apartment, so they manage to get by. The Social Security office was still sending mail to his general pickup address he had when he was homeless even though he updated his address. They sent the award letter to the wrong address and Employee got the letter two weeks ago. He was not aware the letter was related to his workers' compensation case. The letter states he is disabled as of February 22, 2022; the first monthly benefit is $1,294.70. The back pain Employee experienced before the accident did not stop him from working. It was a different pain; he experienced pain in the morning. After the work injury, it is more sensitive and tender. Employee married his wife in December 2011 after moving to Alaska. In 2012, he worked for Trident Seafoods in Kodiak as a mechanic. Employee had no income in 2013, 2014, and 2015; in 2016 he made $14,537. He cannot work to the same ability as a mechanic, so he has not applied for jobs. Employee does not want to hurt his reputation by getting fired and he does not want to cause an accident. Employee was terminated from his job with Employer in November 2024 for "no call no show." He hopes to go back to work; he wants to be 100 percent mentally and physically before going back to work. Employee fears he could hurt someone if he goes back to work

before he is fully well mentally and physically. Before going back to work he would need some sessions with Reger for his hip, to see what is wrong with his left arm and neck, and to fix the confusion he is going through. Employee recorded medical appointments with his phone; he could not recall asking permission to do so. He wears sunglasses as needed. Employee was not light sensitive before the work injury. He had headaches before the work injury. Employee could not recall prior back pain. He did not agree that he had prior concussions playing rugby. Employee wants to obtain medical treatment. His wife works as a financial advisor and in collections and has medical benefits through her job. Employee was unable to drive for a period but could not recall the time period. He was able to go to the park and the Alaska State Fair after surgery. On a good day, Employee can now walk one mile, but he is still having vertigo and migraines; smoke and loud noise affects him. He had anxiety before the work injury. (Employee).

129) On February 3, 2026, the following discussion happened during the hearing:

> Member Ladd: I don't know if there's a point of clarification, but what -- would there be any notification to an employee that they're going to lose their compensation benefits? Like, he would have known before, you know what I mean? It seems kind of strange that he received payments, unknowing, and they -
>
> Meshke: Yeah. I believe that this is incorrect with the -- the Board's record. The Board's record has compensation reports that show that he was paid for compensation through – into October.
>
> Member Ladd:· Okay.· It never tried -- back up --
>
> Meshke: I've never heard of that. I've never heard that being alleged.· It's the first time I'm hearing of it.
> . . . .
>
> Member Ladd: Okay. Yeah. I'm just wondering as a -- how that could be prevented in the future to where -- if it is the case.
>
> Flanigan: There's a controversion that they have to file with the board --
>
> Member Ladd: Uh-huh.
>
> Flanigan: -- but he was unrepresented, I believe, at that early time in 2022. And so, you know, that might -- not -- might not mean a whole lot, even if he got it, you know. I don't know if he got it or not. And so -- it's not -- it's very

complicated how Workers' Comp works, and the average person's lost if they try to navigate it themselves.

Member Ladd: Understood. Yeah, just -- it boggles me that, if the case happened to where you received money in your bank and then you didn't know it was going to be gone, like, how would he -- how would the person know. I just want to know that so it doesn't happen again.

Flanigan:· Right.

Member Ladd: If that's the case.

Meshke: I -- I don't believe –

Member Ladd: Okay. Okay. Copy that. I won't waste any more time on it.

Meshke:· Yeah, I mean -- the thing -- the only thing I can think is if there was a duplicate payment that went out --

Member Ladd: Understood.

Meshke: -- that that would have -- a stop payment possibly --

Member Ladd: Understood.

Meshke: -- but I've never heard that in this case.

Member Ladd: Okay.
. . . .

Member Ladd: He's saying he got the money taken. I'm just -- I'm interested in that for sure. Just very interested in that. To see if, like -- because God bless, with the time of year that it happened to the gentleman, that would be –

Flanigan: It shouldn't happen because under the Workers' Comp rules, if you make an overpayment, you're supposed to go to the Board and seek recoupment, and it's 20 percent out of your additional payments that you received.

Member Ladd: Right. They wouldn't just take the whole thing. Okay.

Flanigan: (Indiscernible.)

Chair Setzer: Okay. So yeah -- I see in our system that's reported to us as through 10/11/2022.

Member Ladd: Got it. (Board Hearing transcript, February 3, 2026).

130) On February 3, 2026, Eunice testified they married on December 9, 2011, in Anchorage, Alaska. Since the work injury, Employee's strength and mental capacity decreased. Employee was a hardworking father for their family before the work injury and was in charge of finances. Since the work injury, Eunice had to add her name to their account, and she is handling the finances to make sure bills get paid. Before the work injury he was really good at paying their bills and trying to make sure they were not past-due on anything. They exhausted their savings, their daughter's savings account, and credit cards and had to look for help from family and friends; some lent help and some took them in to live with them. They became homeless after the work injury. They camped in front of Cabela's and in Kasilof. Eunice was not working before the work injury, she was a stay at home mom for their daughter who had just turned one. They had problems paying rent and a payment from Employer got returned and funds were taken out of their account and her account was negative; they received a letter from the financial institution they bank at for the returned check. Before the surgery, Employee's migraine, trigger fingers, and back pain was more painful than his neck; he also had shooting pain in his left leg. He could not stand for a very long time, bend, or carry anything heavy; he used to be able to carry two to three hundred pounds, but it is really hard for her to tell whether or not he can still carry that much. Employee would "shut off" and they would have to cut whatever they were doing and go home; he used to be outgoing, now he is reserved and not very open about his feelings. He stopped volunteering and is more antisocial. Employee's memory is not as it was before the work injury. Employee had instances where he could not remember coworkers. Since the surgery, his back pain has gotten better, he is not having shooting sciatica as much, but his butt goes numb, he has tingling in his legs. At times when they try to shop, Employee pushes the cart and his left leg would drag, and they would cut it short, pay for groceries and leave. Eunice did not see Employee drag his leg before the work injury. Employee had headaches before the work injury, but they were not as severe. He used to shut them out, sit in a dark area for a couple hours and then come out when he was feeling better. Employee gets better with traction every week; he felt more neck pain in his off week. Dr. Barrington thought a home traction device might benefit Employee. Eunice started working in October 2024 as a member assistant representative and works from home. Her daughter is now five years old. Employee would drag his leg when he walked for some time or at home when he was standing, he would feel the

numbness and tingling and then drag his leg. He has not stopped dragging his leg; it comes on and off at times, it happens out of nowhere. Eunice estimated he would drag his foot once or twice a week after surgery. Employee's back pain "is not there anymore." His butt goes numb if he sits too long and his leg would go numb too. When asked what improvement Eunice had seen, she stated, the back pain he used to complain about so much was not there anymore. But Employee's butt goes numb if he sits for too long and his leg would go numb too. Employee was able to go to the state fair and to parks; he was not able to drive as much before the surgery. Eunice pressured Employee to go back to work. When asked if Employee tried to go back to work, Eunice stated, "Yes" that he made some effort to try to do a detox to try to feel better, especially with constipation, with pain medications that caused some gut issue. She did not recall Employee being light sensitive and using glasses before the work injury. Employee had headaches before the work injury. She did not see Employee have a gout attack. Eunice did not recall that Employee had back pain in 2019 and neck pain in 2019, or anxiety or depression. She remembered that Employee went to a chiropractor in 2021, he used their "FSA card" for one treatment because they had to use it before she left work to be a stay at home mom. Employee gained weight in 2021, like 40 pounds, because he was not moving around as much from the pain, it contributed to his weight gain. Eunice then stated he gained the weight before the work injury, and she was not quite sure what contributed to the weight gain before. When asked what is preventing Employee from going back to work, she said pain in the neck, discharge at times coming from his ears, which we do not know why it happens, the headaches, the migraines, some numbness in the butt, the tingling sensation, and also the numbness on the left leg to where he will drag when he is walking sometimes. She does all of the chores and cooking. When asked what Employee does during the day when she is working and watching their child, Eunice stated, "He just sits there." Employee also helps out by just looking after their daughter. On her two breaks and lunch break, Eunice comes out and helps out as much as she can. Since the injury, Employee is able to stand longer but only at a certain point when he feels that sensation in the leg, it goes numb and he needs to sit down. Eunice stated Employee's back pain has very much improved because he is not complaining as much that his back felt like it was going to pop. She hopes Employee can go back to work and recover. (Eunice).

131) On February 3, 2026, physical therapist Bramstedt with Reger testified he obtained his doctorate in physical therapy from the Mayo Clinic and completed a year of residency; he

specialized in "outpatient ortho." Bramstedt has been practicing for four years. He first saw Employee on August 22, 2025; he saw him twice a week, then once a week. Bramstedt objectively measures lumbar range of motion by measuring where the patient is able to bend forward without pain. He measures his fingertips in relation to Employee's patella to see how far forward Employee could reach. Employee showed linear improvement and recovery. Bramstedt provided manual therapy, soft tissue work, and range of motion exercises. He would have liked to provide further treatment to Employee, but he did not have any more visits; he would benefit from more physical therapy. It is reasonable and necessary treatment. Employee is obese; losing weight may help his back symptoms by reducing systemic inflammation. Bramstedt did not observe any cognitive issues. He did not think Employee exaggerated his symptoms. He acknowledged he made an improper assumption about the reason Employee stopped physical therapy. (Bramstedt).

132) On February 3, 2026, Scott Coronado testified he observed Employee using a cane in his right hand on October 19, 2022. Employee was walking slowly. He entered the passenger side of a truck driven by a female. Coronado observed Employee on October 20, 2022. He was not using a cane while walking and he carried items from his house to his vehicle, and drove. Employee also pulled a trash can up towards his house. He drove to Target, McDonald's, and Kentucky Fried Chicken and he checked his mailbox by bending over. Employee did not use a cane to bend over; he had to bend down to check his mailbox because it was at the bottom. On October 23, 2022, Coronado observed Employee exiting his vehicle from the driver's side; he had grocery bags in his hands and was not using a cane. Coronado did not recall Employee using sunglasses and did not see him walking slowly. He recorded 13 minutes and 25 seconds of video over five days. (Coronado).

133) On February 3, 2026, Dr. Koenen testified he graduated from the University of Washington in 1995; he attended medical school at New York University School of Medicine and graduated in 2000. From 2000 to 2004, he completed a residency in general psychiatry at the University of Washington. From 2004 to 2005, Dr. Koenen completed a fellowship in forensic psychiatry at Tulane University School of Medicine and then his boards in general psychiatry in 2005 and in forensic psychiatry in 2009. He performed six or seven evaluations in the last year; most were forensic evaluations for criminal or involuntary treatment cases. Dr. Koenen currently has an office in Kirkland, Washington and sees approximately 30 patients a

week. He performs forensic evaluations fairly regularly, two or three a months, for mostly involuntary treatment cases, or criminal cases, with only "a smattering" of personal injury and disability claims. Dr. Koenen noted Employee's history included panic attacks in 2019 and he was treated with propranolol. Employee described agoraphobia, specifically concerns about going out and being in public associated with panic disorder. He also had a number of depression symptoms that he claimed were new. Employee's cognitive complaints were not consistent with what one would expect from a ground-level fall that may or may not have involved loss of consciousness. Dr. Koenen stated people can sustain a concussion from an injury like that and the concussive symptoms can last for days or weeks, like transient headache, irritability, photophobia, trouble focusing, and low energy. A fall without evidence of brain bleed, skull fracture, or serous trauma is not going to result in any kind of prolonged cognitive impairment. He noted Employee's cognitive complaints proliferated and expanded over time after the work injury. Employee told Dr. Koenen he had a fairly uneventful childhood and was raised in a strict religious family in American Samoa. He moved to Anchorage for work, and he took a substantial period of time to do unpaid ministry work. Employee decided to return to work around the time he and his wife decided to have a child and that is when he got the job with Employer. Employee was an affable, unremarkable, anxious, and friendly person. Dr. Koenen did not observe evidence of depression or cognitive impairment. Dr. Koenen thought Employee met the criteria for major depressive disorder, although he is less sure with subsequent records, but he thought it was a "good possibility" and gave him the benefit of the doubt. He did not diagnose a somatoform disorder, but it is a possible explanation for "the myriad of physical symptoms" Employee expressed. When determining causation, Dr. Koenen looks at the degree of exposure, alternative explanations, and examines the totality of the evidence. He said it is not really likely for a ground-level fall without real actual evidence to cause panic and depressive disorder. There is evidence that a panic disorder is worse when people are exposed to stressors, but "that is a little iffy" and there is no reliable evidence that adult life stressors cause a major depressive disorder. An alternative explanation is a pre-existing panic disorder, which is a common condition in Employee's age group. Major depressive disorder is "an incredibly common psychiatric condition" and it is not a trauma-related illness. "So if he says he has it, the odds are pretty good that he has it." Dr. Koenen noted inconsistencies including Employee's neurological symptoms are not consistent with an injury of this nature. He also noted

Employee's inflation of the work injury description, as he told NP Green on February 1, 2023 that he had a six-hour loss of consciousness. Finally, the cognitive impairment Employee claimed is not consistent with his presentation. Employee said he could not even remember his wife's name, yet he was able to relate a coherent history and talk without difficulty to his medical providers, which is inconsistent. Employee claimed a high degree of extreme global cognitive impairment, yet he was able to get himself to appointments and show up on time and did not require full-time care. Employee's description of his symptoms is not consistent with his performance. Employee claimed he could not drive, yet there is surveillance data showing he was able to drive. Dr. Koenen noted Employee failed the Word Memory Test with Dr. Villanueva, "which is a test of effort, which invalidates the rest of the test. That was intentional." Employee was one point away from failing the Test of Memory Malingering (TOMM), while that "is not really a black or white cutoff," it was highly probably that was an attempt at deception, rendering the entire test invalid. Dr. Villanueva basically concluded that Employee's cognitive complaints were not credible. A year later, Employee did well on the TOMM test with Dr. Kimmel, but he failed the "RAVLT," a verbal memory test. Dr. Koenen said there was "no way this happens by random chance, it's intentional." The "RAVLT" failure would imply "a totally different part of the brain for memory" so it is another attempt at embellishing. The MMPI-2 with Dr. Villanueva showed a massive degree of exaggeration. The MMPI-3 with Dr. Davis showed more exaggeration and unreliability. Dr. Koenen noted Employee minimized his preinjury headaches and anxiety. Employee claimed to have seizures due to the work injury but an injury like he sustained is not going to cause seizures, his EEG was normal, and his wife deleted the video. The seizures are not credible. Dr. Koenen said the injury he had would also not cause vertigo. Employee's brain MRI and head CT were normal. There are nine criteria for major depressive disorder and only one is verifiable, which is weight gain, and Employee's weight did not change. Dr. Koenen reviewed Dr. Davis's report. Employee told Dr. Davis he had to leave American Samoa because of war and famine. Dr. Koenen noted the only war that occurred during Employee's childhood was the Gulf War, and it was not in American Samoa. The MMPI-3 Dr. Davis performed was also indicative of exaggeration. Employee was "sort of minimizing" any bad news about himself in a manner that was unrealistic. He over endorsed the physical and psychiatric complaints. The MMPI-3 score was not invalid but "was so extreme as to be questionable." Dr. Davis's diagnosis of adjustment

disorder with anxiety and depressed mood caused by the work injury was "a bizarre thing" as he came up with numbers which are completely meaningless. Dr. Koenen said there is no way to quantify the 10 percent is related to pre-existing pathology, 70 percent is related to preexisting pathology, and 20 percent is related to cognitive complaints. But Drs. Bauer, Chong, and McCormack said there was no pathology attributable to the work injury. Dr. Koenen reviewed Dr. McCormack's SIME report. Dr. McCormack said the congenital spinal stenosis would not have been affected by the slip and fall injury of that nature in any significant way. Dr. Koenen reviewed Drs. Hines' and Downs' records and the symptoms expanded and grew, "which is not how head injuries work." "Head injuries start out bad and they get better. And a head injury like this is never that bad. Again, it's annoying. It's, you know, maybe headaches and not feeling great and, you know, maybe some nausea if it's a really bad concussion. You get over that quick. A few -- you know, a few days, week or two, you're fine. You're back to normal. And claiming stuff months later, that's not -- that doesn't happen." Even severe head injuries do not get worse over time. Dr. Koenen stated Dr. Kimmel's report showed Employee completed the TOMM, which did not show any exaggeration, but the "RAVLT" showed less than one percentile, but he did fine on the prior "RAVLT" test, so it was not attributable to English not being Employee's first language. Employee failed an effort test and then presented with non-credible symptoms. Dr. Koenen said Dr. Kimmel's functional neurological disorder diagnosis is "so unbelievably unlikely as to not even warrant mentioning." Dr. Kimmel described the causation of that in a way that Dr. Koenen did not think anyone has used for 50-plus years, and did not appropriately rule it in, "so that particular diagnosis you can throw out." Dr. Koenen explained that a conversion disorder and a functional neurological symptom disorder are the same thing, it is a different name for the same symptoms. He stated Dr. Davis's opinion can also be thrown out because there was nothing to adjust to that is related to the work injury, so the adjustment disorder is not applicable. Dr. Koenen does not believe Employee is motivated to return to work. He spent years out of the work force and only went back after his wife had their child and then he "got out again." Dr. Koenen did not think Employee made a lot of money and "having a disability claim can sometimes pay better and Social Security can pay better." Employee has "some physical pathology" unrelated to his work, which might make labor jobs rather difficult for him, and "I don't know if he has great job prospects to do anything that's necessarily physical." Dr. Koenen stated the degree of likelihood that Employee's current light

sensitivity, confusion, and headaches are related to the work injury is very unlikely, not zero because anything is possible, but "close to zero." He stated postconcussion syndrome is not in the "DSM" because it was not considered a reliable diagnosis. Employee could have sustained a concussion when he fell. Dr. Koenen was not ruling it out and it was reasonable. Dr. Koenen said workers' compensation generally pays less than a regular paycheck and people do not make much on Social Security "but for some people, it is preferable to working." He said, "I've done thousands of evaluations of people that are homeless, and good decision and logical decision making is never anything I've ever associated with any of those evals. So if poor decision making led to here, that would be consistent with every other person I've ever talked to who lives in a car." Dr. Koenen stated Dr. Davis just made up numbers, "You could make up any numbers and put in there, show me the math. There is none because there's no way of quantifying this. You're attempting to quantify something that is fundamentally unquantifiable." He said, "There's actually zero evidence that major depressive disorder is caused by adult life stressors. Zero." Someone can be depressed because bad things happen but that is not major depressive disorder, it is a "different entity," a "very specific neuropsychiatric diagnosis." Dr. Koenen said psychiatric treatment would be helpful in general, but it is not related to the work injury. He stated Dr. Kimmel performed an invalid neuropsychological test so he cannot come up with a reliable whole person impairment. Once Employee failed the effort testing, everything else is considered invalid, so Dr. Kimmel's conclusion is "baseless." Dr. Koenen believes there is secondary gain issues with SSD and workers' compensation benefits being a major driving factor. He does not believe Employee has a functional neurological disorder, which is the notion that a person has a lot of neurological or pseudo-neurological symptoms that are unexplainable that are not consciously produced. "So there's no secondary gain and the person doesn't know they're doing it. Versus malingering, where they are consciously doing it and there is secondary gain, such as to get money or not to get drafted or something." Conversion Disorder is incredibly uncommon, ranges of 0.05 percent to maybe 0.14 percent of the population, and "malingering, in cases like this, they're going to 29 to 50 percent." Dr. Kimmel overlooked the many hundreds of times more likely that it is malingering. Dr. Koenen saw a transient increase in anxiety from the concussion "but that goes away pretty quick" and that is not exacerbation of a preexisting injury; "that's just a concussion." (Koenen).

134) On February 3, 2026, Member Ladd asked Dr. Koenen, "I'm just diving in because one of the comments that got me still kind of got -- kind of vexed, was have you ever yourself been on hard times to where, you know, something may not have been going right or whatever decisions you had led to maybe something, like living in your car or anything like that?" Dr. Koenen answered, "I've had some definitely hard times, but there's a different between like major depressive disorder and --." Member Ladd stated, "No, I'm just asking you. I'm just asking questions, not trying to get too. . . ." Dr. Koenen responded, "Oh, yeah, yeah.· No.· But that's -- that winds up -- that winds up being a -- being a difference.· I mean, people go through bad things in their life, bad breakups, economic problems, health problems. You know, bad stuff. And yeah, it's distressing, but there's a difference. There's normal distress, you know, someone's -- someone's dad dies or they -- yeah, they lose their home. Their home burns down." Member Ladd stated, "Sorry. I'm asking -- I'm asking you. Did you -- anything close to that?" Dr. Koenen answered, "No, not that -- not that kind of stuff." (Board Hearing transcript, February 3, 2026).

135) On February 3, 2026, Dr. Chong testified he is from Canada and completed all of his medical training in Canada. He started at the University of British Columbia for undergraduate, then obtained his medical degree at the University of Calgary. Dr. Chong completed his first postgraduate residency training program in family medicine at Memorial University of Newfoundland and his second in physical medicine and rehabilitation at McMaster University. He became a medical director of neurorehabilitation, treating and rehabilitating patients with injuries, including spinal and brain injuries. Then Dr. Chong worked as the medical director for a health insurance company in 1999. He returned to private practice in 2009 and has been practicing as a specialist in physical medicine and rehabilitation since. Dr. Chong is on staff at Rehabilitation Institute of Washington and is on active staff at Swedish Medical Center. His specialty is the specialty that treats and rehabilitates brain injuries. Dr. Chong has been trained in SSD examinations and in the determination of impairments that the American Medical Association *Guides for Disease and Impairment Ratings* in the sixth and fifth editions. He reviewed Employee's medical record, interviewed him, and then performed a physical examination. Dr. Chong observed inconsistencies in the medical record including subjective complaints not correlating with objective findings. He found systemic complaints after the work injury that were inconsistent with the natural history of a concussion. It is questionable whether

Employee experienced a loss of consciousness. The CT scan showed no fracture to Employee's wrist. Two months after the work injury, Employee presented with back pain and vertigo to his primary care physician. After four to five months, Employee was not diagnosed with vertigo by the neuropsychologist. That was confirmed in Dr. Chong's mind that there were no such signs or symptoms. If vertigo was associated with a TBI, it would present within a few hours and no more than 72 hours after the incident. Trigger finger is the result of a thickening of the tendon in the palm and that thickening takes years to develop; it is not a condition created or caused by an acute traumatic event. Employee's cervical spine MRI showed aged-related changes for degenerative disease and those were accelerated by his long-standing increased body mass index -- his morbid obesity. Employee's Samoan heritage has predisposes him toward a narrower spinal canal, which he has, and Dr. Chong noted there were no complaints of low back pain or any aggravation of symptoms to his back, low back, or legs within the next day of the work injury. Dr. Chong stated Employee presented himself to be very disabled and impaired but that was contradicted by numerous points in the history and physical examination. He scored severely anxious, and severely depressed ,but his demeanor and behavior throughout the evaluation was inconsistent with that. Employee had appropriate affect, meaning he was engaged, with appropriate eye contact, humor, and body gestures. He had no psychomotor retardation. Employee scored at the topmost limit on the "GAD" and "PHQ," which means he would have tremendous retardation, but he did not exhibit it. Employee wore a left wrist brace to the examination even though he was told it was healed and to discontinue using it in July 2022. This was an inconsistency and is symptom magnification. Employee's cane was too short for his height for functional use; he said his therapist instructed him to start using it, but Employee would have to be walking like an old man, bent over quite a bit, for the cane to support him. Employee had less than expected movement in his neck, back, and spine. There was no evidence of any injury to the brain or spinal cord as there were no primitive reflexes upon examination. There was also no evidence of any nerve irritation during the straight leg raising test. Employee's minimal proximal muscle weakness in his hips and shoulders was not present in his distal limbs, his hands, and feet, and that is not anatomical with respect to a brain injury or any spinal cord injury to the neck or back. Employee's muscle mass was symmetrical, which would be asymmetrical if there was a brain or spinal cord injury. Employee was wearing dark glasses throughout the history and physical evaluation; Dr. Chong asked him to take them off

and Employee had no difficulty with the fluorescent lighting and the sun coming in from the window. Dr. Chong discovered Employee was recording the valuation at the end when he was adjusting something. The only treatment Dr. Chong found not to be medically necessary at the time of his exam was the ESI as there was no clear evidence of radiculopathy. Employee's congenital narrower spine canal, his substantially elevated body mass index, and his accelerated aging findings combined to be the substantial cause of his symptoms. Employee denied a history of headache and back pain "categorically" to him, which was inconsistent with the medical record. Employee had profound symptom magnification as Dr. Chong found conscious embellishment and that is why he recommended psychiatric and/or neuropsychological evaluations. Dr. Chong gave Employee "the benefit of the doubt" and found him medically stable in July 2022 due to his seizure complaint at the time of the EEG, which was completely normal. The lumbar spine MRI had no findings that would indicate an acute disc bulge, and Employee had no clear radicular symptoms at the time Dr. Flanum mentioned surgery. Dr. Chong expected Employee's pathology to continue to deteriorate as he ages. He made a supplemental report after reviewing the surveillance report and video and at no point did his appearance correlate with how Employee presented to him the day before the surveillance, "this was quite remarkable what one day difference this did to his appearance." After reviewing the other EMEs and SIME reports, Dr. Chong issued a second addendum report. There was no change to his clinical opinions to causation and medical stability; Employee continued to have aging or degenerative changes to his spine. Dr. Chong felt confirmation that there were other motivations for how Employee presented himself. The decompression was performed by Dr. Fix to open up the spinal column and give more space. Dr. Chong reviewed Dr. Barrington's PPI report with the four percent impairment; there is no class D in the AMA *Guides*; it is class 1A or 1B. Class 1A is for a single-level decompression surgery for the spinal stenosis, class 1B is for a multiple level. Dr. Chong said Employee is a class 1A for single surgical decompression, which is a two percent whole person impairment rating, regardless of causation. Dr. Chong agreed with the zero percent whole person impairment for Employee's cervical sprain/strain but disagreed with Dr. Barrington's causation opinion. Dr. Barrington must have found Employee medically stable to perform the PPI rating. Malingering requires three components, ruling out any physical reason for disparate widespread complaints, consideration of whether there is a true psychiatric diagnosis, and mental status cognitive evaluations. There is no physical, anatomical, structural

reason or Employee's continued complaints outside of any possibility beyond the spine, Employee did not have a true psychiatric diagnosis, and Dr. Villanueva's evaluations showed intentional fabrication of answers. This pointed to malingering. If Employee is still dragging his left leg one to two times per week after the surgery, Dr. Chong stated it was very objective evidence the surgery made no difference "because dragging a leg is actual muscle weakness." Employee's Social Security earnings show a financial motivation. It showed that since 2019, when he first had headaches, then in 2021, when he started having back pain, his earnings started to decline, which suggests that based upon his aging, spinal condition, generally progressive poor health, it points in the direction that there is concern about his financial gain and evidence of secondary gain, leading one to begin to have much a firmer conclusion of malingering. Employee's eligibility for SSD did not change Dr. Chong's opinions:

> I used to do Social Security determinations and what I found was that essentially when you do Social Security determinations, it's a whole bunch of check off boxes and then at the end of the day, whether a person gets a Social Security award or not is very little -- in fact little to not related to an actual physical reason. And there are I think perhaps administrative legal dealings that are beyond my pay grade that I don't understand, so there's very little correlation clinically or medically, and therefore it does not affect my opinions.

Dr. Chong expected Employee's earnings to increase as he gained experience and became better, also with inflation and salary increases, but in 2019 his earnings dropped and in 2020, stayed about the same as in 2019; he estimated Employee was "about $7,000 behind" by the time of the work injury and then his earnings dropped off after that. He acknowledged that the company could have given Employee less work because they got less work and he would revise his opinion if he was provided documentation that indicates work was diverted from Employee. Dr. Chong stated, "physical function is reflected in earning," an objective measure of how function is consideration of how economically productive a person is, and it is another major data point that supports all of the clinical data points, which points toward consideration of malingering. Radiculopathy was ruled out by the lumbar spine MRI, which did not show any pathology impinging upon a nerve root. Employee did not complain of lower back pain to the extent it resulted in medical attention until two months later in April 2022, leading to the May 2022 MRI. He had a history of low back pain, without notation of resolution so he likely had waxing and waning back pain throughout the time. Employee had profound symptom magnification, and his

neuropsychologist found intentional fabrication. Dr. Chong reviewed Employee's earning history from a "functional perspective" to consider whether he was economically productive and whether it corresponded to acute medical events. The MRI showed no nerve root impingement. (Chong).

136) On March 3, 2026, Dr. Villanueva testified he reviewed medical records from Dr. Barrington briefly and Dr. Barrington's hearing testimony. (Videotape Videoconference Deposition of Michael Villanueva, Psy.D., March 3, 2026, at 5-6). He said it would be unusual for Employee to have neurocognitive issues in April 2025, when Dr. Barrington treated Employee, considering the acute duration of the event, brain scan imaging, and how quickly he became coherent after the work injury. (*Id*. at 7-8). Dr. Villanueva said there are "multiple studies, including meta analytic studies" indicating that symptoms are only expected for the next few months after such an incident, and at most three months. (*Id*. at 8). Meta analytic studies consider multiple individual studies and combine the data for "greater statistical power allowing you to make comments with greater confidence." (*Id*.). Dr. Villanueva found evidence of noncredible effort on standardized testing, which means he was not trying his best. (*Id*. at 9). When that happens, you cannot interpret any low score in the test battery to as being indicative of an area of impairment. (*Id*.). He also found Employee has "a tendency to overreport and overfocus on cognitive problems that cannot be reliably objectively verified and does so in a way that over emphasizes related limitations." (*Id*). Based on Dr. Villanueva's examination, records review, and his clinical practice of over 30 years, "having somebody with a head injury presenting with, say, tinted glasses many years after the injury, is highly unexpected." (*Id*. at 9-10). He is not familiar with the metronome treatment Dr. Barrington did. (*Id*. at 10). Dr. Villanueva stated confusion is a somewhat nonspecific term and there is no indication from his examination of Employee or the record regarding the severity of the injury that there would be any sort of confusion that would be associated with the mild injury that occurred from a neuropsychological standpoint. (*Id*. at 11). Dr. Villanueva believes it is possible Employee had a mild concussion based upon the report of possible loss of consciousness by Employee. (*Id*. at 12). A concussion requires an external force to the head with immediate and associated alteration of consciousness, not necessarily loss of consciousness. (*Id*.). A mild concussion by definition would not show changes in a brain MRI or CT scan. (*Id*. at 13). When asked if there was objective testing for a concussion, Dr. Villanueva stated if emergency personnel were on

scene at the time and Employee demonstrated repetitive questioning and disorientation, that would be an objective finding of concussion. (*Id.*). There had never been any objective verification of the "neurocognitive piece of this." (*Id.* at 14). Dr. Villanueva stated there were objective ways of assessing problems with memory or concentration. (*Id.*). He said headaches are a subjective nonspecific symptom and there is no evidence that a person is at a greater risk for headaches if they had a blow to the head at the six month point. (*Id.* at 14-15). When asked if not having headaches all the time before an injury and then all the time afterwards was indicative of postconcussion syndrome, Dr. Villanueva answered, "No. That's why I said it was nonspecific. So if -- you know, recent -- fairly recent study in 2019 demonstrated equal increase in headache complaint for orthopedic controls versus concussion, like, at the 6- to 12-month point." (*Id.* at 15). There are a group of people, for reasons that are not well understood, that continue to complain of nonspecific symptoms, but postconcussion syndrome is not a specific syndrome as the "symptoms are shared by multiple other conditions." (*Id.* at 15-16). The symptoms include headache and dizziness, but not irritability as there is "not a lot of evidence of that in empirical literature," or anxiety as "the prospective literature has not demonstrated" that to be associated with concussion. (*Id.* at 16). When asked if it was true that preexisting conditions can indicate higher risk levels for postconcussion syndrome, Dr. Villanueva answered,

> So the relationship between preexisting conditions and whether or not there was any true condition associated with a head injury is of -- is of great interest. So we know, for example, that for some sub groups of young people that hit their head and have persistent symptoms, that they are more likely to have had, say, psychological difficulties in the past. So the question is whether or not those symptoms seen nine months after the blow to the head have anything to do with the blow to the head or -- or is merely an extension of the previous psychological difficulties.

A concussion can affect memory within the first few weeks up to three months after a blow to the head and you can have findings in terms of memory loss for some people. (*Id.* at 18). Dr. Villanueva does not have any equipment to test for a headache. (*Id.* at 19). If there is persistent confusion, evidence of underlying neurocognitive disorder should be found. (*Id.*). When Dr. Villanueva used the word "acceptable" in his report, he was talking about performance validity testing, when he used the word "average" he was talking about the clinical measures of an

underlying cognitive function. (*Id.* at 21). If there are findings on performance validity testing that indicate lack of credible effort, then you cannot interpret any of the clinical findings that fall below average as being indicative of impairment. (*Id.*). Some of the performance validity tests were performed by Employee within acceptable limits. (*Id.* at 22). When asked if someone is not trying as hard as they could, would it be expected to be across all of the validity tests, Dr. Villanueva said that is not true, "it tends to be hit and miss." (*Id.* at 22). The cutoffs are set very conservatively because you do not want false-positive error where you find a person is not trying their hardest unless you are sure of that; the cutoffs lands some false-negative errors. (*Id.*). In almost all cases, you are going to find only one or two indications of poor effort; the rest will fall within acceptable limits. (*Id.*). Employee tested below average for processing speed, delayed recall for paragraph level material, and verbal comprehension. (*Id.* at 25-26). Verbal comprehension can be highly affect by someone's education level; Employee has a high school education, and his reading recognition fell within the low average range. (*Id.* at 26). Employee was within normal limits in his complex attention score, in terms of number of errors and time of completion, and his inhibition of response, assessing his sustained specific attention, was within normal limits. (*Id.* at 27). Dr. Villanueva stated there is an association of report of light sensitivity with migraine. (*Id.* at 32). Some migraines have only visual variance and no pain. (*Id.*). The referrals to neurology were appropriate to rule out concerns regarding the head injury for the seizures. (*Id.* at 33). When asked whether his report ruled out whether Employee could continue to experience symptoms more than three months after the injury, Dr. Villanueva said it would be very unusual; his examination did not confirm the presence of any underlying neurocognitive syndrome, and some of Employee's subjective complaints regarding memory were highly atypical, like forgetting his wife's name. (*Id.* at 34). He said it is unknown what Employee's reported migraines are caused by and it is unlikely to be caused by the work injury from a cognitive standpoint. (*Id.* at 35). Non-specificity means that there could be multiple causes of the symptoms, for example with headaches, beyond three months you are no more likely to report an increase of headache discomfort if you had a blow to the head than if you had an orthopedic injury with no blow to the head. (*Id.* at 39). Dr. Villanueva does not believe Employee continues to suffer from post-concussive or neurocognitive symptoms related to the work injury. (*Id.* at 41). He does not know what Dr. Downs meant when he said "activated migraine headaches with the head trauma" in his June 2, 2022 report. (*Id.* at 42-43).

137) On March 5, 2026, Employer filed a transcript of the February 3, 2026 hearing. (Notice of Intent to Rely, March 5, 2026; Board Hearing Transcript, February 3, 2026).

138) On March 5, 2026, Employer requested an offset for SSD benefits in accordance with 8 AAC 45.225(b) and recoupment of overpayment in excess of AS 23.30.155(j). (Petition, March 5, 2026). It contended Employee's initial award was $1,145 per month and he was first entitled to benefits in August 2022. Employer contended Employee's weekly reduced TTD benefits based on the offset formula totaled $448.23:

> Initial SS Award $1,145.00 x 12/52 = $264.23
> $890.57 x .8 = $712.46 maximum weekly rate
> $712.46 - $264.23 = $448.23 reduced weekly rate

It contended it paid TTD benefits from February 23, 2022 to October 11, 2022, at the rate of $625.78 per week, which resulted in an overpayment of $177.55 per week for 10 weeks and two days, totaling $1,826.22. Employer requested any lump sum award be reduced by the full value of the overpayment and that any TTD benefits awarded as a result of the work injury be reduced by the offset. (Memorandum in Support of Petition for Social Security Offset and to Recoup Overpayment in Excess of AS 23.30.155(j), March 5, 2026).

139) On March 10, 2026, Employee filed a Notice of Intent to Rely with an email on March 9, 2026, at 8:35 p.m., including a stop payment letter dated November 3, 2022, from Credit Union One for Broadspire Check No. 2301914039 in the amount of $1,251.56 negotiated on October 27, 2022, and a returned item fee of $15, and the last page of the November 28, 2022 SROI. The letter included a copy of the check dated "10/1[illegible]/2022." (Notice of Intent to Rely, March 10, 2026; Credit Union One letter, November 3, 2022; SROI, November 28, 2022).

140) On March 10, 2026, Employee filed a Notice of Intent to Rely with a March 10, 2026 Social Security Benefit Verification letter and a "Disability Determination Explanation." The Social Security Benefit Verification letter stated Employee became disabled under their rules on February 22, 2022. From November 2025, the full monthly SSD payment before any deductions was $1,491, rounded down to the whole dollar. (Notice of Intent to Rely and Social Security Benefit Verification letter and Disability Determination Explanation, March 10, 2026).

141) On March 10, 2026, Employer objected to Employee's March 10, 2026 Notice of Intent to Rely that included the stop payment letter from Credit Union One as well as testimony from Employee and Eunice about the stop payment. It contended the testimony and evidence was not

relevant to the claim "and is only intended to illicit bias against the insurer." Employer contended there was no direct correlation between a stop-payment issued in the case "in accordance with a controversion of benefits in October 2022," and Employee becoming homeless in 2024. It contended it has no tendency to make a question at issue in the case more or less likely. Employer requested all testimony offered by Employee and Eunice as well as the evidence filed with the March 10, 2026 Notice of Intent to Rely be stricken as irrelevant and likely to lead to confusion. (Employer's Objection to Evidence and Testimony, March 10, 2026).

142) On March 10, 2026, Employer filed a Notice of Intent to Rely including a Social Security Administration Function Report completed by Eunice for Employee on August 6, 2025, and Employee's April 7, 2023 SSD application. The Function Report states:

> I still need help with buttons due to my triggered fingers, which make fine motor tasks extremely difficult and sometimes painful. This limits my ability to dress myself independently. Additionally, I require assistance with bending to put on pants because of ongoing vertigo, neck pain, and numbness in my buttocks, all of which affect my balance and flexibility. These symptoms make it unsafe and very challenging for me to perform basic tasks that involve bending or reaching, and I rely on support to avoid falls or further injury.
>
> I need reminders about what I need to eat and the types of food that are appropriate for my condition. Due to memory issues and mental fatigue, I often forget meal times and the specific dietary requirements.
>
> I have tried to prepare meals, but pain and stiffness in my neck, along with discomfort and numbness, make it very difficult. Using my hands causes pain and weakness, which also makes cooking hard to manage. Because of these symptoms, I can no longer cook safely or consistently and now rely on others for meal preparation.
>
> Cane, brace, splint and black sunglasses. They were all prescribed after work injury and are all work related injuries.
>
> I need assistance with cutting food, as the motion causes pain in my hand and leads to numbness, making it difficult to grip utensils properly or cut safely. While I can usually feed myself once the food is prepared, I still struggle with tasks that involve holding or stabilizing items for any extended period.
>
> Bending, Squatting, Kneeling: These movements exacerbate my neck pain and back discomfort, making them very difficult or impossible.

> Talking: My speech has become more slurred, likely due to my head injury.
>
> Since my surgery, my walking ability has slightly improved, but I still walk a guesstimate of around 30 yards or so before needing to stop and rest. My doctor has advised not to force myself beyond what feels comfortable to avoid worsening my condition. This distances varies depending on ground conditions and how I feel on each given day. Despite some improvement, my endurance and mobility remain significantly limited which greatly affects my ability to perform daily activities.
>
> On a good day, I can usually pay attention for about 30 minutes to an hour at a time. However, this often varies depending on my symptoms and the complexity of the task, which require me to take frequent breaks. (Notice of Intent to Rely, March 10, 2026; Function Report, August 6, 2025; SSD application, April 7, 2023).

143) On March 11, 2026, Employee responded to Employer's March 10, 2026 objection and contended the stop payment letter and Employee's and Eunice s testimony were relevant to the credibility of Employee and Eunice, which Meshke cast doubt on at the last hearing. He also contended the evidence was relevant to the request for an finding of an unfair and frivolous controversion and pay penalty. Employee argued the only recovery permitted under AS 23.30.155(j) is a 20 percent reduction of future benefits after the controversion date unless a higher percentage was approved by the Board, and further argued a stop payment to recoup 100 percent of an alleged overpayment violated the Act and should be deemed a bad faith controversion. He also contended the "illegal 'clawback'" was "highly harmful to Employee, who was obviously was [sic] reduced to poverty at that point in time, due to Employer's bad faith stop payment." (Employee's Response to Employer's Objection to the Testimony and Evidence Concering [sic] the Stop Payment of a Compensation Check After It Had Been Issued and Deposited, March 11, 2026).

144) On March 11, 2026, Employer requested Member Ladd be disqualified from further participation, contending his questioning of Dr. Koenen about personal hardships, his statement he was vexed by the insurance company issuing a stop payment, and his misunderstanding about the insurance company issuing a stop payment showed he was biased and lacked impartiality. (Employer).

145) On March 11, 2026, Member Ladd stated he does not have a bias and has not made a prejudgment. (Record).

146) On March 11, 2026, Employee opposed disqualification of Member Ladd contending the stop payment issue was relevant to hearing issues and the questions did not show bias or impartiality. (Employee).

147) On March 11, 2026, Employee answered Employer's March 5, 2026 petition for a SSD offset and agreed that if he is awarded TTD benefits from August 2022 to date, Employer is entitled to an offset. He provided the following calculation of the offset:

> Yearly Past Gross Earnings: 2020 $44,528
> $890.56 per week, TTD rate of 626.62
> SSDI Award Letter $1294.70 per mon. 298.77
> SSDI Offset 626.62 + 298.77 = 925.39 - 712.45
> (80% of 890.56) = 212.94
> 626.62 - 212.94 = 413.68

(Employee's Response to Employer's Petition for a Social Security Offset, March 11, 2026).

148) The parties agreed Employer's March 5, 2026 petition for a SSD offset should be addressed by the panel. (Record).

149) On March 11, 2026, Employee contended Dr. Downs diagnosed him with postconcussion syndrome, depression, and headaches and Dr. Flanum recommended an L4-5 decompression on August 10, 2022. He contended Dr. Flanum disagreed with Dr. Chong's EME report and stated his back should be addressed. Employee contended Employer's stop payment was an illegal recoupment and requested the panel find it unfairly and frivolously controverted benefits for the illegal recoupment. He contended he had relief after the surgery by Dr. Fix, with residual numbness in his legs and buttocks. Employee contended Dr. Fix testified at hearing that his physical complaints are attributed to his workplace injury. He contended that is well supported by the record because he worked for six straight years for Employer. Employee contended Social Security determined he was not able to go back to work at this time because of his physical limitations. He contended the most comprehensive review of his physical abilities was done by Reger. Employee contended the "prognosticators" did not appreciate that a disc bulge combined with the stenosis was sufficient to cause the problem in his back and in his neck. He contended with the narrowing of the spinal cord opening, it takes less disturbance by the disc to cause the spinal cord to be impacted and that is why Dr. Fix's partial reduction of his lumbar disc resulted in improved symptoms. Employee contended that the only person who opened his back and looked at it was Dr. Fix, and that is the most convincing evidence there is. He contended

Dr. McCormack admitted it was easier to harm somebody with that problem. Employee contended Dr. Villanueva admitted a person does not need to see a brain bleed for a concussion and postconcussion syndrome and he could not rule out the light sensitivity, confusion, or headaches because they do not have testing for that. Employee contended he had met his burden of proof, and he was entitled to the presumption with his doctors. He requested past TTD benefits and medical benefits be awarded. Employee agreed there should be a SSD offset if TTD benefits are awarded. (Employee).

150) On March 11, 2026, Employer contended there is no report of low back pain when Employee went to the emergency room on February 23, 2022, and the only imaging done was his cervical spine, head, and left wrist. It contended Employee did not start complaining about low back pain for several months and he did not develop leg pain for a year after the work injury according to Dr. McCormack. Employer contended Dr. McCormack opined Employee had strains superimposed on his preexisting conditions and it was a temporary aggravation. It contended Dr. Fix stated in her operative report stated that Employee did not have a disc herniation. Employer contended there is no pathological or physiological reason for Employee to be experiencing the radicular symptoms he claims to have and there is no EMG testing to corroborate it. It contended Employee was treating with a chiropractor less than a year before the work injury and he did not complete his treatment plan before he ended up getting hernia surgery that took him of his plan, he had complaints of blurry eyes in 2016, and complaints of neck and low back pain, headaches, and difficulty sleeping from 2019 and before. Employer contended Employee filed for SSD benefits before he filed a claim. It contended Employee is "not a worker" when looking at the wage information and work history he provided as he has only been gainfully employed on a full-time, year-round basis for five years of his adult life with Employer. Employer contended there are Alaska Supreme Court cases that repeatedly hold that the argument post hoc ergo propter hoc is not sufficient to establish causation. It contended Employee's credibility is an important factor in this case and he denied prior preexisting symptoms and the medical record contradicts that. Employer contended Dr. Flanum essentially said he had nothing to offer for Employee's neck, which was his first primary symptom. It contended that the EME and SIME physicians' opinions are more persuasive because they looked at all the medical records. Employer contended Employee did not really improve after the surgery Dr. Fix performed because he is still dragging his leg multiple times per week and

Employee's Function Report from August 2025 shows he cannot dress himself, bath himself, or shave, he needs reminders to eat, and he cannot walk more than 30 yards. It contended the severe disability he reported is not documented by any physician to that degree. Employer contended Employee said Dr. McCormack tortured him and that is not credible. It contended the surgery did not do anything based upon Employee's functional report. Employer contended the neurocognitive testing done by two physicians 10 months apart show there is no objective evidence Employee is cognitively impaired. It contended the surveillance report and video showed Employee driving, not wearing sunglasses, walking without a cane, and bending over right around the time his claim was controverted, and he claimed to be unable to drive. Employer contended it rebutted the presumption and Employee failed to prove by a preponderance of the evidence that he is entitled to any further benefits. (Employer).

PRINCIPLES OF LAW

> **AS 23.30.001. Legislative intent.** It is the intent of the legislature that
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> (1) this chapter be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter;
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> (2) workers' compensation cases shall be decided on their merits except where otherwise provided by statute;
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> (3) this chapter may not be construed by the courts in favor of a party;
>
> (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.

The Board may base its decision not only on direct testimony and other tangible evidence, but also on its "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 23.30.010. Coverage.** (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the

> course of the employment. To establish a presumption under AS 23.30.120 (a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.

In *DeYonge v. NANA/Marriott*, 1 P.3d 90 (Alaska 2000), the Alaska Supreme Court (Court) reiterated that preexisting conditions do not disqualify a claim under the work-connection requirement if the employment injury aggravated, accelerated, or combined with the preexisting infirmity to produce the disability for which compensation is sought. The Court stated so long as the work injury worsened the injured person's symptoms, the increased symptoms constitute an aggravation, "even when the job does not actually worsen the underlying condition." *Id*. at 96.

In *Morrison v. Alaska Interstate Construction, Inc*., 440 P.3d 224 (Alaska 2019), the Court for the first time construed AS 23.30.010(a) and its relationship to the *DeYonge* doctrine and the "last injurious exposure rule." *Morrison* found the legislature did not abrogate the *DeYonge* rule when it amended the coverage statute in 2005. It held the Alaska Workers' Compensation Appeals Commission's (Commission) inquiry improperly focused on what qualifies as an injury, "which is not how the legislature chose to reduce the number of potentially compensable claims." *Id*. at 233. Interpreting AS 23.30.010(a), *Morrison* held the Board decides whether "the employment" was "the legal cause," *i.e.*, "a cause important enough to bear legal responsibility for the medical treatment needed for the injury," by looking at the "*causes* of the injury or symptoms" rather than considering the injury type. *Id*. at 233-234; emphasis in original.

Morrison held AS 23.30.010(a) is not complex and requires the Board to consider different causes "of the benefit sought" and the extent to which each contributed to the need for the specific benefit. The Board must then identify one cause as "the substantial cause," meaning, the

cause which "is the most important or material cause related to that benefit." Based on legislative history, *Morrison* found the legislature did not intend to require that the substantial cause be a "51% or greater cause, or even the primary cause, of the disability or need for medical treatment." The comparison made is "among the causes identified, not in isolation or in comparison to an abstract idea." It is a "flexible" and "fact dependent" determination. *Id*. At 237-238. *Morrison* held the Board has the right and responsibility to interpret evidence and draw its own inferences. *Id*. at 239. Finding no error, *Morrison* reversed the Commission and remanded the case with instructions to reinstate the Board's award. *Id*. at 240.

Traugott v. ARCTEC Alaska, 468 P.3d 499 (Alaska 2020) held the new causation standard in AS 23.30.010 required the Board to identify factors contributing to the disability and need for medical treatment and decide which among them was the most material or important one. *Id*. at 514. *Traugott* held "the statute permits the board to determine which cause among all those identified is the most important or material cause of the current disability and need for medical treatment, even if an expert does not regard it as having more than 50% responsibility for the condition." *Id*. at 511, citing *Morrison*. The Board, and not a medical expert, is required to consider the possible cause of an employee's disability and need for medical treatment and determine which of the possible causes is the most important in causing the disability and need for medical care. And the Board, not a medical expert, is charged with determining legal responsibility. The Board as the fact finder has the authority to interpret an expert's opinion and decide what weight to give it. *Id*. at 514.

In *Rife v. B.C. Excavating, LLC.*, AWCB Dec. No. 19-0001 (January 2, 2019), the Board panel agreed with the EME physician's opinions that the employee sustained only soft tissue lumbar strains, which would resolve over several months. The panel found the employee had failed to present sufficient medical evidence of causation. The Commission affirmed the Board's decision and noted both the Commission and the Board had "previously rejected the use of post hoc, ergo propter hoc, as a basis for workers' compensation cases." The Commission stated proof of a causal relationship is necessary. *B.C. Excavating, LLC. v. Rife*, AWCAC Dec. No. 274 (December 31, 2019).

> **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. . . .

Medical benefits, including continuing care, are covered by the AS 23.30.120(a) presumption of compensability. *Municipality of Anchorage v. Carter*, 818 P.2d 661, 664-65 (Alaska 1991). The statute does not require continuing rehabilitative or palliative care be provided in every instance. Rather, it grants the Board discretion to award "indicated" care "as the process of recovery may require." *Id*. at 664.

When a claim is reviewed for continued treatment beyond two years from the injury date, a panel had discretion to authorize "indicated" medical treatment "as the process of recovery may require." Given this discretion, a panel is not limited to reviewing the reasonableness and necessity of the particular treatment sought but has some latitude to choose among reasonable alternatives. *Phillip Weidner & Associates, Inc. v. Hibdon*, 989 P.2d 727, 731 (Alaska 1999). 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. *Id*. at 732.

> **AS 23.30.120. Presumptions**. (a) In a proceeding for the enforcement of a claim for compensation under this chapter it is presumed, in the absence of substantial evidence to the contrary, that
>
> (1) the claim comes within the provisions of this chapter . . . .

"The text of AS 23.30.120(a)(1) indicates that the presumption of compensability is applicable to *any* claim for compensation under the workers' compensation statute." *Meek v. Unocal Corp.*, 914 P.2d 1276, 1279 (Alaska 1996) (emphasis in original). Medical benefits, including

continuing care, are covered by the AS 23.30.120(a) presumption of compensability. *Municipality of Anchorage v. Carter*, 818 P.2d 661, 664-65 (Alaska 1991). The Court in *Sokolowski v. Best Western Golden Lion*, 813 P.2d 286, 292 (Alaska 1991) held a claimant "is entitled to the presumption of compensability as to each evidentiary question."

The presumption's application involves a three-step analysis. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381 (Alaska 1991). First, an employee must establish a "preliminary link" between the "claim" and her employment. In less complex cases, lay evidence may be sufficiently probative to make the link. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Whether or not medical evidence is required depends on the probative value of available lay evidence and the complexity of the medical facts involved. *Id*. An employee need only adduce "some," minimal relevant evidence, *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987), establishing a "preliminary link" between the "claim" and the employment, *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). Witness credibility is not examined at this first step. *Excursion Inlet Packing Co. v. Ugale*, 92 P.3d 413, 417 (Alaska 2004).

Once an employee attaches the presumption, the employer must rebut it with "substantial" evidence that either, (1) provides an alternative explanation excluding work-related factors as a substantial cause of the disability ("affirmative-evidence"), or (2) directly eliminates any reasonable possibility that employment was a factor in causing the disability ("negative evidence"). *Huit v. Ashwater Burns, Inc*., 372 P.3d 904; 919 (Alaska 2016). "Substantial evidence" is the amount of relevant evidence a reasonable mind might accept as adequate to support a conclusion in light of the record as a whole. *Miller v. ITT Arctic Services*, 577 P.2d 1044, 1046 (Alaska 1978). The mere possibility of another injury is not "substantial" evidence sufficient to rebut the presumption. *Huit* at 920, 921. The employer's evidence is viewed in isolation, without regard to an employee's evidence. *Miller* at 1055. Therefore, credibility questions and weight according to the employer's evidence are deferred until it is decided if the employer produced a sufficient quantum of evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Compensation Board*, 880 P.2d 1051, 1054 (Alaska 1994); *citing Big K Grocery v. Gibson*, 836 P.2d 941 (Alaska 1992).

For claims arising after November 7, 2005, employment must be the substantial cause of the disability or need for medical treatment. *Runstrom v. Alaska Native Medical Center*, AWCAC Dec. No. 150 (March 25, 2011) (reversed on other grounds by *Huit*). If an employer produces substantial evidence work is not the substantial cause, the presumption drops out and the employee must prove all elements of the "claim" by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1381 (*citing Miller v. ITT Services,* 577 P 2d. 1044, 1046). The party with the burden of proving asserted facts by a preponderance of the evidence must "induce a belief" in the fact-finders' minds the asserted facts are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

> **AS 23.30.122. Credibility of witnesses**. The board has the sole power to determine the credibility of a witness. A finding by the board concerning the weight to be accorded a witness's testimony, including medical testimony and reports, is conclusive even if the evidence is conflicting or susceptible to contrary conclusions. The findings of the board are subject to the same standard of review as a jury's finding in a civil action.

The Board's credibility findings and weight accorded evidence are "binding for any review of the Board's factual finding." *Smith v. CSK Auto, Inc.*, 204 P.3d 1001; 1008 (Alaska 2009). If the Board is faced with two or more conflicting medical opinions, each of which constitutes substantial evidence, it may rely on one opinion and not the other. *DeRosario v. Chenega Lodging*, 297 P.3d 139, 147 (Alaska 2013). The Board alone is charged with determining the weight it will give to medical reports. *Smith v. University of Alaska, Fairbanks*, 172 P.3d 782, 791 (Alaska 2007).

> **AS 23.30.145. Attorney fees**. (a) Fees for legal services rendered in respect to a claim are not valid unless approved by the board, and the fees may not be less than 25 percent on the first $1,000 of compensation or part of the first $1,000 of compensation, and 10 percent of all sums in excess of $1,000 of compensation. When the board advises that a claim has been controverted, in whole or in part, the board may direct that the fees for legal services be paid by the employer or carrier in addition to compensation awarded; the fees may be allowed only on the amount of compensation controverted and awarded. . . .

> **AS 23.30.155. Payment of Compensation.** (a) Compensation under this chapter shall be paid periodically, promptly, and directly to the person entitled to it,

without an award, except where liability to pay compensation is controverted by the employer. To controvert a claim, the employer must file a notice, in a format prescribed by the director. . . .

(b) The first installment of compensation becomes due on the 14th day after the employer has knowledge of the injury or death. On this date all compensation then due shall be paid. Subsequent compensation shall be paid in installments, every 14 days, except where the board determines that payment in installments should be made monthly or at some other period.

(c) The insurer or adjuster shall notify the division in a format prescribed by the director that the payment of compensation has begun or has been increased, decreased, suspended, terminated, resumed, or changed in type. An initial report shall be filed not later than 28 days after the date of issuing the first payment of compensation. If, at any time, 21 days or more pass and no compensation payment is issued, a report notifying the division of the termination or suspension of compensation shall be filed not later than 28 days after the date the last compensation payment was issued. A report shall also be filed not later than 28 days after the date of issuing a payment increasing, decreasing, resuming, or changing the type of compensation paid. When the insurer or adjuster files a report, the division shall notify the employee of the payment or change in payment of compensation. If the division is not notified within the 28 days prescribed by this subsection for reporting, the insurer or adjuster shall pay a civil penalty of $100 for the first day plus $10 for each day after the first day that the notice was not given. Total penalties under this subsection may not exceed $1,000 for a failure to file a required report. Penalties assessed under this subsection are eligible for reduction under (m) of this section. A penalty assessed under this subsection after penalties have been reduced under (m) of this section shall be increased by 25 percent and shall bear interest at the rate established under AS 45.45.010.

(d) If the employer controverts the right to compensation, the employer shall file with the division, in a format prescribed by the director, a notice of controversion on or before the 21st day after the employer has knowledge of the alleged injury or death. If the employer controverts the right to compensation after payments have begun, the employer shall file with the division, in a format prescribed by the director, a notice of controversion not later than the date an installment of compensation payable without an award is due.

(e) If any installment of compensation payable without an award is not paid within seven days after it becomes due, as provided in (b) of this section, there shall be added to the unpaid installment an amount equal to 25 percent of the installment. This additional amount shall be paid at the same time as, and in addition to, the installment, unless notice is filed under (d) of this section or unless the nonpayment is excused by the board after a showing by the employer that owing to conditions over which the employer had no control the installment

> could not be paid within the period prescribed for the payment. The additional amount shall be paid directly to the recipient to whom the unpaid installment was to be paid.
>
> . . . .
>
> (j) If an employer has made advance payments or overpayments of compensation, the employer is entitled to be reimbursed by withholding up to 20 percent out of each unpaid installment or installments of compensation due. More than 20 percent of unpaid installments of compensation due may be withheld from an employee only on approval of the board.
>
> . . . .
>
> (o) The director shall promptly notify the division of insurance if the board determines that the employer's insurer has frivolously or unfairly controverted compensation due under this chapter. After receiving notice from the director, the division of insurance shall determine if the insurer has committed an unfair claim settlement practice under AS 21.36.125.
>
> (p) An employer shall pay interest on compensation that is not paid when due. Interest required under this subsection accrues at the rate specified in AS 09.30.070(a) that is in effect on the date the compensation is due.

Employers must either pay or controvert benefits without an award but may controvert any time after payments are made. AS 23.30.155(a). A controversion notice must, however, be filed and it must be filed in good faith to protect an employer from a penalty for nonpayment of benefits. *Harp v. ARCO Alaska, Inc.*, 831 P.2d 352 (Alaska 1992). "In circumstances where there is reliance by the insurer on responsible medical opinion or conflicting medical testimony, invocation of penalty provisions is improper. However, when nonpayment results from bad faith reliance on counsel's advice, or mistake of law, the penalty is imposed." *Id.* at 358. The employer must possess sufficient evidence in support of the controversion that, if the employee does not introduce evidence in opposition to the controversion, the Board would find the employee not entitled to benefits. *Id.* The controversion and the evidence on which it is based must be examined in isolation, without assessing credibility and drawing all reasonable inferences in favor of the controversion.

AS 23.30.155(j) permits withholding up to 20 percent of future compensation installments and can be invoked at an employer's discretion. *Davenport v. K&L Distributors, Inc.*, AWCB Dec. No. 92-0180 (July 22, 1992). It does not, however, provide any criteria or factors that should be

considered in determining whether a higher withholding rate is appropriate. Thus, decisions have entertained various considerations when deciding appropriate withholding amounts. For examples, *Barnett v. Lee's Custom Designs*, AWCB Dec. No. 99-0146 (July 8, 1999), considered the financial hardship the employee would suffer as result of a higher withholding rate; *Decker v. Price/Northland J.V.*, AWCB Dec. No. 930304 (November 24, 1993), considered the length of time employee was expected to be disabled and whether the overpayment could be recouped within that time at 20 percent; and *Bathony v. State*, AWCB Dec. No. 98-0101 (April 22, 1998), considered the fact the overpayment arose or was exacerbated by the employee's resistance to providing correct information to the employer.

A workers' compensation award accrues legal interest from the date it should have been paid. *Land and Marine Rental Co. v. Rawls*, 686 P.2d 1187, 1192 (Alaska 1984).

> **AS 23.30.185. Compensation for temporary total disability.** In case of disability total in character but temporary in quality, 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the disability. Temporary total disability benefits may not be paid for any period of disability occurring after the date of medical stability.
>
> **AS 23.30.190. Compensation for permanent partial impairment; rating guides.** (a) In case of impairment partial in character but permanent in quality, and not resulting in permanent total disability, the compensation is $273,000 multiplied by the employee's percentage of permanent impairment of the whole person. The percentage of permanent impairment of the whole person is the percentage of impairment to the particular body part, system, or function converted to the percentage of impairment to the whole person as provided under (b) of this section. The compensation is payable in a single lump sum, except as otherwise provided in AS 23.30.041 , but the compensation may not be discounted for any present value considerations.
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> **AS 23.30.225. Social security and pension or profit sharing plan offsets.**
> . . . .
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> (b) When it is determined that, in accordance with 42 U.S.C. 401 - 433, periodic disability benefits are payable to an employee or the employee's dependents for an injury for which a claim has been filed under this chapter, weekly disability benefits payable under this chapter shall be offset by an amount by which the sum of (1) weekly benefits to which the employee is entitled under 42 U.S.C. 401 - 433, and (2) weekly disability benefits to which the employee would otherwise be

> entitled under this chapter, exceeds 80 percent of the employee's average weekly wages at the time of injury.

Stanley v. Wright-Harbor, AWCB Dec. No. 82-0039 (February 19, 1982) *aff'd* 3 AN-82-2170 Civil (Alaska Super. Ct. May 19, 1983), established guidelines for calculating an employer's Social Security offset under AS 23.30.225(b) and held an offset must be based upon an employee's initial Social Security entitlement. Social Security offsets are calculated as follows:

> A. Determine employee's Gross Weekly Earnings (GWE)
>
> B. From GWE, determine Weekly Compensation Rate for worker's compensation (Weekly WC Rate)
>
> C. Calculate employee's Weekly Social Security benefit by multiplying monthly payment x 12 and ÷ 52 (Weekly SS Benefit)
>
> D. Add Weekly WC Rate + Weekly SS Benefit [B + C]
>
> E. Calculate 80% of GWE [80% of A]
>
> F. Calculate Social Security Offset [D – E]. *Id.*

> **AS 44.62.330. Application of AS 44.62.330 – 44.62.630.** (a) The procedure of the state boards . . . listed in this subsection . . . shall be conducted under AS 44.62.330 -- 44.62.630. This procedure, including . . . conduct of hearing . . . and similar matters shall be governed by this chapter, notwithstanding similar provisions in the statutes dealing with the state boards . . . listed.
> . . . .
>
> (12) Alaska Workers' Compensation Board, where procedures are not otherwise expressly provided by the Alaska Workers' Compensation Act. . . .

> **AS 44.62.450. Hearings**.
> . . . .
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> (c) A hearing officer or agency member shall voluntarily seek disqualification and withdraw from a case in which the hearing officer or agency member cannot accord a fair and impartial hearing or consideration. A party may request the disqualification of a hearing officer or agency member by filing an affidavit, before the taking of evidence at a hearing, stating with particularity the grounds upon which it is claimed that a fair and impartial hearing cannot be accorded. . . .

> **8 AAC 45.020. Transaction of business.** . . . (d) Papers and documents filed by facsimile transmission or by electronic mail must be in compliance with the following:
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> > . . . .
> >
> > (5) a document is considered filed upon receipt unless received on a Saturday, Sunday, a day the board is closed due to a state-recognized closure, or after 5:00 p.m. Alaska time; if the document is filed on a Saturday, Sunday, a day the board is closed due to a state-recognized closure, or after 5:00 p.m. Alaska time, the filing date will be the next working day;
>
> **8 AAC 45.052. Medical summary.** . . . (c) Except as provided in (f) of this section, a party filing an affidavit of readiness for hearing must attach an updated medical summary, on form 07-6103, 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, together with the affidavit of readiness for hearing and an updated medical summary and copies of the medical reports listed on the medical summary, if required under this section.
> >
> > . . . .

The worker's compensation system in Alaska favors the production of medical evidence in the form of written reports, and this preference serves a legitimate purpose. *Employers Commercial Union Insurance Group v. Schoen*, 519 P.2d 819; 822 (Alaska 1974). However, "the statutory right to cross-examination is absolute and applicable to the Board." *Id*. at 824. The medical summary and request for cross-examination process set out in 8 AAC 45.052 was developed in response to the Court's decision in *Commercial Union Insurance Companies v. Smallwood*, 550 P.2d 1261 (Alaska 1976) (holding the employer did not waive its right to cross-examine the employee's treating physicians). This decision is so firmly entrenched in the Alaska's workers' compensation system that the objection to the admission of medical reports based on the unavailability of the author for cross-examination is commonly referred to as a "*Smallwood* objection." 8 AAC 45.900(11).

Medical records, including doctors' chart notes, opinions, and diagnoses, fall squarely within the business records exception to the hearsay rule. *Dobos v. Ingersoll*, 9 P.3d 1020; 1027 (Alaska 2000). However, letters written by a physician to a party or a party's representative to express an expert medical opinion on an issue before the tribunal are not admissible as a business record unless the requisite foundation is established showing it is the physician's regular practice to prepare and send such letters. *Liimatta v. West*, 45 P.3d 310, 318 (Alaska 2002).

> **8 AAC 45.063. Computation of time.** (a) In computing any time period prescribed by the Act or this chapter, the day of the act, event, or default after which the designated period of time begins to run is not to be included. The last day of the period is included, unless it is a Saturday, Sunday or a legal holiday, in which case the period runs until the end of the next day which is neither a Saturday, Sunday nor a holiday.
>
> (b) Upon petition by a party and for good cause, the board will, in its discretion, extend any time period prescribed by this chapter.
>
> **8 AAC 45.070. Hearings.** . . .
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> (i) At hearing, the board will consider a legal memorandum only if it is in accordance with 8 AAC 45.114.
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> **8 AAC 45.105. Code of conduct**. . . .
> . . . .
>
> (c) The recusal of a board panel member for a conflict of interest under the procedures set out in 8 AAC 45.106 may occur only if the recusal is based on clear and convincing evidence that the board panel member
>
> (1) has a conflict of interest that is substantial and material; or
> (2) shows actual bias or prejudgment.
>
> (d) The recusal of a board panel member to avoid impropriety or the appearance of impropriety under the procedures set out in 8 AAC 45.106 may occur only if the recusal is based on clear and convincing evidence that the board panel member
>
> (1) has a personal or financial interest that is substantial and material; or
> (2) shows actual bias or prejudgment.
>
> **8 AAC 45.106. Procedures for board panel members to avoid conflict of interest, impropriety, and appearance of impropriety**. . . .

. . . .

(d) If before a scheduled hearing begins, a party has knowledge of a potential conflict of interest or knowledge that a board panel member's circumstances may present a potential impropriety or appearance of impropriety, the party may file a petition with the commissioner, or the commissioner's designated hearing officer under AS 23.30.005(b), objecting to the board panel member and briefly outline the reasons. If a petition is filed under this subsection, the commissioner, or the commissioner's designated hearing officer, shall forward the objection to the board panel member who is the subject of the petition for the member's review. If the board panel member does not recuse oneself from the proceeding, the remaining board panel members shall determine whether the board panel member who is the subject of the petition may hear the case.

8 AAC 45.114. Legal memoranda. Except when the board or its designee determines that unusual and extenuating circumstances exist, legal memoranda must

(1) be filed and served at least five working days before the hearing, or timely filed and served in accordance with the prehearing ruling if an earlier date was established;

. . . .

8 AAC 45.120. Evidence. (a) Witnesses at a hearing shall testify under oath or affirmation. The board will, in its discretion, examine witnesses and will allow all parties present an opportunity to do so. Except as provided in this subsection and 8 AAC 45.112, a party who wants to present a witness's testimony by deposition must file a transcript of the deposition with the board at least two working days before the hearing. If the board determines that a party is extremely indigent and cannot afford to pay the transcription fee, the board will rely upon the audio or visual recording of the deposition without a transcript. If a party fails to file a transcript of a witness's deposition at least two days before the hearing and if the board or its designee determines that neither unusual and extenuating circumstances exists nor is the party extremely indigent, the witness's deposition testimony will be excluded from the hearing, except for impeachment purposes, and will not be relied upon by the board in reaching its decision. If the board or its designee determines that unusual and extenuating circumstances exist, the board or its designee will determine whether to rely upon either the late-filed transcript or upon the audio or visual recording of the deposition without a transcript.

(c) Each party has the following rights at hearing:

(1) to call and examine witnesses;
(2) to introduce exhibits;

> (3) to cross-examine opposing witnesses on any matter relevant to the issues even though the matter was not covered in the direct examination;
> (4) to impeach any witness regardless of which party first called the witness to testify; and
> (5) to rebut contrary evidence.

> (e) Technical rules relating to evidence and witnesses do not apply in board proceedings, except as provided in this chapter. Any relevant evidence is admissible if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil actions. Hearsay evidence may be used for the purpose of supplementing or explaining any direct evidence, but it is not sufficient in itself to support a finding of fact unless it would be admissible over objection in civil actions. The rules of privilege apply to the same extent as in civil actions. Irrelevant or unduly repetitious evidence may be excluded on those grounds.
> (f) Any document, including a compensation report, controversion notice, claim, application for adjustment of claim, request for a conference, affidavit of readiness for hearing, petition, answer, or a prehearing summary, that is served upon the parties, accompanied by proof of service, and that is in the board's possession 20 or more days before hearing, will, in the board's discretion, be relied upon by the board in reaching a decision unless a written request for an opportunity to cross-examine the document's author is filed with the board and served upon all parties at least 10 days before the hearing. The right to request cross-examination specified in this subsection does not apply to medical reports filed in accordance with 8 AAC 45.052; a cross-examination request for the author of a medical report must be made in accordance with 8 AAC 45.052.

Parties have a constitutional right to prove or defend against claims or petitions. *Granus v. Fell*, AWCB Dec. No. 99-0016 (January 20, 1999). A thorough investigation allows parties to verify information provided by an opponent, effectively litigate issues, and detect fraud. *Id*. Information inadmissible at a civil trial may be discoverable in a workers' compensation case if it is reasonably calculated to lead to relevant facts. *Id*. *Granus* provided a two-step analysis to determine if information was discoverable: (1) Identify matters in dispute; this requires the designee to, at a minimum, review both the claims (which generally state the issues from the injured worker's perspective) and the answers and controversions (which generally state the issues from the employer's perspective). (2) Decide (*i.e.*, analyze) whether the information sought is relevant; or in other words, is it "reasonably calculated" to lead to admissible facts that will tend to make a disputed issue, identified in step (1), more or less likely.

8 AAC 45.900. Definitions. (a) In this chapter

. . . .

(11) "Smallwood objection" means an objection to the introduction into evidence of written medical reports in place of direct testimony by a physician; see *Commercial Union Insurance Companies v. Smallwood*, 550 P.2d 1261 (Alaska 1976);

8 AAC 45.225. Social security and pension or profit sharing plan offsets.

. . . .

(b) An employer may reduce an employee's weekly compensation under AS 23.30.225(b) by

(1) getting a copy of the Social Security Administrations award showing the

(A) employee is being paid disability benefits;

(B) disability for which the benefits are paid;

(C) amount, month, and year of the employee's initial entitlement; and

(D) amount, month, and year of each dependent's initial entitlement;

(2) computing the reduction using the employee or beneficiary's initial entitlement, excluding any cost-of-living adjustments;

(3) completing, filing with the board, and serving upon the employee a petition requesting a board determination that the Social Security Administration is paying benefits as a result of the on-the-job injury; the petition must show how the reduction will be computed and be filed together with a copy of the Social Security Administration's award letter;

(4) filing an affidavit of readiness for hearing in accordance with 8 AAC 45.070(b); and

(5) after a hearing and an order by the board granting the reduction, completing a Compensation Report form showing the reduction, filing a copy with the board, and serving it upon the employee.

. . . .

(d) An employee . . . who is receiving weekly compensation benefits shall

(1) send the employer a copy of the award letter from the Social Security Administration . . . .; and

> (2) upon the employer's request, sign a release for the employer to get information from the Social Security Administration . . . .

In *Underwater Construction, Inc. v. Shirley*, 884 P.2d 150 (Alaska 1994), the Alaska Supreme Court held "'average weekly wages' as a benefit cap under AS 23.30.225(b) is synonymous with 'gross weekly earnings' under AS 23.30.220, insofar as both terms represent a measure of historical earning capacity." *Id*. at 156.

ANALYSIS

1) Was the oral order overruling Employee's objection to consideration of the video of his deposition correct?

Employee objected to consideration of the video of his September 6, 2023 deposition, contending Employer filed it late under 8 AAC 45.120(f) because it did not file an evidence list at least 20 days before the hearing and he did not have enough time to review it with his attorney prior to hearing. Employer contended it did not file it late under 8 AAC 45.120(a).

The November 25, 2025 prehearing conference summary ordered the parties to file "exhibits or other documentary evidence" by 5:00 p.m. Alaska Time on January 14, 2026. The designee did not order the parties to file an evidence list at least 20 days before the hearing. The designee also did not provide an order addressing when deposition transcripts and videos must be filed. 8 AAC 45.120(a) states that a deposition transcript must be filed at least two working dates before the hearing and if a party fails to do so, the panel must determine unusual and extenuating circumstances exists or the party is extremely indigent otherwise the testimony will be excluded from the hearing, except for impeachment purposes, and will not be relied upon. It also states, if the panel "determines that a party is extremely indigent and cannot afford to pay the transcription fee," the panel "will rely upon the audio or visual recording of the deposition without a transcript." Employer filed Employee's September 6, 2023 deposition transcript on January 21, 2026, and the video of Employee's September 6, 2023 deposition on January 27, 2026. Employer timely filed the video six days before the hearing. 8 AAC 45.120(a). The oral order overruling Employee's objection to consideration of the video of his deposition was correct.

2) Was the oral order keeping the record open to take Dr. Villanueva's testimony on March 3, 2026 correct?

Employee objected to consideration of Dr. Villanueva's October 23, 2025 deposition transcripts, contending his due process rights would be violated if it were considered because his attorney was ill and unable to attend the deposition, which Employer knew and it continued with the deposition in his absence. Employer contended depositions are taken according to the Alaska Rules of Civil Procedure, and the onus is on Employee to file a petition for a continuance or an order requiring it be rescheduled, which he failed to do.

Employer took Dr. Villanueva's deposition on October 23, 2025, and Flanigan's paralegal advised Meshke he was ill with pneumonia and on the way to the hospital and Employer continued with Dr. Villanueva's deposition without Flanigan. Flanigan became ill and was unable to cross-examine Dr. Villanueva and the October 29, 2025 hearing was continued by Employer's agreement due to Flanigan's illness under 8 AAC 45.074(b)(1)(C). On May 20, 2025, Employee requested cross-examination of Dr. Villanueva; he made a "*Smallwood*" objection. 8 AAC 45.052; 8 AAC 45.900(11). Dr. Villanueva's November 9, 2023 EME report is hearsay prepared for litigation purposes and does not fall under the business record exception. Evidence Rule 803(6); *Smallwood*; *Dobos*; *Liimatta*. Thus, the onus is on Employer to present Dr. Villanueva for cross-examination at hearing or a deposition because Employee made a "*Smallwood*" objection. Employer agreed to continue the October 29, 2025 hearing due to Flanigan's illness and the October 24, 2025 letter from NP Sather excused Flanigan from working from October 23 through November 2, 2025. On February 2, 2026, Employer noticed Dr. Villanueva's continued deposition would be taken on March 3, 2026. The oral order keeping the record open to take Dr. Villanueva's testimony on March 3, 2026 was correct.

3) Was the oral order overruling Employee's objection to consideration of deposition transcripts correct?

Employee objected to consideration of deposition transcripts filed by Employer on January 21, 2026, including deposition of Drs. Flanum, Bauer, McCormack, and Villanueva and Employee. He contended the November 25, 2025 Prehearing Conference Summary ordered the parties to file all evidence, including deposition transcripts, at least 20 days before the hearing. Employer

contended the November 25, 2025 Prehearing Conference Summary required the filing of exhibits or other documentary evidence 20 days before the hearing and did not provide a date to file deposition transcripts. The November 25, 2025 Prehearing Conference Summary ordered the parties to file "exhibits or other documentary evidence" by 5:00 p.m. Alaska Time on January 14, 2026. The designee did not order the parties to file an evidence list at least 20 days before the hearing. The designee also did not provide an order addressing when deposition transcripts and videos must be filed. 8 AAC 45.120(a) states that a deposition transcript must be filed at least two working dates before the hearing. Two days before the February 3, 2026 hearing was January 30, 2026. 8 AAC 45.063(a). Employer timely filed the deposition transcripts on January 21, 2026. The oral order overruling Employee's objection to consideration of the subject deposition transcripts was correct.

4) Should Employer's objection to Employee's October 23, 2025 hearing brief be sustained?

Employer objects to consideration of Employee's October 23, 2025 hearing brief, contending it was filed late. Employee contends his attorney was ill and Employer agreed to a continuation of the October 29, 2025 hearing due to his illness and his hearing brief was filed late due to the same illness. The July 22, 2025 Prehearing Conference Summary ordered the parties to file hearing briefs by October 22, 2025, which was five working days before the October 29, 2025 hearing.

8 AAC 45.114 states that a hearing brief must be filed at least five working days before the hearing or by a date established in a prehearing conference except when the panel determines unusual and extenuating circumstances exist. 8 AAC 45.020(d) states documents filed by email must be filed by 5:00 p.m. Alaska Time and if it is filed afterwards, the filing date would be the next working day. 8 AAC 45.070(i) provides that a hearing brief can only be considered if it is filed in accordance with 8 AAC 45.114. On October 22, 2025, at 6:14 p.m. Alaska Time, Employee filed his hearing brief; his brief is considered filed on October 23, 2025. Employee filed his hearing brief one hour and fourteen minutes late.

Flanigan was taken to the hospital on October 23, 2025, the day after the hearing briefs were due, and he was excused from work by NP Sather due to bilateral pneumonia. Employer agreed to continue the October 29, 2025 hearing due to Flanigan's illness per 8 AAC 45.074(b)(1)(C). Flanigan's illness was good cause to continue the October 29, 2025 hearing. It was also good cause to extend the hearing brief deadline. 8 AAC 45.063(b). Employer's objection to Employee's October 23, 2025 hearing brief should not be sustained; an order overruling it will be issued.

5) Was the oral order denying Employer's request to disqualify Member Ladd correct?

Panel members hearing workers' compensation cases must be fair, impartial, and free from actual bias, prejudgment, substantial and material conflicts of interest and must avoid impropriety and the appearance of impropriety . A panel member should recuse himself if he determines he cannot meet these requirements. Parties to hearings have the right to seek a panel member's disqualification on these grounds. AS 23.30.001(4); 8 AAC 45.105(c)(1), (2) and (d)(1)(2); 8 AAC 45.106 (b), (c), (d). The Alaska Workers' Compensation Act is silent on how recusal and disqualification requests are handled procedurally. The Administrative Procedures Act (APA) therefore applies. AS 44.62.330(a)(12). The APA states a party may request a hearing officer's disqualification by "filing an affidavit, before the taking of evidence at a hearing, stating with particularity the grounds upon which it is claimed that a fair and impartial hearing cannot be accorded." AS 44.62.450(c).

Employer did not file an affidavit. It contended at hearing that Member Ladd's questioning of Employee regarding the stopped TTD benefit check, and statements he made, showed bias and prejudgment. Employer also contended Member Ladd's questioning of Dr. Koenen, and statements he made also showed bias and prejudgment. It orally requested Member Ladd be disqualified. Employee objected to Employer's request to disqualify Member Ladd, contending the questioning and statements made did not show bias or prejudgment.

Member Ladd stated he was not biased and had not prejudged and declined to recuse himself, turning the matter over to the remaining panel members for their decision on disqualification. 8

AAC 45.106(d). A party seeking to disqualify a panel member for conflict of interest has the burden to show by "clear and convincing evidence," the member has a "substantial and material" conflict or shows actual bias or prejudgment. 8 AAC 45.105(c)(1), (2). To disqualify a panel member to avoid "impropriety or appearance of impropriety," the moving party must show by "clear and convincing evidence" the panel member has a "substantial and material" personal or financial interest or shows actual bias or prejudgment. 8 AAC 45.105(d)(1), (2). The remaining two panel members deliberated and based on Employer's allegations and Member Ladd's response, denied the disqualification request. 8 AAC 45.106(d). The hearing transcript shows Member Ladd was confused regarding when TTD payments were stopped and by Employee's testimony regarding when Employer stopped a TTD benefit check. He asked questions regarding the Act's requirements for notification when payments are stopped "as it boggled" his mind and he wanted to know how an overdrawn bank account could be prevented in in the future, "I just want to know that so it doesn't happen again." Meshke stated the only thing she could think of what a duplicate payment went out, and Flanigan stated it should not have happened because recoupment is only allowed by withholding future benefits.

Dr. Koenen testified, "I've done thousands of evaluations of people that are homeless, and good decision and logical decision making is never anything I've ever associated with any of those evals. So if poor decision making led to here, that would be consistent with every other person I've ever talked to who lives in a car." Member Ladd said he was "kind of vexed" by Dr. Koenen's comment and asked Dr. Koenen whether he had ever had hard times, like living his car or anything like that, and Dr. Koenen answered no. The deliberating panel members found Employer offered inadequate evidence to support its disqualification request based upon actual bias or prejudgment; the panel properly applied the law and the oral order denying the disqualification request was correct. AS 44.62.450(c).

6) Should Employer's objection to Employee's evidence and testimony regarding a stopped TTD benefit check be sustained?

Employer objected to Employee's testimony and Eunice's testimony regarding a stopped TTD benefit check and a letter from Employee's bank and the second page of a SROI, contending it was irrelevant and "intended only to illicit bias against the insurer." Employee contended the

evidence and testimony are relevant to Employee's and Eunice's credibility and to his request for a finding of unfair or frivolous controversion.

Employee has the right to prove his claim. *Granus*. 8 AAC 45.120(e) states, "Any relevant evidence is admissible if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil actions." 8 AAC 45.120(c) provides each party the right to call and examine witnesses and to introduce evidence. Information inadmissible at a civil trial may be discoverable in a workers' compensation case if it is reasonably calculated to lead to relevant facts. *Granus*. On November 2, 2022, Employer denied all benefits after the October 12 and 19, 2022 EMEs. On November 28, 2022, Employer reported it voided an indemnity benefit check in the amount of $1,251.56 and that TTD benefits were paid from February 23, 2022 through October 11, 2022, in the weekly amount of $625.78. On April 21, 2023, Employee sought additional TTD benefits and a finding of unfair or frivolous controversion in his claim. Employee contended Employer unfairly or frivolously controverted benefits when it voided a TTD benefit check before it filed a controversion on November 2, 2022. On May 15, 2024, Employer denied all disability and medical benefits for orthopedic conditions after October 12, 2022, all benefits for any other condition after October 19, 2022, and an unfair or frivolous controversion finding based upon Drs. Bauer's and Chong's EME report cited in its controversion and answer. Employee's and Eunice's testimony, and the November 3, 2022 letter are reasonably calculated to his request for TTD benefits and for a finding of unfair or frivolous controversion and to assess Employee's and Eunice's credibility. Employer's objection to Employee's evidence and testimony regarding a stopped TTD benefit check should not be sustained; an order overruling it will be issued.

7) Is Employee entitled to medical and transportation costs and additional TTD benefits?

Employee sought TTD benefits and medical and transportation costs for injuries to his neck, back, and wrist and for symptoms from a concussion, including sleeping problems, headaches, migraines, depression, anxiety, and cognitive and memory issues, facial numbness, photosensitivity, motor function deficits, vision issues, and tinnitus. Employer denied all

benefits after the October 12 and 19, 2022 EMEs, relying on Dr. Bauer's and Chong's EME reports to contend the work injury was not the substantial cause of Employee's need for medical care and disability, and he was medically stable with no PPI. The presumption of compensability applies to this dispute. AS 23.30.120(a)(1); *Meek*; *Carter*.

Without examining witness credibility, Employee established a preliminary link between his claim and his employment with his testimony and Drs. Fix's, Downs's, Flanum's, and Barrington's opinions. *Wolfer*; *Cheeks*; *Burgess*; *Ugale*.

Without addressing credibility, Employer rebutted the presumption with Drs. Bauer's, Chong's, Koenen's, and Villanueva's EME reports with substantial medical evidence. *Norcon*; *Huit*; *Miller*. Dr. Bauer, an orthopedist, diagnosed a closed head injury, back contusion, congenital spinal stenosis without aggravation, acceleration, or change caused by the work injury, symptom exaggeration, no wrist or hand fracture, and unrelated left hand trigger finger. He said the mechanism of injury for the work injury would not cause trigger finger or disc herniation. Dr. Bauer stated Employee became medically stable on July 1, 2022, without any work restrictions or a PPI rating. He did not recommend further medical treatment.

Dr. Chong, the pain medicine and rehabilitation specialist EME, diagnosed a cervical sprain/strain related to the work injury and nonwork related preexisting back pain, trigger finger, preexisting cervical spine multilevel degenerative disc disease and spondylosis with neural foraminal stenosis not aggravated by the work injury, preexisting lumbar multilevel degenerative disease and spondylosis with spinal stenosis, and profound symptom magnification. He ruled out seizures based on the EEG. Dr. Chong opined the medical treatment to date had been reasonable and necessary except for the ESI because Employee did not demonstrate a clear radiculopathy. He released Employee to work without restrictions and referred him to a psychiatric or neuropsychological EME to ascertain the validity of the behavioral screening instruments which are marked showing severe anxiety and severe depression.

Dr. Villanueva, the neuropsychologist EME, found no evidence of a neuropsychological diagnosis and found no indications of cognitive or neuropsychological symptoms or related

disability as the concussion injury was quite mild. He opined the work injury was no longer the substantial need for treatment three months after the injury for neuropsychological symptoms, such as sleep disruptions and headaches, there were no indications for a PPI rating, and no restrictions for a neuropsychological standpoint.

Dr. Koenen, the psychiatric EME, diagnosed panic disorder, agoraphobia, mild depressive disorder, and a somatoform disorder. He noted Employee's preexisting anxiety and found no relationship between Employee's psychiatric conditions and the work injury. Dr. Koenen stated Employee's work-related concussion symptoms resolved within a few weeks and he never had a psychiatric condition attributable to the work injury. He said malingering was a strong possibility based upon Employee's profound symptom magnification and presentation. Dr. Koenen recommended an antidepressant and psychotherapy but stated Employee's need for treatment was unrelated to the work injury but may facilitate his return to work. Dr. Koenen opined there were no psychiatric work restrictions related to the work injury.

Because Employer produced substantial evidence, the presumption dropped out and Employee must prove the work injury is the substantial cause of his need for medical treatment and disability. *Runstrom*; *Koons*. The relative contribution of different causes of his disability and need for medication treatment must be evaluated. AS 23.30.010(a). Preexisting conditions do not disqualify a claim if the employment aggravated, accelerated, or combined with the preexisting infirmity to produce the disability and need for medical treatment. *DeYonge*. The panel must consider the different causes of the benefits sought and decide whether the work injury was a cause important enough to bear legal responsibility for the medical treatment and disability by looking at the cause of the symptoms rather than considering the injury type. *Morrison*.

The treating orthopedist, Dr. Flanum, recommended an L4-5 decompression on October 10, 2022, he restricted Employee from working, and attributed his restrictions to the work injury. Dr. Flanum stated he did not concur with Dr. Chong's October 19, 2022 EME report, the ESI was for lumbar radiculopathy, and that the timing of the disc displacement at L4-5 was "unknown but should be treated." However, Dr. Flanum noted on August 10, 2022, that

Employee had no clear radicular symptoms, which is inconsistent with his statement that the ESI was for lumbar radiculopathy. Dr. Flanum could not attribute anything in Employee's cervical spine to the work injury, and recommended he leave his neck "well enough alone" and said the work injury made his lumbar spine become symptomatic on August 10, 2022. Like Drs. Downs and Hines, Dr. Flanum did not review Employee entire medical history and was not aware of Employee's preexisting lumbar and neck pain in 2019 and 2021. His opinion will be given lesser weight. AS 23.30.122; *CSK Auto*; *Smith*; *DeRosario.* Dr. Chong reviewed Employee entire medical record and noted Dr. Flanum's inconsistency regarding the radiculopathy; his opinion will be given more weight. *Id.*

The only physicians that opined the work injury is the cause for Employee's need for medical treatment and disability for his cervical and lumbar spine after October 12 and 19, 2022, are Drs. Fix and Barrington and NP Green, although Employee's arguments did not rely upon NP Green's opinions. Dr. Fix, Employee's treating neurosurgeon, diagnosed congenital spinal stenosis with lumbar disc herniation at L4-5 with moderately severe stenosis, a history of TBI, depression, and chronic pain; she recommended a lumbar decompression with partial discectomy at L4-5. At hearing on February 3, 2026, Dr. Fix testified that while she had no doubt Employee had preexisting disease, Employee was able to perform heavy work before the work injury without any difficulty. She believed his ability to work before the work injury and his inability to work afterwards strongly suggests that there was a trigger for the progression of his symptoms. She presumed the fall changed something in his disc that brough him in for treatment. Dr. Fix assumed the cervical treatment was related to the work injury in her testimony. She said the cervical laminoplasty could improve Employee's canal diameter to address his neck symptoms and congenital stenosis.

Dr. Fix's opinion is given less weight because she testified she did not review anyone else's records about Employee, including his past medical records indicating Employee had preexisting lumbar pain in 2019 and 2021, depression in December 2019, that he had been prescribed propranolol, and in September 2021, reported his anxiety was much better using it. AS 23.30.122; *CSK Auto*; *Smith*; *DeRosario.* Furthermore, the basis of Dr. Fix deciding the work injury was the factor causing Employee's need for lumbar medical treatment and disability is

based upon the assumption that because his inability to work occurred after the work injury, the work injury is the cause of his inability to work. Post hoc, ergo proper hoc has been rejected as the basis to award benefits in workers' compensation cases. *Rife*. Her opinion is also given less weight because of her reliance on post hoc, ergo proper hoc reasoning. AS 23.30.122; *CSK Auto*; *Smith*; *DeRosario; Rife*. Finally, because Dr. Fix attributed Employee's need for cervical laminoplasty to his narrow spinal canal, a congenital medical condition not caused by the work injury, and she could not answer whether Employee's cervical spine treatment was related to the work injury, her opinion is given less weight. *Id*.

Like Dr. Fix, Dr. Barrington, a chiropractor, reasoned that because Employee was working before the work injury and was unable to work afterwards, the work injury caused his inability to work. He opined the work injury exacerbated Employee's preexisting conditions. Dr. Barrington provided a four percent PPI rating for Employee's lumbar stenosis that was work related because although it was preexisting, "it was not activated before" his work injury and "subsequent disc bulge" and offered a zero percent PPI rating for his cervical spine. He did not review any records besides the one record sent to him by Dr. Hines, he did not ask Employee whether he had any symptoms before the work injury, and he was not aware of any medical treatment before the work injury. Dr. Barrington's opinion will be given less weight because he did not review Employee's past medical history and he relied upon post hoc, ergo proper hoc reasoning. AS 23.30.122; *CSK Auto*; *Smith*; *DeRosario; Rife*.

NP Green opined the work injury is the substantial cause of Employee's lumbar pain, migraines, memory deficits, and neurological deficits because prior to the work injury, Employee did not experience the symptoms to the degree he does after the work injury. However, on February 1, 2023, NP Green assessed a TBI with loss of consciousness of six to 24 hours, and a loss of consciousness of that duration is not supported by any medical record or testimony. The records show he lost consciousness for a minute at most. Furthermore, NP Green's February 28, 2023 letter, demonstrated she was more like an advocate for Employee by arguing Employer unethically withheld neurological evaluations and stating Dr. Chong had "a longstanding reputation of incestuous relationships with the insurance companies," Dr. Chong and Ms. Freiss have "ruined the lives of far too many individuals," and she would "will not allow this to

continue." Based on this unsubstantiated and overstated loss of consciousness and her focus on advocacy rather than an accurate diagnosis, NP Green's opinion will be given less weight. AS 23.30.122; *CSK Auto*; *Smith*; *Rosario*.

Employee saw two neurologists. Dr. Downs, a neurologist, diagnosed chronic post-traumatic headache and "reactive depression." He said the head trauma "activated a migraine" and prescribed medications for the migraine and Lexapro for depression on June 2, 2022, and he referred Employee to a psychiatrist. Dr. Downs did not review Employee's past medical records, including his past history of headaches, anxiety, and depression from 2019. Initially, Dr. Hines diagnosed Employee with TBI and PTSD. Employee's July 28, 2022 EEG was normal awake and asleep. On September 30, 2022, Dr. Hines found no residual TBI and ruled out seizures; he attributed Employee's memory lapses and "possible convulsions" to stress, anxiety, and depression and recommended behavioral health treatment. He stated Employee was able to return to work with no neurological restriction, reached medical stability, had no PPI rating, and was released from medical care on September 30, 2022. Like Dr. Downs, Dr. Hines did not review Employee's past medical record, including his past history of headaches, anxiety, and depression from 2019. He also did not address whether or not Employee's need for behavioral health treatment was due to the work injury. Drs. Downs and Hines opinions will be given lesser weight than Drs. Villanueva's and Koenen's opinions. AS 23.30.122; *CSK Auto*; *Smith*; *DeRosario.*

Dr. Hoofbourrow, a family medicine doctor, diagnosed TBI, vertigo, back pain, frequent headaches, neck pain, neurological disorder of eye movements, primary insomnia, and current episode of depression without prior episode. However, in December 2019, Employee reported having higher anxiety for the last two years, depression, and restless sleep. He was prescribed propranolol, and in September 2021, he reported his anxiety was much better using it. Employee also had preexisting headaches and neck and back pain in 2019 and 2021. Employee reported sleep disturbances and restless sleep in April 2021, when he had a hernia and was referred for chiropractic care for thoracic spine pain. Dr. Hoofbourrow did not review Employee's past medical records. His opinion will be given less weight. AS 23.30.122; *CSK Auto*; *Smith*; *DeRosario.*

Dr. Myers, Employee's treating ophthalmologist, found Employee's vision to be normal on July 5, 2022 and October 13, 2022. She agreed with referring him to psychiatry and said he needed no further treatment or testing. Dr. Myers did not address whether Employee's need for psychiatric care was due to the work injury. Her opinion regarding Employee's need for psychiatric care will be given less weight. AS 23.30.122; *CSK Auto*; *Smith*; *DeRosario.*

Dr. McCormack, an orthopedic surgeon, performed an SIME, and assessed work related neck and back muscle sprains and a minor head injury with post traumatic headache, congenital lumber stenosis worse on the left at L4-5 and bilateral lateral gutter stenosis at L5-S1 unrelated to the work injury, cervical disc disease unrelated to the work injury, and chronic pain syndrome, for which he deferred causation to a pain specialist. He said Employee reached medical stability within three to four months after the work injury and he did not recommend any additional treatment for the work injury. Dr. McCormack assessed a zero percent PPI rating for Employee's spine and minor head injury and said Employee was capable of working as an auto technician. He opined the lumbar radiculopathy and need for decompression surgery is not caused by the work injury and was not aggravated by the work injury and Employee's cervical disc disease was degenerative, age appropriate, and not caused by the work injury. Dr. McCormack noted inconsistencies in the medical history Employee provided to him when compared to the medical record and inconsistencies in his urinary issues and presentation of disability. He noted psychiatric issues have a lot of "overlap" with concussion type symptoms.

Dr. Kimmel, the psychological SIME, diagnosed a conversion disorder and other specified depressive disorder with anxious distress. He said Employee's delayed recovery could only be explained by either malingering or a dormant psychiatric syndrome. Dr. Kimmel did not believe Employee was a malingerer but that the work injury "likely activated a dormant psychiatric syndrome" and that his prior psychiatric problems were "likely activated by" the work injury. He said the substantial cause of Employee's disability and need for medical treatment is his preexisting, non-industrial psychiatric vulnerability to the expression of the conversion disorder but the work injury resulted in a permanent change because he has become "entrenched in a variety of physiological, emotional, and cognitive symptoms." Dr. Kimmel opined Employee

continued to be disabled due to a combination of industrial and nonindustrial factors, but he reached medical stability within 90 days from the work injury given the mild concussion. He recommended 12 to 15 sessions of cognitive behavioral therapy from a pain psychologist "geared towards disabusing him of many of his negative beliefs regarding his problems." The treatment would not allow him to fully recover from the injury but it "*could* be helpful," by helping reduce the pain, promoting recovery, and by probably reducing permanent impairment. Dr. Kimmel assessed a five percent PPI rating for mild impair of working memory, processing speed, and inconsistent work learning. He found Employee able to resume all usual roles and perform activities of daily living.

The medical records shows Employee's preexisting anxiety was active before the work injury because he began treating for high anxiety since December 2019 and reported it was treated successfully with propranolol about six months before the work injury in September 2021. Employee also reported depression in December 2019. Dr. Kimmel's opinion will be given less weight because his opinion is based upon his conclusion that Employee's psychiatric conditions were dormant before the work injury, which is not true based upon the medical record. AS 23.30.122; *CSK Auto*; *Smith*; *DeRosario.*

Dr. Davis, the psychiatric SIME, found Employee to be a "grossly credible historian" and diagnosed chronic adjustment disorder with mixed anxiety and depressive mood. He assigned 10 percent causation to preexisting anxiety but said there was no clear psychiatric or psychological treatment, 70 percent causation to "musculoskeletal/orthopedic pain and disability presumed due to the slip and fall at work on February 22, 2022," but deferred to the appropriate orthopedic specialist, and 20 percent to neurocognitive problems, including headache and cognitive issues "also presumed due to" the work injury but deferred to the appropriate neurologic specialist. While Dr. Davis opined the substantial cause of Employee's psychiatric condition is the work injury and he recommended psychotherapy and psychotropic medication management, he also opined Employee was never disabled based on a purely psychiatric basis and he was able to work on a psychiatric basis. If Dr. Davis's opinion is relied upon, at best, it supports awarding psychotherapy and psychotropic medication management but not disability benefits.

There are numerous inconsistencies in Employee's and Eunice's testimony and the medical record, including the following:

- On February 23, 2022, Employee estimated he lost consciousness for about a minute after he slipped and fell at work. On March 24, 2022, he told Dr. Miknich he thought he lost consciousness for a few seconds. On July 1, 2022, Employee told Dr. Bauer he lost consciousness for just a few seconds but thought it could have been up to a minute or so. On November 7, 2023, Employee told Dr. Koenen he lost consciousness for a minute or two. Employee told Dr. Davis on June 3, 2024 that his coworkers told him he lost consciousness for a minute.
- On October 19, 2022, Employee told Dr. Chong his coworkers pulled him to a sitting position, yet on February 23, 2022 he told Dr. Quimby and on November 9, 2023, he told Dr. Villanueva his coworkers were unable to lift him up due to his size and he got up on his own. On November 7, 2023, Employee told Dr. Koenen his coworkers helped him up.
- Eunice wrote in the August 6, 2025 Function Report that a cane was prescribed after the work injury. There is no medical record in the file recommending Employee use a cane. Employee used a cane in his right hand in the surveillance video on October 19, 2022, he used a cane in his right hand on June 5, 2024 during Dr. McCormack's SIME, and he used a cane in his left hand on April 4, 2025 when visiting Dr. Barrington.
- Employee denied any history of childhood adversity to Dr. Villanueva on November 9, 2023, and said he met his wife in Alaska and has been married since 2011. He told Dr. Davis on June 3, 2024, that he left American Samoa due to war and famine and married his wife in American Samoa. He told Dr. Kimmel on August 26, 2024, that he and his wife moved to Alaska from Samoa because of low wages in Samoa. Employee and Eunice testified at hearing they married in Anchorage.
- On February 23, 2022, Employee told Dr. Quimby he has a history of head trauma as a football and rugby player about 15 years ago. He was able to rotate his neck further on exiting the clinic than what he presented on examination with Dr. Quimby. In his September 6, 2023 deposition, Employee did not agree that he had prior concussions

playing rugby. On June 3, 2024, he also denied any sporting injuries to Dr. Davis and on August 26, 2024, denied a history of closed head injuries to Dr. Kimmel.

- Employee told Dr. Villanueva on November 9, 2023, that he only took propranolol for about a month before the work injury. On August 26, 2024, he denied taking psychiatric medicines to Dr. Kimmel. The medical record shows NP Green prescribed him propranolol on December 19, 2019, and on September 2, 2021, he reported to her his anxiety was better using propranolol.
- On June 2, 2022, Employee reported to Dr. Downs some suicidal ideation; that his wife and daughter would be better off without him. He told Dr. Koenen he felt depressed and worthless and that his family would be better off without him on November 7, 2023. But then on November 9, 2023, Employee denied feeling depressed and anxious and experiencing thoughts of hopelessness and suicidal ideation to Dr. Villanueva.
- On March 2, 2022, a CT scan showed no fracture in his left hand or wrist. Dr. Janowski diagnosed him with a fracture and recommended he wear a split. On April 21, 2022, PA-C Frangiosa recommended he only wear the splint while sleeping or doing high risk activities and by June 7, 2022, PA-C Frangiosa said he made a full recovery for his left wrist and had no restrictions. Yet on October 12, 2022, Employee wore a left hand brace for the EME with Dr. Bauer, and he wore the brace on October 6, 2023, when Dr. Flanum stated, "he remains in a splint/brace for that." He also wore the brace on June 5, 2024, to the SIME with Dr. McCormack. On June 18, 2024, PA-C Page said Employee's persistent left hand pain is likely caused by his continued use of his splint.
- Employee testified at deposition that he could not recall prior back pain, but he could remember having gout and a hernia surgery and that his ability to exert himself prior to the work injury was not limited by pain. He told Dr. McCormack he had no prior spinal complaints and said he got a massage once a year. However, Employee reported back and spine pain in January 2020 and underwent massage therapy. He reported lumbar pain, radiating into his legs and rated his pain level an eight out of 10 before the work injury, on May 7, 2021. The lower back pain was so severe he could not lift items at work that weighed more than 30 pounds, and he could not walk more than a mile without increased pain, and he underwent chiropractic care seven times in 2021. Yet Eunice

estimated Employee used to be able to lift 200 to 300 pounds before the work injury and that Employee only had one chiropractic treatment in 2021.

- On August 10, 2022, Employee denied any bowel or bladder dysfunction. He denied frank bowel and bladder incontinence to Dr. Flanum on April 12, 2023. However, NP Green's October 15, 2023 letter stated Employee has experienced severe urinary incontinence and retention since the accident. He told PA-C Gootee on March 1, 2024, that he had urinary incontinence for a year. Then, on April 23, 2024, Employee denied bowel and bladder incontinence to PA-C Gootee. Again, on December 2, 2024, NP Green noted he had severe urinary incontinence and sudden onset of bowel continence. On April 14, 2025, Employee told Dr. Barrington he had intermittent episodes of bowel upset and wore adult diapers when necessary.
- On October 5, 2022, Employee said his standing tolerance was less than five minutes but on October 20, 2022, Employee was able to stand and talk with other men for over 10 minutes in his own driveway without a cane. At deposition, on September 6, 2023, Employee said he could not check the mail, yet he was able to so on October 22, 2022. Eunice wrote in the August 6, 2025 Function Report that bending was very difficult or impossible, but Employee was able to bend over to check his mail.
- At his deposition on September 6, 2023, Employee said he dressed himself, but his wife helped him put on his shoes. On June 5, 2024, staff at Dr. McCormack's office had to assist him with undressing and dressing for his SIME. On August 6, 2025, Eunice stated in the Functional Report that Employee needed help with buttons due to his triggered finger and he needed to rely on support to avoid falling when putting on pants because of ongoing vertigo, neck pain, and buttocks numbness.
- Employee told NP Green that Dr. McCormack tortured him when he pounded on his head with significant force on June 28, 2024. But he did not inform Dr. McCormack that during his exam, and Dr. McCormack credibly denied his allegation.
- Even though on September 30, 2022, Dr. Hines ruled out a seizure disorder, Employee told Dr. Davis on June 3, 2024, that he had a seizure disorder.
- On February 1, 2023, NP Green noted Employee has type II diabetes and had been prescribed metformin for it. On February 14, 2024, Employee told Dr. Fix he had

prediabetes. But he denied any diabetes to Dr. Davis on June 3, 2024, when asked if he had a history of diabetes.

- The August 6, 2025 Function Report completed by Eunice for Employee stated he does not cook or prepare meals because of pain and stiffness in his neck, and discomfort and numbness. But he told Dr. Koenen on November 7, 2023, that he did not cook because he left food on the stove, fell asleep, and burned it, and on November 9, 2023, he told Dr. Villanueva he forgot about the food and almost burned the house down. Then, Employee told Dr. Davis on June 3, 2024, that his poor concentration caused him to burn chicken on the grill.
- Eunice also wrote Employee's speech became slurred due to the work injury, yet no medical record noted slurred speech, only "slowed" speech was noted by Dr. Hines. She also wrote Employee's attention span was about 30 minutes to an hour, yet he was able to attend his deposition and the hearing on February 6, 2026, and testify without slurring.

Based on the inconsistencies outlined above, Employee and Eunice are not credible historians regarding his work-related symptoms and past medical history. AS 23.30.122; *CSK Auto*. Employee and Eunice exaggerated the symptoms attributed to the work injury and minimized, omitted, and misrepresented his preexisting back and neck pain and related medical treatment and his preexisting anxiety and depression.

Based upon the analysis of the weight afforded the medical opinions and the credibility analysis above, the preponderance of the evidence shows the work injury caused a lumbar and cervical sprain/strain or contusion that resolved at the latest in July 2022, and the non-work-related preexisting congenital stenosis is the substantial cause of Employee's need for lumbar and cervical spine treatment and disability after October 12, 2022, based upon Drs. Bauer's, Chong's, and McCormack's opinions,. *Rogers & Babler*; *Koons*; *Saxton*. Employee is not entitled to medical benefits and related transportation costs and additional TTD benefits for his lumbar and cervical symptoms after October 12 and 19, 2022.

Dr. Villanueva noted Employee's tendency to overreport symptoms and to overemphasize limitations, and Dr. Koenen opined Employee malingered due to his profound symptom

magnification. Their opinions will be given more weight than Dr. Davis, who found Employee to be a credible historian and Dr. Kimmel, who did not think Employee was malingering. AS 23.30.122; *CSK Auto*; *Smith*; *DeRosario.* While a head injury can cause memory issues and confusion, Employee's presentation is not consistent with the mild head injury he sustained based upon the very short duration of possible loss of consciousness and the lack of disorientation after he slipped and fell, demonstrated by his ability to drive shortly afterwards. Dr. Hines, his treating neurologist, opined his photosensitivity, diffuse pain, and myalgias were beyond what is explainable on the basis of a TBI, and his pain and anxiety interfered with his ability to focus and concentrate which was "being perceived as a memory deficit." The inconsistencies described above are not the result of decreased focus and concentration. The results of the neurological testing performed by Drs. Villanueva and Davis are consistent with exaggeration of symptoms and the inconsistencies described above. The preponderance of the evidence is that the work injury caused a mild head trauma, which has resolved, and that the work injury is not the substantial cause of his need for medical treatment or disability for psychiatric complaints and neurocognitive complaints, including anxiety, depression, headaches, vertigo, seizures, migraines, confusion, memory issues, and light sensitivity, after December 12, 2022, based upon Drs. Villanueva's and Koenen's opinions. *Rogers & Babler*; *Koons*; *Saxton*. Employee's need for psychiatric treatment is due to his preexisting anxiety and depression. *Id*. His claim for medical and related transportation costs and additional TTD benefits for psychiatric complaints and neurocognitive complaints will be denied. AS 23.30.095(a); AS 23.30.185.

8) Is Employee entitled to PPI benefits?

As determined above, the work injury is not the substantial cause of Employee's need for lumbar and cervical spine treatment and disability after October 12 and 19, 2022, based upon Drs. Bauer's, Chong's, and McCormack's opinions. Based upon the same reasoning, the work injury is not the substantial cause of Employee's lumbar PPI rating assessed by Dr. Barrington or for his cervical spine. Employee's claim for PPI benefits for his lumbar and cervical spine will be denied.

While Dr. Kimmel assessed a five percent PPI rating for psychiatric and neurocognitive complaints, as determined above, the work injury is not the substantial cause of Employee's need for medical treatment for psychiatric complaints and neurocognitive complaints. Employee's claim for PPI benefits for his psychiatric neurocognitive complaints will be denied.

Dr. McCormack assessed a three percent PPI rating for Employee's left wrist and middle finger and said the work injury was the substantial cause of the PPI rating. He reasoned that hand and wrist trauma can aggravate tenosynovitis to cause trigger finger. PA-C Frangiosa, PA-C Hartmann, and PA-C Page treated Employee's wrist and trigger finger, but did not address whether the work injury was the cause of his trigger finger symptoms. Employee raised the statutory
presumption of compensability with Dr. McCormack's opinion. AS 23.30.120(a); *Meek*; *Wolfer*; *Cheeks*; *Burgess*; *Ugale*.

Dr. Chong opined the work injury did not cause or aggravate Employee's left middle trigger finger. He reasoned the trigger finger occurred about two months after the work injury and is the result of thickening of the tendon in his palm over time and it is not caused by a traumatic event and also noted Employee did not fracture his hand or wrist because the CT scan showed no fracture. Dr. Bauer opined the work injury was not the substantial cause of Employee's left middle finger trigger finger because that injury is not consistent with the falling and striking the back hand on the ground because the pulley is on the palm. He also stated the trigger finger is an idiopathic condition not caused by trauma, most cases are secondary to thickening of the pulley, and has many etiological factors, such as diabetes, which Employee has. Employer rebutted the presumption with Drs. Chong's and Bauer's opinions. *Norcon*; *Huit*; *Miller*.

Dr. Janowski noted Employee had swelling on his wrist after the work injury on March 2, 2022, and she diagnosed a fracture, although the CT scan found no fracture in his hand or wrist. Employee did not report experiencing trigger finger until April 21, 2022, two months after the work injury. This is delay inconsistent with Dr. McCormack's opinion that his left hand and wrist injury aggravated tenosynovitis to cause trigger finger. Dr. McCormack also noted Employee, "had full middle finger extension but lacked full flexion," and it was not clear to him

"how much of this effort related since there was a large functional component to his examination." In his SIME report, Dr. McCormack also stated Employee presented himself as completely disabled, which was completely disproportionate to his neurologic exam and MRI findings, and that there was a lot of "functional overlay." Clearly, Dr. McCormack expressed doubt regarding his own PPI rating due to Employee's inconsistent and disproportionate presentation. This concern is consistent with PA-C Page's June 18, 2024 opinion that Employee's left hand pain persisted due to his continued use of a splint even though PA-C Frangiosa said he made a full recovery for his left wrist and had no restrictions two years prior on June 7, 2022. As determined above, the panel finds Employee is not credible regarding his work-related symptoms. Dr. Chong's opinion is given more weight than Dr. McCormack's opinion because he took into consideration Employee's delay in trigger finger symptoms and the lack of a wrist or hand fracture. AS 23.30.122; *CSK Auto*; *Smith*; *DeRosario.* Employee has failed to prove by a preponderance of the evidence that the work injury is the substantial cause of Employee's left trigger finger. *Rogers & Babler*; *Koons*; *Saxton*. Employee's claim for PPI benefits for his left hand will be denied. AS 23.30.190.

9) Did Employer unfairly or frivolously controvert benefits?

Employee contended Employer unfairly or frivolously controverted benefits. Employer contended its November 2, 2022 and May 15, 2023 Controversion Notices were made in good faith because they were based upon a responsible medical opinion. As determined above, Drs. Bauer's, Chong's, Villanueva's, and Koenen's opinions were with substantial medical evidence that rebutted the presumption. *Harp*. Employer did not unfairly or frivolously controvert benefits in its Controversion Notices. *Harp*.

Employee contends Employer unfairly and frivolously controverted benefits when it voided a TTD benefit check before it controverted benefits in violation of AS 23.30.155(j), which permits only reduction of future benefits to recoup overpayments. Employer contended that the check was voided because it was issued in error, to void a duplicate payment, not to illegally recoup an overpayment. When nonpayment of compensation results from mistake of law, a penalty for an unfair or frivolous controversion of benefits is imposed. *Harp*. If an employer recoups an

overpayment by voiding a check, a penalty for unfair of frivolous controvert could be imposed. AS 23.30.155(j), (o); *Harp*.

TTD benefits must be paid in installments every 14 days and a penalty is due if it is not paid within 7 days after it becomes due. AS 23.30.155(b). An employer must file a Controversion Notice if payment of TTD benefits is terminated or suspended no later than the date an installment of TTD benefits payable without an award is due. AS 23.30.155(c), (d). The November 28, 2022 SROI states Employer voided an indemnity check in the amount of $1,251.56, which is two weeks of TTD benefits at the weekly rate of $625.78, and that it paid TTD benefits for 33 weeks from February 23, 2022 through October 11, 2022, totaling $20,650.74. Thirty-three weeks of indemnity benefits totaled $20,650.74 (33 weeks x $625.78 = $20,650.74). Employee provided a November 3, 2022 letter from his bank showing a check issued by Employer was stopped in that same amount. The date the check was issued is illegible; it appears to have been issued in October 2022, on a date between the 10th and the 19th because only the first digit of the day in the date on the check is legible. It is unknown for which dates Employer made the previous TTD payments and for which period of time the voided check was issued. Therefore, the panel is unable to find the voided check was an overpayment recouped in violation of AS 23.30.155(j). Employee has not proven Employer recouped an overpayment or advancement of TTD benefits by voiding a TTD benefit check. Employee's request for a finding of unfair or frivolous controvert will be denied. AS 23.30.155(o).

10) Is Employee entitled to interest and a penalty?

Because Employee was not awarded any benefits, he is not entitled to interest. Employee's request for interest will be denied. AS 23.30.155(p).

Penalties are imposed when employers fail to controvert in good faith or fail to pay compensation when due. AS 23.30.155(e); *Haile*. As determined above, Drs. Bauer's, Chong's, Villanueva's, and Koenen's opinions were with substantial medical evidence that rebutted the presumption, and Employer did not unfairly or frivolously controvert benefits. *Harp*. No penalty will be assessed for late-paid compensation. Employee is not entitled to a penalty.

11) Is Employer entitled to a Social Security disability offset and recoupment of overpayment?

Employer contends it is entitled to a SSD offset because Employee was paid SSD benefits for the work injury for which he filed a claim. It requests recoupment for overpayment of past benefits and an order granting an offset, should additional disability benefits be awarded. Employee agrees Employer is entitled to a SSD offset.

An employer seeking a Social Security offset to reduce an employee's weekly compensation must first obtain an order before it is entitled to offset its compensation liability against an employee's SSD benefit entitlement. 8 AAC 45.225(b). Employer has complied with the required procedures for its Social Security offset request. *Id.* Employer obtained a copy of the SSA's Notice of Award showing Employee receives monthly SSD insurance (SSDI) benefits of $1,145 in December 2025. Employee's initial entitlement began in August 2022 at $1,294 per month. 8 AAC 45.225(b)(1)(A) and (C). The award notice states Employee is receiving SSDI benefits for his disability that started on February 22, 2022, the day Employee was injured. 8 AAC 45.225(b)(1)(B). Employee is married and has two dependents. 8 AAC 45.225(b)(1)(D). Employer calculated a $264.23 Social Security offset, using $1,145 as Employee's initial monthly entitlement, and Employer showed how the reduction was calculated. 8 AAC 45.225(b)(2) and (3). Employer has met 8 AAC 45.225(b)'s criteria to reduce Employee's weekly compensation under AS 23.30.225(b). Employee does not object to Employer's SSD offset but did provide his own offset calculation.

Applying the *Stanley* Social Security offset formula, Employee's compensation rate with the offset is calculated as follows:

Employee's Gross Weekly Earnings (GWE)	$890.56
Weekly Compensation Rate (CR)	$626.62
Weekly Social Security Benefit ($1,294 x 12 = $15,528 ÷ 52) =	$298.62
Weekly WC Rate + Weekly SS Benefit	$925.24
80% of GWE [$890.56 x 0.8]	$712.45
Social Security Offset ($925.24 - $712.45)	$212.79
Weekly Compensation Rate with Social Security Offset ($626.62 - $212.79)	$413.83

Employer is entitled to take a weekly $212.79 SSD offset retroactively to August 1, 2022, the date Employee's SSDI benefits began. Employee's weekly TTD benefit compensation rate reduced by the Social Security offset is $413.83. AS 23.30.225.

Without an order, an employer can withhold up to 20 percent of future compensation payments if it has made an overpayment. AS 23.30.155(j); *Davenport*. If Employer wishes to withhold more than 20 percent, an order is required. *Id*. Employee's entitlement to SSDI started on August 1, 2022, and he continues to receive SSDI benefits. Employer paid TTD benefits from February 23, 2022 to October 11, 2022. Employer is entitled to a SSD offset for TTD benefits paid from August 1 through October 11, 2022; this is a 33-week period. Employer overpaid Employee $211.95 per week based on the November 28, 2022 SROI which stated it paid TTD benefits of $625.87 per week ($625.78 - $413.83 = $211.95), resulting in an overpayment of $6,994.35.

Employee is not entitled to continuing TTD benefits or PPI benefits as determined above and it is not likely that Employer will be able to recoup any overpayment. *Decker*. Employee was found eligible for SSDI benefits on December 14, 2025, well after Employer stopped paying benefits in October 2022; the overpayment was not exacerbated by his delay in providing the information to Employer. *Bathony*. Employee continues to receive SSDI benefits and he did not object to recoupment against future benefits if awarded. *Barnett*. Employer's request for a 100 percent recoupment against future benefits will be granted.

12) Is Employee entitled to attorney fees and costs?

Employee requested attorney fees under AS 23.30.145(a), and paralegal costs. Because Employee was not awarded any benefits, he is not entitled to minimum attorney fees or costs under AS 23.30.145(a). His claim will be denied.

CONCLUSIONS OF LAW

1) The oral order overruling Employee's objection to consideration of the video of his deposition was correct.

2) The oral order keeping the record open to take Dr. Villanueva's testimony on March 3, 2026 was correct.

3) The oral order overruling Employee's objection to consideration of deposition transcripts was correct.

4) Employer's objection to Employee's October 23, 2025 hearing brief should not be sustained.

5) The oral order denying Employer's request to disqualify Member Ladd was correct.

6) Employer's objection to Employee's evidence and testimony regarding a stopped TTD benefit check should not be sustained.

7) Employee is not entitled to medical benefits and related transportation costs and additional TTD benefits after October 12, 2022.

8) Employee is not entitled to PPI benefits.

9) Employer did not unfairly or frivolously controvert benefits.

10) Employee is not entitled to interest and is not entitled to penalty.

11) Employer is entitled to a Social Security disability offset and recoupment of overpayment.

12) Employee is not entitled to attorney fees and costs.

ORDER

1) Employee's April 21, 2023 claim is denied.

2) Employer's objection to Employee's evidence and testimony regarding a stopped TTD benefits check is overruled.

3) Employee's claim for medical benefits and related transportation costs and for TTD benefits after October 11, 2022, and continuing, is denied.

4) Employee's claim for PPI benefits is denied.

5) Employee's claim for interest is denied.

6) Employee's claim for a penalty is denied.

7) Employer's March 5, 2025 petition for a SSD offset is granted.

8) Employer is entitled to take a $212.79 Social Security offset retroactively from August 1, 2022 to October 11, 2022, from Employee's past weekly TTD benefits.

9) Employer is entitled to take a 100 percent recoupment against future indemnity benefits.

10) Employer overpaid Employee $6,994.35.

11) Employee's claims for statutory minimum attorney fees, and costs, are denied.

Dated in Anchorage, Alaska on April 2, 2026.

ALASKA WORKERS' COMPENSATION BOARD

/s/

Kathryn Setzer, Designated Chair

/s/

Micheal Dennis, Member

/s/

Anthony Ladd, Member

APPEAL PROCEDURES

This compensation order is a final decision. It becomes effective when filed in the office of the board unless proceedings to appeal it are instituted. Effective November 7, 2005 proceedings to appeal must be instituted in the Alaska Workers' Compensation Appeals Commission within 30 days of the filing of this decision and be brought by a party in interest against the boards and all other parties to the proceedings before the board. If a request for reconsideration of this final decision is timely filed with the board, any proceedings to appeal must be instituted within 30 days after the reconsideration decision is mailed to the parties or within 30 days after the date the reconsideration request is considered denied due to the absence of any action on the reconsideration request, whichever is earlier. AS 23.30.127.

An appeal may be initiated by filing with the office of the Appeals Commission: 1) a signed notice of appeal specifying the board order appealed from and 2) a statement of the grounds upon which the appeal is taken. A cross-appeal may be initiated by filing with the office of the Appeals Commission a signed notice of cross-appeal within 30 days after the board decision is filed or within 15 days after service of a notice of appeal, whichever is later. The notice of cross-appeal shall specify the board order appealed from and the ground upon which the cross-appeal is taken. AS 23.30.128.

RECONSIDERATION

A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accord 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 accord 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 Final Decision and Order in the matter of Salualo Apaisa, employee / claimant v. L&M Motors, Inc., employer; Employers Preferred Insurance Company, insurer / defendants; Case No. 202204156; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by certified US Mail on April 2, 2026.

/s/

Trisha Palmer, Workers' Compensation Technician