ALASKA WORKERS' COMPENSATION BOARD

P.O. Box 25512 **Juneau, Alaska 99802-5512**

RAMON RIVERO, Employee, Claimant, v. COLDFOOT ENVIRONMENTAL SERVICES, INC., Employer, and ZURICH AMERICAN INSURANCE CO., Insurer, Defendants.	FINAL DECISION AND ORDER AWCB Case No. 200906554 AWCB Decision No. 13-0108 Filed with AWCB Anchorage, Alaska on September 04, 2013

On February 5, 2013, Ramon Rivero's (Employee) February 2, 2010 workers' compensation claim, as amended, was heard in Anchorage, Alaska, a date selected on June 13, 2012. Employee appeared, testified, and represented himself. Attorney Jeffrey Holloway appeared and represented Cold Foot Environmental Services, Inc. (Employer). M. Grace Anderson served as interpreter. The parties' January 25, 2013 stipulation for approval of employee's attorney's fees and costs was approved on June 3, 2013.

As a preliminary matter, Employee offered medical records from Alfred Lonser, M.D., at hearing as evidence. Employer objected. This decision addresses the preliminary matter and decides Employee's claim and Employer's petition appealing the Rehabilitation Benefits Administrator's (RBA) designee's decision on their merits.

The record was left open to allow Employee to submit a transportation log, to which Employer objected. Employee submitted the log on February 15, 2013, and the record closed on February 19, 2013, when the board next met.

ISSUES

Employee contended his reports from Dr. Lonser should be considered at hearing. He contended the records were recently obtained and were, therefore, timely filed.

Employer objected, contending the records were untimely under 8 AAC 45.120(f), and were not filed on a medical summary. Employer also contended its May 16, 2011 request for cross examination of Dr. Lonser, and Employee's failure to produce Dr. Lonser for cross-examination precluded Employee from relying upon these records at hearing.

1. *Should Dr. Lonser's chart notes be admitted in full or in part?*

Employee contends he continues to need back surgery because of his work injury. He seeks an order requiring Employer to preauthorize it.

Employer contends work is not the substantial cause of Employee's disability or need for treatment for Employee's back. It seeks an order denying medical care for the low back.

2. *Was Employee's work for Employer the substantial cause of the need for Employee's lower back treatment?*

Employee contends he was injured at work, continues to suffer from pain, is unable to work, and, as a result, is entitled to additional temporary total disability (TTD) payments plus interest beginning January 23, 2010, and continuing.

Employer contends Employee was medically stable as of January 22, 2010. It contends it paid TTD through this date and does not owe additional TTD based on the opinion of employer medical evaluator (EME) John Ballard, M.D.

3. *Is Employee entitled to TTD from January 23, 2010, to the present?*

Employer contends the RBA designee erred by finding Employee eligible for retraining benefits. It seeks an order vacating the designee's decision based on the fact Employee can return to work as a barber.

Employee contends his pain precludes him from returning to his job at the time of injury or any jobs he held in the ten years before his injury, and he is therefore entitled to reemployment benefits. He seeks an order affirming the RBA designee's finding.

4. *Is Employee eligible for reemployment benefits?*

Employee contends he is entitled to interest on all benefits unpaid when due. He seeks an order awarding statutory interest

Employer contends Employee is not entitled to any additional benefits. Therefore, it contends he is not entitled to interest.

5. *Is Employee entitled to interest?*

Employee contends he is entitled to costs related to travel to obtain medical treatment for his work injury. He seeks an award of transportation expenses.

Employer contends Employee never properly itemized or submitted his transportation log, even when given another opportunity to do so. It contends Employee's request for medical travel expenses should be denied.

6. *Is Employee entitled to transportation costs?*

The parties stipulated to an attorney's fee award to Employee's former lawyer. They jointly request approval of the stipulation.

7. *Should the stipulation for attorney's fees and costs be approved?*

FINDINGS OF FACT

A review of the entire record establishes the following facts by a preponderance of the evidence:

1. Employee is a Cuban immigrant who speaks Spanish, and understands little English. He was assisted at most appointments and Board proceedings by Spanish interpreters of various skill levels. (Record. Observations, experience, and judgment.)
2. On April 1, 2005, Employee was off work two to three days due to back muscle spasms from weight lifting. (4/1/2005 off work slip, Kevin Maguire, DO).
3. On May 25, 2008, Employee was evaluated in the Providence Alaska Medical Center (PAMC) Emergency Department by Vincent Imbriani, MD, for an upper respiratory infection and back pain. Employee complained of pain in the eight out of ten range. He was evaluated for a possible urinary tract infection due to "left flank pain" and prescribed an antibiotic and decongestant. (5/25/2008 PAMC ER Note, Dr. Imbriani).
4. On February 6, 2009, three months prior to his work injury, Employee completed a Respirator Medical History Questionnaire in which he stated he had no current back pain. (Respirator Medical History Questionnaire, pg. 3, question 15(b), February 6, 2009).
5. Employee denied chronic low back pain on February 9, 2009. (Medical Examination Report for Commercial Driver Fitness Determination, 2/9/2009).
6. On May 7, 2009, Employee injured his shoulder in the course and scope of his employment when "lifting and moving heavy equipment without any assistance." (Report of Occupational Injury or Illness, 5/13/2009).
7. After his injury on May 7, 2009, Employee finished the last hour of his shift using his left arm and went home. (Employee).
8. Employer's Job Labor Journal for May 7, 2009, includes a Fernando Maga-Leon and Joseph Coca. (5/7/2009 Coldfoot Job Labor Journal).
9. "Jose" is a Spanish variation of the given name Joseph. (Experience, observations, judgments and conclusions).
10. On May 8, 2009, Employee was treated in the Providence Alaska Medical Center (PAMC) Emergency Department by John Hanley, MD, for right shoulder pain. Dr. Hanley noted Employee's injury occurred at work while lifting heavy pipe, but Employee "denied "any direct trauma to the shoulder." He was taken off work for four days and

referred to Anchorage Neighborhood Health for follow up. No interpreter was utilized during this treatment. (5/8/2009 Chart note, Dr. Hanley).

11. On May 10, 2009, Employee filled a prescription from Dr. Hanley for a three day supply of Tramadol. (Wal-Mart pharmacy record, SIME record no. 376).
12. On May 12, 2009, Employee returned to PAMC Emergency Department and was examined by Michelle McCall, MD, who noted Employee's persistent shoulder pain and his reported inability to lift his arm. Employee said he had severe pain if he moved his arm more than a small amount. The pain radiated into his neck, but there was no numbness in his fingers. Dr. McCall suspected a rotator cuff injury and referred him to orthopedist R.J. Hall, MD. A Spanish interpreter was present at this appointment. (5/12/2009 chart note, Dr. McCall).
13. On May 14, 2009, Employee filled a prescription for a one day supply of hydrocodone and a ten day supply of ibuprofen. (Wal-Mart pharmacy record, SIME record no. 376).
14. On May 15, 2009, Employer's Operations Manager Claudia Rodriguez-Zinn signed a statement doubting Employee's injury was valid. She stated Employee left at the end of his shift on May 7, 2009, and made no mention of his injury to the foreman as employees are trained to do. Ms. Rodriguez-Zinn also stated Employee returned to work on May 8, 2009, with his right arm in a sling and stated his shoulder was sore and that he had possibly pulled a muscle at the gym. (5/15/2009 Statement RE: Question 46, C. Rodriguez-Zinn).
15. On May 18, 2009, John Love, PA-C evaluated Employee, in Dr. Hall's office, on referral from Dr. McCall. PA-C Love referred Employee for a magnetic resonance imaging (MRI) scan, prescribed additional pain medications, instructed Employee on pendulum exercises, and kept him off work pending further evaluation by Dr. Hall. An interpreter was available for this appointment. (5/18/2009 chart note, PA-C Love).
16. On May 18, 2009, Employee filled a prescription for a five day supply of hydrocodone/APAP from PAC Love. (Wal-Mart pharmacy record, SIME record no. 376).
17. On May 19, 2009, Employee had a right shoulder MRI which showed marked impingement due to the shape of the acromion, degenerative change in the acromioclavicular joint, fluid in the subacromial bursa, supraspinatus and infraspinatus tendinosis, a full thickness oblique tear of the supraspinatus along the posterior

midportion, and partial thickness acromial and articular tears in the infraspinatus. (5/19/2009 MRI Report, Harold Cable, MD).

18. On May 28, 2009, Employee saw Dr. Hall in follow up, and complained of shoulder pain radiating down to his fingertips and significant neck pain accompanied by headaches. Concerned about the decreased sensation in Employee's right arm and hand, as well as weakness in his wrist, Dr. Hall ordered a cervical MRI. An interpreter was present for this appointment. (5/28/2009 chart note, Dr. Hall).
19. On May 29, 2009, a cervical MRI showed reversal of the cervical lordosis consistent with muscular spasm and foraminal stenosis on the right at C7-T1. There was no central stenosis, no bulges, protrusions, nor frankly extruded disc herniations identified, nor were any acute abnormalities present. Employee's MRI was intrinsically normal. (5/29/2009 MRI report, John McCormick, MD).
20. On June 9, 2009, Employee was evaluated by James Eule, MD, on referral from Dr. Hall, for "significant cervical spondylolysis with significant right shoulder and arm pain and numbness." Dr. Eule noted cervical film studies showed severe multilevel degenerative changes with disc space narrowing, large anterior osteophytes, and facet arthropathy. Dr. Eule's review of the May 29, 2009 MRI revealed:

> [S]evere degenerative changes in all of his discs. He has decerased cervical lordosis. No significant disc herniations. His foramen may have some variable narrowing at multiple levels, although not one specific level that is worse and no level that is horrible, particularly no horrible ones on the right side.

21. Dr. Eule assessed severe cervical spondylosis with some neck pain, questionable brachial plexus injury, and possible soft tissue shoulder injury. Dr. Eule could not explain the numbness in Employee's hand, and prescribed four weeks of physical therapy along with anti-inflammatories. An interpreter was present at this appointment. (6/9/2009 appointment, Dr. Eule).
22. On June 12, 2009, Employee had his first physical therapy appointment for evaluation of his right shoulder pain and possible brachial plexus injury. Jeff Evans, PT, noted they were unable to do much testing due to pain levels, but set modest goals for an eight week therapy program. Employee reported his pain level as a ten out of ten on this day. PT Evans noted low back pain and Employee not being able to sit or stand too long, and also

recorded Employee was nervous about this issue. An interpreter was present at this appointment. (6/12/2009 PT notes, PT Evans).

23. On June 18 and 22, 2009, Employee continued to complain of low back pain at his physical therapy appointments with PT Evans. (PT Daily Notes, PT Evans, June 19-22, 2009).
24. On June 26, 2009, Employee filled two prescriptions from Dr. Eule, a ten day supply of cyclobenzaprine and five day supply of hydrocodone/APAP. (Wal-Mart pharmacy record, SIME record no. 376).
25. On June 29, 2009, Dr. Hall confirmed for Nova Pro Adjuster Amber Lawton that the May 7, 2009 work event was the substantial cause of Employee's right upper extremity injury. (6/26/2009 letter to Dr. Hall from A. Lawton with questions answered by Dr. Hall and signed by Dr. Hall).
26. On June 30, 2009, Employee filled out a questionnaire for the adjuster in which he listed information about himself including his five children's and wife's names, the body parts injured as his right shoulder, neck and spine, that his symptoms began on May 7, 2009, and his injury was witnessed by "Jose" and "Maga." He also wrote he was currently experiencing severe pain, unable to move his arm properly, had numbness in his arm and neck, and pain in his arm, neck, and back. Employee stated he stopped lifting weights two years prior to his injury. (6/30/2009 Questionnaire, R. Rivero).
27. On July 6, 2009, Employee had electrodiagnostic testing performed by Erik Kussro, MD, which included nerve conduction studies, Electromyography (EMG), and paraspinal EMG. Employee provided Dr. Kussro a history, which included Employee was getting "electric shock type impulses" in his legs, more often if he was up and walking, his legs felt heavy, and he had low back pain. Employee reported his right shoulder was extremely painful to the point he is nauseated, has vomiting episodes, and sometimes feels short of breath. Employee reported his entire right arm felt numb, including all five digits on his right hand, and his hand easily gets cold. Dr. Kussro reviewed Employee's medications and found Employee "may be taking quite a large amount of Vicodin and he may be taking pills from each of the different prescriptions he has gotten from different providers." Dr. Kussro urged Employee to follow up with Dr. Eule regarding the proper dose he should be taking. The EMG findings were:

> (1) The right median distal sensory and motor latencies are mildly prolonged but amplitudes remain normal. The radial and ulnar nerve conduction studies are normal.
> (2) Needle EMG study of select right upper limb and cervical paraspinal muscles is unremarkable. There are no areas of muscle membrane instability or abnormal motor unit action potential morphology.

28. Dr. Kussro's impressions were evidence of mild right carpal tunnel syndrome, but no evidence of right brachial plexopathy, cervical radiculopathy, or ulnar neuropathy. An interpreter was present during this testing. (7/6/2009 Electrodiagnostic Studies Report and Letter from Dr. Kussro to Dr. Eule).
29. On July 7, 2009, Employee returned to Dr. Eule in follow up to his EMG studies and physical therapy. Dr. Eule noted physical therapy was ended due to Employee's extreme pain. Further, Dr. Eule noted Employee was basically incapacitated due to the pain, he continued to have "terrible" neck pain, arm pain which radiated into his hands, and back pain. Upon examination Dr. Eule found Employee hypersensitive and his extreme pain out of proportion to what it should be given the EMG findings. Dr. Eule diagnosed mild right carpal tunnel syndrome, right rotator cuff tendinitis/impingement, possible early reflex sympathetic dystrophy/complex regional pain syndrome (CRPS), and cervical spondylosis. As a result of the suspected CRPS diagnosis, Dr. Eule referred Employee to the Alaska Spine Institute for further evaluation and to determine if sympathetic nerve blocks were warranted. Dr. Eule also referred Employee back to Dr. Hall for shoulder treatment. An interpreter was present for this appointment. (7/7/2009 chart note, Dr. Eule).
30. On July 9, 2009, Dr. Hall noted Employee's EMG was normal; Employee did not have radiculopathy, but had significant arm pain out of proportion to anything the providers had been able to find. Dr. Hall administered a steroid injection into the subacromial space in an attempt to alleviate some of Employee's shoulder pain, but deferred more aggressive treatment until after Employee's appointment with Alaska Spine Institute. (7/9/2009 chart note, Dr. Hall).
31. On July 15, 2009, Employee completed a multidimensional pain scale for his appointment scheduled on July 16, 2009, with Dr. Gevaert, in which he indicated he could never lift up to five pounds, he could not use his right hand for simple grasping, for pushing or pulling arm controls, or fine manipulation, was never able to bend, squat, crawl,

climb, reach, or get on his knees, he was not independent when he dressed, ate, cared for his hair, washed, or went to the toilet. He stated, "I brush my teeth, and can eat pretty much with my left hand, everything else my wife helps me with." (7/15/09 Ramon Rivero, Multidimensional Pain Scale for ASI).

32. On July 17, 2009, Employee was seen in the PAMC Emergency Department by Vincent Imbriani, MD, for acute musculoskeletal low back pain; Employee rated his pain as ten out of ten. Dr. Imbriani ordered a lumbar MRI, which showed mild annulus bulging at L5-S1, but no disk herniation or foraminal or spinal stenosis. The lumbar vertebral body alignment was normal; vertebral body heights were intact; there was no significant disk space narrowing. There was early disk desiccation at L5-S1. Dr. Imbriani noted Employee had suffered no trauma since the May 7, 2009 work injury, and opined his back pain may be from spasm, either compensating for his right shoulder injury or as a result of his prolonged inactivity since the work injury. Dr. Imbriani assessed acute and ongoing musculoskeletal low back pain with no evidence of significant degenerative disk disease by MRI, chronic right shoulder pain, and "injuries sustained status post work related incident on May 7, 2009,". Dr. Imbriani changed Employee's pain medication and directed him to follow up with Dr. Eule. A fluent Spanish-speaking admitting clerk acted as an interpreter during this evaluation. (7/17/2009 chart note, Dr. Imbriani; 7/17/2009 Providence Health System Emergency Flow Sheet Record).
33. On July 22, 2009, Employee was evaluated at the Alaska Spine Institute by Michel Gevaert, MD, on referral from Dr. Eule. Dr. Gevaert noted inconsistencies in Employee's history, and stated the inconsistencies may or may not be a language issue; however, he found the lumbar spine MRI, right shoulder x-ray, and EMG and nerve conduction study were not congruent with Employee's clinical presentation. Dr. Gevaert stated, "The clinical examination and presentation is nonphysiologic." Employee again reported 10 out of 10 pain at its worst. Dr. Gevaert's impressions were: 1) right shoulder injury, x-rays reveal calcification, 2) nonphysiologic signs and symptoms combined with significant symptom magnification, 3) cervical spine reveals diffuse spondylosis, 4) normal right upper extremity EMG, and 5) lumbar spine MRI, benign. Dr. Gevaert did not have access to Employee's complete record and ordered another right shoulder MRI. He noted if the MRI was not congruent with Employee's present symptomology Employee would be

released to work in a medium category effective the following week. Dr. Gevaert prescribed Mobic, Neurontin, a lumbosacral support, and five days of daily physical therapy. An interpreter was present for this appointment. (7/22/2009 chart note, Dr. Gevaert).

34. On July 30, 2009, Employee returned to Dr. Gevaert for reevaluation. Employee's pain was not responding to physical therapy or pain medication, and after reviewing the right shoulder MRI, which showed impingement syndrome, evidence of bursitis and fluid in the shoulder, Dr. Gevaert referred Employee back to Dr. Hall for a surgical opinion. (7/30/2009 chart note, Dr. Gevaert).
35. On August 4, 2009, Employee returned to Dr. Hall to schedule surgery. Employee was scheduled for an arthroscopic subacromial decompression, possible rotator cuff repair, and open Mumford procedure. An interpreter was present for this appointment. (8/24/2009 chart note, Dr. Hall).
36. On August 10, 2009, Employee was surveilled by Employer getting into the driver seat of a Hummer 2 vehicle and holding a conversation with someone in the rear seat. Employee gestures with his left hand, turns his head from left to right, and wears his right arm in a sling. Employee remained in the vehicle while his wife loaded grocery bags in the rear of the vehicle. Upon returning home, Employee emerged from the driver's side of the vehicle and carried a single grocery bag into the home with his left hand. (8/10/2009 video surveillance from Northern Investigative Associates).
37. On August 11, 2009, Dr. Hall performed surgery on Employee's right shoulder. An arthroscopic subacromial decompression, mini-open rotator cuff repair, and open Mumford procedure were performed. The post-operative diagnoses were right shoulder rotator cuff tear and acromioclavicular joint degenerative disease. (8/11/2009 Operative Report, Dr. Hall).
38. On August 15, 2009, Dr. Ballard conducted an EME. He diagnosed right shoulder acromioclavicular joint arthritis, partial rotator cuff tear of the right shoulder, contusion to the right shoulder, and cervical degenerative disc disease (DDD). Dr. Ballard opined the cervical DDD was related to age and the mechanism of injury did not support relating any type of cervical spine injury to the May 7, 2009 work injury. Dr. Ballard opined the acromioclavicular joint arthritis, which is a degenerative condition, was permanently

aggravated by the May 7, 2009 work injury. Dr. Ballard further opined the May 7, 2009 work injury permanently aggravated degenerative changes present in Employee's right rotator cuff, leading to the partial tear. Dr. Ballard opined the May 7, 2009 work injury was the substantial cause of Employee's disability and need for shoulder surgery. Dr. Ballard did not attribute Employee's complaints of low back pain, which occurred a month after the May 7, 2009 work injury, to Employee's work for Employer. Dr. Ballard noted, "It certainly does appear in reviewing the medical providers' notes that Mr. Rivero had a significant amount of pain out of proportion, which is not explained by any of the diagnostic studies that were performed." (8/15/2009 EME report, Dr. Ballard).

39. On August 24, 2009, Employee began his post-surgery physical therapy with PT Evans, who noted Employee's post-surgery pain was much different than his pain prior to surgery, and overall he was doing much better. (8/24/2009 PT note, PT Evans).
40. On September 3, 2009, Dr. Hall noted Employee's pain was different than before surgery, and Employee had pain on the medial border of his scapula and in his low back. Employee was progressing in physical therapy, had good passive range of motion. Dr. Hall cleared Employee for active assist range of motion. Dr. Hall kept Employee off work an additional six weeks and refilled his pain medication. (9/3/2009 chart note, Dr. Hall).
41. On September 20, 2009, Employee was seen in the PAMC Emergency Department for left lower back and right knee and calf pain. Employee reported to the triage nurse he had an injury "years ago" and has had ongoing problems since that time. Dr. McCall reviewed a prior lumbar MRI which showed mild bulging of a disk annulus at L5 – S1. Dr. McCall and ordered a Doppler study of Employee's right leg given his recent surgery and decreased activity. There was no evidence of deep vein thrombosis. A right knee x-ray was also unremarkable. Dr. McCall's diagnoses were viral syndrome, internal knee injury, and low back pain. No interpreter was present for this evaluation. (9/20/2009 chart note, Dr. McCall).
42. On September 21, 2009, Employee returned to physical therapy after missing two appointments due to low back pain, and resulting lack of sleep. PT Evans noted the low back was the major area of pain and interfered with Employee's ability to do active range of motion shoulder exercises. PT Evans consulted Dr. Hall who referred Employee to Dr.

Gevaert to follow up on the lumbar pain, and to restart shoulder PT following consultation with Dr. Gevaert. (9/21/2009 PT note, PT Evans).

43. On October 2, 2009, Employee returned to Dr. Hall who noted increased pain in the shoulder and in the low back that radiated into both legs and prevented Employee from sleeping. Dr. Hall stated the back pain was causing the shoulder pain through increased stress and lack of sleep, and attempted to move up Employee's appointment with Dr. Gevaert for low back pain and pain management. Dr. Hall noted shoulder physical therapy would not restart until after Employee was evaluated by Dr. Gevaert. An interpreter was present at this appointment. (10/2/2009 chart note, Dr. Hall).
44. On October 14, 2009, Dr. Hall signed a letter agreeing with Dr. Ballard's August 15, 2009 EME report. Dr. Hall he had no opinion on Employee's low back pain because Dr. Hall had not evaluated or treated Employee's low back. (10/8/2009 letter from A. Lawton to Dr. Hall signed by Dr. Hall on 10/14/2009).
45. On October 14, 2009, Employer notified Alaska Spine Institute Employee's lower back was not covered by workers' compensation. (10/14/2009 ASI chart notes for Rivero).
46. On October 19, 2009, Dr. Hall noted Employee's shoulder postoperative course was complicated by his lower back pain, which had been denied by workers' compensation. Employee was referred back to physical therapy for his shoulder. Employee was advised regarding treatment options for his back, including applying for Project Access, self-pay, and appeal of his workers' compensation denial. An interpreter was available at this appointment. (10/19/2009 chart note, Dr. Hall).
47. On October 21, 2009, Employee was involved in a motor vehicle accident for which he was seen in the PAMC Emergency Department on October 23, 2009, by Kathy McCue, MD. Employee's primary complaints on October 23, 2009, were low back, upper back, right shoulder, and neck pain. Employee's reported pain was 10 out of 10; and although pain in his upper and lower back and right shoulder had been chronic, the pain in all these areas became significantly worse since the car accident. Dr. McCue noted Employee had classic symptoms of frozen shoulder based on his limited range of motion. She also noted Employee's increased pain in his lower back and positive bilateral straight leg raises. Dr. McCue assessed acute exacerbation of chronic neck, back and right shoulder pain, prescribed a muscle relaxer and pain medication, and directed Employee to keep his

already scheduled appointments with Drs. Gevaert and Hall. No interpreter was present for this appointment; however, Dr. McCue noted, "He speaks Spanish primarily but is able to express himself very adequately in English." (10/23/2009 chart note, Dr. McCue).

48. On October 26, 2009, Employee returned to physical therapy for his shoulder with PT Evans who noted Employee's activities of daily living and shoulder exercises were limited by his back pain. PT Evans reported any active mobility of the right shoulder caused thoracolumbar pain, which frustrated Employee who said he was limited in what he could do with the shoulder. No interpreter was available for this appointment. (10/26/2009 PT note, PT Evans).
49. On November 5, 2009, Employee's low back pain was evaluated by Dr. Gevaert. In completing a multidimensional pain scale, Employee indicated he could occasionally lift up to five pounds, but never anything heavier; he could occasionally carry up to five pounds, but never anything heavier; he could walk zero to two blocks, painfully; he could use both his right and left hands for simple grasping, but neither hand for pushing or pulling arm controls, or fine manipulation; he was never able to climb, but was occasionally able to bend, squat, crawl, and get on his knees, and frequently able to reach. He was able to dress, eat, perform hair care, wash, and engage in toilet activities independently. Employee reported the low back pain started in June 2009. Dr. Gevaert noted Employee offered no explanation for the four week gap between the May 7, 2009 work injury and the time the low back pain started, but since June it has progressively worsened. Employee reported the pain was constant, "24 x 7;" severe headaches; and pain of ten on a scale from zero to ten. Dr. Gevaert's impressions were diffuse thoracic and lumbar pain, nonfocal neurologic examination, four positive Waddell signs, and July 17, 2009 lumbar MRI, which reportedly showed mild disc bulge of the annulus at L5-S1 without frank herniation. Dr. Gevaert also noted Employee barely complained of low back pain when examined in mid-July, presented with significant symptom magnification and / or altered pain perception, and provided no explanation as to why his low back pain started five weeks following his work injury. Dr. Gevaert indicated the origin of Employee's pain was unclear; and Dr. Gevaert concluded he did not believe Employee's low back pain was work related. Dr. Gevaert recommended continuation of palliative care for Employee's

"self-reported" back pain. No interpreter was present for this appointment. (11/5/2009 chart note, Dr. Gevaert).

50. On November 5, 2009, Dr. Eule agreed with Dr. Ballard's EME report. (10/30/2009 letter from A. Lawton to Dr. Eule, signed by Dr. Eule on 11/5/2009).
51. On November 5, 2009, Dr. Eule advised Employer Employee was last seen in his facility on October 19, 2009, and required physical therapy two to three times a week for two to three more months. (10/30/2009 letter from A. Lawton to Dr. Eule, signed by Dr. Eule on 11/5/2009).
52. On November 11, 2009, Employee returned to physical therapy for his shoulder where PT Evans continued to note active range of motion exercises were severely limited by Employee's back pain. (11/11/2009 PT note, PT Evans).
53. On November 19, 2009, Dr. Hall discussed Dr. Gevaert's report with Employee. Dr. Hall consulted with rheumatologist John Botson, MD, to rule out an inflammatory process. Due to the soft tissue calcification on either side of the cervical spine, Dr. Botson suggested an ultrasound of the carotids to rule out potential calcification in carotid arteries and possible artherosclerotic disease. There is no indication an interpreter was present for this appointment. (11/19/2209 chart note, Dr. Hall).
54. On November 19, 2009, an ultrasound of Employee's carotid arteries was normal. (11/19/2009 Carotid Ultrasound Report, Marc Beck, MD).
55. On November 25, 2009, Dr. Hall reviewed the computed tomography (CT) scan of Employee's neck, which determined the calcifications are posterior to the skin of the cervical spine; and represented density associated with Employee's pony tail at the back of his head. The soft tissues surrounding Employee's cervical spine and in the paravertebral musculature were not calcified. Dr. Hall instructed Employee to return to physical therapy for his shoulder without restriction on range of motion exercises, and referred to Project Access so he could get lower back treatment. There is no indication an interpreter was present for this appointment. (11/25/2009 chart note, Dr. Hall).
56. On December 9, 15, 18, and 21, 2009, Employee attended physical therapy with PT Evans. For each appointment PT Evans noted Employee's progress was limited by his back pain. (PT notes 12/9, 15, 18 and 21, PT Evans).

57. On December 28, 2009, Dr. Hall noted Employee's continued frustration with his lack of progress and inability to return to work and provide for his family. Employee continued to complain of shoulder pain with any activity, which is not the normal post-operative course. Employee was referred to AA Pain Clinic. Dr. Hall ordered a diagnostic injection of the glenohumeral joint to determine if Employee's pain was intrinsic to the shoulder. An interpreter was present for this appointment. (12/28/2009 chart note, Dr. Hall).
58. The glenohumeral joint injection was performed on December 28, 2009. (12/28/2009 Procedure Report, Kamran Janjua, MD).
59. Employee was surveilled again on December 28, 2009, Employee was observed standing outside an unidentified public building holding a conversation, then walking across a snow covered parking lot using a cane before getting into his vehicle and driving away. Employee was observed at home in his driveway without the cane. He was then observed driving his vehicle. He once again walked across a snow covered parking lot using a cane for assistance coming and going from a public building. Employee was observed using his cane when crossing a snow covered parking lot to enter Costco. Employee was observed using his right hand to program an automated car wash and stepping into his Hummer 2, upon exiting the car wash he exited and inspected his vehicle without the use of the cane. Employee drove his vehicle home and exited the vehicle without his cane. Employee can be seen carrying small amounts of groceries in his left hand. On January 22, 2010, Employee can be seen leaving his house and entering his vehicle without the use of his cane, and carrying a bag in his left hand and his keys in his right hand. (12/28/2009 and 1/22/2010 video surveillance from Northern Investigative Associates).
60. On January 5, 2010, Employee returned to Dr. Hall accompanied by Employer's case manager and an interpreter. Employee received temporary relief from the glenohumeral injection that lasted only as long as the temporary anesthetic. Dr. Hall notified Employee there was no further treatment he could offer and referred him to AA Pain Clinic. (1/5/2010 chart note, Dr. Hall).
61. On January 23, 2010, Dr. Ballard conducted a second EME. Employee reported he cannot "lift anything" or "do anything"; he does not use his shoulder at all, and it is painful when he attempts passive motion exercises; he gets strong penetrating cramps in his

posterior and anterior shoulder, which go away if he presses up on his arm and cold makes it worse; surgery did not help, expect it decrease the pain a little; he always holds his arm across his body, which makes his symptoms feel better. Employee reported his low back pain is constant, cramping, and penetrating, it goes up and down his spine; he has lost leg strength; can only walk or sit for five minutes before he must change positions; he cannot lie down in bed and has to constantly turn over; he loses his balance if he doesn't use a cane. Dr. Ballard noted Employee stated his low back pain began right after the accident. Dr. Ballard stated Employee's "physical examination was filled with significant signs of symptom magnification, pain behavior, and facial grimacing. . . . With any type of testing on physical examination, he was wincing and grimacing in pain." Dr. Ballard's diagnoses were significant symptom magnification, pain behavior, and psychological overlay, diffuse back pain without objective explanation, right rotator cuff tear status post right subacromial decompression and rotator cuff repair, right acromioclavicular arthritis status post clavicle excision, and cervical degenerative disc disease and multilevel spondylosis. Dr. Ballard opined Employee's low back pain did not have an objective cause and was not related to the work injury. Dr. Ballard also opined Employee needed no further treatment for the work related right shoulder condition and was medically stable. Dr. Ballard determined it was not possible to do an accurate permanent impairment rating because of Employee's pain behavior. Dr. Ballard assessed a two percent whole person permanent partial impairment under the 6th Edition of the *AMA Guides*, and stated it is an appropriate rating considering the aggravation of the partial rotator cuff tear, causing a full component for which surgery was performed and Employee's significant psychological factors and significant pain behavior. Dr. Ballard found no reason Employee could not return to his regular job at the time of injury without restrictions and any reason Employee could not return without restrictions was not due to the May 7, 2009 injury. (1/23/2010 EME report, Dr. Ballard).

62. On February 5, 2010, Dr. Ballard supplemented his EME report after reviewing video surveillance provided by Employer. Dr. Ballard observed the following:

> 8/10/09: He is seen getting into an SUV type of car. He is turned to the right apparently talking to someone in the backseat. He is wearing a sling on the

right shoulder. He is then seen, after apparently having gone back to his house, walking with his sling on, slow gait. No significant limp is noted.

12/28/09: He is seen getting out of a car. He is walking, using his cane with arm across his chest. He apparently was going to a medical appointment. It then shows him driving the car. He is approaching his residence. He is then seen exiting his residence walking without his cane. He is noticed to be walking normally with both arms apparently at his side. This occurred at approximately 12:27. He is then noticed to be walking around his residence without a limp, without a cane. The arm is not held across his chest, but it is not used a lot on the right side. He then is noticed to be going to a doctor's appointment. He is noticed to be walking using his cane with his arm held across his chest. He seems to be using his right arm, and certainly, the right arm is not being held across his chest. No significant limp is noted. He is then noticed going to Costco using a cane, holding his right arm across his chest. He is then noticed walking out of Costco, his arm dangling from the side, normal walk, holding his cane but not using it. He is actually lifting his arm somewhat. At 5:38, he is then noticed to be out of the car. This time, there is good visualization that he is using his right arm, able to button his jacket, no activities above, but certainly he is using it to do certain items with what appears to be some type of a machine or device outside of his car. He is then noted to be getting out of the car wash walking around on the ice without his cane. He then is arriving at this residence. He is then at his house outside without using his cane. He seems to be using both of his arms. He is also noted to be carrying things into his house without use of his cane.

1/22/10: He is carrying groceries with his left arm. No limp is noted.

(2/5/2010 letter from Dr. Ballard to A. Lawton.)

63. Dr. Ballard opined the video surveillance confirmed his opinions offered in his EME report, that Employee has significant psychological factors that are interfering with his ability to recover from his injury. Dr. Ballard believed Employee can function at a much higher level than he demonstrated when Dr. Ballard conducted Employee's evaluation. *Id.*
64. On February 16, 2010, Employee was seen in the PAMC Emergency Department by Laura Abts, MD, for right shoulder and low back pain. Employee reported his pain level was ten out of a possible 10. Employee was out of pain medication and his scheduled appointment with AA Pain Clinic had been canceled and rescheduled. He was given pain medication and a prescription, and referred to Dr. Hall and / or AA Pain Clinic. An interpreter was available for this appointment. (2/16/2010 chart note, Dr. Abts; 2/16/2010 Providence Health Systems Emergency Flow Sheet Record, Ramon Rivero).

65. On March 25, 2010, Employee filled prescriptions for hydrochlorothiazide, cyclobenzaprine, and piroxicam from Dr. McAlister, his primary care physician. (Wal-Mart pharmacy record, SIME record no. 376 and 377).
66. On April 5, 2010, Employee had his initial evaluation with Alfred Lonser, MD, for his chronic back and shoulder pain. No interpreter was available for this appointment; however, Dr. Lonser noted, "However, between the patient's limited English and my limited Spanish, we will be able to come to an understanding regarding the issues." Dr. Lonser assessed lumbar degenerative disc disease and right shoulder pain, and scheduled Employee for a L5-S1 lumbar epidural steroid injection. (4/5/2010 chart note, Dr. Lonser).
67. On April 22, 2010, Dr. Hall signed a letter from Employer stating he agreed with the opinions in an EME report. (4/21/2010 letter from A. Lawton to Dr. Hall signed by Dr. Hall on 4/22/2010, labeled 2nd attempt). It is not clear from the letter which of Dr. Ballard's reports is referred to in the letter and no report is attached in the record. (Observations).
68. On April 23, 2010, Employee presented at Dr. Lonser's office without an interpreter complaining of chest and back pain. Employee was advised to go to the emergency room multiple times; and Dr. Lonser was uncertain if Employee understood the significance of chest pain. Employee questioned when he would receive an injection. The injection had not been scheduled because Employee failed to obtain a scheduled date from the surgery center. (4/23/2010 Chart Note, Dr. Lonser).
69. On May 3, 2010, Employee returned to Dr. Lonser with an interpreter. Employee reported his chest pain has been "worked up" and attributed to hypertension and pain. However, the record contains no such medical report. Employee complained of pain on palpation of his entire thoracic and lumbar spine. Dr. Lonser ordered an L5-S1 epidural steroid injection to treat Employee's annular disc bulge. Because Employee complained of "some dramatic spasm and pain in his mid-thoracic and lower spine," Employee was also given samples of Zanaflex and Flexor patches for muscle spasms and pain. (5/3/2010 chart note, Dr. Lonser).
70. On May 13, 2010, Employee received a L5-S1 interlaminar epidural steroid injection from Susan Bertrand, MD. (5/13/2010 chart note, Dr. Bertrand).

71. On May 25, 2010, Employee reported to Dr. Lonser he received no relief from the epidural steroid injection and believed it made his pain worse. Dr. Lonser referred Employee for a surgical consult. (5/25/2010 chart note, Dr. Lonser).
72. On June 5, 2010, Employee returned to the PAMC Emergency Department complaining of right arm pain after an arrest, when his arm was twisted behind his back. Employee reported his pain was 10 on a scale of 10; and hydrocodone had not helped his discomfort. David Ingraham, MD, assessed a sprain of the previous rotator cuff injury and prescribed ice, anti-inflammatories, and Percocet. (6/5/2010 chart note, Dr. Ingraham).
73. On June 22, 2010, Employee returned to Dr. Lonser and continued to state he saw no improvement from the epidural steroid injection. Employee described "his pain as 10/10 on the Visual Analogue Scale at worse and a 10/10 at best." Employee believed his pain medication dosage was too high since he was experiencing numbness over his entire body; Employee asked to discontinue oral pain medications. Employee was given a copy of the surgical consult. An interpreter was available for this appointment. (6/22/2010 chart note, Dr. Lonser).
74. On July 15, 2010, based on Dr. Ballard's January 23, 2010 EME report, Employer controverted all benefits related to Employee's cervical, thoracic, and lumbar spine, TTD from January 23, 2010, and continuing, PPI above two percent, medical benefits not related to the right upper extremity, interest, attorney's fees and costs, and a second independent medical evaluation (SIME). (7/15/10 Controversion. J. Holloway).
75. On July 19, 2010, Employee returned to Dr. Lonser to refill Employee's hydrocodone since he was unable to get an appointment for his surgical consult for another month. Employee rated "his pain as 10/10 on the Visual Analogue Scale at worse and a 10/10 at best. It is worsened with everything and improved with nothing." Employee requested a second epidural steroid injection, which was scheduled. (7/19/2010 chart note, Dr. Lonser).
76. On July 28, 2010, Employee received a second midline L5-S1 interlaminar epidural steroid injection from Dr. Lonser. (7/28/2010 chart note, Dr. Lonser).
77. On August 3, 2010, Employee was examined by Dr. Eule on referral by Dr. Lonser. Dr. Eule noted Employee's low back pain had progressively worsened since he was last examined approximately a year prior, and he was now severely incapacitated with bilateral

leg pain and numbness from the knees down. Dr. Eule ordered repeat lumbar MRI and EMG with follow up after the tests. There is no indication an interpreter was present for this appointment. (8/3/2010 chart note, Dr. Eule).

78. On August 3, 2010, Employee had an MRI of the lumbar spine which showed degenerative disc disease at L4-L5 and L5-S1 with a focal protrusion of disc material in the foramen on the right at L4-L5, moderate sized, and a small right sided protrusion of disc material at L5-S1 not encroaching the foramen. (8/3/2010 MRI report, John Fischer, MD).
79. On August 12, 2010, EMGs of the lower extremities were completed and were normal. (8/12/2010 EMG results, Dr. Bertrand).
80. On August 17, 2010, Employee returned to Dr. Eule to follow up on his EMG and MRI. Dr. Eule noted due to Employee's incapacitating pain the only possible option to consider was disc replacement which would require a discogram, which was scheduled for levels L3-L4 for control, and at L4-L5 and L5-S1. After the discogram a decision would be made regarding surgery. (8/17/2010 chart note, Dr. Eule). There is no mention of an interpreter being present at this appointment. (*Id*).
81. On August 20, 2010, Employee returned to Dr. Lonser to follow up on his pain complaints. Dr. Lonser reviewed with Employee the procedure for a discogram with an interpreter present to make sure Employee understood the procedure and obtained his consent for the procedure which was scheduled for September 2, 2010. (8/20/2010 chart note, Dr. Lonser).
82. On September 2, 2010, a discogram was performed by Dr. Lonser on levels L3-L4, L4-L5, and L5-S1. Employee's pain was concordant at levels L4-L5 and L5-S1. (9/2/2010 Discography Procedure Note, Dr. Lonser).
83. On September 2, 2010, the CT discogram was read by Jonathan Coyle, M.D., to show:

> …L4-L5, there is extension of contrast material through the annulus within both foraminal regions….the right foraminal region lesion contrast is within the introgenic tract….however, the left…also extends out to the extreme outer edge of Sharpey's fibers…In L5-S1 disk there is extensive contrast material throughout the disk proper…extends to outer disk fibers anteriorly and posteriorly in the right foraminal region. A mild disk bulge remains present at this level, appearing to produce mild central canal stenosis…. Annular tears at L4-L5 and L5-S1. (9/2/2010 CT discogram report, Dr. Coyle).

84. On September 8, 2010, Dr. Eule responded to a letter from Michael Patterson, Esq., former counsel for Employee. Dr. Eule stated Employee would not be able to return to any of the "heavy lifting" jobs he held in the ten years prior to his injury, recommended Employee be retrained, stated that it "does not appear to be the case" that the pain medication prescribed for the shoulder masked the low back problem identified some five weeks after the original date of injury, answered "no" when asked if Employee's low back condition was related to his work injury, and when asked if Employee was a candidate for low back surgery, Dr. Eule stated Employee would first require a pre-operation psychological evaluation because he appeared to be a poor candidate. (9/8/2010 letter from M. Patterson, Esq., to Dr. Eule signed by Dr. Eule on 9/8/2010).
85. On September 9, 2010, Employee returned to Dr. Eule to follow up on his discogram. Dr. Eule explained to Employee his concerns regarding Employee's history of symptom magnification, positive Waddell signs, poor recovery from shoulder surgery, and two levels of concordant pain on his discogram. Dr. Eule explained he would require a psychological evaluation that must say Employee is a good surgical candidate before Dr. Eule would consider seeking approval for a two-level disc replacement. An interpreter was present for this appointment. (9/9/2010 chart note, Dr. Eule).
86. On September 17, 2010, Dr. Lonser, in response to a letter from Mr. Patterson, stated Employee would be unable to work in any "heavy lifting" job due to his severe degenerative disc disease at L4-L5 and L5-S1, which causes severe pain and his significant shoulder pain. Dr. Lonser recommended retraining and thought Employee would benefit from a functional analysis. Dr. Lonser marked "yes," the May 7, 2009 work injury is the substantial cause of Employee's need for treatment being provided and that treatment is reasonable and necessary. Dr. Lonser commented, "I [sic] seems more likely than not, that his injury has at the very least complicated and/or worsened his pain." (9/15/2010 letter from M. Patterson, Esq., to Dr. Lonser and signed by Dr. Lonser on 9/17/2010).
87. On September 17, 2010, Dr. Lonser noted Medicaid declined Dr. Eule's recommendations and Employee asked Dr. Lonser to provide a second opinion. Dr. Lonser had no additional interventional recommendations for Employee. Dr. Lonser specifically attributed Employee's low back pain to a worsening of his degenerative disc

disease by the May 7, 2009 work injury. An interpreter was present at this appointment. (9/17/2010 chart note, Dr. Lonser).

88. On September 29, 2010, Employer filed a Request for Cross Examination of Dr. Lonser based on the September 15, 2010 Patterson letter. (9/29/2010 RCE, J. Holloway).
89. On October 13, 2010, Employee was deposed through an interpreter. Employee's pastor accompanied him and corrected the interpreter seven times during the deposition, which the interpreter acknowledged the correction. (10/13/2010 Deposition of R. Rivero).
90. During his deposition, Employee described his mechanism of injury as "I was carrying one . . . through two frames . . . in that moment . . . one of the pipes had like an elbow. . . . I hit the frame of the door and fell . . . the pipe fell on my right shoulder and so I fell on the floor." Employee stated he went to work the next day to talk to his boss and get the day off to go to the hospital. Employee also testified he returned to his job later that day, to go to the office, with the documents from the hospital, and that was when he was seen with the sling. (*Id.*).
91. Employee further testified at deposition regarding his physical abilities during August, September, and December, 2009, the period of time captured in video surveillance. Employee testified he was able to drive a car and would drive his wife to the store and himself to his medical appointments since his wife does not drive, he was sometimes able to carry a bag with groceries in his left hand to help his wife, and he started using a cane sometimes in the winter after slipping and falling getting out of the car. (*Id.*).
92. Employee was unaware of the 2009 video surveillance at the time of the deposition. (Record).
93. On October 29, 2010, Employer controverted reemployment benefits except for an eligibility evaluation. (10/29/2010 Controversion. J. Holloway).
94. On January 17, 2011, Employee returned to Dr. Lonser for a medication refill for his severe back and shoulder pain. No interpreter was available for this appointment. (1/17/2011 chart note, Dr. Lonser).
95. On February 14, 2011, Employee returned to Dr. Lonser to follow up on his pain. At this appointment another lumbar epidural steroid injection was decided upon; however this time the injection would be tried at the L4-L5 level to see if it offered more long lasting

relief. An interpreter was available for this appointment. (2/14/2011 chart note, Dr. Lonser).

96. On February 23, 2011, Dr. Lonser performed an L4-L5 interlaminar epidural steroid injection. (2/23/2011 Procedure note, Dr. Lonser).
97. On March 14, 2011, Employee was examined by Jane Sonnenburg, PA-C, to follow up on his pain complaints. Employee was experiencing cramping in his lower extremities which prevented him from sleeping. PA Sonnenburg prescribed Norflex and Cymbalta, and scheduled follow up with Dr. Lonser. PA Sonnenburg noted Employee had some, though not long lasting, benefit from the L4-L5 epidural steroid injection on February 23, 2011. No interpreter accompanied Employee to this appointment. (3/14/2011 chart note, PA Sonnenburg).
98. On April 11, 2011, Dr. Lonser prescribed a TENS unit and physical therapy for Employee. Dr. Lonser also noted Employee's pain had improved to an 8/10 at worst and a 7/10 at best, as opposed to 10/10 in previous visits. (4/11/2011 chart note, Dr. Lonser).
99. On April 14, 2011, Employee was seen by Robert McAlister, MD, who is his family physician. Dr. McAlister noted Employee's history including his May 7, 2009 work injury, and assessed back pain due to on-job-injury two years ago. (4/14/2011 chart note, Dr. McAlister).
100. On April 23, 2011, John J. Lipon, DO, conducted an SIME on Employee. An interpreter was provided for the examination. Dr. Lipon's SIME was limited to Employee's right shoulder. Employee's current shoulder symptoms were limited range of motion, pain or discomfort with lifting over five pounds, and pain, tingling and cramps in the posterior of his shoulder. As far as his shoulder treatment, Employee wanted to return to Dr. Hall and physical therapy to continue treatment and see if his pain could be alleviated. Dr. Lipon diagnosed the following right shoulder conditions: a) contusion of the right shoulder related to May 7, 2009 work injury; b) preexisting degenerative changes of the right shoulder acromioclavicular joint, partial rotator cuff tear, and calcific tendonopathy of the distal supraspinatus tendon aggravated by the May 7, 2009 work injury; c) right shoulder surgery performed by Dr. Hall on August 11, 2009, which included a right shoulder arthroscopic subacromial decompression, right shoulder mini open rotator cuff repair, and right shoulder open Mumford procedure, and noted a full

thickness tear throughout a large portion of the supraspinatus tendon, consistent with the aggravation of his preexisting right shoulder condition noted in "b," related to the May 7, 2009 work injury; d) October 21, 2009, motor vehicle accident which caused a temporary aggravation of his preexisting condition; and e) June 2010 altercation with the police during which Employee's arm was pulled behind his back which caused a temporary aggravation of his right shoulder condition. Dr. Lipon opined Employee's shoulder injury on May 7, 2009, occurred at the time it did, to the degree it did, and by the way it did due to his employment with Employer. Dr. Lipon noted the absence of records documenting any earlier complaints or treatment to his right shoulder as evidence he had no preexisting right shoulder injury or symptoms prior to May 7, 2009. Dr. Lipon opined Employee needed no further formal medical treatment, including palliative care, for his shoulder and should continue in his self-directed home exercise program to maximize his range of motion and function. Dr. Lipon also opined Employee's treatment to date had been reasonable and necessary, and Employee was medically stable. Dr. Lipon disapproved seven jobs in Employee's 10 year work history (Asbestos Removal Technician, Washer, Machinist, Driver, Sales Route Worker, Janitor, and Kitchen Helper) based on the jobs being in the light-medium to heavy classification and requiring above shoulder-level or repetitive work with the right arm. Dr. Lipon opined Employee is capable of working five days a week on a sustained basis as relates to his right shoulder condition, but he would have restrictions limiting above shoulder level work and repetitive work with his right upper extremity, and would likely fit best in a light work duty setting for his right shoulder condition. Dr. Lipon recommended a physical capacity evaluation. Dr. Lipon also rated Employee's shoulder for permanent impairment under the 6th Edition of the *AMA Guides* and assigned a seven percent impairment rating related entirely to the May 7, 2009 work injury. (4/23/2011 SIME Report, Dr. Lipon).

101. Dr. Lipon was deposed on October 20, 2011, at which time he testified consistently with his report. Dr. Lipon was asked to review the "barber" job description and stated Employee would not be able to perform the job because "there's constant movement of the arms . . . often having to get into awkward positions . . . repetitive activity required." (10/20/2011 deposition of Dr. Lipon, pg. 37).

102. On May 4, 2011, Employee, through counsel, requested a reemployment eligibility evaluation by amending his workers' compensation claim and sending a letter to the RBA. (5/4/2011 WCC and letter to RBA. M. Patterson).

103. On May 9, 2011, Dr. Lonser and PA-C Sonnenburg responded to a letter from Mr. Patterson in which they agreed Employee's shoulder pain could have masked his low back pain for the first two months after his injury. Dr. Lonser and PA-C Sonnenburg also opined Employee's May 7, 2009 work injury was the substantial cause of his need for treatment for his low back condition. (5/3/2011 letter from M. Patterson to Dr. Lonser signed by Dr. Lonser and PA-C Sonnenburg on 5/9/2011). These opinions were incorporated into a chart note of the same date by PA-C Sonnenburg. (5/9/2011 chart note, PA-C Sonnenburg).

104. On May 12, 2011, Employer filed a request for cross examination of Dr. Lonser, based on the May 9, 2010 document attached to the May 9, 2011 Medical Summary. (5/12/2011 RCE, J. Holloway).

105. On May 19, 2011, Employee returned to Dr. Eule who noted a psychiatric evaluation provided no contraindication for lumbar surgery. Dr. Eule stated:

> My thought would be based on our ability to get him authorized for surgery, not based on what we think is best for the patient; what I think is best for the patient is probably a two-level lumbar arthroplasty, and if he can get his Workers' Compensation reinstated since this originally dates back to a work injury, then maybe we can do a two-level lumbar arthroplasty, otherwise we will try to get him approved for an L4-5 lumbar arthroplasty with an L5-S1 anterior lumbar interbody fusion.

An interpreter was present for this appointment. (5/19/2011 chart note. Dr. Eule).

106. Dr. Eule's May 19, 2011 report does not provide a medical opinion stating Employee's employment with Employer was the substantial cause of his need for surgery; it simply states what Dr. Eule proposes to do if Employee prevailed on his worker's compensation claim. (Observation, experience, judgment and inferences from all the above).

107. On May 24, 2011, Employer, through counsel, notified the RBA it did not object to Employee's request for a reemployment eligibility evaluation and conceded he missed more than 90 days of work. (5/24/2011 letter to RBA. J. Holloway).

108. On May 26, 2011, Employer renewed the controversion originally issued on July 15, 2010. (5/26/2011 Controversion. J. Holloway).
109. On May 31, 2011, the RBA notified the parties Steve Coley was appointed to conduct Employee's reemployment eligibility evaluation. (5/31/2011 Notification Letter. D. Reed).
110. On June 23, 2011, Dr. Eule predicted Employee would have a permanent impairment, confirmed a permanent impairment greater than zero existed at that time, disapproved the SCODRDOTs for Construction Worker II, Truck Driver, Commercial or Industrial Cleaner, Cleaner I, Machine Washer, Cook Helper, and Barber, in which Dr. Eule noted Employee may not be able to stand for extended time. (6/9/2011 letter from S. Coley to Dr. Eule, signed by Dr. Eule on 6/23/2011, with attached signed SCODRDOTs).
111. Occupations employee held in the 10 years prior to injury include barber, which has a 1 – 2 year specific vocational preparation (SVP) requirement and requires two years' experience, with a "light" physical demand level. (8/28/2011 Re-employment Benefits Eligibility Evaluation, at 6).
112. Employee was a barber for 20 years in Cuba from 1983 to 2003. Employee has the required experience and SVP to perform the barber duties. (*Id.,* at 5).
113. On June 27, 2011, Specialist Coley sought an extension of time from the RBA due to not receiving a response from Dr. Eule regarding the job descriptions sent to him. This letter was copied to S. Williams at Nova Pro. (6/27/2011 letter to M. Kemberling from S. Coley). Nova Pro Risk Solutions is Employer's adjusting service. (Record).
114. On June 30, 2011, Dr. Eule responded to Specialist Coley's request for an opinion regarding job descriptions. He indicated Employee could not do any of the provided job descriptions but on the "barber" job description Dr. Eule checked both the "yes" and "no" lines and explained: "He may have trouble standing for an extended time." (6/30/11 Job Analysis Description, Dr. Eule Responses).
115. On June 30, 2011, Employer's counsel transmitted to the RBA's office the documentation required under current 8 AAC 45.522(d), which became effective July 9, 2011. (6/30/2011 transmittal letter to D. Reed from J. Holloway with attachments). No controversions were transmitted with this documentation. (*Id.;* enclosure list. Record).

116. On July 12, 2011, Employee returned to Dr. Lonser for follow up on his chronic pain. Employee asked for a repeat lumbar epidural steroid injection as it provided the most relief for his pain, and declined refills on his pain medications. Employee reported his pain to be a nine out of ten. Employee explained he does not like taking pain medications and wanted to reduce or eliminate them. An interpreter was available for this appointment. (7/12/2011 chart note, Dr. Lonser).
117. On July 14, 2011, Dr. Lonser administered a repeat L4-L5 interlaminar epidural steroid injection. (7/14/2011 Procedure Note, Dr. Lonser).
118. On August 12, 2011, Employee returned to Dr. Lonser and reported some improvement from his recent epidural steroid injection. However he continued to suffer from constant, severe pain and asked for refills on his pain medications. An interpreter was available for this appointment. (8/12/2011 chart note, Dr. Lonser).
119. On August 28, 2011, specialist Coley submitted his eligibility evaluation. Specialist Coley noted Employee's claimed injuries to his right shoulder and low back, but specialist Coley made no mention of a controversion related to Employee's lumbar spine. Despite the use of an interpreter, specialist Coley was unable to determine the name of Employee's physician at AA Pain Center, referring to him as "Lance." Specialist Coley determined Dr. Eule to be the current primary physician. Specialist Coley noted Dr. Eule predicted Employee was unable to return to any of the jobs he held in the ten years prior to his injury or his job at the time of injury, and SIME physician Dr. Lipon agreed with Dr. Eule in this respect. Specialist Coley recommended Employee be found eligible for reemployment benefits. (8/28/2011 Reemployment Eligibility Evaluation, S. Coley).
120. On September 9, 2011, Employee was evaluated by Sarah Bigelow, PA-C, for his chronic pain. Employee complained about side-effects of his medications and asked for another epidural steroid injection, which was scheduled. An interpreter was available for this appointment. (9/9/2011 appointment, PA-C Bigelow).
121. On September 15, 2011, a repeat L4-L5 interlaminar epidural steroid injection was administered by Dr. Lonser. (9/15/2011 Procedure Note, Dr. Lonser).
122. On September 21, 2011, Dr. Lonser's deposition was scheduled for December 5, 2011, by Mr. Patterson on behalf of Employee. (9/21/2011 note, Employee's 5/21/2012 Medical

Summary). There is no deposition transcript in the agency file and no indication in the record as to why the deposition was not conducted. (Record).

123. Employee received monthly refills of his pain medications from AA Pain Clinic beginning October 2011 through August 2012, with the exception of July 2012. The medications dispensed from AA Pain Clinic during this time period were Ambien, Cymbalta, Flexeril, and hydrocodone-acetaminophen. (R. Rivero Medication History, printed 8/27/2012).
124. On October 13, 2011, RBA designee Deborah Torgerson found Employee eligible for reemployment benefits based on Specialist Coley's evaluation. Designee Torgerson found Dr. Eule predicted Employee would not be able to return to any of the jobs he held in the ten years prior to his injury or at the time of injury, and in a footnote, explained that although Dr. Eule checked both the "yes" and "no" boxes on the SCODRDOT for barber, he wrote "he may have trouble standing for extended time" which is a prediction Employee will not have the permanent physical capacities to perform the physical demands of this job. Designee Torgerson also noted since Employee performed the barber job in another country, he has not received the training required to obtain a license to perform this job in the U.S. (10/13/2011 Eligibility Notification Letter. D. Torgerson).
125. On October 17, 2011, with the help of a phone interpreter, Employee was examined by Robert McAlister, MD, for chest pain and back pain. Dr. McAlister noted a history of "chronic recurrent back pain and shoulder pain related to an industrial injury several years ago." Dr. McAlister noted Employee was being seen at a pain clinic, was using a TENS unit, and was anticipating surgery very soon. Dr. McAlister also noted Employee had many stressors in his life including unemployment, six children and chronic pain. "Patient does not have any pain at this time." Dr. McAlister assessed chest wall pain, suspected large contribution from anxiety and chronic pain issues, and hypertension. Dr. McAlister made some changes to Employee's blood pressure medications. (10/17/2011 chart note, Dr. McAlister).
126. On October 19, 2011, Employer filed a petition seeking review of the RBA designee's October 13, 2011 eligibility determination. (10/17/2011 Petition).

127. On October 26, 2011, Employee opposed Employer's petition seeking review RBA designee's October 13, 2011 eligibility determination. (10/26/2011 Employee's Answer to Employer's 10/17/2011 Petition).
128. On November 4, 2011, the parties filed a stipulation to continue the April 23, 2011 hearing on the merits of Employee's claim due to the need for a second SIME on Employee's low back condition. (11/4/2011 Stipulation). Dr. Lipon did not perform the second SIME; it is unclear from the record why Dr. Lipon did not perform the second SIME examination. (Record).
129. On December 13, 2011, Employee was seen by Thomas Naughton, MD, for blurred vision. Employee had been recently diagnosed with Type II insulin dependent diabetes mellitus. A telephone interpreter was utilized for this appointment. (12/13/2011 chart note. Dr. Naughton).
130. On December 21, 2011, Employee was seen by Dr. McAlister in follow up for his diabetes. Dr. McAlister noted Employee's blood sugar seemed under good control, but he had recently been hospitalized for diabetic ketoacidosis. Employee's daughter acted as interpreter for this appointment. (12/21/2012 chart note, Dr. McAlister).
131. On February 1, 2012, Employer controverted reemployment benefits from November 12, 2011 forward based on Employee being non-cooperative under AS 23.30.041(g) and (n). (2/1/2012 controversion. J. Holloway).
132. On February 2, 2012, Employee returned to Dr. Lonser where he reported aching and shooting low back pain and pain radiating into the right leg on a 9/10 scale. Dr. Lonser noted Employee's blood sugar was under control at this visit. Employee noted improvement from the last epidural steroid injection and requested another injection, which was scheduled. An interpreter was present for this appointment. (2/2/2012 chart note, Dr. Lonser).
133. On February 8, 2012, a repeat L4-L5 interlaminar epidural steroid injection was administered by Dr. Lonser. (2/8/2012 Procedure Note, Dr. Lonser).
134. On March 1, 2012, Employee reported to Dr. Lonser he had 14 days of some improvement from the February 8, 2012 injection. No interpreter was present for this appointment. (3/1/2012 chart note, Dr. Lonser).

135. On March 21, 2012, Employee was evaluated by James Scoggin, III, MD, for an SIME regarding his low back pain. Dr. Scoggin obtained Employee's history of injury and treatment through an interpreter. Dr. Scoggin noted the mechanism of injury to be "carrying a heavy metal pipe that weighed 200 pounds on his right shoulder . . . the pipe hit the frame of a door, and he fell against the frame of the door, twisting his back . . . felt a "big pain" in his right shoulder . . . he had to stop working and went home . . . did not feel any pain in his back at first . . . in fact, he did feel a little pain in his back at first . . . he told the doctor in the clinic about his back on the first day . . . back pain gradually got worse." Under "current complaints," Dr. Scoggin noted Employee continued to experience pain in his right shoulder at a level of five out of 10, his neck at a level of five out 10, and his back at a level of six out 10. Dr. Scoggin noted Employee was diagnosed with diabetes three months earlier and was currently on insulin. Dr. Scoggin reviewed Employee's medical history, but was not provided any imaging studies despite the numerous studies done on Employee's shoulder, low back and neck. Dr. Scoggin opined Employee did not exhibit excessive pain behavior at the time of the examination and was very cooperative. Dr. Scoggin's diagnoses were: 1. right shoulder pain with rotator cuff tear attributed to the May 7, 2009 work injury; 2. complaints of right sided neck pain attributed to the May 7, 2009 work injury; 3. preexisting diffuse cervical degenerative disc disease and multiple level spondylosis; 4. right acromioclavicular joint arthritis, preexisting but aggravated by the May 7, 2009 work injury resulting in the need for distal clavicle excision; 5. right shoulder rotator cuff tear, status post right subacromial decompression and rotator cuff repair; and 6. low back pain without radiculopathy not related to the May 7, 2009 work injury. Dr. Scoggin opined Employee had no objective evidence of radiculopathy based on his review of the reports from the radiological studies. Dr. Scoggin based his low back opinions on: inconsistencies in the descriptions in the mechanism of injury on reports dated May 8 and 18, and June 9, 2009, and at the time of his examination; the history of low back pain treatment on April 1, 2005 for back spasm after weight lifting; treatment on May 25, 2008 for an upper respiratory infection with "left flank pain;" and the September 20, 2009 statement made by Employee to the triage nurse of an injury "years ago." Dr. Scoggin concluded the May 7, 2009 work injury was not the substantial cause of Employee's need for treatment or disability for his low back pain. Dr. Scoggin opined

there was no evidence the May 7, 2009 injury played a role in Employee's lumbar degenerative disc disease becoming symptomatic. Dr. Scoggin found the treatment to date had been reasonable and necessary, but not related to the May 7, 2009 work injury. Dr. Scoggin found the May 7, 2009 work injury to be the substantial cause of the neck and shoulder pain; however a home exercise program with appropriate strengthening for his rotator cuff was the only remaining treatment necessary. Dr. Scoggin concurred with Dr. Lipon, "that [Employee] had reached medical stability status by 4/23/2011." Dr. Scoggin agreed with Dr. Lipon Employee is capable of performing light-duty work, but should undergo a functional capacity evaluation that controls for sincerity of effort. Dr. Scoggin also agreed Employee's low back condition is the main limiting factor in his ability to return to work. Dr. Scoggin affirmed Employee was unable to return to his job at the time of injury due to the May 7, 2009 injury to his shoulder and remains restricted to sedentary or light duty work on a full time basis, and agreed with the restrictions placed on any return to work by Dr. Lipon. (4/4/2012 SIME Report, Dr. Scoggin. Workers' Compensation System notes approving 11/4/2011 Stipulation to Continue Hearing and New SIME).

136. On April 23, 2012, the parties filed a stipulation to continue the May 22, 2012 hearing based on the unavailability of Dr. Scoggin for deposition until late June 2012, and the intent of the parties to mediate. The board approved the stipulation on April 25, 2012. (4/23/2012 Stipulation).
137. On April 26, 2012, Employee's urine was tested for compliance with his medication regimen. His urine was again negative for the opiates he was prescribed. A recheck at the next appointment was ordered. (4/26/2012 Lab Report, Quest Diagnostics, with hand notation).
138. On May 23, 2012, Employee had a routine follow up appointment with Sarah Bigelow, PA-C at AA Pain Clinic, for medication refills. A follow up drug urinalysis was ordered. No interpreter was present for this appointment. (5/23/2012 chart note, PA-C Bigelow).
139. On May 23, 2012, Employee's urine was tested for compliance with his medication regimen. His urine was again negative for the opiates he was prescribed. A recheck at the next appointment was ordered. (5/23/2012 Lab Report, Quest Diagnostics, with hand notation).

140. On June 8, 2012, Employee was referred to Chugach Physical Therapy for right shoulder adhesive capsulitis. (6/8/2012 PT referral, signature illegible, filed on Employee's 6/12/2012 Medical Summary).
141. On June 20, 2012, Employee was seen by PA-C Bigelow for prescription refills but discussions regarding his negative drug screens were limited due to the lack of an interpreter. Employee's prescriptions were refilled. (6/20/2012 chart note, PA-C Bigelow).
142. On August 15, 2012, Employee returned to PA-C Bigelow for prescription refills without an interpreter. His prescriptions were refilled and he was directed to bring an interpreter to the next visit. (8/15/2012 chart note, PA-C Bigelow).
143. Mr. Patterson withdrew as Employee's attorney on August 31, 2012, and filed a lien for $32,000 in attorney's fees and costs for services provided. (9/4/2012 Withdrawal, 9/4/2012 Lien, M. Patterson).
144. On January 21, 2013, Dr. Scoggin was deposed and testified consistently with his report. Dr. Scoggin testified Employee would have reached medical stability for his neck by September 30, 2009. Dr. Scoggin also reviewed the job description for barber and approved it on a full time basis. Dr. Scoggin maintained it was unlikely six medical providers would all come to the conclusion Employee's back pain started somewhere around June 2009, which is approximately five weeks after the injury. Dr. Scoggin stated the pain medication Employee was taking for his shoulder would not have masked the pain in his back for the initial five weeks after his injury. Dr. Scoggin also stated there was no objective reason Employee cannot work as related to his low back. (1/21/2013 Deposition of Dr. Scoggin).
145. Dr. Ballard was deposed on January 23, 2013, and testified consistently with his three EME reports. (1/23/2013 Deposition of Dr. Ballard).
146. Employer paid Employee the following indemnity benefits: TTD benefits from May 18, 2009 to January 22, 2010, a lump sum 2% PPI in the amount of $3,540.00 on January 28, 2010, and bi-weekly PPI for the remaining $8,850.00 of his seven percent PPI, and AS 23.30.041(k) stipend from October 19, 2011 to January 31, 2012. (Workers' Compensation System, Payments Screen).

147. Cultural differences between a medical provider and patient can increase the risk of the medical provider misinterpreting a patient's responses and physical cues, including Waddell's signs which are considered invalid in non-Anglo cultures. (Experience, observations, judgments and conclusions. AMA *Guides to Evaluation of Permanent Impairment,* 6th Edition, p. 27). The AMA *Guides* also require evaluators to use interpreters and be aware of the quality of interpreters used in medical appointments, including those used when recording a patient's medical history. (*Id.*).
148. At hearing, Employee testified providers did not understand his reports to them because the interpreters did not properly interpret his Spanish dialect. Immediately after Employee's testimony, interpreter M. Grace Anderson requested permission to clarify. She explained, for example, just as someone from Georgia has a different dialect than someone from New York, both speak English. Similarly, a Spanish speaking individual from Cuba has a different dialect than a Spanish speaking person from Mexico; however, both speak Spanish. She stated she served as Employee's interpreter for many of his medical appointments and properly interpreted on his behalf. (Anderson).
149. No prehearings were held in this case between the time Mr. Patterson withdrew on August 31, 2012, and the February 5, 2013 hearing on the merits of Employee's claim. The last prehearing conference in which Mr. Rivero participated was held on July 15, 2010. (Prehearing Conference Summary, July 15, 2010).
150. The deadline for filing evidence was January 16, 2013, and the deadline for filing briefs and witness lists was January 29, 2013. (6/13/2012 Prehearing Conference Summary; experience, observations, judgments and conclusions).
151. At hearing Employee tendered chart notes from Dr. Lonser ranging from June 22, 2010, to January 3, 2013. The chart notes dated June 22, 2010, through August 15, 2012, were duplicates of records already filed on medical summaries and/or as part of SIME binders. The chart notes dated September 12, 2012, through January 3, 2013, were not previously filed by either party and contained in the record prior to hearing. (Record. Dr. Lonser records tendered by Employee at hearing in manila envelope).
152. On February 15, 2013, Employee filed a transportation log claiming 2,360 miles in medical related transportation costs. Employee claimed 20 miles for each PAMC Emergency visit on May 8 and 12, 2009, 500 miles for orthopedic visits from May 18, 2009 to 2010, 400

miles for 10 physical therapy appointments, and 1,440 miles for visits to AA Pain Clinic between February 2010 and February 2013. (2/14/2013 Transportation Log). There is no certificate of service on this transportation log showing it was served on Employer. (*Id.).*

153. The mileage claimed on the February 15, 2013 log was not in the proper format and not specific to each medical appointment. (Experience, observations, judgments and conclusions).

154. The majority finds Employee not credible, particularly in his symptoms and exertional limit reports to medical providers. (Experience, judgment, observations and inferences drawn from all the above).

PRINCIPLES OF LAW

> **AS 23.30.001. Intent of the legislature and construction of chapter**. It is the intent of the legislature that
>
> 1) this chapter be interpreted . . . to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to . . . employers. . . .

’’The board may base its decision not only on direct testimony, medical findings, and other tangible evidence, but also on the board’s “experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above.” *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-534 (Alaska 1987). A finding a disability would not have occurred “but for” employment may be supported not only by a doctor’s testimony, but inferentially from the fact that an injured worker had been able to continue working despite pain prior to the subject employment but required surgery after that employment. A finding reasonable persons would find employment was a cause of the Employee’s disability and impose liability is, “as are all subjective determinations, the most difficult to support.” However, there is also no reason to suppose board members who so find are either irrational or arbitrary. That “some reasonable persons may disagree with a subjective conclusion does not necessarily make that conclusion unreasonable” (*id.*).

> **AS 23.30.010. Coverage**. Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability . . . or the need for medical treatment of an Employee if the disability . . . or the Employee’s need for medical

treatment arose out of and in the course of the employment. . . When determining whether or not the . . . 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 the need for medical treatment. Compensation or benefits under this chapter are payable for the disability . . . or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability . . . or need for medical treatment. . . .

AS 23.30.041. Rehabilitation and reemployment of injured workers. . . .
. . .
(c) . . . If the employee is totally unable to return to the employee's employment at the time of the injury for 90 consecutive days as a result of the injury, the administrator shall, without a request, order an eligibility evaluation unless a stipulation of eligibility was submitted. . . .

(d) Within 30 days after the referral by the administrator, the rehabilitation specialist shall perform the eligibility evaluation and issue a report of findings. . . . Within 14 days after receipt of the report from the rehabilitation specialist, the administrator shall notify the parties of the employee's eligibility for reemployment preparation benefits. Within 10 days after the decision, either party may seek review of the decision by requesting a hearing under AS 23.30.110. The hearing shall be held within 30 days after it is requested. The board shall uphold the decision of the administrator except for abuse of discretion on the administrator's part.

(e) An employee shall be eligible for benefits under this section upon the employee's written request and by having a physician predict that the employee will have permanent physical capacities that are less than the physical demands of the employee's job as described in the 1993 edition of the United States Department of Labor's 'Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles' for:

(1) the employee's job at the time of injury; or

(2) other jobs that exist in the labor market that the employee has held or received training for within 10 years before the injury or that the employee has held following the injury for a period long enough to obtain the skills to compete in the labor market, according to specific vocational preparation codes as described in the 1993 edition of the United States Department of Labor's 'Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles.*'* (Emphasis added).

The RBA's decision must be upheld absent "an abuse of discretion on the administrator's [designee's] part." *Miller v. ITT Arctic Services*, 367 P.2d 884, 889 (Alaska 1962). Several definitions of "abuse of discretion" appear in Alaska law although none appear in the Alaska Workers' Compensation Act (Act). The Alaska Supreme Court stated abuse of discretion consists

of “issuing a decision which is arbitrary, capricious, manifestly unreasonable, or which stems from an improper motive.” *Sheehan v. University of Alaska,* 700 P.2d 1295, 1297 (Alaska 1985). An agency’s failure to apply controlling law or to exercise sound, reasonable and legal discretion may also be considered an abuse of discretion. . *Manthey v. Collier*, 367 P.2d 884, 889 (Alaska 1962).

The RBA fails to exercise sound, reasonable and legal discretion where he relies on a rehabilitation specialist’s report which fails to consider statutorily mandated factors. *Irvine v. Glacier General Construction*, 984 P.2d 1103 (Alaska 1999). Where the board upholds an RBA decision based on such a flawed report, the board commits legal error. *Id.* at 1107.

The Administrative Procedures Act, at AS 44.62.570, provides another definition used by courts in considering appeals from administrative agency decisions. It contains terms similar to those cited above, and expressly includes reference to a “substantial evidence” standard:

> Abuse of discretion is established if the agency has not proceeded in the manner required by law, the order or decision is not supported by the findings, or the findings are not supported by the evidence . . . . If it is claimed that the findings are not supported by the evidence, abuse of discretion is established if the court determines that the findings are not supported by (1) the weight of the evidence; or (2) substantial evidence in the light of the whole record.

On appeal to the Alaska Worker’s Compensation Appeals Commission and the courts, decisions reviewing RBA Designee determinations are subject to reversal under the “abuse of discretion” standard in AS 44.62.570, incorporating the “substantial evidence test.” While applying a substantial evidence standard a “[reviewer] may not reweigh the evidence or draw its own inferences from the evidence. If, in light of the record as a whole, there is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion, then the order …must be upheld.” *Miller v. ITT Arctic Services*, 367 P.2d 884, 889 (Alaska 1962). “Substantial evidence” is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Tolbert v. Alascom, Inc*., 973 P.2d 603, 611-612 (Alaska 1999).

AS 23.30.041(e) is clear -- the board must compare the physical demands of a specific job as found in the SCODRDOT with the employee’s physical capacities. Employees are eligible for

reemployment benefits if their physical capacities are less than the physical demands described in the SCODRDOT. *Yahara* at 73; *Rydwell v. Anchorage School Dist.*, 864 P.2d 526, 529 (Alaska 1993). '

> **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. . . .
>
> **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.
>
> (2) notice of the claim has been given;

The Alaska Supreme Court held the presumption of compensability is applicable to any claim for compensation under the workers' compensation statute, and applies to claims for medical benefits and continuing care. *Meek v. Unocal Corp.*, 914 P.2d 1276, 1279 (Alaska 1996); *Municipality of Anchorage v. Carter*, 818 P.2d 661, 664-665 (Alaska 1991). An employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski v. Best Western Golden Lion*, 813 P.2d 286, 292 (Alaska 1991).

Application of the presumption to determine the compensability of a claim for benefits involves a three-step analysis. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381 (Alaska 1991). First, the claimant must adduce "some" "minimal," relevant evidence establishing a "preliminary link" between the disability and employment, or between a work-related injury and the existence of disability, to support the claim. *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.,* 742 P.2d 239, 244 (Alaska 1987). The evidence necessary to raise the presumption of compensability varies depending on the claim. In claims based on highly technical medical considerations, medical evidence is often necessary to make that connection. *Burgess Construction Co. v. Smallwood*, 623

P.2d 312, 316 (Alaska 1981). In less complex cases, lay evidence may be sufficiently probative to establish causation. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). 'Witness credibility is not weighed at this stage in the analysis. *Resler v. Universal Services Inc.*, 778 P.2d 1146, 1148-49 (Alaska 1989). If there is such relevant evidence at this threshold step, the presumption attaches to the claim

In *Runstrom v. Alaska Native Medical Center,* AWCAC Decision No. 150 (March 25, 2011), the Alaska Workers' Compensation Appeals Commission held the 2005 legislative amendment to AS 23.30.010 altered the longstanding presumption analysis“”*Runstrom,* AWCAC Decision No. 150, at 3. The Commission held the second stage of the presumption analysis now requires the employer:

> [R]ebut the presumption with substantial evidence that excludes any work-related factors as the substantial cause of the employee's disability, etc. In other words, if the employer can present substantial evidence that demonstrates that a cause other than employment played a greater role in causing the disability, etc., the presumption is rebutted. However, the alternative showing to rebut the presumption under former law, that the employer directly eliminate any reasonable possibility that employment was *a factor* in causing the disability, etc., is incompatible with the statutory standard for causation under AS 23.30.010(a). In effect, the employer would need to rule out employment as *a factor* in causing the disability, etc. Under the statute, employment must be more than *a factor* in terms of causation. *Id.* at 7. (Emphasis in original).

“Substantial evidence” is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 611-612 (Alaska 1999); *Miller* at 1046. Since the presumption shifts only the burden of production and not the burden of persuasion, the employer's evidence is viewed in isolation, without regard to any evidence presented by the claimant. *Id.* at 1055. Credibility questions and weight to give the employer's evidence are deferred until after it is decided if the employer has produced a sufficient quantum of evidence to rebut the presumption the claimant is entitled to the relief sought. *Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051 (Alaska 1994); *Wolfer* at 869.

Runstrom held once the employer has successfully rebutted the presumption of compensability,

> [the presumption] drops out, and the employee must prove, by a preponderance of the evidence, that in relation to other causes, employment was the substantial cause of the disability, need for medical treatment, etc. Should the employee meet this burden, compensation or benefits are payable. *Id.* at 8.

In *Runstrom v. Alaska Native Medical Center,* 280 P.3d 567, 573 (Alaska 2012), the Supreme Court said: "Once an employee is disabled, the law presumes the employee's disability continues until they employer produces substantial evidence to the contrary." Citing *Grove v. Alaska Constr. & Erectors,* 948 P.2d 454, 458 (Alaska 1997) (citing *Bailey v. Litwin Corp.,* 713 P.2d 249, 254 (Alaska 1986).

> **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.

If the board is faced with two or more conflicting medical opinions, each of which constitutes substantial evidence, and elects to rely upon one opinion rather than the other, the Supreme Court will affirm the board's decision. *Yahara v. Construction & Rigging, Inc.,* 851 P.2d 69 (Alaska 1993).

The AMA *Guides* direct medical evaluators to consider cultural differences present when evaluating non-English speaking patients, including specifically stating Waddell signs should not be relied upon, and are indeed invalid in non-English speaking patients. The Alaska Supreme Court has recognized the role a language barrier can play both in an injured workers' care and in credibility determinations made by medical evaluators. *Sosa de Rosario v. Chenega Lodging,* 297 P.3d 139 (Alaska 2013).

> **AS 23.30.130. Modification of Awards.**
> (a) Upon its own initiative, or upon the application of any party in interest on the ground of a change in conditions, including, for the purposes of AS 23.30.175, a change in residence, or because of a mistake in its determination of a fact, the board may, before one year after the date of the last payment of compensation benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, whether or not a compensation order has been issued, or before one year after the rejection of a

> claim, review a compensation case under the procedure prescribed in respect of claims in AS 23.30.110. Under AS 23.30.110 the board may issue a new compensation order that terminates, continues, reinstates, increases or decreases the compensation, or award compensation.

In the case of a factual mistake or a change in conditions, a party "may ask the board to exercise its discretion to modify the award at any time until one year" after the last compensation payment is made, or the board rejected a claim. *George Easley Co. v. Lindekugel*, 117 P.3d 734, 743 (Alaska 2005). AS 23.30.130 has been applied to changes in conditions affecting reemployment benefits and vocational status. *See, e.g.*, *Griffiths v. Andy's Body & Frame, Inc.*, 165 P.3d 619 (Alaska 2007); *Imhof v. Eagle River Refuse*, AWCB Decision No. 94-0330 (December 29, 1994).

Right to board review under AS 23.30.130(a) arises whether or not a compensation order has been issued. The board may modify so long as the board's review process begins within one year of the last payment of compensation or the rejection of the claim. *See, e.g.*, *Griffiths*, 165 P.3d at 623.

> **AS 23.30.135. Procedure before the board**. (a) In making an investigation or inquiry or conducting a hearing the board is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by this chapter. The board may make its investigation or inquiry or conduct its hearing in the manner by which it may best ascertain the rights of the parties….

> **AS 23.30.155. Payment of compensation**. . . .
> . . .
>
> (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.

> **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 23.30.395. Definitions**. In this chapter,
> . . .
>
> (27) 'medical stability' means the date after which further objectively measurable improvement from the effects of the compensable injury is not reasonably expected to result from additional medical care or treatment, notwithstanding the possible need for additional medical care or the possibility of improvement or deterioration resulting from the passage of time; medical stability shall be presumed in the absence of objectively measurable improvement for a period of 45 days; this presumption may be rebutted by clear and convincing evidence;

> **8 AAC 45.052. Medical summary.** (a) A medical summary on form 07-6103, listing each medical report in the claimant's or petition's possession which is or may be relevant to the claim or petition, must be filed with a claim or petition. The claimant or petitioner shall serve a copy of the summary form, along with copies of the medical reports, upon all parties to the case and shall file the original summary form with the board . . .
>
> (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.
> >
> > . . .
>
> (d) After a claim or petition is filed, all parties must file with the board an updated medical summary form within five days after getting an additional medical report. A copy of the medical summary form, together with copies of the medical reports listed on the form, must be served upon all parties at the time the medical summary is filed with the board.

A party has a right to cross-examine the authors of a medical record, if the right is not waived. *Commercial Union Companies v. Smallwood*, 550 P.2d 1261 (Alaska 1976).

> **8 AAC 45.084. Medical travel expenses.** (a) This section applies to expenses to be paid by the employer to an employee who is receiving or has received medical treatment.

(b) Transportation expenses include

(1) a mileage rate, for the use of a private automobile, equal to the rate the state reimburses its supervisory employees for travel on the given date if the usage is reasonably related to the medical examination or treatment;

(2) the actual fare for public transportation if reasonably incident to the medical examination or treatment; and

(3) ambulance service or other special means of transportation if substantiated by competent medical evidence or by agreement of the parties.

(c) It is the responsibility of the employee to use the most reasonable and efficient means of transportation under the circumstances. If the employer demonstrates at a hearing that the employee failed to use the most reasonable and efficient means of transportation under the circumstances, the board may direct the employer to pay the more reasonable rate rather than the actual rate.

(d) Transportation expenses, in the form of reimbursement for mileage, which are incurred in the course of treatment or examination are payable when 100 miles or more have accumulated, or upon completion of medical care, whichever occurs first.

(e) A reasonable amount for meals and lodging purchased when obtaining necessary medical treatment must be paid by the employer if substantiated by receipts submitted by the employee. Reimbursable expenses may not exceed the per diem amount paid by the state to its supervisory employees while traveling.

8 AAC 45.112. Witness list. A witness list must indicate whether the witness will testify in person, by deposition, or telephonically, the witness's address and phone number, and a brief description of the subject matter and substance of the witness's expected testimony. If a witness list is required under 8 AAC 45.065, the witness list must be filed with the board and served upon all parties at least five working days before the hearing. If a party directed at a prehearing to file a witness list fails to file a witness list as directed or files a witness list that is not in accordance with this section, the board will exclude the party's witnesses from testifying at the hearing, except that the board will admit and consider

(1) the testimony of a party, and

(2) deposition testimony completed, though not necessarily transcribed, before the time for filing a witness list.

8 AAC 45.120. Evidence. (a) Witnesses at a hearing shall testify under oath or affirmation. . . .

> (f) Any document . . . 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.
> . . .
>
> (i) If a hearing is scheduled on less than 20 days' notice or if a document is received by the board less than 20 days before hearing, the board will rely upon that document only if the parties expressly waive the right to cross-examination or if the board determines the document is admissible under a hearsay exception of the Alaska Rules of Evidence.
>
> (j) Subsections (f) – (i) apply only to objections based on hearsay, and do not limit the parties' right to object to the introduction of document on other grounds.

In *Tolbert v. Alascom, Inc.,* 973 P.2d 603 (Alaska 1999), the only evidence Tolbert presented to prove medical expenses stemming from her work injury was her testimony. Alascom's adjuster denied having received Tolbert's medical bills. The adjuster's testimony was found credible; Tolbert's testimony was found vague and lacking documentary support. The board determined "because Tolbert failed to submit the bills to Alascom at all, much less in the form required by 8 AAC 45.082, and, independently, because she failed to submit the bills to the Board, it lacked sufficient evidence upon which to base an award of medical benefits." *Id.,* at 607. The Supreme Court concluded the record supported the board's ruling Tolbert failed to present sufficient evidence on the issue of medical expenses.

> **8 AAC 45.142. Interest**. (a) If compensation is not paid when due, interest must be paid at the rate established in AS 45.45.010 for an Injury that occurred before July 1, 2000, and at the rate established in AS 09.30.070(a) for injury that occurred on or after July 1, 2000. If more than one installment of compensation is past due, interest must be paid from the date each installment of compensation was due, until paid. If compensation for a past period is paid under an order issued by the board, interest on the compensation awarded must be paid from the due date of each unpaid installment of compensation. . . .

> **8 AAC 45.195. Waiver of procedures.** A procedural requirement in this chapter may be waived or modified by order of the board if manifest injustice to a party would result from a strict application of the regulation. However, a waiver may not be employed merely to excuse a party from failing to comply with the requirements of law or to permit a party to disregard the requirements of law.

> **8 AAC 45.522. Ordering an eligibility evaluation without a request.** (a) For injuries occurring on or after November 7, 2005, if an employee has been totally unable to return to employee's employment at the time of injury for 90 consecutive days as a result of the injury, the administrator shall refer the employee for an eligibility evaluation, unless employer controverts on grounds identified under AS 23.30.022, 23.30.100, 23.30.105, and 23.30.250, or 8 AAC 45.510(b). If reemployment benefits have been controverted on any of these grounds, the administrator shall forward the matter to the board to conduct a prehearing conference and hold a hearing in accordance with 8 AAC 45.510(b).
>
> (b) If a controversion notice has not been filed under (a) of this section, the administrator shall, no later than five working days after notice received under 8 AAC 45.507(b), send a letter to the parties identifying the name and address of the rehabilitation specialist selected in accordance with AS 23.30.041(c) to evaluate the employee.
>
> . . .
>
> (c) "No later than 10 working days after receipt of the administrator's letter selecting a rehabilitation specialist, the employer at the time of injury or the employer's adjuster shall forward'''. . . . a copy of . . . controversions to the rehabilitation specialist, the employee, and the administrator.
>
> (d) No later than 10 working days after receipt of the administrator's letter selecting a rehabilitation specialist, the employer at the time of injury or the employer's adjuster shall forward a copy of the employee's resume and job application, and a job description or summary of the employee's job duties, if available, to the rehabilitation specialist, the employee, and the administrator. The employer or employer's adjuster shall also forward a copy of the report of injury and all medical reports, compensation reports, and controversions to the rehabilitation specialist, the employee, and the administrator.

ANALYSIS

1. *Should Dr. Lonser's chart notes be admitted in full or in part?*

The law requires a party to file medical evidence on a medical summary 20 days prior to hearing and serve it on the other party, or the fact-finders may not consider the evidence. 8 AAC 45.120(f). Employee did not file the disputed chart notes on a medical summary by the evidence deadline. Employer timely requested cross examination of Dr. Lonser.

8 AAC 45.082. He was not produced for cross-examination at deposition or hearing. Employee did not file a witness list as directed or produce Dr. Lonser as a witness. Employee argued he was only able to obtain the chart notes the day before the hearing, but the latest treatment date record is January 3, 2013, a record which clearly existed in time to be filed by January 16, 2013, if it had been requested from AA Pain Clinic prior to February 4, 2013. Many of the chart notes tendered by Employee are duplicates of chart notes already in the record making admission of those chart notes (dates of service June 22, 2010 through August 15, 2012) unduly repetitive and therefore moot. However, chart notes (September 12, 2012 through January 3, 2013) that are not duplicates will be excluded from the record because Employee failed to comply with the applicable regulations. Employer's objection is sustained.

2. Was Employee's work for Employer the substantial cause of the need for Employee's lower back treatment?

This is a factual dispute to which the presumption of compensability applies. AS 23.30.120. Employee attached the presumption work is the substantial cause of his need for treatment for his low back through his testimony and Dr. Lonser's September 17, 2010 opinion his need for surgery on his low back is attributable to the work injury. Employer rebutted the presumption with Dr. Ballard's and Scoggin's opinions Employee's low back complaints are not related to his May 7, 2009 work injury. *Runstrom*.

Employee must prove his low back claim by a preponderance of the evidence. Employee's repeated inconsistencies when describing his injury undermine his credibility and his testimony his back pain arose from the May 7, 2009 work injury AS 23.30.122. By contrast, the opinions of Drs. Scoggin, Gevaert, Hall, Eule, and Ballard, that Employee's significant pain behavior, his inconsistent injury description, and his late reporting of back pain five weeks after the injury lead to a conclusion Employee did not injure his back at work on May 7, 2009. These physicians' opinions are credible and are given the most weight. AS 23.30.122. Based on these opinions and Employee's lack of credibility, Employee's need for treatment for his low back, including the surgery recommended by Dr. Eule, is not work related, and Employer will not be ordered to authorize it. *Rogers & Babler*.

3. Is Employee entitled to TTD from January 23, 2010, to the present?

TTD benefits are payable during periods of work-related total disability through the date of medical stability. AS 23.30.185. Since Employee's back condition is not compensable, any TTD owed beginning January 23, 2010, would have to be related to the accepted shoulder condition. There is no dispute as to compensability of the right shoulder injury; the only dispute is the medical stability date.

Employee's entitlement to additional TTD benefits is a factual issue to which the presumption of compensability applies. AS 23.30.120. Employee attached the presumption he is entitled to additional TTD with opinions from SIME Drs. Lipon and Scoggin and treating physician Dr. Hall. Employer rebutted the presumption with an opinion from EME Dr. Ballard.

Employee must, therefore, prove his TTD claim by a preponderance of the evidence. Dr. Lipon did not specify a medical stability date for Employee's shoulder; however, he indicated Employee's condition had not changed since the injury occurred. Dr. Lipon stated Employee was considered medically stable, but did not give a precise date when medical stability occurred. Dr. Scoggin concurred with Dr. Lipon that Employee was medically stable, but he did not provide a date either. Applying the date of an examination to determine medical stability fails to take into account the Act's definition of medical stability, which requires a determination of "the date" after which further objectively measurable improvement from the effects of Employee's work related shoulder injury were not reasonably expected to result from additional medical care or treatment, bearing in mind medical stability shall be presumed in the absence of objectively measurable improvement for a period of 45 days. AS 23.30.185.

Dr. Ballard found Employee medically stable as of January 22, 2010. He provided a specific date, as required by law. Dr. Ballard opined Employee needed no further treatment for the work related right shoulder condition. Dr. Ballard determined it was impossible to do an accurate PPI rating because of Employee's pain behavior. He assessed a two percent shoulder PPI considering the work-related aggravation of the partial rotator cuff tear, causing the need for surgery, given Employee's significant psychological and pain behaviors. Dr. Ballard found no

reason Employee could not return to his regular job at the time of injury without restrictions. After reviewing *sub rosa* videotapes, Dr. Ballard noted Employee was seen using his arm, in contrast to his historical reports to his physicians in which he stated he could "do nothing" with his arm. For example, Dr. Ballard saw "good visualization that he is using his right arm, able to button his jacket, no activities above, but certainly he is using it to do certain items with what appears to be some type of a machine or device outside of his car." These observations confirmed Dr. Ballard's EME opinions, and he determined Employee has significant psychological factors that are interfering with his ability to recover. Dr. Ballard said Employee can function at a much higher level than he demonstrated when Dr. Ballard conducted Employee's evaluation. This evidence is given great weight and credibility. AS 23.30.122.

These findings also support Dr. Ballard's January 22, 2010 medical stability opinion. Based on Dr. Ballard's opinion, as of January 22, 2010, it was not reasonable to expect Employee's shoulder was likely to improve in an objectively measurable way as the result of any additional medical care or treatment because there was nothing objectively wrong with his shoulder. Employee was, therefore, medically stable effective January 22, 2010. Employee cannot receive TTD after the date of medical stability. AS 23.30.185. Therefore, his claim for TTD beginning January 23, 2010 will be denied.

4) Is Employee eligible for reemployment benefits?

An RBA or designee decision must be upheld absent an abuse of discretion. AS 23.30.041(d). An abuse of discretion occurs where a decision is arbitrary, capricious, manifestly unreasonable, or stems from an improper motive. *Manthey.* There is no evidence of this and none of these circumstances exist here because the RBA designee acted properly given the medical evidence before her. But an abuse of discretion will also be found where a decision fails to apply controlling law, or fails to exercise sound legal discretion. *Id.* Similarly, the RBA designee did not fail in this regard either, given the evidence before her when she rendered her decision. However, RBA designee decisions may be reviewed, reversed or vacated based upon a change in condition, including subsequently obtained evidence. For example, if an injured worker is found eligible for reemployment benefits based upon a physician's prediction the worker will have a

PPI rating, and several months later it is determined there is no ratable impairment, the RBA designee's decision may be modified based on this factual mistake. AS 23.30.130.

On October 23, 2011, based on specialist Coley's recommendation, the RBA designee found Employee eligible for reemployment benefits. The RBA designee relied on Dr. Eule's predictions regarding Employee's permanent physical capacities and PPI. Dr. Eule found Employee could not return to his job at the time of injury. Additionally, Dr. Eule's "yes" and "no" response to the barber description implies Employee could return to his barber position, but may have trouble standing for extended time due to his low back, the only condition for which Dr. Eule was treating Employee. Since this decision finds Employee's low back not compensable, Dr. Eule's opinion cannot be found to say Employee cannot return to his barber job because of his shoulder.

8 AAC 45.070(b)(1)(A) requires the fact-finders to consider the evidence available to the RBA designee at the time she made her decision unless the panel determines any newly discovered evidence could not have been produced to the RBA designee with due diligence.

Employer's contention the RBA designee abused her discretion is largely based on SIME physician Scoggin's opinion regarding Employee's ability to return to work as a barber and the RBA designee's consideration of Dr. Eule's low back opinions when all benefits for the back condition were controverted. Dr. Scoggin's examination did not take place until March 21, 2012, five months after Employee was found eligible for reemployment benefits. The RBA designee was required to make her determination based on the evidence before her. Specialist Coley presented the RBA designee with a summation of available, relevant medical evidence though he was unaware of the compensability controversion in place on the back injury Specialist Coley made the appropriate eligibility recommendation based on the available information regarding both the shoulder and back injuries.

However, neither the specialist nor the RBA designee considered Employee's credibility. Employee is not credible and physicians who support his position have unwittingly relied upon his statements concerning his symptoms and his exertional limitations. Thus, their opinions are

tainted and unreliable. AS 23.30.122. Dr. Ballard recognized Employee's lack of credibility early on. Neither the specialist nor the RBA designee is tasked with determining an injured worker's credibility. The fact-finder has "the sole power to determine the credibility of a witness." AS 23.30.122. The specialist and RBA designee are tasked with weighing and relying on medical records provided by physicians who make predictions. AS 23.30.041. *See also, Yahara,* 851 P.2d 69, 73. This decision does not fault either the specialist or the RBA designee in this regard. Both followed the law. But some physicians weigh the injured worker's credibility and factor their findings into their medical predictions. Some do not. But if the fact-finders on appeal from the RBA designee's decision later concur with those medical providers who state Employee can return to one or more job he held in the past, this forms a basis to reverse and vacate a contrary RBA designee eligibility determination. AS 23.30.122; AS 23.30.130.

Although the RBA designee in a footnote stated Employee had not received the training necessary to obtain a barber license in the U.S., neither the statute nor regulation require the RBA designee to consider licensure. Employee is eligible for reemployment benefits if he has physical capacities less than the physical demands of his job at the time of injury or other jobs in the labor market, which he held 10 years prior to his injury and held long enough to meet the SVP code. AS 23.30.041(e)(1),(2). Conversely, because Employee possesses the physical capabilities to be a barber and meets the SVP with 20 years' experience, he is not eligible for reemployment benefits.

Further, the medical records are replete with instances of Employee changing how his injury occurred. In most instances, an interpreter was present when Employee provided his history. Accounts are markedly different. Language issues could not have accounted for these differences. Furthermore, on April 26, 2012, Employee's urine was tested for compliance with his medication regimen. His urine was negative for the prescribed opiates. On May 23, 2012, Employee's urine was again tested for compliance. His urine was again negative for the prescribed opiates. There is no scientific reason offered to explain this, though there may well be one. These astonishing results lead the majority to one of two conclusions: 1) Employee was obtaining but not taking his medication as prescribed, and his symptoms were not adequately

mitigated so his alleged inability to return to his prior employments was an illusion; or 2) Employee was diverting his opioids to others, perhaps for profit. In either case, the repeated lack of opioids in Employee's urine demonstrates he was not taking his medication – for whatever reason – all the while complaining bitterly about his symptoms. He is not credible. AS 23.30.122.

Dr. Scoggin's opinions are substantial evidence demonstrating Employee can, at the very least, return to work as a barber, if not other jobs he held in the relevant time period. Reemployment benefits are not required in this instance. AS 23.30.130 gives the fact-finders authority to modify an RBA designee decision. Findings concerning Employee's credibility, which may influence physicians' opinions and predictions, were not available to the specialist or the RBA designee when their recommendation and decision, respectively, were rendered. Therefore, these credibility findings are newly discovered evidence, adequate to support the majority's decision to reverse and remand the RBA designee's decision. Employer's appeal will be granted. The RBA designee will be directed to determine Employee's eligibility for reemployment benefits in accord with this decision.

5) Is Employee entitled to interest?

The law requires payment of interest to an injured worker on compensation not paid when due. Interest is mandatory. AS 23.30.155(p). As Employee is not entitled to any additional benefits, he is not entitled to interest. His interest request will be denied.

6) Is Employee entitled to transportation costs?

Employee did not submit a transportation log prior to hearing as required by law. 8 AAC 45.084. The record was left open for Employee to submit a post-hearing transportation log. He did so, but it was not specific enough and could not support a transportation award. Employee had opportunities to submit his log before hearing and failed to, even though he was represented by an attorney for a season. Employee was given another chance when the chair left the record open so Employee could file an appropriate log. He still failed to do so. Employee

has had ample opportunity to submit a transportation log but failed. He will not be given another chance. His transportation request will be denied.

CONCLUSIONS OF LAW

1) Dr. Lonser's chart notes will not be admitted in full or in part.

2) Employee's work for Employer was not the substantial cause of the need for treatment for Employee's lower back.

3) Employee is not entitled to TTD from January 23, 2010, to the present.

4) Employee is not eligible for reemployment benefits.

5) Employee is not entitled to interest.

6) Employee is not entitled to transportation costs.

ORDER

1. Medical records from Dr. Lonser not properly and timely filed and served on medical summaries, and subject to cross-examination were not considered in this decision.

2. Employee's request for benefits for his low back is denied.

3. Employee's claim for TTD is denied.

5) The RBA designee's decision is reversed and remanded. The RBA designee is to determine Employee's eligibility to reemployment benefits in accord with this decision.

6) Employee's claim for interest is denied.

6) Employee's transportation claim is denied.

Dated in Anchorage, Alaska on September 04, 2013.

ALASKA WORKERS' COMPENSATION BOARD

____
Linda Hutchings, Member

____
Rick Traini, Member

DISSENT OF DESIGNATED CHAIR de MANDER

The dissent respectfully disagrees with the majority concerning compensability for Employee's lumbar injury, the date of medical stability, TTD, interest, transportation, and Employee's eligibility for reemployment benefits.

Compensability for Employee's lumbar injury

Substantial evidence in the record supports the conclusion Employee's work injury is the substantial cause of his need for low back treatment, including the surgery recommended by Dr. Eule. The substantial evidence includes: 1. the absence of records reflecting treatment for prior back conditions; 2. Employee's credible, consistent, testimony regarding the mechanism of injury, absence of any significant, symptomatic, preexisting lumbar pathology; and 3. the persuasive opinions from Drs. Lonser and Imbriani, and PA-C Sonnenburg.

Employer and the majority give great weight to Dr. Scoggin's SIME report, however Dr. Scoggin relied on Employee's description of the injury mechanism given in medical records without accounting for presence of an interpreter or interpretation quality. Dr. Scoggin opined Employee's work injury was not the substantial cause of his lumbar complaints based on perceived "inconsistencies" in Employee's medical reports. Dr. Scoggin specifically noted inconsistencies between a May 8, 2009 medical record, when a family member translated in the emergency room; May 18, 2009, when Employee was initially evaluated by PAC Love in Dr. Hall's office when an unknown interpreter was present; June 9, 2009, when he was first evaluated by Dr. Eule for his neck when Ms. Anderson was the interpreter; and the SIME evaluation in which yet another interpreter was used.

The AMA *Guides* direct medical evaluators to consider cultural differences when evaluating non-English speaking patients. *The Guides* specifically direct that Waddell signs should not be relied upon and are invalid in non-English speaking patients. *The Guides* specifically direct that medical evaluators be aware of questionable interpreters, especially untrained family members or office staff utilized as interpreters due to their lack of familiarity with medical terminology and procedures. This cultural awareness includes recognition that interpreting is an art not a science. Minor "inconsistencies" are merely nuances lost in translation. They represent interpretation

errors, not substantive errors. Clues as to the quality of an interpreter can be obtained from other areas of the report. For example, see findings of fact twenty-six and one-hundred twenty-five to compare Employee's number of children -- a relatively simple topic to interpret.

In addition, Dr. Scoggin placed great emphasis on a September 20, 2009 triage note stating Employee had an injury "years ago." The nurse was not a Spanish speaker and no interpreter was present. Dr. Scoggin also heavily weighted two other chart notes stating Employee treated for back spasms in 2005 and back pain was noted when he had an upper respiratory infection in 2008. While Employer had releases to search for low back related medical records prior to the May 7, 2009 work injury, these two questionable records were all that existed. Dr. Scoggin used these three records to piece together a "history" of low back pain. However, if Employee had a history of lumbar back pain working as he did in heavy to very heavy jobs, there would have been many more records of unambiguous treatment for his lumbar spine complaints to support the assertion. The dearth of records for treatment for low back pain is a clear indication Employee had no significant, symptomatic history of lumbar pain prior to his May 7, 2009 work injury.

Furthermore, it is not unusual for the character and intensity of work injuries to change over time. The immediate trauma Employee sustained was to his shoulder, when he fell while carrying a two-hundred pound pipe which landed on his shoulder. Given the immediate shoulder pain, and subsequent complexity of the shoulder injury, one would expect Employee's attention would first be directed to his shoulder. It is not uncommon that Employee first reported his back pain to a medical provider five weeks after the injury date given the severity of his shoulder injury and the amount of pain medication he was taking for it early on. There is no history of Employee taking narcotic pain medication previously; Employee's tolerance level would have been low initially, so masking of back pain was likely, as confirmed in chart notes by pain management physician Dr. Lonser on September 17, 2010, and PA Sonnenburg on May 9, 2011. Also, Dr. Imbriani opined Employee's low back pain may have come to light after the work injury due to his back compensating for his right shoulder injury or as a result of prolonged inactivity since the work injury. A medical provider's failure to note a complaint of back pain until five weeks after the date of injury does not support a finding Employee had none, especially

given the fact he was seeking treatment solely for his shoulder during that initial five week period. Dr. Imbriani's opinion regarding the five week delay in onset of low back symptoms is credible and persuasive. Dr. Lonser and PA Sonnenburg are more persuasive regarding the question of whether Employee's back pain could have been masked by the pain medication he was taking for his shoulder injury for the first five weeks.

Dr. Gevaert made errors similar to those of Dr. Scoggin. Employee was evaluated by Dr. Gevaert on July 22, 2009, for reflex sympathetic dystrophy/CRPS in the right upper extremity. Employee also complained of low back pain. While Dr. Gevaert noted "inconsistencies" in Employee's history, he acknowledged they may be language issues. Dr. Gevaert also found significant pain behavior at this visit, and stated he would release Employee back to medium duty work immediately based on his present symptomatology, but backed off that opinion once he reviewed Employee's shoulder MRI. When Dr. Hall referred Employee back to Dr. Gevaert on November 5, 2009, for his low back pain, Dr. Gevaert characterized Employee's complaints regarding low back pain on July 22, 2009, as "barely complained" but offered no explanation why he prescribed a lumbosacral support to a patient who "barely complained" of low back pain. Like Dr. Scoggin, Dr. Gevaert is a doctor who routinely rates patients for PPI under the 6th Edition of the *AMA Guides to Evaluation of Permanent Impairment*, who misapplied the *Guides* when he relied on positive Waddell signs to assess symptom magnification in a non-English speaking patient.

The dissent further takes issue with the conclusion one's credibility can be determined based on their reporting of pain using the very subjective zero to ten pain scale where a patient is told a ten out of ten is the worst pain imaginable. Communicating pain levels is admittedly difficult which is why pain scales were developed. However single dimensional pain scales are flawed for evaluating patients with chronic pain or complex cases because they do not account for the nature and location of the pain, which is important in this case. Multidimensional scales, which are utilized by pain management doctors, are more beneficial because they provide more information regarding the type of pain, and the impact the pain is having on a patient's activities of daily living. However, regardless of which scale is used pain reporting by its very nature is subjective. While Mr. Rivero's ten out of ten pain may be very different than someone else's ten

out of ten, we cannot judge it is not an indication he is not feeling the worst pain he can imagine. No explanation is provided to patients as to the underlying meaning of the numbers associated with each pain level so there is no way for a patient to know that a three or below is minor and a seven or above is severe, so if a patient reports anything above an eight to a medical provider they are expected to be suicidal due to the pain.[1] On a comparative pain scale, a mosquito bite is a one, getting an injection from a medical provider is a three, a toothache or bee sting is a four, mild back pain is a five, and bad back pain that makes it difficult to hold a job is a six.[2] This becomes even more complicated in a patient who does not speak English and has a different cultural heritage. There is variability in pain thresholds across patients of different sexes, ethnicities, and race. Use of a subjective pain scale measurement to determine the credibility of Employee is not appropriate when he does not fully understand what has been asked of him. In this case, the majority has twisted the multidimensional pain scales by an interpreter or someone else on Mr. Rivero's behalf to further debase Employee's credibility.

Finally, on May 19, 2011, Dr. Eule connected Employee's need for surgery with his work injury. Dr. Eule noted the recommended surgical procedure, a two-level lumbar arthroplasty, would only be possible if approval could be obtained from the workers' compensation carrier. In addition, Dr. Eule completed the reemployment paperwork requested by specialist Coley. These actions are contradictory to Dr. Eule's earlier answer on September 8, 2010, to attorney Patterson's "check the box" question about the work-relatedness of Employee's low back condition. Given the context of Dr. Eule telling Employee the next day he will require a psychological evaluation before agreeing to perform surgery, and the number of doctors who accused Employee of symptom magnification without considering cultural factors, it is not surprising Dr. Eule questioned Employee's credibility. But once the psychological evaluation came back without contraindications, Dr. Eule no longer hesitated in linking the need for surgery to the work injury. Dr. Eule is experienced in the workers' compensation system. When he made his recommendation on May 19, 2011, he was not merely contemplating payment of his fee as the majority suggests, but relating the need for surgery to the May 7, 2009 work injury.

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[1] Comparative Pain Scale.
[2] *Id.*

Based on the above, the dissent would find Employee proved by a preponderance of the evidence his May 7, 2009 work injury is the substantial cause of his need for low back medical treatment, including the surgery recommended by Dr. Eule. As a result of this finding, Employee's medical providers would be entitled to payment of unpaid medical bills and interest on bills not paid timely, Employee would be entitled to an order preauthorizing the surgery recommended by Dr. Eule, continuing TTD through medical stability for his low back, and transportation expenses related to medical care for his low back.

Date of Medical Stability and TTD

Dr. Hall released Employee from treatment on January 5, 2010, noting there was nothing further he could offer him other than referral to AA Pain Clinic. Dr. Hall did not release Employee to work that day or find him medically stable. Dr. Ballard found Employee medically stable as of January 22, 2010. Dr. Lipon did not specify a date of medical stability for the shoulder, but opined Employee was medically stable as of his examination on April 23, 2011, a conclusion with which Dr. Scoggin concurred. The majority discounts Dr. Lipon, and by reference Dr. Scoggin, on this issue by saying Dr. Lipon "indicated Employee's condition had not changed since the injury occurred" which entirely mischaracterizes Dr. Lipon's report. Dr. Lipon's report states that Employee, "in spite of treatment to date,…, says there has been no change in his condition since the date of injury."[3] The opinions of the board's SIME physicians, Drs. Lipon and Scoggin, are the most credible on this issue. Employee did not become medically stable until April 23, 2011, the date of his examination by Dr. Lipon. Substantial evidence supports a finding Employee is entitled to additional TTD from January 23, 2010, through the date of medical stability with respect to the undisputedly work-related shoulder injury, April 23, 2011. As a result of being entitled to additional TTD, Employee would also be entitled to interest on TTD not paid when owed.

Eligibility for Reemployment Benefits

Employee was injured on May 7, 2009. Compensability of his shoulder injury was accepted, and Employee became entitled to a reemployment eligibility evaluation ninety days later, on August 6, 2010. AS 23.30.041(c). On May 4, 2011, Employee amended his claim to include a

[3] Dr. Lipon's response to question #9.

reemployment eligibility evaluation after having been off work for much longer than ninety days. At that time, the RBA was also notified by Mr. Patterson of Employee's request for an eligibility evaluation, and Employer notified the RBA of its non-opposition on May 24, 2011. By this point, Employer had already controverted all benefits related to Employee's back as of July 15, 2010, and re-controverted those benefits again two days after agreeing to the eligibility evaluation. On May 31, 2011, the RBA's office sent the parties a letter regarding the appointment of Mr. Coley, which included the following "compensability of your claim does not appear to be in dispute." Employer did not provide copies of any controversions as part of the reemployment packet furnished by Employer on June 30, 2011. Further, on June 27, 2011, Specialist Coley notified Employee and the adjuster, Ms. Williams, he needed a thirty day extension to finish his evaluation because he was awaiting a response from the treating physician, Dr. Eule, regarding "correspondence relevant to eligibility issues." Dr. Eule is well known in the workers' compensation community as an orthopedic spinal surgeon. Ms. Williams is an experienced adjuster and Mr. Holloway is experienced counsel, however neither contacted the RBA or Mr. Coley regarding Employer's controversion of Employee's back injury, which would have been the easiest way to avoid this costly appeal of the RBA designee's decision.

Mr. Coley submitted his report to the RBA on August 28, 2011, with copies to counsel for both parties, recommending Employee be found eligible for reemployment benefits. The RBA designee did not issue her decision until October 23, 2011, more than six weeks later. During that six week interval Employer did not send Mr. Coley or the RBA designee any objection to the report based on the use of Dr. Eule's recommendation or to point out the July 15, 2010 controversion based on the compensability of the back injury.

On October 23, 2011, based on Mr. Coley's recommendation, the RBA designee found Employee eligible for reemployment benefits. While the RBA designee relied on Dr. Eule's predictions regarding Employee's permanent physical capacities and PPI, Mr. Coley also noted in his report Employee had undergone an SIME with Dr. Lipon who had reviewed the SCODRDOTs and "agreed with Dr. Eule's assessment that Mr. Rivero is unable to return to any of the jobs held at the time of injury, or jobs held within ten years prior to the injury" and has a PPI. This is a clear indication that Mr. Coley incorporated into his report medical opinions

regarding both Employee's shoulder injury and his back injury, although he was only required to present one as part of the report. Like Dr. Eule, as noted by the RBA designee in a footnote in the eligibility notification letter, Dr. Lipon was also concerned about Employee's ability to perform the light duty job of barber based on his shoulder injury, which he described in his deposition as "constant movement of the arms and often having to get into awkward positions to use scissors or the shaver or washing hair…it's my opinion, he would not be able to do this because of that repetitive activity required."

8 AAC 45.070(b)(1) requires the board to consider the evidence that was available to the RBA designee at the time of her decision unless the board determines that any newly discovered evidence could not have been produced to the RBA designee with due diligence. Clearly Employer could have produced the controversions, which would have included the July 15, 2010 controversion of all benefits related to Employee's back injury, prior to the RBA designee's decision. Moreover, after counsel and the adjuster received letters from the RBA's office and Mr. Coley stating compensability was not in dispute, and only documentation from Dr. Eule was needed before a recommendation could be made, neither took any step to contact the RBA's office or Mr. Coley.

The majority's contention that Dr. Ballard somehow had unique insight into Employee's credibility that the SIME physician's lacked and their reliance on Dr. Ballard's credibility findings is an unfortunate relinquishment of the board's responsibility. Dr. Ballard's opinions were part of the SIME binders. They were reviewed, considered, and mentioned by both Drs. Lipon and Scoggin in their written reports and their depositions, as was Employee's deposition. There was considerable evidence by which the SIME physicians could judge Employee's credibility should they have chosen to do so. Both Dr. Scoggin, who stated Employee did not exhibit excessive pain behavior, and Dr. Lipon, who noted some pain behavior but was able to complete his exam, were neutral physicians, unlike Dr. Ballard, so they were expected to provide their observations without drawing conclusions regarding his credibility. Credibility findings are the sole province of the board. They are to be made independently, after review of the full administrative record, without undue influence by any party or outside influence.

Dr. Ballard exceeded his role as a medical examiner by usurping the board's role in determining credibility on more than one occasion in his evaluations. By following Dr. Ballard's lead on Employee's credibility, the majority abdicated its responsibility to use its independent judgment. The majority blindly accepted Dr. Ballard's description of the surveillance not borne out by an independent viewing. For example, there is no evidence in the surveillance video that Employee was "apparently…going to a medical appointment" on December 28, 2009, when he was surveilled. Also, Employee was observed carrying no more than a single plastic grocery bag with his left arm at any one time at any point in the surveillance video as opposed to "carrying groceries with his left arm." Further, there was no indication in the video surveillance of Employee carrying things into his house with both of his arms. The portion of the surveillance referred to by Dr. Ballard is taken from across the street from Employee's home, and in the dark, so it is not possible to distinguish between Employee and the other adult, who is presumably his wife, carrying items into the home, much less what arm is being used to carry those items. (8/10/2009, 12/28/2009 and 1/22/2010 video surveillance from Northern Investigative Associates). Dr. Ballard's description of the surveillance contained in his third EME report was merely recited and accepted by the majority blindly without verification, despite Employee confirming at deposition, without knowledge of the surveillance, his use of a cane at times during the winter because of a fall on the ice, and that he was required to drive himself and his family because his wife does not drive. In his description of the surveillance, Dr. Ballard conceded there was no evidence of Employee being able to use his shoulder to work above shoulder level, which would rule out the job at the time of injury.

Furthermore, the majority's assertion Employee was faking his pain or diverting his pain medication was not supported by substantial evidence. The majority reaches this conclusion because no scientific reason was offered to explain the two negative urinalysis tests for opioids Employee was prescribed for his pain; however the majority conclusion fails to consider the basic science behind common false negatives in urinalysis. As one example, urinalysis for semisynthetic opioids, such as hydrocodone like Employee was taking, often produce false negatives based on the timing of the test, metabolism of the patient, or the amount of fluid intake of the patient. The majority also fails to consider that the two urinalyses which showed no hydrocodone were conducted after Employee was diagnosed with diabetes, his blood sugar was

under control, which was when he was reporting better pain control. At that time, he was taking the hydrocodone as needed for pain, not at prescribed intervals. He was also required to drive to the doctor's office, so it is possible he did not take any prior to his appointment for the safety of himself, his family, and others on the roadway. Indeed, the fact Dr. Lonser and his colleagues continued to treat Employee and provide pain medications after the two negative urinalyses, instead of dismissing him from care, is further indication the urinalyses were explained and not substantial evidence of drug diversion.

Finally, the majority's contention the RBA designee abused her discretion is based in part on SIME physician Scoggin's opinion regarding Employee's ability to return to work as a barber. Dr. Scoggin's SIME was assigned and performed regarding the low back injury. However, SIME physician Dr. Lipon evaluated Employee's shoulder and ruled out Employee's return to work as a barber. In his report, Dr. Scoggin deferred to Dr. Lipon regarding the date of medical stability and PPI for the shoulder injury. In his deposition, Dr. Scoggin approved the SCODRDOT for barber as far as the back injury, but did not address the remaining restrictions Dr. Lipon placed on Employee's ability to work related to his shoulder, and to which Dr. Scoggin agreed, in his report. Dr. Scoggin's opinion would only have the effect of neutralizing Dr. Eule's opinion Employee's back injury precluded his return to former employment; it does not diminish the opinion of Dr. Lipon that Employee's accepted shoulder injury precluded his return to former employment, including as a barber due to the frequent and awkward hand and arm movements. While fully informing Mr. Coley and the RBA designee with Dr. Scoggin's report on remand may slightly alter Mr. Coley's report and somewhat change the RBA designee's letter, it would be putting form over substance since they both clearly considered Dr. Lipon's opinion in their determination Employee's work injury precluded his return to his former employment. The RBA designee's determination Employee is eligible for reemployment benefits was supported by substantial evidence. The RBA designee did not abuse her discretion when she found Employee eligible for reemployment benefits. Therefore her decision should be affirmed.

Dated in Anchorage, Alaska, on September 04, 2013.

Laura Hutto de Mander, Designated Chair

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 board 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 grounds 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 accordance with 8 AAC 45.050. The petition requesting reconsideration must be filed with the board within 15 days after delivery or mailing of this decision.

MODIFICATION

Within one year after the rejection of a claim, or within one year after the last payment of benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, a party may ask the board to modify this decision under AS 23.30.130 by filing a petition in accordance with 8 AAC 45.150 and 8 AAC 45.050.

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of RAMON RIVERO Employee / applicant v. COLDFOOT ENVIRONMENTAL SERVICES, INC., Employer; and ZURICH AMERICAN INSURANCE CO., defendants; Case No. 200906554; dated and filed in the office of the Alaska Workers' Compensation Board in Anchorage, Alaska, on September 04, 2013.

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Marianna Subeldia, Office Assistant I