ALASKA WORKERS' COMPENSATION BOARD

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

JOSEPH M. BAKER, Employee, Claimant,	)	FINAL DECISION AND ORDER
v.	)	AWCB Case No. 201106861
ASRC ENERGY SERVICES, INC., Employer,	)	AWCB Decision No. 14-0005
and	)	Filed with AWCB Fairbanks, Alaska On January 13, 2014.
ARCTIC SLOPE REGIONAL CORP., Insurer, Defendants.	)	

Joseph Baker's (Employee) March 28, 2012 claim was heard on September 19, 2013, a date selected on June 24, 2013. Attorney Joseph Kalamarides appeared and represented Employee, who appeared and testified. Attorney Nora Barlow appeared and represented ASRC Energy Services, Inc. (Employer). Employee's wife, Robin Baker, appeared and testified for Employee. At the hearing's conclusion, Employee requested one week to file a supplemental affidavit of fees. Employer requested an additional five days to review and object to Employee's affidavit. Following initial deliberations, the panelists requested an opportunity to review the medical reports and deposition transcripts. The record closed when deliberations ended on November 7, 2013.

ISSUE

At a December 14, 2012 prehearing conference, the parties agreed the sole issue for hearing would be compensability of Employee's injury. Employee contends he was driving a 30-ton

articulating water wagon truck when the center pin broke causing the driveline to come apart and the rear wheel brakes to lock. He contends the truck bounced, hopped and skidded to an abrupt stop, injuring his neck. Employee acknowledges previous injuries to his head, neck and lower back, as well as previous low back and neck pain from being bounced around in heavy equipment and bracing himself with his right hand to adjust his weight. He contends he loves his job as an equipment operator and always went back to work notwithstanding previous pain and injuries. However, Employee contends this particular injury was a "game changer" and his inability to return to work following this incident demonstrates the work injury is the substantial cause of his need for medical treatment and disability. He relies on opinions of Mark Flanum, M.D., and William Erickson, A.N.P., in support of his position. Employee further contends the second independent medical evaluation (SIME) report of Lowell Anderson, M.D., should not be relied on because it is contradictory and confusing; and Employer's medical evaluator, Stephen Marble, M.D., should not be relied on because he did not "take the victim as [he found] him" but, instead, focused on Employee's preexisting condition.

Employer contends Employee does not present a clear theory on how the work injury is the substantial cause of his disability or need for medical treatment. It contends both of Employee's experts' theories are flawed and the standard for compensability is not: "Employee could work before and can't work now." Instead, Employer contends Employee had documented signs of radiculopathy involving his cervical spine dating back to 1998 and has experienced a progression of symptoms since. It denies the work injury caused permanent aggravation to Employee's preexisting condition. Employer relies on the opinions of Drs. Marble and Anderson in support of its position. Employer further contends ANP Erickson's opinions cannot be relied on because he was a poor record keeper and Dr. Flanum's opinions are not reliable because he did not review the entire medical record and because he is less experienced than Employer's experts.

Is the May 15, 2011 work injury the substantial cause of Employee's need for medical treatment and disability?

FINDINGS OF FACT

The following facts and factual conclusions are established by a preponderance of the evidence:

1) In addition to the instant work injury, Employee acknowledges he has a history of spinal "aches and pain," including: an injury to his low back in April 1998, when he fell off a backhoe; injuries to his chest, back, left arm and shoulder in 2007, when he fell off the fly bridge of a boat; back, right shoulder and neck pain in 2008, "due to manual labor and bouncing from work as a heavy equipment operator"; and head and neck pain in 2009, after hitting his head on a control panel. (Employee's hearing brief, September 10, 2013; Record; Emergency room note, April 16, 1998; Urgent Care chart notes, July 26, 2007; Heller chart notes, November 7, 2008; Medical Record of Injury, June 30, 2009).

2) On April 16, 1998, Employee sought treatment for severe low back pain and after slipping and falling off a backhoe at work. At the time, he also reported "one episode of some neck pain," which was improved. Contusion and sprain of the low back were diagnosed. X-rays showed mild anterior wedging at C5 suggestive of an old compression injury or congenital defect; small osteophyte formation in the mid and lower dorsal spine; and mild anterior wedging at T12 and L1, suggestive of old anterior compressions at these levels. (Emergency room chart notes, April 16, 1998; X-ray reports, April 17, 1998).

3) On May 8, 1998, while seeking follow-up care for his back, Employee also reported some right hand paresthesias and numbness and was diagnosed with some radicular complaints with no clear-cut clinical evidence of radiculopathy. (Carlsen report, May 8, 1998).

4) On September 24, 1998, Employee was given a five percent whole person permanent partial impairment (PPI) rating for his April 16, 1998 low back, work injury. (Carlson report, September 24, 1998).

5) From October 1998 to February 1999, Employee continued to complain of low back pain and underwent physical therapy. (HealthSouth physical therapy notes, October 5, 1999 to February 24, 1999).

6) By February 25, 1999, Employee was much improved and had returned to baseline. (Carlson report, February 25, 1999).

7) There is a significant gap in the medical records until 2006. (Record; observations).

8) On July 26, 2007, Employee sought treatment for chest, back, left shoulder and arm pain after falling off the fly bridge of a boat. X-rays of Employee's left shoulder and elbow showed mild osteoarthritis but no fractures or dislocations. X-rays of Employee's thoracic spine showed

osteoarthritis and anterior wedging at T9, T10 and T11. (Urgent Care chart notes, July 26, 2007; X-ray reports, July 26, 2007).

9) Until August 25, 2007, Employee continued to treat his ongoing back and rib pain with medications, including Ultram. (Urgent Care chart notes, July 28, 2007 to August 25, 2007).

10) On December 6, 2007, Employee began treating with Margaret Heller, PA-C, at Mat Su Health Services after being recently diagnosed with diabetes. Employee also reported unspecified back and joint pain but denied neck pain. (Heller report, December 6, 2007).

11) On November 17, 2008, Employee reported to Ms. Heller his right shoulder was starting to bother him from positioning himself while operating heavy equipment. He also began reporting neck pain. On physical examination, tenderness and spasm was noted in the trapezius muscles. (Heller report, November 17, 2008).

12) On January 29, 2009, Employer sent Employee to Thomas Cross, PA-C, for a return to work evaluation due to his medication usage. Employee acknowledged hydrocodone at bedtime, occasionally with Skelaxin or Ultram, for back and neck pain. (Cross chart notes, January 29, 2009).

13) On March 9, 2009, Dr. Heller advised Employee she would not be able to treat his chronic pain indefinitely. She referred Employee to David Chisholm, M.D., for chronic pain management. (Heller report, March 9, 2009; Chisholm report, May 5, 2009).

14) On May 5, 2009, Employee saw Dr. Chisholm and reported chronic low back pain, occasional pain at the base of his neck when his back worsens and some shoulder discomfort. (Chisholm report, May 5, 2009).

15) On June 12, 2009, Dr. Chisholm noted Employee was having some numbness in his shoulders and upper arms bilaterally and burning at the bilateral trapeziums and thought Employee should have a cervical x-ray and possibly a magnetic resonance imaging (MRI) study. (Chisholm report, June 12, 2009).

16) On June 30, 2009, Employee was getting into a water truck when he hit his head on a control panel. He developed neck pain and complained of pain going across the top of his right shoulder. Employee also developed cervical spasms that were successfully treated with message therapy. He was released back to work on July 7, 2009. (Hall reports, July 2, 2009; July 7, 2009).

17) On July 30, 2009, Employee began treating with William Erickson, ANP, for neck pain, headache and pain in the middle of his back and lumbar area. He also reported right upper extremity tingling. (Erickson report, July 30, 2009).

18) On July 31, 2009, Dr. Chisholm again noted Employee was having some numbness in his shoulders and upper arms bilaterally, burning at the bilateral trapeziums and thought Employee should have a cervical x-ray and possibly a MRI. (Chisholm report, July 31, 2019).

19) On September 11, 2009, Thomas Williamson-Kirkland, M.D., performed an employer medical evaluation (EME) for Employee's 1998 low back injury. He did not think that injury continued to be "a substantial factor" for Employee's chronic low back pain, but rather thought that injury was "one episode among many that have aged his thoracic and lumbar spine." Dr. Williamson-Kirkland did not recommend any further treatment in regards to that claim. He also noted diabetics tend to get more arthritic conditions and spurring in their spine. Dr. Williamson-Kirkland commented on Employee's use or narcotics and stated the use of narcotics was now counterproductive since Employee was habituated to them, making them less effective. He recommended Employee use narcotics sparingly. (Williamson-Kirkland report, September 11, 2009).

20) Between October 22, 2009 and April 7, 2011, Employee periodically treated with ANP Erickson for his chronic back pain. Treatment primarily consisted of prescription medications, including Ultram, hydrocodone, and MS Contin. On January 6, 2010 ANP Erickson noted Employee needed an MRI of his neck and lumbar spine. (Erickson chart notes, October 22, 2009 to April 7, 20011; observations; Erickson Dep. pp. 7-14).

21) On August 12, 2010, MRI's were taken of Employee's lumbar spine and right shoulder. The lumbar MRI showed: 1) high grade L5-S1 spondylosis secondary to broad-based disc/osteophyte bulging with possible right and probable left nerve root impingements; 2) moderate multilevel inferior lumbar neural foraminal stenosis secondary to lateral disc encroachment with possible bilateral L4-L5 foraminal nerve root impingements; 3) moderate to severe multilevel and facet lumbar degenerative disease; and 4) chronic T12 and L2 central vertebral body compression injuries. The right shoulder MRI showed: 1) a chronic, low grade, partial thickness supraspinatus tendon tear; and 2) chronic, severe, near circumferential glenoid labral complex tear and intralabral/paralabral cystic degeneration. Complex bicipital tenosynovitis was also noted. (MRI reports, August 12, 2010).

22) On May 15, 2011, Employee injured his neck and right shoulder when the center pin fell out of a water wagon he was driving causing the rear tires to "lock up" bringing it to a fast stop. (Report of Occupational Injury or Illness, May 23, 2011).

23) On May 17, 2011, Employee sought treatment from Jose Diaz, PA-C. Employee reported he felt no pain immediately following the accident but had a slightly stiff neck a day later. When he woke up the following day, his neck pain had become severe and he was unable to turn his neck. Employee also reported pain radiating into his right shoulder. PA-C Diaz's report states: "Employee admits to having chronic neck and back problems." (Diaz chart notes, May 17, 2011).

24) On May 18, 2011, Thomas Cross, PA-C, evaluated Employee. PA-C Cross assessed neck and right shoulder strain, "probably muscular in nature," and referred Employee for MRI studies. (Cross report, May 18, 2011).

25) On May 19, 2011, a right shoulder MRI showed a paralabral cyst along the inferior margin of the glenoid tendon and minimal atrophy of the teres minor muscle. No significant rotator cuff pathology was noted. The study also showed a subacromial spur. When the May 19, 2011 MRI was compared to Employee's August 12, 2010 MRI, the inferior paralabral cyst had not appreciably changed and the atrophy of the teres minor appeared stable. The supraspinatus tendon was also stable. The cervical MRI showed multilevel degenerative changes, including diffuse disc desiccation, osteophytes, spurring and mild to moderate foraminal narrowing. (MRI reports, May 19, 2011).

26) On May 20, 2011, Emile Vandermeer, M.D., evaluated Employee and assessed cervical strain with radiculopathy symptoms. Employee treated conservatively with physical therapy and his condition reportedly improved, including his neck range of motion. (Vandermeer report, May 20, 2011; Denali Physical Therapy reports, May 23, 2011; Vandermeer report, May 25, 2011).

27) By June 1, 2011, Employee reported being 40 to 50 percent better following continued physical therapy. (*Id.*).

28) On June 9, 2011, Employee stated he was 80 percent better overall. On June 10, 2011, he reported being 60 to 65 percent improved. (Denali Physical Therapy report, June 9, 2011; Vandermeer report, June 10, 2011).

29) On June 17, 2011, because of continuing neck pain and paresthesias in Employee's right arm, Dr. Vandermeer referred Employee to Larry Kropp, M.D., for a nerve root block injection. (Vandermeer report, June 17, 2011).

30) On June 22, 2011 and June 29, 2011, Dr. Kropp performed C4-5 and C5-6 nerve root block injections. Employee reported feeling worse pain following the injections. (Kropp reports, June 22, 2011 and June 29, 2011; Erickson report, July 6, 2011).

31) On July 27, 2011, a repeat cervical MRI showed marked disc degeneration at multiple levels. Marked foraminal stenosis was also noted at C4-5. (MRI report, July 27, 2011).

32) On July 28, 2011, nerve conduction and needle electromyography (EMG) studies were normal with no evidence of cervical radiculopathy or nerve entrapment in Employee's right arm. (Taylor report, July 28, 2011).

33) On August 8, 2011, Employee's condition continued to worsen and he reported severe neck pain that would cause him to pass out at times, migraines with tunnel vision, difficulty swallowing, and tremors in his right arm. ANP Erickson referred Employee to Dr. Flanum for an orthopedic evaluation. (Erickson report, August 8, 2011).

34) On August 24, 2011, with respect to Employee's cervical spine, Dr. Flanum assessed "clear evidence of cervical radiculopathy" secondary to cervical disc displacement and neutral foraminal stenosis. He also assessed a superior labrum anterior and posterior (SLAP) tear, bicep tendon pathology and perilabral cyst with respect to Employee's right shoulder. Dr. Flanum recommended C4-5 and C5-6 anterior cervical discectomy and fusion, as well as future treatment for Employee's right shoulder labral tear. (Flanum report August 24, 2011).

35) On September 27, 2011, a repeat cervical MRI showed severe right-sided foraminal stenosis at C3-4 and C4-5 and severe bilateral foraminal stenosis at C5-6. (MRI report, September 27, 2011).

36) On October 4, 2011, Dr. Flanum performed C4-5 and C5-6 cervical discectomies and fusions. (Flanum report, October 4, 2011).

37) On December 5, 2011, Employee told ANP Erickson he was still having a lot of neck pain and could not sleep because of the pain. He also reported burning and numbness in his right arm and hand. (Erickson report, December 5, 2011).

38) On January 6, 2012, Dr. Marble performed an EME. Employee reported surgery had not improved his neck condition and stated, in hindsight, he would not have elected to have surgery.

Employee brought numerous compact discs (CD's) of MRI and x-ray studies to the evaluation, including a June 8, 2009 lumbar spine MRI, which contained whole-spine scout films. Dr. Marble interpreted the scout films to show significant disc protrusions at C4-5 and C5-6. In the records review section of his January 6, 2012 report, Dr. Marble added parenthetical "reviewer's comments" identifying possible early radicular signs in a July 2, 2009 medical report and identifying right shoulder symptomology, "likely radicular in nature from cervical pathology," in a May 19, 2011 medical report. He stated the medical records showed evidence of related preexisting conditions, including cervical MRI findings of advanced multilevel degenerative spondylosis, and opined Employee suffered a temporary cervical spine strain as a result of the May 15, 2011 mechanical failure and "may have" returned to pre-injury status in two months. However, to clarify whether the strain was a temporary or permanent aggravation, Dr. Marble suggested numerous other pre-claim medical reports be examined. (Marble report, January 6, 2012).

39) On March 28, 2012, Employee filed a claim seeking TTD from January 18, 2012 ongoing, PPI, medical and transportation costs, penalty, interest, attorney's fees and costs and an SIME. (Claim, March 28, 2012).

40) On September 28, 2012, Dr. Anderson performed a secondary independent medical evaluation (SIME). Dr. Anderson noted Employee's history of spine injuries over the course of the last 20-30 years; his use of chronic pain medications for neck, mid back and low back discomfort for the past 12-15 years; an increase on pain medication dosages over the past 5-10 years as his symptoms progressed and additional records of neck and right shoulder pain for the last 10-15 years. He also noted the failed nerve root block injections and the normal EMG study. Based on MRI studies, Dr. Anderson stated Employee's right shoulder pathology pre-existed the May 15, 2011 work injury and was not affected by it. Instead, he thought Employee's right shoulder symptoms were, more likely than not, related to referred pain from the cervical spine. Regarding causation and Employee's cervical spine condition, Dr. Anderson stated:

> Based on symptoms, without objective findings of cervical radiculopathy, there may have been a permanent aggravation of cervical spondylosis related complaints resulting in the need for medical treatment to include the subsequent cervical spine surgery and present disability. The upper right extremity complaints were without objective electrodiagnostic study findings for radiculopathy or other pathology to account for the subjective complaints. No

> evidence of cervical instability. No evidence of acute injury based on multiple cervical MRI studies. Subsequent pain management treatment included selective nerve root blocks without substantive improvement. With normal electrodiagnostic studies there was discussion regarding cervical facet etiology accounting for the ongoing symptoms. In spite of these considerations, the surgical evaluation concluded that cervical disc pathology accounted for ongoing subjective complaints, resulting in the surgical treatment recommendations. . . . Based on objective findings from cervical x-rays and MRI as well as electrodiagnostic studies, there did not appear to be a permanent change in the preexisting condition. Best considered a temporary aggravation of preexisting cervical spondylosis symptoms.

Evaluating the relative contributions of different causes, Dr. Anderson concluded the "major contribution to the present complaints would be the natural progression of preexisting cervical spondylosis and facet pathology symptoms. He also thought post-surgical changes and scar tissue were also contributing the Employee's present symptoms. Dr. Anderson further explained his rationale as follows:

> The employment injury of 5-15-2011 resulted in claimed increased neck and right upper extremity complaints without objective findings of acute injury or radiculopathy. Subsequent medical evaluations and orthopedic surgical assessment, in spite of these findings, determined that surgical treatment was indicated. Nonsurgical care was an appropriate consideration related to the claimed injury and objective findings based on diagnostic studies and physical exam findings. Initial physical therapy estimation of 80% improvement in symptoms. This would indicate resolving cervical strain symptoms and/or resolving symptoms from temporary aggravation of preexisting cervical spondylosis with some nerve root irritation. Because there is identified pathology (from the cervical MRI) does not indicate that that pathology is the primary source of claimed acute symptoms. It is noted that at the time of electrodiagnostic studies that the evaluating physician felt that present exam findings were related to facet pathology and not disc or nerve root pathology. The substantial cause of the need for medical treatment would be acute cervical strain and the natural progression of preexisting cervical spondylosis.

Dr. Anderson opined Employee was medically stable by September 1, 2011, and further opined Employee is unable to return to work in any capacity because of his preexisting cervical, thoracic and lumbar spondylosis, functional limitations, deconditioning, narcotic pain medication usage and disability conviction. He also cited Employee's diabetes and obesity as conditions that would preclude him from work activity. (Anderson report, September 28, 2012).

41) On December 17, 2012, the parties took Dr. Marble's deposition. Dr. Marble did not think the work injury was the substantial cause of Employee's need for medical treatment because of two factors: imaging studies revealed preexisting degenerative changes to Employee's neck and medical records indicate Employee had been symptomatic from those changes prior to the work injury. (Marble deposition at 20-21).

42) Dr. Marble identified a May 4, 1998 record that indicated Employee was experiencing right hand paresthesias and numbness, which he felt was significant because it indicates Employee was experiencing some radiculitis or radiculopathy at that point. He explained it is very common for pain to radiate or be referred into the upper back when there is cervical spine pathology. (*Id*. at 26).

43) When asked about a November 17, 2008 medical record, Dr. Marble explained neck pain extending towards the right shoulder mean many times the patient is experiencing referred or radiating symptoms from the neck or it could be radicular pain from some of the upper cervical segments. Dr. Marble pointed out that at that point, Employee was prescribed hydrocodone, Skelaxin and tramadol. (*Id*. at 29).

44) Dr. Marble stated Employee's medications escalated from Tramadol to narcotic hydrocodone and a muscle relaxant indicates an escalation of Employee's symptom sufficient to alter the medication regime. He further explained degenerative spondylosis symptoms usually wax and wane. It is not unusual for the waxing and waning episodes to become more frequent and longer lasting. Then, some patients get to a point where they have chronic pain. (*Id*. at 30).

45) Dr. Marble stated a May 5, 2009 medical record, which indicated Employee had occasional pain at the base of his neck, some shoulder discomfort and hand to arm discomfort, demonstrates Employee's neck symptoms were expanding out into his shoulders arms and hands, which is suggestive of nerve root irritation. (*Id*. at 33).

46) Dr. Marble opined Employee changing medications on January 6, 2010 from Norco and Ultram to morphine indicated an escalation of symptoms. (*Id*. at 38-39).

47) Given the degree of Employee's existing pathology, Dr. Marble opined the work injury caused an aggravation of Employee's symptoms and Employee returned to baseline within a couple of months. (*Id*. at 40-41; 56; 64).

48) Dr. Marble explained the potential significance of Employee's unsuccessful nerve root block injections: it could mean the targeted space is not the pain generator, the injection was not

properly placed or the pathology at the space is so severe an injection will not be effective. (*Id*. at 43).

49) Although Dr. Marble stated MRI scout films are not intended for making diagnosis, he felt they are worth looking at. (*Id*. at 51).

50) Discussing Employee's imaging studies, Dr. Marble testified Employee has "really got a potential for pain generators primarily at C4/5 and C5/6." (*Id*. at 56).

51) Dr. Marble stated the vast majority of soft tissue injuries resolve in one month. Based on the pre- and post-claim pain diagrams, and Employee's reported level of improvement, Dr. Marble opined Employee's work related condition resolved in a couple of months but was "superimposed" on Employee's preexisting condition. (*Id*. at 61; 64-65).

52) It was important to note, Dr. Marble thought, a "preexisting condition is not a static condition; it's progressive. So, by the time you return to . . . pre-injury status in six months . . . that pre-injury status, had it followed its natural course, was going to be different six months regardless of whether the accident occurred or not." (*Id*. at 66-67).

53) Dr. Marble stated having additional pre-injury medical records at deposition that were not available to him at the time he wrote his January 6, 2012 report provided him with a clear picture of Employee's condition. (*Id*. at 67-68).

54) In his opinion, Dr. Marble believed the availability of the previously unavailable medical reports strengthened the opinions he expressed in his January 6, 2012 report. (*Id*. at 23).

55) When asked if the work injury accelerated Employee's preexisting condition, Dr. Marble explained:

> It's possible that you can have --- in general that you can have injuries that accelerate the process. I would certainly agree with that. It's only fair for a doctor like me to consider that. In other words, did I see some acceleration of the process and distinct change in the process or any objective findings that would suggest that there had been an acceleration?
>
> And this is no. In other words, in the end, months down the road were we seeing any signs or symptoms different than what you would expect had this injury not occurred? No. Again, to be fair, that's one of the things I was trying to point out in my report. I said, looks like he had some issues beforehand, and that's why oftentimes I'll recommend a more extensive review of the pre-claim medical records so I can gain a clear picture of what was going on. I don't want to just make assumptions. These subsequent records that we've been provided, I think, provide that clear picture.

(Id. at 67-68).

56) When questioned on Dr. Anderson's report, Dr. Marble provided a cogent and articulate interpretation of that report, especially with respect to Dr. Anderson's opinion of Dr. Flanum's surgical recommendation. He also related conclusions in Dr. Anderson's report to those in his own. (*Id*. at 56-61; experience, judgment, observations and inferences drawn from the above).

57) On August 22, 2013, the parties took ANP Erickson's deposition. During an office visit on May 18, 2011, ANP Erickson noted Employee's complaints included neck pain, in addition to back pain, which was "[d]efinatly different" than Employee's other visits. (Erickson deposition at 15-16).

58) On June 30, 2011, ANP Erickson recorded additional symptoms, including migraines and pain and numbness down Employee's right hands. (*Id*. at 22).

59) In January and February of 2012, ANP Erickson testified Employee's neck pain was worse. Employee was not comfortable in any position, sitting or standing. Employee rated his pain 10 out of 10 on a pain scale of 1 to 10 and complained of dizziness, burning in his neck and not being able to move his hand. ANP Erickson thought Employee was in severe pain and stated he was tearful all the time. (*Id*. at 33).

60) When ANP Erickson was asked to explain why, in his opinion, the work injury was the substantial cause of Employee's need for medical treatment, he stated:

> What I can say is he was worse after his accident. There's just no doubt, he was worse. And, he required more and more medications, more and more shots, more and more treatments. And, I thought he got to such a complicated and severe nature that I had to get help. And, so I asked Dr. Flanum to help us out and get a consultation.

(*Id*. at 38-39).

61) ANP Erickson had not reviewed Employee's medical records that predated their nurse-patient relationship. (*Id*. at 42).

62) It is possible ANP Erickson would have intake forms and MRI referrals that do not appear in the medical record. (*Id*. at 44-45).

63) ANP Erickson was questioned repeatedly about his chart notes. With respect to an October 21, 2010 chart note, ANP Erickson stated: "I can't comment on that. I don't know what that is -- what my scribble means." (*Id*. at 12).

64) ANP Erickson did not identify specific conditions he was treating in his chart notes, such as a specific nerve root, stenosis or spondylosis. He also did not describe MRI results in his chart notes. (*Id*. at 52).

65) Regarding his chart notes, Employer asked ANP Erickson: "So you don't really describe what you were treating, other than pain?" Mr. Erickson answered: "You know, in my notes it's not documented that way . . . . They're just notes. They're not all inclusive of every single thing you do." (*Id*.).

66) Employer contends ANP Erickson's treatment consisted of poorly documenting Employee's pain complaints and prescribing medication. (Employer hearing brief, September 11, 2013, at 5).

67) Although getting prior medical records is "always part of the plan," ANP Erickson did not know if this was done in Employee's case. (*Id*. at 63).

68) On July 29, 2013, the parties took Dr. Flanum's deposition. Dr. Flanum testified as follows: Employee's fusion surgery was based on a positive Spurling's test and MRI's. He explained the Spurling's test is when a patient's cervical spine is extended and slightly rotated and compressed. It is indicative of nerve compression in the cervical spine. In Employee's case, the pain radiated into the left trapezius and Employee had increased weakness and decreased strength in the left biceps and left wrist flexion. (*Id*. at 7-12).

69) Dr. Flanum thought Employee had preexisting degenerative changes, such as neural foraminal stenosis, that were substantially aggravated by the work injury. (*Id*. at 20; 26).

70) Even though Dr. Flanum sometimes later learns patients have "exhaustive medical records with a very long history of previous similar complaints," he takes the patient "at their word." He explained: "if a person comes in and says, nope, I was doing fine, I was working on the North Slope, I had this accident, and since then I have had neck pain . . . then I say, this is the reason you need surgery, is because you were living with it before. I'm accepting the patient as they were on that day, and that was the day that things changed." (*Id*. at 23).

71) Dr. Flanum explained sometime discs are completely asymptomatic and a jarring-type injury to the nerve "triggers that person into that place where they need surgery." (*Id*. at 25).

72) It is common for Dr. Flanum to see patients with large disc herniations and "clear" radiculopathy that cannot be "picked up" on an EMG. (*Id*. at 26).

73) Dr. Flanum thought the work injury enlarged a disc herniation, or created a disc herniation, that then pressed on a nerve and generated Employee's symptoms. (*Id*. at 36).

74) Dr. Flanum did not review 600 pages of Employee's medical records. (*Id*. at 37-38).

75) Although MRI scout films can raise Dr. Flanum's clinical suspicion of a diagnosis, he does not make diagnosis from them. (*Id*. at 44-45).

76) Employee testified at hearing as follows: Employee is a heavy equipment operator and has worked at the Kuparak oil field and on the North Slope. He is qualified to operate graders, loaders, "CAT's," all trucks, tankers and cranes. Employee has worked for 30 years and started with Employer in 2008. He testified regarding prior injuries, including, a low back injury in 1998, after which he returned to work. He also fell off the fly bridge of a private 30 foot Bayliner boat. Following this incident, Employee stated it was hard to breath and he took off work and went to an urgent care for treatment. Employee also has experienced neck pain, which he states was from adjusting his weight on account of low back pain. Specifically, he testified he would use his right hand as a support while operating heavy equipment at work. In 2009, Employee hit his head on a control panel at work. He went off the Slope to receive massage therapy. After this incident, Employee's neck was very stiff, but he was approved to return to work on the Slope. Employee also testified about the instant injury. When the center pin broke, the water wagon dropped in the center and the drive line pulled apart. The hydraulic system broke and drained. The water wagon bounced, hopped and skidded to a stop. His seat in the vehicle only extended about one-half way up his back and the vehicle only had a lap belt. He deployed barriers to contain the approximately 80 gallons of oil that spilled onto the ground. Employee was covered in hydraulic oil. He also looked for the pin but could not find it. The next day, Employee's was stiff and he was put on light duty. He was then sent off the Slope, then to Dr. Kropp for nerve root block injections. Employee next received a "second opinion" from ANP Erickson, who sent him to Dr. Flanum. When questioned about June 9, 2011physical therapy report, which noted him as being 80 percent improved following the injury, Employee explained the goal of his physical therapist was to return him to 80 percent since he did not think Employee could return to 100 percent of his pre-injury status. Employee testified his condition worsened after surgery. He now has constant migraines, sleeping problems and a "pinch" in his neck. Employee does not feel surgery corrected his problems. He contended Mr. Marble's examination just consisted of him taking off his shoes and walking. Employee contended the

examination lasted 35 minutes and he just spent one hour total in Dr. Marble's office, including paperwork. He stated Employer controverted him after just three physical therapy sessions following surgery, but he has had no physical therapy since then and has not had any follow-up visits with Dr. Flanum. Employee pays what he can afford and just buys whatever medications he can afford. He described his pain as radiating down his shoulder to "T10-11." Employee has difficulty breathing because, according to him, a bone spur is growing inwards. Employee experiences numbness in both his hands, which he described as a "pins and needles" sensation. He has migraines two to three times per month that last one to three days. Employee stated he is sensitive to light and noise. Listening to the TV hurts. He has a constant pounding that starts in his neck and the back of his eyes. Employee testified his whole life has changed since the work injury: he cannot play with his grandchildren, fish or hunt. Employee's wife helps him with his shoes and socks 40-60 percent of the time. He cannot take his pants all the way off. With respect to using the restroom, Employee cannot reach around himself on account of the "pinch" in his neck. Employee's goal is to go back to work to support his family like they were used to. On cross-examination, Employee testified at the time of the work injury, an elderly man named "James" was riding in the jump seat behind him, who was not injured. The jump seat is equipped with a lap and shoulder belt. Employee stated he gets a fishing license every year and obtained a deck hand license since the injury to go shrimping with a friend, who owns a boat. He contended he did not do any work on the boat, but his friend's wife and two "other guys" pulled the pots. Employee buys fishing and hunting licenses for proxy hunting. When asked about a physical therapy chart note that stated Employee had a full range of motion, Employee answered he "never had a full range of motion." When asked about Dr. Marble's report, which references "palpation" during the exam, Employee denied Dr. Marble ever touched him. He confirmed he had pain similar to what he is experiencing now after hitting his head on the control panel, as represented by a June 12, 2009 physical therapy pain diagram. (Employee).

77) Robin Baker, Employee's wife, testified at hearing as follows: She and Employee have "been together" 10 years and married for seven years. After the work injury, Employee was "not the same man," with respect to fishing, hunting and camping or with respect to interacting with his children and grandchildren. Since Employee has "lost his grip," Mrs. Baker keeps paper towels handy and assists Employee with cleaning up messes around the house. She also keeps their home free of obstacles for Employee since he has lost mobility. She and Employee try to

live off the land as much as possible and they live off the food bank. Mrs. Baker testified Employee has always worked, always went to work early and always worked overtime. She stated Employee is now "stir crazy, like a caged animal." Mrs. Baker stated Dr. Marble did not touch Employee during his examination. On cross-examination, Mrs. Baker stated she assisted Employee with documenting information in advance of his deposition, including a list of Employee's former wives and his work history. (Mrs. Baker).

78) On September 12, 2013, Employee filed affidavits of attorney's fees and costs and paralegal fees and costs. The affidavits list 49.33 hours of attorney time at a rate of $350.00 per hour, and a total of 63.04 hours of paralegal time at a rate of $150.00 per hour, for total fees in an amount of $26,721.50. The affidavits list a total of $741.23 in costs. (Employee affidavits, September 10, 2013).

79) On September 25, 2013, Employee filed supplemental affidavits of attorney's fees and costs and paralegal fees and costs. The affidavits list 62.43 hours of attorney time at a rate of $350.00 per hour, and a total of 64.98 hours of paralegal time at a rate of $150.00 per hour, for total fees in an amount of $31,597.50. The affidavits list a total of $4,616.45 in costs. (Employee affidavits, September 23, 2013).

PRINCIPLES OF LAW

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

> **AS 23.30.010. 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. To establish a presumption under AS 23.30.120(a)(1) that the disability . . . or the need for medical treatment arose out of and in the course of the employment, the Employee must establish a causal link between the employment and the disability . . . or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the . . . disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the . . . 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. . . .

Compensation or benefits are owed under AS 23.30.010 if employment was "the substantial cause" in bringing about the disability or need for medical treatment. A preexisting disease or infirmity does not disqualify a claim if employment aggravated, accelerated, or combined with disease or infirmity to produce death or disability. *Thornton v. Alaska Workers' Compensation Board*, 411 P.2d 209; 210 (Alaska 1966) (applied under the current AS 23.30.010 in *City and Borough of Juneau v. Olsen*, AWCAC Decision No. 185 (August 21, 2013) at 15-16).

An aggravation of a preexisting condition occurs when a job worsens an employee's symptoms such that she can no longer perform her job functions, even when the job does not worsen the underlying condition. *Hester v. State, Public Employee's Retirement Board*, 817 P.2d 472; 476 (Alaska 1991). For an employee to establish an aggravation claim, the employment need only have been the substantial factor in bringing about the disability. *Olsen* at 17-18 (*citing DeYonge v. NANA/Marriott*, 1 P. 3d 90 (Alaska 2000)). Whether employment is the substantial cause of the need for medical treatment requires an evaluation of the relative contributions of the employment and the preexisting condition. *Id.* Aggravation of a preexisting condition may be found absent any specific traumatic event. *Providence Washington Insurance v. Banner*, 680 P.2d 96; 99 (Alaska 1984). To prove a work injury combined with a preexisting condition, to produce a disability, the employee must show: 1) the disability would not have happened "but for" an injury sustained during the course and scope of employment, and 2) reasonable persons would regard the injury as the cause of the disability and attach responsibility to it. *Thurston v. Guys With Tools*, 217 P.3d 824; 828 (Alaska 2009) (applied under the current AS 23.30.010 in *Olsen* at 18).

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

"The text of AS 23.30.120(a)(1) indicates that the presumption of compensability is applicable to *any* claim for compensation under the workers' compensation statute." *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996) (emphasis in original). Therefore, an injured worker is afforded a presumption all the benefits she seeks are compensable. *Id.* Medical benefits including continuing care are covered by the AS 23.30.120(a) presumption of compensability. *Municipality of Anchorage v. Carter*, 818 P.2d 661, 664-65 (Alaska 1991). The Alaska Supreme Court in *Sokolowski v. Best Western Golden Lion*, 813 P.2d 286, 292 (Alaska 1991) held a claimant "is entitled to the presumption of compensability as to each evidentiary question." 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." *Rogers & Babler*, 533-34. However, there is also no reason to suppose Board members who so find are either irrational or arbitrary. *Id.* at 534. That "some reasonable persons may disagree with a subjective conclusion does not necessarily make that conclusion unreasonable." *Id*.

The presumption's application involves a three-step analysis. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381 (Alaska 1991). First, Employee must establish a "preliminary link" between the "claim" and her employment. In less complex cases, lay evidence may be sufficiently probative to make the link. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Whether or not medical evidence is required depends on the probative value of available lay evidence and the complexity of the medical facts involved. *Id.* Employee need only adduce "some," "minimal" relevant evidence (*Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987)) establishing a "preliminary link" between the "claim" and the employment. *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). The witnesses' credibility is of no concern in this first step. *Excursion Inlet Packing Co. v. Ugale*, 92 P.3d 413, 417 (Alaska 2004).

Second, in claims arising after November 5, 2005, employment must be the substantial cause of the disability or need for medical treatment. AS 23.30.010(a). In *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 (March 25, 2011), the Alaska Workers' Compensation Appeals Commission (commission) set out how to apply the presumption analysis for claims arising after November 5, 2005. An employer can rebut the presumption with substantial evidence a cause other

than employment played a greater role is causing the disability and is not required to rule out employment as a factor in causing the disability. *Id.* at 7. "If the employer rebuts the presumption, it 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.

"Substantial evidence" is the amount of relevant evidence a reasonable mind might accept as adequate to support a conclusion. *Miller v. ITT Arctic Services*, 577 P.2d 1044, 1046 (Alaska 1978). Employer's evidence is viewed in isolation, without regard to Employee's evidence. *Id.* at 1055. Therefore, credibility questions and weight accorded Employer's evidence is deferred until after it is decided if Employer produced a sufficient quantum of evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Compensation Board*, 880 P.2d 1051, 1054 (Alaska 1994); *citing Big K Grocery v. Gibson*, 836 P.2d 941 (Alaska 1992).

If an employer produces substantial evidence work is not the substantial cause, the presumption drops out and the employee must prove all elements of the "claim" by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1381; *citing Miller v. ITT Services,* 577 P 2d. 1044, 1046. The party with the burden of proving asserted facts by a preponderance of the evidence must "induce a belief" in the fact finders' minds the asserted facts are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

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

The legislative history of AS 23.30.122 states the intent was "to restore to the Board the decision making power granted by the Legislature when it enacted the Alaska Workers' Compensation Act." *De Rosario v. Chenega Lodging*, 297 P.3d 139, 146 (Alaska 2013). The Alaska Workers' Compensation Appeals Commission is required to accept the board's credibility determinations. *Id.* The Alaska Supreme Court defers to board determinations of witness credibility. *Id.* If the board is faced with two or more conflicting medical opinions, each of which constitutes substantial

evidence, and elects to rely on one opinion rather than the other, the Supreme Court will affirm the board's decision. *Id*. at 147. The board can also choose not to rely on its own expert. *Id.* It is error for the commission to disregard the board's credibility determinations. *Id*. at 145-147.

ANALYSIS

Is the May 15, 2011 work injury the substantial cause of Employee's need for medical treatment or disability?

This is a factual question to which the presumption of compensability applies. Employee raises the presumption with his own testimony linking his cervical condition to the May 15, 2011 work incident. He also raises the presumption with the expert opinions of ANP Erickson and Dr. Flamun, who both opine the May 15, 2011 work injury is the substantial cause of Employee's need for medical treatment. *Cheeks.* Without regard to credibility, Employer rebuts the presumption with the expert opinions of Drs. Marble and Anderson, both of whom opine the May 15, 2011 work injury caused a temporary aggravation to Employee's preexisting cervical condition that resolved within a couple of months. *Runstrom.* Employee is now required to prove by a preponderance of the evidence the work injury is the substantial cause of his disability or need for medical treatment. *Saxton*.

Here, the parties present a classic "battle of the experts," making it necessary to choose between competing opinions: ANP Erickson and Dr. Flanum on behalf of Employee; and Dr. Marble and Dr. Anderson on behalf of Employer. At the outset, it is noted Employer characterized ANP Erickson's treatment as consisting of poorly documenting Employee's pain complaints and prescribing medication. After reviewing ANP Erickson's chart notes and his deposition testimony, Employer's characterization is not unfair. Although he did document Employee's pain complaints, ANP Erickson did not describe specific conditions he was treating. He did not record MRI results. He testified at one point he did not know what his "scribble" means. ANP Erickson had not reviewed Employee's medical records that predated his nurse-patient relationship with Employee. Although ANP Erickson testified getting prior medical records is "always part of the plan," he was not sure whether it was done in Employee's case. Employer's description of ANP Erickson as a "poor record keeper" is accurate. Finally, there was ANP Erickson's explanation of his opinion on

causation: "What I can say is he was worse after his accident. There's just no doubt, he was worse. And, he required more and more medications, more and more shots, more and more treatments." To paraphrase Employer, the legal standard is not: "Employee was better before the accident and got worse after it." ANP Erickson's deposition testimony and chart notes offer little, if any probative value on what actually caused Employee's disability or his need for medical treatment. Consequently, Mr. Erickson's opinions are afforded little weight. AS 23.30.122.

Dr. Flanum's deposition testimony was more substantial. He set forth his opinion on causation: the work injury aggravated Employee's preexisting neural foraminal stenosis to cause Employee's need for treatment. Dr. Flanum explained sometime discs are completely asymptomatic and a jarring-type injury to the nerve "triggers that person into that place where they need surgery." He also explained it is common to see patients with large disc herniations and radiculopathy that cannot be "picked up" on an EMG. Dr. Flanum thought the work injury enlarged a disc herniation, or created a disc herniation, that then pressed on a nerve and generated Employee's symptoms.

However, while Dr. Flanum's deposition testimony has significantly more to offer than ANP Erickson's, it still suffers from some of the same infirmities. For examples, like ANP Erickson, Dr. Flanum had not reviewed Employee's complete medical records. Also, like ANP Erickson's reliance on Employee's pain complaints, Dr. Flanum also acknowledged he takes his patient's "at their word," even in cases where there are "exhaustive medical records with a very long history of previous similar complaints." Finally, Dr. Flanum's credibility suffers from the less than successful surgical result in this case, which both Dr. Anderson and Dr. Marble tactfully commented on. AS 23.30.122.

When the medical record is both examined in detail and viewed in its entirety, a credible and consistent consensus of medical opinion emerges between Drs. Marble and Anderson. In addition to being the retained as the SIME expert in this case, Dr. Anderson explicitly considered the relative contribution of different causes in his report, including Employee's reported symptoms. In fact, Dr. Anderson candidly went so far as to say Employee's symptoms alone may indicate a permanent aggravation of his preexisting cervical spondylosis. Employee cites this statement as evidence of an inconsistent or contradictory opinion. However, Dr. Andersen also looked for

objective findings from physical examinations, MRI findings and electrodiagnostic studies that would evidence an acute injury. Finding none, and based on Employee's reports of improvement following the work injury, he concluded Employee suffered a temporary, rather than a permanent, aggravation from the work injury. In addition to citing Employee's preexisting cervical spondylosis as the substantial cause of Employee's disability and need for medical treatment, Dr. Andersen also pointed out many of Employee's symptoms may be indicative of cervical facet pathology.

Although Employee alleges Dr. Anderson's report to be contradictory, it is not. In fact, Dr. Anderson's serious consideration of Employee's reported symptoms indicates he maintained an objective approach while forming his opinion. These factors strengthen the credibility of Dr. Anderson's report. AS 23.30.122. Additionally, both Drs. Marble and Anderson attribute significance to Employee's reports of symptom improvement following the work injury. Meanwhile, Employee denies reporting an 80 percent improvement to his physical therapist following the work injury and provided an alternative explanation for that figure. Employee instead testified his physical therapist wanted to return him to 80 percent of his pre-injury status since his physical therapist did not think Employee could return to 100 percent. However the report in question explicitly states Employee reported an 80 percent improvement. Furthermore, there are additional contemporaneous reports in the medical record which also record post-injury improvements of 40 to 65 percent. Drs. Marble and Anderson did not rely on a single report.

Turning to Dr. Marble's opinions, examination of his deposition testimony demonstrates his opinions merit far more weight than his January 6, 2012 report alone would initially suggest. For example, in his initial report, Dr. Marble added parenthetical "reviewer comments" that annotated potential pre-injury radicular signs involving Employee's right shoulder. Also in his initial report, Dr. Marble realized he did not have complete medical records for Employee at that point in time and suggested other, specific records be reviewed in order to clarify whether the strain resulted in a temporary or permanent aggravation. This indicates Dr. Marble also did not immediately dismiss the possibility of a permanent aggravation. Additionally, Dr. Marble was appropriately cautious in expressing his opinion at that point, stating Employee "may have" returned to pre-injury status in

two months based on the records he had at the time. These factors indicate intellectual honesty and significantly enhance Dr. Marble's credibility. AS 23.30.122.

Later, at deposition, Dr. Marble was presented with many documents unavailable to him at the time of his January 6, 2012 report. Dr. Marble again identified potential pre-injury radicular signs involving Employee's right shoulder. He also identified pre-injury changes to Employee's medication regime indicative of significant symptom escalations. Dr. Marble testified about identifying pre-injury disc protrusions at C4-5 and C5-6 in the June 8, 2009 lumbar MRI scout films and also acknowledged Employee had "real potential" for pain generators at these locations. Incidentally, on the issue of reviewing MRI scout films, both Drs. Marble and Flanum agree. Neither one would use scout films to diagnose, but both agree they can be useful. Also, not coincidentally, C4-5 and C5-6 are the very same levels at which Dr. Flanum later performed the discectomies and fusions. Dr. Marble explained the progressive nature of a degenerative condition and stated Employee's condition was going to continue to worsen whether the work accident had occurred or not. He further stated having previously unavailable records provided him with a clear picture of Employee's condition that only strengthened the opinions expressed in his January 6, 2012 report.

In the instant case, there are two possible causes for Employee's disability and need for medical treatment. According to Dr. Flanum, the work injury caused a permanent aggravation to Employee's preexisting neural foraminal stenosis. According to Drs. Anderson and Marble, Employee's disability and his need for medical treatment are the result of a natural progression of his degenerative cervical spondylosis. Meanwhile, it is believed Employee and his wife, for the most part, delivered credible testimony at hearing, especially regarding the severity of Employee's symptoms. There is little doubt Employee has been, and continues to be, in a great deal of pain, especially following the less than successful surgical result. It is further believed, based on their testimony, Employee sincerely misses work and wants to continue working. However, the instant inquiry involves legal causation, which must be resolved.

In addition to Dr. Flanum's and ANP Erickson's opinions, there is other evidence in the medical record that suggests Employee may have suffered a permanent aggravation as a result of the work

injury. For example, Employee's primary complaints while treating with ANP Erickson prior to the work injury were lower back pain. Following the work injury, his primary complaints to ANP Erickson were severe neck pain. However, the more one focuses on the details of Dr. Marble's deposition testimony, the more credible his position becomes. AS 23.30.122. He cites information in the medical record to paint a logical, coherent and convincing picture of the natural progression of Employee's degenerative condition. Furthermore, Dr. Marble's opinions are in accord with Dr. Anderson's own credible opinions. Therefore, based on a preponderance of medical evidence, the substantial cause of Employee's continuing disability and need for medical treatment is the natural progression of his degenerative cervical spondylosis and not the May 15, 2011 work injury.

CONCLUSIONS OF LAW

The May 15, 2011 work injury is not the substantial cause of Employee's need for medical treatment or disability.

ORDER

Employee's claim is denied.

Dated in Fairbanks, Alaska on January 13, 2014.

ALASKA WORKERS' COMPENSATION BOARD

/s/_____
Robert Vollmer, Designated Chair

/s/_____
Krista Lord, Member

/s/_____
Rick Traini, Member

APPEAL PROCEDURES

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

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

RECONSIDERATION

A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accord with 8 AAC 45.050. The petition requesting reconsideration must be filed with the board within 15 days after delivery or mailing of this decision.

MODIFICATION

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

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of JOSEPH M BAKER, employee / claimant; v. ASRC ENERGY SERVICES, INC., employer; ARCTIC SLOPE REGIONAL CORP., insurer / defendants; Case No. 201106861; dated and filed in the Alaska Workers' Compensation Board's office in Fairbanks, Alaska, and served on the parties on January 13, 2014.

/s/_____
Darren Lawson, Office Assistant II