ALASKA WORKERS' COMPENSATION BOARD

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

DOUGLAS C. JONES, Employee, Claimant, v. STATE OF ALASKA, Employer, and ALASKA, STATE OF, Insurer, Defendants.	)	FINAL DECISION AND ORDER AWCB Case Nos. 200719434M, 200122670, 200211270, 200420434, 200510652, 200611455. AWCB Decision No. 14-0042 Filed with AWCB Anchorage, Alaska On March 27, 2014

Douglas C. Jones' June 24, 2009 and October 11, 2011 claims for benefits under the Alaska Workers' Compensation Act (Act) were heard on February 4, 2014, in Anchorage, Alaska, a hearing date selected on January 16, 2014. Non-attorney representative Barbara Williams represented Douglas C. Jones (Employee). Employee appeared personally and testified. Assistant Attorney General M. David Rhodes appeared and represented the State of Alaska (Employer). Timothy Craven, M.D. testified through deposition. No other witnesses were called.

During his six and a half year tenure with Employer's Division of Natural Resources, Employee reported seven injuries. At Employee's request, all seven cases were joined. The instant hearing addressed two of those reported injuries: injuries from a ditch collapse on or about November 1, 2001, the subject of Employee's October 11, 2011 claim; and vision and associated headache and neck complaints Employee alleges resulted from his lateral transfer from fieldwork to an office

position in 2007, the subject of his June 24, 2009 claim. The record closed at the hearing's conclusion on February 4, 2014, but was re-opened to allow panel members additional time to review medical and deposition records. The record closed when the panel's review was complete and deliberation concluded on February 12, 2014.

ISSUES

Employee contends the November 1, 2001 work injury is a substantial factor in his need for continuing medical care and disability for spinal and shoulder pain, and for anxiety and post-traumatic stress disorder (PTSD). He seeks continuing medical and transportation benefits, permanent partial impairment (PPI) benefits, and permanent total disability (PTD) benefits. Alternatively, Employee seeks reemployment benefits. Employer contends work was not a substantial factor in Employee's need for continuing medical care or disability and Employee is not entitled to further benefits under the Act.

1. *Was the November 1, 2001 work injury a substantial factor in Employee's need for continuing medical care for myofascial pain?*
2. *Was the November 1, 2001 work injury a substantial factor in Employee's need for medical care for bilateral shoulder complaints?*
3. *Was the November 1, 2001 work injury a substantial factor in Employee's need for medical care for anxiety or post-traumatic stress disorder (PTSD)?*
4. *Is Employee permanently and totally disabled as a result of the November 1, 2001 work injury?*
5. *Is Employee entitled to additional PPI benefits as a result of the November 1, 2001 work injury?*
6. *Is Employee entitled to a reemployment benefits evaluation and reemployment benefits as a result of the November 1, 2001 work injury?*

Employee contends employment was the substantial cause of his disability and need for medical treatment for vision and associated headache and neck symptoms he developed in 2007. He seeks temporary total disability (TTD) benefits from November 29, 2007 and continuing, medical and associated transportation costs and attorney fees. Employer contends work was not

the substantial cause of any disability or need for medical care and Employee is not entitled to benefits under the Act.

7. *Was his employment, either in 2001 as a Natural Resources Technician (Field), or in 2007 as a Natural Resources Technician (Desk), a substantial factor, or the substantial cause respectively, of Employee's need for medical treatment for his vision and associated headache and neck complaints in 2007?*
8. *Is Employee entitled to temporary total disability benefits as a result of his vision and headache and neck complaints from November 29, 2007 and continuing?*
9. *Is Employee entitled to an award of attorney fees and costs?*

FINDINGS OF FACT

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

1. Employee began employment as a seasonal Natural Resources Technician (Field) for the State of Alaska, Department of Natural Resources, on April 18, 2001. (Report of Occupational Injury, November 8, 2001).
2. On or about November 1, 2001,[1] Employee was struck from behind, reportedly injuring his back and shoulders, when the wall of a septic line trench in which he was standing gave way. According to initial reporting, he was buried in soils up to either mid-calf or knee level. There is no mention in any reporting of Employee suffering injury to his head, or a concussion, from the dirt wall collapse. (Report of Occupational Injury or Illness (ROI), November 8, 2001; Supervisor's Accident Investigation Report; November 8, 2001; observation).
3. This injury occurred at the end of Employee's seasonal employment for 2001. (Memo from Jerry Lewanski, Chief Ranger, to Al Meiners, Supt. Chugach State Park, November 3, 2001). Employee suffered no compensable time loss from work. (WC database "Payments," AWCB Case No. 200122670).
4. On November 5, 2001, Employee first sought care from Gregory Culbert, D.C., reporting injury to his lower neck and back when a wall of dirt gave way, "falling on his back and

[1] The injury is described in different records as occurring on either October 31, or November 1, 2001. For purposes of this decision, on precisely which of these two dates this event occurred is immaterial.

shoulders." Dr. Culbert noted "He does not complain of any symptoms in the upper extremities and no headache currently." Dr. Culbert diagnosed lumbosacral strain/sprain, thoracic strain/sprain, and cervical joint dysfunction. (Dr. Culbert, November 5, 2001). On a Physician's Report seeking authorization for treatment which would exceed frequency standards, Dr. Culbert reported Employee's complaints as "neck and back pain, left thigh pain." There is no mention of shoulder complaints or head injury. (Physician's Report, November 6, 2001; observation).

5. The contemporaneous reporting of this occupational accident and injury, that Employee was buried in soils up to mid-calf or knee level, injuring his back and shoulders, is considered more reliable than Employee's later reporting these events to numerous medical providers over the next ten years, where ultimately Employee described being buried alive and having to be dug out by co-workers. (*Compare* ROI, November 8, 2001, *with* various medical records including Alaska Spine Institute (ASI), November 15, 2004; Rafael Prieto, M.D., October 17, 2005; Emergency Room, October 7, 2007; Catherine Barrett, ANP, October 29, 2007; Richard Bensinger, M.D., April 29, 2010; Timothy Craven, M.D., December 14, 2010; Employee's Claim, October 11, 2011; observation; judgment).
6. Between November 5, 2001 and April 8, 2002, Employee had 38 chiropractic visits with Dr. Culbert. In none of those sessions did Employee complain, or did Dr. Culbert treat for complaints of either shoulder pain or headache. There is no mention of anxiety or nightmares. Dr. Culbert's March 6, 2002 note reflects Employee's return to his regular seasonal employment with the state the following day. (Dr. Culbert notes, November 5, 2001 to April 8, 2002; observation).
7. At an April 8, 2002 visit with Dr. Culbert, Employee reported occasional stiffness and aches in the cervical, thoracic and lumbar regions, but no restrictions in his activities of daily living. Dr. Culbert released Employee from care with no impairment or disability, noting his expectation Employee would continue improving. (Dr. Culbert April 8, 2002).
8. On May 30, 2002, while moving logs and brush to a chipper, Employee reported injuring his low back. (ROI, June 12, 2002).
9. On June 3, 2002, Employee returned to Dr. Culbert, reporting injury to his low back and neck after bending, twisting and moving logs and brush into a wood chipper. Dr. Culbert diagnosed lumbar strain/sprain and cervical strain secondary to the May 30, 2002 work

injury; and thoracic and sacroiliac joint dysfunction secondary to the May 30, 2002 work injury. (Dr. Culbert, June 3, 2002; Physician's Report, June 4, 2002).

10. Between June 3, 2002 and December 26, 2002, Employee had 46 chiropractic sessions with Dr. Culbert. In none of those visits did Employee complain, or did Dr. Culbert treat for any complaints of shoulder pain. On only two occasions is a headache complaint noted, June 3, 2002 and July 10, 2002, both described as occasional and alleviated with aspirin. Specific absence of headache complaints is reported on August 14, 2002 and October 18, 2002. There is no mention of anxiety or nightmares. (Dr. Culbert, June 3, 2002 through October 18, 2002; observation).
11. Between August 12, 2002 and September 3, 2002, Employee attended six physical therapy sessions prescribed by Dr. Culbert. Employee described his pain as in his low back, from the sacrum to L3-4, which occasionally radiated up to his mid thoracic-spine, and occasional right lateral thigh pain. In none of those sessions did Employee complain, or did the therapist treat for complaints of shoulder pain or headache. No mention is made in any of the records of anxiety or nightmares. (Eagle Center Physical Therapy, Initial Evaluation, August 12, 2002; PT notes, August 14, 16, 19, 22, 24, 2002; observation).
12. Due to Employee's persisting low back complaints, Dr. Culbert ordered magnetic resonance imaging (MRI). Conducted on December 19, 2002, the MRI impression was of a large right L4-5 disk hernia with superior fragment migration and narrowing of the canal; and degenerative joint disease at other levels with mild bony L5-S1 bilateral neuroforamen narrowing. (Leonard Sisk, M.D., MRI Report). Dr. Culbert referred Employee to physiatrist Michael Gevaert, M.D. (Referral letter, December 24, 2002).
13. On January 3, 2003, Employee saw Dr. Gevaert. Employee's complaints were of chronic intermittent low back pain with intermittent radicular symptom in the right lower extremity. No complaints of shoulder pain or headache were noted. There is no mention of anxiety or nightmares. Nerve conduction study revealed mild to moderate chronic left S1 radiculopathy. Noting Employee's job required a lot of lifting, bending and twisting, Dr. Gevaert opined he would not be able to continue in his occupation given his herniated disk. Dr. Gevaert proposed two options: a surgical referral if Employee wished to continue in his current heavy duty job, or that Employee be deemed medically stable and job retraining considered. He opined Employee would experience marked exacerbation of his pain,

resulting in recurrent periods of temporary disability, if he continued in his customary work in the field. Employee was to take time to consider these options while returning to chiropractic care. (Dr. Gevaert, January 3, 2003).

14. From January 8, 2003 through April 9, 2003, Employee continued under Dr. Culbert's care. During ten chiropractic visits in this period, Employee's complaints of pain were limited to his neck and upper and lower back. No complaints of shoulder pain or headache were noted or addressed, nor mention made of anxiety or nightmares. (Dr. Culbert, January 8, 2003 through April 9, 2003; observation).
15. Following consultation with orthopedic surgeon Drew Peterson, M.D., and return to Dr. Gevaert, Employee was ultimately placed on six months light duty, to be followed by medium duty. Dr. Gevaert found Employee medically stable with a 15% whole person permanent partial impairment (PPI) due to his thoracic and lumbar spine injuries, and opined Employee could not perform as a Landscape Specialist, but could perform the lighter duties of a Landscape Supervisor. (Dr. Peterson, February 13, 2003; Dr. Gevaert, PPI rating, Return to Work Recommendations, May 14, 2003).
16. Employee continued to be followed by both Dr. Gevaert and Dr. Culbert for his cervical and thoracic symptoms, which Dr. Gevaert characterized as cervical and thoracic myofascial pain. No complaints of shoulder pain, headache, anxiety or nightmares were noted. Dr. Gevaert prescribed anti-inflammatory and muscle relaxant medication, a Theracane for trigger point pain relief, and cervical and thoracic myofascial massage, which he noted provided Employee great relief, more than any other treatment. The Physician Reports form Dr. Gevaert completed for Employee's myofascial massage therapy omit both an injury date and AWCB Case Number, but indicate the injury for which the treatment is prescribed was for the neck, shoulders and low back from a wall of dirt falling over Employee while he worked in a trench. In other words, the 2001 work injury. Dr. Culbert performed chiropractic manipulation. (Dr. Culbert, July 23, 2003; August 1, 4, 8, 2003; Dr. Gevaert, July 22, 2003; September 3, 16, 2003; November 7, 2003; December 5, 2003; January 26, 2004; April 15, 21, 2004; July 12, 2004; Physician Report forms; observation).
17. During his recovery from the May 30, 2002 work injury, Employee suffered time loss from work, was paid TTD benefits, and was rated for and paid a 15% PPI benefit. (Compensation Report, AWCB Case No. 200211270, May 5, 2004).

18. On February 3, 2004, Employee was found ineligible for reemployment benefits based on Dr. Gevaert's opinion he could return to his job at time of injury. (Letter from RBA to Employee, February 3, 2004). Employee did not appeal this decision and it became final on February 16, 2004. (AS 23.30.041(d)). He ultimately returned to work as a Natural Resources Technician, in medium duty status, on April 23, 2004. (WC database "Payments," AWCB Case No. 200211270; Compensation Report, May 5, 2004; Dr. Gevaert notes, January 26, 2004, April 21, 2004).
19. On July 12, 2004, Employee returned to Dr. Gevaert with complaints of increasing neck pain and pain in the "interscapular[2] region." Prescription anti-inflammatory and muscle relaxant medications were continued. Physical therapy was prescribed, at which Employee's "Problem List" consisted of cervical, thoracic and lumbar spine. (PT Evaluation July 19, 2004). A cervical spine MRI ordered in response to Employee's "mid back and bilateral shoulder pain and pain that 'radiates up and down the entire spine and into the head at times,' reflected a normal cervical spine: "cervical vertebral bodies . . . intact. No congenital or post-traumatic lesions . . . intervertebral disc spaces . . . preserved. No protrusions or frank extrusions of disc material . . . on any level. The cord is intrinsically normal." (MRI Report, July 20, 2004). (Dr. Gevaert, July 12, 2004). On August 31, 2004, Employee reported pain shooting up his back into his neck and sometimes into his head, shoulders sensitive to touch, and he was "stressed out" over disputes with his Employer. Dr. Gevaert added Lidoderm patches and Neurontin at bedtime to Employee's medication regimen. Dr. Gevaert characterized Employee as "a very poor historian." (Dr. Gevaert, August 31, 2004).
20. On September 8, 2004, Employee reported a lower back and shoulder strain injury. He suffered no compensable time loss from work. (WC database "Injury," "Payments," AWCB Case No. 200420434).
21. On September 30, 2004, Employee returned to Dr. Gevaert reporting the September 8, 2004 injury increased his neck and "shoulder" pain. Dr. Gevaert's impression was "chronic low back pain exacerbated by lifting heavy items; lower extremity radicular symptoms and neck pain. Dr. Gevaert prescribed therapeutic massage for Employee's myofascial pain in his neck and low back. (Dr. Gevaert, September 30, 2004).

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[2] The upper thoracic, between the shoulder blades. *Dorland's Illustrated Medical Dictionary*, 25th Edition, 1974.

22. On November 9, 2004, in response to Employee's complaints of cervical, thoracic and low back pain with radiation into the left leg, Dr. Gevaert noted: "He requests a letter indicating that he is disabled. This would enable him to collect Workers' Compensation payments all winter. Apparently, this was his status all winter last year, though he is, by definition, a seasonal employee." Dr. Gevaert prescribed additional physical therapy. (Dr. Gevaert, November 9, 2004).
23. There is no further mention of shoulder pain in the medical records following the 2004 injury. Employee described the ditch collapse to evaluating physical therapist Alan Blizzard as having been pinned by falling dirt "to the waist." (Dr. Gevaert, November 9, December 6, 2004, January 3, 2005; Alaska Spine Institute Physical Therapy & Rehabilitation, November 15, 19, 22, 2004; December 1, 6, 9, 14, 17, 21, 28, 30, 2004).
24. On January 7, 2005, Dr. Gevaert conducted electromyography (EMG) and nerve conductions studies, and ordered an MRI of Employee's lumbar spine. The EMG results were normal. The MRI reflected disc degeneration at several levels, greatest at L5 and L1. At no level was there stenosis of the canal. Some mild neural foraminal encroachment was observed bilaterally at L5. The large right L4-5 disk hernia with superior fragment migration observed in the December 19, 2002 MRI had resolved. (Dr. Gevaert, January 7, 2005; MRI Report, January 10, 2005; Judgment, experience, observation).
25. On February 9, 2005, Dr. Gevaert noted Employee's complaints of neck pain, interscapular pain and low back pain, but noted the MRI did not correlate with his reported symptoms and the EMG was negative. He released Employee to full duty, with no follow-up visit, on February 9, 2005. (Dr. Gevaert, February 9, 2005; Attending Doctor Return to Work Recommendation, February 9, 2005).
26. Employee was seen again at Dr. Gevaert's office on June 15, 2005 complaining of neck, low back and bilateral leg pain. Nurse Practitioner Catherine Giessel explained Employee's MRI and EMG studies were normal. She recommended over the counter cooling patches and ice for Employee's low back. She continued the Neurontin and Flexeril for occasional muscular discomfort. To Employee's dissatisfaction, she declined further massage therapy. (FNP Giessel, June 15, 2005).
27. On July 7, 2005, Employee reported injuring his back on June 27, 2005, while pulling down a snow fence, and hauling and loading it onto a trailer. (ROI, July 7, 2005). He suffered no

compensable time loss from work. (WC database "Payments," AWCB Case No. 200510652). There are no contemporaneous medical records associated with this report of injury. (Record).

28. On September 28, 2005, Employee presented at Advanced Pain Centers of Alaska, and was seen by pain specialist Grant Roderer, M.D. Employee complained of cervical and lumbar spine pain since the trench collapse in late 2001. Dr. Roderer reviewed multiple x-ray studies, and the recent cervical and lumbar MRI reports, observing disc degeneration at L5 and L1, no canal stenosis, mild neural foraminal encroachment bilaterally at L5, and normal cervical spine. Dr. Roderer assessed cervicalgia (neck pain) with some evidence of cervical diskogenic pain, cervicogenic headache, possible cervical facet joint arthropathy and degenerative disk disease of the lumbar spine. He ordered a physical therapy evaluation regarding Employee's upper cervical spine pain and possible related headaches. Employee's pain diagram reflects pain in the back and sides of the head and above and below the eyes, and in the upper back, at the thoracic vertebrae. No complaints of anxiety or nightmares were noted. (Dr. Roderer, September 28, 2005; observation).
29. On October 4, 2005, Employee's was evaluated for physical therapy. He related his problem began on Halloween of 2001 while working in a pit, stating the earth behind him caved in and forced him into the wall of dirt in front of him, and he has had problems off and on in his lumbar and thoracic spine since the incident. He stated that most of his problems are "between his shoulder blades" and at the base of his neck. There is no mention of anxiety or headaches. The therapist noted left upper cervical spine hypomobility, thoracic spine hypomobility at levels T3-5 on the left and T3-6 on the right with a left elevated 1st rib, with allodynia[3] in the upper thoracic spine. The therapist assessed pain in lumbar and thoracic spine. Physical therapy was begun. The records reflect Employee continued PT at Advanced Physical Therapy through at least December 4, 2007. The Patient Statement Inquiry indicates payment by Employer's insurance adjuster, Harbor Adjustments, for these visits. (Advanced PT, October 4, 2005; Patient Statement Inquiry; observation).
30. On October 12, 2005, Dr. Roderer recommended an upper thoracic epidural steroid injection in an effort to decrease the upper thoracic pain Employee was reporting between his shoulder

[3] Pain resulting from a stimulus (as a light touch of the skin) which would not normally provoke pain; *also*: a condition marked by allodynia. *http://www.merriam-webster.com/medical/allodynia.*

blades. In light of Dr. Gevaert's having released him to work, Employee asked for a referral for a second opinion regarding Employee's return to full duty. (Dr. Roderer, October 12, 2005; Referral Form, Dr. Roderer to Dr. Prieto).

31. On October 17, 2005, Employee saw physiatrist Rafael Prieto, M.D. on referral from Dr. Roderer. Employee's chief complaint was back pain. He described a 2001 work injury where he was "partially buried . . . up to his thoracic spine and initially found it difficult to breathe until some of his co-workers dug him out of the ground." No complaints of headache, anxiety or nightmares were noted. Dr. Prieto assessed mechanical cervico-thoraco-lumbar spine pain, "predominantly myofascial." He added "degenerative disk pain might be present at the L5-S1 disk with comorbid right sacroiliac joint pain syndrome." Dr. Prieto noted "I agree with ongoing physical therapy/soft tissue massage," stating after Employee plateaued through physical therapy and injection, he would consider ordering a functional capacity evaluation. (Dr. Prieto, October 17, 2005). Employee continued in physical therapy for diagnoses of thoracic spine pain, disc disorder, lumbar region, and cervicocranial syndrome. (Advanced PT, October 18, 24, 25, 26, 27, 28, 31, 2005; November 2, 7, 11, 14, 16, 17, 21, 28; December 1, 2005).
32. On November 3, 2005, Dr. Roderer performed a thoracic epidural steroid injection. (Procedure Report, November 3, 2005). Employee reported almost complete absence of right mid thoracic allodynia, but by November 28, 2005, reported his symptoms were beginning to return. The physical therapist noted Employee might benefit from a repeat of the thoracic epidural, as well as a possible evaluation with "psyh" (sic) "to discuss his frustrations with his health, anxiety about returning to work and frustrations with employer." (Advanced PT, November 28, 2005). This is the first mention of Employee exhibiting "anxiety" in the medical records. (Observation).
33. On November 12, 2005, at Employer's request, Employee was seen for an Employer medical evaluation (EME) by physiatrist Patrick Radecki, M.D., and orthopedist Holm Neumann, M.D., for work injuries dated May 30, 2002 and June 27, 2005. (EME Reports, Drs. Radecki, Neumann, November 12, 2005).
34. According to his reporting to Dr. Radecki, Employee's headaches were occasional (3-4 times weekly), are normal headaches, and do not originate in the cervical spine. They originated in Employee's occipital region (back of the head), lasted just moments to three minutes long,

and if he rubbed the back of his head with his fingers and massaged the area it felt better. (Dr. Radecki at 9). Relative to his neck, according to Dr. Radecki, Employee's pain was in the mid cervical spine region, occurred about three times per week, and lasted from ten seconds to five minutes. He reported it not a significant problem, and he had no radicular symptoms. (*Id.*). With respect to his thoracic pain, Employee described it as occurring at T4 through T6, daily and constant in nature, triggered by activity as simple as lifting a carton of milk, and centered between the shoulder blades. Employee had no pain with range of motion of the shoulders themselves, no pain with reaching to the right or left, and his shoulder joints were noted as problem-free. (*Id.*). Employee reported his low back pain as daily and constant, with a deep aching pain in his right leg, but no definite radiation, no numbness or weakness in the lower extremities. (*Id.* at 10).

35. Dr. Radecki diagnosed "diffuse, ill-defined, widespread chronic pain syndrome involving the three main spinal levels, cervical, thoracic and lumbar." He noted Employee's herniated disc had resolved, and he had not had radiating pain to a lower extremity since 2004. Acknowledging Employee's belief his symptoms were related to work injuries, Dr. Radecki opined "I believe his symptoms are probably due to psychogenic factors." (*Id.* at 15). Dr. Radecki did not believe further treatment or medication necessary, other than occasional anti-inflammatories for standard aches and pains of middle age. He imposed no restrictions on employment, found Employee was medically stable and suffered no permanent impairment. (*Id.*).
36. EME orthopedist Dr. Neumann, however, attributed Employee's symptoms to objective evidence of degenerative disc and degenerative joint disease, and did not believe Employee demonstrated "overt functional behavior." He otherwise concurred with Dr. Radecki's responses to the specific questions asked with respect to medical stability, impairment and release to work. Dr. Neumann did not offer an opinion on what caused Employee's degenerative disc and joint disease. (Dr. Neumann report at 5).
37. On December 1, 2005, based on Drs. Radecki and Neumann's EME reports, Employer controverted all further medical treatment and indemnity benefits with respect to injury date June 27, 2005. (Controversion Notice, November 29, 2005).
38. On January 16, 2006, Employee was seen at Advanced Pain Centers of Alaska by Deborah Kiley, ANP. Employee reported increased pain in his cervical and upper thoracic spine with

throbbing in his back. He referred to the 2005 work injury. He expressed concern on the status of payment for his medical care, apparently aware of the December 1, 2005 controversion. He reported the Lidoderm patches relieved pain, and the Zanaflex (muscle relaxant) and Neurontin were helpful. The November 3, 2005 injection eased pain but it was now returning. He reported the physical therapy was also helpful, especially traction. Ms. Kiley continued the Lidoderm, Zanaflex and Neurontin. Ms. Kiley noted Employee "significantly anxious . . . speech is rambling," and assessed "significant anxiety surrounding his pain and exacerbation for his pain from last summer." She recommended a behavioral health evaluation "focusing specifically on some relaxation techniques as well as refocusing and understating his reaction to his pain." Ms. Kiley noted she would investigate "if something has happened to his coverage that precludes him from the physical therapy which clearly was quite helpful." (Kiley, January 16, 2006).

39. In consultation with psychiatric nurse practitioner Catherine E. Barrett on January 20, 2006, Employee denied depression, anxiety and anger, although Ms. Barrett noted the presence of anxiety and a need for Employee to work on anger issues, particularly over his belief Employer has exacted retribution against him for his reporting the 2001 ditch collapse to OSHA, and a general assault on his character by his employer. Employee was "provided education regarding stress reduction, the impact of stressor on mood and pain, and the effect of strong emotions such as anger and rage on mood and pain." No follow-up appointment was made. (Barrett, January 20, 2006).
40. On February 8, 2006, Dr. Roderer assessed cervicalgia with mild pain on end range flexion, and degenerative disk disease lumbar spine, currently without symptoms; this despite Employee's complaints of cervical pain at an eight out of 10 on a 10 point pain scale, and lumbar pain at a seven out of 10. Dr. Roderer noted no evidence of muscle spasms on examination. No complaints of shoulder pain or headaches were noted. Dr. Roderer reported Employee's mood and affect at "his baseline." He noted Employee's workers' compensation claim had been controverted, and he would see Employee in follow-up on an as-needed basis. (Dr. Roderer, February 8, 2006).
41. On July 11, 2006, Employee reported injuring his back lifting three full five gallon water containers from the back of a truck. (ROI, July 27, 2006). He suffered no compensable time loss from work. (WC database "Payments," AWCB Case No. 200611455).

42. Employee returned to Dr. Roderer on July 25, 2006 complaining of increase in pain symptoms in his upper thoracic spine following the July 11, 2006 work injury. Dr. Roderer assessed thoracic spine pain secondary to degenerative disk disease. Low dose Neurontin was restarted. Employee was to return as needed. (Dr. Roderer, July 25, 2006). On a return visit on September 5, 2006, Employee was complaining of aching and pressure in his upper thoracic spine radiating to the back of his head and to his shoulders. Dr. Roderer assessed degenerative disk disease of the thoracic spine, restricted his work to no overhead lifting and no lifting greater than 10 pounds frequently, no lifting above the waist. Lidoderm patches were noted as helpful in decreasing sensitivity in the upper thoracic spine. Neurontin was continued. Physical therapy was again prescribed, including use of a TENS unit, which Employee reported "helped significantly with the pain." (Dr. Roderer, July 25, 2006; Return to Work Recommendations, September 5, 2006: PT Initial Evaluation, September 7, 2006; PT progress notes September 7, 12, 25, 2006; October 2, 4, 26, 30, 2006; November 2, 7, 9, 14, 22, 28, 2006; December 6, 15, 2006; January 27, 2006).
43. On September 25, 2006, Employee received a Performance Evaluation Report for the period May 1, 2006 through September 30, 2006. Of 16 performance rating factors, Employee scored in the "Acceptable" range in nine categories, "High Acceptable" in six categories, and "Outstanding" in one category. He received no "Unsatisfactory" or "Low Acceptable" ratings. (State of Alaska Performance Evaluation Report, October 19, 2006).
44. On October 5, 2006, Dr. Roderer performed another thoracic epidural steroid injection which provided good relief. (Dr. Roderer, November 1, 2006).
45. On November 1, 2006, Dr. Roderer assessed thoracic spine pain with reduction in symptoms after a combination of thoracic epidural injection, medication management, TENS unit therapy and physical therapy. He continued Lidoderm patches, low dose Neurontin at bedtime, finish PT, continue TENS unit, and obtain a six month Alaska Club membership to continue exercise. He opined Employee's pain exacerbations have been due to heavy lifting and moving heavy objections at work, and his then current need for treatment, including the TENS unit, Neurontin, PT and a six month gym program were the result of the July 11, 2006 work injury. He deemed Employee medically stable, to be seen again only as needed. (Dr. Roderer, November 1, 2006; PT Referral, November 1, 2006; Causation Letter, Dr. Roderer,

November 5, 2006; November 6, 2006; Response to Letter from Harbor Adjustment Service).

46. On January 31, 2007, during his off-season from Employer, Employee was hired as a full-time front desk clerk at the Alaska Club. (Offer of Employment, January 31, 2007; Payroll/Status Change). He continued the PT prescribed by Dr. Roderer, twice reporting to the therapist that shooting pains between his shoulder blades up to the base of his skull caused him to leave work with a bad headache. (PT Progress notes, February 12, 16, 22, 28, 2007; March 2, 2007).
47. On March 19, 2007, Employee was transferred to The Alaska Club's cleaning team, also a full-time position. (Offer of Employment, January 31, 2007; Payroll/Status Change).
48. On April 21, 2007, at Employer's request, Employee was seen by orthopedist Timothy R. Borman, D.O., concerning the July 11, 2006 injury. Dr. Borman was provided with the December 19, 2002 lumbar MRI; July 19, 2004 cervical MRI; and the January 7, 2005 lumbar MRI. He was provided with Drs. Radecki and Neumann's November 12, 2005 EME reports, and records from Dr. Prieto and Dr. Roderer, beginning October 17, 2005. Notably, on physical examination, Dr. Borman found Employee had "absolutely no motion on full flexion" in the thoracic spine. He reported normal active range of motion of the shoulders, and shoulder apprehension test and impingement maneuvers negative for pain. He diagnosed cervical, thoracic and lumbar spine degenerative disk disease. He opined that none of Employee's symptoms were related to the July 11, 2006 work injury, which he found did not aggravate, accelerate or combine with his preexisting condition thereby requiring medical treatment, as Employee's pre-existing symptoms for which he had received extensive treatment had not changed as a result of the July 11, 2006 injury. (Dr. Borman Report, April 21, 2007, at 12-13). Dr. Borman opined: "The July 11, 2006, work event was mainly due to activities which increased the pain without worsening the condition associated with his chronic, painful degenerative disk disease of the cervical, thoracic, and lumbar spine. (*Id.* at 13). Dr. Borman opined that further treatment, epidural steroid injections, use of a TENS unit, medications and a gym program are reasonable and medically acceptable for Employee's prior existing cervical, thoracic and lumbar degenerative disk disease, but not for the July 11, 2006 work injury. (*Id.* at 12-13). He opined job modification was appropriate. Although Dr. Borman did not perform a permanent partial impairment rating in accordance

with the AMA Guides, he opined Employee's prior 15% PPI rating was generous, and no further impairment was justified as Employee's condition had not changed since the rating was provided in 2003. (*Id*. at 13). Employer controverted all further benefits for the July 11, 2006 injury based on Dr. Borman's report. (Controversion Notice, May 9, 2007).

49. Dr. Borman concurred with Dr. Neumann, that Employee had a legitimate source for his pain in his degenerative disk and joint disease. (Judgment, observation). Like Dr. Neumann, Dr. Borman did not concur with Dr. Radecki's opinion Employee's complaints were of psychogenic origin. (*Id.;* observation).
50. Employee continued treating with Dr. Roderer, and as his return to seasonal employment with the State approached, enlisted his aid in obtaining accommodations at work. (Dr. Roderer Progress notes, April 17, 2007; May 15, 23, 2007; Dr. Roderer letter to DNR, April 4, 2007). Dr. Roderer opined Employee was unable to lift more than 20 pounds occasionally, required medications and a TENS unit, and his condition was permanent. (ADA Reasonable Accommodation Request: Health Care Provider Information, May 29, 2007).
51. In May, 2007, Employee was involved in a contested divorce action. The evidence and testimony suggest this was acrimonious, involving child custody and support issues, and came, according to Employee, after long-standing and extreme spousal abuse inflicted upon him and making him fearful of his partner of 24 years. (Authorization for Release of Records and Information, May 10, 2007; Letters from Law Office of Dan Allan to The Alaska Club regarding wage information, October 16, 2007, February 12, 2008, February 21, 2008; Consultation Reports, Catherine Barrett).
52. On May 21, 2007, Employee filed an ADA Reasonable Accommodation Request with the State of Alaska. On June 13, 2007, his request for reassignment to a lighter duty position was granted. (Letter from Pam Day to Employee, June 13, 2007). On August 16, 2007, Employee was transferred laterally from a Natural Resources Technician II field position, a seasonal job, to an available Natural Resources Technician II full-time office position. The physical requirements of the new position were frequent sitting, walking and standing, frequent hand and finger motion and grasping, and lifting/carrying 10-25 pounds frequently, with no other lifting, and no pushing, pulling, running, bending, twisting, squatting, kneeling, reaching above shoulder level, or climbing. (Personnel Action, October 3, 2007; *Compare* Position Descriptions, Natural Resource Technician II, PCN 10-5031 *with* PCN 10-1807).

53. On September 19, 2007, Employee returned to Dr. Roderer complaining of cervical, thoracic and lumbar spine pain, stabbing and numbness on the left side of his head, aching and radiation into the lower extremities and pain in his left elbow into his fingers, made worse by reading and work on the computer. On examination Dr. Roderer reported musculoskeletal and neurologic examination remained unchanged, and assessed thoracic spine pain, cervicalgia, and thoracic disk disease. Dr. Roderer noted Employee's report his workers' compensation claim was denied and he could no longer afford his prescriptions for Lidoderm patches, Neurontin and Zanaflex. These prescriptions were renewed in order to decrease Employee's pain levels. (Dr. Roderer, September 19, 2007).
54. On October 1, 2007, Employee saw optometrist Robert J. Fleckstein, O.D. complaining of decline or change in vision, and daily frontal-temporal headaches. Dr. Fleckstein diagnosed myopia and astigmatism and provided an optical prescription change, noting "The proposed new spectacle correction should decrease distance vision symptoms if it is worn with advised frequency. (Dr. Fleckstein, October 1, 2007).
55. On October 5, 2007, Employee arrived at the Alaska Regional Hospital Emergency Room (ER) complaining of recurrent headache. He reported having intermittent headaches "for the past 6 years since a construction accident were (sic) he states he was buried alive and was hit (sic) the head." He reported his symptoms had not changed, although his pain was keeping him awake at night. Head CT imaging showed no evidence of acute intracranial abnormalities nor evidence of sinus disease. Employee was assessed with recurrent headache, and told to follow-up with Dr. Roderer the following week. Twenty Vicodin for breakthrough pain were prescribed. (ER note, October 5, 2007).
56. Employee saw ANP Kiley at Dr. Roderer's office on October 10, 2007, seeking assistance for "anxiety/ headache," and reporting relief from PT. Employee stated he was working on a computer, was bothered by lights, and was afraid he had an aneurysm. He does not appear to have mentioned having had a negative head CT scan five days earlier. Nurse Kiley referred him to PT for evaluation and treatment, and to Advanced Behavioral Health for assessment, noting he had been seen by ANP Barrett in January, 2006, and was now requesting assistance for anxiety and stress. (ANP Kiley, October 10, 2007; observation).
57. On October 22, 2007, Employee saw ANP Barrett for consultation. His stated complaints were headache, anxiety about his new job and fear he might have an aneurysm. He

complained of sleep problems. In the medical history, Ms. Barrett recorded "Negative for head injury . . . The patient was in an accident . . . a wall of dirt fell on him while he was working in a hole . . . He felt as if he could not breathe." In the mental status exam Ms. Barrett recorded "He has no evidence of any paranoia, delusions, ideas or reference, thought insertion, thought blocking, de-personalization, obsessions, compulsions, fears or phobias." She noted Employee's stressors as frustration at work, from caring for his brother who suffered a traumatic brain injury, the brother's recent death, a history of spousal abuse inflicted upon him, a pending divorce, concern over being able to see his children when he wanted to, and sleep difficulties. Notably absent from Ms. Barrett's assessment is any mention by Employee of nightmares. She diagnosed mood disorder secondary to medical condition, marital and family circumstances. She noted Employee lacked insight into his mental health, and it was unclear he would engage in any treatment. She reviewed with him depression, anxiety and sleep disturbances associated with chronic pain and situational stressors, and the impact of stressors on mood. She recommended Employee follow-up at work regarding an ergonomic work station and a screen for his computer. A trial of Lunesta for sleep was provided. Employee was to follow-up in one month. (ANP Barrett, October 29, 2007).

58. On October 23, 2007, Employee was evaluated for PT. He reported increasing posterior head and neck pain as he worked on a computer. He noted he had not had an ergonomic assessment at work but was expecting one to be performed. He reported he was getting a special screen and had gotten new glasses to wear when working with bright lights. On November 1, 2007, he reported he had the lights lowered at work. (Pamela Nelson, PT, October 23, November 1, 2007).

59. On October 27, 2007, Employee received a memorandum of instruction from his supervisor concerning his "on-going absences and how we can work together . . . in resolving the impact the absences are having on the workplace." He was reminded of the need to communicate with his supervisor regarding any circumstances that affect his ability to work as assigned, barring emergencies any leave must be pre-approved, and in instances of illness he was required to provide a doctor's note upon return to work. He was asked to "please follow the office's sick leave and late call-in policy" when he had an unplanned absence. He was advised that continued excessive leave usage may result in the State requiring a fit for duty

assessment from a physician to determine if he could continue to work and perform the essential functions of his position and be at work on a regular and consistent basis. He was asked to please schedule future appointments to have the least impact on the work flow. (Memorandum of Instruction, October 26, 2007).

60. On November 1 and 2, 2007, Employee arrived to work late, or left early due to PT appointments. On or about November 5, 2007, he informed his supervisor he was resigning effective November 8, 2007. He never returned to work. (Time and Attendance Report, Pay period 11/1/2007 – 11/15/2007; Leave Report, November 8, 2007, Note: Employee resigning 11-8-07).
61. On November 6, 2007, Employee was seen by neurology ANP Mary Margaret Hillstrand at Advanced Pain, complaining of daily headache, reporting he is frequently awakened during the night by headache and neck ache. There is no mention of nightmares. ANP Hillstrand described Employee's mood as anxious. She advised use of non-steroidal anti-inflammatories for headache, opining his headaches will improve with the tizanidine (generic for the muscle relaxant Zanaflex) and increased activities. (ANP Hillstrand, November 6, 2007; Dr. Roderer, November 28, 2007).
62. When Employee failed to provide a current doctor's certification justifying his repeated absences from work, on November 19, 2007, Employee was notified of an investigatory interview scheduled for November 21, 2007 for his alleged failure to keep his supervisor informed of the status of his absences and his return to work. At that meeting the allegations were upheld: "You have been repeatedly asked for a note from your physician stating that you are unable to work in your current position. You have failed to provide me with this information . . . to substantiate your absence since November 5, 2007; therefore your absences have been unauthorized . . . You are directed to report to work immediately during your scheduled hours. If you fail to report, we will make a decision regarding your continued employment based on the information we have available. This decision could mean that you are administratively separated due to your unavailability to work. (Report to Work Memo, November 27, 2007).
63. On November 28, 2007, Employee returned to Dr. Roderer seeking support for his work absences. He complained of mild head cramping, no cervical pain, and 5 out of 10 pain in his thoracic and lumbar spine. Dr. Roderer recorded musculoskeletal and neurologic

examination remained unchanged. Pain symptoms essentially unchanged. He assessed cervicalgia, degenerative disk disease of the thoracic and lumbar spine, headache and mood disorder. Dr. Roderer endorsed ANP Hillstrand's anti-inflammatory and muscle relaxant recommendations, as well as a sleep aid and Lidoderm patch as necessary. Dr. Roderer recorded: "I cannot give the patient a letter of support for his work absences. He has told me that he believes it is in his best interest to discontinue this particular job. This is the patient's choice." Dr. Roderer noted Employee was to return as needed, and encouraged him to continue with behavioral health. (Dr. Roderer, November 28, 2007).

64. Employee never returned to work for Employer. On November 29, 2007 he submitted a formal written resignation, citing "severe headaches, caused by the close and constant work on the computer which has been further aggravated by the overhead lighting." (Resignation, November 29, 2007).
65. On December 11, 2007, Employee was seen by Jeff Keene, O.D., at Vision Therapy Center. On December 12, 2007, Dr. Keene wrote to Dr. Roderer:

> The visual complaints that Doug has are the following:
> Gets headaches when reading or on the computer
> Eyes feel strained after moderate periods of time using a computer
> Experiences a lot of tension during close work activities
> Light bothers eyes

Dr. Keene diagnosed convergence insufficiency, deficiencies of smooth pursuit movements, deficiencies of saccadic eye movements, suppression binocular vision and binocular vision disorder. Dr. Keene noted that a head injury interrupts signals coming from the eye which overload and stress the whole brain network causing instant distress and often manifesting as a headache or an overwhelming pain. "Doug has this reaction." Dr. Keene opined that because there is a mismatch between Employee's central and peripheral vision systems, when he sees movement in his periphery it causes tension, stress and often head and neck pain. Dr. Keene prescribed vision therapy to help alleviate Employee's vision problems. (Dr. Keene, December 12, 2007).

66. On December 20, 2007, in a letter to Dr. Fleckstein, Employee's regular optometrist, Dr. Keene opined Employee has many characteristics of Post Trauma Vision Syndrome, and related Employee's current visual stress to his neck, back, and head injury six years ago. (Letter, December 20, 2007).

67. On January 17, 2008, Dr. Keene opined Employee's vision problems involve dysfunction in how Employee's eye system adjusts to close up activity such as computer work, deskwork or other types of office work. "He should never have been given a job that involves this type of work. Because of these visual problems Doug has had excruciating and debilitating headaches and overwhelming fatigue." (Dr. Keene, January 17, 2008).
68. On June 24, 2009, Employee filed a workers' compensation claim (claim) alleging injury to his head, neck and vision from his Natural Resources Technician II office employment. Employer answered, denying compensability, and alleging Employee failed to file a timely Report of Injury, thus barring his claim under AS 23.30.100(d). Alternatively, Employer alleged that should the Board excuse Employee's untimely reporting, Employee is not entitled to the presumption of compensability pursuant to AS 23.30.120(b). (Claim, June 24, 2009; Answer, July 14, 2009).
69. After resigning his employment with the State, Employee continued working as a janitor at The Alaska Club. On April 3, 2009, Employee's status at The Alaska Club was changed from full-time to part-time. An internal memorandum reflects this change was due in part to Employee's failure to work his assigned hours since his hire in 2007. "He wasn't thrilled, but I showed him that he had only worked the required amount of hours 3 times in over two years. He's OK now." This assertion is corroborated by The Alaska Club time card records. (Memorandum, April 3, 2009; Time card records).
70. On July 8, 2009, Employee reported he was injured while employed at The Alaska Club when a ladder on which he was standing collapsed, and he fell onto a weight machine, injuring his lower back, shoulders and head. (ROI, July 10, 2009; AWCB Case No. 200910052).
71. On July 13, 2009, Employee returned to Dr. Culbert for care for injuries sustained when he fell from the ladder on July 8. Dr. Culbert noted Employee was standing approximately two feet up on a ladder when it collapsed. "He fell hitting his right shoulder and head against a weight machine, and lower back against a weight stack. He did grab a support to the weight machine with his right upper extremity as he fell." (Letter from Dr. Culbert to Sea Bright Insurance in support of treatment greater than frequency standards, July 13, 2009). Examining Employee's shoulder, Dr. Culbert recorded impingement testing caused moderate pain on the right; mild pain on the left. O'Brien's test caused pain both in the supinated and

pronated positions. Empty can test caused moderate pain on the right with slight weakness over the supraspinatus. X-ray imaging reflected normal cervical spine, and thoracic and lumbar degenerative disk disease, particularly at L1-2. (X-ray report, July 13, 2009). In addition to cervicothoracic strain/sprain, cervicogenic headaches and lumbar strain/sprain, all secondary to the July 9, 2009 work injury, Dr. Culbert diagnosed right rotator cuff tear, secondary to July 9, 2009 work injury. (*Id.*).

72. Employee's complaints of right shoulder pain as a result of his fall from the ladder were prominent and persistent in successive visits with Dr. Culbert. (July 14, 15, 21, 22, 23, 27, 28, 30, 2009; August 3, 4, 5, 11, 12, 13, 17, 18, 19, 20, 24, 26, 2009; September 1, 3, 8, 10, 15, 17, 22, 24, 2009; October 5, 8, 12, 19, 28, 2009; November 3, 10, 17, 25). An MRI scan of Employee's right shoulder showed a small anterior-inferior glenoid labrum tear, acromioclavicular joint degenerative joint disease with supraspinatus impingement and tendinopathy fluid in the subacromial and subdeltoid bursa suggestive of bursitis, and moderate to severe glenohumeral joint degenerative joint disease. (Leonard Sisk, M.D., MRI Report, August 27, 2009).
73. On October 22, 2009, on referral from Dr. Culbert for shoulder pain, Employee was seen by orthopedist Jeffrey Moore, M.D. History included right shoulder injury when he fell off a ladder jamming his right shoulder. Employee reported persistent discomfort with reaching or lifting activities and doing anything overhead since the July, 2009 injury, including occasional popping and clicking sensations in the shoulder. Dr. Moore assessed (1) right shoulder tendinipathy/rotator cuff impingement, rotator cuff bursitis with Employee's main symptoms more related to the rotator cuff area; and (2) degenerative changes in the right glenohumeral joint. Steroid injection in the right glenohumeral joint was performed for diagnostic and therapeutic purposes. (Dr. Moore, October 22, 2009).
74. On December 2, 2009, Dr. Culbert opined Employee had attained pre-July, 2009 injury status with respect to his neck and back, and was released from chiropractic care. Employee would continue care for his shoulder with Dr. Moore, which had not reached pre-injury status, "as it was essentially pain free prior to [Employee's] July 9, 2009 work-related injury." (Dr. Culbert, December 2, 2009).
75. Employee returned to Dr. Moore on January 14, 2010, complaining of recurrence of right shoulder pain since injection three months ago. Dr. Moore assessed recurrent right shoulder

impingement/partial rotator cuff tear, and administered a second injection. Dr. Moore reported Employee "is also complaining of increasing pain and discomfort over his left shoulder and had a similar injury at the time of his right shoulder injury with similar findings and similar pain." (Dr. Moore, January 14, 2010). The medical records do not support this latter assertion by Employee to Dr. Moore. (Record; judgment, observation). Dr. Moore ordered a left shoulder MRI which reflected evidence of tendinopathy bursitis but no rotator cuff tear on the left, and some changes around the glenohumeral joint, but articular surfaces appeared fairly well-maintained. Examination reflected "still excellent range of motion." Dr. Moore recommended continued strengthening and rehab exercises for the rotator cuff. (Dr. Moore, January 14, 21, 2010; X-ray report, January 15, 2010).

76. On February 4, 2010, Employee's complaints again centered around his right shoulder. Examination showed positive impingement signs. Employee requested work restrictions, and Dr. Moore recommended avoiding stooping activities on all fours. Dr. Moore explained no further injections could be administered to Employee's right shoulder, and prescription strength Motrin was ordered. If Employee's pain were to significantly worsen, consideration could be given to arthroscopic decompression and possible rotator cuff repair. Employee was to return as needed. Limited work duties, with no stooping activities or down on all fours were ordered through March 31, 2010. (Dr. Moore, February 4, 2010).
77. On April 29, 2010, at Employer's request and relative to the November 2007 report of injury, Employee was seen for a panel EME by ophthalmologist Richard Bensinger, M.D., and occupational medicine specialist Michael Allison, M.D. To Dr. Bensinger Employee reported he was first injured on November 1, 2001, when he was working in a trench and the wall collapsed, burying him underneath the wall of dirt that hit him. He was buried below the surface but was immediately dug up and pulled out by colleagues. "He said he could not have breathed had he stayed underground, but was retrieved quickly enough that breathing very rapidly ensued." Employee reported to Dr. Bensinger experiencing "significant headaches" following the 2001 injury, but no indication for several years of any difficulty with his vision. (Dr. Bensinger EME Report, April 29, 2010 at 2). Employee related Dr. Keene's diagnoses, but admitted he voluntarily ended the visual therapy sessions because he did not feel they were providing any benefit. (*Id*. at 3). Dr. Bensinger opined Employee's visual performance "is superb. He sees at 20/15 with proper correction. He would benefit

from presbyopic spectacles, as befits his age, but this is not related to his injury." (*Id.* at 5). Dr. Bensinger found no eye condition caused by a work injury. (*Id.* at 8). There was no aggravation of visual symptoms caused by computer use. (*Id.* at 6). Dr. Bensinger debunked Dr. Keene's diagnosis of "post trauma vision syndrome," labelling it a "construct developed by optometrists who" perform what they call "visual therapy." He informed that "post trauma vision syndrome" has never been formally diagnosed, and no CPT code exists for it. "There are no formal medically acceptable studies demonstrating it is an actual phenomenon." He opined Employee does not suffer "post trauma vision syndrome" and suffered no injury to his eyes. (*Id.* at 6-7). He found Employee had excellent vision, excellent visual motility, and no diagnosable dysfunction of the visual system to support a diagnosis of anything. (*Id.* at 7). Dr. Bensinger speculated Employee could possibly have suffered a mild concussion as a result of the 2001 work injury, which could have resulted in his delayed headache and light sensitivity, but he gleaned no other diagnosis as a consequence of Employee's 2001 work injury. (*Id.* at 7). He opined Employee experienced no changes in his visual sensation from his occupation as a natural resources technician, was medically stable, sustained no permanent impairment, and from a visual standpoint could work in an office environment or cubicle without restriction. (*Id.* at 9).

78. Dr. Bensinger's speculation Employee could have suffered a mild concussion as a result of the 2001 work injury causing delayed headache and light sensitivity is based on a version of the facts imparted to him by Employee which is not supported in the medical records. This is but one example of Employee as a poor historian. Employee was not buried alive or his breathing compromised in the trench wall collapse. He did not suffer a concussion, and he never complained of headaches following the 2001 injury. The voluminous medical records reflect Employee never complained of headaches to any of his many medical providers until one mention to Dr. Roderer on September 28, 2005. To Dr. Radecki in November, 2005, he described his headaches as "normal," not cervicogenic, and alleviated within minutes with aspirin or massaging the back of his head. (Judgment, observation, facts of the case and inferences therefrom).

79. Dr. Allison's diagnoses included history of low back injury from 2001 trench collapse producing herniated disk, resolved, with no other occupational injury or illness. Other, non-occupational diagnoses noted included headaches of unknown cause, probably due to stress

and other factors; upper back and neck myofascial pain; complaints of visual disturbances off and on, cause unknown; and age-related onset of presbyopia. (Dr. Allison EME Report, April 29, 2010 at 17). Dr. Allison opined Employee's transition to an office environment did not cause occupational injury or aggravate his pre-existing myofascial pain. (*Id.* at 18-19). Dr. Allison too opined there is no such thing as "post trauma vision syndrome," and Employee's headache and reported visual changes were non-occupational in origin. He characterized Employee's complaints as "subjective" and "non-physiologic," the persistence of which over several years with no objective findings suggested either malingering or the result of non-occupational psychosocial factors. (*Id.* at 20). Dr. Allison opined Employee was medically stable, could return to work without restriction, his headaches and visual complaints should not have caused time loss from work, and he sustained no permanent impairment beyond the "generous" 15% rating previously awarded for his neck and back. (*Id.* at 21).

80. On July 22, 2010, Employee returned to Dr. Moore's office reporting his left shoulder more bothersome than his right. He received a steroid injection on the left. Surgical decompression and possible rotator cuff tear repair was again discussed. (PA-C Jared Crawford, July 22, 2010).
81. On December 8, 2010, at The Alaska Club's request with respect to the July 9, 2009 work injury, Employee was seen for a medical evaluation by orthopedist Richard D. Gardiner, M.D. Dr. Gardiner reviewed a compact disc (CD) containing the August 27, 2009 MRI of Employee's right shoulder. He interpreted it as demonstrating mild impingement with rotator cuff tendinopathy, but no frank tear. Dr. Gardiner diagnosed (1) bilateral shoulder sprain/strain, right greater than left, from the July 9, 2009 work injury, resolved; (2) acromioclavicular joint osteoarthritis bilateral shoulders, pre-existing; (3) right rotator cuff tendinopathy, pre-existing; (4) right shoulder glenoid scapular contusion, non-displaced, healed; (5) cervical sprain/strain, resolved; (6) lumbosacral sprain/strain, resolved. He opined Employee required a home exercise program, sustained no permanent injury, and could return to work without restrictions. (EME Report, Dr. Gardiner, December 8, 2010).
82. Employee would eventually enter into a Compromise & Release Agreement (C & R) with The Alaska Club for his bilateral shoulders, cervical and lumbar injuries. (Compromise & Release Agreement, August 15, 2012).

83. On December 14, 2010, Employee was seen for a second independent medical evaluation (SIME) by occupational medicine specialist Timothy J. Craven, M.D. relative to the reported 2007 injury. Providing history to Dr. Craven, Employee reported a wall of dirt fell in on him when he was working in a trench. He was buried for a short period of time before he was rescued by his coworkers. He developed chronic neck and back pain. He noted a worsening of symptoms, including headaches and blurred vision, when he moved to a sedentary position involving frequent computer work in 2007. (Dr. Craven SIME Report, December 14, 2010 at 2). Employee reported he "occasionally has bad dreams or nightmares related to being buried alive as happened in the work injury of 11/1/01." (*Id.* at 6). In the voluminous medical records spanning nine years since the trench wall collapse, this is the first mention by Employee of experiencing nightmares. (Observation). Dr. Craven diagnosed chronic myofascial neck and back pain, related to the November 1, 2001 work injury, and degenerative disc disease of the lumbar spine, not work related, but caused by the natural aging process. (*Id.* at 8). The following interrogatories were posed, and Dr. Craven's responses are probative:

> Q: Which complaints or symptoms are or are not related to the 11/29/2007 employment injury?
>
> A: None of his complaints or symptoms is related to the 11/29/07 employment injury. They are related to the 11/1/01 employment injury. . .
>
> Q: If the employee suffers a condition pre-existing his 11/29/2007 employment injury, please identify and evaluate the relative contribution of different causes of the complaints or symptoms.
>
> A: He has a preexisting history of chronic neck and back pain that was entirely the result of the 11/1/01 employment injury. Since that injury, he has had these chronic complaints or symptoms.
>
> A: The injury of 11/29/07 did not cause or was a substantial facture (sic) . . . In my opinion, his current complaints and symptoms are a result of the previous 11/1/01 employment injury.
>
> Q: What specific additional treatment, if any is indicated/recommended?

A: None for the 11/29/07 employment injury.

(*Id*. at 9).

84. Dr. Craven opined Employee was medically stable from the November 29, 2007 report of injury on December 7, 2007, when he saw Dr. Roderer, Employee had the physical capacity to perform his sedentary job in an office setting without restriction, and he suffered no permanent impairment as a result of his employment in 2007. (Dr. Craven, SIME Report, December 14, 2010 at 10).
85. On December 15, 2010, Employee was seen for a further SIME by ophthalmologist Leonard B. Alenick, M.D. Dr. Alenick diagnosed myopia[4] and presbyopia,[5] not injury related; and normal stereopsis and normal convergence with appropriate prescribed glasses. (Dr. Alenick SIME Report, December 15, 2010 at 3). Dr. Alenick opined that all of Employee's ocular symptoms are normal problems that happen in the mid-40s, and appropriate prescription bifocal glasses with high segments set at computer range if he will be doing computer work should solve all of his visual problems. Dr. Alenick noted that because Employee has astigmatism in his left eye, over-the-counter reading glasses are not adequate for close-up work. Dr. Alenick opined that Employee's ocular complaints were precipitated solely by the normal aging process and not by any work injury occurring from 2001 to present. (*Id.*). Dr. Alenick stated that from an ocular point of view Employee needs normal vision care, which he has never obtained. (*Id.* at 4).
86. On March 15, 2011, Dr. Craven testified through deposition concerning the December 14, 2010 evaluation of Employee he conducted at the Board's request. In response to questions posed by the State, Dr. Craven elaborated on his diagnosis of chronic myofascial neck and back pain, explaining myofascial pain is pain related to the muscles, ligaments and soft tissue of the neck and back area, and is common after trauma to the neck and back. It is objectively diagnosable through exam findings, such as stiffness and decreased movement of the back and pain with movement, and sometimes with associated nerve symptom such as nerve pain in the legs, reproducible pain, x-ray and history. Employee demonstrated these objective findings. (Dr. Craven deposition, March 15, 2011 at 11-13). Dr. Craven conceded that an individual's emotional issues, such as depression and anxiety, can contribute to myofascial

[4] Nearsightedness. *Dorland's Illustrated Medical Dictionary*, 25th Edition, 1974.
[5] Farsightedness, due to advancing years. *Dorland's Illustrated Medical Dictionary*, 25th Edition, 1974.

pain, was aware from the medical records Employee had symptoms of depression, but did not think Employee's emotional makeup was a significant factor in his myofascial pain. (*Id*. at 14). Dr. Craven reiterated the opinions in his December 14, 2010 report, noting Employee's continuing complaints are unrelated to his November 29, 2007 employment, but are the result of his November 1, 2001 work injury. (*Id*. at 15, 19-20). He opined Employee's myofascial pain is likely permanent, but reasonable and appropriate palliative treatment would include physical therapy, exercise, chiropractic treatment, medications including Lidoderm patches and a TENS unit. (*Id*. at 21-25, 31-32). Based on the medical record and his examination, Dr. Craven believed Employee's pain complaints were valid, and he was not malingering. (*Id*. at 30-31). He opined Employee's November 29, 2007 employment did not cause his preexisting PPI rating to change, and that Employee was able to perform his job at the time of injury. (*Id*. at 21-22).

87. On October 11, 2011, Employee filed a claim for medical and transportation costs, permanent partial impairment, a reemployment benefits eligibility review, and "permanent partial impairment?," for injuries to his "whole body-external and internal," as a result of the November 1, 2001 injury where he reported a "wall of dirt fell on me burying me with dirt." (Claim, October 11, 2011). Employer answered the claim on November 1, 2011. The State has not asserted an affirmative defense under AS 23.30.105. (Answer, November 1, 2011; observation).
88. On December 22, 2011, Employee returned to Dr. Moore for follow up of shoulder pain, now reported as left greater than right, and weakness and difficulty with reaching or overhead lifting. Reviewing the January 2010 left shoulder MRI, Dr. Moore noted "AC arthritic changes as well as inflammation bursitis, and probable small partial thickness tearing of the rotator cuff. The right shoulder shows similar findings." His impression was progressive symptoms bilateral shoulders, left greater than right, with impingement/partial rotator cuff tearing. Dr. Moore noted conservative management, including prolonged therapy, strengthening exercises, anti-inflammatory medications and injections had been tried, and suggested consideration of an arthroscopy with subacromial decompression, acromioplasty, and possible rotator cuff repair. (Dr. Moore, December 22, 2011).

89. Employee reported a second work injury while employed at The Alaska Club on December 9, 2011. He reported injury to his back. He suffered no time loss from work. There has been no activity in that case. (AWCB database, AWCB Case No. 201119610).
90. On March 2, 2012, Employee was evaluated by psychiatrist S. David Glass for a psychiatric EME. Dr. Glass diagnosed "pain disorder associated with psychological factors," opining Employee's subjective pain complaints are not in keeping or explained by actual physical pathology, objective physical findings or known medical illness. He opined Employee's psychiatric disorder was caused by preexisting constitutional and developmental factors, along with ongoing psychosocial issues, and not by any work injury. (Dr. Glass EME Report, March 2, 2012).
91. On March 3, 2012, Employee was evaluated by neurologist Alan J. Goldman, M.D., and orthopedist John Ballard, M.D. Relevant diagnoses included: (1) Status post industrially related injury 01/11/01 (sic, 11/01/01) with probable musculo-ligamentous injury to the cervical, thoracic, and lumbar spines, of the sprain/strain variety; (2) Multiple episodes of other probable musculoskeletal injuries/events (5/30/02; ~ 12/07/02; 09/18/04; 07/07/05; 07/11/06; 11/28/07); (3) Subjective complaints of headaches, possibly muscle tension-type in nature; (4) Degenerative arthritis with tendonitis of the bilateral shoulders. (Goldman, Ballard EME Report, March 3, 2012 at 101). With the exception of degenerative disease of the bilateral shoulders, Drs. Goldman and Ballard believed Employee's diffuse body symptomatology was without anatomic or electrophysiologic basis. With the exception of his bilateral shoulders, they opined Employee was medically stable, and required no further treatment. Although asserting Employee's shoulder symptoms were unrelated to his employment for the State, they recommended physical therapy, further injections, a possible arthroscopy with debridement and/or other surgical repair if indicated on the arthroscopy. (*Id*. at 103).
92. Employee continued in his employ with The Alaska Club until September 17, 2012, when he was terminated for violating a previous written warning. (Notice of Termination, September 17, 2012). He later worked in the delicatessen department at Carrs Safeway, and as a delivery team-mate for General Parts Distribution, LLC. He currently works in the delicatessen department at Walmart. (Safeway letter August 28, 2013; Certification of Records, General Parts Distribution, LLC, July 17, 2013; Jones).

93. On March 23, 2013, Employee was again seen by SIME physician Dr. Craven. Dr. Craven described the scope of his evaluation: "I was asked to see this worker again to see if he would benefit for (sic) further medical treatment for his claim 200719434; date of injury November 29, 2007." Employee reported increased stress, anxiety, depression and difficulty sleeping. Employee reported having nightmares. Dr. Craven diagnosed: (1) Myofascial pain syndrome with chronic neck and back pain, caused by his back injury at work on November 1, 2001; (2) Degenerative disc disease of the lumbar spine; (3) Bilateral degenerative arthritis of both shoulders; (4) History of herniated lumbar disc at L4-L5, resolved per MRI January 7, 2005; (5) Thoracic vertebral fracture T7/T8; caused by work injury on December 9, 2011; and (6) Status post right ACL tear and surgical repair in 1989. Concerning causation, Dr. Craven offered the following opinions:
    (a) The November 29, 2007 injury was not the substantial cause of Employee's current complaints or need for medical treatment.
    (b) "The substantial cause ["100%"] for his disability or need for medical treatment for his myofascial pain syndrome is the work injury of November 1, 2001."
    (c) The November 29, 2007 employment injury did not aggravate, accelerate, or combine with Employee's pre-existing condition to temporarily or permanently change his pre-existing condition.
    (b) Employee's chronic tension headaches are "100%" caused by life stresses or anxiety.
    (c) The cause of his visual complaints is unknown.
    (d) The substantial cause for his disability or need for medical treatment for his right shoulder degenerative arthritis and bilateral rotator cuff tendonitis is "100%" his general activities of daily living and the aging process.

    (Dr. Craven, March 26, 2013 SIME Report at 12-13).

94. Dr. Craven further opined that the November 29, 2007 employment injury was not the substantial cause of the need for treatment, no specific treatment is indicated or recommended, and no further treatment is reasonable and necessary for the November 29, 2007 injury in order to help the employee recover, promote recovery from attacks caused by a chronic condition, limit or reduce his permanent impairment, or enable him to continue or return to work. (*Id.* at 13-14).

95. Dr. Craven concurred with Dr. Gevaert's May 14, 2003 15% PPI rating, and concluded Employee was medically stable on the date of the rating. He opined Employee had the physical capacity to perform as a Natural Resources Technician (Desk), but not as a Natural Resources Technician (Field), nor as a commercial janitor or cleaner. (*Id.* at 14-15).
96. Responding to written interrogatories propounded by Employee, Dr. Craven opined "it is possible" that "being buried alive" can "cause a person to suffer from nightmares/bad dreams and stress." When queried about a hypothetical injury: "impact from a wall of dirt" "weigh[ing] as much as a car," "causing whiplash, concussion, neck and back injuries," and "having the wind knocked out of your lungs, being crushed and losing ability to breathe for *x* amount of time, [and] caus[ing] the brain to lose oxygen," Dr. Craven noted "such an impact to the head and/or neck could cause injury to the nervous and visual systems." (*Id.* at 16).
97. Responding to written interrogatories propounded by Employer, Dr. Craven opined Employee's myofascial pain syndrome was caused by his work injury on November 1, 2001, none of his diagnoses were caused, aggravated or accelerated by Employee's employment with the State of Alaska after November 7, 2005, Employee's myofascial pain was medically stable as of May 14, 2003, and he does "not recommend any further treatment for the condition related to his employment with the State of Alaska."_ Finally, Dr. Craven attributed Employee's work restrictions, and his inability to perform as a Natural Resources Tech (Field), to the November 1, 2001 work injury. (*Id.* at 18-19).
98. In the 2007 work injury case, AWCB Case No. 200719434, Employee was represented by attorney William Erwin for a period of time between 2009 and 2011. Although Mr. Erwin represented Employee at the two depositions in this case, and during the entire SIME process, including deposing the SIME physician, Mr. Erwin has not filed an affidavit of attorney fees, requested approval of fees, or filed an attorney's lien for services rendered on Employee's behalf. (Record).
99. Attorney Robert Rehbock entered an appearance on Employee's behalf in all six of the joined cases referenced above on June 27, 2012. He withdrew his representation in all six cases on November 9, 2012. Also on June 27, 2012, Mr. Rehbock entered his appearance in AWCB Case No. 200910052, Employee's case against The Alaska Club for bilateral shoulder, low back and head injuries from the ladder collapse and his fall onto a weight machine and stack. Six weeks after Mr. Rehbock entered his appearance in that case, the parties signed a

Compromise & Release Agreement in which Employee waived his rights under the Act in return for $7,500.00. Under the C & R's terms, Mr. Rehbock received $5,000.00 in attorney fees. He did not file an Affidavit of Attorney Fees reflecting the services rendered in return for that fee award. (Entry of Appearance, June 27, 2012; Notice of Withdrawal, November 7, 2012; Compromise & Release Agreement, AWCB Case No. 200910052, August 15, 2012). When he withdrew his representation of Employee in the six joined cases against the State, he filed a Notice of Attorney Fee Lien and a Petition for Attorney Fees, seeking an additional $10,508.28. (Notice of Attorney Fee Lien; Petition for Attorney Fees). Neither his petition nor his notice of attorney lien was accompanied by an Affidavit of Attorney Fees. (Observation). Employer opposes any award of fees, contending the parties stipulated in writing Mr. Rehbock obtained no benefit for Employee in his claims against the State. Employee did so stipulate. (Response to Petition for Attorney Fees; Stipulation to Facts, December 10, 2012; observation).

100. Review of the original and electronic case files in the joined cases against the State reflects that between his June 27, 2012 Entry of Appearance and his November 9, 2012 Notice of Withdrawal in the joined cases, Mr. Rehbock performed no cognizable services on Employee's behalf. (Record; observation).

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 so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter;

(2) workers' compensation cases shall be decided on their merits except where otherwise provided by statute;

(3) this chapter may not be construed by the courts in favor of a party;

(4) hearings in workers' compensation cases shall be impartial and fair to all parties and that all parties shall be afforded due process and an opportunity to be heard and for their arguments and evidence to be fairly considered.

The board may base its decision not only on direct testimony, 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. [in effect prior to November 7, 2005]**
> Compensation is payable under this chapter in respect of disability or death of an employee.

For injuries occurring prior to November 7, 2005, to prove a claim for benefits under the Act, an employee must show the work injury was "a substantial factor" in bringing about the disability or need for medical care. *Ketchikan Gateway Borough v. Saling*, 604 P.2d 590, 595 (Alaska 1979). Employment is "a substantial factor" in bringing about the disability or need for medical care where "but for" the work injury, a claimant would not have suffered disability or required the prescribed care, at that time, in that manner, or to that degree, and reasonable people would regard work as a cause and attach responsibility to it. *Fairbanks North Star Borough v. Rogers & Babler,* 747 P.2d 528, 533 (Alaska 1987).

A finding reasonable persons would find employment was a cause of the employee's disability or need for medical care, 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.* at 534.

Legislative amendments constricted the Act's coverage provisions for work injuries occurring after November 7, 2005:

> **AS 23.30.010. Coverage. [Effective November 7, 2005]** (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the

> employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.
>
> (b) Compensation and benefits under this chapter are not payable for mental injury caused by mental stress, unless it is established that (1) the work stress was extraordinary and unusual in comparison to pressures and tensions experienced by individuals in a comparable work environment; and (2) work stress was the predominant cause of the mental injury. The amount of work stress shall be measured by actual events. A mental injury is not considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, termination, or similar action taken in good faith by the employer.[6]

For injuries occurring on or after November 7, 2005, to prove a claim for benefits under the Act, an employee must show, in relation to all possible causes, the work injury was "the substantial cause" of the disability or need for medical care. *Runstrom v. Alaska Native Medical Center,* AWCAC Decision No. 150 (March 25, 2011).

Work-related mental injuries have been divided into three groups for purposes of analysis: mental stimulus that causes a physical injury, or "mental-physical" cases; physical injury that causes a mental disorder, or "physical-mental cases" and mental stimulus that causes a mental disorder, or "mental-mental" cases. *Kelly v. State, Dept. or Corrections*, 218 P.3d 291, 298 (Alaska 2009). The presumption of compensability does not apply in "mental-mental" cases. AS 23.30.120(d). "Mental-mental" cases are subject to the further requisites and limitations established in AS 23.30.010(b).

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[6] Prior to November 7, 2005, similar limitations on stress-related claims were found in the definition of "injury" at AS 23.30.395(17). In 2005 the legislature removed the provisions related to mental stress from the definition of "injury," and moved it to a different statutory section. *Compare* Ch. 10, sec. 66, FSSLA 2005 *with* Ch. 10, sec 9, FSSLA 2005. *See Kelly v. State, Dept. of Corrections*, 218 P.3d 291, 297 at fn 11.

AS 23.30.041. Rehabilitation and reemployment of injured workers . . . .
. . .
(c) . . . If an employee suffers a compensable injury and, as a result of the injury, the employee is totally unable, for 45 consecutive days, to return to the employee's employment at the time of injury, the administrator shall notify the employee of the employee's rights under this section within 14 days after the 45th day. If the employee is totally unable to return to the employee's employment for 60 consecutive days as a result of the injury, the employee or employer may request an eligibility evaluation. The administrator may approve the request if the employee's injury may permanently preclude the employee's return to the employee's occupation at the time of the injury. 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. . . (effective November 7, 2005).

AS 23.30.045. Employer's liability for compensation.
(a) An employer is liable for and shall secure the payment to employees of the compensation payable under AS 23.30.041, 23.30.050, 23.30.095, 23.30.145, and 23.30.180 - 23.30.215 . . .

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. However, if the condition requiring the treatment, apparatus, or medicine is a latent one, the two-year period runs from the time the employee has knowledge of the nature of the employee's disability and its relationship to the employment and after disablement. 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 . . .

Under the Act, an employer must pay for medical treatment which "the nature of injury or process of recovery requires" within the first two years of the injury. AS 23.30.095(a). When the board reviews an injured worker's claim for medical treatment within two years of injury, its review is limited to whether the treatment sought is reasonable and necessary. *Phillip Weidner & Associates v. Hibdon*, 989 P.2d 727, 731 (Alaska 1999). But when the board examines a claim for continued treatment beyond two years from date of injury, it is "not limited to deciding if the treatment is reasonable and necessary." *Voorhees Concrete Cutting v. Kenneth Monzulla,*

AWCAC Decision No. 68, February 4, 2008, at fn. 45. Rather, the board has "discretion to authorize 'indicated' medical treatment 'as the process of recovery may require,'" (*Hibdon* at 731*),* and "latitude to choose among reasonable alternatives." *Monzulla* at fn. 45. The "process of recovery" language includes awards of medical benefits for purely palliative care where it is established such care promotes the employee's recovery from individual attacks caused by a chronic condition. *Municipality of Anchorage v. Carter*, 818 P.2d 661 (1991) at 665-666.

Effective November 7, 2005, AS 23.30.095 was amended, *inter alia*, to add subsection (o), which eliminated employer liability for palliative care after the date of medical stability unless the palliative care is reasonable and necessary (1) to enable the employee to continue in the employee's employment at the time of treatment, (2) to enable the employee to continue to participate in an approved reemployment plan, or (3) to relieve chronic debilitating pain.

Consistent with and for the purpose of effectuating AS 23.30.095(o), AS 23.30.395 was amended to add definitions for the terms "chronic debilitating pain" and "palliative care" found in subsection (o).[7]

> (9) "chronic debilitating pain" means pain that is of more than six months duration and that is of sufficient severity that it significantly restricts the employee's ability to perform the activities of daily living;
> . . .
>
> (28) "palliative care" means medical care or treatment rendered to reduce or moderate temporarily the intensity of pain caused by an otherwise stable medical condition, but does not include those medical services rendered to diagnose, heal, or permanently alleviate or eliminate a medical condition; . . .

Where a change in the law significantly alters the legal consequences of the events giving rise to the cause of action, the change is substantive and may only apply to events occurring after its effective date. *Pan Alaska Trucking v. Crouch*, 773, P.2d 946 (1989).

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[7] The definition of "medical or related benefits" did not change with the 2005 statutory changes to the Act. However, the 2005 revisions which added definitions to AS 23.30.395, necessitated renumbering all of the subsections to maintain alphabetization. The definition of "medical or related benefits," previously found at AS 23.30.395(20), was renumbered AS 23.30.395(26).

The 2005 amendments to AS 23.30.095 and AS 23.30.395, do not apply to injuries occurring prior to November 7, 2005. *Voorhees Concrete Cutting v. Kenneth Monzulla,* AWCAC Decision No. 68 (February 4, 2008) at fn. 44.

> **AS 23.30.100**. **Notice of injury or death**. (a) Notice of an injury or death in respect to which compensation is payable under this chapter shall be given within 30 days after the date of such injury or death to the board and to the employer.
>
> (b) The notice must be in writing, contain the name and address of the employee and a statement of the time, place, nature, and cause of the injury or death, and be signed by the employee or by a person on behalf of the employee, or in case of death, by a person claiming to be entitled to compensation for the death or by a person on behalf of that person.
>
> (c) Notice shall be given to the board by delivering it or sending it by mail addressed to the board's office, and to the employer by delivering it to the employer or by sending it by mail addressed to the employer at the employer's last known place of business. If the employer is a partnership, the notice may be given to a partner, or if a corporation, the notice may be given to an agent or officer upon whom legal process may be served or who is in charge of the business in the place where the injury occurred.
>
> (d) Failure to give notice does not bar a claim under this chapter
>
> (1) if the employer, an agent of the employer in charge of the business in the place where the injury occurred, or the carrier had knowledge of the injury or death and the board determines that the employer or carrier has not been prejudiced by failure to give notice;
> (2) if the board excuses the failure on the ground that for some satisfactory reason notice could not be given;
> (3) unless objection to the failure is raised before the board at the first hearing of a claim for compensation in respect to the injury or death.

In *Cogger v. Anchor House*, (936. P.2D 157, 160 (Alaska 1997), the Alaska Supreme Court held:

> An employee must provide formal written notice to his or her employer within thirty days of an injury in order to be eligible for workers' compensation under AS 23.30.100. For reasons of fairness and based on the general excuse in AS 23.30.100(d)(2), this court has read a "reasonableness" standard, analogous to the "discovery rule" for statutes of limitations, into the statute. *Alaska State House. Auth. v. Sullivan*, 518 P.2d 759, 761 (Alaska 1974). Under this standard, the thirty-day period begins when "by reasonable care and diligence it is discoverable and apparent that a compensable injury has been sustained." *Id.* at 761 (quoting 3 Arthur Larson, *Workmen's Compensation*, AS 78.41, at 60 (1971)). . . . Under *Sullivan*, the thirty-day period begins to run when the worker could reasonably discover an

> injury's compensability. 518 P.2d at 761. The exact date when an employee could reasonably discover compensability is often difficult to determine, and missing the short thirty-day limitation period bars a claim absolutely. For reasons of clarity and fairness, we hold that the thirty-day period can begin no earlier than when a compensable event first occurs. However, it is not necessary that a claimant fully diagnose his or her injury for the thirty-day period to begin. *Id.*

In *Tinker v. VECO, Inc.*, 913 P.2d 488 (Alaska 1996), the Court held that oral notice to a supervisory employee was sufficient because when a supervisor is provided notice there is sufficient information given to the employer for the employer to complete its necessary investigation. The court noted that under AS 23.30.070(e) an "agent of the employer in charge of the business in the place where the injury occurred" has a statutory obligation to provide notice of an injury.

> **AS 23.30.105. Time for filing of claims.** (a) The right to compensation for disability under this chapter is barred unless a claim for it is filed within two years after the employee has knowledge of the nature of the employee's disability and its relation to the employment and after disablement. However, the maximum time for filing the claim in any event other than arising out of an occupational disease shall be four years from the date of injury …
>
> (b) Failure to file a claim within the period prescribed in (a) of this section is not a bar to compensation unless objection to the failure is made at the first hearing of the claim in which all parties in interest are given reasonable notice and opportunity to be heard….

> **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;
>
> . . .
>
> (b) If delay in giving notice is excused by the board under AS 23.30.100(d)(2), the burden of proof of the validity of the claim shifts to the employee notwithstanding the provisions of (a) of this section.
>
> (c) The presumption of compensability established in (a) of this section does not apply to a mental injury resulting from work-related stress . . .

Under AS 23.30.120, an injured worker is afforded a presumption the benefits he or she seeks are compensable. 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). The presumption of compensability continues during the course of the claimant's recovery from the injury and disability. *Olson v. AIC/Martin J.V.*, 818 P.2d 669, 675 (Alaska 1991). 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.

Once the preliminary link is established, the employer has the burden to overcome the presumption by coming forward with substantial evidence to the contrary. *Miller v. ITT Arctic Services*, 577 P.2d 1044, 1046 (Alaska 1978). "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. Testimony from a qualified expert is usually sufficient 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). Evidence is

not weighed nor is credibility assessed at this step. *Veco, Inc. v. Wolfer*, 693 P.2d 865, 869-870 (Alaska 1985).

If the presumption is raised and not rebutted, the claimant prevails solely on the raised but un-rebutted presumption. *DeYonge v. NANA/Marriott*, 1 P.3d 90, 96-97 (Alaska 2000); *Williams v. State*, 938 P.2d 1065 (Alaska 1997). If an employer produces substantial evidence the injury or need for medical treatment is not work-related, the presumption drops out, and the employee must prove all elements of the case by a preponderance of the evidence. *Miller* at 1046. The employee must "induce a belief" in the minds of the fact finders that the facts asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

At the third step in the presumption analysis, the evidence is weighed, inferences are drawn from the evidence, and credibility is considered. For injuries occurring prior to November 7, 2005, to prove a claim for benefits under the Act an employee must show the work injury was "a substantial factor" in bringing about the disability or need for medical care. *Ketchikan Gateway Borough v. Saling*, 604 P.2d 590, 595 (Alaska 1979). Should the employee meet this burden, the compensation or benefits sought are payable. *Miller* at 1046.

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: "…[W]e conclude that the legislature intended to modify the second and third steps of the presumption analysis by amending AS 23.30.010 as it did." *Runstrom,* AWCAC Decision No. 150, at 3. The Commission held the second stage of the presumption analysis now requires the employer to

> "rebut 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).

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.

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

The board's finding of credibility is binding for any review of the board's factual findings. *Smith v. CSK Auto, Inc.,* 204 P.3d 1001, 1008 (Alaska 2009). The board has the sole power to determine witness credibility, and its findings about weight are conclusive even if the evidence is conflicting. AS 23.30.128; *See, e.g.*, *Harnish Group, Inc. v. Moore*, 160 P.3d 146, 153 (Alaska 2007); *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249, 1253 (Alaska 2007); *Municipality of Anchorage v. Devon*, 124 P.3d 424, 431 (Alaska 2005).

> **AS 23.30.145. Attorney fees.** (a) Fees for legal services rendered in respect to a claim are not valid unless approved by the board . . . When the board advises that a claim has been controverted, in whole or in part, the board may direct that the fees for legal services be paid by the employer or carrier in addition to compensation awarded; the fees may be allowed only on the amount of compensation controverted and awarded. . . . In determining the amount of fees the board shall take into consideration the nature, length, and complexity of the services performed, transportation charges, and the benefits resulting from the services to the compensation beneficiaries.
>
> (b) If an employer fails to file timely notice of controversy or fails to pay compensation or medical and related benefits within 15 days after it becomes due or otherwise resists the payment of compensation or medical and related benefits and if the claimant has employed an attorney in the successful prosecution of the claim, the board shall make an award to reimburse the claimant for the costs in the proceedings, including a reasonable attorney fee. The award is in addition to the compensation or medical and related benefits ordered.

> **AS 23.30.180. Permanent total disability**. In case of total disability adjudged to be permanent, 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the total disability. . . .

> **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.

"The concept of disability compensation rests on the premise that the primary consideration is not medical impairment as such, but rather loss of earning capacity related to that impairment. An award for compensation must be supported by a finding that the claimant suffered a compensable disability, or more precisely, a decrease in earning capacity due to a work-connected injury or illness." *Vetter v. Alaska Workmen's Compensation Board,* 524 P.2d 264, 266 (Alaska 1974). If a claimant, through voluntary conduct unconnected with his injury, takes himself out of the labor market, there is no compensable disability. *Id.*

> **AS 23.30.190. Compensation for permanent partial impairment; rating guides.** (a) In case of impairment partial in character but permanent in quality, and not resulting in permanent total disability, the compensation is $177,000 multiplied by the employee's percentage of permanent impairment of the whole person. The percentage of permanent impairment of the whole person is the percentage of impairment to the particular body part, system, or function converted to the percentage of impairment to the whole person as provided under (b) of this section. The compensation is payable in a single lump sum, except as otherwise provided in AS 23.30.041 but the compensation may not be discounted for any present value considerations.
>
> (b) All determinations of the existence and degree of permanent impairment shall be made strictly and solely under the whole person determination as set out in the American Medical Association Guides to the Evaluation of Permanent Impairment, except that an impairment rating may not be rounded to the next five percent. The board shall adopt a supplementary recognized schedule for injuries that cannot be rated by use of the American Medical Association Guides.
>
> (c) The impairment rating determined under (a) of this section shall be reduced by a permanent impairment that existed before the compensable injury. If the combination of a prior impairment rating and a rating under (a) of this section

would result in the employee being considered permanently totally disabled, the prior rating does not negate a finding of permanent total disability.

AS 23.30.395. Definitions. In this chapter

. . .

"medical and related benefits" includes but is not limited to physicians' fees, nurses' charges, hospital services, hospital supplies, medicine and prosthetic devices, physical rehabilitation, and treatment for the fitting and training for use of such devices as may reasonably be required which arises out of or is necessitated by an injury, and transportation charges to the nearest point where adequate medical facilities are available; . . .

8 AAC 45.050. Pleadings.

. . .

(f) **Stipulations**.

. . .

(2) Stipulations between the parties may be made at any time in writing before the close of the record, or may be made orally in the course of a hearing or a prehearing.

(3) Stipulations of fact or to procedures are binding upon the parties to the stipulation and have the effect of an order unless the board, for good cause, relieves a party from the terms of the stipulation. . . .

(4) The board will, in its discretion, base its findings upon the facts as they appear from the evidence, or cause further evidence or testimony to be taken, or order an investigation into the matter as prescribed by the Act, any stipulation to the contrary notwithstanding.

8 AAC 45.180. Costs and attorney's fees. . . .

(a) A fee under AS 23.30.145 will only be awarded to an attorney licensed to practice law in this state or another state. An attorney seeking a fee from an employer for services performed on behalf of an applicant must apply to the board for approval of the fee; the attorney may submit an application for adjustment of claim or a petition. An attorney requesting a fee in excess of the statutory minimum in AS 23.30.145(a) must (1) file an affidavit itemizing the hours expended, as well as the extent and character of the work performed, and (2) if a hearing is scheduled, file the affidavit at least three working days before the hearing on the claim for which the services were rendered; at the hearing, the attorney may supplement the affidavit by testifying about the hours expended and the extent and character of the work performed after the affidavit was filed. If the request and affidavit are not in accordance with this subsection, the board will deny the request for a fee in excess of the statutory minimum fee, and will award the minimum statutory fee.

ANALYSIS

1. Was the November 1, 2001 work injury a substantial factor in Employee's need for continuing medical care for myofascial pain?

This is a factual question to which the presumption of compensability applies. Employee raises the presumption he is entitled to medical benefits and associated costs for treatment for his myofascial pain from his testimony he has had persisting pain requiring continuing care since the 2001 injury. The presumption is further supported by Dr. Gevaert's diagnosis of cervical and thoracic myofascial pain, his opinion Employee would experience marked exacerbation of his pain if he continued as a field technician, and conservative measures including prescribed anti-inflammatory and muscle relaxant medications, and cervical and thoracic myofascial massage provide appropriate symptomatic relief.

Once the presumption is raised, Employer must rebut the presumption the 2001 work injury with Employer is a substantial factor in Employee's need for medical treatment for myofascial pain. Employer has rebutted the presumption the November 1, 2001 work injury is a substantial factor in Employee's need for medical treatment for myofascial pain through the opinions of Drs. Radecki and Glass, who opined Employee's pain is of psychogenic origin, with no objective basis.

Once Employer rebuts the presumption of compensability, Employee must prove his claim by a preponderance of the evidence. Employee has proven by a preponderance of evidence the 2001 work injury is a substantial factor in his continuing need for medical care for myofascial cervical, thoracic and lumbar pain. He has further proven by a preponderance of evidence that conservative care is reasonable and medically acceptable for symptomatic relief from his pain, including such modalities as physical therapy, massage therapy, chiropractic care, injections, non-opioid medications, Lidoderm patches and a TENS unit and supplies.

Treating physicians Dr. Culbert, Dr. Gevaert and Dr. Prieto diagnosed EE's continuing pain complaints as myofascial pain, cervical, thoracic and lumbar in origin. (Findings of Fact 16, 21, 31). EME physician Dr. Allison also opined Employee's chronic pain was myofascial pain, the origin of which preceded the 2006 injury for which he examined Employee. (Finding of Fact 79). EME Drs. Ballard and Goldman not only diagnosed musculo-ligamentous injury to the

cervical, thoracic, and lumbar spines, but attributed it to the original November 1, 2001 work injury, noting multiple similar events in succeeding years while employed with Employer. (Finding of Fact 91). EME physicians Dr. Neumann and Dr. Borman disagreed with EME Drs. Radecki and Glass' opinions Employee's complaints of spinal pain were psychogenic, finding Employee had a legitimate source for his pain complaints in his cervical, thoracic and lumbar spine. (Findings of Fact 36, 48).

Dr. Gevaert opined appropriate symptomatic care included cervical, thoracic and lumbar myofascial massage, physical therapy, chiropractic care, anti-inflammatory and muscle relaxant medication and the anticonvulsant Neurontin for pain, a sleep aid, and Lidoderm patches. (Findings of Fact 13, 16, 19, 21, 22, 26). Dr. Prieto opined appropriate care included physical therapy, massage and injections. (Finding of Fact 31). Dr. Roderer endorsed massage, injection, physical therapy, the anticonvulsant Neurontin prescribed off label for pain, Lidoderm patches, and a TENS unit for Employee's chronic pain. (Findings of Fact 28-29, 30, 32, 38, 42, 45, 50, 53, 63). Dr. Borman concurred, opining epidural spinal injection, a TENs unit and medication were reasonable and medically acceptable options for the injuries Employee sustained prior to the 2006 injury for which he examined Employee. (Finding of Fact 48).

Perhaps the most persuasive opinion on diagnosis and causation are those repeatedly stated by Dr. Craven in his two SIME reports and his deposition. Dr. Craven has consistently opined Employee continues to suffer cervical, thoracic and lumbar myofascial pain as a result of the November 1, 2001 work injury, stating in his first SIME report:

- "None of his complaints or symptoms is related to the 11/29/07 employment injury. They are related to the 11/1/01 employment injury;"
- "He has a preexisting history of chronic neck and back pain that was entirely the result of the 11/1/01 employment injury. Since that injury, he has had these chronic complaints or symptoms." (Finding of Fact 83).

In his March 15, 2011 deposition testimony, Dr. Craven elaborated on his diagnosis of chronic myofascial cervical, thoracic and lumbar pain. Dr. Craven described myofascial pain as pain related to the muscles, ligaments and soft tissue of the neck and back area, common after trauma

to the neck and back. He noted myofascial pain is objectively diagnosable through physical exam findings, such as stiffness and decreased movement of the back and pain with movement, and x-ray findings, and by its ability, if legitimate, to be accurately reproduced. Dr. Craven opined Employee demonstrated these objective findings of myofascial cervical, thoracic and lumbar pain. While conceding an individual's emotional issues, such as depression and anxiety, can contribute to myofascial pain, and although aware from the medical records Employee had symptoms of depression, Dr. Craven did not find Employee's emotional makeup was a significant factor in his myofascial pain. Rather, he found Employee's pain complaints valid, and opined he was not malingering. (Finding of Fact 86). In his March 26, 2013 SIME report, Dr. Craven again repeated his opinion Employee's chronic cervical, thoracic and lumbar pain complaints are primarily myofascial in nature. (Finding of Fact 93).

Dr. Craven's diagnosis of myofascial or musculoligamentous pain is consistent with that of Drs. Gevaert, Prieto, Allison, Ballard and Goldman. His opinion Employee exhibited objective and reproducible evidence of legitimate pain, and is not suffering a somatoform disorder or simply malingering, conforms also with the opinion of EME Dr. Neumann, who openly disagreed with his EME panel member Dr. Radecki on the subject. In both of his reports and in his deposition testimony, Dr. Craven was unwavering in his opinion Employee's chronic myofascial cervical, thoracic and lumbar pain was caused *entirely* by the November 1, 2001 work injury (Findings of Fact 83, 86, 93, 97).

Dr. Craven's opinion, stated clearly and with specificity in his deposition testimony, is his most persuasive on appropriate treatment for what he opined was a permanent condition: Employee's chronic myofascial neck and back pain. Acknowledging Employee was not likely to recover from the pain given its persistence and longevity, Dr. Craven opined physical therapy, chiropractic, exercise and medication "can help it and maybe it would help it – resolve it." (Craven deposition at 23). He opined the medication and Lidoderm patches Employee was being prescribed were "appropriate" treatment modalities. (*Id.* at 24). When asked was there treatment for the 2001 injury Employee should be receiving Dr. Craven responded "palliative type treatment . . . would . . . be beneficial, such as medication, use of the TENs unit, maybe a periodic – if he has some worsening that he needs some short-term physical therapy or chiropractic, yes. . . That would be what I would consider more palliative to help him be more

functional and help his pain." (*Id.* at 25). "Palliative" care . . . to help his pain and function . . . would seem reasonable." (*Id.* at 31-32).

No weight is accorded answers to questions about further treatment posed to Dr. Craven in interrogatories in 2013, which are internally inconsistent, conflate the application of the pre- and post-2005 Act amendments, and inexplicably contradict Dr. Craven's unambiguous deposition testimony. For example, although reiterating that "the substantial cause for [Employee's] disability or need for medical treatment for his myofascial pain syndrome is the work injury of November 1, 2001," Dr. Craven opined Employee has been medically stable since May 14, 2003, and is capable of performing his duties as a Natural Resources Technician (Desk). (SIME report, March 26, 2013, *compare* page 12, paragraph 4 *with* page 14, paragraph 10 *and* page 15, paragraph 15). Since Dr. Craven opines Employee is medically stable and capable of performing his last job with Employer, by definition, Dr. Craven is stating Employee is not disabled. *Vetter*. Thus, although Dr. Craven's response was written in the disjunctive as the question was posed, correcting it for consistency his response must be:: "the substantial cause for his ~~disability or~~ need for medical treatment for his myofascial pain syndrome is the work injury of November 1, 2001."[8] This statement is consistent with his deposition testimony.

However, in answers to later questions, Dr. Craven goes on to say: "no specific treatment is indicated or recommended," and "he does not need palliative care" to either "promote recovery," "reduce . . . permanent impairment," "relieve chronic debilitating pain," or "enable [Employee] to return to or continue working." (*Compare* SIME Report, March 26, 2013 at 12 *with* page 13, paragraphs 7-9). The confusion appears to have arisen from Dr. Craven's continuing belief the questions asked pertained to treatment, if any, necessitated by the 2007 work injury. In his introductory remarks Dr. Craven outlined the framework of his directive: "I was asked to see this worker again to see he (sic) would benefit for (sic) further medical treatment for his claim 200719434; date of injury November 29, 2007." (*Id.* at 2). If viewed in this context, Dr. Craven's responses in this report: that Employee required no palliative care, is consistent with

[8] Moreover, since Employee's injury was in 2001, the lesser standard, whether the injury was "a substantial factor" in Employee's need for medical treatment applies, yet Dr. Craven finds the old work injury "the substantial cause" of his need for care.

his identical response with respect to the 2007 injury in his first SIME Report, and similar to that in his deposition testimony: that Employee required no further care for any injury in 2007.

If Dr. Craven's statement Employee requires no palliative care is applied to the 2001 injury, however, it is, without explanation, diametrically opposite the opinions stated and elaborated upon at length in his deposition testimony. This confusion appears to have arisen out of the limitations inherent in written questions, particularly, as here, where the author's and the SIME physician's focus was a post-Act amendment injury in 2007, but the relevant causative injury occurred in 2001, prior to the November 7, 2005 amendments effective date.

The 2013 SIME questions sought answers concerning care for Employee's 2007 injury. In doing so it supplied an incorrect legal standard for the 2001 injury: "the substantial cause" as opposed to the lesser "a substantial cause," and posed questions reflecting restrictions on the availability of palliative care which do not apply to pre-amendment injuries. For these reasons, Dr. Craven's deposition testimony is more reliable, more complete and more persuasive than his March 26, 2013 report. No weight will be given to his answers to the confusing and conflated questions concerning further treatment found in his later report. The November 1, 2001 work injury was a substantial factor in Employee's need for continuing conservative medical care for his cervical, thoracic and lumbar myofascial pain, and his claim against Employer for medical and related benefits for his myofasical pain complaints will be granted.

2. Was the November 1, 2001 work injury a substantial factor in Employee's need for medical care for his bilateral shoulder complaints?

This is a factual question to which the presumption of compensability applies. Employee raises the presumption he is entitled to medical benefits and associated costs for treatment of his bilateral shoulder complaints from his testimony he injured his shoulders when the trench wall collapsed on him from behind, he has had persisting shoulder complaints since November 1, 2001, and requires continuing care. The presumption is further supported by Dr. Gardner's opinion Employee's bilateral shoulder symptoms, specifically bilateral acromioclavicular joint osteoarthritis and right rotator cuff tendinopathy, pre-existed his 2009 injury at The Alaska Club.

Once the presumption is raised, Employer must rebut the presumption the 2001 work injury with Employer is a substantial factor in Employee's need for medical treatment with substantial evidence. Employer's evidence is viewed in isolation and without a determination of credibility. Employer has rebutted the presumption the November 1, 2001 work injury is a substantial factor in Employee's need for medical treatment for his bilateral shoulder complaints through the opinions of Drs. Goldman and Ballard, who opined Employee's shoulder complaints are the result of degenerative arthritis with tendonitis of the shoulders, and are not work-related. The presumption is further rebutted by Dr. Craven's concurring opinion Employee's bilateral degenerative arthritis and rotator cuff tendonitis were caused entirely by the use of his shoulders in activities of daily living and the normal aging process.

Once Employer rebuts the presumption of compensability, Employee must prove his claim by a preponderance of the evidence. Employee is unable to meet this burden. Although Employee's 2001 report of injury identifies his injured body parts as "back and shoulders," his complaints to his treating providers following the work injury were of back and neck pain exclusively. Not once in 94 chiropractic sessions with Dr. Culbert over the course of 17 months, did Employee complain of, nor did Dr. Culbert treat or diagnose any shoulder injury. Nor were shoulder complaints related to the 2001 work injury reported to, or diagnosed or treated by Dr. Gevaert during the course of care he provided to Employee from January 3, 2003 through June 15, 2005. One brief mention of shoulder pain is found in Dr. Gevaert's records from September 30, 2004, which Employee related to a September 8, 2004 shoulder strain work injury (AWCB Case No 200420434). Employee's brief mention of "shoulder" pain in a few of Dr. Gevaert's later records were in fact complaints of interscapular pain, or pain between the shoulder blades which Dr. Gevaert attributed to myofascial thoracic pain, unrelated to Employee's shoulder joints. During Dr. Radecki's evaluation in 2005, Employee reported no pain with range of motion of the shoulders themselves, no pain with reaching to the right or left, and his shoulder joints were problem free.

Employee's complaints of right shoulder *joint* pain do not appear in the medical records until July 13, 2009, following Employee's July 8, 2009 fall onto a weight machine and weight stack, when a ladder collapsed while he was employed at The Alaska Club. On July 13, 2009 he told Dr. Culbert he injured his right shoulder and head when he fell, hitting his right shoulder and

head against a weight machine, and grabbing a support on the weight machine with his right upper extremity as he fell. Dr. Culbert diagnosed right rotator cuff tear, secondary to July 9, 2009 work injury, and ultimately referred Employee for an MRI, which reflected right shoulder pathology, including a rotator cuff tear. Employee never complained about pain in his *left* shoulder joint until his complaint to Dr. Moore on January 14, 2010.

Evaluation of the medical evidence shows it more likely than not the substantial cause of Employee's right degenerative arthritis and rotator cuff tendinopathy was the 2009 injury at The Alaska Club, when Employee fell from the ladder onto a weight machine, striking his right shoulder and grabbing for support with his right arm. The evidence shows it more likely than not the substantial cause of his left shoulder degenerative arthritis is his activities of daily living and the normal aging process. The November 1, 2001 work injury was not a substantial factor in Employee's need for medical care for his bilateral shoulders, and his claim against Employer for medical and related benefits for his bilateral shoulder complaints will be denied.

3. ***Was the November 1, 2001 work injury a substantial factor in Employee's need for medical care for anxiety or post-traumatic stress disorder?***

Employee alleges that as a result of the injuries he sustained in the trench collapse on November 1, 2001, he developed anxiety and post-traumatic stress disorder (PTSD). Under the Act, work-related mental injuries fall into three categories for purposes of analysis: mental stimulus that causes a physical injury, known as "mental-physical" cases; physical injury that causes a mental disorder, or "physical-mental cases;" and mental stimulus that causes a mental disorder, or "mental-mental" cases.

Employee contends he was hit from behind by falling dirt when the wall of the trench in which he was standing collapsed. He asserts he was hit in the back and shoulders, thrown forward against the opposing wall, was ultimately buried alive, and had to be dug out by coworkers and normal breathing restored. Employee's is a "physical-mental" claim to which the presumption of compensability applies. At the first stage of the presumption, Employee must present some, minimal relevant evidence that as a result of the November 1, 2001 work injury, he developed anxiety and post-traumatic stress disorder. Credibility is not assessed at this stage of the

analysis. Employee has raised the presumption he suffers anxiety and post-traumatic stress disorder as a result of the November 1, 2001 trench collapse, by his contention he was buried alive in the trench when the wall collapsed. The presumption is supported by ANP Barrett's behavioral health evaluations where she described Employee as anxious and fidgety. It is further supported by Dr. Craven's opinion, in response to Employee interrogatories, that it is possible being buried alive can cause a person to suffer from nightmares and stress.

Once the presumption is raised, Employer must rebut the presumption the work injury is a substantial factor in Employee's need for medical treatment with substantial evidence. Employer's evidence is viewed in isolation and without a determination of credibility. Employer has rebutted the presumption through the reporting of psychiatrist Dr. Glass, who performed a psychiatric evaluation, and attributed all of Employee's complaints to a diagnosis of Pain Disorder Associated with Psychological Factors. He described the diagnosis as a psychiatric disorder caused by preexisting constitutional and developmental factors along with ongoing psychosocial issues. It is a non-deliberate, subconscious way of dealing with problems in living, intrapersonal conflicts or bothersome emotional feelings, and include receiving some benefits, psychological and tangible, engendered by the invalid role. Dr. Glass opined Employee's mental disorder was not caused or worsened by any work injury with the State.

Once Employer rebuts the presumption of compensability, Employee must prove his claim by a preponderance of the evidence. Employee is unable to meet this burden. In the more than twelve years since Employee was injured in the trench collapse, he has never been diagnosed with PTSD by any medical provider. The term does not appear in a single medical report, despite a voluminous medical record involving countless visits with treating chiropractors, physical therapists, physiatrists, orthopedists, pain specialists, a psychiatric nurse practitioner, optometrists and ophthalmologists, and in ten thorough evaluations of the records and physical examinations conducted by medical evaluators for Employer and for the Board. Employee's reporting to Dr. Craven in December, 2010, that he "occasionally has bad dreams or nightmares related to being buried alive as happened in the work injury of 11/1/01," is belied by the totality of the medical records, which demonstrate Employee not once complained of nightmares to any of innumerable providers, not even to psychiatric ANP Barrett, to whom he was referred for a behavioral evaluation by his treating physician, Dr. Roderer, in January 2006.

ANP Barrett's January 20, 2006 and October 22, 2007 behavioral health assessments, years after the November 1, 2001 injury, are the very first medical records where Employee is noted as appearing "anxious," although he denied he was anxious or depressed and stated he was "optimistic." Evaluation of the record as a whole shows it more likely than not the substantial cause of Employee's anxiety, stress and possible depression were psychosocial issues leading up to Dr. Roderer's referral to Barrett in January, 2006. These included the stress from Employee's caring for his brother during his debility from a brain injury and aneurysm and his brother's death; Employee's own unfounded fear of similarly developing a brain aneurysm; the long-term spousal abuse Employee reported suffering at the hands of his partner during his 24-year relationship and marriage; and the family acrimony leading to divorce during this period.

Dr. Craven's response to the hypothetical question being buried alive can cause a person to suffer from nightmares and stress is of no utility. The contemporaneous reporting of the November 1, 2001 trench collapse, that Employee was buried in soils up to mid-calf or knee level, is considered more reliable than his later reporting the dirt fall at increasingly greater depths, culminating in his eventual assertion he was buried alive and his breathing compromised. The November 1, 2001 work injury was not a substantial factor in Employee's need for medical care for PTSD or anxiety, and his claim against Employer for medical and related benefits for PTSD and anxiety will be denied.

4. Is Employee permanently and totally disabled as a result of the November 1, 2001 work injury?

This is a factual question to which the presumption of compensability applies. At the first stage of the presumption, Employee must present some, minimal relevant evidence that because of his work injuries he is unable to perform services other than those which are so limited in quality, dependability or quantity that a reasonably stable market for them does not exist. Employee has failed to raise the presumption he is permanently and totally disabled as a result of the November 1, 2001 work injury or any work injury. Following the November 1, 2001 work injury, Employee continued his seasonal employment with Employer as a Natural Resources Technician (Field) through mid-2007, and then through November, 2007 as a full-time Natural Resources Technician (Desk). In January, 2007, he was hired to a full-time position with The Alaska Club,

first as a front desk clerk, and then on the janitorial staff. He continued his employment with The Alaska Club until he was terminated on September 17, 2012. The record reflects employment with Carrs Safeway, and with General Parts Distribution, LLC following The Alaska Club. He is currently employed in the deli department at Walmart.

Had Employee raised the presumption, however, it would be rebutted by the opinions of every one of his treating physicians, every EME physician, and every SIME physician, all of whom opined Employee is physically capable of performing the sedentary duties of Natural Resources Technician (Desk), and indeed, any job that did not require lifting greater than 20 pounds, or crawling on all fours. With the exception of Dr. Keene, whose theories fall outside the mainstream of recognized medical practice and whose treatment Employee abandoned as useless, all of the optometrists and ophthalmologists opined Employee simply needed appropriately prescribed spectacles for his office work. Employee has not met his burden of proof he is permanently and totally disabled, and his claim for PTD benefits will be denied.

5. Is Employee entitled to PPI benefits as a result of the November 1, 2001 work injury?

This is a factual question to which the presumption of compensability applies. At the first stage of the presumption, Employee must present some, minimal relevant evidence that as a result of the November 1, 2001 work injury, he sustained permanent impairment. He has failed to raise the presumption he sustained permanent impairment as a result of the 2001 work injury. Following the injury, Employee sought treatment with Dr. Culbert, who treated him regularly from November 5, 2001 through April 8, 2002, at which time he released him from care, to unrestricted return to work, with no permanent impairment.

Following and as a result of Employee's May 30, 2002 work injury causing a herniated disk, Dr. Gevaert rated Employee with a 15% whole person permanent impairment, with no apportionment for any previous injury. The herniated disk was eventually reabsorbed.

Had Employee raised the presumption, however, it would have been rebutted by the opinions of Drs. Radecki and Neumann, Borman, Allison, Goldman and Ballard, all of whom opined that when each examined Employee over the years, on November 12, 2005, April 21, 2007, April 29, 2010, and March 3, 2012 respectively, he had no impairment greater than the 15% rated by Dr.

Gevaert on May 14, 2003, following the 2002 work injury. Indeed, all believed the 15% rating was overly generous both at the time it was given and at the time of each physician's subsequent examination. Dr. Craven, whose diagnosis was primarily myofascial cervical, thoracic and lumbar myofascial pain, concurred with Dr. Gevaert's 15% PPI rating, but opined Employee's impairment when he examined him on March 26, 2013 was no greater than the 15% already rated and awarded. Employee has not met his burden of proof he sustained permanent impairment from the November 1, 2001 work injury, and his claim will be denied.

6. Is Employee entitled to a reemployment benefits evaluation as a result of the November 1, 2001 work injury?

On November 1, 2001, absent unusual and extenuating circumstance, an employee suffering a compensable injury which might permanently preclude his return to his occupation at the time of injury, was required to request a reemployment benefits eligibility evaluation within 90 days after giving his employer notice of injury. Employee did not request an eligibility evaluation until he filed his claim on October 11, 2011, almost ten years later. Employee has cited no unusual and extenuating circumstance to excuse his late request, and his request for an eligibility evaluation for the November 1, 2001 injury must be denied.

Although Employee cites no unusual and extenuating circumstance which might extend the period for seeking a reemployment benefits eligibility evaluation, and none is discerned, assuming such a circumstance was found to excuse the late request, Employee would still not be entitled to an eligibility evaluation. Employee sought care from Dr. Culbert within days of the work injury, and continued receiving chiropractic care from him until April 8, 2002, when Dr. Culbert released Employee to work without restriction and without permanent impairment. Because Employee's was a seasonal position, and his injury occurred at the end of the season, he lost no compensable time from work. Following Employee's 2002 work injury, Employee was found ineligible for reemployment benefits based on Dr. Gevaert's opinion he could return to his employment at the time of injury. Employee then returned to his work as a Natural Resources Technician, and continued in that seasonal employment until the 2007 season. During that time he was accommodated with a lateral transfer from a Natural Resources Technician (Field), the heavier job, to a Natural Resources Technician (Desk), a sedentary job and in fact to a full-time

rather than seasonal position. He remained in that position for several months until he resigned in November, 2007. Every physician who has examined Employee, treating physicians, Employer's evaluators, and the SIME physician concurred Employee is physically capable of performing as a Natural Resources Technician (Desk). Dr. Keene notwithstanding, every persuasive optometrist and ophthalmologist has reached the same conclusion. Dr. Roderer specifically refused to provide Employee's request for a work release from his desk job, stating Employee's decision to leave his employment was his own, and Dr. Roderer did not believe it supportable. After quitting his job with Employer, Employee continued working at The Alaska Club until September 2012, then for Carrs Safeway, General Parts Distribution LLC, and currently for Walmart. Employee's request for a reemployment benefits eligibility evaluation will be denied.

7. Was employment for the State either in 2001 as a Natural Resources Technician (Field), or in 2007 as a Natural Resources Technician (Desk), a substantial factor, or the substantial cause respectively, of Employee's need for medical treatment for his vision and associated headache and neck complaints in 2007?

This is a factual question to which the presumption of compensability applies.[9] Employee raises the presumption he is entitled to medical benefits for his vision and associated headache and neck complaints through his own testimony his vision and associated complaints began with his computer use when he was transferred to a desk job in 2007. He has raised the presumption he is entitled to medical benefits for his vision and associated headache and neck complaints through the medical opinion of optometrist Dr. Jeff Keene, who diagnosed Post-Traumatic Vision Syndrome and attributed the Employee's vision and associated headache and neck complaints to "his neck, back and head injury 6 years ago." (Dr. Keene, December 20, 2007).

Once the presumption is raised, Employer, through substantial evidence, must rebut the presumption the work injury is a substantial factor or the substantial cause of Employee's need

[9] Employer's early allegation Employee failed to timely file a Report of Injury with respect to his vision and associated complaints, thus either barring his claim under AS 23.30.100(d) or relinquishing the presumption of compensability under AS 23.30.120(b), appears to have been abandoned. In any event, while Employee did not file a formal Report of Injury, he reported his injury in his November 29, 2007 resignation letter, soon after his apparent attribution of his symptoms to his work station. Oral notice to a supervisory employee is sufficient notice to the employer to begin its necessary investigation. *Tinker v. Veco, Inc.*, 913 P.2d 488 (Alaska 1996).

for medical treatment for his vision and associated headache and neck complaints. Employer's evidence is viewed in isolation and without assessing credibility. Through the opinions of treating optometrist Dr. Fleckstein, EME ophthalmologist Dr. Bensinger and SIME ophthalmologist Dr. Alenick, Employer has rebutted the presumption the November 1, 2001 work injury is a substantial factor, and has rebutted the presumption the 2007 employment was the substantial cause for medical treatment for Employee's vision and associated headaches and neck complaints,

Once Employer rebuts the presumption of compensability, Employee must prove his claim by a preponderance of the evidence. It is at this stage that the evidence is weighed and credibility assessed. Employee is unable to meet this burden. Dr. Keene stands alone in his opinion Employee's vision, neck and headache symptoms represent Post-Trauma Vision Syndrome, and are connected to Employee's Natural Resources (Desk) position. The weight of medical opinion, from Employee's treating optometrist, and the EME and SIME ophthalmologists, is that Employee simply needed prescriptions glasses, specifically bifocals with high segments to allow both close up and computer work.

Moreover, Drs. Bensinger and Alenick were persuasive in their assessment that Post-Trauma Vision Syndrome is a construct by optometrists who perform vision therapy, there are no formal medically accepted studies demonstrating its existence, it is not recognized among medical doctors, and no CPT codes exist for it. Indeed, Employee ultimately admitted the "vision therapy" provided him no benefit and he abandoned it.

Finally, according to both Dr. Keene's notes and his December 20, 2007 letter, his opinions were premised on the mistaken belief Employee suffered a head injury and was "buried alive" in 2001, when in fact the dirt level in the trench likely reached no further than Employee's knees, and his reported injury was to his back and shoulders, not his head or neck. Employee's work for Employer as a Natural Resources Technician (Field) in 2001 was not a substantial factor in his need for medical treatment for vision and associated complaints in 2007. Employee's work as a Natural Resources Technician (Desk) in 2007 was not the substantial cause of any need for medical treatment for his vision and associated complaints in 2007. He needed prescription bifocal glasses with high segments to work at both close and computer range as the job required,

yet failed to obtain them, choosing instead to quit his job. Employee's claim for medical benefits for his 2007 vision and associated complaints will be denied.

8. Is Employee entitled to temporary total disability benefits as a result of his vision and associated headache and neck complaints from November 29, 2007 and continuing?

The law provides for payment of temporary total disability benefits arising from a compensable injury. AS 23.30.010; AS 23.30.190. Employee's report of vision and associated headache and neck complaints has been found non-compensable. "Disability" means incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment. AS 23.30.395(16). With the exception of Dr. Keene, whose theories fall outside the mainstream of acceptable medical opinion, and whose opinions are based on inaccurate factual information, all of the substantial body of medical opinion concluded Employee was physically capable of performing his Natural Resources Technician (Desk) job at the time he complained of vision and associated symptoms. Indeed, his treating physician, Dr. Roderer, when asked to support his claim for disability refused stating: "I cannot give the patient a letter of support for his work absences. He has told me that he believes it is in his best interest to discontinue this particular job. This is the patient's choice." Where a claim voluntarily removes himself from the labor market, there is no compensable disability. Moreover, at the time Employee quit his Natural Resources position in 2007, he continued working at his janitorial position at The Alaska Club until he was terminated in September 2012. He thereafter worked at a few other jobs, and is currently employed in the deli department at Walmart. Employee did not suffer a compensable injury in 2007, nor has he proven he is been unable to earn comparable wages since leaving his state employment in 2007. Employee's claim for TTD benefits from November, 2007, will be denied.

9. Is Employee entitled to an award of attorney fees and costs?

Employee seeks an award of attorney fees and costs for representation by counsel in the 2007 work injury case. An award of attorney fees will be made where an employer resists payment of compensation and the employee hires an attorney who obtains a benefit for the employee. An Affidavit of Attorney Fees itemizing the hours expended, as well as the extent and character of

the work performed, must be filed for any request for or award of fees above the statutory minimum.

In the 2007 work injury case, AWCB Case No. 200719434, Employee was represented by attorney William Erwin between 2009 and 2011. Mr. Erwin has not filed an affidavit of attorney fees, requested approval of fees or filed an attorney's lien for services rendered on Employee's behalf. No award of fees will be made for Mr. Erwin.

Attorney Robert Rehbock entered an appearance on Employee's behalf in all six of the joined cases involving Employer, including the 2007 case, on June 27, 2012. He withdrew his representation in all six cases on November 9, 2012. Although Mr. Rehbock filed an Attorney Lien for $10,508.28, and later a petition for attorney fees, he never filed an Affidavit of Attorney Fees reflecting the extent and character of the services performed to support his request for fees. On December 10, 2012, after Mr. Rehbock's withdrawal, Employee and Employer signed a stipulation stating Mr. Rehbock obtained no benefit for Employee on his claims. The parties' stipulation is supported by the original and electronic case files in the joined cases, which reflect that between his June 27, 2012 Entry of Appearance and his November 9, 2012 Notice of Withdrawal, Mr. Rehbock performed no cognizable services on Employee's behalf in these cases. While he performed services for Employee in his claim against The Alaska Club for his bilateral shoulder injuries in 2009, Mr. Rehbock received $7,500.00 in the August 2012 C & R for un-itemized services rendered during the same time frame. No additional award of attorney fees will be made for Mr. Rehbock.

CONCLUSIONS OF LAW

1. The November 1, 2001 work injury was a substantial factor in Employee's need for continuing medical care for myofascial pain. Conservative medical care indicated to relieve individual attacks of Employee's chronic condition if recommended by his treating physician include physical therapy, massage therapy, epidural steroid injections for the spine, not the shoulders, Lidoderm patches, non-opioid medications including muscle relaxant, anti-inflammatory and anticonvulsant medication prescribed for pain, and TENS unit and pads.
2. The November 1, 2001 work injury was not a substantial factor in Employee's need for medical care for his bilateral shoulder complaints.
3. The November 1, 2001 work injury was not a substantial factor in Employee's need for medical care for anxiety or post-traumatic stress disorder.
4. Employee is not permanently and totally disabled as a result of the November 1, 2001 work injury.
5. Employee is not entitled to PPI benefits beyond the 15% rating he received in AWCB Case No. 200211270.
6. Employee is not entitled to reemployment benefits as a result of the November 1, 2001 work injury.
7. Employee's 2001 employment was not a substantial factor, and his 2007 employment was not the substantial cause of any need for medical treatment for vision and associated headache and neck complaints beginning in 2007.
8. Employee is not entitled to medical and transportation expenses for vision and associated headache and neck complaints.
9. Employee is not entitled to temporary total disability benefits for vision and associated headache and neck complaints from November 27, 2007 and continuing.
10. Employee is not entitled to an award of attorney fees and costs.

ORDER

1. Employee's October 11, 2011 claim for medical and transportation expenses for chronic myofascial pain is GRANTED.

2. Employee's October 11, 2011 claim for medical and transportation expenses for bilateral shoulder complaints is denied.

3. Employee's October 11, 2011 claim for medical and transportation expenses for anxiety and PTSD is denied.

4. Employee's October 11, 2011 claim for permanent total disability benefits, additional PPI benefits, and reemployment benefits is denied.

5. Employee's June 24, 2009 claim for benefits for vision, headache and neck complaints is denied.

6. Employee's June 24, 2009 claim for attorney fees is denied.

Dated in Anchorage, Alaska on March 27, 2014.

ALASKA WORKERS' COMPENSATION BOARD

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Linda M. Cerro, Designated Chair

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Rick Traini, Member

If compensation is payable under terms of this decision, it is due on the date of issue. A penalty of 25 percent will accrue if not paid within 14 days of the due date, unless an interlocutory order staying payment is obtained in the Alaska Workers' Compensation Appeals Commission.

If compensation awarded is not paid within 30 days of this decision, the person to whom the awarded compensation is payable may, within one year after the default of payment, request from the board a supplementary order declaring the amount of the default.

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 DOUGLAS C. JONES, employee / claimant; v. STATE OF ALASKA, employer; ALASKA, STATE OF, insurer / defendants; Case Nos. 200719434M, 200122670, 200211270, 200420434, 200510652, 200611455; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on March 27, 2014.

Kimberly Weaver, Office Assistant