ALASKA WORKERS' COMPENSATION BOARD

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

SARAH BERGEN, Employee, Claimant, v. PROVIDENCE ALASKA MEDICAL CENTER, Employer, and PROVIDENCE HEALTH SYSTEM WASHINGTON, Insurer, and AFOGNAK NATIVE CORPORATION, Employer, and ZURICH AMERICAN CORPORATION, Insurer, Defendants.	FINAL DECISION AND ORDER AWCB Case Nos. 201002658M; 201002657; 200519957 AWCB Decision No. 14-0094 Filed with AWCB Anchorage, Alaska on July 3, 2014

Sarah Bergen's (Employee) September 23, 2010, and two February 7, 2011 claims were heard on the written record in Anchorage, Alaska, on June 12, 2014, a date selected on February 3, 2014. Employee represented herself. Attorney Shelby Davison represented Providence Alaska Medical Center and Providence Health System Washington (Providence). Attorney Robert Bredesen

represented Afognak Native Corporation and Zurich American Insurance Company (Afognak). On June 9, 2011, the parties resolved all indemnity and vocational rehabilitation benefits through a compromise and release agreement. Employee now seeks an award of medical benefits. The record closed on June 12, 2014.

ISSUES

Employee contends she is entitled to an order awarding medical benefits beginning in January 2010, for injuries to her neck and upper extremities while employed by Afognak in June, 2005. Afognak contends Employee's need for medical treatment is the non-work-related natural progression of her pre-existing degenerative spine condition, and no further medical benefits are due.

1) **Was Employee's work for Afognak a substantial factor in her continuing need for medical treatment for her neck and upper extremity symptoms?**

Employee contends she is entitled to an order awarding medical benefits for injuries to her lumbar and thoracic spine and right hip while employed by Providence in January, 2010. She further contends work stress aggravated her pre-existing cervical spine and upper extremity symptoms requiring medical treatment, and contributing to her need for psychiatric care. She contends her need for medical and psychiatric treatment is continuing.

Providence contends Employee's need for medical treatment is the non-work-related natural progression of her preexisting degenerative spine. It further contends any stress Employee may have experienced at work was not unusual or extraordinary, and a pre-existing mental disorder, not her employment, is the substantial cause of her need for psychiatric care.

2) **Was Employee's work for Providence the substantial cause of her continuing need for medical treatment for her back, hip, neck, headache and upper extremities?**

3) **Was stress Employee perceived while working for Providence the substantial cause of her need for psychiatric care?**

FINDINGS OF FACT

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

1) While employed by Afognak in June, 2005, Employee reported neck pain, and upper extremity pain, numbness and tingling, citing long hours using a handset telephone and computer as the cause. (Report of Injury, AWCB Case No. 200519957).

2) Employee filed further reports of injury while employed by Providence in January and March, 2010. The first was for injury to her back, right leg and "shook up whole back/body," from a January 18, 2010 fall when an exercise ball she was using as a desk chair burst. (Report of Injury, AWCB Case No. 201002657). The second, filed March 8, 2010, was for neck pain and mental stress, reportedly from working long hours at a desk, using a computer and telephone. (Report of Injury, AWCB Case No. 201002658). She added injury to her upper extremities to this claim at a February 7, 2011 prehearing conference. (Prehearing Conference Summary, February 7, 2011).

3) Medical records prior to the 2005 injury reveal a longstanding history of complaints of and treatment for cervical, thoracic and lumbar pain, upper extremity paresthesia, headaches, bilateral shoulder pain, including rotator cuff tear, depression and anxiety. (Medical records June, 1991 to June, 2005, SIME binder 001-199).

4) Medical records preceding Employee's November 24, 2008 hire by Providence, and her January and March 2010 reports of injury, reflect complaints of and treatment for similar symptoms, as well as for more serious psychiatric illness. (Medical records, SIME binder 200-948). A small representative sampling of Employee's innumerable physician visits for similar complaints for these body parts, both before and after the June, 2005, January 18, 2010 and March 8, 2010 reported injuries, are memorialized here.[1]

5) On June 5, 1991, William Tewson, D.C., treated Employee for thoracic and lumbar spine pain. (Chart Note, Dr. Tewson, Tewson Chiropractic Clinic, June 5, 1991).

6) On July 22, 1991, Dr. Tewson treated Employee for cervical spine pain and diagnosed acute traumatic subluxation strain and sprain of the cervicothoracic spine. (Chart Note, Dr. Tewson, July 22, 1991).

[1] The SIME physician's medical records review, which covers only the period March, 2005 through February, 2012, is 86 pages in length, single-spaced. (Observation).

7) On April 24, 1992, Bruce Kiessling, M.D., treated Employee for right shoulder blade pain. Employee stated she pulled a muscle under the right shoulder blade, it was numb and tingly at times, with pain going up into her neck. She acknowledged she had similar problems with her right shoulder the previous summer. (Chart Note, Dr. Kiessling, Primary Care Associates, April 24, 1992).

8) On October 23, 1992, Dr. Kiessling treated Employee for a flare up in her right rhomboid and paravertebral area of the upper thorax, and recommended physical therapy. (Chart Note, October 23, 1992).

9) In June, 1993, Employee was seen for a wrist injury by orthopedic hand surgeon Robert Lipke, M.D. Flexor carpi radialis tenosynovitis was diagnosed and a wrist splint and anti-inflammatory medication prescribed. (Chart note, Dr. Lipke, June 21, 1993).

10) On October 26, 1994, Mark Barbee, D.C., treated Employee for low back pain following a work injury while employed at Fred Meyer. She treated with Dr. Barbee through February 23, 1995, then transferred to Deborah Kloby, D.C. (Physician Reports, Mark Barbee, D.C., October 26, 1994 through February 23, 1995).

11) She treated with Dr. Kloby for low back pain until May 25, 1995; then transferred to John Shannon, D.C., (Physician Reports, Dr. Kloby, February 23, 1995 through May 25, 1995).

12) On August 17, 1995, Dr. Shannon noted based on Employee's thermography, Employee "has an ongoing musculoskeletal irritation and possible L5 autonomic nerve irritation, which cannot be expected to change." (Physician Report, Dr. Shannon, September 18, 1995).

13) On September 25, 1995, Edward Voke, M.D., examined Employee for an employer's medical evaluation (EME) and diagnosed chronic lumbar facet syndrome. He opined Employee was medically stable and assessed a five percent whole person permanent partial impairment (PPI). (EME Report, Dr. Voke, September 25, 1995).

14) On May 29, 1996, Dr. Shannon discharged Employee from care, indicating no treatment had been required for exacerbations in 45 days. (Physician Report, Dr. Shannon, May 29, 1996).

15) On August 13, 2001, Employee reported having broken a wine glass and cut her right ring finger. Right ring finger laceration with ulnar digital nerve injury and partial laceration of the flexor tendon were assessed. In an August 15, 2001 follow-up with Leslie Dean, M.D., Employee chose not to have the injury repaired, stating she could live with the numbness in the ulnar aspect of her right ring finger. Dr. Dean noted Employee was taking the anti-depressant

Serzone. (Emergency Room note, August 13, 2001; Chart notes, Leslie Dean, M.D., August 13, 15, 2001).

16) On January 29, 2002, Employee treated at United Physical Therapy (PT) for right shoulder pain, severe neck and low back pain, and occasional headaches. Employee reported numbness into both hands and occasional tingling of both hands. (Referral from Ernest Meinhardt, M.D., January 24, 2002; Chart Note, United PT, January 29, 2002).

17) In a June 28, 2002 patient history Employee completed for Medical Park Family Care (Medical Park) after falling and injuring her left wrist, Employee acknowledged she was still taking Serzone, and was also taking Anexsia for headaches. (Patient History, Medical Park Family Care, June 28, 2002).

18) On September 13, 2002, Employee reported numbness and tingling in her hands, daily headaches and neck pain. Dr. Meinhardt's notes reflect "Answering phone without HS" (headset). (Intake notes, Dr. Meinhardt, September 13, 2002).

19) On September 18, 2002, Employee reported daily headaches and increasing neck pain. (Chart Note, United PT, September 18, 2002).

20) On September 18, 2002, Employee treated at United PT for right upper extremity numbness and tingling, daily headaches, and increasing neck pain. (Chart Note, United Physical Therapy, September 18, 2002).

21) On October 11, 2002, cervical spine magnetic resonance imaging (MRI) showed minimal annular bulges but otherwise unremarkable cervical spine. (Radiologist Report, George Ladyman, M.D., October 11, 2002).

22) By December, 2002, Employee's anti-depressant had been changed to Celexa. (Chart Note, Medical Park Family Care, December 14, 2002).

23) In early 2003, Employee was receiving prescriptions for Anexsia, Flexeril, Celexa and Xanax from providers at Medical Park. (Chart Notes, January 13, 2003, January 31, 2003, February 6, 2003, February 27, 2003, March 21, March 24, 2003).

24) On March 9, 2003, Employee presented at the Providence Alaska Medical Center (PAMC) Emergency Room for migraine headache, reporting the Anexsia did not help. She was given intramuscular Demerol and Toradol to resolve the headache. (ER Note, PAMC, March 9, 2003).

25) On April 14, 2003, Employee treated at United PT for flare-up of neck pain with radiation into both upper extremities and increasing headaches. Employee reported she was unable to lie

on her right side due to onset of immediate numbness of her arms. (Chart Note, United PT, April 14, 2003).

26) On June 21, 2003, Timothy Coalwell, M.D., one of many providers Employee saw over the years at Medical Park, treated Employee for right shoulder pain following a four-wheeler accident, in which she landed on her right shoulder and hit her head. Vioxx and Lorcet Plus, a hydrocodone derivative, were prescribed for pain. (Chart Note, Dr. Coalwell, June 21, 2003).

27) On August 15, 2003, Employee reported having posterior headaches originating from her neck for the last four months. The anti-depressant Lexapro, and the sleep aid Ambien were prescribed. (Chart note, Dr. Meinhardt, August 15, 2003).

28) On October 4, 2003, Glenn Schultes, M.D., treated Employee for acute chronic neck pain, left shoulder dyesthesias, and headaches. He diagnosed acute chronic neck pain, and referred Employee to physical therapy. (Chart Note, Dr. Schultes, Medical Park Family Care, October 4, 2003).

29) On October 14, 2003, Shawn Johnston, M.D., treated Employee for chronic headaches, neck and upper back pain. He diagnosed cervicogenic headaches and chronic cervical pain. Dr. Johnston prescribed Ultram and Zanaflex. (Chart Note, Dr. Johnston, Rehabilitation Medicine Associates, October 14, 2003).

30) On June 25, 2004, Dr. Coalwell treated Employee for chronic back pain, increasing headaches, and increased depression. He refilled Employee's Xanax prescription and added Trazadone as a sleep aid and antidepressant. (Chart Note, Dr. Coalwell, Medical Park Family Care, June 25, 2004).

31) On July 9, 2004, Dr. Coalwell treated Employee for elbow, right hip, and knee pain after Employee fell off her bicycle. (Chart Note, Dr. Coalwell, July 9, 2004).

32) On November 17, 2004, Employee sought care from Charles Aarons, M.D., asking for pain medicine or a muscle relaxant for her neck. Dr. Aarons noted, "She has had previous complaints of this sort." (Chart note, November 17, 2004, Dr. Aarons).

33) On March 19, 2005, Employee saw Darren B. Lewis, M.D. for headaches, shoulder pain, anxiety, insomnia due to anxiety and chronic back pain. Dr. Lewis noted Employee was on narcotics for muscle aches and pains, had been on Lexapro and Celexa for depression, had tried Ambien and Sonata for insomnia, but neither was effective, and was requesting Xanax or Valium. Dr. Lewis prescribed Zoloft, Xanax at bedtime, and Vicodin for severe pain only.

Employee complained of ongoing insomnia and situational stress on the job. He counselled Employee Valium and narcotics were not the manner in which to relieve stress, discussed the addictive nature of Xanax and other narcotics, and recommended exercise and meditation. Dr. Lewis' assessment was anxiety disorder, insomnia and chronic back pain. (Chart note, Dr. Lewis, Medical Park Family Care, March 19, 2005).

34) On March 21, 2005, Employee was hired by Afognak as a Risk Management Analyst. (Report of Occupational Injury or Illness, June 2, 2005).

35) On May 10, 2005, Dr. Coalwell treated Employee for chronic right shoulder pain and headache. Employee attributed her shoulder pain to playing baseball. (Chart Note, Dr. Coalwell, May 10, 2005).

36) On June 1, 2005, Employee reported neck and shoulder pain, and arm and hand numbness and tingling she associated with talking on the phone with a handset. AWCB Case No. 200519957 was assigned. (Report of Injury, June 2, 2005).

37) On June 2, 2005, Employee sought care from Mark Bilan, D.C., reporting "ongoing – off & on irritation last couple of months" and "neck/shoulder pain w/ numbness & pins needles in arm, hands" and from "repetitive movement" and "talking on phone with handset." (Patient Information, Bilan Chiropractic Clinic, June 2, 2005).

38) On Dr. Bilan's patient information sheet Employee noted she had previously treated for the same complaints with Dr. Coalwell, her treatment had been "ongoing-years," her neck and shoulder pain were "long term" and "acts up often," and listed her private insurance with Blue Cross. Dr. Bilan began treating Employee multiple times per week, and billing Afognak's workers' compensation carrier. On his Physician Report Form 07-6102, Dr. Bilan stated the condition for which he was treating Employee was work-related cervicobrachial syndrome, cervicalgia and headache arising over "the past couple months." (Physician Report, Dr. Bilan, June 4, 2005, June 14, 2005, July 7, 2005, July 21, 2005, November 10, 2005, etc.).

39) On June 15, 2005, Dr. Bilan opined Employee's work activities were a substantial factor in her need for treatment for her bilateral upper extremity injury. (Response to inquiry from Amber Lawton, Adjuster, Ward North America, Inc., June 15, 2005).

40) In an August 2, 2005 visit to Medical Park, Employee reported a migraine headache for several days, and she was under a lot of stress. Migraine was assessed. Relpax and Norco were

prescribed for pain, Xanax for stress. (Chart note, Richard R. Taylor, Jr., M.D., Medical Park Family Care, August 2, 2005).

41) On September 9, 2005, a cervical spine MRI showed no significant foraminal stenosis, nerve root compromise or central canal stenosis. (Radiologist Report, James W. McGee, M.D., September 9, 2005).

42) On October 3, 2005, at Dr. Bilan's request, Edward Barrington, D.C., examined Employee for bilateral arm and hand numbness and tension headaches, and performed electro diagnostic testing. Employee described the gradual onset of symptoms "possibly from using her computer at work." She described a past history of "occasional neck soreness." Dr. Barrington noted Employee used her left hand for the mouse, and talked on the phone holding it between her left shoulder and her ear. He diagnosed mild carpal tunnel syndrome (CTS) and bilateral cervical nerve root irritation. He noted the testing "points toward bilateral ulnar nerve entrapment at the elbows" and "symptoms of thoracic outlet syndrome" which "may be partly due to workplace ergonomics." He opined Employee's condition may tend to improve after a workplace ergonomic assessment. He recommended conservative care. (Chart Note, Dr. Barrington, Chiropractic Neurology of Alaska, October 3, 2005).

43) On November 1, 2005, Larry Levine, M.D., diagnosed ongoing cervical spine pain with radiation into the arms and numbness in a fairly classic ulnar distribution, with the electro diagnostic study showing ulnar neuropathy of bilateral elbows and some slight cervical root level irritation. Dr. Levine recommended an ergonomic workplace assessment, and use of elbow sleeves at work and while sleeping to protect the ulnar nerve. Dr. Levine did not diagnose thoracic outlet syndrome (TOS), nor attribute Employee's symptoms to her employment. (Chart Note, Dr. Levine, Alaska Spine Institute, November 1, 2005).

44) On November 15, 2005, Holm Neumann, M.D., examined Employee for an employer medical evaluation (EME) and diagnosed tardy ulnar nerve palsy,[2] unrelated to the June 1, 2005 work injury; chronic cervical strain, pre-existing the claimed work injury; early degenerative disc disease, multilevel, cervical spine, pre-existing the work injury; and temporary aggravation of the underlying degenerative cervical spine from the June 1, 2005 work injury. He opined Employee was medically stable at the time of examination, and her need for medical care resulting from the work-related

[2] Tardy ulnar nerve palsy is another term for ulnar nerve entrapment or ulnar neuropathy. *http://www.hopkins medicine.org/neurology_neurosurgery/centers_clinics/peripheral_nerve_surgery/conditions/ulnar_nerve_ entrapment. html.* (June 18, 2014).

temporary aggravation of her cervical spine would have resolved within three to four months post-injury. Dr. Neumann opined Employee's then-current need for treatment was her underlying degenerative cervical spine disease and the June 1, 2005 work injury was no longer a substantial factor in any need for medical treatment. (EME Report, Dr. Neumann, November 15, 2005).

45) On November 25, 2005, based on Dr. Neumann's report, Employer controverted all further benefits. (Controversion Notice, dated November 21, 2005).

46) Employee did not lose time from work for this reported injury. (Record).

47) Employee continued treating with Dr. Bilan through April 24, 2006. (Chart notes, Dr. Bilan, through April 24, 2006).

48) By August, 2006, Employee had left her employ with Afognak, and was working as a marketing assistant at Willis of Alaska, Inc. (Bergen deposition at 22-23; August 30, 2008 email from Employee, identified as "Marketing Assistant," Willis of Alaska, Inc.).

49) On August 12, 2006, Employee returned to Medical Park for refills of her Cymbalta for depression and Norco for stress headaches. (Chart note, Julie L. Prigge, M.D.).

50) On November 17, 2006, Employee returned to Medical Park complaining of neck pain and daily headaches. Dr. Coalwell diagnosed headache and neck pain with degenerative disc disease. (Chart Note, Dr. Coalwell, November 17, 2006).

51) On January 31, 2007, Employee treated with United PT for neck pain located mainly on the right side with radiation into the top of the shoulder, increasing left neck pain radiating up in the back of the head occasionally resulting in headaches, jaw pain, and occasional numbness and tingling of hands. (Chart Note, United PT, January 31, 2007).

52) On March 26, 2007, Dr. Coalwell refilled Employee's Xanax and Lortab prescriptions. (Chart Note, Dr. Coalwell, March 26, 2007).

53) On March 28, 2007, a thoracic spine MRI was normal. (Radiologist Report, Mark Davis, M.D., March 28, 2007).

54) In April, 2007, unrelated to employment, Employee cut into the volar aspect of her right ring and small fingers while cleaning a new knife. Employee reported having previously suffered a nerve injury in her right ring finger in 2001. Loren Jensen, M.D., performed flexor digitorum sublimis and flexor digitorum profundus repair to Employee's fourth and fifth fingers on the right. (Leslie Dean, M.D., Referral Consultation, July 26, 2007).

55) On July 30, 2007, Dr. Coalwell treated Employee for pain between her shoulder blades. (Chart Note, Dr. Coalwell, July 30, 2007).

56) On August 2, 2007, Employee had a decompression osteotomy to correct hallux limitus with degenerative joint disease of the first metatarsophalangeal joint on her right foot. (Operative Report, Matt Heilala, DPM).

57) On October 24, 2007, on referral from Medical Park, Employee saw Gregory Polston, M.D., of Advanced Medical Centers of Alaska (Advanced Medical). Employee reported she had always had neck pain, worse on the right than left, mostly posterior. Dr. Polston treated Employee for neck pain; diagnosed cervicogenic facet arthropathy, myofascial pain, status post tendon laceration, status post bunionectomy, and deconditioning, and recommended physical therapy. He listed Employee's current medications as Xanax, Cymbalta, Hydrocodone, Trazodone, Baclofen, and Acyclovir. Dr. Polston did not attribute Employee's symptoms to her employment. (Chart Note, Dr. Polston, Advanced Medical Centers of Alaska, October 24, 2007).

58) On November 1, 2007, psychiatric ANP Catherine Barrett, at Advanced Medical, evaluated Employee and diagnosed major depression and provisional dysthymia.[3] (Chart Note, Catherine Barrett, ANP, November 1, 2007).

59) On November 29, 2007, Dr. Polston diagnosed Employee with cervical spondylosis and cervicogenic headaches. (Chart Note, Dr. Polston, November 29, 2007).

60) On January 8, 2008, Deborah Kiley, ANP, of Advanced Medical, treated Employee for cervical pain and refilled Employee's prescriptions for hydrocodone and Zanaflex. (Chart Note, ANP Kiley, Advanced Medical Centers of Alaska, January 8, 2008).

61) On March 3, 2008, Employee treated at Advanced Physical Therapy for neck, lumbar spine and bilateral shoulder complaints. (Chart Note, Advanced Physical Therapy, March 3, 2008).

62) On March 5, 2008, ANP Kiley saw Employee for bilateral shoulder and neck/thoracic spine pain. (Chart Note, ANP Kiley, March 5, 2008).

63) On May 21, 2008, ANP Kiley treated Employee for continued cervical/neck pain radiating into bilateral arms and upper back. ANP Kiley did not attribute Employee's complaints to any

[3] Dysthymia is a chronic type of depression in which a person's moods are regularly low. *http://www.nlm.nih.gov/ medlineplus /ency/article/000918.htm* (June 23, 2014).

employment. ANP Kiley refilled Employee's medications of Flector, Zanaflex and Hydrocodone-Acetaminophen. (Chart Note, ANP Kiley, May 21, 2008).

64) On August 15, 2008, at Employee's request, ANP Kiley referred Employee to another provider for psychiatric assessment. (Chart Note, Deborah Kiley, August 15, 2008).

65) On August 22, 2008, David Wilcox, Ph.D., evaluated Employee and diagnosed major depression, bipolar II disorder with hypomanic episode, and suicide episode. Employee reported having recently stabbed herself with a small knife. (Chart Note, Dr. Wilcox, August 22, 2008).

66) On September 6, 2008, T. Noah Laufer, M.D., at Medical Park, treated Employee for migraine and prescribed Compazine. He reported Employee has a long history of migraine, probably triggered by longstanding cervical degenerative neck disease. Dr. Laufer did not attribute Employee's complaints to employment. (Chart Note, Dr. Laufer, September 6, 2008).

67) On September 10, 2008, Dr. Levine treated Employee for neck and shoulder pain, and diagnosed chronic cervical, shoulder, and thoracic spine pain with negative MRI findings, compound medical issues including self-reported depression, previous knee and hand surgeries, and positive EMG findings with bilateral ulnar neuropathy. He listed her current medications as Effexor, Baclofen, Hydrocodone, Zanaflex, Zanaflex XR, and Flector patches. Employee reported her neck, shoulder, and between her shoulder blades had been giving her pain since 2004. Cervical injections helped some but provided no lasting solution. Employee stated her pain and headaches are daily and constant. Dr. Levine did not attribute Employee's complaints to any employment. (Chart Note, Dr. Levine, September 10, 2008).

68) On November 12, 2008, Grant Roderer, M.D., treated Employee for neck pain and headache and performed a left sided C5-C6 and C6-C7 cervical facet joint injection. He opined Employee's symptoms are consistent with an upper cervical facet joint arthropathy. He prescribed Kadian (morphine) and continued use of Flector patches and Zanaflex. Dr. Roderer did not attribute Employee's complaints to any employment. (Chart Note, Dr. Roderer, November 12, 2008).

69) On November 24, 2008, Employee was hired by Providence as a senior accountant. (Report of Occupational Injury, March 25, 2010).

70) Within weeks of Employee's hire, an ergonomic assessment was done of her work area. (Bergen, deposition at 89).

71) Soon after her hire, management began expressing performance concerns relating to Employee's interpersonal relations and communication style. (Providence Memo to Employee from Katherine Wray, October 19, 2009).

72) On January 12, 2009, Dr. Coalwell treated Employee for irritated neck and headaches and diagnosed neck pain, obesity, and migraines. He did not attribute her complaints to her employment. (Chart Note, Dr. Coalwell, Medical Park Family Care, January 12, 2009).

73) On February 25, 2009, ANP Kiley treated Employee for neck, mid-back, and low back pain and headache; diagnosed cervical spondylosis and degenerative disc disease, and prescribed continued use of Zanaflex, Hydrocodone-Acetaminophen, and MS Contin. Employee stated, "Everything increases pain, nothing provides relief." ANP Kiley did not attribute Employee's complaints to her employment. (Chart Note, ANP Kiley, February 25, 2009).

74) On March 3, 2009, another ergonomic assessment of Employee's work area was completed and most recommendations implemented. (Ergonomic Evaluation, March 3, 2009; Bergen deposition, 88-92).

75) On April 22, 2009, ANP Kiley treated Employee for neck and back pain and headache, diagnosed cervical spondylosis, and prescribed continued use of Zanaflex, Hydrocodone-Acetaminophen, and MS Contin. (Chart Note, ANP Kiley, April 22, 2009).

76) On June 17, 2009, Dr. Roderer treated Employee for cervical spine pain, increased Employee's Zanaflex dosage, and recommended Employee continue her current prescription regimen consisting of Hydrocodone and occasional use of MS Contin. Again, he made no attribution of Employee's complaints to her employment. (Chart Note, Dr. Roderer, June 17, 2009).

77) On August 28 and 31, 2009, Employee was seen on referral by psychiatrist Deborah Geeseman, M.D. Current medications included Baclofen (prescribed for neck and back pain), Effexor EX, Zanaflex and hydrocodone (prescribed for neck pain); Imitrex and Relpax for migraine headaches; and Flector patch and Voltaren gel (prescribed for back pain). Past psychiatric medications included Wellbutrin, Celexa, Lexapro, Cymbalta, Paxil, Ambien, Zoloft, Xanax and Trazodone. (Intake Information, Dr. Geeseman, August 28, 31, 2009).

78) On September 28, 2009, Employee was seen at Providence Family Medical Center for neck pain. She was diagnosed with chronic neck pain, depression and anxiety, history of decreased thyroid stimulating hormone (TSH), and migraine headache. Employee's prescription regime

included Acyclovir, Baclofen, Effexor, Hydrocodone-Acetaminophen, Ondansetron hcl, Pristiq, Relpax, Sumatriptan, Wellbutrin, Xanax, and Zanaflex. She was referred for physical therapy for her neck. No attribution of Employee's complaints to her employment appears in the chart note. (Chart Note, Julia Sicillia, MD, September 28, 2009; PT referral, September 28, 2009).

79) On September 29, 2009, Employee returned to Dr. Roderer for follow-up for cervical spine pain. Dr. Roderer again assessed cervical facet joint arthropathy. He maintained Employee on her current pain medication regimen consisting of MS Contin, hydrocodone and Baclofen. Dr. Roderer noted Employee's last cervical facet joint injection was in February, 2009. Dr. Roderer did not attribute Employee's need for care to her employment. (Progress Note, Dr. Roderer, September 29, 2009).

80) On October 2, 2009, Employee attended her eighth individual therapy session with psychologist Dr. Wilcox. Among the topics addressed was a discussion Employee had with Dr. Geeseman concerning bipolar disorder. At her next weekly session with Dr. Wilcox Employee complained of depressed mood, and stressors related to work, finances, medical and legal issues. She reported Dr. Geeseman had recently changed her medications. (Progress Notes, David Wilcox, Ph.D., October 2, 9, 2009).

81) In an October 19, 2009 memorandum following "another incident" at work the previous week, Providence wrote Employee a performance memo concerning her tardiness and communication style, characterizing it as angry, aggressive, negative and impatient with others, and the detrimental impact of her behavior on her coworkers. The memo referred to previous conversations with her on these topics in February, April and August, 2009. "While we understand there are personal circumstances impacting your performance in this area, the behaviors expressed last week are unacceptable." Employee's supervisors stated a belief Employee could improve, but cautioned further disciplinary action up to or including termination could follow. (Performance Management Concerns Memo, October 19, 2009).

82) On November 5, 2009, Employee signed a detailed Performance Management Plan to address her tardiness and her angry, negative, impatient and aggressive communication style. (Performance Management Plan, November 5, 2009).

83) At a December 4, 2009 appointment with Dr. Wilcox, Dr. Wilcox diagnosed Employee with bipolar disorder II. He noted Employee expressed interest in going on social security disability, feeling she won't make it at work; had lost friends over the past ten years; admitted she was

angry, aggressive and impatient; displayed bad body language; and had a bad attitude at work. (Progress Notes, David Wilcox, Ph. D., December 4, 2009).

84) On December 7, 2009, Employee was placed on 'Second Conference' in Providence's Performance Management Process. (Memo, March 15, 2010).

85) On January 9, 2010, Michael Hansen, PA-C, at Independence Park Medical Center, noted Employee reported mid-back pain, body aches, and a past medical history of neck and back pain. PA-C Hansen did not attribute Employee's reported symptoms to her employment. (Chart note, Michael Hansen, PA-C, January 9, 2010).

86) On January 13, 2010, Nicolette Thude, ANP, noted Employee had "a strong past history of neck and back pain with headaches" and was seeing a psychiatrist with a diagnosis of possible bipolar disorder. She did not attribute Employee's neck pain, back pain or headaches to her employment. (Chart Note, ANP Thude, January 13, 2010).

87) On January 14, 2010, James Bertelson, M.D., referred Employee to physical therapy for mid-back pain. Dr. Bertelson did not attribute Employee's complaints of mid-back pain to her employment. (Chart Note, Dr. Bertelson, January 14, 2010).

88) On January 18, 2010, Employee reported injuring her low back, right leg, and "fall shook up whole back/body" when she fell to the floor when the exercise ball she was using as a desk chair popped. (Claim, February 6, 2011).

89) On January 19, 2010, Employee was seen for back pain by Katherine Ingle, ANP, at Providence's Alaska Employee Health & Wellness Clinic. Employee reported the fall at work the previous day caused her chronic back pain to flare up. Employee did not report injuring her neck or her hip in the fall. ANP Ingle wrote: "The fall yesterday flared up her back pain. She already has an order for PT for her mid back and right hip but she would also like PT to evaluate her lower back." Employee was referred for physical therapy. ANP Ingle assessed "Back Pain, Chronic." (Chart note, Alaska Employee Health & Wellness, January 19, 2010).

90) On January 19, 2010, Employee also sought care from Edward J. Barrington, D.C., for "back and neck pain." There is no indication Employee mentioned the fall at work to Dr. Barrington. Responding to the inquiry "Other doctors seen for this" Employee wrote "Adv Pain." (Chart Note, Dr. Barrington, January 19, 2010).

91) On February 11, 2010, Employee underwent a physical therapy evaluation at Providence Sports Medicine & Rehabilitation Therapy. She noted the purpose of her evaluation was for

"back pain." She reported originally injuring her low back at age 23, with pain continuing thereafter, waxing and waning in intensity, a longstanding history of neck pain, which has gotten worse and was extending into the mid-back between her shoulder blades, and a history of mid back pain for about six months. On the intake questionnaire Employee noted she was currently receiving treatment for neck pain. She made no mention of hip pain. Twice weekly physical therapy sessions for four weeks were recommended. (Initial Evaluation, Providence Sports Medicine & Rehabilitation Therapy, Rina Luban, PT, February 11, 2010).

92) On February 17, 2010, Dr. Roderer treated Employee for cervical spine pain and noted Employee had received lower cervical facet joint injections previously at C6-C7 with good reduction in pain. Dr. Roderer did not attribute Employee's neck complaints to her employment. (Chart Note, Dr. Roderer, February 17, 2010).

93) On March 2, 2010, the physical therapist (PT) noted thoracic spine pain as the primary diagnosis for physical therapy intervention. In none of the numerous PT sessions following the initial PT intake did Employee mention or did PT Luban treat for hip pain. (Progress/Treatment note, Rina Luban, PT, Providence Sports Medicine & Rehabilitation Therapy, March 2, 2010, and continuing.).

94) Employee continued treating with Dr. Wilcox, attending her 17th individual therapy session with him on March 5, 2010. Employee reported she was working 50 hours per week at work, was frustrated and stressed. (Progress Note, Dr. Wilcox, March 5, 2010).

95) Employee continued treating with Dr. Geeseman for psychiatric medication management. (Progress Note, March 8, 2010).

96) On March 8, 2010, Employee reported neck pain due to use of the telephone *headset*, tension headaches and mental stress. (Report of Injury, March 25, 2010).

97) On March 9, 2010, Employee reported a headache on arrival for her PT appointment. She tolerated PT well, and her headache was gone at the end of the session. (Progress note, PT Luban, March 9, 2010).

98) On March 11, 2010, Employee went to the Providence Hospital emergency room complaining of headaches and neck pain. Tension headache was assessed. Employee was prescribed Ibuprofen, Valium and Vicodin. (Emergency Department Chart Note, March 11, 2010).

99) On March 15, 2010, Employee was placed on one day leave with pay "so that you may give serious consideration to your continued employment with Providence." She was to report back the following day with a written action plan outlining how she would meet her job requirements, or resign from her position. (Performance Memo, March 15, 2010).

100) Also on March 15, 2010, Dr. Wilcox completed a disability claim form on Employee's behalf. He indicated Employee's primary diagnosis was bipolar II disorder, it was a chronic condition that impacted her functioning making her unable to interact at a professional level with others, and caused a lack of sleep or oversleep, mood instability and depressed mood. He noted Employee was taking Depakote, Trileptal, Xanax, Baclofen, Zanaflex and Hydrocodone, and remained under his and Dr. Geeseman's care. (Unum Disability Claim Form, Dr. Wilcox, March 15, 2010).

101) On March 16, 2010, Employee presented her action plan to Employer. She requested a leave of absence before beginning the plan in order to have her psychiatric medications stabilized. She acknowledged her "actions both verbally and nonverbally have brought Providence team members and management to placing me on PMP plans. My negative actions and attitude will not be in evidence upon my return to work. I will maintain steady positive reactions and actions as stated in Providence values when I return to work. I will not cause any more disruptions with my behavior." (Performance Evaluation Plan, dated March 15, 2010).

102) Employee did not return to work after March 16, 2010. (Bergen deposition, at 119).

103) On March 23, 2010, Employee saw Kristen Solana-Walinshaw, M.D., of Providence Family Medicine, asking that another disability claim form be completed for her neck pain. She was referred to Michael Gevaert, M.D., at Alaska Spine Institute, for a functional evaluation to assist in her request for disability. (Chart note, Providence Family Medicine Center, March 23, 2010; Referral, March 23, 2010).

104) On March 26, 2010, Dr. Roderer performed bilateral cervical facet joint injections. (Procedure Note, March 26, 2010).

105) On March 29, 2010, Employee returned to Dr. Meinhardt, reporting right hip and low back pain after falling to the floor when the exercise ball on which she was sitting popped. Dr. Meinhardt prescribed PT for low back pain and right hip pain, and ordered imaging of her lumbar spine and right hip. (Physician Report, Dr. Meinhardt, March 29, 2010).

106) The lumbar spine imaging showed a few small osteophytes but disc spaces, alignment and development were otherwise normal, with minor degenerative changes only. The right hip imaging showed no obvious bony or articular abnormality. (Radiologist Report, Harold Cable, M.D., March 29, 2010).

107) On March 30, 2010 and March 31, 2010, cervical spine x-ray and MRI showed a small left paracentral disk osteophyte complex at C6-7, mild left neuroforaminal stenosis at C3-4, and loss of normal curvature consistent with muscle spasm. Disc spaces, soft tissue planes and alignment were considered normal. (Radiologist Report, Harold Cable, M.D., March 30, 2010; W. Bryan Winn, M.D., March 31, 2010).

108) On March 30, 2010, Dr. Meinhardt completed a disability form, stating Employee was totally disabled from March 16, 2010, due to pain in neck from "long hours/telephone use/ stressful work sit[uation]." (Disability form, Dr. Meinhardt, March 30, 2010). In his progress note from March 31, 2010, Dr. Meinhardt indicated Employee would be off work until April 19, 2010. He referred Employee for physical therapy for neck pain. (Progress note, March 31, 2010; PT referral, March 31, 2010).

109) On April 6, 2010, Dr. Wilcox treated Employee for mood disorder, opined it prevents Employee from working, and stated her mood disorder "is a chronic condition and recently destabilized around work related stress." (Chart Note, Dr. Wilcox, April 6, 2010).

110) In an April 26, 2010 letter, Dr. Wilcox summarized Employee's care, stating Employee began counseling with him on August 22, 2008 and was diagnosed with major depressive disorder. Employee had a break in treatment between November, 2008 and February, 2009. She was then seen on a monthly basis from February, 2009 to May, 2009. Treatment resumed in September, 2009 and on December 4, 2009 her diagnosis was changed to bipolar II disorder. Employee's symptoms worsened as she reported increased pressure and stress at work. (Letter, Dr. Wilcox, April 26, 2010).

111) On April 29, 2010, Dr. Meinhardt treated Employee for neck pain, diagnosed cervical and thoracic strain, and restricted her from returning to work until May 18, 2010. (Chart Note, Dr. Meinhardt, April 29, 2010).

112) On May 10, 2010, Employee returned to Dr. Barrington, apparently her first visit since January 19, 2010. On this visit Dr. Barrington diagnosed cervical sprain/strain and thoracic sprain/strain. Dr. Barrington prescribed myotherapy massage, which Employee received in Dr.

Barrington's office on several occasions in May, 2010. For each myotherapy session either the therapist or Employee circled the names of body parts for which massage was either sought or provided. Not once was "hips" circled until a session on June 11, 2010. (Chart Note, Dr. Barrington, May 10, 2010; Myotherapy notes, various dates, May - June, 2010).

113) On May 12, 2010, on referral from Dr. Meinhardt for her neck pain, Employee was seen by neurosurgeon Estrada J. Bernard, Jr., M.D. She reported a history of neck pain in the past, but developing "a different type of neck pain" in November 2009, after a period of working 50-60 hours a week. Dr. Bernard noted Employee was working with telephone equipment which "was ergonomically sound by her report." He opined a March 30, 2010 cervical MRI was notable only for mild degenerative changes, with very mild left foraminal stenosis at C3-4 and no other stenosis. He noted a disc osteophyte at C6-7, which did not cause spinal cord or nerve root compromise. He suspected Employee suffered occipital neuralgia.[4] (Consultation report, May 12, 2010).

114) On May 19, 2010, a lumbar spine MRI showed mild degenerative disc disease at L4-5, with a small posterior annular tear, mild associated diffuse disc bulging left greater than right, and mild lateral recess narrowing. (Radiologist Report, Heather Tauschek, M.D., May 19, 2010).

115) In response to a June 1, 2010 inquiry from the insurance carrier, Dr. Bernard listed Employee's diagnoses as occipital neuralgia and degenerative cervical spine disease. He opined Employee's diagnoses were not attributable to her work exposure as an accountant. (Response to Intracorp inquiry, June 1, 2010).

116) On June 2, 2010, on referral from Dr. Meinhardt, Employee returned to Dr. Barrington. (Referral, June 1, 2010; Examination Report, Dr. Barrington, June 2, 2010). This appears to be the first time Employee told Dr. Barrington about the January 18, 2010 fall from the exercise ball, which she reported caused her back pain and headache. She reported neck pain which "is activity dependent, aggravated by driving a car, using a computer and doing desk work." She complained of headaches and bilateral arm tingling, and pain between her shoulder blades. Employee did not report and Dr. Barrington did not record any injury to her hip. Dr. Barrington

[4] Occipital neuralgia is a distinct type of headache characterized by piercing, throbbing, or electric shock-like chronic pain in the upper neck, back of the head, and behind the ears, usually on one side of the head. Typically, the pain of occipital neuralgia begins in the neck and then spreads upwards. *http://www.ninds.nih.gov/disorders/occipitalneuralgia/occipitalneuralgia.htm.* (June 18, 2014).

assessed cervicodorsal sprain/strain, by history and examination, and lumbar sprain/strain, by history and examination. (Evaluation Report, Dr. Barrington, June 2, 2010).

117) On June 7, 2010, at Providence's request, Eric Goranson, M.D., examined Employee for a psychiatric evaluation (EME). Dr. Goranson diagnosed non-work-related borderline personality disorder, caused by genetic, developmental and constitutional factors, not external events. He opined Employee could not return to her job as an accountant, but opined this was not due to any work-related stress. He opined the predominant cause of Employee's inability to work was her medication regimen which he opined was not within the standard of care for pain management. (EME Report, Dr. Goranson, June 7, 2010).

118) On June 10, 2010, also at Providence's request, John Ballard, M.D., examined Employee for an orthopedic EME. Employee reported to Dr. Ballard her neck pain from the 2005 work injury "got better with chiropractic treatment." (Dr. Ballard, EME Report, June 10, 2010, at 12).

119) Dr. Ballard diagnosed a) depression, b) history of migraine headaches, c) chronic neck pain and history of chronic paresthesias in both hands, d) chronic mid-back pain, e) chronic low back pain, f) work-related lumbosacral strain relative to the January 18, 2010 work injury, resolved, and g) mild cervical spondylosis at C6-C7 with mild left neural foraminal stenosis at C3-C4. He opined Employee's January 18, 2010 fall from the exercise ball caused a temporary aggravation of her chronic low back pain for a period of four to six weeks, she attained medical stability within six weeks, but could return to work within one. He concluded the January 18, 2010 fall aggravated her lumbar spine, but did not cause any aggravation of her neck or mid-back conditions. (EME Report, Dr. Ballard, June 10, 2010).

120) With respect to Employee's reported March 8, 2010 work injury, Dr. Ballard opined the Employee's work on March 8, 2010 did not cause any new symptoms, she had cervical symptoms and upper extremity paresthesia prior to January 18 and March 8, 2010, and her employment for Providence did not cause any aggravation of her pre-existing cervical, thoracic lumbar or upper extremity symptoms. He concluded Employee attained medical stability from any work-related symptoms by the end of March, 2010, needed no further work-related medical treatment, and could return to her job as an accountant without limitation. (*Id*.).

121) On June 9, 2010, Employee, together with both Afognak and Providence, resolved all indemnity and vocational rehabilitation benefits through a compromise and release agreement (C&R). Medical benefits were not waived. (C&R, June 9, 2010).

122) On June 17, 2010, based on Dr. Ballard's reporting, Employer filed a Controversion Notice, denying all benefits for Employee's neck and back, retroactive to March 8, 2010. (Controversion Notice, dated June 16, 2010).

123) On September 23, 2010, Employee filed a claim for medical benefits against Providence for cumulative neck pain and mental stress, citing March 8, 2010 as her date of injury. Injury to her upper extremities was added to this claim at a subsequent prehearing conference. (Claim; Prehearing conference summary, February 7, 2011).

124) On December 23, 2010, Employee was evaluated by psychologist Rebekah Bond, Ph.D. Dr. Bond diagnosed Bipolar II Disorder, which she described as a lifelong malady, causing intractable, deeply established, dysfunctional behavior patterns. She noted Employee's illness fueled her communication problems, reflected in a brusque interpersonal style, which has been the primary impediment to any occupational success. (Evaluation, Dr. Bond, December 23, 2010).

125) On December 31, 2010, Dr. Barrington disagreed with Dr. Ballard's opinion Employee injured only her lumbar spine in January, 2010, and suffered no new injury in March. Dr. Barrington opined Employee suffered minor neck and upper back strain, in addition to injuring her low back, when she fell from the ball on January 18, 2010. He opined Employee's March, 2010 work exposure exacerbated her chronic pre-existing conditions in these body parts. He opined Employee was not medically stable from these injuries until June, 2010, three months later than Dr. Ballard's medical stability date for both injuries, but that the exacerbation of Employee's chronic pre-existing conditions had resolved. (Letter, Dr. Barrington, December 31, 2010).

126) On January 4, 2011, Rae Lee Stevenson, M.D., evaluated Employee and diagnosed bipolar disorder. (Chart Note, Dr. Stevenson, January 4, 2011).

127) On January 11, 2011, Ray Pastorino, Ph.D., treated Employee for bipolar disorder. (Chart Note, Dr. Pastorino, January 11, 2011).

128) On February 7, 2011, Employee filed two separate claims: one for medical benefits for neck and upper extremity symptoms she attributed to working long hours without a headset while employed by Afognak in 2005, and a second against Providence for medical benefits for low back and right leg symptoms and "shook up whole body," for the January 18, 2010 fall from the exercise ball. (Claim; AWCB Case No. 200519957).

129) On March 24, 2011, her then-treating psychiatrist, Janet E. DiPreta, M.D., noted Employee's psychiatric diagnoses as "Bipolar disorder MRE (most recent episode) depressed, attention deficit hyperactivity disorder, borderline personality disorder." (Progress Note, Dr. DiPreta, March 24, 2011).

130) On March 30, 2011, a cervical spine MRI showed a small left paracentral disk osteophyte complex at C6-7, and mild left neuroforaminal stenosis at C3-4. (Radiologist Report, W. Bryan Winn, M.D., March 30, 2011).

131) On October 3, 2011, at Afognak's request, Marilyn Yodlowski, M.D., examined Employee for an orthopedic EME. Dr. Yodlowski assessed chronic long-term, nonspecific pain complaints of Employee's entire spine and upper extremities, and nonspecific sensory complaints of numbness and tingling, with no objective basis of injury, disease or pathology other than mild age-related cervical spine degenerative changes. She opined Employee's need for medical treatment is unrelated to her June 1, 2005 work injury, noting Employee had similar pain complaints since the 1990s. She concurred with Dr. Neumann's opinion Employee attained medical stability from the reported injury by the time Dr. Neumann examined her in November, 2005. Dr. Yodlowski opined Employee's need for medical treatment was due to a combination of psychiatric/psychosocial factors and continuation of chronic opioid pain medications, which have likely led to dependence and/or addiction. (EME Report, Dr. Yodlowski, October 3, 2011).

132) Employee was found eligible for social security disability (SSDI) and remained on SSDI when deposed on November 4, 2011. (Bergen deposition, November 4, 2011, at 72).

133) On February 6, 2012, in a visit to her primary care provider for non-work-related issues, Employee mentioned experiencing shoulder pain she stated her chiropractor thought was a rotator cuff tear. Employee noted her shoulder had been bothering her for about five years. (Chart note, Christina C. Brown, D.O., Providence Family Medicine, February 6, 2012).

134) On February 23, 2012, a right shoulder MRI showed a small superior labral anterior-posterior (SLAP) tear and a small paralabral cyst. (Radiologist Report, Kelly Powers, M.D., February 23, 2012).

135) There is no medical evidence or opinion Employee's right shoulder SLAP tear occurred in the course and scope of any employment. Rather, the record reflects Employee reported right shoulder symptoms in 1991, 1992, and 2002. Thereafter Employee reported shoulder pain

following a four-wheeler accident in 2003, and while playing baseball in 2005. (Record; judgment, observation, facts of the case).

136) On March 23, 2012, Employee saw physical and rehabilitation medicine specialist Linda Rowan, M.D., for a second independent medical evaluation (SIME). (SIME Report, Dr. Rowan, March 23, 2013).

137) Dr. Rowan opined Employee's borderline personality disorder, bipolar disorder, migraine headaches, and right shoulder strain/sprain were unrelated to any work injury. (SIME Report, March 23, 2012, at 9).

138) She further opined Employee required no further medical treatment for the June 1, 2005 injury while employed by Afognak. (*Id.* at 17).

139) Relative to the January 18, 2010 work injury, Dr. Rowan diagnosed lumbosacral spine sprain/strain; right hip sprain/strain; history and records suggesting right sacroiliac joint dysfunction, but no evidence on examination; and myofascial pain with possible piriformis sprain/strain. (*Id.* at 9).

140) Dr. Rowan disagreed with Dr. Ballard's assessment Employee's January 18, 2010 fall aggravated a pre-existing chronic back condition, stating, "I do not have medical records predating this injury that suggest she was having that problem before. . . I did not find any records . . . that predate the 1/18/10 injury showing Lumbar spine pathology. As such, I would . . . consider her 1/18/10 injury . . . a new injury" and the substantial cause of Employee's low back and right hip pain. (*Id*. at 12, 16, 20).

141) Although finding the January 18, 2010 work injury was the substantial cause of Employee's lumbar and hip sprain/strains and myofascial pain, Dr. Rowan also opined no further medical treatment was reasonable or necessary for the process of recovery from the January 18, 2010 injury. (*Id*. at 20).

142) Relative to the March 8, 2010 work injury, Dr. Rowan diagnosed cervical spine sprain/strain; bilateral shoulder sprain/strain; persistent positionally related upper extremity paresthesias, more probable than not an aggravation of a pre-existing injury, possibly thoracic outlet syndrome diagnosed in October, 2005; and myofascial pain syndrome. (*Id*. at 9).

143) Dr. Rowan's opinion Employee's March 8, 2010 employment exposure was the substantial cause of the neck and upper extremity symptoms was erroneously based on her belief Employee

did not return to work after March 16, 2010, because the physical symptoms she was reporting precluded her ability to do so. (*Id*. at 11).

144) Dr. Rowan opined the March 8, 2010 reported injury was the substantial cause of Employee's neck and upper extremity symptoms, but concluded no further medical treatment was reasonable or necessary for the process of recovery from this injury. (*Id*. at 11, 20).

145) Dr. Rowan opined "the majority" of Employee's persistent symptoms were from thoracic outlet syndrome, and recommended electromyography and nerve conduction studies. (*Id*. at 12).

146) Although Employee's medical records dating back to 1991 were provided to her, Dr. Rowan's medical records review inexplicably begins with the March 19, 2005 chart note from Dr. Lewis, just three months prior to the June 1, 2005 injury, and disregards the previous 15 years, and 181 pages, of available records. (*Compare* SIME Report, at Appendix A: Medical Records Review, March 23, 2012, *with* SIME binder; observation).

147) On July 3, 2012, at Dr. Rowan's request, EMG and nerve conduction studies of Employee's bilateral upper extremities were performed. The studies showed no evidence of ulnar neuropathy and no evidence of thoracic outlet syndrome. Employee had normal median ulnar and median antebrachial sensory responses, and normal median and ulnar motor nerve responses. (Neurology Consultation Report, Marci L. Troxell, DO, July 3, 2012).

148) When deposed on October 30, 2012, Dr. Rowan conceded she could not state to a reasonable degree of medical certainty Employee suffered from TOS. If it were TOS, however, treatment would consist of eight physical therapy sessions to ensure proper posture, strengthen back and shoulder muscles, and stretch chest muscles. Dr. Rowan conceded it was more likely than not Employee had been suffering myofascial pain prior to her work injuries. (Dr. Rowan, at 18, 20).

149) Dr. Rowan further opined none of Employee's use of narcotic or other prescription medications is attributable to any of the three reported work injuries, as Employee was taking these medications in some form prior to those injuries. (*Id*. at 24, 26, 29).

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. . . .

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).

An adjudicative body must base its decision on the law, whether cited by a party or not. *Barlow v. Thompson*, 221 P.3d 998 (2009).

At the time of Employee's June 1, 2005 injury while employed by Afognak, the Alaska Workers' Compensation Act (Act) provided:

> **AS 23.30.010. Coverage**. Compensation is payable under this chapter in respect of disability or death of an employee.

Decisional law interpreted former AS 23.30.010 to require payment of benefits when employment was "a substantial factor" in a claimant's disability or need for medical treatment. *Ketchikan Gateway Borough v. Saling*, 604 P.2d 590 (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 at the time he did, in the way he did, or to the degree he did, and reasonable people would regard it as the cause and attach responsibility to it. *Fairbanks North Star Borough v. Rogers and Babler*, 747 P.2d 528 (Alaska 1987).

It is a fundamental principle of workers' compensation law that the employer must take the employee "as he finds him." *Fox v. Alascom, Inc.*, 718 P.2d 977, 982 (Alaska 1986), *citing*

S.L.W. v. Alaska Workmen's Compensation Board, 490 P.2d 42, 44 (Alaska 1971). A pre-existing condition does not disqualify a claim if the employment aggravates, accelerates or combines with the pre-existing condition to produce the disability or need for medical treatment for which compensation is sought. *DeYonge v. NANA/Marriott*, 1 P.3d 90, 96 (Alaska 2000); *Peek v. SKW/Clinton*, 855 P.2d 415, 416 (Alaska 1993).

For injuries prior to the Act's November 7, 2005 amendments, in order to prove a work injury aggravated, accelerated or combined with a preexisting condition to produce a disability or need for medical care, the claimant must show "(1) the disability or need for medical care would not have happened 'but-for' an injury sustained in the course and scope of employment; and (2) reasonable persons would regard the injury as a cause of the disability and attach responsibility to it." *Thurston v. Guys with Tools, Ltd*., 217 P.3d 824, 828 (Alaska 2009), *citing Rogers & Babler*, 747 P.2d at 532. Aggravation of a preexisting condition may be found absent any specific traumatic event. *Providence Washington Insurance v. Banner*, 680 P.2d 96; 99 (Alaska 1984).

At the time of Employee's 2010 injuries while employed by Providence, the Act provided:

> **AS 23.30.010. Coverage.** (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.

> (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.

Compensation or benefits are owed under AS 23.30.010 if, relative to all possible causes, employment was "the substantial cause" in bringing about the disability or need for medical treatment. *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 (March 25, 2011).

In *City and Borough of Juneau v. Olsen*, AWCAC Decision No. 11-0175 (August 21, 2013), the Commission applied "the substantial cause" standard in cases where a work injury "aggravates or accelerates" or "combines" with a preexisting condition. When an employee asserts a work injury caused the aggravation or acceleration of a preexisting condition, the board must evaluate the relative contribution of both the preexisting condition and the work injury. To establish causation, the employee must show the work injury played a greater role in the disability or need for medical treatment than did the preexisting injury. *Olsen*, 17-18. When an employee asserts his disability or need for medical treatment arose as a result of a combination of his work injury and a preexisting condition, the employee must establish two additional facts to prevail: first, that the disability or need for treatment would not have happened "but for" the work injury, and second, that reasonable persons would regard the work injury as the substantial cause of the disability or need for medical treatment. *Olsen*, 18-19.

A finding reasonable persons would find employment was or was not a cause of the Employee's disability and impose or deny liability is, "as are all subjective determinations, the most difficult to support." There is 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." *Rogers & Babler*, 747 P.2d at 534.

> **AS 23.30.095. Medical treatments, services, and examinations**. (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. . . . It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require.
> . . .
>
> **AS 23.30.120 Presumptions**. (a) In a proceeding for the enforcement of a claim for compensation under this chapter it is presumed, in the absence of substantial evidence to the contrary, that
>
> (1) the claim comes within the provisions of this chapter. . . .
>
> . . .
> (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(a)(1), benefits sought by an injured worker are presumed to be compensable. *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996). Unless otherwise provided by statute, the presumption of compensability is applicable to any claim for compensation under the workers' compensation statute. *Id.* The presumption applies to claims for medical benefits, including continuing care. *Municipality of Anchorage v. Carter*, 818 P.2d 661, 664-665 (Alaska 1991). Application of the presumption involves a three-step analysis. To attach the presumption of compensability, an employee must first establish a "preliminary link" between his or her injury and the employment. *See, e.g., Tolbert v. Alascom, Inc.*, 973 P.2d 603, 610 (Alaska 1999). Employee need only adduce "some," "minimal" relevant evidence establishing a "preliminary link" between the "claim" and the employment. *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987) *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). Witness credibility is not considered in this first step. *Excursion Inlet Packing Co. v. Ugale*, 92 P.3d 413, 417 (Alaska 2004). Once the preliminary link is established, the presumption is raised and attaches to the claim.

For injuries prior to November, 2005, to rebut the presumption at the second stage of the analysis, the employer must produce substantial evidence that either (1) non-work-related events alone caused the employee's disability or need for medical care; or (2) there was no possibility employment caused the disability or need for medical care. *DeYonge v. Nana/Marriott,* 1 P.3d 90, 96-97 (Alaska 2000); *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. *Id.* at 1046. The employer's evidence is viewed in isolation, without regard to employee's evidence at this stage. *Id.* at 1055. Credibility questions and the weight of evidence are again deferred until after it is determined the employer produced evidence 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). It has always been possible to rebut the presumption of compensability by presenting a qualified expert who testifies that a claimant's work was probably not a substantial cause of her disability or need for medical care. *Cowen v. Wal-Mart,* 93 P.3d 420, 424 (Alaska 2004).

If an employer produces substantial evidence rebutting the presumption, the presumption drops out, and the employee must prove all elements of the claim by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1381; *citing Miller* at 1046. The party with the burden of proving asserted facts by a preponderance of the evidence must "induce a belief" in the fact-finders' minds the asserted facts are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

For injuries occurring after the 2005 amendments to the Act, if the employee establishes the preliminary link, to overcome the presumption the employer must present substantial evidence demonstrating a cause other than employment played a greater role in causing the disability or need for medical treatment. *Runstrom v. Alaska Native Medical Center,* Alaska Workers' Comp. App. Comm'n Dec. No. 150 at 7 (March 25, 2011).

If the board finds the employer's evidence is sufficient, the presumption of compensability drops out, and the employee must prove by a preponderance of the evidence, that in relation to all other causes, employment was the substantial cause of the disability or need for medical treatment.

Runstrom v. Alaska Native Medical Center, Alaska Workers' Comp. App. Comm'n Dec. No. 150 at 8 (March 25, 2011). It is only at the third step in the analysis that the evidence is weighed, inferences are drawn from the evidence, and credibility determined.

Work-related mental injuries have been divided into three groups for purposes of analysis: mental stimulus causing physical injury, known as "mental-physical" cases; physical injury causing a mental disorder, or "physical-mental cases," and mental stimulus causing 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(c). "Mental-mental" cases are subject to the further requisites and limitations established in AS 23.30.010(b).

> **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 has the sole power to determine witness credibility, and its findings about weight are conclusive even if the evidence is conflicting. *Smith v. CSK Auto, Inc.*, 204 P.3d 1001, 1008 (Alaska 2009); *Harnish Group, Inc. v. Moore*, 160 P.3d 146, 153 (Alaska 2007); *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249, 1253 (Alaska 2007). The board has the sole discretion to determine the weight of the medical testimony and reports. When doctors' opinions disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.*, Alaska Workers' Comp. App. Comm'n Dec. No. 087 at 11 (Aug. 25, 2008). The board can choose not to believe its own expert. *Rosario v. Chenega Lodging*, 297 P.3d 139, 147 (Alaska 2013).

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

ANALYSIS

1) Was Employee's work for Afognak a substantial factor in her continuing need for medical treatment for her neck and upper extremity symptoms?

This is a factual issue to which the presumption of compensability applies. At the first stage of the analysis, Employee must show at least "some" "minimal" evidence establishing a preliminary link between her employment and her need for medical care. *Tolbert.* Employee raised the presumption through Dr. Bilan's medical records, which relate Employee's complaints of neck and upper extremity pain, numbness and tingling, to her use of a handset telephone while employed by Afognak, beginning on or about June 1, 2005.

To rebut the presumption, Afognak must produce substantial evidence demonstrating either (1) events unrelated to her employment for Afognak alone caused Employee's continuing need for medical care for her neck and upper extremities; or (2) there was no possibility Employee's work for Afognak caused a continuing need for medical care. *DeYonge.*

The presumption of compensability may be rebutted by a qualified expert who attests that a claimant's work was probably not a substantial cause of her disability or need for medical care. *Cowen*. Here, after comprehensive examinations of Employee, and reviews of her extensive medical records, both Dr. Neumann and Dr. Yodlowski opined Employee's employment with Afognak caused only a temporary aggravation of her pre-existing neck and upper extremity symptoms. Both physicians concluded that by the time Dr. Neumann examined Employee on November 15, 2005, she had recovered from the acute symptoms suffered in June, and her then-present symptoms were secondary to her underlying degenerative cervical spine disease.

At the third stage of the presumption analysis, Employee must prove by a preponderance of evidence her work for Afognak in 2005 was a substantial factor in her need for continuing treatment for her neck and upper extremity complaints beyond Afognak's November 15, 2005 controversion. To do so she must demonstrate that "but for" her work for Afognak she would not have required continuing care, and reasonable persons would regard the 2005 injury as a

cause of the need for continuing care and attach responsibility to it. *Rogers & Babler*. Employee has failed to meet this burden.

Dr. Neumann's finding Employee's work with Afognak in 2005 caused only a temporary, time-limited aggravation of her pre-existing cervical spine and upper extremity symptoms, and Dr. Yodlowski's concurrence, provide the most persuasive evidence Employee attained medical stability from the reported injury by November 15, 2005. Both physicians examined Employee, reviewed her extensive medical records, and noted her long history of similar symptoms. While Dr. Bilan attributed Employee's acute presentation of neck pain and extremity paresthesia to her work for Employer, his records do not dispute Dr. Neumann's opinion the work-relatedness of Employee's neck and upper extremity symptoms was time-limited, and ceased within months of initial presentation.

Rather, Dr. Bilan's notes reflect Employee's admission her symptoms were of longstanding duration: "ongoing-years," "long term" and "acts up often." Although Dr. Barrington opined Employee's symptoms were "possibly from using her computer at work," and "partly due to workplace ergonomics," Dr. Barrington's opinion was based on an inaccurate medical history from Employee, who informed Dr. Barrington she had suffered only "occasional" neck soreness in the past. For this reason Dr. Barrington's opinion is accorded less weight than Dr. Neumann's. Dr. Levine, also referred by Dr. Bilan, did not attribute Employee's upper extremity symptoms to her employment. Additionally, SIME Dr. Rowan opined no further medical treatment was indicated relative to the June 1, 2005 work injury. Indeed, by Employee's own admission to Dr. Ballard, the acute symptoms arising from her 2005 employment for Afognak resolved following the chiropractic treatment she received at that time.

Employee has failed to demonstrate by a preponderance of evidence her work for Afognak was the substantial cause of any need for continuing medical care beyond November 15, 2005. Accordingly, Employee is not entitled to an award of medical benefits from Afognak for neck and upper extremity symptoms beyond the effective date of Employer's November 25, 2005 controversion notice.

2) Was Employee's work for Providence the substantial cause of her continuing need for medical treatment for her back, hip, neck, headache and upper extremities?

These are factual issues to which the presumption of compensability applies. Employee raised the presumption through her assertion she injured her low back, hip, neck and upper extremities when the exercise ball she was using as a desk chair popped, causing injury when she fell to the floor. With respect to her back, the presumption is also supported by ANP Ingle's January 19, 2010 chart notes reflecting Employee's assertion her fall caused her chronic back pain to flare up. With respect to her right hip, the presumption of compensability was raised by Dr. Rowan's opinion the fall from the exercise ball was the substantial cause of Employee's right hip sprain/strain. The presumption attached to her cervical, thoracic and lumbar spine complaints with Dr. Barrington's December 31, 2010 opinion the January 18, 2010 fall from the ball, as well as the March, 2010 work exposure, exacerbated Employee's chronic pre-existing conditions in these body parts.

At the second stage of the analysis, if Employer can present substantial evidence demonstrating a cause other than employment played a greater role in causing the need for continuing medical care, the presumption is rebutted. *Runstrom*. Through the opinion of Dr. Ballard, Employer has rebutted the presumption of continuing care for injuries to Employee's back, hip, neck and upper extremities. Through the opinion of Dr. Bernard, Employer has rebutted the presumption of continuing care for Employee's neck pain and headaches.

Dr. Ballard opined Employee's January 18, 2010 fall from the exercise ball caused a temporary aggravation of her chronic low back pain for a period of four to six weeks, but did not aggravate her chronic pre-existing neck or thoracic conditions, or the intermittent upper extremity parethesias she had reported for years. He opined the March 8, 2010 work exposure was not an injury causing new symptoms, nor did it cause any aggravation of Employee's longstanding pre-existing cervical symptoms. He concluded Employee was medically stable when he examined her on June 10, 2010. Dr. Ballard opined she likely attained medical stability from the January 18, 2010 fall within six weeks, and from the symptoms reported on March 8, 2010 by the end of March, 2010. Also in June, 2010, treating physician Dr. Bernard diagnosed Employee's headaches as occipital neuralgia originating from her degenerative cervical spine disease, unequivocally opining they were not attributable to any work exposure. At this stage of

the analysis, the presumption drops out and the burdens of proof and persuasion return to Employee.

For injuries after November, 2005, where an employee is asserting a work injury caused the aggravation or acceleration of a preexisting condition, the board must evaluate the relative contribution of both the preexisting condition and the work injury. *Runstrom*. To establish her case for compensable medical care for her back, hip, neck, headaches and upper extremities, Employee must show the 2010 work injuries played a greater role in her need for medical treatment for these body parts and symptoms than did her pre-existing conditions. *Olsen,* 17-18.

Dr. Barrington's opinion the January 18, 2010 fall from the ball aggravated Employee's pre-existing cervical, thoracic and lumbar symptoms provides support for Employee's contention. Notably, however, Dr. Barrington did not attribute hip pain to Employee's work injury. Dr. Barrington's opinion Employee did not attain medical stability from the two work injuries until June, 2010, three months after Dr. Ballard's medical stability date, supports Employee's contention she required care beyond March 31, 2010. Dr. Barrington did not, however, opine Employee required continuing care for symptoms to any body part from either work injury beyond June, 2010. Because Dr. Barrington was not fully apprised of the extent of Employee's chronic pre-existing cervical, thoracic, lumbar and upper extremity symptoms, his opinion she did not attain medical stability from the January and March, 2010 incidents for an additional three months beyond Providence's controversion of benefits is unpersuasive.

Dr. Rowan's opinion Employee's January 18, 2010 lumbar and hip complaints represented injuries to new body parts, rather than an aggravation of a pre-existing lumbar spine condition, is based on her mistaken assumption Employee had no reported or documented history of low back pain prior to the January 18, 2010 fall. In light of the voluminous medical records reflecting complaints of and treatment for reported low back pain as far back as 1991, Dr. Rowan's opinion Employee's lumbar spine and hip represented new injuries is unconvincing.

Had Dr. Rowan carefully examined the earlier medical records provided, those dating back to 1991, rather than beginning her review with records from March, 2005, the scope of Employee's pre-existing lumbar spine condition would have been evident. The very first medical record provided, from June 5, 1991, reveals Employee receiving chiropractic care for low back pain, decreased lumbar range of motion with accompanying pain, and radicular pain to the right lower extremity after lifting heavy items repeatedly. In 1995, Dr. Voke diagnosed lumbar facet syndrome, finding Employee suffered a five percent permanent partial impairment as a result of a lumbar spine injury. Even considering the more recent records her report reflects she did review, Dr. Rowan's opinion overlooks Employee's own report to ANP Ingle on January 19, 2010, that the fall caused her "chronic back pain to flare up." It disregards a February, 2010, physical therapy note where Employee reported she originally injured her back at age 23, and her "pain has continued, waxing and waning in intensity" ever since. Dr. Rowan's opinion Employee's hip complaints arose from the January 18, 2010 fall from the exercise ball ignores the fact Employee did not begin complaining about hip pain, despite multiple doctor, physical therapy and massage appointments addressing Employee's numerous pain complaints during the period, until several months after the fall occurred.

Relative to the March 8, 2010 work exposure, Dr. Rowan initially diagnosed cervical spine sprain/strain; bilateral shoulder sprain/strain; persistent positionally related upper extremity paresthesias, more probable than not an aggravation of a pre-existing injury, possibly thoracic outlet syndrome; and myofascial pain syndrome. But when electromyography conducted at Dr. Rowan's request to assess Employee's upper extremity complaints was returned negative for both ulnar neuropathy and TOS, Dr. Rowan conceded she could not state to a reasonable degree of medical certainty Employee's upper extremity complaints were ulnar neuropathy or TOS at all. At her deposition Dr. Rowan further conceded it was more likely than not Employee's myofascial pain existed prior to any of the work injuries examined here. Having retreated from her assertion Employee's upper extremity paresthesia and myofascial pain syndromes originated with her employment for Providence, Dr. Rowan's opinions in this regard will be accorded no weight. Moreover, Dr. Rowan's conclusion Employee's upper back and upper extremity symptoms were related to her employment because she could no longer work after March 16, 2010, lacks an accurate factual basis. The evidence demonstrates

Employee did not return to work in March, 2010, following a lengthy disciplinary process concerning her disruptive behaviors, which were fueled by her underlying psychiatric illness. She did not leave work because of neck strain and upper extremity symptoms.

With respect to Dr. Rowan's assessment Employee suffered bilateral shoulder sprain/strains from her work for Providence; Dr. Rowan stands alone in her opinion. Upon exactly what medical records she bases this opinion is unknown. The medical records demonstrate Employee had been complaining of shoulder symptoms since at least April 24, 1992, when she reported having injured her shoulder the previous summer. In 2002, Employee injured her shoulder in a four-wheeler accident, in 2005 it was baseball. In 2012, she reported having had pain in her shoulders for five years and was told she had a rotator cuff tear. She was ultimately found to have a SLAP tear and a paralabral cyst. There is no medical evidence or opinion Employee's right shoulder SLAP tear occurred in the course and scope of any employment. The weight of the evidence establishes Employee's right shoulder complaints are longstanding and wholly unrelated to her employment with Providence.

Although Dr. Rowan's attribution of Employee's cervical sprain/strain to her work for Providence also differs from Dr. Ballard's opinion, her conclusion Employee requires no further treatment for this or any other injuries sustained while employed by either Afognak or Providence is consistent with both Dr. Neumann's and Dr. Ballard's opinions. Her opinion Employee's use of narcotic and other prescription medications cannot be attributed to any of her work injuries since she was taking these medications in some form prior to the reported injuries is also consistent with Drs. Neumann, Ballard and Yodlowski.

Employee has failed to prove by a preponderance of evidence her work for Providence was the substantial cause of her continuing need for medical treatment for her back, hip, neck, shoulders and upper extremities. Accordingly, Employee is not entitled to an award of medical benefits for her back, hip, neck, shoulders and upper extremity symptoms.

3) Was stress Employee perceived while working for Providence the substantial cause of her need for psychiatric care?

Employee's March 8, 2010 claim alleges she suffered work-related stress from having to work long hours as an accountant for Providence, resulting in disablement and a need for psychiatric and psychological care. The presumption of compensability does not apply to a mental injury resulting from work-related stress. AS 23.30.120(c).

Rather, in order to prove her claim for compensation and benefits for mental injury caused by mental stress, Employee must establish by a preponderance of evidence that (1) the work stress was extraordinary and unusual in comparison to pressures and tensions experienced by individuals in a comparable work environment; (2) work stress was the mental injury's predominant cause; and (3) the work stress did not result from a disciplinary action, work evaluation, job transfer, layoff, demotion, termination, or similar action taken in good faith by the employer. The amount of work stress is measured by actual events. AS 23.30.010(b). Employee has not met her burden on any one of the three factors she must prove in order to obtain compensation.

There is no evidence Employee suffered work stress considered extraordinary and unusual in comparison to pressures and tensions experienced by individuals in a comparable work environment. Employee was a senior accountant for Providence. It was a sedentary position, involving primarily paperwork and computer use. Employee was occasionally called upon to work up to 50 hours per week. While no evidence was adduced with respect to pressures experienced by individuals in a comparable work environment, administrative notice is taken that it is not uncommon for accountants and other professionals to be called upon to work longer than a normal 40 hour work week when job demands require it.

Nor has Employee demonstrated that work stress was the predominant cause of her mental injury. At the time Employee began her employment with Providence in 2008, she had long-standing diagnoses of anxiety and depression dating back to at least 2001. She had reported suffering stress at several previous jobs. She was first evaluated by psychiatric professionals in November, 2007. She began seeing Dr. Wilcox in regular therapy sessions after an August 22, 2008 intake with him. Dr. Wilcox, Dr. Geeseman, and Dr. Bond ultimately diagnosed her with

bipolar disorder II, describing it as a lifelong malady, causing intractable, deeply established, dysfunctional behavior patterns, and the primary impediment to Employee's occupational success. EME psychiatrist Dr. Goranson diagnosed Employee with borderline personality disorder. Like Dr. Bond, he opined Employee's reported mental stress was not caused by her work for Providence, but from the genetic, developmental and constitutional factors inherent in her psychological makeup. Dr. Goranson's and Dr. Bond's opinions are uncontroverted. They are in fact supported by Employee's treating psychologist, Dr. Wilcox, who also attributed Employee's inability to perform at work to underlying psychiatric illness, not to undue stress suffered at work.

Moreover, Employee is unable to demonstrate any stress she was experiencing was not the result of disciplinary action, work evaluation, or similar action taken in good faith by the employer. Her earliest employment records from Providence reflect unacceptable work performance, and repeated efforts at improvement plans. Both the employment records and the therapy notes reflect Employee's acknowledgement she displayed an angry, negative, impatient and aggressive communication style at work, and her concession the disciplinary actions against her were warranted. Also noteworthy, at her November 4, 2011 deposition, Employee stated she was withdrawing her mental injury claim.

Employee has failed to prove by a preponderance of evidence her employment with Providence was the substantial cause of her need for psychological or psychiatric care due to mental stress.

CONCLUSIONS OF LAW

1) Employee's work for Afognak was not a substantial factor in her continuing need for medical treatment for her neck and upper extremity symptoms.

2) Employee's work for Providence was not the substantial cause of her continuing need for medical treatment for her back, hip, neck, headache and upper extremities.

3) Employee's work for Providence was not the substantial cause of her need for psychiatric care.

4) Employee is not entitled to continuing medical care from either Afognak or Providence for injuries sustained on or about June 1, 2005, January 18, 2010, or March 8, 2010.

ORDER

1) Employee's claim for benefits for injuries while employed by Afognak on June 1, 2005 is denied and dismissed.
2) Employee's claim for benefits for injuries while employed by Providence on January 18, 2010 is denied and dismissed.
3) Employee's claim for benefits for injuries while employed by Providence on or about March 8, 2010 is denied and dismissed.

Dated in Anchorage, Alaska on July 3, 2014.

ALASKA WORKERS' COMPENSATION BOARD

_____
Janel Wright, Designated Chair

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Linda Hutchings, Member

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Mark Talbert, Member

APPEAL PROCEDURES

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

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

RECONSIDERATION

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

MODIFICATION

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

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of SARAH BERGEN, employee / claimant; v. PROVIDENCE ALASKA MEDICAL CENTER, employer; PROVIDENCE HEALTH SYSTEM WASHINGTON, insurer / AFOGNAK NATIVE CORPORATION, employer, ZURICH AMERICAN CORPORATION, insurer/defendants; Case Nos. 201002658M, 201002657, 200519957; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on July 3, 2014.

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Pamela Murray, Office Assistant