ALASKA WORKERS' COMPENSATION BOARD

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

ALLEN LASH,	)	FINAL DECISION AND ORDER
	)	
Employee,	)	AWCB Case No. 200918991
Applicant,	)	
	)	AWCB Decision No. 14-0158
v.	)	
WINNRESIDENTIAL LIMITED PARTNERS,	)	Filed with AWCB Fairbanks, Alaska
	)	on December 8, 2014
Employer,	)	
and	)	
	)	
LIBERTY MUTUAL INSURANCE CO.,	)	
Insurer,	)	
Defendants.	)	

Allen Lash's (Employee) October 10, 2012 claim for benefits under the Alaska Workers' Compensation Act (Act) was heard on July 31, 2014, in Fairbanks, Alaska. The hearing date was selected on March 5, 2014. Attorney Bob Beconovich appeared and represented Employee, who appeared and testified. Attorney Connie Livsey appeared and represented Winnresidential Limited Partners and Liberty Mutual Insurance Co. (Employer). Scott McDevitt also appeared and testified. The record was left open to receive Employee's supplemental attorney fee affidavit and objection thereto. The record closed when the supplemental pleadings were received and the board next met and deliberated, on August 25, 2014. On September 12, 2014, the board on its own motion reopened the record to inform the parties there may be a dispute warranting a second independent medical evaluation. The parties agreed to have that issue heard on the written record on November 6, 2014. The record closed after the board deliberated, on

November 6, 2014. This decision addresses all issues heard at both the August 24, 2014 and November 6, 2014 hearings.

ISSUES

Employee contends an SIME on the question of whether Employee's repetitive motion activities at work in 2009 are the substantial cause of Employee's disability and need for treatment for ulnar neuropathy would be helpful to the board. Employee contends the question of whether Employee's repetitive motion activities at work in 2009 aggravated a preexisting condition to result in Employee's disability and need for medical treatment was fully answered by Lowell Anderson, MD, and no additional SIME on that question is necessary.

Employer contends there is no need for an additional SIME, as all questions related to whether Employee's repetitive motion activities are the cause of Employee's current disability and need for medical have been answered by medical providers and their opinions are in the existing record. Employer contends ordering another SIME simply allows Employee a "second bite at the apple."

1) Should an additional SIME be ordered?

Employee contends his December 30, 2009 work injury is the substantial cause of his current disability and need for medical treatment related to his ulnar neuropathy. Specifically, Employee contends his work for Employer aggravated or combined with his pre-existing ulnar neuropathy to result in his current disability and need for medical treatment. Employer contends the December 30, 2009 bicep tear is not the substantial cause of Employee's disabling ulnar neuropathy and thus his claim is not compensable.

2) Is the December 30, 2009 bicep injury the substantial cause of Employee's continued disability and need for medical treatment for ulnar neuropathy?

Alternatively, Employee contends his repetitive motion activities at work in 2009 are the substantial cause of his ulnar neuropathy and subsequent disability and need for medical treatment. Employer contends Employee's work for employer is not the substantial cause of Employee's disabling ulnar neuropathy and thus his claim is not compensable.

3) Are Employee's repetitive motion activities at work in 2009 the substantial cause of his continued disability and need for medical treatment for ulnar neuropathy?

FINDINGS OF FACT

Evaluation of the record as a whole establishes the following facts and factual conclusions by a preponderance of the evidence:

1) On December 30, 2009, Employee injured his right arm "moving a fridge" while working for Employer. (Report of Occupational Injury or Illness, January 20, 2010).

2) On January 14, 2010, Employee reported he "snapped" his bicep nine days prior lifting a refrigerator. He complained of immediate pain in his right biceps and "later noted numbness [in the] right small finger and partially [in the] ring finger." The urgent care physician diagnosed right bicep rupture and ulnar neuropathy. (Fairbanks Urgent Care report, January 14, 2010).

3) On January 20, 2010, Employee complained of continued pain, a "large lump mid-bicep" and "also now has numbness to [right] 5th finger." An MRI taken that day revealed a torn bicep tendon. (Fairbanks Urgent Care report, January 20, 2010; Aurora Diagnostic Imaging report, January 20, 2010).

4) On January 25, 2010, Employee saw Michael Pomeroy, PA-C. Employee noted he "had some numbness in the ulnar nerve distribution in his ring and fifth finger." PA-C Pomeroy recommended surgery to repair Employee's torn bicep. (PA-C Pomeroy report, January 25, 2010).

5) On January 29, 2010, Richard Cobden, MD diagnosed bicep tendon rupture of the long head of the right shoulder and carpal tunnel syndrome and ulnar neuritis of the right wrist. Dr. Cobden performed a right biceps tendon repair and right wrist injection with Depo-Medrol. (Dr. Cobden Operative Report, January 29, 2010).

6) On March 1, 2010, Employee began a course of physical therapy. He initially complained of pain varying from 6-8/10, difficulty sleeping and numbness in his right fifth finger. (Advanced Physical Therapy chart note, March 1, 2010).

7) Over the course of his physical therapy, Employee's range of motion improved and his pain level decreased, but he continued to complain of frequent numbness in the right fifth finger. (Advanced Physical Therapy chart notes, March – June 2010).

8) On July 5, 2010, Employee attended a follow-up appointment with Dr. Cobden. He complained of numbness and tingling in his right fifth finger. Dr. Cobden noted: "He has an

ongoing weakness of his right upper extremity which is well-documented above. He also has a chronic ulnar neuritis every (sic) since the injury, which is probably related to his cubital tunnel syndrome." Dr. Cobden opined Employee was medically stable and assessed a 4% permanent partial impairment rating. (Dr. Cobden report, July 5, 2010).

9) On September 22, 2010, Employee attended a follow-up appointment with Dr. Cobden. He noted he was "doing better with regard to the biceps, but he is having increasing ulnar symptoms into the right fifth finger." Dr. Cobden recommended a nerve conduction study. (Dr. Cobden report, September 22, 2010).

10) On September 28, 2010, Employee underwent a nerve conduction study which revealed possible severe right median neuropathy at the wrist, severe right ulnar neuropathy at the elbow and a right C8 and T1 radiculopathy or right brachial plexopathy. (Nerve Conduction Study, September 28, 2010).

11) On January 28, 2011, Lowell Anderson, MD conducted an employer's medical examination (EME). Employee's primary complaints were right upper arm pain, right fourth and fifth finger discomfort, dysesthesia and paresthesias and weakness in the right hand. Dr. Anderson noted the following history:

> Allen Lash was involved with work activity in the fall of 2009 when he began noticing right hand weakness and intermittent numbness and paresthesias to the fourth and fifth fingers of the right hand. He spoke to his boss in early December of 2009, noting that the discomfort to the fingers had progressed to the point where he had to pull on his fifth finger to provide some relief of the symptoms on a frequent basis. He recalls that his boss told him that he needed to do some stretching and some exercises. This did not change his symptoms. He then sustained a work related injury to his right shoulder on December 30, 2009…. Following questioning regarding his past history, he recalls that he did have symptoms and paresthesias to the 4^{th} and 5^{th} fingers of his right hand that were progressing, beginning approximately two to three months prior to his shoulder injury. He notes that his work activity involved repetitive strenuous heavy lifting, gripping, and squeezing activities. He used a carpet knife on a frequent basis and found that he was losing control of the knife more frequently due to hand weakness prior to the shoulder injury. He is quite certain that he then talked to his boss about this decreased function two to four weeks prior to his shoulder injury and his boss recommended stretching activities.

Dr. Anderson diagnosed right shoulder biceps tendon disruption due to the December 30, 2009 injury and pre-injury work related right elbow ulnar nerve compression neuropathy. He opined the December 30, 2009 injury was not the substantial cause of the ulnar neuropathy, but the wrist

and finger numbness was the result of a "preexisting occupational disease involving the right upper extremity ulnar nerve at the elbow, as well as the median nerve in the carpal tunnel; related to his pre-injury work activity…." Dr. Anderson further opined:

> His work activity with his employer would be considered the cause of the occupational disease resulting in the ulnar nerve compression neuropathy and the right carpal tunnel median nerve compression. Additionally, the work with the employer caused the right shoulder biceps tendon disruption. No preexisting condition identified to the shoulder.

Dr. Anderson recommended additional diagnostic studies and opined more likely than not Employee would need ulnar nerve transposition at the elbow and possible carpal tunnel release. He recommended an evaluation by an orthopedic upper extremity specialist. He opined Employee was medically stable related to the bicep tear but not yet medically stable related to the ulnar neuropathy. (Dr. Anderson EME, January 28, 2011).

12) On February 17, 2011 Liberty Northwest case manager Lori McFarland contacted Dr. Cobden and requested his opinion on Dr. Anderson's report. On February 28, 2011, Dr. Cobden issued an addendum report noting he generally agreed with most of Dr. Anderson's conclusions, including Dr. Anderson's recommendation for additional treatment for the ulnar nerve compression neuropathy and Dr. Anderson's conclusion the neuropathy was work related. He noted

> [c]ausation has not been rate is (sic) an issue, but it was apparently reported to his employer (Winnresidential) on a timely basis and therefore should be included in his treatment plan. This plan would include an ulnar and median nerve decompression and anterior transposition. We will plan to go ahead with the suggested treatment as soon as it can be authorized.

(L. McFarland letter to Dr. Cobden, February 17, 2011; Dr. Cobden addendum, February 28, 2011).

13) On March 9, 2011, Employee attended a follow-up appointment with Dr. Cobden. Dr. Cobden noted he and Dr. Anderson agreed Employee "has an occupationally related injury to his right arm (cubital tunnel syndrome) which must be addressed and treated." (Dr. Cobden report, March 9, 2011).

14) On November 8, 2011, Dr. Cobden performed an anterior transposition of the right ulnar nerve and cubital tunnel release and release of carpal canal in the right wrist. (Dr. Cobden operative report, November 8, 2011).

15) Employee continued to experience numbness and tingling in his right fourth and fifth fingers and underwent a course of physical therapy, without improvement. (Willow Physical Therapy chart notes, December 2011).

16) On December 26, 2011, Employee attended a follow-up appointment with Dr. Cobden. Dr. Cobden refilled Employee's pain medication prescription and recommended continued physical therapy. (Dr. Cobden report, December 26, 2011).

17) On January 26, 2012, Employee attended a follow-up appointment with Dr. Cobden. Employee complained of continued paresthesias and pain and weakness in his right upper arm. Dr. Cobden recommended continued physical therapy. (Dr. Cobden report, January 25, 2012).

18) On February 29, 2012, Employee attended a follow-up appointment with Dr. Cobden. Because his symptoms were not improving, Dr. Cobden referred Employee for additional nerve conduction studies. Employee complained of difficulty with urination, and Dr. Cobden referred Employee to a urologist to determine if his medications were causing dysuria. (Dr. Cobden report, February 29, 2012).

19) On March 7, 2012, PA-C Pomeroy reviewed nerve conduction studies which revealed abnormal results in both arms. Employee complained for the first time of symptoms in his left arm as well as his right. PA-C Pomeroy noted "[o]ur concern is that his entrapment neuropathies are occurring at a more proximal level and that would explain why he has not enjoyed good resolution of his symptoms following surgery for ulnar nerve transposition and carpal tunnel release." (PA-C Pomeroy report, March 7, 2012).

20) On March 14, 2012, Employee was admitted to Fairbanks Memorial Hospital with severe urinary tract symptoms. James Cagle, DO initially evaluated Employee and diagnosed acute renal failure. Employee had a fever, altered mental status, elevated bilirubin, and right hand swelling. Dr. Cagle noted Employee's family member left a note at the nursing station stating Employee had experienced difficulty urinating since he was a child. Employee was evaluated by John Huffer, MD, a urologist. Employee complained of dysuria, straining to urinate and urge incontinence. He stated the incontinence had occurred "for about 10 years" and worsened after recent surgeries. He admitted to a prolonged history of heavy alcohol abuse and that he had stopped drinking one year prior. Dr. Huffer ordered an ultrasound which revealed large volume bladder and moderate to severe bilateral hydroureteronephrosis. A catheter was placed and

nearly two liters of urine was collected. Employee was medevaced by airplane to Anchorage for possible dialysis. (Fairbanks Memorial Hospital records, March 14, 2012).

21) Upon admission to Providence Medical Center in Anchorage, Employee was in critical condition with altered mental status, acute renal failure and right hand cellulitis. On March 17, 2012, Employee underwent surgical irrigation and debridement of the right hand, at the prior carpal tunnel release incision. The surgeon noted "immediate purulent drainage, which represented pus under pressure that came out of the wound. There was over 10 ml of yellow thick gross purulent material that was drained from the wound." Cultures revealed Group B strep infection. (Providence Medical Center records, March 15 – 27, 2012).

22) On May 8, 2012, Employee saw hand specialist Christopher Jensen, MD. Employee complained of complete numbness in all five fingers of the right hand not improved since the irrigation and debridement. Dr. Jensen indicated additional surgery may be necessary. (Dr. Jensen report, May 8, 2012).

23) On June 25, 2012, Employee underwent a neurology evaluation with James Foelsch, MD. Dr. Foelsch ordered nerve conduction studies and diagnosed right ulnar neuropathy, right median neuropathy and persistent right wrist pain with loss of range of motion, possibly related to postsurgical immobility and possibly the effects of the localized infection. (Dr. Foelsch report, June 25, 2012).

24) On July 17, 2012, Employee underwent an EME with a three-member panel. The panel consisted of addiction and pain medicine specialist Gary Olbrich, MD, orthopedic surgeon Steven Groman, MD, and neurologist Gerald Reimer, MD. (EME Reports, July 17, 2012).

25) Dr. Olbrich diagnosed alcohol dependence, in early full remission, and active opioid dependence maintained by prescription narcotics. (Dr. Olbrich EME report, July 17, 2012).

26) Drs. Groman and Reimer diagnosed:

1. Pre-existing polyneuropathy bilateral upper extremities, unrelated to work.
2. Regarding the accepted condition of right biceps tendon: tear/right arm injury related to the 12/30/09 work injury, this condition was resolved by surgical tenodesis of the long head of the biceps and became medically stationary on 07/05/10.
3. Status-post unsuccessful cubital tunnel surgery, with subcutaneous anterior ulnar nerve transposition, 11/08/11. The condition for which the surgery was intended is likely related to a polyneuropathy condition and was pre-existent to the 12/30/09 injury and, in our opinion, unrelated to any work injury.

4. Status-post right carpal tunnel release, 11/08/11, with no history of carpal tunnel symptoms, based on electrodiagnostic abnormalities, in our opinion, consistent with polyneuropathy and unrelated to work or injury. As carpal tunnel syndrome is a clinical diagnosis based on symptoms, and the claimant was asymptomatic, this condition did not exist.
5. Deep abscess light carpal tunnel, status post decompression and debridement, concomitant with acute on chronic renal failure and sepsis, which occurred four months after the carpal tunnel release of the right hand.
6. Severe right median neuropathy secondary to *#5* above.
7. Stiffness right hand, secondary to *#5* above.
8. Previous history of right shoulder surgery sometime in the past, resulting in mild restriction of internal rotation of the right shoulder, pre-existent to the claimant's current work injury.

Drs. Groman and Reimer opined Employee's neuropathy condition was unrelated to any work activity and disagreed with the carpal tunnel diagnosis, as Employee did not complain of carpal tunnel symptoms. They opined Employee's bicep tendon tear was medically stable as of July 5, 2010 and required no further treatment. (Drs. Groman and Reimer EME Report, July 17, 2012).

27) On September 5, 2012, Employer filed a controversion notice, denying treatment related to kidney, liver and urinary tract conditions, Hepatitis C, and right carpal tunnel syndrome; future surgery of the right arm or hand, and further treatment for the right bicep tendon tear, based on Drs. Olbrich, Groman and Reimer's reports. Employer noted "continued therapy and disability benefits for the right arm will continue to be paid as reasonable and necessary until such time as the ulnar neuropathy condition is deemed medically stable or determined unrelated to the 12/30/2009 injury." (Controversion Notice, August 29, 2012).

28) On October 10, 2012, Employee filed a workers' compensation claim, seeking permanent partial impairment (PPI) benefits, medical benefits, reemployment eligibility determination, penalty, interest, SIME, and attorney's fees and costs. (WCC, October 10, 2012).

29) On October 26, 2012, Employer filed a controversion notice and answer to Employee's claim, admitting liability for reasonable and necessary medical treatment for Employee's bicep tendon tear and noting

> Continued therapy and disability benefits for the right arm continue to be paid as reasonable and necessary until such time as the ulnar neuropathy condition is deemed medically stable or determined to be unrelated to the 12/30/09 injury. However, the 7/17/12 EIME report concludes the kidney, liver, and Hepatitis C conditions are chronic in nature and were not caused by the 12/30/2009 injury.

> The 3/15/12 acute condition of renal and liver failure was caused by urinary retention and sepsis. Therefore, any and all treatment related to conditions of the kidney, liver, and urinary tract, Hepatitis C, and right carpal tunnel syndrome are controverted. Any and all future surgery of the right arm or hand is controverted, as the EIME physicians believe Employee does not suffer from right carpal tunnel syndrome. His symptoms are due to a pre-existing, non-industrial condition.

(Answer and Controversion Notice, October 24, 2012).

30) On December 7, 9, and 10, 2013, Employee underwent a three-member SIME with an orthopedic surgeon, urologist and infectious disease specialist. Orthopedic surgeon John Lipon, DO, opined Employee's December 30, 2009 bicep tear and subsequent surgical repair was work-related and medically stable as of July 5, 2010. Dr. Lipon opined there was no injury to Employee's right wrist, ulnar forearm or cubital tunnel at the time of the December 30, 2009 accident. Dr. Lipon noted typical work activities associated with cubital tunnel syndrome are leaning on elbows at a desk or workbench or repetitive trauma to the ulnar nerve at the cubital tunnel. "Based on my review of the records and Mr. Lash's explanation of his work activities as a maintenance person, he does a variety of activities, but none include repetitive trauma to the ulnar nerve at the elbow or putting pressure on his elbows…." Dr. Lipon concluded there is insufficient evidence attributing Employee's cubital tunnel syndrome to any work activities and stated the cause is "probably idiopathic." He opined there was no work injury to the ulnar nerve, and that the work injury (the bicep tear) did not aggravate, accelerate or combine with any preexisting condition to produce a change in the preexisting condition. (Dr. Lipon SIME report, December 7, 2013).

31) Urologist James Downey, MD, opined Employee had a preexisting underlying bladder problem which was aggravated by long-term narcotic use related to his right arm orthopedic problems. Specifically, Dr. Downey attributed 75% of the disability and need for medical treatment to narcotic use and 25% to the underlying bladder dysfunction. He opined Employee will require medication to treat his urinary problems indefinitely. (Dr. Downey SIME report, December 9, 2013).

32) On December 10, 2013, infectious disease specialist Peter Marsh, MD, opined Employee's carpal tunnel syndrome, which "per orthopedic notes … was also work related, and the carpal tunnel syndrome followed by surgery and postoperative infection" is now "the substantial cause of his disability." Dr. Marsh opined the postoperative infection "markedly

worsened" Employee's preexisting carpal tunnel syndrome and ulnar nerve compression. (Dr. Marsh SIME, December 10, 2013).

33) On January 30, 2014, in response to a letter by Employer's counsel, Dr. Downey issued an addendum report:

> It was not clear to me from the material I had been provided that the distal right arm problems were unrelated to the work injury. In answer to your first question, since, as per Dr. Lipon, they are unrelated and there was an interval of no narcotic use I have to change my conclusion as to the causality of the urinary retention problem. Because the only connection between the orthopedic therapies and his urinary retention would be the narcotic use, and since the concurrent use of narcotics at the time of the urinary retention was not for the original work injury (per Dr. Lipon), I have to conclude that the urinary retention was not related to the original work injury.

(Dr. Downey addendum report, January 30, 2014).

34) Scott McDevitt, Employee's supervisor at Winnresidential, credibly testified about Employee's work. Employee was a general laborer, doing demolition work in military housing. He described Employee's repetitive work as tearing up carpet, cutting the carpet into lengths, rolling it up, and carrying it out. He would remove carpet staples with a crowbar or flatbar on his hands and knees. It testified it could "take force" to remove the staples. Employee began this work in February 2009 and continued until his injury in December 2009. McDevitt had "no recollection" of Employee having problems with his hand. (McDevitt).

35) Employee credibly testified about his work for Employer, his injury and subsequent medical problems. He worked for Employer doing "general maintenance" demolition work in military housing units. While he removed appliances and cabinetry, roughly 90% of his job was carpet removal. He described the work as using a carpet knife to cut the carpet, roll it up, shrink wrap it, haul it out, then do the same with the carpet pad. He used a crowbar to pull up the staples. On hard floors, it was difficult to remove the staples and he used a repetitive motion with his right arm "all day." He started to notice numbness in his right little finger about two months before his bicep injury, and then noticed numbness in his right ring finger. He reported the finger numbness to his supervisor Scott McDevitt, who told him to "do stretches." He tried stretching exercises but they did not reduce the numbness and tingling. He reported the numbness and tingling to Dr. Cobden when he first saw him after the bicep injury. After his bicep surgery, Employee began noticing more numbness, and Dr. Cobden did another surgery in

November 2011. Employee went to physical therapy but his pain continued. He complained of a burning sensation at the incision scar, but Dr. Cobden told him it was normal. His hand swelled and his sister took him to the emergency room. He has no memory of the hospital visit and was told later he was hallucinating. He vaguely remembered the medevac flight but his only clear memories are of the last days of treatment in Anchorage. When he returned to Fairbanks he saw orthopedic surgeon Wendy Boucher, MD and urologist Dr. Huffer. He had severe kidney damage and had to wear a catheter for a year. He denies having "lifelong" urology problems and stated his sister gave an inaccurate history to emergency room staff. He had treated for urology problems in the late 1980s but received antibiotics and did not have further urinary problems until after the work injury. While he has been a "lifelong drinker," he does not believe he is an alcoholic, and he stopped drinking completely "about three years ago." When asked about the bilateral abnormal neurology results, he stated he has never had any symptoms on his left side, but he still has very little strength in his right hand and experiences significant right hand pain. He continues to monitor with a kidney specialist. (Employee).

36) On September 12, 2014, the board sent the parties a letter:

> Upon review of the written record and in light of testimony at the July 31, 2014 hearing, it appears a significant gap in the medical evidence exists in this case, warranting an SIME under AS 23.30.110(g). Specifically, there is no clear medical opinion answering the following questions:
>
> > 1) Are Employee's repetitive motion activities at work in 2009 the substantial cause of Employee's ulnar neuropathy and subsequent need for medical treatment?
> >
> > 2) Did Employee's repetitive motion activities at work in 2009 aggravate, accelerate, or combine with a pre-existing condition to result in Employee's disability or need for medical treatment?
>
> The purpose of this letter is to provide the parties the opportunity to brief the issue of whether an additional SIME is appropriate in this case. A prehearing conference is scheduled for **September 29, 2014 at 10:00 am** to set briefing deadlines, or in the alternative, to set deadlines related to the SIME.

(Board letter, September 12, 2014)(emph. in original).

37) On September 29, 2014, the parties agreed the issue of whether an additional SIME is warranted would be heard on the written record on November 6, 2014. (PHC Summary, September 29, 2014).

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.

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.

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….
…

(k) In the event of a medical dispute regarding determinations of causation, medical stability, ability to enter a reemployment plan, degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's independent medical evaluation, the board may require that a second independent medical evaluation be conducted by a physician or physicians selected by the board from a list established and maintained by the board. . . .

AS 23.30.110. Procedure on claims.
. . .
(g) An injured employee claiming or entitled to compensation shall submit to the physical examination by a duly qualified physician which the board may require. The place or places shall be reasonably convenient for the employee. The physician or physicians as the employee, employer, or carrier may select and pay for may participate in an examination if the employee, employer, or carrier so requests. Proceedings shall be suspended and no compensation may be payable for a period during which the employee refuses to submit to examination.

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;

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 in this chapter. The board may make its investigation or inquiry or conduct its hearing in the manner by which it may best ascertain the rights of the parties. . . .

AS 23.30.155. Payment of compensation.
. . .

> (h) The board may upon its own initiative at any time in a case . . . where right to compensation is controverted . . . make the investigations, cause the medical examinations to be made, or hold the hearings, and take the further action which it considers will properly protect the rights of all parties.

8 AAC 45.092. Selection of an independent medical examiner.

. . .

(g) If there exists a medical dispute under AS 23.30.095(k),

. . .

> (2) a party may petition the board to order an evaluation; the petition must be filed with 60 days after the party received the medical reports reflecting a dispute, or the party's right to request an evaluation under AS 23.30.095(k) is waived;
>
> > (A) the completed petition must be filed timely together with a completed second independent medical form, available from the division, listing the dispute; and
> >
> > (B) copies of the medical records reflecting the dispute; or
>
> (3) the board will, in its discretion, order an evaluation under AS 23.30.095(k) even if no party timely requested an evaluation under (2) of this subsection if
>
> > (A) the parties stipulate, in accordance with (1) of this subsection to the contrary and the board determines the evaluation is necessary; or
> >
> > (B) the board on its own motion determines an evaluation is necessary.

The following, general criteria are typically considered when ordering an SIME, though the statute does not expressly so require:

> 1) Is there a medical dispute between Employee's physician and Employer's EME?
> 2) Is the dispute "significant?"
> 3) Will an SIME physician's opinion assist the board in resolving the disputes? (*Digangi v. Northwest Airlines*, AWCB Decision No. 10-0028 at 13 (February 9, 2010)(citations omitted)).

Section 095(k) is procedural and not substantive for the reasons outlined in *Deal v. Municipality of Anchorage* (AWCB Decision No. 97-0165 at 3 (July 23, 1997). Section 135 provides the board wide discretion pursuant to §095(k) to consider any evidence available when deciding whether to order an SIME to assist in investigating and deciding medical issues in contested claims. AS 23.30.155(h) also allows for board-ordered medical evaluations in controverted cases.

Under the Act, an employer shall furnish an employee injured at work any medical treatment "which the nature of the injury or process of recovery requires" within the first two years of the injury. The medical treatment must be "reasonable and necessitated" by the work-related injury. Thus, when the board reviews an injured employee's claim for medical treatment made within two years of an indisputably work-related injury, "its review is limited to whether the treatment sought is reasonable and necessary." *Philip Weidner & Associates v. Hibdon*, 989 P.2d 727, 730 (Alaska 1999).

AS 23.30.095(a) requires employers to pay for treatment necessitated by the nature of injury or the process of recovery up to two years after the injury date. After two years the board may authorize treatment necessary for the process of recovery or to prevent disability. In *Hibdon*, the Alaska Supreme Court noted "when the Board reviews a claim for continued treatment beyond two years from the date of injury, it has discretion to authorize 'indicated' medical treatment 'as the process of recovery may require.'" *Citing Municipality of Anchorage v. Carter*, 818 P.2d 661, 664 (Alaska 1991). "If the treatment is necessary to prevent the deterioration of the patient's condition and allow his continuing employment, it is compensable within the meaning of the statute." *Leen v. R.J. Reynolds Co.*, AWCB Dec. No. 98-0243 (September 23, (1998); *Wild v. Cook Inlet Pipeline*, 3AN-80-8083 (Alaska Super. Ct. Jan. 17, 1983); *see accord Dorman v. State*, 3AN-83-551 at 9 (Alaska Super. Ct., February 22, 1984).

Under AS 23.30.120, an injured worker is afforded a presumption the benefits he or she seeks are compensable. The Alaska Supreme Court held the presumption of compensability is applicable to any claim for compensation under the workers' compensation statute, and applies to claims for medical benefits and continuing care. *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996); *Municipality of Anchorage v. Carter*, 818 P.2d 661, 664-665 (Alaska 1991). An employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski v. Best Western Golden Lion*, 813 P.2d 286, 292 (Alaska 1991).

Application of the presumption to determine the compensability of a claim for benefits involves a three-step analysis. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381 (Alaska 1991). First,

the claimant must adduce "some" "minimal," relevant evidence establishing a "preliminary link" between the disability and employment, or between a work-related injury and the existence of disability, to support the claim. *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987). The evidence necessary to raise the presumption of compensability varies depending on the claim. In claims based on highly technical medical considerations, medical evidence is often necessary to make that connection. *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). In less complex cases, lay evidence may be sufficiently probative to establish causation. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). 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. If the presumption is raised and not rebutted, the claimant need produce no further evidence and the claimant prevails solely on the raised but un-rebutted presumption. *Williams v. State*, 938 P.2d 1065 (Alaska 1997).

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

> "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).

"Substantial evidence" is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 611-612 (Alaska 1999); *Miller* at 1046.

Since the presumption shifts only the burden of production and not the burden of persuasion, the employer's evidence is viewed in isolation, without regard to any evidence presented by the claimant. *Id.* at 1055. Credibility questions and weight to give the employer's evidence are deferred until after it is decided if the employer has produced a sufficient quantum of evidence to rebut the presumption the claimant is entitled to the relief sought. *Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051 (Alaska 1994); *Wolfer* at 869.

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

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

The AWCAC further commented on the legal standard for proving "aggravation" and "combination" claims for injuries occurring after the 2005 amendments in *City of Juneau v. Olsen*, AWCAC Decision No. 185 (August 21, 2013):

> The starting point is the [S]upreme [C]ourt's statement, under former law, that "for an employee to establish an aggravation claim under workers' compensation law, the employment need only have been 'a substantial factor in bringing about the [need for medical treatment].'" Here, it follows that, for Olsen to establish an aggravation claim under the 2005 amendments to the Act, she must show that her employment was the substantial cause in bringing about the need for treatment in the form of the implantation procedure. Second, AS 23.30.010(a) requires the board to evaluate the relative contribution of different causes of the need for medical treatment. Consequently, in the present context, we hold that the board needs to evaluate the relative contribution of the two causes of Olsen's knee pain, the preexisting arthritis and the work incidents. The next step is for the board to apply the presumption of compensability analysis in these specific circumstances. Because there is consensus that Olsen attached the presumption and CBJ rebutted it, this task is made simpler. The only remaining question is whether Olsen can prove by a preponderance of the evidence that employment, that is, the work incidents, were the substantial cause in bringing about her need for the implantation procedure….

> For "combination" claims, if Olsen's claim is considered to be one, the [S]upreme [C]ourt introduced supplementary criteria in terms of the showing an employee must make to satisfy the burden of proof by a preponderance of the evidence. Under pre-amendment law, in order "[t]o prove that a work injury combined with a preexisting condition to produce a [need for medical treatment], the employee must show that '(1) the [need for medical treatment] 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 [need for medical treatment] and attach responsibility to it.'" As discussed below, with some revision to reflect the 2005 amendments, including enactment of AS 23.30.010(a), the commission considers it incumbent on Olsen to satisfy these two supplementary criteria in order make the showing that will satisfy her burden of proof by a preponderance of the evidence for a "combination" claim.

ANALYSIS

1) Should an additional SIME be ordered?

An SIME may be required if certain factors are met, beginning with a medical dispute between Employee's attending physician and the EME, or a "gap" in the relevant medical evidence. Here, upon initial deliberation, the panel noted the complexity of the medical issues, which involve multiple body systems, the duration and severity of treatment, and the varying theories of compensability raised by the parties. It appeared at first blush there was a paucity of medical opinion specifically addressing Employee's second theory of the case, that Employee's repetitive motion activities at work in 2009 caused his ulnar neuropathy. Specifically, the panel informed the parties it appeared an SIME may be necessary to address the following questions:

> 1) Are Employee's repetitive motion activities at work in 2009 the substantial cause of Employee's ulnar neuropathy and subsequent need for medical treatment?
>
> 2) Did Employee's repetitive motion activities at work in 2009 aggravate, accelerate, or combine with a pre-existing condition to result in Employee's disability or need for medical treatment?

Upon more in-depth review of the record and the parties' respective briefs on the issue of whether an additional SIME is warranted, the panel determines there is sufficient evidence in the existing record to answer these two questions. Specifically, Dr. Lipon noted typical work activities associated with cubital tunnel syndrome are leaning on elbows at a desk or workbench

or repetitive trauma to the ulnar nerve at the cubital tunnel. He stated, "Based on my review of the records and Mr. Lash's explanation of his work activities as a maintenance person, he does a variety of activities, but none include repetitive trauma to the ulnar nerve at the elbow or putting pressure on his elbows…." Dr. Lipon concluded there is insufficient evidence attributing Employee's cubital tunnel syndrome to any work activities and stated the cause is "probably idiopathic." He later stated there was no work injury to the ulnar nerve and that Employee's work injury (the bicep tear) did not aggravate, accelerate or combine with any preexisting condition to produce a change in the preexisting condition. While Dr. Lipon did not specifically describe the work activities Employee reported to him, his opinion is sufficient to find he took a thorough patient history and considered the nature of the work activities Employee described. This is sufficient evidence for the board to answer its questions related to Employee's repetitive work activities. The facts and the law do not provide a basis to order an additional SIME.

2) Is the December 30, 2009 bicep injury the substantial cause of Employee's continued disability and need for medical treatment for ulnar neuropathy?

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 ulnar neuropathy and subsequent complications with the reports of his treating physician Dr. Cobden and EME Dr. Anderson. Specifically, Dr. Cobden opined Employee's ulnar nerve compression neuropathy was work related. In response to the question whether the work injury aggravated, accelerated or combined with a preexisting condition to produce the need for treatment or disability, Dr. Anderson opined Employee's work activity was the cause of the occupational disease resulting in the ulnar nerve compression and right carpal tunnel median nerve compression.

Once the presumption is raised, Employer must rebut the presumption the work injury is the substantial cause of Employee's need for medical treatment for ulnar neuropathy and subsequent complications with substantial evidence, which is viewed in isolation and without a determination of credibility. Employer relies on the opinions of EME physicians Drs. Groman and Reimer, and SIME physician Dr. Lipon, who opined the December 30, 2009 work injury resulted in a torn bicep only, which became medically stable on July 5, 2010. They further

opined Employee's finger numbness and resulting surgeries were caused by non-industrial preexisting upper extremity polyneuropathy. Employer further relies on Dr. Olbrich, who opined Employee's polyneuropathy was most likely related to Employee's long history of alcohol abuse. Finally, Employer relies on the SIME physicians Drs. Marsh and Downey, who opined Employee's palmar space infection and urinary problems are not related to the December 30, 2009 injury.

Once Employer rebuts the presumption of compensability, employee must prove his claim by a preponderance of the evidence. Under *Olsen,* to prevail on his claim for benefits related to his ulnar neuropathy and subsequent complications under his first theory, Employee must show his December 30, 2009 work injury is the substantial cause, in relation to all other causes, of his disability and need for continued medical treatment. Further, to prevail on a "combination claim," Employee must additionally satisfy two supplemental criteria: that (1) the need for medical treatment would not have happened "but-for" the work injury, and (2) reasonable persons would regard the injury as a cause of the need for medical treatment and attach responsibility to it.

Employee relies on Dr. Anderson's opinion "the work activity was the cause of the occupational disease resulting in the ulnar nerve compression and right carpal tunnel median nerve compression." Dr. Cobden concurred with Dr. Anderson's opinion the neuropathy was "work related." However, while Dr. Anderson rendered that opinion in response to the question whether the work injury aggravated or combined with a preexisting condition, it is unclear whether he is referring to the December 30, 2009 bicep tear or Employee's reported earlier work activities. Dr. Cobden does not specifically address the issue of whether the polyneuropathy preexisted the bicep injury and if so, whether the bicep injury aggravated or accelerated the neuropathy. In contrast, Drs. Groman and Reimer opine the bicep injury was completely separate and distinct from the polyneuropathy, and the bicep injury was medically stable and required no additional treatment by July 2010. Dr. Lipon explicitly stated the December 30, 2009 injury did not aggravate, accelerate or combine with any preexisting condition to produce a change in the preexisting condition. Further, even Dr. Anderson's opinion was equivocal, noting

additional diagnostic testing was necessary "to further characterize the pathology" of the neuropathy.

The weight of the evidence favors finding the December 30, 2009 bicep tear did not aggravate, accelerate or combine with Employee's preexisting neuropathy to permanently change the preexisting condition. Further, there is no evidence the bicep injury directly caused the neuropathy. Evaluation of the medical evidence shows it is more likely than not the December 30, 2009 work injury is not the substantial cause of Employee's disability and need for medical treatment for his ulnar neuropathy and subsequent complications.

3) Are Employee's repetitive motion activities at work in 2009 the substantial cause of his continued disability and need for medical treatment for ulnar neuropathy?

Again, this is a factual question to which the presumption of compensability applies. Employee raises the presumption his repetitive motion activities at work in 2009 are the substantial cause of his continued disability and need for medical treatment with his hearing testimony and the reports of Drs. Cobden and Anderson.

Employer rebuts the presumption with the reports of EME physicians Drs. Groman and Reimer, and SIME physician Dr. Lipon. The burden now shifts to Employee to prove by a preponderance his repetitive work activities in 2009 are the substantial cause of his polyneuropathy and subsequent complications. He fails to meet this burden.

At hearing, Employee described in detail his repetitive motion work activities. He used a carpet knife to cut carpet and carpet pads, roll and shrink wrap them, shrink wrap it, and haul them out. He used a crowbar to pull up the carpet staples. On hard floors, it was difficult to remove the staples and he used a repetitive motion with his right arm "all day." Dr. Anderson attributes Employee's finger numbness to work activities he did during the fall of 2009, where he used a carpet knife and performed "strenuous heavy lifting, gripping, and squeezing activities." Dr. Anderson diagnosed work related right elbow ulnar nerve compression neuropathy. He opined the December 30, 2009 injury was not the substantial cause of the ulnar neuropathy, but the wrist and finger numbness was the result of a "preexisting occupational disease involving the right

upper extremity ulnar nerve at the elbow, as well as the median nerve in the carpal tunnel; related to his pre-injury work activity…." Dr. Cobden concurred with Dr. Anderson's opinion, with a brief conclusory statement the neuropathy was work related.

The panel finds Employee's testimony credible and does not doubt his description of either his work activities or symptoms. However, the weight of the evidence simply shows it is more likely than not the neuropathy was not caused by Employee's work activities. Drs. Groman and Reimer opined Employee's neuropathy condition was unrelated to any work activity and disagreed with the carpal tunnel diagnosis, as Employee did not complain of carpal tunnel symptoms. SIME Dr. Lipon noted typical work activities associated with cubital tunnel syndrome are leaning on elbows at a desk or workbench or repetitive trauma to the ulnar nerve at the cubital tunnel. "Based on my review of the records and Mr. Lash's explanation of his work activities as a maintenance person, he does a variety of activities, but none include repetitive trauma to the ulnar nerve at the elbow or putting pressure on his elbows…." The panel notes when Employee described his work activities he demonstrated the repetitive motion he used to cut carpet and remove staples. The motion did not place pressure on his elbows. Dr. Lipon concluded there is insufficient evidence attributing Employee's cubital tunnel syndrome to any work activities and stated the cause is "probably idiopathic." Dr. Anderson's opinion was equivocal, recommending additional diagnostic testing to determine pathology. Dr. Cobden simply agreed with Dr. Anderson.

There is no question Employee's current disability and need for treatment, which is extensive and involves multiple body systems, stems from the November 8, 2011 cubital tunnel and carpal tunnel surgery. To find the surgery compensable is to find all treatment and associated disability flowing from it compensable. However, evaluation of the totality of the medical evidence shows it is more likely than not Employee's work activities in the fall of 2009 are not the substantial cause of Employee's need for treatment for ulnar neuropathy or the subsequent complications. Employee's claim will be denied.

CONCLUSIONS OF LAW

1) An additional SIME will not be ordered.

2) The December 30, 2009 work injury is not the substantial cause of Employee's disability or need for medical treatment for ulnar neuropathy.

3) Employee's repetitive motion activities at work in 2009 are not the substantial cause of his disability or need for medical treatment for ulnar neuropathy.

4) Employee's October 10, 2012 claim will be denied.

ORDER

Employee's October 10, 2012 claim is DENIED.

Dated in Fairbanks, Alaska, this 8th day of December, 2014.

ALASKA WORKERS' COMPENSATION BOARD

/s/_____
Amanda K. Eklund, Designated Chair

/s/_____
Sarah Lefebvre, Member

RICK TRAINI, MEMBER, CONCURRING IN PART, AND DISSENTING IN PART

The labor member respectfully dissents in part from the majority's decision. I agree with and join in the majority's conclusion no additional SIME is warranted. I also agree the December 30, 2009 bicep tear is not the substantial cause of Employee's continued disability and need for medical treatment. However, I disagree with the majority's analysis and conclusion related to Employee's repetitive motion activities at work and his subsequent ulnar nerve injury. Employee suffered a compensable repetitive motion injury while working for Employer, and he is entitled to medical and indemnity benefits related to that injury. Employee's October 10, 2012 claim for benefits should be granted.

/s/_____
Rick Traini, Member

APPEAL PROCEDURES

This compensation order is a final decision and becomes effective when filed in the Board's office, unless it is appealed. Any party in interest may file an appeal with the Alaska Workers' Compensation Appeals Commission within 30 days of the date this decision is filed. All parties before the Board are parties to an appeal. 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 because the Board takes no action on reconsideration, whichever is earlier.

A party may appeal by filing with the Alaska Workers' Compensation Appeals Commission: (1) a signed notice of appeal specifying the board order appealed from; 2) a statement of the grounds for the appeal; and 3) proof of service of the notice and statement of grounds for appeal upon the Director of the Alaska Workers' Compensation Division and all parties. Any party may cross-appeal by filing with the Alaska Workers' Compensation Appeals Commission a signed notice of cross-appeal within 30 days after the board decision is filed or within 15 days after service of a

notice of appeal, whichever is later. The notice of cross-appeal shall specify the board order appealed from and the grounds upon which the cross-appeal is taken. Whether appealing or cross-appealing, parties must meet all requirements of 8 AAC 57.070.

RECONSIDERATION

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

MODIFICATION

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

CERTIFICATION

I hereby certify that the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of ALLEN LASH, employee v. WINNRESIDENTIAL LIMITED PARTNERS, employer; and LIBERTY MUTUAL INSURANCE CO., insurer; Case No. 200918991, dated and filed in the office of the Alaska Workers' Compensation Board in Fairbanks, Alaska, and served on the parties this 8th day of December, 2014.

/s/_____
Darren Lawson, Office Assistant II