ALASKA WORKERS' COMPENSATION BOARD

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

GREG WEAVER, Employee, Claimant,	)	FINAL DECISION AND ORDER
v.	)	AWCB Case No. 201320030
ASRC FEDERAL HOLDING COMPANY, Employer,	)	AWCB Decision No. 17-0124
and	)	Filed with AWCB Fairbanks, Alaska on October 27, 2017
ARCTIC SLOPE REGIONAL CORP., Insurer, Defendants.	)	

Greg Weaver's February 19, 2014, and June 17, 2014 claims were heard in Fairbanks, Alaska on March 9, 2017, a date selected on October 10, 2016. The hearing resumed on July 6, 2017, a date selected on March 28, 2017. Attorney Michael Jensen appeared and represented Greg Weaver (Employee). Attorney Nora Barlow appeared and represented ASRC Federal Holding Company (Employer). Employee's physician, Joyce Restad, D.O., and his father, Greg Weaver, Sr., testified on Employee's behalf. Employee also testified on his own behalf. Employer's medical evaluator, Patrick Radecki, M.D., and its Facilities and Electronics Section Operations Manager, John Williamson, testified on Employer's behalf. The record closed upon receipt of the parties' post-hearing briefs on July 13, 2017.

ISSUES

Employee contends he filed a request for cross-examination on one of Employer's medical examiners (EME), Stephen Marble, M.D., and Employer did not produce him for hearing. He

contends, therefore, Dr. Marble's January 9, 2014 report should be excluded from consideration. In response to Employer's contention that Employee relied on Dr. Marble's report in his hearing brief, Employee contends, at the time he filed his hearing brief, he did not have Employer's witness list, but he anticipated Dr. Marble would testify based on his request for cross-examination, so he thought it best to address Mr. Marble's anticipated testimony in his hearing brief.

Employer contends Employee relies on Dr. Marble's report, which he prominently featured in his brief, so Dr. Marble's report should not be excluded.

1) Should Dr. Marble's January 9, 2014, EME report be excluded from consideration?

Employee contends he filed a request for cross-examination of Shawn Johnston, M.D., who indicated he concurred with Dr. Marble's January 9, 2014 opinions. Employee objects to any consideration of Dr. Johnston's February 3, 2014, "check-the-box" concurrences since Dr. Johnston did not testify at hearing. Employee contends Dr. Johnston's concurrences are not admissible as a business records exception to the hearsay rule because it was prepared by Employer's nurse case manager in anticipation of litigation and not by Dr. Johnston as part of a regular activity of his medical practice. Employee denies *Frazier v. H.C. Price/Ciri Construction JV*, 794 P.2d 103; 105 (Alaska 1990), is applicable under the circumstances, because it was not him, but rather Employer's nurse case manager, who authorized Dr. Johnston's responses.

Employer contends Dr. Johnston's concurrences are admissible under the business records exception to the hearsay rule and under *Frazier* since Employee vouched for the credibility of Dr. Johnston as his treating physician.

2) Should Dr. Johnston's "check-the-box" concurrences be excluded from consideration?

Employer contends the issues for hearing are Employee's February 19, 2014, and June 17, 2014, claims, which are both based on Employee's July 23, 2013, work injury. It contends, although Employee petitioned to join his December 7, 2010, work injury to the instant case, he never filed

a claim seeking benefits for that injury. Employer further contends any such claim would also be barred by operation of AS 23.30.105.

Employee contends Employer's argument his 2010 injury is not joined as an issue for hearing should be "dismissed." He contends Employer clearly knew his 2010 injury was joined because it filed a non-opposition to his petition seeking joinder, it questioned the second independent medical evaluator (SIME) about his 2010 injury at that physician's deposition, and Employer referenced Employee's 2010 injury in letters to its defense medical experts. Employee contends the benefits he seeks for his 2013 injury "are the same as would be part of the 2010 claim, since the two claims have been joined."

3) Is a claim for benefits arising from Employee's December 7, 2010, injury an issue for hearing?

Employee contends he performed a variety of heavy, physical labor for Employer leading up to his July 23, 2013 injury, including shoveling, erecting scaffolding, pushing a wheelbarrow and using a heavy jack. He contends that labor is the substantial cause of his need for medical care and he seeks an award of medical and related transportation costs.

Employer contends the labor Employee performed is not the substantial cause of his need for medical care, so he is not entitled to an award of medical and related transportation costs.

4) Is Employee entitled to medical and related transportation costs?

Employee contends the heavy, physical labor described above is also the substantial cause of his disability and he seeks an award of past and future temporary total disability (TTD) benefits.

5) Is Employee entitled to TTD?

Employee contends his 2013 injury resulted in a 1 percent to 9 percent permanent partial impairment (PPI), for which he seeks an award.

Employer contends Employee has no PPI rating, so this benefit should be denied.

6) Is Employee entitled to PPI benefits?

Employee contends his vocational rehabilitation specialist was unable to complete his eligibility evaluation due to Employer's controversion. He seeks completion of his evaluation and development of a reemployment plan.

Employer's position on reemployment benefits is unknown, however it is presumed Employer opposes an award of any reemployment benefits.

7) Is Employee entitled to reemployment eligibility evaluation?

Employee seeks an award of statutory interest on all past-due medical and indemnity benefits.

Employer's contends it has timely paid all benefits due Employee and no further benefits are owed. Therefore, it opposes an interest award.

8) Is Employee entitled to interest?

Employee contends he has enlisted the services of an attorney in the prosecution of his claims. He seeks an award of actual attorney's fees "as an advance on the value of statutory minimum fees due on any past and continuing indemnity and medical benefits."

Employer contends, since no additional benefits are due, neither would Employee be entitled to attorney's fees and costs.

9) Is Employee entitled to attorney fees and costs?

FINDINGS OF FACT

The following facts and factual conclusions are established by a preponderance of the evidence:
1) In 1991, Employee received an "OTHER THAN HONORALE" discharge from the United States Marine Corps for alcohol abuse rehabilitation failure. In 1993, Employee was convicted of DUI after a motor vehicle accident that left him with a lacerated aorta, upper extremity

brachial plexus injury, pancreatitis and a traumatic brain injury. In 2015, Employee was convicted of DUI after an incident that occurred in 2014, where he was riding his ATV in a construction zone and harassing a flagger that later turned out to be his wife. Following his 2014 DUI arrest, Employee attended an inpatient treatment facility in Georgia for substance abuse. Employee's wife filed for divorce in 2014 and sought both short and long-term protective orders, citing alleged alcohol abuse and physical abuse by Employee. Short-term and long-term protective orders were granted. In 2017, Employee was charged with a third DUI. (DD-214; Fu report, April 21, 1993; Weaver, Jr.; Summary of Proceedings, January 15 and January 16, 2015; Vivian Weaver Divorce Complaint, January 22, 2014; Petition for Domestic Violence Protective Orders, December 15, 2014; Short-Term Domestic Violence Protective Order, December 15, 2014; Long-Term Domestic Violence Protective Order, January 16, 2015; CourtView party information, undated).

2) On February 25, 2001, Employee injured his low back while working for a former employer. The mechanism of injury was unclear. Due to Employee presenting with moderate to severe pain, his chiropractor desired to treat Employee in excess of the Alaska frequency standards. (Physician's Report, March 12, 2001).

3) On March 25, 2009, Employee was evaluated and treated for low back pain after performing heavy labor in cold weather. (Eagle River Family Practice chart notes, March 25, 2009).

4) On December 9, 2010, Employee injured his low back two days earlier while tightening tire chains on a dump truck and road grader as a relief station mechanic. Employee never filled a workers' compensation claim seeking benefits for his December 7, 2010, work injury. (First Report of Occupational injury or Illness, December 9, 2010; record; observations).

5) Following his December 9, 2010 injury, Employee sought chiropractic treatment several times and his low back symptoms resolved in about two months. (Larson Chiropractic chart notes, January 12, 2010 to January 14, 2011; Marble report, January 9, 2014).

6) On January 12, 2011, Employee sought chiropractic treatment for low back pain that began about one month previous. (Larson Chiropractic Registration and History, January 12, 2011).

7) On February 16, 2012, Employee reported injuring his back while installing garage door panels as a station mechanic. (Report of Occupational Injury or Illness, February 16, 2012).

8) On February 17, 2012, Employee sought treatment for low back pain, which had been intermittent for the last five years. Previous back treatment had included osteopathic

adjustments, which significantly improved Employee's low back pain, and chiropractic adjustments, which also improved his low back pain for a period-of-time. Employee's medical history was significant for mild depression, and he reported "drinking more alcohol than he probably should." (Martin report, February 17, 2012).

9) On April 12, 2013, Employee's supervisor, Troy Klingfus, emailed Employer expressing his concerns that Employer had not provided rigging for he and Employee to handle 180-pound valves they were moving. Mr. Klingfus was concerned he or Employee might be injured. (Klingfus email, April 12, 2013).

10) On July 23, 2013, Employee reported waking up with back pain after shoveling, erecting scaffolding and pushing a wheelbarrow while working as a station mechanic on Barter Island, Alaska. (First Report of Injury, July 26, 2013).

11) On July 26, 2013, Employee sought treatment for low back pain from Joyce Restad, D.O., and reported, "He had been shoveling large amounts of sand and gravel in Kaktovik. He slept on an old, soft, bed with a thin mattress and unsupportive 'springs', and woke up in a lot of pain, on 7/23/13." Dr. Restad ordered a lumbar magnetic resonance imaging study (MRI). (Restad reports, July 26, 2013; July 29, 2013).

12) An August 2, 2013 MRI was interpreted to show mild lower lumbar degenerative disc changes with moderate bilateral neural foraminal stenosis at L5-S1. (MRI report, August 2, 2013).

13) On August 9, 2013, Employee's low back pain was now radiating into his buttocks. He reported he had this pain in his back for over a year and thought it was a kidney stone passing. An epidural steroid shot was recommended. (Algone Interventional Pain Clinic report, August 9, 2013).

14) On August 16, 2013, Dr. Restad referred to Employee's injury as an "overuse injury 7/23/2013 at work." Dr. Restad noted Employee was scheduled to receive three epidural steroid injections, but Employer's case manager thought this treatment was "aggressive" and requested a second opinion, to which Dr. Restad agreed. (Restad report, August 16, 2013).

15) On August 20, 2013, Dr. Restad referred Employee to Dr. Shawn Johnston, M.D. (Restad referral, August 20, 2013).

16) On August 21, 2013, Employee saw Dr. Johnston, who opined most of Employee's pain was facet-mediated and he recommended physical therapy, between one to three times per week, for four weeks. (Johnston report, August 21, 2013)

17) On August 30, 2013, Employee underwent a physical therapy evaluation and reported he was experiencing the worst episode of back pain he could recall. (Excel Physical Therapy report, August 30, 2013).

18) On October 4, 2013, Dr. Johnston noted physical therapy had not provided Employee with much relief, so he decided to "try some lumbar traction over the next two weeks." (Johnston report, October 4, 2013).

19) On October 14, 2013, Employee began traction therapy with Thomas DeSalvo, D.C. Employee's back pain was now radiating into both buttocks. Over the course of numerous treatments, Employee reported his back pain "come [sic] and goes but lately not getting any better." Dr. DeSalvo reported Employee's prognosis was "guarded," and his impression was Employee has "sustained a cumulative trauma injury to the lumbrosacral spine (chronic)." (DeSalvo reports, October 14, 2013 to November 1, 2013).

20) On October 28, 2013, Dr. DeSalvo updated Dr. Johnston's office on Employee's progress. Employee had asked Dr. DeSalvo to decrease the weight of his traction, but since the weight was already relatively light, Dr. DeSalvo thought doing both physical therapy and traction "are too much." Dr. DeSalvo recommended putting physical therapy on hold. (Alaska Spine Institute chart notes, October 28, 2013).

21) On October 31, 2013, Dr. DeSalvo indicated he thought Employee's condition was work related. (Physician's report, October 31, 2013).

22) On November 3, 2013, Dr. Johnston decided to discontinue lumbar traction since it seemed to aggravate Employee's symptoms and he was considering prescribing a work hardening program instead. (Johnston report, November 4, 2013).

23) On November 11, 2013, Employee began an eight-week work hardening program that was to consist of two hours per day for two weeks; four hour per day for two weeks; six hours per day for two weeks; and eight hours per day for two weeks. (Initial Evaluation, November 11, 2013).

24) On December 10, 2013, Dr. Johnston discontinued Employee's work hardening program because Employee could not tolerate it. Employee continued with physical therapy, but did not

improve. (Alaska Spine Institute chart notes, December 10, 2013; Linn report, December 30, 2013).

25) On January 9, 2014, Stephen Marble, M.D., a physiatrist, conducted an EME, during which Employee initially related his current low back symptoms to performing strenuous labor and sleeping on a bed with little support "sometime during the summer of 2013." Later in the evaluation, Employee commented, for the last three to four years, he had had low back pain so severe that he had to lay down in the fetal position, squeeze his legs, and rock back and forth. Dr. Marble noted Employee to be a "vague/poor historian." Upon reviewing the August 2, 2013 MRI imaging study, Dr. Mable saw significant disc desiccation at L4-5 and L5-S1 with a significant loss of disc height at L5-S1, as well as a broad based disc protrusion at L4-5 and a "very broad based" disc protrusion at L5-S1. Dr. Marble assessed multilevel lumbar degenerative disease, greatest at L5-S1, and thought Employee's recorded history and the imaging findings were evidence of a preexisting, evolving, lumbar degenerative disease. Although Dr. Marble acknowledged there was certainly the potential for the work factors Employee described causing a symptomatic aggravation, because Employee did not describe a specific mechanism of injury, he thought Employee had been experiencing evolving degenerative disc disease symptoms over the course of approximately three years. The substantial cause of Employee's lumbar "condition," according to Dr. Marble, was a combination of the combined effects of heredity, aging, and possibly remote major trauma. (Marble report, January 9, 2014).

26) On January 24, 2014, Employer controverted Employee's benefits based on Dr. Marble's January 9, 2014 report. (Controversion, January 24, 2014).

27) On February 3, 2014, Employer's nurse case manager prepared a letter to Dr. Johnston, which included "check-the-box" answers for Dr. Johnston to indicate whether or not he agreed with the opinions set forth in Marble's January 9, 2014, EME report. On that same date, Dr. Johnston checked each box "yes," indicating he agreed with Dr. Marble's opinions, including Dr. Marble's opinion that no specific medical treatment was reasonable and necessary for Employee's work-related aggravation of his preexisting condition. Dr. Johnston memorialized the meeting with Employer's nurse case manager in a chart note titled "CARE CONFERENCE," where he wrote the following: "Today was a 15-minute care conference with nurse case manager

. . . . I did fill out paperwork detailing [Employee's] work-related injury and his treatments." (Davis letter, February 3, 2014; Johnston chart note, February 3, 2014).

28) On February 18, 2014, Dr. Restad authored a letter describing Employee's work activities at the time of the 2013 work injury and urging Employer to "reconsider." On February 21, 2014, Dr. Restad wrote another letter "in support" of Employee, relating an assessment of lumbar strain to his work. She again urged Employer to "re-consider." (Restad letters, February 18, 2014; February 21, 2014).

29) On February 21, 2014, Employee filed a claim for a low back injury sustained on July 23, 2013 while "lifting and twisting while erecting scaffolding; pushing wheelbarrow; shoveling large amounts of sand and gravel while on knees; followed by sleeping in camp on old, thin mattress; woke the next morning with intense pain radiating into the buttocks." He sought temporary total disability (TTD), temporary partial disability (TPD), permanent total disability (PTD), PPI, medical and transportation costs, a reemployment eligibility evaluation, penalty, interest, a finding of unfair or frivolous controversion, attorney fees and costs and an SIME. (Claim, February 19, 2014).

30) On March 11, 2014, Employee was discharged from physical therapy due to "insurance complications." (Discharge Note, March 11, 2014).

31) On May 14, 2014, Employee reported severe pain in his lumbar spine that radiated into his buttocks, but not below. He also stated he was "having a lot of family issues going through a divorce and issues with a workers comp claim." Tramadol was prescribed for Employee's low back pain. (Inouye report, May 14, 2014).

32) On May 21, 2014, Andrea Trescott, M.D., evaluated Employee for low back pain and recommended a left transforaminal epidural steroid injection at L5-S1. (Trescott report, May 21, 2014).

33) On May 22, 2014, Employee reported Tramadol had not helped with his low back pain. (Inouye report, May 22, 2014).

34) On May 23, 2014, Dr. Trescott administered an epidural steroid injection at L5-S1. She also responded to questions from Employee's attorney, opining Employee's low back symptoms were substantially caused by his work activities. (Trescott report, May 23, 2014; Trescott responses, May 23, 2014).

35) On June 10, 2014, Dr. Restad responded to questions from Employee's attorney, opining Employee's low back symptoms were substantially caused by his work activities. (Restad responses, June 10, 2014).

36) On June 17, 2014, Employee amended his claim for the July 23, 2013 low back injury "due to a traumatic incident and / or cumulative trauma sustained in the course and scope of his employment." He sought ongoing TTD from January 15, 2014, PPI, medical and related transportation benefits, reemployment stipend, interest and attorney fees and costs. (Claim, June 17, 2014).

37) On July 10, 2014, a lumbar spine MRI showed a diffuse disc bulge and mild facet arthritis, but no stenosis, at L3-4, a diffuse disc bulge and mild facet arthritis with minimal foraminal stenosis at L4-5, and a diffuse disc bulge and bilateral facet arthritis with moderate bilateral neural foraminal stenosis at L5-S1. These findings were unchanged from the previous MRI. (Walsh report, October 8, 2014).

38) On July 24, 2014, Employee filed a request for cross-examination of Dr. Marble's January 9, 2014 EME report, and Dr. Johnston's February 3, 2014, concurrences with Dr. Marble's report. (Request for Cross-Examination, July 22, 2014).

39) On August 26, 2014, Employee testified, after Dr. Trescott administered the epidural steroid injections, he "felt great for a day," and "pretty good" the second day, but over the course of several weeks, "it eventually wore off." (Weaver depo. at 9). Employee has problems with both his short-term and long-term memory as a result of his automobile accident. (*Id*. at 11). Employee served in the U.S. Marine Corps and was discharged in 1991. (*Id*. at 15). Employee initially testified he could not remember why he was discharged from the military, (*id*. at 17), but later testified he was discharged for trouble involving alcohol, (*id*. at 46). At the time of his deposition, Employee was going through a divorce, (*id* at 13-14), and had been arrested in July for a DUI after driving his four-wheeler through a construction zone, (*id*. at 45). Employee also had a DUI 20 years ago. (*Id*. at 46). Employee's wife contends alcohol was an issue leading up to the divorce, but Employee does not agree with his wife's contentions. (*Id*. at 46). Employee initially testified he was currently in treatment for alcohol abuse, (*id*. at 45), then later testified he was "thinking about doing that," (*id*. at 46). When asked if he had a pattern of problems involving alcohol, Employee answered, "If you say so." (*Id*.). Employee does not think alcohol is a problem for him, but rather "underlying issues" are a problem for him. (*Id*. at 47). All the

pills Employee has "don't really seem to help" his pain, and alcohol is "all that really seems to take [his] pain away." (*id*. at 47-48). Physical therapy and work hardening did not help Employee. (*Id*. at 48). Employee had been working at the Barter Island Radar Site for three or four weeks when he was injured in 2013. (*Id*. at 49). He woke up with pain that had been building up for several months and did not seem to go away. (*Id*.). Before working at Barter Island, Employee had been working at the Indian Mountain Radar Site for several weeks, which was where "the majority of the heavy lifting was." (*Id*.). Employee testified about his interactions with Employer's nurse case manager, and Dr. Johnston. (*Id*. at 57-76). He also described the work he performed, including shoveling sand and gravel on his knees, erecting scaffolding, lifting large pipes while twisting and jacking up fuel tanks with a jack that weighed 100 pounds. (*Id*. at 76-77). Employee experienced back pain prior to 2013, after adjusting tire chains on a grader." (*Id*. at 80-81). The first time Employee sought medical treatment for his back was in 2001. (*Id*. at 82). (August 26, 2014).

40) On October 7, 2014, Employee was evaluated by Louis Kralick, M.D., who planned to obtain Employee's pain management records and obtain flexion and extension x-rays. (Kralick report, October 7, 2014).

41) On October 8, 2014, Employee reported Dr. Trescott's epidural steroid injection provided him with excellent relief for two days. Two additional injections were ordered. (*Id*.).

42) On October 14, 2014, Employee received another epidural steroid injection. (Operative report, October 14, 2014).

43) On October 16, 2014, Employee filed a "Petition to Join Additional Employer(s) and/or Insurers" from his 2010 injury to his 2013 case. Employer did not oppose the petition. (Employee Petition, October 13, 2014; Employer's Non-Opposition, October 28, 2014).

44) On October 30, 2014, Employee saw Amy Murphy, D.O., for an initial assessment of a traumatic brain injury he suffered during a car accident 21 years earlier. Employee reported stress, alcohol use, anxiety, and recently attending an inpatient unit in Georgia for seven and one-half weeks for dual diagnosis. Employee also reported using alcohol to "deal with" the symptoms of his traumatic brain injury. Employee's stressors included his workers' compensation case and his wife filing for divorce. Employee also reported suffering a heart attack the previous week, which resulted in the placement of two stents. Dr. Murphy prescribed

Cymbalta for anxiety, depression and Employee's cognitive defects. (Murphy report, October 30, 2014).

45) On December 2, 2014, *Greg Weaver v. Arctec Alaska*, AWCB Decision No. 14-0154 (December 2, 2014) (*Weaver I*), rejected Employee's contentions that Employer's nurse case manager and Dr. Johnston were EMEs. The decision concluded Employer had not made an excessive change of physician and denied Employee's petition to exclude Dr. Marble's January 9, 2014, EME report on that basis. Although *Weaver I* found Employer's nurse case manager "came dangerously close to directing Employee's medical care," it nevertheless concluded she "made suggestions [concerning Employee's medical care], which Employee and his treating providers sometimes accepted." Employer did not assert a defense based on AS 23.30.105 at the hearing. (*Weaver I*; observations).

46) On December 11, 2014, Employee reported taking one Oxycodone per day, which "was not helping with the pain at all." Employee's prescription for oxycodone was changed from 10 milligrams to 15 milligrams. (Kile report, December 11, 2014).

47) A December 31, 2014 lumbar spine MRI was unchanged from Employee's July 10, 2014 MRI. (MRI report, December 31, 2014).

48) On January 6, 2015, Dr. Kralick interpreted x-rays to show spondylitic changes in Employee's lumbar spine and recommended Employee undergo facet injections at L4-5 and L5-S1. (Kralick report, January 6, 2015).

49) At a January 21, 2015, prehearing conference, Employee's 2010 and 2013 cases were joined. Employer did not assert a defense based on AS 23.30.105 during the conference. (Prehearing Conference Summary, January 21, 2015; observations).

50) On January 29, 2015, Employee was restricted from driving for three to four months after having been charged with DUI. He was "having a lot of feelings of betrayal," as his wife was one of the persons who testified against him. Employee was also "dealing with a lot of legal issues surrounding his divorce." (Murphy report, January 29, 2015).

51) On January 29, 2015, Employee denied any improvement in his low back pain. His medication was changed from Oxycodone to Hydromorphone. (Walsh report, January 29, 2015).

52) January 29, 2015, Employee's vocational rehabilitation specialist determined she was unable to complete Employee's eligibility evaluation because of Employer's controversion. (Samson report, January 29, 2015).

53) On February 24, 2015, Employee reported an 80 percent relief in his lower back pain for five hours following a medial branch block. (Stonebridge report, February 24, 2015).

54) On March 20, 2015, Patrick Radecki, M.D., conducted an EME, at which Employee recounted the 2010 injury he sustained while putting 200 pound tire chains on a road grader, as well as his 2013 back problems, which "seemed to build up over time" while he was performing strenuous labor. Employee's answers to a number of Dr. Radecki's questions concerning the history of his present illness included, "does not recall" and "cannot recall." Dr. Radecki found Employee's memory of his past medical history "not so good." Employee's biggest complaint, according to Dr. Radecki, was the bunk bed on which he was sleeping, which just had springs and offered little support. Dr. Radecki reviewed and summarized medical records prior to Employee's 2013 back complaints, as well post-injury medical records from July 24, 2013 through November 4, 2013. His reports states, "All additional notes are reviewed but not dictated. Complaints continued despite treatments." Dr. Radecki observed Employee did not sit while Dr. Radecki was taking his history, but "stood with much pain behavior, deep breathing, and posturing, leaning at time against the exam table." Dr. Radecki recorded the following findings on physical examination:

> Relative to his head, I put my hand on his head without pressure and he said that was fine. . . . I then pushed down on my hand with a **total pressure of about 5 pounds, and he said that gave him low back pain, and that would be nonphysiologic.** Minimal pressure on the top of your head downward is not going to give you low back pain.
>
> Then, I did a very slight traction on his mastoid process bilaterally with no more than 5 pounds of traction, and he said that caused neck pain. He also had tenderness at each mastoid process, where I was lifting. He said there additional pain with the lifting, which was very gentle.
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> EXAMINATION OF THE CERVICAL SPINE
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> | | |
> |---|---|
> | Flexion: | 10 degrees |
> | Extension: | 30 degrees |
> | Right Lateral Bending: | 15 degrees |
> | Left Lateral Bending: | 20 degrees |
> | Right Rotation: | 35 degrees |
> | Left Rotation: | 45 degrees |

> So, there were great restrictions in range of motion. Relative to his neck; in the midline on palpation, he had tenderness at the C5, C6, and C7 spinous processes. The paraspinal muscles were diffusely tender at all areas, C3 to C7, without spasms.
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> EXAMINATION OF THE THORACIC SPINE
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> In the thoracic region, he had pain to palpitation over spinous processes T5 through T12, with the pain at T5, T6, T6, T7, and T8 about a 3 to 4, and then the same at T9 and T10. At T11 and T12, he said the pain was a 5 or 6.
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> EXAMINATION OF THE LUMBAR SPINE
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> In the lumbar area, L1 through L5, he rated the pain at least a 7; just brushing the skin with a fingertip, he was saying his pain was a 7, which would be grossly nonphysiologic. His paraspinal muscles in the low back were likewise, all said to be pain level 6 to 7, without spasms. **Just pinching his skin, he said there is significant pain; nonphysiologic.**
> . . . .
>
> **Supine, just a 10 degree straight leg raise on the right was said to give him maximal back pain**, which is nonphysiologic since a 10 degree straight leg raise does not possibly stretch the sciatic nerve and on the left, he said is was 20 degrees, again, nonphysiologic. Pain was only in the back with that as well.
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> **Knee flexion**, which would cause subsequent hip flexion with hip flexion of 80 degrees on the left **was said to cause pain in the low back** despite the fact that hip and knee flexion simultaneously actually shorten the sciatic nerve. On the right side, at 40 degrees, he complained of back pain with the same maneuver, so grossly nonphysiologic.
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> [Range of motion findings omitted] With the maneuver of rotation of the pelvis with simultaneous shoulder rotation, he said minimal rotation to the left of 5 degrees gave him low back pain, **which is nonphysiologic and that to the right at 15 degrees did the same.** Approximately 15 pounds of pressure on the shoulders was said to give him low back pain and that is nonphysiologic. Lifting up on the **elbows was said to give him neck pain and that is nonphysiologic.**

[Emphasis in original]. Dr. Radecki opined the 2010 injury resulted in muscle strain that resolved rather quickly. To support his opinion, Dr. Radecki cited range of motion findings from January 12, 2011, which showed a "fairly minimal effect" of the injury on Employee's range of motion, and he noted Employee's pain level the next day was just a 1 out of 10. Dr. Radecki also added Employee did not miss work as a result of the 2010 injury. Dr. Radecki did not think "there was any specific injury whatsoever" in 2013, and alternatively referred to Employee's

2013 injury as a "[c]hoice to seek medical attention following sleep." Dr. Radecki thought imaging studies did not show evidence of an acute change and were consistent with preexisting degenerative disc disease in the lumbar spine. Instead, Dr. Radecki opined the cause of Employee's persistent pain was predominantly due to "psychosocial factors." Dr. Radecki also noted Employee's denial of attending an inpatient treatment unit in Georgia for stress, anxiety and alcohol use. (Radecki report, March 20, 2015).

55) On March 23, 2015, Employee reported Hydromorphone has been ineffective for his lower back pain. It was noted Employee tested "greater than 150,000" for ethyl alcohol on his last visit. Employee stated he drinks to help with the pain. Employee's medication was changed from Hydromorphone to Morphine. (Fitzgerald report, March 23, 2015).

56) On April 6, 2015, Employee reported Morphine was ineffective for his lower back pain. He also admitted to taking more of his Hydromorphone than prescribed and to taking Oxycodone from an old prescription. A decision was made to treat Employee's facet joints with radio frequency ablation. Employee was advised radio frequency ablation typically provides relief lasting between six month to two years. (Peterson report, April 6, 2015).

57) On April 22, 2015, Employer deposed Dr. Restad, who testified regarding Employer's nurse case manager's, and Dr. Johnston's, involvement in Employee's treatment, her radiculopathy diagnosis, referrals she had made on Employee's behalf and Employee's need for a travel companion. (Restad depo., April 22, 2015). Dr. Restad referred Employee to Dr. Johnston because Employee wanted a second opinion on conservative treatment options. (*Id*. at 24).

58) On April 30, 2015, *Greg Weaver v. Arctec Alaska*, AWCB Decision No. 15-0050 (April 30, 2015) (*Weaver II*) decided issues related to SIME records and the parties' SIME questions. Employer did not assert a defense based on AS 23.30.105 at the hearing. (*Weaver II*; observations).

59) On May 7, 2015, Employee underwent left-sided radio frequency ablation at L3-4, L4-5 and L5-S1. (Operative Report, May 7, 2015).

60) On May 14, 2015, Employee underwent right-sided radio frequency ablation at L3-4, L4-5 and L5-S1. (Operative Report, May 14, 2015).

61) On May 20, 2015, Employee reported Morphine was not helping with his low back pain. His medication was changed from Morphine to Hydrocodone. (Walsh report, May 20, 2015).

62) On August 5, 2015, Employee reported a decrease in the efficacy of his Hydrocodone. His medication was changed from Hydrocodone to Percocet. He also continued to complain of debilitating back pain. Because Employee had failed to respond to aggressive medical management and physical therapy, as well as minimally invasive pain management procedures, he was referred a neurosurgeon. (Walsh report, August 5, 2015).

63) On September 1, 2015, Employee reported no pain relief following the radio frequency ablation procedures. MS Contin was added to his Percocet prescription due to reports of increased lower back pain. (Walsh report, September 1, 2015).

64) On October 1, 2015, Employee underwent acupuncture treatment for low back pain. (Wedge report, October 1, 2015).

65) On October 27, 2015, Employee related his low back pain to a 2013 work injury. Dr. Kralick opined Employee's symptoms were the result of Employee's job duties, and L4-5 and L5-SI discograms were ordered. (McGrath report, October 27, 2015).

66) On November 9, 2015, Employee reported his medications "do not work." One of the medications was changed from MS Contin to Fentanyl. (Walsh report, November 9, 2016).

67) On November 19, 2015, because Employee was having difficulty obtaining Fentanyl patches, his medications were changed from Percocet and Fentanyl to MS Contin and Morphine. (Walsh report, November 19, 2015).

68) On January 15, 2016, Employee reported the Morphine "doesn't take the edge off his pain." He was re-started on Oxycodone and MS Contin. (Harrell report, January 15, 2016).

69) On February 19, 2016, James Scoggin, M.D., an orthopedic surgeon, performed a second independent medical evaluation (SIME), during which Employee described being injured sometime prior to July 23, 2013, when he was working at remote radar sites. Employee explained changing valves in a fire pump room and handling 6-inch to 8-inch pipe in confined spaces. Employee also described performing "very physical" work jacking up fuel tanks with a large, heavy jack to build and prepare the ground under the tanks at the Indian Mountain site, as well as moving tanks using heavy equipment and digging on his knees at another radar site. Meanwhile, according to Employee, he was sleeping on bunk beds that offered no back support. Dr. Scoggin reviewed and summarized medical records between March 13, 1993 and May 7, 2015. Dr. Scoggin diagnosed preexisting chronic low back pain, preexisting degenerative disc disease, multiple prior episodes of recurrent low back pain and injury, including another work

injury in 2001 and the tire chain injury in 2010, and an industrial lumbosacral soft tissue injury on July 23, 2013. In Dr. Scoggin's opinion, the July 23, 2013 injury combined with a preexisting condition to cause Employee's disability and need for treatment, but it did not result in a permanent change. Employee was medically stable at the time of Dr. Marble's January 9, 2014 EME, according to Dr. Scoggin. In support of his opinions, Dr. Scoggin cited Employee's reports of back pain predating the July 23, 2013 work injury and imaging studies showing only chronic-appearing degenerative changes in Employee's lumbosacral spine, which were stable on three separate MRI studies. Dr. Scoggin thought Employee's current complaints were subjective and primarily related to his preexisting degenerative disc disease and its expected progression over time. Dr. Scoggin did not think Employee would benefit from surgical intervention. (Scoggin report, February 19, 2016).

70) On April 5, 2016, Dr. Scoggin reviewed Dr. Radecki's March 20, 2015, EME report and Dr. Restad's April 22, 2015, deposition transcript, which did not change his February 19, 2016 opinions. (Scoggin addendum, April 5, 2016).

71) On April 6, 2016, a discogram was positive at L4-5 and L5-S1. (Operative Report, April 6, 2016).

72) A July 12, 2016 lumbar computed tomography (CT) study showed multilevel degenerative disc disease, most severe at L4-5 and L5-S1. At L4-5, a moderate disc protrusion was superimposed on a broad disc bulge resulting in mild central spinal canal stenosis. At L5-S1, a disc osteophyte complex resulted in moderate bilateral neural foraminal stenosis. (CT report, July 12, 2016).

73) A July 12, 2016 lumbar MRI showed moderate bilateral neural foraminal stenosis at L5-S1 and probable mild spinal stenosis at L4-5. (MRI report, July 12, 2016).

74) On July 13, 2016, Dr. Kralick performed an L4-S1 laminectomy with spinal canal and neural foraminal decompression and disc excision at L4-5 with interbody fusion. Dr. Kralick's report notes, "[s]ignificant canal compromise of the thecal sac by bone and thickened ligamentum flavum was encountered at both the L4-5 and L5-S1 levels." (Operative Report, July 13, 2016).

75) On July 17, 2016, Employee suffered a myocardial infarction, which resulted in the placement of two stents. (Emergency Department report, July 17, 2016; Cardiology Discharge Summary, July 19, 2016).

76) On July 26, 2016, Employee saw Dr. Kralick for a postoperative wound check and reported soreness in his lower back, bilateral leg weakness, balance changes and left leg numbness and tingling. (Kralick report, July 26, 2016).

77) On August 4, 2016, Dr. Scoggin responded to interrogatories posed by Employee and cited numerous records documenting Employee experiencing low back pain prior to the July 26, 2013 work injury. Dr. Scoggin added, since both Drs. Marble and Radecki observed Employee to be a poor historian, a review of medical records becomes more important in Employee's case. He wrote, "We know that [Employee] suffered chronic, recurrent low back pain prior to 7/23/13, because his medical records so state this." As a result, Dr. Scoggin could rule out performing "strenuous physical labor" for Employer as the substantial cause of Employee's back pain. Referring to Employee's consistent, subjective, pain-scale reports, and his three MRI studies, where no significant changes were observed, Dr. Scoggin concluded, "Since there is no objective evidence of any significant improvement in his condition and no subjective evidence of any significant change in his complaints, the logical conclusion is that [Employee] was, in fact, medically stable as stated." Dr. Scoggin noted Employee reported the three epidural steroid injections he had received provided him, at most, two days' relief, and the four radio frequency ablations per side Employee had received did not provide him with any short-term or long-term relief. Therefore, Dr. Scoggin concluded, the additional care Employee received after Dr. Marble's January 9, 2014 EME did not result in any subjective or objective benefit to Employee. Dr. Scoggin again expressed his opinion that the July 23, 2013 injury resulted in a lumbrosacral soft tissue injury, which temporarily exacerbated Employee's subjective complaints, and reiterated his opinion that Employee was medically stable at the time of Dr. Marble's January 9, 2014 EME. (Scoggin interrogatories, August 4, 2016).

78) On August 15, 2016, Dr. Radecki reviewed additional medical records and noted inconsistencies between findings upon physical examinations performed by other medical providers and himself, and concluded differences in these findings mean Employee is "not reliable." Dr. Radecki also emphasized medical reports that mentioned Employee's alcohol and marijuana use, frustration, anger, difficulties paying bills and legal fees, taking more pain medication than prescribed, taking pain medication from a past prescription, lack of improvement radio frequency ablation, numerous changes to Employee's narcotic pain management medication with no improvement in his reported symptoms, as well as medical

reports where Employee reported the onset of his history of present illness prior to the 2013 work injury. He issued an addendum report that stated the additional medical records reviewed did not change the opinions expressed in his March 20, 2015 EME report. (Radecki addendum, August 15, 2016).

79) On August 23, 2016, lumbar spine x-rays were interpreted to show disc space narrowing at L5-S1 and anterior spurs through the lumbar spine similar to a previous study. Employee was to begin physical therapy to improve his range of motion and improve his residual pain. (X-ray report, August 23, 2016; Tempel report, August 23, 2016).

80) On August 24, 2016, Employer deposed Dr. Scoggin, who testified he concluded Employee's July 23, 2013 injury did not permanently aggravate Employee's low back condition. (Scoggin depo. at 12). Dr. Scoggin thought "there was some room for discussion in this case" as to what caused the aggravation in Employee's low back because Employee did not point to a single incident, but rather reported more than ten different potential causes for the aggravation, including shoveling, changing valves, jacking up fuel tanks, bending, lifting, moving tanks, digging, "and the most common one is sleeping on a thin mattress." (*Id*.at 12-13). Employee reported to one of his providers that his pain had been occurring for over a year and was aggravated by coughing, bending, twisting, lifting, sitting and standing, "which are all activities of daily living," according to Dr. Scoggin. (*Id*. at 13). Dr. Scoggin did not see any evidence Employee had radiculopathy based on Dr. Restad's July 26, 2013 report, (*id*. at 18), and he did not see evidence of canal stenosis on Employee's August 2, 2013 MRI, (*id*. at 26). Dr. Scoggin disagreed with Dr. Kralick's decision to perform surgery for lumbar stenosis because lumbar stenosis was not documented by Employee's MRIs. (*Id*. at 34). Dr. Scoggin would not have performed surgery on Employee because Employee did not have any of the indications for spinal fusion listed in the "Occupational Disability Guidelines. (*Id*. at 39). Dr. Scoggin thinks there were multiple factors contributing to Employee's need for medical care, and because Employee had a physical job, Dr. Scoggin thought is was reasonable to conclude Employee experienced increased pain until January 9, 2014. (*Id*. at 44). On cross-examination, Dr. Scoggin testified Dr. Kralick's findings that Employee's spinal canal was compromised by bone and thickened ligamentum flavum are consistent with degenerative changes. (*Id*. at 53). According to Dr. Scoggin, Employee did not have a herniated disc, a fracture, or anything else that is clearly identifiable as a specific injury. *Id*. at 59. Instead, Employee only experienced an increase in

symptoms. (*Id*.). Dr. Scoggin found reports from multiple examiners, who described their findings as degenerative, and Employee's medical records show Employee had prior symptoms. (*Id*. at 60). Dr. Scoggin noted, prior to the 2013 injury, Employee had been having pain, averaging 6 out of 10 for one year. He also noted, "way back" in 2001, Employee was having pain that was 6 out of 10. Therefore, Dr. Scoggin does not think there is any objective evidence that shows Employee's pain is worse after the 2013 work injury than it was before the work injury. (*Id*. at 63). In Dr. Scoggin's opinion, Employee has multi-factoral pain, which is consistent with degenerative changes. (*Id*. at 64). Dr. Scoggin stated, "I think he's got facet, he's got disc, he's got now the spinal stenosis. He merely has pain. And he doesn't have radiculopathy, and he doesn't have symptoms of spinal stenosis." (*Id*. at 65). There is not a specific injury that would explain Employee's symptoms following the 2013 work injury, in Dr. Scoggin's opinion. "There's no heavy weight he lifted and suddenly had a sharp pain, the types of things we usually see," according to Dr. Scoggin. Without additional information, Dr. Scoggin thinks Employee's 2010 work injury is a substantial factor in Employee's need for medical treatment, because Employee's medical records show he had back pain re-dating the 2013 injury. (*Id*. at 107; 108). However, Dr. Scoggin also thinks Employee was medically stable after January of 2014, because none of Employee's medical treatment has resulted in objectively measurable improvement. (*Id*. at 112).

81) On August 28, 2016, Employee continued to report lower back soreness and left leg numbness. (Tempel report, August 23, 2016).

82) On September 7, 2016, Employee filed an Affidavit of Readiness for Hearing on his February 19, 2014 and his June 17, 2014 claims. (Affidavit of Readiness for Hearing, September 7, 2016).

83) Physical therapy daily progress notes from September of 2016 indicate Employee "admits a sedentary lifestyle," and lists Employee's primary functional limitation as his inability to "resume exercise routine or tolerate functional activities at home due to persistent nature of his [low back pain]." (Daily Progress Notes, September 7, 2015 to September 29, 2016).

84) Following his July 13, 2016 surgery, Employee continued with medical pain management and consistently reported his current pain levels as 3-6 out of 10, and his average pain levels as 2-6 out of 10. On October 26, 2016, Employee's medical pain management provider had the following conversation with Employee: "Discussed with [Employee] what he does to keep busy

as he does not currently work. He states that he does not do much of anything. I advised him that it is important for his health to find some kind of hobby to keep him busy. This will improve both his mood and his pain." (Algone reports, August 10, 2016 to July 10, 2017).

85) On September 22, 2016, Dr. Kralick opined Employee's 2013 injury was the substantial cause of his low back symptoms. (Kralick responses, September 22, 2016).

86) On October 5, 2016, Employee reported "constant" low back aching, "stable" left leg numbness and temporary increases in his low back pain after physical therapy. (Tempel report, October 5, 2016).

87) At an October 10, 2016 prehearing conference, the parties agreed Employee's February 19, 2014, and his June 7, 2014, claims would be heard on March 9, 2017. (Prehearing Conference Summary, October 10, 2016).

88) On January 5, 2017, Dr. Scoggin reviewed additional imaging studies, which did not change any of his previously expressed opinions. (Scoggin addendum, January 5, 2017).

89) On February 17, 2017, Dr. Radecki evaluated Employee a second time. Dr. Radecki asked Employee about returning to work, and Employee informed Dr. Radecki he is already on Social Security Disability for his low back and, if he had a heart problem on the North Slope, he could not be reliably evacuated for medical care. Dr. Radecki concluded, regardless of how Employee's back felt, he would not work remotely because of his heart conditions. Employee was "a little unclear on his medications," and reported he was taking Flexeril three time per day on some days and, and on some days, he takes less. Employee was taking five Oxycodone tablets, "probably 5 mg tablets," twice per day. In addition, he was taking morphine sulfate, either 15 or 30 mg tablets, twice per day. He also was taking two or three Aleve tablets twice per day and baby aspirin, as well. Dr. Radecki remarked, Employee rated his pain as a 5 or 6, even on all this medication. Upon physical examination, Employee complained of great pain when Dr. Radecki brushed Employee's skin with one fingertip in the lumbar region. Employee's paraspinal muscles were very tender on palpation throughout the thoracic and lumbar regions. Dr. Radecki found hip flexion to be 80 degrees on the right and 70 degrees on the left, where Employee complained of great pain. Dr. Radecki observed, when Employee was sitting on the exam table, he was leaning forward, "so his hip flexion was certainly 100 degrees or greater, so there was an inconsistency between Employee's sitting and supine hip flexion." Employee could not tolerate hip rotation past 5 degrees because it was "very, very painful." Employee

complained of non-physiologic low back pain when Dr. Radecki placed his hands on Employee's shoulders. Traction applied upward at Employee's elbows was very painful, which Dr. Radecki thinks should lessen the pain, since it is taking weight off the low back. When Dr. Radeck pulled on Employee's thigh while Employee was laying supine on the exam table, Employee complained of low back pain, which is "grossly non-physiologic since pulling on one thigh does not stretch any nerves of change any joint positions." Dr. Radecki observed, "Pushing on the knees likewise provoked complaints in the hips and low back despite again the fact that no nerves are being stretched, no tissues are actually being moved." He also wrote,

> Hip rotations were the most painful; they are painful at 0 degrees rotations and yet when [Employee] walks and even squats 20 degrees, rotations occurring and he did not complain. Additionally, when [Employee] sat up from a supine position, he put one leg on each side of the exam table, essentially straddling the table, which would require external rotation of each hip and was totally painless.

The findings from Employee's physical examination were "totally unreliable," since he had pain with provocative maneuvers "that cannot possibly cause pain," according the Dr. Radecki. Dr. Radecki diagnosed chronic pain along most of the spine, but predominantly at the lumbar region, longstanding by history, "well before the incident of July 23, 2013." He also concurred with Dr. Marble's opinion that Employee's 2010 injury had "resolved quite quickly." Dr. Radecki observed Employee's condition had changed minimally notwithstanding having undergone spinal surgery, and opined the pathology documented at surgery was bony encroachment on the spinal canal and a thickened ligamentum flavum, "neither of which is due to a one time incident." Employee's inability to work as a Station Mechanic was twofold, according to Dr. Radecki, and included, 1) psychosocial factors and chronic pain behaviors, and 2) Employee's heart condition. (Radecki report, February 17, 2017).

90) On February 17, 2017, Ronald Teed, M.D., an orthopedic surgeon, also performed an EME, during which Employee reported his surgery helped with some of the sharp pains in his back, but he still had chronic disabling pain. Dr. Teed found Employee very "nonspecific" and "avoidant" during the evaluation. Employee reported his work career has been very sporadic throughout his life due to "personal reasons." Dr. Teed began to measure Employee's range of motion in his cervical, thoracic and lumbar spine, but Employee reported his spine was too painful to perform additional range of motion evaluations. Dr. Teed found this to be inconsistent

because he observed Employee moving his head to the left and right without hesitation during questioning and that movement was "well beyond" what was measured with the inclinometer. Similarly, Dr. Teed noted Employee sat on the bed and leaned forward "far beyond" the lumbar range of motion measured with the inclinometer. Employee was exquisitely tender to palpation, even to light touch, over the cervical and lumbar spinous processes and paraspinous musculature, and was tender "just about anywhere" Dr. Teed touched Employee over his thoracic spine. Dr. Teed also found Employee inconsistently tender over the sciatic notch. Other inconsistencies noted by Dr. Teed included inconsistent pain complaints upon hip rotation while seated and supine and reported low back pain when Employee rotated his torso through his legs. Employee reported increased, diffuse, neck tension when Dr. Teed applied "very light" axial pressure on Employee's scalp. Dr. Teed diagnosed functional overlay, which included closed head injury, history of alcohol abuse, history of anxiety/depression, chronic narcotic use/abuse, and chronic non-specific neck pain, chronic non-specific low back pain, including lumbar spondylosis, and cardiovascular disease, none of which were related to Employee's employment, in Dr. Teed's opinion. Dr. Teed stated, "[Employee's] presentation is that of overwhelmingly inconsistent, inorganic, non-anatomic findings on exam." As a result, Dr. Teed concluded his findings on exam were unreliable. Dr. Teed found Employee's history of chronic neck, mid and low back pain "well predate" the July 23, 2013 work injury. Additionally, Employee was also unable to describe a specific mechanism of injury for Dr. Teed. Dr. Teed observed Employee had been treated by many providers since the injury, and those providers findings were commonly inconsistent, even between the same providers. In Dr. Teed's opinion, Employee underwent lumbar fusion surgery without a clear presentation of radicular findings or neural defects. The cause of Employee's disability and need for medical treatment, according to Dr. Teed, "are unknown, but unrelated to the July 23, 2013 job injury claim." Because Employee's highly inconsistent presentation, Dr. Teed recommended Employee undergo a multispecialty evaluation, including a psychological evaluation. (Teed report, February 17, 2017).

91) On February 28, 2017, Employee deposed Dr. Trescot, who saw Employee once for an evaluation and once to administer a transforaminal injection. When she evaluated Employee on May 23, 2014, she thought he had "an early degree of lumbar radiculopathy," based on his MRI, which showed a disc bulge. (*Id*. at 31-32). When Dr. Trescot administered the injection, she uses x-ray contrast dye to show her the medicine is going where she wants it to go. (*Id*. at 34-

35). In Employee's case, the dye did not go past the dorsal root ganglion, which was consistent with narrowing and impingement at that spot. (*Id*.). Dr. Trescot opined performing heavy labor traumatized an already weakened area of Employee's back. (*Id*. at 39-40). She also thought Employee's lumbar facets contributed to Employee's pain. (*Id*. at 45-46). Dr. Kralick's operative report, which states he found thickening of the ligamentum flavum, is consistent with her findings of spinal stenosis, according to Dr. Trescott. (*Id*. at 49-50). She explained the ligament holding Employee's spine together became thickened because it was moving too much, and his body was "laying down" extra calcium in response, which was then encroaching on the spinal column. (*Id*.). On cross-examination, Dr. Trescot acknowledged she obtained Employee's history of the work injury from him, (*id*. at 51-52), she did not record a neurological examination, which is the best information for diagnosing radiculopathy, (*id*. at 61-62), and she cannot opine on whether Employee's disc pathology is acute or chronic, (*id*. at 64). Dr. Trescot was not aware Employee had seen Dr. Inouye on May 14th and May 23rd, was not aware Dr. Inouye had also prescribed Employee medications, and she would be surprised if Employee did not report leg pain to Dr. Inouye on those visits. (*Id*. at 69-70). She thinks it is important to assess the mental health of pain patients but she did not document non-work related stress in Employee's life. (*Id*. at 70-71). Dr. Trescot was critical of another physician for not documenting a patient's history of substance abuse, but she did not document Employee's history of substance abuse. (*Id*. at 71). She thinks anxiety can contribute to pain, but she did not consider anxiety in Employee's case. (*Id*.). If a pain patient has tried narcotics, anti-inflammatories, medial branch blocks, radiofrequency ablation and surgery, and there is no improvement, Dr. Trescot would be concerned there might be an underlying issue that is not being addressed. (*Id*. at 73). There can be reasons, other than something physiological or anatomical reasons, why patients' pain do not improve, such as untreated depression or anxiety, substance abuse and secondary gain, according to Dr. Trescot. (*Id*. at 74). Dr. Trescot interpreted Employee's MRI to show a "disruption" of the posterior interspinous ligament, (*id*. at 86), but she acknowledged this is not a commonly accepted finding, (*id*. at 90).

92) On March 2, 2017, Employer contended the issues for hearing are Employee's February 19, 2014, and June 17, 2014 claims, which are both based on Employee's 2013 injury. It contended, although Employee petitioned to join his 2010 injury to the instant case, no claim had

ever been filed for that injury, and any claim for Employee's 2010 injury would be barred by AS 23.30.105. (Employer's hearing Brief, n1, March 2, 2017).

93) On March 6, 2017, Employee sought dismissal of Employer's argument his December 7, 2010 injury is not joined as an issue for hearing. He contended Employer clearly knew his 2010 injury was joined because it filed a non-opposition to his petition seeking joinder, it questioned Dr. Scoggin on his 2010 injury at Dr. Scoggins deposition, and it referenced his 2010 injury in letters to its medical experts. (Employee's petition to dismiss Employer's argument, March 6, 2017).

94) On March 7, 2017, Employer deposed Dr. Teed, who testified Employee had spondylosis, an arthritic condition, and chronic nonspecific low back pain. (*Id*. at 5). According to Dr. Teed, spondylosis "describes the whole," and involves disc degeneration, facet arthritis and ligamentum hypertrophy, all combined. (*Id*.). Chronic nonspecific back pain means the etiology is unclear - "It's just a subjective complaint." Dr. Teed did not see any evidence in the medical records to support a diagnosis of radiculopathy. (*Id*. at 7). Commenting on Employee's lack of improvement after receiving a variety of treatments, Dr. Teed stated, there is no "Level 1," evidence-based medicine that shows epidural steroid injections, medial and lateral branch blocks or nerve ablations work. (*Id*. at 9; 60). Dr. Teed testified there were inconsistencies between Employee's reports of pain relief to him and Employee's reports of pain relief following various treatments documented in his medical records. (*Id*. at 10). According to Employee at the time of Dr. Teed's evaluation, no treatment has helped his low back pain. (*Id*. at 7). Dr. Teed disagrees with Dr. Kralick's decision to perform surgery because Dr. Kralick performed surgery to address Employee's pain and pain is not an indication for surgery. (*Id*. at 11). Dr. Teed thinks an MRI showed Employee had mild stenosis, but Employee did not have symptoms of stenosis, which include increased back pain that radiates into the lower extremities and lower extremity weakness with increased walking or standing. (*Id*. at 12-13). Dr. Teed explained, "functional overlay" means inconsistencies on exam. (*Id*. at 15). Those inconsistencies can be a patient's attendance at appointments, the inconsistency in a patient's history, and a patient's physical exam and other findings on exam, such as inorganic or non-anatomic findings that do not make sense from a physiological standpoint. (*Id*.). Dr. Teed recounted the inconsistencies on examination, such as during straight leg raises, torso rotation, hip rotation, palpation and breakaway strength and cogwheeling. (*Id*. at 17-19). Dr. Teed summarized his examination: he

made no objective findings, and the subjective findings were Employee would not go through range of motion with his spine because it was too painful. (*Id*. at 20). He also explained the Bradford Hills criteria for causation, which is the human body will generally get better when the causative agent is removed. (*Id*. at 22-23). In other words, if the causative factor is increased, one will have more symptoms, but if the causative factor is decreased, one will have less symptoms. (*Id*.). Patients with spondylosis present with symptoms that wax and wane over time, which has been Employee's presentation back to 2001. (*Id*. at 23-24). Additionally, Employee's symptoms since 2013 have been due to his chronic nonspecific low back pain. (*Id*.). Dr. Teed was unable to identify an acute injury during his evaluation, and Employee was unable to describe a specific injury during the evaluation. (*Id*. at 25). Rather, Employee attributed his symptoms to digging and performing manual labor during the months prior to him quitting work. (*Id*.). An x-ray showed Employee had the onset of spondylosis as far back as 2001. (*Id*. at 27). On cross-examination, Dr. Teed testified he does not administer epidural steroid injections, medial branch blocks, facet blocks or radiofrequency ablation, but he has ordered all of them. (*Id*. at 32-33). He also, again, addressed inconsistencies in Employee's medical records where Employee reported one-week relief from an epidural steroid injection to one provider, and two weeks' later Employee reported the injection provided him with no relief to another provider. Dr. Teed commented, "So, I mean, the notes get confusing because they are consistently conflictive. They are conflicting and most consistent with functional overlay. That's what I'm talking about the inconsistencies." (*Id*. at 73-74). When asked if he relied on the Bradford Hills criteria in determining Employee's symptoms were not related to work, Dr. Teed responded, "No. I can't really rely on that criteria because there are episodes that we just described where [Employee] said his pain was gone and then episodes that we just described where [Employee] said the pain never went away." (*Id*. at 75). Additionally, Employee told Dr. Teed his pain never went away, and when Employee was evaluated the same day by Dr. Radecki, Employee reported surgery had reduced his pain one level. (*Id*. at 78). Imaging studies, both before and immediately after the 2013 work injury document Employee's preexisting degenerative conditions, which took many years to develop, according to Dr. Tweed. (*Id*. at 99-100). Dr. Teed opines there is no correlation between Employee's spondylosis and the symptoms he describes. (*Id*. at 104-05). He agrees with Dr. Trescott's opinions that it is a "red flag" for functional overlay when a patient fails to improve after multiple, different treatments, and it is

important to have information about a patient's substance abuse history and psychological issues when treating pain. He thinks Employee's chronic pain could be caused by psychosocial issues, but he would defer to a psychological or psychiatric evaluator. (*Id*. at 109-110). Dr. Teed did not think Employee's work activities were a substantial factor in his disability or need for treatment, (*id*. at 107), and based on his evaluation, Dr. Teed was able to rule out Employee's work activities as a cause of his disability or need for treatment, (*id* at 113).

95) On March 8, 2017, Employee filed an affidavit that set forth $161,147.46 in attorney fees and costs. (Affidavit, March 8, 2017).

96) At the March 9, 2017 hearing, Dr. Radecki testified, Employee's 2013 injury history differs depending on which chart notes are consulted. Employee explained to Dr. Radecki that his back pain increased over time, but Employee's biggest complaint was the bed on which he was sleeping, which Dr. Radecki thought was odd, because Employee had slept on that bed before. During Dr. Radecki's evaluation, Employee did not connect any specific work activity to his injury. Dr. Restad's chart notes indicate Employee reported going to bed and waking up with pain, and Employee "gave [him] the same story." An August 9, 2013 pain clinic chart note indicates Employee reported he had had pain for over a year, and a February 17, 2012 chart note references back pain in connection to a possible kidney stone. It is "obvious" Employee had back pain pre-dating his injury. Dr. Radecke thinks a patient's early history is most reliable, since it is fresh in the patient's memory and psychosocial factors are not yet prominent. Dr. Restad's August 16, 2013 report, which shows Employee's pain level went down from a 9 to a 3, means Employee was making a good recovery. By October 14, 2013, the records show Employee was "doing pretty darn well," because he had a full range of motion without pain for flexion. When Employee saw Dr. DeSalvo on October 23, 2013, Employee's pain would come and go as usual, and on November 4, 2013, Dr. Johnston opined Employee could go back to work again, so Dr. Johnston must have felt Employee's condition was stable. On November 5, 2013, Employee reported his pain level as a 2 or 3, and by November 11, 2013, Employee's pain level was elevated to 6 or 7 "for no reason at all." Psychosocial factors are one of two statistical factors that can predict the development of low back pain. Substance abuse and secondary gain are psychosocial factors that can effect pain. Employee denied being hospitalized in Georgia. Dr. Radecki found Employee not to be a reliable historian, and is not reliable on physical exam either. Dr. Radecki agrees with Dr. Marble and Dr. Scoggin – Employee was medically stable

by January 19, 2014. When Dr. Kralick performed surgery on Employee, Dr. Kralick was operating based on symptoms, which Dr. Radecki thought was "wishful thinking surgery." Dr. Radecki repeatedly testified Employee had pain with provocative maneuvers that should not cause pain. Employee is a "perfect picture" of someone who has a somatization disorder. Employee presents with a very complex situation. He has "one psychosocial problem after another." Dr. Radecki thinks Employee's treatment has made him worse, which is what he would expect in a patient with psychosocial phenomenon. Employee is the "last person in the world" who should be treated with narcotics or surgery. Employee was "absolutely destined" not to get better. On cross-examination, Dr. Radecki testified, when Employee saw Dr. Trescott, Employee's pain was a 5, and he was not taking any medication. Now, after years of treatment and invasive surgery, Employee is on both short-acting and long-acting narcotics, and his pain level is at 5 or 6, so Employee is worse. According to Dr. Radecki, there is no specific task documented in the medical record to which a specific injury is attributable, and no doctor diagnosed Employee with spinal stenosis the first time the doctors saw him. Employee improved 80 percent with a facet block, which is "a long way from the spinal canal," according to Dr. Radecki. Employee also reported getting a little better with a transforaminal epidural steroid injection, which would not affect the spinal canal, according to Dr. Radecki. Employee did not have any of the classic symptoms of spinal stenosis, such as awaking at night in bed, or pain while walking. Dr. Radecki does not believe the majority of Employee's back pain is physical, but rather psychological, due to Employee's substance abuse, his depression, his anxiety and his divorce. Dr. Radecki thinks it was very bad judgment, at best, for Dr. Kralick to perform surgery on Employee. On redirect examination, Dr. Radecki testified, the fact that Employee's pain decreased in November shows he was recovering, and the escalation of Employee's pain beginning on November 20th can only be explained by psychosocial factors, since Employee's MRIs showed no interval change. Employee's complaints of pain just about everywhere is a psychosocial phenomenon. About five percent of the population have widespread, unexplained pain, and Employee is one of those five percent, in Dr. Radecki's opinion. There were eight diagnosis in the first month or two with Employee, which shows how nonspecific Employee's symptoms were. Dr. Radecki stated there was never a consistent symptom complex that would indicate radiculopathy. He also stated there was never a consistent symptom complex that would indicate lumbar stenosis. This is why Employee's providers did a "shotgun" approach,

according to Dr. Radecki. "They gave Employee epidurals. They gave Employee facet blocks." Dr. Radecki thinks this approach to Employee's treatment was "nonsensical." (Radecki).

97) At the March 9, 2017 hearing, Employee's father, Greg Weaver, Sr. (Mr. Weaver), testified Employee's pre-injury activities, between 2009 and 2013, included moose hunting, building hunting camps around the state, running four wheelers through the woods, driving riverboats, water skiing, teaching kids to swim and riding jet skis. When Employee returned from work, around July 23, 2013, he was "all gimped up," and his back was definitely hurting. Mr. Weaver instructed Employee he needed to see somebody regarding his back. He never saw Employee with similar symptoms in the four years prior to the work injury. Mr. Weaver is "absolutely" aware of his son's alcohol problem, but he "never had any problem with that" in the four years prior to the work injury. After Employee was injured, Mr. Weaver noticed an increase in Employee's alcohol consumption. Since Employee's surgery, Mr. Weaver has noticed Employee is doing more. On cross-examination, when asked about Employee's discharge from the military for alcoholism, Mr. Weaver stated he had already testified regarding Employee's alcohol problem. Mr. Weaver acknowledged Employee's 1993 car accident and DUI. Mr. Weaver denied Employee had a serious problem with alcohol prior to 2013. (Weaver, Sr.).

98) At the March 9, 2017 hearing, Employee testified he was in "pretty good" shape when he started working for Employer in 2009. He "absolutely has problems" with memory due to a closed head injury and he carries a notebook to write things down. Employee could not recall having any lasting back problems when he went to work for Employer in 2009. In 2010, Employee was injured tightening chains that had come loose on a road grader and a dump truck. He came home and saw a chiropractor on his own insurance. He did not feel "good at all then," and his pain level was at least a 5. Prior to his 2013 injury, Employee had been installing heat exchangers at power plants. Some weighed over 800 pounds. Employee was also travelling to "dome" sites and repairing and maintaining sprinkler systems, which involved replacing 4, 6, 8 and 10-inch pipes that were between 8 to 20 feet long, as well as "gate" valves. His supervisor was Troy Klingfus, who emailed Dave Horn to point out no rigging or lifting devices had been provided to move the 180-pound valves they were moving by hand. Employee and Mr. Klingfus had "very sore body parts" and were icing them in the evenings. After a job hazard analysis, Employer sent some chain hoists and chain that could be used as rigging. After those jobs, Employee was moving large fuel tanks at Indian Mountain for five or six weeks at Barter Island.

Employee jacked up the tanks with a railroad jack, which weighed about 120 pounds. The jack handle was a six-foot long bar that weighed 80 pounds or more. Employee also used a chain saw to cut cribbing that came in 18-foot lengths. After Employee lifted the tanks, he would compact the site and set 14-inch by 14-inch beams, which were 10-feet long. Next, Employee would use a D10 Cat to drag the tanks close to where it needed to be, and then he would dig underneath the tanks to get the tow chain out. For Employee, it was the "worst kind of digging" – down on his knees with his legs spread apart. He also used a wheelbarrow to move rock, which was difficult to push over the rocky surface. Employee noticed himself becoming stiff. The beds Employee slept on did not have steel across them and when someone would lay in them, the bed would sag 8 or 10 inches, like a hammock. Employee tried to reinforce the bed with plywood, but when he woke up in the morning, he could hardly walk. Employee then left the worksite to see a professional. Employee received epidurals, branch blocks and radiofrequency ablations, but none of those treatments helped for more than 24 hours. Employee was also prescribed opioids, which did not help as much as he expected. Employee's pain management provider notified him alcohol showed up in his screenings at least once, and he notified his pain management provider he used marijuana for sleep. Employee was drinking more than he should. Employee was "obviously" self-medicating. His pain was "all over the map," and he would have different symptoms every day. Since the surgery, Employee is able to get out of bed earlier and his pain is 3 ½ to 5 on most days. He is also able to spend more time with his sons. On cross-examination, Employee testified he had been feeling increasingly "odd" in his midsection before the "final straw" in 2013. Employee does not recall telling a provider in 2012 he had been having back pain for the last five years. A March 8, 2001 medical record described Employee as having lower back pain, which he rated 6 out of 10. Employee thinks that record was from when he was working for another employer on the Slope. When questioned on his pain level being a 3 out of 10 on August 16, 2013, and a 3 or 4 out of 10 in November of 2013, Employee thinks he was misunderstanding the pain scale to that point and was underestimating the level of pain he was in. Substance abuse was "one of the reasons" Employee went to Georgia in September of 2014. Regarding his 2014 DUI, Employee explained, "I rode my four-wheeler down to see my wife and try to get her to take our kids to therapy . . . and . . . ended up going to jail for that." Employee was discharged from the military for alcohol problems. Employee was almost killed in a DUI car accident in 1993. Employee's wife had alleged in divorce papers that she left

Employee because of physical abuse and his alcohol use, but "nothing could be further from the truth." Employee denied he has a problem with alcohol. Employee denied his DUI two weeks ago had anything to do with alcohol or drugs, but then went on to explain, "Well, there aren't any troopers at the table, so I . . . will go so far as to tell you . . . that I only took, I believe, two five-milligram oxy's that morning and a 10-milligram baclofen around lunchtime." When asked about alcohol abuse delaying his recovery, Employee discussed his brain injury. Employee attributes his lack of sobriety to his brain injury. Employee cannot explain how his pain ended up being at its worst when he woke up on July 23, 2013. On re-direct examination, Employee stated he was not going to deny he has overused and abused alcohol. When asked if he acknowledges he is an alcoholic, Employee answered by discussing symptoms of brain injuries. Employee drinks because of brain injury and he drinks because of his back pain. Employee was repeatedly evasive, and repeatedly used the word "overuse," instead of "abuse," when asked about his alcohol abuse. (Weaver, Jr.; Record).

99) At the March 9, 2017 hearing, Dr. Restad testified Employee's symptoms did get worse from work and the delay in receiving injections contributed to Employee's chronic pain. Dr. Restad has not seen Employee in two years and when she did, she may not have gone into "great detail" in her exam. Dr. Restad diagnosed Employee with radiculopathy, degenerative disk disease with neural foraminal stenosis and back pain. She "absolutely" thinks Employee would not have experienced his low back symptoms had it not been for work. Dr. Restad was "absolutely horrified" at the delays in Employee's treatment. On cross-examination Dr. Restad testified she did not diagnose Employee with radiculopathy, but a specialist did. Dr. Restad knows when to refer to a specialist. She diagnosed Employee with compression of a spinal nerve root. She recalls Employee reporting he was standing on a dock and was having odd sensations in his feet, but she did not document Employee's report in her chart notes. Dr. Restad may have made an error in her documentation. When Employee first came to Dr. Restad on July 26, he reported his pain was 9 out of 10. On August 16, Employee's pain was 3 out of 10. Dr. Restad agreed that was an improvement. Regarding her referral to Dr. Johnston, Employee told Dr. Restad he wanted a second opinion on receiving epidural steroid injections, so she made the referral. "Everyone is entitled to a second opinion," according to Dr. Restad. On redirect examination, Dr. Restad testified she saw Employee over the course of a year and a half, and Employee's symptoms remained constant over that time. In Dr. Restad's opinion, the work

Employee performed in July of 2013 was the substantial cause of triggering Employee's pain. (Restad).

100) At a March 28, 2017 prehearing conference, the parties agreed to conclude the March 9, 2017 hearing on July 6, 2017. (Prehearing Conference Summary, March 28, 2017).

101) On July 6, 2017, John Williamson testified he has worked in numerous capacities for Employer for 18 years, and his duties have included performing job hazard analysis to ensure workers' health and safety. Employee's former supervisor, Troy Klingfus, is now employed on a full-time basis as a station mechanic at a radar site. Mr. Klingfus' April 13, 2013 email was not inappropriate or unusual, as Mr. Klingfus had been injured a couple of times previously and Employer was concerned he might have been "cutting corners." Employer's expectations under the circumstances would have been for Mr. Klingfus to stop work while Employer arranged for the purchase of the requested materials. Employer did purchase the requested materials as an "O&A" project, which Mr. Williamson clarified meant "over and above" budget, versus "O&M," which stands for "operate and maintain." These terms are contract requirements. Employee continued to work with Mr. Klingfus during the summer of 2013. Mr. Williamson trains new employees on reporting injuries. Because of its remote work locations, Employer "can't afford" for someone to get hurt because medical attention is so far away. Employer requires all employees to report injuries as soon as they happen. The Indian River job involved a tank farm where the ground had heaved and the tanks were no longer level. Therefore, the job involved levelling the tanks. This was an O&A job that involved special equipment to lift and shore the tanks and a procedure to set the tanks back down. There were two to five people on the job. Workers would rotate job duties, so even though Mr. Klingfus was the "lead," he would share in the work. Mr. Williamson worked on the Barter Island job, which involved building pads and access points for two large tanks the Air Force had delivered. Five workers were assigned to this job, including him. He would also lend a hand shoveling and pushing the wheelbarrow. The tanks had to be drug into place on skids, then, scaffolding was erected. The "dirt work" and the scaffolding work was all completed by the time he left the jobsite. Employee knew he was the "safety person" onsite, and employees are "well aware" to report injuries. During the period of time Mr. Williamson was at the jobsite, he heard no complaints to the effect, "I'm hurt," or "I can't work," though they were all complaining about sore muscles. He is familiar with the beds at Barter Island, they are Tall Taul brand beds and he does not think they

are worse than any other site. It is not accurate to describe the beds as not having any support or being concave. Mr. Willianson is not aware of any other emails from Mr. Klingfus between April and July of 2013. He never had to go back out to the worksite on a safety issue and is confident the employees were provided proper equipment to do the job. Employee never made any specific complaints. On cross-examination, Mr. Williamson testified he first saw Mr. Klingfus' email when another employee approached him on the O&A. Every site has lifting and rigging equipment, so he presumed that equipment was not available for some reason. Employee was on the worksite one week and 10 days prior to his arrival. Mr. Klingfus' email was sent after he had left the jobsite. Mr. Williamson described having sore muscles as the "nature of the beast" whenever heavy stuff needs to be moved – "it's a very physical job." Employee's photographic exhibits accurately reflected the work site. The Indian Mountain site involved jacking up the tanks. The Barter Island site involved a bulldozer pulling the tanks. He is not familiar with the tanks getting stuck and Employee getting under the tanks. Mr. Williamson confirmed the valves being moved were large and heavy, though he does not know that they weighed 180 pounds. Moving and installing the valves involved working in tight areas and awkward positions. (Williamson).

102) Employee repeatedly asserted his objections to any consideration of Dr. Marble's report during the hearing on his claims. (Record).

103) On July 13, 2017, Employee supplemented his March 8, 2017 affidavit, claiming a revised total of $175,806.50 in attorney fees and costs.

PRINCIPLES OF LAW

AS 23.30.041. Rehabilitation and reemployment of injured workers.

. . . .

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

> for 90 consecutive days as a result of the injury, the administrator shall, without a request, order an eligibility evaluation unless a stipulation of eligibility was submitted.
>
> **AS 23.30.105. Time for filing of claims.**
>
> (a) The right to compensation for disability under this chapter is barred unless a claim for it is filed within two years after the employee has knowledge of the nature of the employee's disability and its relation to the employment and after disablement. . . .
>
> (b) Failure to file a claim within the period prescribed in (a) of this section is not a bar to compensation unless objection to the failure is made at the first hearing of the claim in which all parties in interest are given reasonable notice and opportunity to be heard.
> . . . .
>
> **AS 23.30.110. Procedure on claims.**
>
> (a) Subject to the provisions of AS 23.30.105, a claim for compensation may be filed with the board in accordance with its regulations at any time after the first seven days of disability following an injury, or at any time after death, and the board may hear and determine all questions in respect to the claim.
>
> (b) Within 10 days after a claim is filed the board, in accordance with its regulations, shall notify the employer and any other person, other than the claimant, whom the board considers an interested party that a claim has been filed. The notice may be served personally upon the employer or other person, or sent by registered mail.
>
> (c) Before a hearing is scheduled, the party seeking a hearing shall file a request for a hearing together with an affidavit stating that the party has completed necessary discovery, obtained necessary evidence, and is prepared for the hearing. . . . If the employer controverts a claim on a board-prescribed controversion notice and the employee does not request a hearing within two years following the filing of the controversion notice, the claim is denied.

Use of the word "claim" in the last sentence of subsection (c) means a written application for benefits filled with the board. *Jonathan v. Doyon Drilling, Inc.*, 773 P.2d 1121 (Alaska 1995).

> **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.

"The text of AS 23.30.120(a)(1) indicates that the presumption of compensability is applicable to *any* claim for compensation under the workers' compensation statute." *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996) (emphasis in original). Medical benefits, including continuing care, are covered by the AS 23.30.120(a) presumption of compensability. *Municipality of Anchorage v. Carter*, 818 P.2d 661, 664-65 (Alaska 1991). The Alaska Supreme Court in *Sokolowski v. Best Western Golden Lion*, 813 P.2d 286, 292 (Alaska 1991) held a claimant "is entitled to the presumption of compensability as to each evidentiary question."

The presumption's application involves a three-step analysis. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381 (Alaska 1991). First, an employee must establish a "preliminary link" between the "claim" and her employment. In less complex cases, lay evidence may be sufficiently probative to make the link. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Whether or not medical evidence is required depends on the probative value of available lay evidence and the complexity of the medical facts involved. *Id.* An employee need only adduce "some," minimal relevant evidence, *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987), establishing a "preliminary link" between the "claim" and the employment, *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). Witness credibility is not examined at this first step. *Excursion Inlet Packing Co. v. Ugale*, 92 P.3d 413, 417 (Alaska 2004).

Second, once an employee attached the presumption, the employer must rebut it with "substantial" evidence that either, (1) provides an alternative explanation excluding work-related factors as a substantial cause of the disability ("affirmative-evidence"), or (2) directly eliminates any reasonable possibility that employment was a factor in causing the disability ("negative-evidence"). *Huit v. Ashwater Burns, Inc*., 372 P.3d 904; 919 (Alaska 2016). "Substantial evidence" is the amount of relevant evidence a reasonable mind might accept as adequate to support a conclusion. *Miller v. ITT Arctic Services*, 577 P.2d 1044, 1046 (Alaska 1978). The mere possibility of another injury is not "substantial" evidence sufficient to rebut the presumption. *Huit* at 920, 921. The employer's evidence is viewed in isolation, without regard to an employee's

evidence. *Miller* at 1055. Therefore, credibility questions and weight accorded the employer's evidence are deferred until after it is decided if the employer produced a sufficient quantum of evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Compensation Board*, 880 P.2d 1051, 1054 (Alaska 1994); *citing Big K Grocery v. Gibson*, 836 P.2d 941 (Alaska 1992).

For claims arising after November 7, 2005, employment must be the substantial cause of the disability or need for medical treatment. *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 (March 25, 2011) (reversed on other grounds by *Huit*). If an employer produces substantial evidence work is not the substantial cause, the presumption drops out and the employee must prove all elements of the "claim" by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1381 (*citing Miller v. ITT Services*, 577 P 2d. 1044, 1046). The party with the burden of proving asserted facts by a preponderance of the evidence must "induce a belief" in the fact-finders' minds the asserted facts are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

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

The legislative history of AS 23.30.122 states the intent was "to restore to the Board the decision making power granted by the Legislature when it enacted the Alaska Workers' Compensation Act." *DeRosario v. Chenega Lodging*, 297 P.3d 139, 146 (Alaska 2013). The Alaska Workers' Compensation Appeals Commission is required to accept the board's credibility determinations. *Id.* The Alaska Supreme Court defers to board's credibility determinations. *Id.* If the board is faced with two or more conflicting medical opinions, each of which constitutes substantial evidence, it may rely on one opinion and not the other. *Id.* at 147. The board may also choose not to rely on its own expert. *Id.*

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

> conduct its hearing in the manner by which it may best ascertain the rights of the parties. . . .
>
> **AS 23.30.145. Attorney fees**. (a) Fees for legal services rendered in respect to a claim are not valid unless approved by the board, and the fees may not be less than 25 percent on the first $1,000 of compensation or part of the first $1,000 of compensation, and 10 percent of all sums in excess of $1,000 of compensation. When the board advises that a claim has been controverted, in whole or in part, the board may direct that the fees for legal services be paid by the employer or carrier in addition to compensation awarded; the fees may be allowed only on the amount of compensation controverted and awarded. . . .
>
> (b) If an employer fails to file timely notice of controversy or fails to pay compensation or medical and related benefits within 15 days after it becomes due or otherwise resists the payment of compensation or medical and related benefits and if the claimant has employed an attorney in the successful prosecution of the claim, the board shall make an award to reimburse the claimant for the costs in the proceedings, including a reasonable attorney fee. The award is in addition to the compensation or medical and related benefits ordered.

In *Harnish Group, Inc. v. Moore*, 160 P.3d 146 (Alaska 2007), the Alaska Supreme Court discussed how and under which statute attorney's fees may be awarded in workers' compensation cases. A controversion, actual or in-fact, is required for the board to award fees under AS 23.30.145(a). "In order for an employer to be liable for attorney's fees under AS 23.30.145(a), it must take some action in opposition to the employee's claim after the claim is filed." *Id*. at 152. Fees may be awarded under AS 23.30.145(b) when an employer "resists" payment of compensation and an attorney is successful in the prosecution of the employee's claims. *Id*. In this latter scenario, reasonable fees may be awarded. *Id.* at 152-53.

> Although the supreme court has held that fees under subsections (a) and (b) are distinct, the court has noted that the subsections are not mutually exclusive (citation omitted). Subsection (a) fees may be awarded only when claims are controverted in actuality or fact (citation omitted). Subsection (b) may apply to fee awards in controverted claims (citation omitted), in cases which the employer does not controvert but otherwise resists (citation omitted), and in other circumstances (citation omitted).

Uresco Construction Materials, Inc. v. Porteleki, AWCAC Decision No. 09-0179 (May 11, 2011).

In *Wise Mechanical Contractors v. Bignell*, 718 P.2d 971, 974-75 (Alaska 1986), the Court held attorney's fees awarded by the board should be reasonable and fully compensatory. Recognizing attorneys only receive fee awards when they prevail on the merits of a claim, the contingent nature of workers' compensation cases should be considered to ensure competent counsel is available to represent injured workers. *Id*. The nature, length, and complexity of services performed, the resistance of the employer, and the benefits resulting from the services obtained, are also considerations when determining reasonable attorney's fees for the successful prosecution of a claim. *Id*. at 973, 975.

The statute at AS 23.30.145(a) establishes a minimum fee, but not a maximum fee. *Lewis-Walunga v. Municipality of Anchorage*, AWCAC Decision No. 123 (December 28, 2009) at 5. A fee award under AS 23.30.145(a), if in excess of the statutory minimum fee, requires the board to consider the "nature, length, and complexity of the services performed, transportation charges, and the benefits resulting from the services to the compensation beneficiaries." *Id.*

> **AS 23.30.155. Payment of Compensation.**
> . . . .
>
> (p) An employer shall pay interest on compensation that is not paid when due. Interest required under this subsection accrues at the rate specified in AS 09.30.070(a) that is in effect on the date the compensation is due.
>
> **AS 23.30.185. Compensation for temporary total disability.** In case of disability total in character but temporary in quality, 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the disability. Temporary total disability benefits may not be paid for any period of disability occurring after the date of medical stability.
>
> **AS 23.30.190. Compensation for permanent partial impairment; rating guides.**
>
> (a) In case of impairment partial in character but permanent in quality, and not resulting in permanent total disability, the compensation is $177,000 multiplied by the employee's percentage of permanent impairment of the whole person. The percentage of permanent impairment of the whole person is the percentage of impairment to the particular body part, system, or function converted to the percentage of impairment to the whole person as provided under (b) of this section. The compensation is payable in a single lump sum, except as otherwise

provided in AS 23.30.041, but the compensation may not be discounted for any present value considerations.
. . . .

8 AAC 45.032. Files. Upon receiving written notice of an injury, the division will

(1) establish an injury number;

(2) set up a case file in a format prescribed by the director, using the injury number;

(3) notify the employee or beneficiary, the employer, and the insurer in writing in a format prescribed by the director of the injury number;

(4) put the written notice of the injury in the case file together with documents or anything relating to the employee's injury that is filed with the division or board; and

(5) use the injury number as the claim number if a claim is filed.

8 AAC 45.040. Parties.

(a) Except for a deceased employee's dependent or a rehabilitation specialist appointed by the administrator or chosen by an employee in accordance with AS 23.30.041, a person other than the employee filing a claim shall join the injured employee as a party.
. . . .

(c) Any person who may have a right to relief in respect to or arising out of the same transaction or series of transactions should be joined as a party.

(d) Any person against whom a right to relief may exist should be joined as a party.

(e) In a death case, all persons, except minor children, who may be dependents or beneficiaries of the deceased employee, should either join or be joined as parties so the entire liability of the employer or carrier to the dependents or beneficiaries is determined in one proceeding. . . .

(f) Proceedings to join a person are begun by

(1) a party filing with the board a petition to join the person and serving a copy of the petition, in accordance with 8 AAC 45.060, on the person to be joined and the other parties; or

(2) the board or designee serving a notice to join on all parties and the person to be joined.

(g) A petition or a notice to join must state the person will be joined as a party unless, within 20 days after service of the petition or notice, the person or a party files an objection with the board and serves the objection on all parties. If the petition or notice to join does not conform to this section, the person will not be joined.

. . . .

(i) If a claim has not been filed against the person served with a petition or notice to join, the person may object to being joined based on a defense that would bar the employee's claim, if filed.

(j) In determining whether to join a person, the board or designee will consider

. . . .

(5) if a claim was not filed as described in (4) of this subsection, whether a defense to a claim, if filed by the employee, would bar the claim.

(k) If claims are joined together, the board or designee will notify the parties which case number is the master case number. After claims have been joined together,

(1) a pleading or documentary evidence filed by a party must list the master case number first and then all the other case numbers;

(2) a compensation report, controversion notice, or a notice under AS 23.30.205(f) must list only the case number assigned to the particular injury with the employer filing the report or notice;

(3) documentary evidence filed for one of the joined cases will be filed in the master case and the evidence will be considered as part of the record in each of the joined cases; and

(4) the original of the board's decision and order will be filed in the master case file, and a copy of the decision and order will be filed in each of the joined case files.

(*l*) After the board hears the joined cases and, if appropriate, the division will separate the case files and will notify the parties. If the joined case files are separated, a pleading or documentary evidence filed thereafter by a party must list only the case number assigned to the particular injury with the employer filing the pleading or documentary evidence.

8 AAC 45.050. Pleadings.

(a) A person may start a proceeding before the board by filing a written claim or petition.

(b) **Claims and petitions.**

(1) A claim is a written request for benefits, including compensation, attorney's fees, costs, interest, reemployment or rehabilitation benefits, rehabilitation specialist or provider fees, or medical benefits under the Act, that meets the requirements of (4) of this subsection.

. . . .

(5) A separate claim must be filed for each injury for which benefits are claimed, regardless of whether the employer is the same in each case. . . .

(c) Answers.

. . . .

(5) The evidence presented at the hearing will be limited to those matters contained in the claim, petition, and answer, except as otherwise provided in this chapter.

8 AAC 45.052. Medical summary.

(a) A medical summary on form 07-6103, listing each medical report in the claimant's or petitioner's possession which is or may be relevant to the claim of petition, must be filed with a claim or petition. The claimant or petitioner shall serve a copy of the summary form, along with copies of the medical reports, upon all parties to the case and shall file the original summary form with the board.

(b) The party receiving a medical summary and claim or petition shall file with the board an amended summary on form 07-6103 within the time allowed under AS 23.30.095(h), listing all reports in the party's possession which are or may be relevant to the claim and which are not listed on the claimant's or petitioner's medical summary form. . . .

(c) Except as provided in (f) of this section, a party filing an affidavit of readiness for hearing must attach an updated medical summary, on form 07-6103, if any new medical reports have been obtained since the last medical summary was filed.

(1) If the party filing an affidavit of readiness for hearing wants the opportunity to cross-examine the author of a medical report listed on the medical summaries that have been filed, the party must file with the board,

> and serve upon all parties, a request for cross-examination, together with the affidavit of readiness for hearing and an updated medical summary and copies of the medical reports listed on the medical summary, if required under this section.
> . . . .
>
> (5) A request for cross-examination must specifically identify the document by date and author, generally describe the type of document, state the name of the person to be cross-examined, state a specific reason why cross-examination is requested, be timely filed under (2) of this subsection, and be served upon all parties.
>
> > (A) If a request for cross-examination is not in accordance with this section, the party waives the right to request cross-examination regarding a medical report listed on the updated medical summary.
> >
> > (B) If a party waived the right to request cross-examination of an author of a medical report listed on a medical summary that was filed in accordance with this section, at the hearing the party may present as the party's witness the testimony of the author of a medical report listed on a medical summary filed under this section.
> > . . . .

The worker's compensation system in Alaska favors the production of medical evidence in the form of written reports, and this preference serves a legitimate purpose. *Employers Commercial Union Insurance Group v. Schoen*, 519 P.2d 819; 822 (Alaska 1974). However, "the statutory right to cross-examination is absolute and applicable to the Board." *Id.* at 824. The medical summary and request for cross-examination process set out in 8 AAC 45.052 was developed in response to the Alaska Supreme Court's decision in *Commercial Union Insurance Companies v. Smallwood*, 550 P.2d 1261 (Alaska 1976) (holding the employer did not waive its right to cross-examine the employee's treating physicians). This decision is so firmly entrenched in the Alaska's workers' compensation system that the objection to the admission of medical reports based on the unavailability of the author for cross-examination is commonly referred to as a "*Smallwood* objection." AAC 45.900(11).

Medical records, including doctors' chart notes, opinions, and diagnoses, fall squarely within the business records exception to the hearsay rule. *Dobos v. Ingersoll,* 9 P.3d 1020; 1027 (Alaska 2000); *Loncar v. Gray*, 28 P.3d 928; 934-35 (Alaska 2001). However, letter's

written by a physician to a party or a party's representative to express an expert medical opinion on an issue before the tribunal are not admissible as a business record unless the requisite foundation is established showing it is the physician's regular practice to prepare and send such letters. *Liimatta v. West*, 45 P.3d 310; 318 (Alaska 2002); *Geister v. Kid's Corps, Inc.*, AWCAC Decision No. 045 (June 6, 2007).

In *Frazier v. H.C. Price/CIRI Const. J.V.*, 794 P.2d 103 (Alaska 1990), the Alaska Supreme Court revisted the issue of medical evidence as hearsay after the board had promulgated its evidence regulation, 8 AAC 45.120, which addressed evidence filing and service deadlines, and the right to request cross-examination. *Frazier* reviewed decisions from other jurisdictions, which routinely held medical documents were admissible against the party "that authorized the report" because the party had in effect "vouched for the competence and credibility of the report's author." Thus, the need to impeach the author's credibility and competence through cross-examination was "less urgent." *Id*. at 105. In applying Alaska Evidence Rule 801(d)(2)(C), *Frazier* found such medical reports were not "hearsay," reversed the board's decision and remanded for an order requiring the employer to reimburse the employee for the costs of making the clinic physicians available for cross-examination, because the employer had "vouched for the credibility and competence of the physicians." *Id*. at 105-06.

In *Olson v. Federal Express Corp.*, AWCB Decision No. 15-0012, the employee relied on early medical opinions of her treating physician to support her claims for benefits. Later, after being shown the employee's contemporaneous medical records and her supervisor's statement, the employee's physician reversed his position and stated the work incident was not the substantial factor of the employee's disability or her need for treatment. The employee's attorney then filed a *Smallwood* objection to the physician's later opinion, and neither party called the physician to testify at hearing. *Olson* decided to exclude the physician's latter opinion and afford less weight to his earlier opinion because it was based on "misinformation," and was "not in accordance with the facts."

8 AAC 45.070. Hearings.

. . . .

(b) Except as provided in this section and 8 AAC 45.074(c), a hearing will not be scheduled unless a claim or petition has been filed, and an affidavit of readiness for hearing has been filed and that affidavit is not returned by the board or designee nor is the affidavit the basis for scheduling a hearing that is cancelled or continued under 8 AAC 45.074(c).

. . . .

(g) Except when the board or its designee determines that unusual and extenuating circumstances exist, the prehearing summary . . . governs the issues and the course of the hearing.

8 AAC 45.120. Evidence.

(a) Witnesses at a hearing shall testify under oath or affirmation. . . .

(c) Each party has the following rights at hearing:

(1) to call and examine witnesses;

(2) to introduce exhibits;

(3) to cross-examine opposing witnesses on any matter relevant to the issues even though the matter was not covered in the direct examination;

(4) to impeach any witness regardless of which party first called the witness to testify; and

(5) to rebut contrary evidence.

. . . .

(e) Technical rules relating to evidence and witnesses do not apply in board proceedings, except as provided in this chapter. Any relevant evidence is admissible if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil actions. Hearsay evidence may be used for the purpose of supplementing or explaining any direct evidence, but it is not sufficient in itself to support a finding of fact unless it would be admissible over objection in civil actions. . . .

(h) If a request is filed in accordance with (f) of this section, an opportunity for cross-examination will be provided unless the request is withdrawn or the board determines that

> (1) under a hearsay exception of the Alaska Rules of Evidence, the document is admissible;
>
> (2) the document is not hearsay under the Alaska Rules of Evidence; or
>
> (3) the document is a report of an examination performed by a physician chosen by the board under AS 23.30.095(k) or AS 23.30.110(g).
> . . . .

8 AAC 45.900. Definitions.
. . . .

(5) "claim" includes any matter over which the board has jurisdiction;
. . . .

ANALYSIS

1) Should Dr. Marble's January 9, 2014, EME report be excluded from consideration?

The statutory right to cross-examination is absolute and applicable in workers' compensation cases. *Schoen*. On July 24, 2014, Employee properly and timely submitted his request to cross-examine Dr. Marble on the basis of his opinions. 8 AAC 45.052(c)(1), (5); 8 AAC 45.120(h). Furthermore, Employee repeatedly asserted his objections to any consideration of Dr. Marble's report during the hearing on his claims. Marble did not testify at hearing and his January 9, 2014, report does not fall into a recognized hearsay exception. Therefore, Dr. Marble's January 9, 2014, EME report will be excluded from consideration. *Liimatta*; *Geister*.

2) Should Dr. Johnston's "check-the-box" concurrences, be excluded from consideration?

In *Weaver I*, Employee unsuccessfully sought to exclude Dr. Marble's January 9, 2014, EME report on the grounds it was the product of an excessive change of physician. In its decision, another panel rejected Employee's contentions that Employer's nurse case manager and Dr. Johnston were EMEs. *Weaver I* is now the law of the case and the conclusions reached in that decision will be recognized.

Weaver I necessarily concluded Dr. Johnston is Employee's, and not Employer's, physician. In support of this conclusion, the instant decision also points out Dr. Restad's August 20, 2013

referral to Dr. Johnston. In fact, during Dr. Restad's deposition and hearing testimony, she confirmed she referred Employee to Dr. Johnston at Employee's own behest.

Here, Employee presents an issue similar to the one presented in *Olson*, where an employee sought to cross-examine her own physician. Seemingly, this issue would be controlled by *Frazier*, which concluded a party "that authorized the report" had "vouched for the credibility of the report's author," thus the need to impeach the author's credibility through cross-examination was "less urgent." However, the stated basis for the Court's decision in *Frasier* are notably absent in this case.

First, *Weaver I* concluded, although Employer's nurse case manager "came dangerously close to directing Employee's medical care," she did not. Nevertheless, there was no doubt, either in *Weaver I* or in this decision, that Employer's nurse case manager was acting as Employer's agent. She undisputedly authored Dr. Johnston's February 3, 2014 opinions and the facts here create genuine doubt about the extent to which Employee had ever "authorized" Dr. Johnston to respond to the February 3, 2014 inquiries of Employer's agent in the first place, especially in light of Dr. Restad's deposition and hearing testimony, where she explained she referred Employee to Dr. Johnston for the limited purpose of obtaining a second opinion on treatment options. Second, this decision is also mindful of the Court's measured language in *Frazier*, where it wrote the right to cross-examination was "less urgent" under the facts in that case. The Court did not hold the appellant's right to cross-examination were entirely non-existent. Third, the requisite foundation establishing it was Dr. Johnston's regular business practice to respond to letters from a party during litigation is lacking. *Liimatta*; *Geister*.

Most persuasive of all, however, is Employee's argument that Dr. Johnston's February 3, 2014, opinions are unreliable and therefore should not be considered. His point is well taken. Dr. Johnston's responses to Employer's February 3, 2014, letter run contrary to his own treatment recommendations in the months leading up to February 3, 2014, which included traction therapy, physical therapy and work hardening. Then, on February 3, 2014, Dr. Johnston suddenly and inexplicably agreed with Dr. Marble's opinion that no specific medical treatment was reasonable and necessary for the work-related aggravation of Employee's preexisting condition. Under

these facts, Employee should have been afforded an opportunity to explore the foundations of Dr. Johnston's February 3, 2014 opinions via cross-examination. *Dobos*; *Loncar*. Given the inherent unreliability of Dr. Johnston's February 3, 2014, opinions, and the lack of a requisite foundation under the business records exception, and genuine doubt as to the extent Employee ever authorized Dr. Johnston to make any statements on the subjects presented in Employer's February 3, 2014, letter, Dr. Johnston's February 3, 2014, opinions will be excluded from consideration. *Schoen*; 8 AAC 45.120(h).

3) Is a claim for benefits arising from Employee's December 7, 2010, work injury an issue for hearing?

The prehearing conference summary governs issues for hearing. 8 AAC 45.070(g). The October 10, 2016, prehearing conference summary identifies Employee's February 19, 2014, and his June 7, 2014 claims as issues for the March 9, 2017 hearing. Both of these claims seek benefits arising from Employee's 2013, not his 2010, injury. Thus, any claim seeking benefits for Employee's 2010 injury, even if one existed, was not an issue for this hearing. *Id*.

Nevertheless, Employee contends the benefits he seeks for his 2013 injury "are the same as would be part of the 2010 claim, since the two claims have been joined." Here, Employee conflates "claim" and "case." A claim is a written request for benefits. 8 AAC 45.050(b)(1); *see also Jonathan* (defining "claim" in the last sentence of AS 23.30.110(c) as a written application for benefits filled with the board). Once a claim has been filled, then broad authority exists "to hear and determine all questions in respect to the claim." AS 23.30.110(b); 8 AAC 45.900(5). Even a cursory review of the Act will show many events in workers' compensation proceedings are contingent upon the filling of a claim. For examples, the "right to compensation for disability is barred unless a *claim* for it is *filed* within two years after the employee has knowledge of the nature of the employee's disability and its relation to the employment and after disablement." AS 23.30.105(a) (emphasis added). Proceedings may be started "by *filing* a *written claim* or petition," 8 AAC 45.050(a) (emphasis added), and the scheduling of a hearing is predicated upon a "*claim*" having first been "*filed*." AS 23.30.110(a), (b); 8 AAC 45.070(b) (emphasis added). Meanwhile, and quite distinct from a claim, a case is created upon receipt of an injury notice, 8 AAC 45.032, and the regulations specifically contemplate the creation of

cases where no claims are ever filed. 8 AAC 45.032(5) (prescribing an injury number will be used as the claim number "if a claim is filed"). Employee's December 9, 2010 injury report created a case, but Employee did not file a claim for benefits in that case.

The regulation governing joinder mentions joining "persons," "claims," and "cases." 8 AAC 45.040. Employee's October 13, 2014, petition sought to join "Additional Employers and/or Insurers," or in other words, additional persons or parties, to the instant case. Employer did not oppose Employee's petition, and at the January 21, 2015, prehearing conference, the designee joined Employee's 2010 and 2013 cases, which also effectively joined Employer as a party, just as Employee's petition sought. However, the designee did not, and could not join a claim for Employee's 2010 injury, because there was no claim that could be joined. Neither did Employee file a claim for his 2010 injury subsequent to case joinder.

The regulations also provide that "a separate claim must be filed for each injury for which benefits are claimed, regardless of whether the employer is the same in each case." 8 AAC 45.050(b)(5). The "evidence presented at hearing will be limited to those matters contained in the claim . . . ." 8 AAC 45.050(c)(5). Therefore, not only is a claim for benefits from Employee's 2010 injury not an issue for hearing because the prehearing conference summary does not list it as a hearing issue, but also because such a claim never existed. 8 AAC 45.070(g); 8 AAC 45.050(c)(5). Given these conclusions, it is not necessary to decide whether such a claim, had one been filed, would have been barred by operation of AS 23.30.105.

4) Is Employee entitled to medical and related transportation costs?

Employee contends he performed a variety of heavy, physical labor for Employer leading up to his July 23, 2013, injury and seeks an award of medical and related transportation costs. For medical benefits to be comepnsable, Employee's employment must be "the substantial cause" of his need for medical treatment. AS 23.30.110(a). Compensability raises a factual dispute to which the statutory presumption of compensability applies. *Meek.* Employee attaches the presumption with his own testimony, as well as with Dr. Restad's, Dr. DeSalvo's, Dr. Kralick's and Dr. Trescott's opinions, which all relate Employee's continuing need for medical treatment

to his work injury. *Cheeks*. Employer rebuts the presumption with Dr. Radecki's opinion that Employee's continuing need for medical treatment was caused by factors other than work, and Dr. Scoggin's opinion that Employee suffered a soft tissue injury that had resolved by the time of Dr. Marble's January 9, 2014 EME evaluation.[1] *Miller*. Employee must now prove, by a preponderance of the evidence, that his injury with Employer is the substantial cause of his need for continuing medical treatment. *Koons.*

Employee's primary treating physician, Dr. Restad, has issued numerous opinions, both in writing and during delivered testimony, that support Employee's claims. When Dr. Restad first began treating Employee, she initially thought Employee had an "overuse injury." Following Employer's initial controversion, Dr. Restad wrote a letter, wherein she related lumbar strain to Employee's work. Dr. Restad later opined Employee's symptoms were substantially caused by his work activities. Dr. Restad was afforded an opportunity to explain her opinions at the March 9, 2017 hearing.

Dr. Restad's hearing testimony was contradictory and problematic. For example, on direct examination, she testified she diagnosed Employee with radiculopathy, degenerative disk disease with neural foraminal stenosis and back pain, but, on cross-examination, she testified she did not diagnose Employee with radiculopathy, but rather a specialist did. Similarly, on cross-examination, Dr. Restad testified, when Employee first came to her, he reported his pain was 9 out of 10. A month and a half later, Employee reported his pain was 3 out of 10. Dr. Restad thought that was an improvement. Then, on redirect examination, Dr. Restad testified Employee's symptoms remained constant over time. During her testimony, Dr. Restad also acknowledged she may not have gone into "great detail" during her examination, and she may have also made a documentation error. For these reasons, Dr. Restad's opinions are afforded little weight.

Another of Employee's early providers, Dr. DeSalvo, Employee's chiropractor, initially diagnosed Employee with "cumulative trauma to the lumbosacral spine," and later indicated Employee's treatment was work related. Employee's surgeon, Dr. Kralick also twice opined on

[1] For reason's explained below, Dr. Teed's opinion on causation will not be used to rebut the presumption.

the work-relatedness of Employee's need for treatment. However, neither Dr. DeSalvo, nor Dr. Kralick, were deposed, and neither did they testify at hearing, so the parties have not had an opportunity to explore the basis of their opinions. Furthermore, there is no evidence Dr. DeSalvo or Dr. Kralick reviewed Employee's medical records in their entirety. Therefore, Dr. DeSalvo's and Dr. Kralick's opinions are considered cursory and are afforded little weight.

Dr. Trescott saw Employee twice. She evaluated Employee for back pain at one appointment, and administered epidural steroid injections at the second, where she also opined Employee's low back symptoms were substantially caused by work. Then, nearly three years after treating Employee, Dr. Trescott was deposed. Like Dr. Restad, Dr. Trescott's opinions faltered on cross-examination, where she acknowledged she obtained her history of the work injury from Employee, she did not record a neurological examination, which is the best information for diagnosing radiculopathy, and she cannot opine on whether Employee's disc pathology is acute or chronic. Dr. Trescott further acknowledged she thinks it is important to assess the mental health of pain patients but she did not document non-work related stress in Employee's life. Dr. Trescot admitted she was once critical of another physician for not documenting a patient's history of substance abuse, yet she did not document Employee's history of substance abuse. Dr. Trescott also thinks anxiety can contribute to pain, but she did not consider anxiety in Employee's case. Finally, Dr. Trescott interpreted Employee's MRI to show a "disruption" to the posterior interspinous ligament, an opinion she acknowledged is not a commonly accepted medical finding. Accordingly, Dr. Trescott's opinions are afforded little weight.

As previously determined, the opinions of Employer's first EME physician, Dr. Marble, will not be considered in this decision, and neither will Dr. Johnston's "check-the-box" answers to Employer's February 3, 2014 letter. Employer's second EME physician, Dr. Radecki, first evaluated Employee on March 20, 2015, and most of his findings upon physical examination are quoted verbatim in this decision's findings of facts. They are remarkable and were initially viewed with some skepticism by this panel. Dr. Radecki reported he found numerous, dramatic, and what he termed, "non-physiological," pain responses upon examination that were not previously noted by other providers.

Dr. Radecki opined Employee's 2010 injury resulted in muscle strain and resolved fairly quickly. He cited Employee's range of motion findings from January 12, 2011, his subjective pain level of 1 out-of 10 (1/10), and the fact that Employee reported not missing any work following this injury, in support of his opinion. Regarding Employee's 2013 injury, Dr. Radecki did not think there was "any specific injury whatsoever," since Employee told Dr. Radecki his biggest complaint was the bed on which he was sleeping, and characterized Employee's need for medical treatment as his "choice to seek medical attention following sleep." Instead, Dr. Radecki opines Employee's pain was due to, what he termed, "psychosocial factors."

Following Dr. Radecki's initial evaluation, Dr. Scoggin performed an SIME. Dr. Scoggin concluded Employee's 2013 injury had combined with a preexisting condition to cause Employee's need for treatment, but he further opined this change was not permanent and thought Employee was medically stable at the time of Dr. Marble's January 9, 2014, EME. In support of his opinions, Dr. Scoggin cited Employee's reports of back pain predating the July 23, 2013 work injury and imaging studies showing only chronic-appearing degenerative changes in Employee's lumbosacral spine, which were stable on three separate MRI studies. Dr. Scoggin thought Employee's current complaints were subjective and primarily related to his preexisting degenerative disc disease and its expected progression over time.

As Employee's medical record became more fully developed, and as that same medical record disclosed additional details of his personal life, Drs. Radecki and Scoggin continued to expound upon the opinions expressed in their initial reports. Dr. Radecki performed two medical evaluations, issued an addendum after reviewing updated medical records, and testified at hearing. Meanwhile, after Dr. Scoggin issued his initial report, he responded to Employee's interrogatories, issued two addendums after reviewing updated medical records, and was deposed. For these reasons, and those that follow, Dr. Radecki's and Dr. Scoggin's opinions are afforded substantial weight.

Dr. Teed also evaluated Employee on referral from Dr. Radecki. On physical examination, Dr. Teed observed many behaviors similar to what Dr. Radecki calls "non-physiologic" responses. Dr. Teed's diagnosis included, functional overlay, which included closed head injury, history of

alcohol abuse, history of anxiety/depression, chronic narcotic use/abuse, chronic non-specific neck pain, and chronic non-specific low back pain. In his February 17, 2017 report, Dr. Teed opined the cause of Employee's disability and need for treatment are "unknown, but unrelated to the July 23, 2013 job injury." For this reason, his opinion was not used to rebut the presumption. *Huit*. His opinions suffer from other infirmities, as well.

At his deposition, Dr. Teed testified, "there is no Level 1, evidence-based medicine that shows epidural steroid injections, medial and lateral branch blocks or nerve ablations work." Yet, on cross-examination, Dr. Teed testified he has ordered all of these treatments. Dr. Teed's deposition testimony also made clear, he places a great deal of weight on the Bradford Hill criteria for causation. According to Dr. Teed, this criteria is based on theory that human bodies will generally get better when the causative agent is removed. In other words, if the causative factor is increased, one will have more symptoms, but if the causative factor is decreased, one will have less symptoms. While such a theory may make sense when a typical patient is exposed to an allergen or a toxic substance, it is hardly applicable in the workers' compensation system when an employee suffers any number of traumatic injuries at work requiring medical treatment. *Rogers & Babler*. Accordingly, Dr. Teed's opinions will be afforded little weight.

At the conclusion of Employee's hearing, several aspects of this case particularly compelling. Here, there is no doubt Employee performed heavy, physical labor for Employer, but he never identified a particular injury. Instead, at hearing, Employee presented a laundry list of his work activities to this panel, just as he did with his providers in seeking medical treatment. In fact, Employee even acknowledged at hearing, he still cannot explain why he woke up with back pain on July 23, 2013.

Like Dr. Radecki, Dr. Scoggin was also troubled by Employee's inability to point to any specific injury. At his deposition, Dr. Scoggin observed, Employee did not point to a single injurious incident, but rather reported more than ten different potential causes for the aggravation. Neither could Dr. Scoggin identify any injury that would explain Employee's symptoms following his 2013 injury. "There's no heavy weight he lifted and suddenly had a sharp pain, the types of

things we usually see," according to Dr. Scoggin. Dr. Teed was also unable to identify an acute injury during his evaluation, and Employee was unable to describe a specific injury to Dr. Teed.

Employee's alcohol abuse a compelling aspect in this case. In many cases, the details of claimant's personal life are not relevant to their workers' compensation claims. However, in this case, Employee's alcohol abuse was relevant because Dr. Radecki had identified it as one of the psychosocial factors causative of Employee's disability and need for medical treatment. Employee's history of alcohol abuse, as well as his deposition and hearing testimony regarding that issue, are set forth in detail in this decision's factual findings. It will suffice to note, Employee's denial of his alcohol abuse, and his evasiveness in answering questions on this issue, were obvious during his hearing testimony, which can be fairly interpreted as Employee blaming his alcohol abuse, and its consequences, on his wife, his brain injury, his back injury and even Employer. AS 23.30.122. Employee's father also testified Employee never had an alcohol problem prior to the 2013 injury. However, on cross-examination, Employee's father evaded answering a question on Employee's 1991 discharge from the military for alcohol rehabilitation failure, and acknowledged Employee's 1993 car accident and DUI. AS 23.30.122.

Employee's alcohol abuse was not the only psychosocial factor Dr. Radecki identified in the medical record. He also identified marijuana use, divorce, frustration, anger, difficulties paying bills and legal fees, taking more pain medication than prescribed, and taking pain medication from a past prescription, as additional psychosocial factors causing Employee's disability and need for medical treatment. Dr. Radecki also documented inconsistencies between findings upon physical examination performed by other medical providers and himself, and concluded Employee is not reliable on examination. He went even further and stated findings from his physical examination of Employee were "totally unreliable." Dr. Teed's findings and conclusions were similar to Dr. Radecki's. Employee's result on physical examination, according to Dr. Teed, indicated functional overlay, which he explained means inconsistencies on exam, and includes such things as inorganic or non-anatomic findings that do not makes sense from a physiological standpoint and are unreliable. Dr. Scoggin also found inconsistencies on exam, which he described as "non-specific." Meanwhile, Employee's physician, Dr. Trescott, agrees with Dr. Radecki, to a large extent. She also thinks it is important to evaluate the mental

health and substance abuse history of a patient, even though she did not do so in Employee's case. So, too, does Dr. Teed, who thinks information about a patient's substance abuse and psychological history is important when treating pain.

However, without a doubt, the most impressive aspect of this case was Employee's lack of response to very extensive and prolonged treatment. Over the course of three years, Employee underwent physical therapy, traction therapy, work hardening, acupuncture, epidural steroid injections, radio frequency ablation, and back surgery, which included laminectomies, decompressions and inter-body fusions. Employee reported no pain relief following the radio frequency ablations, despite having been advised that the treatment typically provides relief lasting between six months to two years. Employee's pain management was entirely ineffective too. At the same time he is obtaining the treatments just mentioned, he was also being prescribed Tramadol, Oxycodone, Hydromorphone, Morphine, Hydrocodone, Percocet, MS Contin, Fentanyl, in various combinations over time. Drs. Scoggin, Radecki, Trescott and Teed all addressed Employee's lack of response to treatment and medication in their opinions.

Dr. Scoggin noted Employee had been having pain, averaging 6 out of 10 for one year prior to the 2013 injury. He also noted, "way back" in 2001, Employee was having pain that was 6 out of 10. Therefore, Dr. Scoggin did not think there is any objective evidence that shows Employee's pain was worse after the 2013 work injury than it was before the work injury. Dr. Radecki then observed Employee did not improve after the work injury, either, even after receiving extensive treatment. When Employee saw Dr. Trescott, "Employee's pain was a 5, and he was not taking any medication. Now, after years of treatment and invasive surgery, Employee is on both short-acting and long-acting narcotics, and his pain level is at 5 or 6, so Employee is worse," according to Dr. Radecki. Dr. Trescott also opines, if a pain patient has tried narcotics, anti-inflammatories, medial branch blocks, radiofrequency ablation and surgery, and there is no improvement, she would be concerned there might be an underlying issue that is not being addressed. Dr. Teed also agrees with Dr. Trescott's opinion in this regard.

Drs. Scoggin and Radecki both opine Employee suffered, at most, a soft tissue injury and was medically stable, at the latest, by the time of Dr. Marble's January 9, 2014 EME. Even at that,

Dr. Scoggin admitted he was giving Employee the benefit of the doubt only because Employee performed physical labor. Ultimately, there is no identifiable work injury anywhere in this case's voluminous record. The evidence also shows Employee's non-work related, personal factors, are a far more likely explanation for Employee's disability and his continuing need for medical treatment than a work injury. Finally, Employee's lack of improvement, notwithstanding extensive and prolonged medical treatment, also shows his disability and continuing need for medical treatment were not caused by a traumatic or cumulative work injury. Employee has failed to carry his burden and his claim for medical and related transportation costs will be denied. *Saxton*.

5) Is Employee entitled to TTD?

The law provides for TTD to compensate an injured worker for a loss of earning capacity. AS 23.30.185. For the reasons set forth above, Employee's claim for TTD will be denied. *Id*.

6) Is Employee entitled to PPI benefits?

The law provides for PPI to compensate an injured worker for loss of a body part or function. AS 23.30.190. The reasons set forth above, Employee's claim for PPI will be denied. *Id*.

7) Is Employee entitled to reemployment eligibility evaluation?

The law provides for reemployment benefits to return an injured worker to remunerative employment. AS 23.30.041. For the reasons set forth above, Employee's claim for reemployment benefits will be denied. *Id*.

8) Is Employee entitled to interest?

The law provides for interest to compensate the party entitled to payment for the time value of money. AS 23.30.155(p). For the reasons set forth above, Employee's claim for interest will be denied. *Id*.

9) Is Employee entitled to attorney fees and costs?

The law provides are attorney fees and costs to compensate an injured worker who enlists the assistance of counsel in the successful prosecution of a claim. AS 23.30.145. For the reasons set forth above, Employee's claim for attorney fees and costs will be denied. *Id*.

CONCLUSIONS OF LAW

1) Dr. Marble's EME report is excluded from consideration.
2) Dr. Johnston's "check-the-box" concurrences is excluded from consideration.
3) A claim for benefits arising from Employee's December 7, 2010 injury was not an issue for hearing.
4) Employee is not entitled to medical and related transportation costs.
5) Employee is not entitled to TTD.
6) Employee is not entitled to PPI.
7) Employee is not entitled to reemployment benefits.
8) Employee is not entitled to interest.
9) Employee is not entitled to attorney fees and costs.

ORDER

Employee's February 19, 2014, and June 17, 2014, claims are denied.

Dated in Fairbanks, Alaska on October 27, 2017.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Robert Vollmer, Designated Chair

/s/
Jacob Howdeshell, 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 GREG WEAVER, employee / claimant; v. ASRC FEDERAL HOLDING COMPANY, employer; ARCTIC SLOPE REGIONAL CORP., insurer / defendants; Case No. 201320030M; dated and filed in the Alaska Workers' Compensation Board's office in Fairbanks, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on October 27, 2017.

/s/
Ronald C. Heselton, Office Assistant II