ALASKA WORKERS' COMPENSATION BOARD

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

CHARLAYNE W. O'BRIEN, Employee, Claimant,	)	FINAL DECISION AND ORDER
v.	)	AWCB Case Nos. 200308494 and 200701733
CENTRAL PENINSULA GENERAL HOSPITAL, Employer,	)	AWCB Decision No. 17-0131 Filed with AWCB Anchorage, Alaska on November 21, 2017
and	)	
WAUSAU UNDERWRITERS INSURANCE COMPANY, and ALASKA NATIONAL INSURANCE COMPANY Insurers, Defendants.	)	

Charlayne W. O'Brien's October 22, 2008 and August 9, 2013 claims were heard on August 23, 2017, August 24, 2017, and October 25, 2017 in Anchorage, Alaska. These hearing dates were selected on August 8, 2017, August 18, 2017 and August 30, 2017. Ms. O'Brien (Employee) appeared, represented herself, and testified. Attorney Nora Barlow appeared and represented Central Peninsula General Hospital (Employer) and Wausau Underwriters Insurance Company (Wausau). Attorney Rick Wagg appeared and represented Employer and Alaska National Insurance Company (Alaska National). Witnesses included Calvin O'Brien, Liz Dowler, Rebecca Byerley, Margaurite McIntosh, M.D., David Weiss, M.D., Steven Fuller, M.D., and Keyhill Sheorn, M.D. The record closed at the hearing's conclusion on October 25, 2017.

ISSUES

Employee contends her May 28, 2003 work injury is a substantial factor in her subsequent disability and need for medical treatment. Alaska National contends Employee's 2003 injury was only a minor low back strain that did not result in any disability and required only minimal medical care.

1. Is Employee's May 28, 2003 work injury a substantial factor in her subsequent disability or need for medical care?

Employee contends her January 30, 2007 work injury remains the substantial cause of her disability and need for medical treatment after January 28, 2008. Wausau concedes Employee was injured on January 30, 2007, and it paid benefits through January 28, 2008 when Employee was found medically stable and released to work. Wausau contends no further benefits are due.

2. Is Employee's January 30, 2007 work injury the substantial cause of her subsequent disability or need for medical care?

Employee contends that due to either the 2003 injury or the 2007 injury, she is entitled to permanent total disability (PTD) or temporary total disability (TTD), additional permanent partial impairment (PPI) benefits, medical and transportation costs, penalty, interest, and attorney fees and costs. Both Alaska National and Wausau contend Employee is not entitled to any additional benefits.

3. If either the 2003 or 2007 work injuries is the cause of Employee's disability or need for medical treatment, to what benefits is Employee entitled?

FINDINGS OF FACT

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

1. Employee has been a physical therapist since 1985. She moved to Alaska and began working for Employer in 1994. (Employee).
2. In February 1999, Employee was swimming and felt a "kinked" sensation in her neck. The problem progressively worsened, and by March 1999 she was unable to hold her head up. She was seen by several doctors, and an electrodiagnostic study showed "fairly marked" C7 radiculopathy. On November 30, 1999, she was seen by Larry Levine, M.D. At that time she was complaining of pain in the head, neck, left ear, left scapula, low back, shoulder, bilateral hands, left hip and buttock as well as the left leg. Dr. Levine performed additional

electrodiagnostic studies, and found the C7 radiculopathy was resolving. He noted she had a different presentation than a review of her medical records indicated. Dr. Levine recommended a bone scan and an MRI of the brain. At the time of her appointment with Dr. Levine, Employee completed a pain diagram showing burning pain on the left side of her head and neck, the top and front of her left shoulder, down the outside of her left leg and in both big toes. She also indicated aching in her left arm, both hands, and both shoulder blades. (Dr. Levine, Chart Notes, November 30, 1999).

3. On March 3, 2000, Employee was seen by Charles Nussbaum, M.D., at the Virginia Mason Medical Center in Seattle, Washington. Employee complained her "whole body" hurt and she was "not sure where the pain is." Dr. Nussbaum reviewed three MRIs done after the February 1999 injury and noted a mild bulging disc at C5-6 with no evidence of cord or nerve root compression. He thought it unlikely that the mild spondylotic changes shown on the MRIs could be the cause of her widespread pain complaints. He did not consider her to be a candidate for surgery, but recommended a rheumatologic consultation. (Dr. Nussbaum, Chart Note, March 3, 2000).
4. On March 3, 2000, Employee was also seen by David Stage, M.D., a rheumatologist at the Virginia Mason Medical Center. Dr. Stage noted Employee's symptoms could be compatible with fibromyalgia, but were more severe than typically encountered and the normal fibromyalgia tender points were absent. Dr. Stage recommended a multidisciplinary pain clinic involving a physiatrist, pain psychologist, and physical and occupational therapists. (Dr. Stage, Chart Note, March 3, 2000).
5. On March 23, 2000, Dr. Pitkethly at Harborview Medical Center in Seattle examined Employee and reviewed x-rays and three MRIs. (Dr. Pitkethly, Chart Note, April 13, 2000). He concluded surgery was not warranted and would not prove an obvious benefit. (Eisenman, Chart Note, April 13, 2000).
6. On April 17, 2000, Employee was seen by Darrell Brett, M.D., at Adventist Medical Center in Portland, Oregon. Dr. Brett noted a functional overlay to Employee's presentation, but because conservative measures had failed, he recommended a discectomy and fusion at the C5-6 and C6-7 levels. (Dr. Brett, Chart Notes, April 17, 2000).
7. On April 24, 2000, Dr. Brett performed the discectomy and fusion. (Dr. Brett, Operative Report, April 24, 2000).

8. In total, Employee was examined or treated by eleven medical providers for her neck before Dr. Brett. None of those providers considered Employee to be a candidate for surgery. (Medical Records.).
9. On June 10, 2003, Employee reported she injured her back lifting a patient from a wheel chair to a mat on May 28, 2003. (Report of Injury, June 10, 2003). That same day, she was seen by Steven Debella, M.D, Dr. Debella diagnosed bilateral SI (sacroiliac) joint pain and advised Employee there was no hint of a dangerous problem and a rapid recovery was expected. He prescribed a muscle relaxer and an anti-inflammatory, but did not restrict her from work. (Dr. Debella, Chart Note, June 10, 2003).
10. Employee testified she had no leg pain as a result of the 2003 incident, but her low back pain never fully resolved. (Employee). In her deposition she testified she had seen Dr. Debella twice, but had no other treatment. (Employee Deposition, February 20, 2009). She later recalled another physical therapist had given her some massage therapy at the time. (Employee).
11. On January 30, 2007 that while doing a "draw sheet lift" to reposition a patient she felt a pain on the left side of her neck. A "draw sheet lift" is used to reposition a patient who has slid down in the bed. A sheet is placed under the patient, and individuals on each side lift the sheet and slide the patient upwards. In this particular case, the patient's condition required his head and upper body be elevated, resulting in an "uphill" slide. Employee assisted nurses in performing three lifts that day, twice on the patient's left, and once on his right. (Employee).
12. The lift occurred with the last patient of the day, and Employee was not scheduled to work for several days. When the pain did not resolve on its own, she went to the emergency room on February 6, 2007. She reported pain and stiffness on the left side of her neck that radiated into the thoracic region. The doctor suspected a cervical strain, prescribed pain medication and a muscle relaxer, and restricted her from work for four days. (Emergency Department Note, February 6, 2007).
13. On February 8, 2007, Employee reported the injury to Employer. (Report of Injury, February 8, 2007). Employer accepted the injury and began paying benefits. (Compensation Report, February 21, 2007).

14. On February 14, 2007, Employee was seen by Marguerite McIntosh, M.D. Employee's chief complaint was neck and back pain. She reported her neck pain was getting "worse and worse" since her visit to the emergency room. Dr. McIntosh noted Employee also had tension pain between her shoulder blades and her arms felt sore. Dr. McIntosh continued the pain medication and muscle relaxer and referred Employee for physical therapy. (Dr. McIntosh, Chart Note, February 14, 2007).
15. In a report dated February 14, 2007, Dr. McIntosh also noted the pain in Employee's left scapula extended to her low back. (Physician's Report, February 14, 2007).
16. Employee began a six-week course of physical therapy on February 15, 2007. She reported pain in her cervical spine, upper back, both arms, and occasionally in her low back, the left side of her rib cage, and her left calf. (Physical Therapy Initial Evaluation, February 15, 2007).
17. On February 28, 2007, Employee was seen by Paul Sanders, M.D. She reported neck pain continued and she had aching in her shoulders and both arms. Employee rested her head against the wall during the exam. (Dr. Sanders, Chart Note, February 28, 2007).
18. On March 20, 2007, Employee was seen by Dr. Brett. Dr. Brett noted there were no objective neurological deficits, but an MRI showed a new, moderate disc herniation at C4-5, although there was no cord compression and only moderate narrowing of the foramen. He stated she was unlikely to respond to further conservative care, and recommended fusion. Dr. Brett, Chart Note, March 20, 2007).
19. On April 2, 2007, Dr. Brett performed the fusion surgery at C4-5, and at the same time removed hardware that had been placed during the 2000 fusion. (Dr. Brett, Operative Report, April 2, 2007).
20. On May 8, 2007, Employee filled out a physical medicine questionnaire that included a pain diagram. Employee indicated she had tightness in both jaws, pain on the top and front of her shoulders, and pain in her neck and upper back, extending to her buttock on the left. (Physical Medicine Questionnaire, May 8, 2007).
21. Also on May 8, 2007, Employee began a 12-week course of physical therapy. (Physical Therapy Initial Evaluation, May 8, 2007).
22. On May 11, 2007, Employee was seen by Thomas Dietrich, M.D., for an employer's medical evaluation (EME). Employee stated she was "much improved" from before the

operation, but still had some discomfort and stiffness in her neck. She was still taking pain medication. Dr. Dietrich opined the disc protrusion at C4-5 was caused by the January 30, 2007 work injury and the surgery was reasonable and necessary. He anticipated Employee would be able to return to work in about 30 days. (Dr. Dietrich, EME Report, May 11, 2007).

23. Employee continued physical therapy. On July 24, 2007, the physical therapist recommended six to eight weeks additional therapy. (Physical Therapy Progress Note, July 24, 2007).
24. On August 12, 2007, Employee completed a "Rolfing" questionnaire, and indicated she had chronic discomfort in her neck, hips, right ankle, and back. She completed another pain diagram indicating pain in those areas. (Rolfing Questionnaire, August 12, 2007).
25. On August 24, 2007 Employee reported that after lying on her side on pillows for about 2 hours on August 5, 2007, she had increased cervical pain. (Physical Therapy Progress Note, August 24, 2007).
26. On August 31, 2007, Employee returned to Dr. McIntosh. Dr. McIntosh was unable to say when Employee would be able to return to work, but it was clear she could not return to light duty. Dr. McIntosh referred Employee to a physiatrist. (Dr. McIntosh, Chart Note, August 31, 2007).
27. On September 24, 2007, Employee reported to her physical therapist that she had an exacerbation of her low back and SI joint pain on September 11, 2007. She also reported she had been using a walker. (Physical Therapy Progress Note, September 24, 2007).
28. On September 27, 2007, Employee reported to Dr. McIntosh that she had developed a clicking in her left hip, which got so bad she had to use a walker. She also reported her SI joint was "partially dislocated." (Dr. McIntosh, Chart Note, September 27, 2007).
29. On November 15, 2007, Employee was seen by physiatrist Larry Levine, M.D. Employee reported gradual improvement since the fusion; she was able to sit upright up to 11 hours per day, with two one-hour rests. In connection with the visit, Employee completed a pain diagram showing aching on the sides and back of her neck, continuing down her back to the buttocks. She reported an aggravation of her symptoms in mid-September that included low-back and SI joint pain. Dr. Levine noted her recovery was slower than one would expect, but her previous fusions could compound the situation. He did not believe she could

return to work, but recommended she continue with therapy. Employee also took a BBHI 2 (Brief Battery for Health Improvement 2) test. Her profile indicated she was reporting a level of physical illness symptoms comparable to a typical non-patient, and patients with her profile tended to perceive themselves as having a limited capacity for working and difficulties with activities of everyday life. (Dr. Levine, Chart Note, November 15, 2007).

30. On November 27, 2007, Dr. Levine wrote to Employee to review the BBHI 2 results. He explained that the test showed "a significant abnormality in relation to what we described as functional complaints." He suggested Employee review the report with Dr. McIntosh and that a consultation with a pain psychologist would be of benefit. (Dr. Levine, Letter, November 27, 2007.) On December 7, 2007, Dr. Levine wrote a chart note regarding Employee's BBHI-2 results. He stated there was a significant barrier to improving her functional status and return to work. He advised that she see a pain psychologist or a psychiatrist. (Dr. Levine, Chart Note, December 7, 2007).
31. Functional complaints are general pains and symptoms that do not appear to arise from organic or pathological cause. (Observation).
32. On January 18, 2008, Employee was seen by Dr. Dietrich for another EME. Dr. Dietrich did not have any medical records since his May 2007 evaluation, but did examine Employee. Again, he opined the work injury was the substantial cause of the need for the C4-5 fusion, but he stated Employee had reached medical stability and no further treatment was necessary. He rated her with a three percent PPI. (Dr. Dietrich, EME Report, January 18, 2008).
33. On February 22, 2008, Employer controverted further TTD and medical benefits based on Dr. Dietrich's January 18, 2008 report. (Controversion Notice, February 22, 2008).
34. On April 14, 2008, Employee had an MRI of her lumbar spine that revealed Schmorl's nodes at multiple levels and disc disease at L1-2 and L5-S1. (Central Peninsula Hospital, Diagnostic Imaging Report, April 14, 2008).
35. Employee completed another physical medicine questionnaire on April 22, 2008, which included a pain diagram. The diagram showed pain in abdomen, low back, buttocks, and both legs. (Physical Medicine Questionnaire, April 22, 2008).
36. Employee returned to Dr. Levine on April 29, 2008. She reported that she had not felt any lumbar spine pain at the time of the January 2007 injury, but within two weeks she began to

have left-sided back pain and left leg symptoms. At the time of the exam, she reported pain down both legs. Dr. Levine noted Employee had approximately one year of physical therapy without significant relief. Employee explained she originally thought it was SI joint pain due to leg length discrepancies; however, in his exam Dr. Levine did not see any abnormalities. After reviewing the April 14, 2008 MRI, Dr. Levine diagnosed disc degeneration at L1-2 and L3-4, and mild disc protrusion at L4-5 and L5-S1, as well as "significant altered functional status." Employee asked about surgery, but Dr. Levine recommended epidural steroid injections before considering surgery. (Dr. Levine, Chart Note, April 29, 2008).

37. On May 1, 2008, Employee returned to Dr. McIntosh. Employee reported that Dr. Levine had recommended "more medications or a steroid shot," and she would rather see a surgeon for a surgical opinion. Dr. McIntosh referred Employee to Kim Wright, M.D. (Dr. McIntosh, Chart Note, May 1, 2008).
38. On May 28, 2008, Employee wrote a letter to the adjuster regarding her back, SI, and leg pain. Employee stated she had developed pain down her left side, including her leg and foot within three days of the January 30, 2007 injury, but she had attributed it to "walking funny" because of the neck injury. She stated she developed symptoms in her buttocks in August 2007 and had an exacerbation in September 2007 that required the use of a walker. (Employee, Letter, May 28, 2007). The medical records do not indicate Employee reported symptoms in her buttocks in August 2007, and although Employee used a walker in September 2007, there is nothing indicating a doctor suggested or required her to do so. (Observation).
39. On May 13, 2008, Employee was seen by Dr. Wright, a neurosurgeon. Dr. Wright reviewed the April 28, 2008 MRI with Employee and told her he did not see anything that "looks to be fixable" from a surgical standpoint. Dr. Wright recommended a CT scan as well as tests to screen for arthritis. (Dr. Wright, Chart Note, May 13, 2008).
40. On May 21, 2008, Employee had a CT scan of her lumbar spine. The scan revealed arthritis of the facet joints, degenerative joint disease at several levels, and the previously identified Schmorl's nodes. It did reveal mildly bulging discs at the L1-2, L4-5, and L5-S1 levels, but no nerve root entrapment. (Radiology Report, May 21, 2008).

41. On June 9, 2008, Employee returned to Dr. Brett. Dr. Brett examined Employee and reviewed the recent MRI and CT scan. Dr. Brett stated there was "little I have to offer her from the neurosurgical viewpoint in view of the lack of nerve impingement or objective neurological deficit." (Dr. Brett, Chart Note, June 9, 2008).
42. On June 12, 2008, Employee had a CT myelogram. It showed minimal, very mild bulging of the discs at L1-2, L2-3, and L3-4, with no central or foraminal stenosis and no disc herniations in the lumbar spine. Employee's SI joints appeared normal on both sides. (Radiology Report, Jun 12, 2008).
43. Also on June 12, 2008, Employee was seen by Dr. Wright, who reviewed the CT myelogram. He stated :

> The patient seems to be severely disabled with back and leg pain but I must say all of her studies to date have yet to explain why she is suffering so much pain. Once again, I reiterated my request that she undergo a set of laboratory studies include a bone scan. (Dr. Wright, Chart Note, June 12, 2008).

44. On June 18, 2008, a bone scan was done. The scan showed no trauma to the lumbar spine or pelvis and minimal degenerative disease at L2. (Bone Scan, June 18, 2008).
45. On June 23, 2008, Employee returned to Dr. McIntosh. Employee told Dr. McIntosh she believed she had sacroiliac dysfunction. She had done research on SI dysfunction and brought information with her to the appointment. Employee asked Dr. McIntosh to refer her to a clinic in Georgia, and Dr. McIntosh did so. (Dr. McIntosh, Chart Note, June 23, 2008).
46. On July 19, 2008, Dr. Dietrich reviewed additional records, including Dr. Brett's report, the June 12, 2003 CT myelogram and the June 16, 2008 bone scan, and responded to questions from Employer's adjuster. Dr. Dietrich stated Employee's low back condition was not related to the January 2007 work injury. He explained it was highly unlikely that two areas of the spine would be simultaneously injured, and analogized it to two links in a chain breaking simultaneously. (Dr. Dietrich, EME Supplement, July 19, 2008).
47. On August 5, 2008, Employee was seen by Todd Stewart, M.D., at a pain management clinic in Georgia. Dr. Stewart noted Employee had "rather odd symptoms, severe back pain that does respond to ice. In fact, she lives on ice. That is the only modality that is effective" and she describes a "distribution of pain in the thighs and distal lower extremities that is stocking glove in nature and described as burning." Dr. Stewart reviewed x-rays,

myelograms, a CT scan, and MRIs but did not find an obvious source for the pain. (Dr. Stewart, Chart Note, August 5, 2008).

48. On August 7, 2008, Dr. Stewart performed a caudal epidural steroid injection, and on August 22 and September 2, 2008, he performed bilateral SI joint injections which provided 75 percent relief. Dr. Stewart stated he "did not have a good feel for all of her pain generators," but felt an SI joint fusion may give her some relief. (Dr. Stewart, Chart Note, September 2, 2008).
49. On September 3 2008, Employee was seen by David Weiss, M.D. Dr. Weiss's physical examination showed tenderness near the SI joints, and stressing the SI joints caused discomfort. Dr. Weiss noted the injections by Dr. Stewart had provided relief, but only for a few days. Because Employee had not responded to conservative treatment, Dr. Weiss recommended bilateral SI joint fixation. (Dr. Weiss, Chart Note, September 3, 2008.
50. On September 9, 2008, Dr. Weiss performed bilateral SI joint fixation and fusion surgery on Employee. (Northeast Georgia Medical Center, Operative Report, September 9, 2008).
51. On September 17, 2008, Employee returned to Dr. Weiss for a follow-up visit. She reported her pelvis felt better than it did before the operation. Dr. Weiss predicted Employee would reach maximum medical improvement in three months, and authorized her return to Alaska the next week. (Dr. Weiss, Chart Note, September 17, 2008).
52. On January 5, 2009, Employee returned to Dr. McIntosh. She reported she continued to take the muscle relaxer and pain medication and was icing her sacroiliac area two to three times per day. Her leg pain was mostly gone, but she still had occasional pains on the inside of her thigh, the outside of her thigh, her shin, and her calf. (Dr. McIntosh, Chart Note, January 5, 2009).
53. On March 18, 2009, Employee wrote to Dr. Weiss asking that he answer some questions in connection with her workers' compensation case. In response to the question of whether bending forward, lifting, and rotating during the draw sheet lift could cause SI dysfunction, Dr. Weiss responded, "Yes." In response to a question asking whether SI dysfunction could first present as minor symptoms and progress over time, Dr. Weiss answered, "Yes." And in in response to a question asking if the January 30, 2007 injury was the substantial cause of her need for the SI fusion and her disability, Dr. Weiss responded, "Yes." (Employee, Letter, March 18, 2009).

54. Between April 7, 2009 and June 29, 2009, Employee attended eleven physical therapy sessions. Each time she completed a pain diagram. In each case, they show pain in her lower back, buttocks, and the back and front of her thighs. (Physical Therapy Notes, April 7 through June 29, 2009).
55. On July 11, 2009, Employee attended a second independent medical evaluation (SIME) with a board-ordered orthopedic surgeon, John Lipon, D.O. Dr. Lipon reviewed 835 pages of Employee's medical records and examined Employee. In connection with the evaluation, Employee completed a pain diagram that showed tenderness, spasms and aching on the front of her thighs, and spasms, aching and tenderness on her low back, extending into her buttock and posterior thighs. She added a comment stating she had "burning LB [low back], SI, ant [anterior] thigh fairly consistent in day -- occasionally post [posterior] thigh and lower legs." He diagnosed pre-existing degenerative changes in her lumbar and thoracic spine, which were not caused or aggravated by the January 2007 work injury. He did state Employee's C4-5 disc extrusion was caused by the January 2007 work injury. He also diagnosed a cervicothoracic strain caused by the work injury, but found the strain had resolved. Dr. Lipon opined Employee's SI joint dysfunction was not caused by the January 2007 work injury. He identified possible causes of SI joint function, including arthritis, leg length discrepancy, and lifting, bending, and torsional strain. He ruled out lifting, bending and torsional strain because the first mention of an SI condition was September 27, 2007, and, had she injured the area in the January 30th injury, she would have symptoms by the time she went to the emergency room on February 6th. He pointed to Employee's leg length discrepancy and the degenerative disease in her lumbar spine as possible causes. Dr. Lipon also noted that treating doctors had expressed concerns about a possible functional overlay and self-imposed disability. He indicated Employee was capable of returning to her job. (Dr. Lipon, SIME Report, July 11, 2009).
56. On August 26, 2009, Employee reviewed Dr. Lipon's report with Dr. McIntosh. Dr. McIntosh disagreed with Dr. Lipon's opinion that the SI joint dysfunction was not caused by the work injury. Dr. McIntosh explained the condition was not present beforehand and was probably masked by the cervical symptoms. (Dr. McIntosh, Chart Note, August 26, 2009).

57. On April 5, 2010, Employee told Dr. McIntosh that she planned to return to her job on a volunteer basis for short periods of time as a form of work hardening. (Dr. McIntosh, Chart Note, April 5 2010).
58. Dr. Weiss was deposed on April 15, 2010. He explained a diagnosis of SI dysfunction was based on symptoms; it would not show up on imaging. Generally, people with SI dysfunction present with pain in the posterior buttocks that can extend down the thigh or into the groin and hip. They exhibit a problem with sitting and prolonged walking, and typically have tenderness around the posterior SI ligaments. He stated Employee's complaints have at times been hard to explain physiologically, for example pain below the knees and into the feet when there is no radiculopathy or neuropathy. He stated Employee also had transient complaints that were not always consistent. (Dr. Weiss, Deposition Testimony, April 15, 2010).
59. On June 18, 2010, Employee went to the emergency room requesting an MRI to see if anything had changed. She explained that while volunteering, she was bending over making beds and just being up in general exacerbated her low back pain. An MRI was scheduled for June 22, and Employee was discharged. (Central Peninsula Hospital, Emergency Department Note, June 18, 2010).
60. A lumbar MRI was done on June 22, 2010 that showed minimal stenosis at L1-2 and L4-5 due to degenerative disc disease. Facet hypertrophy at all levels, but no central or foraminal narrowing, pinning for fusion of the SI joints, and an old endplate fracture of L2 that was of doubtful clinical significance. (Diagnostic Imaging Report, June 22, 20101).
61. On June 25, 2010, Employee returned to Dr. McIntosh. Dr. McIntosh noted the MRI did not reveal the cause of Employee's pain, but Employee felt the MRI was inaccurate because of differences from earlier MRIs. Employee had done research online and requested a dynamic MRI, but Dr. McIntosh noted that would require travel, and Employee could not even sit up. (Dr. McIntosh, Chart Note, June 25, 2010).
62. On July 1, 2010, Employee had another MRI of her lumbar spine, which showed moderate degenerative disease at L1-2, pinning of the SI joints, and no abnormal movement of the vertebrae. (Diagnostic Imaging Report, July 1, 2010).
63. On July 21, 2010, Employee returned to the emergency room complaining of increased pain about two hours before she was scheduled for an epidural steroid injection. The doctor

noted that neither the June 22 nor the July 1 MRIs showed any marked neurological abnormalities, and Employee reported there had been no trauma in the interim. She was discharged for the epidural steroid injection at L4-5, which she received later that day. (Central Peninsula Hospital, Emergency Department Note, July 21, 2010; Central Peninsula Hospital, Procedure Note, July 21, 2010).

64. Still later on July 21, 2010, Employee returned to the emergency room. She had returned home after the epidural steroid injection, and was getting ready to have dinner. She explained what happened:

> A friend placed his hand very lightly on her left shoulder as they were saying grace. She felt like the pressure from his hand caused an asymmetric loading on her lower back. She began to develop pain and a short time thereafter was in such excruciating pain that was unable to ambulate. She laid down on the floor where she had all the individuals involved in the dinner party holding her extremities legs and arms. She as directing them to position them in certain ways that was most comfortable for her at 1 point in time they were all singing to her in an effort to comfort her as well.

The doctor stated there were several factors at play in Employee's presentation. Undoubtedly here was some mechanical back pain that was triggering Employee's symptoms, but he had reviewed the MRIs and had done two neurological exams, which were relatively normal. Her husband stated he felt there was a significant emotional component, and the doctor noted there may be an intellectual component as well given Employee's history of physical therapy and knowledge of neurological problems. The doctor admitted her to the hospital for pain control and physical therapy. (Central Peninsula Hospital, Emergency Department Note, July 21, 2010).

65. On July 22, 2010, while in the hospital, Employee was seen by Allison Smith, M.D. Employee provided her medical history and the onset of her pain the preceding day. Employee also expressed a significant concern over her lack of regular care in the home. She stated her husband was frequently gone, and on one occasion her back spasms started because her husband went fishing with "the boys." Employee felt she needed more assistance in the home to assure she was eating and drinking regularly and taking her medications properly. Dr. Smith suspected an element of secondary gain in her presentation. Dr. Smith stated she could be discharged later that day if she was able to

ambulate with nursing staff. (Central Peninsula Hospital, History and Physical, July 22, 2010).

66. On July 22, 2010, Dr. Smith telephoned Cynthia Kahn, M.D, who had been providing pain management services to Employee. Dr. Smith explained Employee had been admitted to the hospital with back pain, and while Dr. Smith was concerned Employee was complaining for secondary gain, she asked if Dr. Kahn had any suggestions. Dr. Kahn recommended increasing the dosage of Employee's fentanyl patch, and noted Employee may need psychiatric help. (Dr. Kahn, Telephone Encounter Note, July 22, 2010).
67. Dr. Kahn also examined Employee on July 22, 2010 and diagnosed lumbar degenerative disc disease. Dr. Kahn prescribed a muscle relaxer, increased the dosage of the fentanyl patch, and prescribed a TENS unit. (Dr. Kahn, Chart Note, July 22, 2010). .
68. On July 23, 2010 Employee was seen by Ryan Kern, M.D., while in the hospital. Dr. Kern noted Employee had not been discharged because of severe pain while ambulating. Dr. Kern described his encounter with Employee:

> Today while examining her myself, the patient complained of severe 10/10 excruciating back pain. She was yelling, screaming and clutching the bed rail trying to place traction on her lower back while we were holding her feet.

Dr. Kern noted that while Employee had spasmodic back pain, there seemed to be a component of secondary gain as noted by other providers, and it was unclear how much of her pain was related to the underlying mood disorder and how much was related to intolerance to back pain. He stated the degree of her symptoms was well out of proportion to what is normally seen. (Central Peninsula Hospital, Progress Note, July 23, 2010).

69. On July 26, 2010 Employee had lumbar and thoracic MRIs. (Diagnostic Imaging Reports, July 26, 2010).
70. On July 28, 2010, Employee was seen by Dr. Kahn who noted the recent MRIs and radiologic studies showed no abnormalities that would account for her leg weakness. Dr. Kahn recommended an EMG study to rule out neuropathy or radiculopathy and sacroiliac joint injections to rule out a failed fusion. (Dr. Kahn, Chart Note, July 28, 2010).
71. On July 28, 2010, Dr. McIntosh noted that she wanted to send Employee home that day, but Employee stated he has to have somebody with her 24/7 to wait on her, get her meals, help her shower, et cetera. (Dr. McIntosh, Chart Note, July 28, 2010).

72. Employee was discharged from the hospital on August 2, 2010. (Central Peninsula Hospital, Chart Note, August 2, 2010).
73. On August 5, 2010 Employee returned to Dr. Kahn. Dr. Kahn diagnosed sacroiliitis, and recommended Employee obtain an EMG and consult with the facility that had done the SI joint fusion. (Dr. Kahn, Chart Note, August 5, 2010).
74. Employee began keeping a handwritten journal shortly after her 2007 injury in which she documented her symptoms, medication, activities, and interactions with health care providers. In many cases the handwriting is difficult to decipher. Entries run from one-half to one page per day. In the, beginning Employee details activities from the time slept at night to the time she awakened, the time to shower and do her hair, the time, location, and degree of pain, usually to the nearest 15 minutes, but occasionally to the minute. Over time, the entries focus more on symptoms and become more disorganized. By 2010, the entries are a listing of symptoms and times medication was taken. As an example, the entry for February 19, Employee noted pain in her right buttock, L4, L5, and S1 "packing standing pain" that was 7 out of 10, and kneeling pain that "could be L3-4ish." She documented taking 18 doses of medication at nine different times that day. In many cases, Employee revised the entries by crossing out portions and adding comments in the margins. (Employee Journal).
75. On August 19, 2010, Employee was seen by Dr. McIntosh who reported:

> I also spent some time with Charlayne and her husband discussing the psychological effects of chronic pain and debility, which Charlayne is now experiencing. Some of her coping mechanisms have included almost intense investigations of possible treatments through Internet, etc., and detailing all of her signs and symptoms in written form. Charlayne is no longer able to be up to that task and I gave her permission to stop doing it, but to just keep seeing her physicians. I reassured Charlayne that I do not think she is malingering or attempting to get secondary gain as had been suggested on the basis of one hospital visit by Dr. Smith; Charlayne saw that entry and was very upset by it. (Dr. McIntosh, Chart Note, August 19, 2010).

76. On August 26 2010, Kristen Jessen, M.D., performed an EMG of Employee's right leg. The test suggested there may be S1 level pathology. It was unclear, however, what was causing Employee's pain. Dr. Jessen also diagnosed a vitamin B12 deficiency. (Dr. Jessen, Chart Note, August 26 2010).

77. On September 1, 2010, Employee had CT scans of her pelvis that showed severe osteoarthritic changes in both SI joints, but no bony fusion. She also had MRIs of her cervical spine and brain. The cervical MRI showed the discectomy and fusion from C4 to C7, but no central or foraminal stenosis and no neural impingement. The brain MRI showed nothing abnormal. (Central Peninsula Hospital, Diagnostic Imaging Reports, September 1, 2010).
78. On September 3, 2010, Employee was readmitted to the hospital with a diagnosis of health care associated pneumonia and back pain. She was seen by Dr. Kern who noted, "The patient has some fixed beliefs about the nature of her back pain and the possibility that this may cause some cord compression and paralysis. I have tried to explain to the patient that this is likely not the case and will continue to work on this." (Central Peninsula Hospital, Progress Note, September 3, 2010).
79. On September 3, 2010 Dr. Kahn performed a diagnostic SI joint injection. (Central Peninsula Hospital, Procedure Noted, September 3, 2010).
80. Later on September 3, 2010, Employee reported to Dr. Kahn that she had initially felt good after the injections, when she got out of bed to use the bathroom, her pain went from a zero to a six. She had pain down both legs to the heels. (Dr. Kahn, Telephone Encounter, September 7, 2010).
81. On September 8, 2010, Dr. Weiss reviewed Employee's CT scan and felt she had good bridges of bone in the SI joint. He did not believe the SI joint were the cause of Employee's pain, and recommended a full spine CT myelogram to rule out a neurological problem.. (Dr. Weiss, Chart Note, September 8, 2010).
82. On September 10, 2010 Employee returned to Dr. Wright. She arrived for the appointment in a wheelchair. Employee updated Dr. Wright on her medical history since she had last seen him in June 2008. He reviewed the recent CT and MRIs, and noted Employee "certainly has no radiographic explanation for her disabling pain and recurrent neurological conditions." Dr. Wright explained he did not see surgical intervention as favorable and strongly encouraged her to stay away from future surgeries. He suspected some sort of rheumatological condition and recommended Employee seek a definitive opinion at the Mayo Clinic. (Dr. Wright, Chart Note, September 10, 2010).

83. On September 16, 2010, Employee had a CT myelogram of her lumbar spine. The SI joint screw were in place, but no fusion was seen. Some degenerative changes were seen at the L5-S1 level. (John McCormick, M.D., Procedure Report, September 22, 2010).
84. On September 22, 2010, Employee had a CT myelogram of her cervical spine. The hardware was in place, and the fusions were solid. No central or foraminal stenosis was noted. (Dr. McCormick, Procedure Report, September 22, 2010).
85. On October 8, 2010, Dr. Levine performed right L5-S1 and right L4-5 discograms. Dr. Levine reported it did not appear that Employee pain was discogenic at either the L4-5 or the L5-S1 levels. The maximum pressure used at both levels was 75 psi, and Employee reported only slight discomfort at both levels. (Dr. Levine, Letter, October 8, 2010).
86. On October 25, 2010, employee was seen by Lawrence Stinson, M.D., a pain management specialist. Employee disagreed with Dr. Levine's characterization that she had felt only slight discomfort; she stated she had pain during the procedure. Dr. Stinson reviewed the discogram films and determined Employee had a complete annular tear at the L4-5 level. Dr. Stinson diagnosed degenerative disc disease with an annular tear. He proposed repeating the discography. (Dr. Stinson, Chart Note, October 25, 2010).
87. On October 27, 2010, Dr. Stinson performed an epidural steroid injection at L5-S1. Dr. Stinson, Chart Note, October 27, 2010).
88. On November 8, 2010, Employee had another lumbar MRI. The MRI showed moderately severe degenerative changes at L1-2 and a mild diffuse disc bulge at L4-5. (MRI Report, November 11, 2010).
89. On December 7, 2010, Steven Fuller, M.D., reviewed Employee's medical records for Employer. Dr. Fuller disagreed with Drs. Dietrich and Lipon, stating the January 30, 2007 lifting incident was not the substantial cause of Employee's herniated C4-5 disc. Dr. Fuller explained that when lifting with the arms, there is no increased load on the neck. He also concluded that neither Employee's low back nor SI complaints were due to the work injury. He pointed out that although Employee had reported some vague back complaints after the injury, it was not until September 2007 that she "basically switched body parts" and began complaining about her lumbar spine. And when the lumbar imaging and testing were normal, she switched to her SI joints. After her SI fusions, she switched back to complaints about her lumbar spine. Dr. Fuller noted that many tests had been performed more than

once, and all organic diagnoses had been exhausted. As a result he concluded her complaints were consistent with a somatoform pain disorder or something similar. Dr. Fuller noted that Drs. Levine and Smith had both suggested several of Employee's presentations are in the psychological realm. (Dr. Fuller, EME Report, December 7, 2010).

90. On January 5, 2011, Dr. Stinson repeated the discography testing. Employee reported no provocation with pressurization of L3-4 to 61 psi. When L4-5 was pressurized to 75 psi, it reproduced her pain exactly. And when L5-S1 was pressurized to 111 psi, she again reported her pain was reproduced exactly. (Dr. Stinson, Procedure Note, January 5, 2011).
91. On February 2, 2011, Dr. Fuller reviewed additional medical records. He noted the additional records filled in some gaps in the records he had previously reviewed. He did not change his opinions based on the additional records, noting they showed additional inconsistencies which had no support due to the lack of organic pathology. (Dr. Fuller, EME Supplement, February 2, 2011).
92. On February 7, 2011, Employee was seen by Rick Delamarter, M.D., at Cedars-Sinai Medical Center in Los Angeles. Given Employee's prior SI fusions, Dr. Delamarter stated he "certainly would not recommend artificial disc replacement," and while he was not sure any surgery on the lumbar spine was warranted, he did not rule out fusion at L45 and L5-S1. (Dr. Delamarter, Chart Note, February 7, 2011). Dr. Delamarter is recognized as one of the leading surgeons for disc replacement surgery. (Observation, Experience).
93. Employee's deposition was taken on February 20, 2011. Employee was asked about the 2003 injury. She explained the injury was limited to her back, the pain lasted approximately one month, and she had aches and pains, but no significant back pain since that time. She explained she would experience discomfort when leaning over a bed for a long period of time holding a patient, had not had any backaches. Other than her treatment with Dr. Debella, she had not seen a medical provider since, nor had she taken any medication. She explained that at the time of the 2007 injury she felt her back muscles straining, and an hour later the pain in her neck began. Within three days her back started bothering her, and the pain went from the left side of her trunk to her hip and into her leg. (Employee, Deposition Testimony, February 20, 2011).
94. On February 24, 2011, Employee returned to Dr. Stinson. She reported she "did not hit it off very well" with Dr. Delamarter's physician's assistant. She told Dr. Stinson that Dr.

Delamarter had given her the option of either a two-level disc replacement or a two level fusion. She asked for, and Dr. Stinson gave her, a referral to Dr. Peterson. (Dr. Stinson, Chart Note, February 24 2011).

95. On March 3, 2011, Employee was seen by Davis Peterson, M.D. Dr. Peterson noted the fact that Dr. Stinson had used pressures above 60 psi in the January 5, 2011 discogram could have resulted in false positives. Because the discogram had used pressures in excess of 50 psi, Dr. Peterson suggested another discogram and an updated EMG study. Depending on the results, he thought Employee might be a candidate for disc arthroplasty at L4-5 and fusion at L5-S1. He also indicated a neuropsychiatric screening should be done. (Dr. Peterson, Chart Note, March 3, 2011).
96. On March 31, 2011, Employee was seen by Shawn Hadley, M.D., for EMG/electrodiagnostic testing. At the time of the exam, Employee had severe swelling in her legs. The study showed no clear lumbrosacral radiculopathy on the left or right, and no clear polyneuropathy. There were unexplained abnormalities in the muscles on the tops of Employee's feet, but Dr. Hadley explained the abnormalities could be due to local muscle trauma or the swelling. (Dr. Hadley, Chart Note, March 31, 2011).
97. On April 7, 2011, Dr. Fuller reviewed additional medical records. He reaffirmed his earlier opinions, stating there was no objective basis in the records for Employee's lumbar, pelvic, SI, or hip and leg pain. (Dr. Fuller, EME Supplement, April 7, 2011).
98. On April 8, 2011, Employee returned to Dr. Stinson for a repeat discogram, however the results are not included in the medical records. (Dr. Stinson, Procedure Note, April 8, 2011; Observation).
99. On April 20, 2011, Dr. Lipon reviewed an additional 631 pages of medical records as well as CDs and x-rays. He reaffirmed his opinion that any SI dysfunction was not caused by the January 30, 2007 work injury, pointing out that it was not until eight months later on September 27, 2007 that it was mentioned. Dr. Lipon agreed there was a solid fusion on both SI joints, and he stated the degenerative changes in Employee's lumbar and thoracic spine were not aggravated by the work injury. Dr. Lipon disagreed with Dr. Fuller's explanation that there was no load on the neck while doing the draw sheet lift. He explained Employee would have been tensing her muscles and rotating her neck, which most probably caused the C4-5 disc protrusion. However, Dr. Lipon agreed with Dr. Fuller that Employee

has a somatoform disorder or something similar, and he recommended a psychiatric evaluation. (Dr. Lipon, SIME Supplement, April 20, 2011).

100. On May 5, 2011, Employee returned to Dr. Stinson. Although Dr. Stinson's chart note refers to a positive result from a discogram, it is not clear whether he is referring to the January 5, 2011 or the April 8, 2011 discogram. He explained to Employee that neuropsychological testing would be required before any disc replacement surgery. (Dr. Stinson, Chart Note, May 5, 2011).

101. On May 17, 2011, Employee was seen by Jacqueline Bock, PhD, for neuropsychological testing. The purpose of the evaluation was to ascertain whether Employee understood the risks and potential complications of her proposed surgery and to better understand her personal attributes that contribute to or detract from her recovery. Information regarding Employee, symptoms and background was obtained through "a medical record from Dr. McIntosh" listing the conditions for which Employee was currently receiving treatment and an interview with Employee. Employee told Dr. Bock that she had three fusions in her neck, and recent discography showed torn discs at L45 and L5-S1. She stated Dr. Stinson told her that while there were other options, he recommended disc replacement. Dr. Bock's testing showed Employee's anxiety score was above average, and she might be suffering mild depression and anxiety. She stated Employee did not appear to have any psychiatric disorder or distress at the time. Dr. Bock did not find any contraindications to surgery, but noted there was a risk Employee might pursue recovery too aggressively and might experience more depression and anxiety during her recovery. (Dr. Bock, Neuropsychological Report, May 17, 2011).

102. Employee did not tell Dr. Bock of her bilateral SI fusion, and none of Dr. Stinson's medical reports state he recommended disc replacement. According to the medical records, no doctor has recommended disc replacement, although Dr. Peterson did say she might be a candidate depending on the result of additional testing. (Observation).

103. There is no indication that Employee returned to Dr. Peterson after completing the discogram, EMG study, and neuropsychiatric evaluation. (Observation).

104. On July 11, 2011, Dr. McIntosh noted Employee would be travelling to Germany for a multiple level disc replacement with Dr. Bertagnolli. Dr. McIntosh agreed to the referral

because of Dr. Bertagnolli's experience in disc replacement surgery, having done over 5,000 of them. (Dr. McIntosh, Chart Note, July 6, 2011).

105. Dr. Bertagnolli's chart notes are not in evidence. Information regarding Employee's surgery in Germany must be gleaned from other medical reports. (Observation).

106. On August 31, 2011, Dr. McIntosh reported Employee went to Germany "to have a world-reknown [sic, renown] specialist, Dr. Bertagnolli" perform disc replacement surgery. Although Employee had anticipated replacement of both the L4-5 and L5-S1 discs, a discogram done before the surgery showed the L5-S1 was not so symptomatic as to justify replacement. After the surgery, Employee reported she was much improved, although she still had leg pain. (Dr. McIntosh, Chart Note, August 31, 2011).

107. On September 6, 2011, Employee went to Steven Humphreys, M.D., with pain in the back of her neck and back, primarily in the mid and lower lumbar spine radiating into the buttocks, thighs, calves and feet. Dr. Humphreys recommended a corset and gentle range of motion exercises. (Dr. Humphreys, Chart Note, September 6, 2011).

108. On November 13, 2011, Employee had a lumbar MRI. The replacement disc at L4-5 limited the examination at that level, but the exam showed no significant progression of the disc disease at L1-2 and L2-3. It also showed the mild disk herniation at L1-2. (Central Peninsula Hospital, Diagnostic Imaging Report, November 13, 2011).

109. Employee returned to Dr. Humphreys on November 14, 2011 stating she was miserable from her back and right leg pain, which were the same symptoms she had before the surgery. Employee and her husband felt that the L5-S1 disc was the source of the pain. Dr. Humphreys recommended a repeat discogram. (Dr. Humphreys, Chart Note, November 14, 2011).

110. On November 18, 2011, Employee returned to Dr. Stinson for the discogram. There was no provocation at L3-4 at 75 psi, but L5-S1 did produce symptoms at 120 psi. (Dr. Stinson, Chart Note, November 18, 2011).

111. On November 29, 2011, Employee and her husband returned to Dr. Humphreys. Dr. Humphreys reported:

> I had a very long talk with the patient about the ramification of her discogram and the tears at both L3-4 and L5-S1. I also discussed with her that discograms can help guide clinical decisions but should not be used to absolutely make them. I also discussed with both of them that the more surgeries she has the less likely the

> next is going to help. . . I have discussed continuing conservative care but she appears and repeatedly states that the pain is too severe. I have told her that if surgery were planned I believe she should have a fusion for the lower level L5-S1. I had discussed with her that some of the pain could be coming from the prosthesis and that there was no good way to determine this. She asked about a disc replacement at L5-S1 under her first disc replacement. I have told her that I do not do these. But they are only approved for one level and that she would need to go back to Germany if she wanted this done. I have told her that I believe the best option would be a fusion. . . . She has done quite a bit of research on her own . . . She understands and would like to think about whether she wants to do the fusion or explore the disc replacement.

112. On December 28, 2011, Employee discussed her upcoming L5-S1 disc replacement surgery in Germany with Dr. McIntosh. (Dr. McIntosh, Letter, January 3, 2012).
113. On February 16, 2012, Employee had a disc replacement at L5-S1 in Germany. (Pro Spine, Medical Report, February 20, 2012.).
114. On May 21, 2012, an x-ray showed the replacement discs at L4-5 and L5-S1 were in good position. (Dr. Humphreys, Radiology Report, May 21, 2012).
115. On August 13, 2012, Employee called Dr. McIntosh's office. She was crawling on the floor in pain, and suspected one of the disc replacements had gone bad. She knew that she was going to need surgery on discs. She asked that Dr. McIntosh order a discogram of her lumbar spine because she needed the information for Germany. (Dr. McIntosh, Telephone Encounter, August 13, 2012).
116. On August 15, 2012, Employee had lumbar x-rays taken per Dr. McIntosh's order. They showed the artificial discs at L4-5 and L5-S1, with no indication of hardware failure, and some degenerative changes and narrowing at L1-2. (Central Peninsula Hospital, Diagnostic Imaging Report, August 15, 2012).
117. Later on August 15, 2012, Employee called Dr. McIntosh's office and reported the x-rays had shown no disc space between L1-2 and L3-4. She felt an MRI could expedite her getting through the ordeal. (Dr. McIntosh, Telephone Encounter, August 15, 2012).
118. On August 21, 2012, Employee was seen by a physician's assistant in Dr. Humphrey's office. She reported that the February disc replacement had provided immediate relief of her symptoms, which lasted about four months. Since then, he had progressive pain in her low back radiating into her left and right hips. "The patient is convinced that it is this adjacent level at L3-4 which is her pain generator." She had contacted Dr. Bertagnolli, who

asked for some laboratory studies before considering replacement of the L3-4 disc. (Dr. Humphreys, Chart Note, August 21, 2012).

119. On August 26, 2012, Employee had an MRI of her lumbar spine. Because of the implants, L4-5 and L5-S1 could not be visualized. The MRI again noted moderately severe degenerative disc disease at L1-2, and not spinal or foraminal stenosis at L2-3 or L3-4. A CT myelogram done the same day showed the artificial discs at L4-5 and L5-S1, mild to moderate foraminal narrowing at the L3-4, and degenerative disc disease at L1-2. (Central Peninsula Hospital, Radiology Reports, August 26, 2012).

120. On September 4, 2012, Dr. Stinson performed another discogram. There was no provocation at L1-2 at 72 psi, no provocation at L2-3 with 107 psi, and no provocation at L3-4 with 77 psi. Dr. Stinson told Employee that no obvious surgical lesions had been observed. (Dr. Stinson, Chart Note, September 4, 2012).

121. On November 5, 2012, Employee returned to Dr. Humphreys to discuss the possibility of a fusion at L4-5 and L5-S1 and the placement of a spinal cord stimulator. Dr. Humphreys stated he would consider fusing L4-5 and L5-S1 because it appeared most of her pain was in that region. He also told her that a spinal cord stimulator was an option, but a psychological evaluation would be required first. (Dr. Humphreys, Chart Note, November 5, 2012).

122. On November 30, 2012, Dr. Humphreys implanted a trial spinal cord stimulator. When Employee reported improvement in her pain, a permanent stimulator was implanted on December 4, 2012, (Dr. Humphreys, Chart Notes, November 30,2012, December 2, 2012, and December 4, 2012).

123. On January 1, 2013, Employee had x-rays of her lumbar spine that showed no loosening or disruption of the fixations at L4, L5, and S1. (Central Peninsula Hospital, Diagnostic Imaging Report, January 1, 2013).

124. On January 29, 2013, Dr. Humphreys performed surgery to fuse Employee's L4, L5, and S1 vertebrae. (Dr. Humphreys, Chart Note, January 29, 2013).

125. On February 8, 2013, Employee reported feeling improvement since the surgery. (Dr. Humphreys, Chart Notes, February 8, 2013, March 11, 2013, April 17, 2013).

126. On February 14, 2013, Employee reported to Dr. McIntosh that she was still having a hard time managing her pain and asked for an increase in her pain medications. She reported arm fatigue just from brushing her teeth. (Dr. McIntosh, Chart Note, February 14, 2013).

127. On March 14, 2013, Employee reported she was still in pain following her surgery, but she did not want to tell Dr. Humphreys because she did not want to disappoint him. Dr. McIntosh stopped Employee's OxyContin and Oxycodone prescriptions and prescribed morphine. (Dr. McIntosh, Chart Note, March 14 2013).
128. On June 6, 2013, Employee had lumbar x-rays that showed no loosening or disruption of the fixations at L4, L5, and S1. (Central Peninsula Hospital, Diagnostic Imaging Report, June 6, 2013).
129. On June 10, 2013, Employee reported continued improvement, but muscle spasms and pain in her neck, shoulders, back, and feet. She had turned her spinal cord stimulator off for 10 days and had not noted any difference. (S. Winter, PA-C, Chart Note, June 10, 2013).
130. On August 9, 2013, Employee returned to Dr. Humphreys for a follow-up visit. She was doing much better and was able to walk, although she was somewhat stiff. (Dr. Humphreys, Chart Note, August 9, 2013).
131. On August 29, 2013, Jay Caldwell, M.D., performed a functional capacity assessment in connection with Employee's application for Social Security benefits. Dr. Caldwell noted Employee's symptoms were attributable to a medically determinable impairment, but the severity or duration of the symptoms was disproportionate to what was expected. (Dr. Caldwell, Functional Capacity Assessment, August 29, 2013).
132. On December 12, 2013, Employee told Dr. McIntosh she felt like she had a 50 pound backpack on her back, and had pain in the right side of her neck and the left side of her back. (Dr. McIntosh, Chart Note, December 12, 2013).
133. On December 13, 2013, Employee was again seen by Dr. Humphreys. She was continuing to improve and reported she was off all narcotics, although she still had some pain in her low back and buttock. (Dr. Humphreys, Chart Note, December 13, 2014).
134. On January 21, 2014, Employee was seen by Dr. Fuller for another EME. In connection with the evaluation, Employee completed a pain diagram that showed aching pain in the back of her neck, across both shoulders, and down both arms. She had burning pain in her mid and low back extending down the front and back of both legs to her feet. She rated her pain at a 6 out of 10, but completed the evaluation without pain behavior. Dr. Fuller stated Employee's 2003 work injury was consistent with a strain, which would have resolved in four to six weeks without any permanent effects, and the 2003 injury was not a substantial

factor in her 2007 presentation or her need for medical treatment after that time. He reiterated his opinion from his December 7, 2010 report that the January 30, 2007 injury was not the cause of her need for low back, SI, or leg treatment. He opined Employee was medically stable and could return to her job as a physical therapist. Dr. Fuller recommended a neuropsychiatric evaluation to determine the cause of her ongoing need for medical treatment. (Dr. Fuller, EME Report, January 21, 2014).

135. On January 23, 2014, Employee returned to Dr. McIntosh to discuss Dr. Fuller's EME report. Although Dr. McIntosh had not had time to fully review the report, she disagreed with Dr. Fuller's conclusion that Employee had psychological symptoms. She pointed out that Dr. Fuller had not reviewed Dr. Bock's neuropsychological evaluation, which showed Employee might have some adjustment disorder, depression, and anxiety, as a result of her medical condition, but no psychological disorders. Dr. McIntosh reiterated her opinion that the cascade of surgeries Employee had undergone was due to the injury at work. (Dr. McIntosh, Chart Note, January 23, 2014).

136. Employee returned to Dr. McIntosh on March 4, 2014 for further review of Dr. Fuller's report. Dr. McIntosh included an extensive "General Medical History" covering about two and one half pages in her chart note. She pointed out that Employee did not meet the diagnostic criteria for somatization disorder in that symptoms had not begun before Employee was 30 years of age. Dr. McIntosh stated Dr. Stinson's January 5, 2012 discogram was an objective finding of annular tearing at L3-4, L4-5, and L5-S1. Dr. McIntosh noted that Employee may have had a preexisting SI condition as in 1999 a chiropractor was able to produce left SI pain with flexion of the right hip. She opined the 2003 work injury was a substantial cause of Employee's ongoing disability and need for medical treatment, noting Employee had received massage every three to four months thereafter as well as independent stretching and exercise program. Noting that Employee's condition deteriorated significantly after the 2007 injury, Dr. McIntosh concluded that injury was the substantial cause of Employee's disability or need for medical treatment. She referred Employee to Paul Craig, PhD., for a complete neuropsychological evaluation. (Dr. McIntosh, Chart Note, March 4, 2014).

137. Dr. McIntosh's March 4, 2014 "General Medical History" is for all practical purposes a verbatim copy of a seven-page handwritten letter Employee provided to Dr. McIntosh. (Dr. McIntosh, Employee's Handwritten Letter, Date Illegible).

138. On March 10, 2014, Dr. Fuller issued a supplemental EME report after reviewing Dr. Bock's neuropsychological evaluation. He disagreed with Dr. Bock, pointing out she had not reviewed the entire record. Dr. Bock was unaware the SI joints were objectively normal and the fusion did not cure her pain. Also, Dr. Bock was not aware that Employee's discs were objectively normal as shown by the first discogram, and the disc replacement surgery never cured her. (Dr. Fuller, EME Supplement, March 10, 2014).

139. On April 16, 2014, Dr. McIntosh wrote a referral letter to Dr. Craig:

> Charlayne O'Brien has been a patient in my practice since 1995. She is a physical therapist and has been very active in the community and a well respected employee of Central Peninsula Hospital since 1994. She had two cervical fusions in 2000. She recovered from these and returned to work until her major injury of 2007. Since that time, she has required multiple surgeries to allow her to function just in the sphere of activities of daily living. Until this recent injury, she was in very good health. Medical records have been sent showing the objective findings on diagnostic prior to surgery, as well as surgery reports. Also enclosed is Dr. Bock's presurgical psychological evaluation showing expected adjustment and normal somatization.
>
> Please address the issue of whether Charlayne has somatization disorder as that has come into question by her insurance company. I have never diagnosed this condition in her, and in my professional relationship with her of nearly 20 years, I have always found her to be truthful about her symptoms, and she has always had objective findings to corroborate them. (Dr. McIntosh, Employee Letter, April 16, 2014).

140. Dr. McIntosh's letter to Dr. Craig is taken essentially verbatim from a handwritten letter Employee provided to Dr. McIntosh on April 14, 2014. (Dr. McIntosh, Employee's Handwritten Letter, April 14, 2014).

141. On April 21 and 22, 2014, Dr. Craig evaluated Employee. He obtained a history from Employee and through the records provided by Dr. McIntosh. Employee reported she had seven spinal surgeries since her C4-5 fusion in 2000. She reported that each of them had been "helpful," but reported to Dr. Craig she had pain "throughout her back." Employee fell within normal limits on one validity scale in the testing done by Dr. Craig, but on another scale she was on the cusp between normal patients and compensation-seeking patients. Dr.

Craig noted the elevated score raised some concerns, but did not otherwise invalidate the results. He also determined Employee had a tendency to pay more attention to bodily complaints than the average person, but that could not be used to determine whether the surgeries that had been done were warranted or not. He diagnosed an "unspecified neurocognitive disorder, a depressive disorder, and some findings of a somatic symptom disorder, but he did not conclude her pain and suffering were primarily or exclusively psychological. Rather, he concluded her chronic pain had been a focus of her consciousness and lifestyle for several years. Dr. Craig explained "somatization disorder" had been removed from the most current diagnostic guidelines. He recommended a neurological consultation, some cognitive rehabilitation, and a follow-up neuropsychological evaluation in 12 to 24 months. (Dr. Craig, Neuropsychological Evaluation, April 22, 2014).

142. Although a neuropsychologist is a psychologist, their practice differs from that of a clinical psychologist. A clinical psychologist generally diagnoses and treats psychological and mental health problems while a neuropsychologist focuses on the diagnosis and treatment of psychological disorders associated with brain-based conditions. (Observation, Experience).

143. On May 16, 2014, Dr. McIntosh added an addendum to her chart note regarding Employee's April 4, 2014 visit. The addendum begins:

> I have reviewed the State of Alaska Department of Labor definitions of the substantial cause and medical probability provided by the State of Alaska Worker's Compensation Board. Charlayne O'Brien has been a patient of mine since 1995 and I have also observed her in the workplace at Central Peninsula Hospital in her function as a physical therapist since 1994. There has been a permanent change in her condition as a direct result of her work injury of 1/30/07. Following is a summary of her six primary diagnoses. 1. Cervical disc herniation at C4-5. This is an acceleration of a preexisting condition. Degenerative disc changes as a result of her fusions at CS-6 7, creating increased potential for stress at levels above and below. 2. Cervical muscle spasm. Again, this is an aggravation of preexisting cervical fusion at CS-6-7. 3. Thoracic disc pain. This is a permanent aggravation of a preexisting condition. Some left trunk pain was noted several months following her neck injury of 1999. However, now a disc herniation is noted at T9-10 since her more recent injury. 4. Sacroiliac dysfunction. This is an acceleration of a preexisting condition, namely the work injury of 5/28/03, where sacroiliac pain was noted. 5. Lumbar disc disease L1to L4. There has been permanent aggravation of trunk and leg pain. Annular tearing has been noted on a CT scan. There was trunk and leg pain several months later, following her 1999 neck injury, however, this had resolved. 6. Lumbar disc annular tearing L4-5, 51. This is an acceleration of a preexisting condition, her work injury of 5/28/03, when low back pain was noted, although no leg pain.

> Charlayne returned to full duty with periodic massages and self-stretching and led a full and active life. *Page 2* In my opinion, the work injury of 5/28/03 is a substantial cause of her disability and need for ongoing medical treatment, as her low back pain and sacroiliac dysfunction was specifically mentioned In Dr. Dibella's reports. However, the work injury of 1/30/07 is the substantial cause in her inability to return to work for the last 7 years, and the cause of her 7 subsequent surgeries. The condition would not have occurred at the time it did, the way it did, or to the degree it did if it were not for performing several very heavy rotational lifts on an incapacitated heavy ICU patient. Additional complications of her injuries, which I have previously noted, include the following: Sleep apnea; choking; peripheral neuropathy in lower extremities; TMJ dysfunction; constipation; hypertension due to pain; lower extremity edema; periorbital edema; shoulder and hip pain; left knee pain; weakness in the upper extremities, lower extremities, and spinal muscles; pelvic floor weakness; incontinence; insomnia; some expected reactive depression due to adjustment to injury; and there is also some memory loss and concentration difficulties that were not present prior to this injury, possibly attributable to long-term medication use, or anesthesia from multiple surgical interventions, or hypoxemia that may have occurred prior to treatment of her sleep apnea. The patient will have permanent impairment. She is currently receiving physical therapy and massage therapy, which is promoting recovery from her multiple surgeries and extremely weakened state following her last 2-level lumbar fusion surgery. She continues to make objective gains and is not medically stable. She will require ongoing medical treatment permanently due to her disability. She most certainly will not be able to return to work as a physical therapist. The job description at Central Peninsula Hospital, which states the requirement of her Job, has been [reviewed]. (Dr. McIntosh, Chart Note, May 16, 2014, *emphasis added*).

144. Dr. McIntosh's May 16, 2014 addendum is essentially a verbatim repetition of a two-page handwritten note Employee provided to Dr. McIntosh on April 14, 2014. The "*Page 2*" in Dr. McIntosh's addendum corresponds to the pagination of Employee's note. (Dr. McIntosh, Employee Note, April 4, 2014; Observation).

145. On June 5, 2014, Employee was seen by Henry Krull, M.D., for an initial evaluation for shoulder pain. Employee reported her symptoms began after a work injury more than five years earlier, and had progressively worsened. Dr. Krull ordered x-rays and physical therapy. (Dr. Krull, Chart Note, June 5, 2014).

146. On June 11, 2014, Employee returned to Dr. Humphreys. He reviewed her records with her because she had a workers' compensation hearing coming up. He stated the 2003 injury had been managed by over-the-counter medication and "occasional" massage therapy. He noted that after the 2007 injury, and following conservative care, she had a bilateral SI joint

fusion, which helped initially. Then she had two disc replacements, both of which worked temporarily, but the pain returned and a fusion was required. The fusion helped, although she still has back pain. Dr. Humphreys concluded that there was a substantial injury that occurred in 2007, as she did not get better with conservative care and no other cause was noted. (Dr. Humphreys, Chart Note, June 11, 2014).

147. On September 23, 2014, Employee was seen by Dr. McIntosh. Employee asked Dr. McIntosh to comment about her prognosis, and Dr. McIntosh responded that she was concerned Employee might need further surgery, and she doubted Employee would ever be able to return to gainful employment. (Dr. McIntosh, Chart Note, September 23, 2014).

148. On August 5, 2015, Employee was seen by psychiatrist Keyhill Sheorn, M.D., for an EME. Dr. Sheorn examined Employee and reviewed many significant medical reports from Employee's treating doctors, the EME and SIME reports, as well as Employee's daily journal. Dr. Sheorn's primary diagnosis was Factitious Disorder, which is also known as Munchausen's Syndrome. It is a mental disorder in which a person repeatedly and deliberately acts as if he or she has an illness when they are not really sick. The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) diagnostic criteria are:

> A. Falsification of physical or psychological signs or symptoms or induction of injury or disease, associated with identified deception.
>
> B. The individual presents himself or herself to others as ill, impaired, or injured.
>
> C. The deceptive behavior is evident even in the absence of obvious external rewards.
>
> D. The behavior is not better explained by another mental disorder, such as a delusional disorder or another psychotic disorder.

Dr. Sheorn noted several warning signs of factitious disorder that are evident in Employee's case:

- Dramatic but inconsistent medical history.
- Unclear symptoms that are not controllable, become more severe, or change once treatment has begun.
- Predictable relapses following improvement in the condition.

- Extensive knowledge of hospitals and/or medical terminology, as well as the textbook descriptions of illness.
- Presence of many surgical scars.
- Appearance of new or additional symptoms following negative test results.
- Presence of symptoms only when the patient is alone or not being observed.
- Willingness or eagerness to have medical tests, operations, or other procedures.
- History of seeking treatment at many hospitals, clinics, and doctors' offices, possibly in different cities.

Dr. Sheorn stated Employee's psychiatric condition was pre-existing and was not caused by the 2007 work injury. (Dr. Sheorn, EME Report, August 5, 2015).

149. On October 7, 2015, Employee returned to Dr. Humphreys, who determined she was medically stable. (Dr. Humphreys, Chart Note, October 7, 2015).

150. On February 10, 2016, Dr. Humphreys performed a PPI evaluation and found Employee to have a 14 percent whole body impairment. (Dr. Humphreys, PPI Rating, February 10, 2016).

151. On February 26 and 28, 2016, Employee underwent a physical capacities evaluation. At the time she reported constant burning pain from waist to toes that wraps around her lower spine when she overdoes activities. That caused a burning in the upper lumbar and lower thoracic areas radiating into her legs 24 hours per day. She also had diffuse bilateral numbness below the knees, with the left worse than the right. Due to her low stamina, strength, and the results of early testing, testing involving weight lifting, carrying, and pushing and pulling was not done. She could perform at the sedentary level, but was not capable of working at that level because of pain and weakness creating the need to lie down as needed. (L. Dowler, Physical Capacities Evaluation, March 30, 2016.)

152. On March 18, 2016, Employee had a CT myelogram of her lumbar spine. The scan showed the new fusion hardware at L4-S1, but no changes since the August 2012 CT myelogram. (Central Peninsula Hospital, Radiology Report, March 18, 2016).

153. On March 28, 2016, Employee was seen by Mark Simonson, M.D. Employee reported she have been doing relatively well until the functional capacity evaluation, when she did some

crossover stepping that markedly increased her pain. Employee was reporting pain from the T5 to T7 level anteriorly all the way to the feet, and pain posteriorly from about T5 to the waist and into the lower extremities. Employee told Dr. Simonson that she would like to undergo discography again at the L3-4 level. Dr. Simonson noted Employee's complex spine history, including four discograms with pressures to 120 psi or more. He stated he was not familiar with pressurization above 50 psi, which is the limit recommended by the International Spine Intervention Society. He did not recommend discography at L3-4, which might lead to another fusion. Dr. Simonson noted Employee's SI joints were suspicious, and recommended a bone scan to be followed up with SI joint injections. (Dr. Simonson, Chart Note, March 28, 2016).

154. On March 28, 2016, Dr. McIntosh wrote to Dr. Weiss asking him to review recent x-rays and CT scans, including the one done on March 18, 2016. She explained Employee had an exacerbation of SI joint pain after a functional capacities evaluation. Dr. McIntosh reported Employee had a frequent vibrating sensation over the left iliac crest as well as occasional "popping." Dr. McIntosh asked for confirmation that the SI fusions remained solid and asked for treatment recommendations. (Dr. McIntosh, Letter, March 28, 2016).

155. On March 31, 2016, Employee had the bone scan recommended by Dr. Simonson. The scan showed radiotracer uptake at L1-2, consistent with degenerative changes, but no abnormal uptake at the SI joints. (Central Peninsula Hospital, Diagnostic Imaging Report, March 31, 2016).

156. Employee returned to Dr. Humphreys on April 12, 2016. He stated the CT did not show a solid SI fusion, but it is not clear which CT scan he is referring to. Employee again asked for a discogram at L3-4, but Dr. Humphreys deferred because the disc height was relatively well preserved. He did suggest a diagnostic SI joint injection with Dr. Simonson. (Dr. Humphreys, Chart Note, April 12, 2016).

157. On April 21, 2016, Dr. Simonson performed CT guided injections of both SI joints. The images showed SI joint fusion, but the results of the testing are not included. (Dr. Simonson, Procedure Note, April 21, 2016).

158. On May 2, 2016 Employee was seen by a PA in Dr. Humphrey's office. Employee reported she had near complete relief for two hours after the SI joint injections, but the pain returned.

Employee also reported that she had a very hoarse voice that went away after the SI joint injections, but did not return. (Dr. Humphreys, Chart Note, May 2, 2016).

159. On May 18, 2016, Dr. Weiss responded to Dr. McIntosh's March 28, 2016 letter. He noted the SI fusion had increased a little bit from 2012 to 2016. Dr. Weiss also stated that Employee had written to him on April 22, 2016 stating her pain had resolved for two hours after the April 21, 2016 SI joint injections. He concluded the fusion might not be strong enough to prevent all motion, and a repeat fusion using implants rather than screws was an option. However, before considering further surgery, he recommended a second diagnostic SI injection. (Dr. Weiss, Letter, May 18, 2016).
160. On May 31, 2016, Jesse Kincaid, M.D., performed the second SI joint injections. Again, the results are not included in his procedure note. (Dr. Kincaid, Procedure Note, May 31, 2016).
161. On June 16, 2016, Dr. Weiss reviewed records Employee had sent. He recommended surgery to remove the screws from Employee's SI joint and an SI joint fusion using implants. (Dr. Weiss, Chart Note, June 16, 2016).
162. On August 2, 2016, Employee completed a physical therapy evaluation for Vicki Sims, a physical therapist in Georgia. Employee reported that while performing "braid walking" at the February 2016 functional capacity evaluation, the "pain became severe and radiated down the leg to the foot." (V. Sims, Physical Therapy Evaluation, August 2, 2016).
163. On August 3, 2016, Dr. Weiss examined Employee and included an extensive review of Employee's history in his chart note. He notes that the April 21, 2016 SI joint injection provided 80 percent relief for two hours, and the May 31, 2016 injection provided seven hours of relief. He also noted the EMG testing Employee had in Georgia showed only minimal abnormal findings on the left tibial nerve. Employee reported pain in response to subjective SI testing. Dr. Weiss recommended continuing with surgery, but opined Employee exhibited a significant psychogenic overlay as well. (Dr. Weiss, Chart Note, August 3, 2016).
164. On August 25, 2016, Dr. Weiss performed the revision surgery on Employee's SI joints. (Dr. Weiss, Procedure Note, September 25, 2016).

165. On September 21, 2016, Dr. Weiss noted he had received Dr. Bock's May 17, 2011 evaluation as well as Dr. Craig's 2014 evaluation. (Dr. Weiss, Chart Note, September 21, 2016).

166. On December 16, 2016, Dr. Fuller reviewed new medical records as well as medical records dating back to the 1990s and issued a supplemental report. He stated there were no objective indications for the SI revision surgery done by Dr. Weiss. He points out that the only objective testing was the bone scan, which would have shown uptake at the SI joints if there had been a failed fusion. He also points out that valid responses to SI joint injection usually show some relief for several weeks as the cortisone diminishes the inflammation in a joint. Dr. Fuller opined the primary cause of all of her surgeries was Munchausen's syndrome. (Dr. Fuller, EME Supplement, December 16, 2016).

167. On December 29, 2016, Dr. Weiss stated Employee was initially injured in 2003, and was never asymptomatic between the 2003 and 2007 injuries. The 2007 injury severely exacerbated her prior injury and was the substantial cause of her need for surgery in 2008 and 2016. (Dr. Weiss, Chart Note, December 29, 2016).

168. In his January 11, 2017 chart note, Dr. Weiss explains that the abnormality in the EMG testing done in Georgia might indicate neurapraxia/piriformis syndrome, which was treated conservatively. He also stated that after reviewing Dr. Bock's report, his listing of somatoform disorder and psychogenic overlay was in error. (Dr. Weiss, Chart Note, January 11, 2017).

169. On May 31, 2017, Employee returned to Dr. Stinson with neck, back, and extremity pain. She completed a pain diagram showing aching in both arms, the back of her neck and head, and in her forehead as well as burning pain in her lower back and down both legs into the feet. She reported the pain varied from four to eight out of ten, and averaged five to six. She was seeking a comprehensive evaluation of her treatment. Dr. Stinson explained that would need to be done at a tertiary care center, and suggested Dr. McIntosh refer her to the University of Washington in Seattle. (Dr. Stinson, May 31, 2017).

170. Employee has been in physical therapy essentially continuously since the 2007 work injury. (Medical Records; Observation).

171. Although Employee represented herself at hearing with the assistance of her husband, she was represented by two different attorneys at different times during her case. (Record).

172. Liz Dowler, who has a doctorate in ergonomics performed a February 2016 physical capacities evaluation on Employee. Ms. Dowler did not do a validity analysis because Employee was unable to complete the evaluation, but Employee appeared to be consistent in her efforts. In her opinion, Employee will be limited to sedentary work and will have to change position frequently. She will be unable to work as a physical therapist, which requires medium level strength. She acknowledged that Employee had done "grapevine" steps as part of the evaluation. (Dr. Dowler, Hearing Testimony).

173. Although Dr. McIntosh had stated in her deposition that the 2003 injury was a cause of Employee's need for treatment, she stated she had been confused and was thinking of the 1999 injury. She did not have enough information to offer an opinion as to whether the 2003 injury was a cause of her disability or need for treatment after 2007. Dr. McIntosh first saw Employee for the 2007 injury about a week after it had happened. There is nothing in her records regarding Employee's low back or SI joint pain after the 2007 injury until July 31, 2007, when Dr. McIntosh noted tenderness in Employee's low back. (Dr. McIntosh, Hearing Testimony).

174. Dr. Fuller has issued five EME or supplemental EME reports in this case. He explained that with low back pain, an MRI should correlate with the patient's presentation in that if it shows nerve impingement or disc bulge, the location of the patient's pain should be in the areas served by the affected nerves. Evidence of impingement on the MRI alone is not an indication that surgery is necessary. He had diagnosed Employee with a low-back strain, and explained that a strain is a pulled muscle. A strain would normally shows up within 24 hours and should resolve over six to ten days. A strain in the low back would not cause pain to radiate into the legs, because the strain does not impinge on nerves. While other doctors pointed to Employee's discograms as evidence of disc problems, Dr. Fuller stated discograms rely on the patient's subjective report of pain. Additionally, he stated the pain reported on Dr. Stinson's discograms occurred at pressures far higher than the recommended maximum of 50 psi. Coupled with the lack of any nerve impingement on the MRIs, Dr. Fuller stated there was no objective evidence to support the lumbar disc replacements. He explained the annular tears in Employee's discs that showed up on MRIs are not unusual. Seventy to eighty percent of the tears are genetically based, and, unless they impinge on a nerve, they are not a reason for surgery. He also explained the SI joint is very

tight, with virtually no motion, and it takes a significant amount of force, such as a motor vehicle accident, to dislocate it. When it is damaged, the ligaments tear, and the joint moves apart, which can be seen on an x-ray or MRI. The damage will also show up on a bone scan for the remainder of a person's life, although it may diminish over time. There are no objective provocative maneuvers to diagnose SI dysfunction; all of the maneuvers rely on the patient's subjective response. Dr. Fuller pointed out that there was no objective evidence showing Employee had SI joint dysfunction in the MRIs, x-rays, CT scans, or the bone scan. In his opinion, neither Employee's lumbar spine nor her SI joints were injured in the January 2007 lifting incident. The 2003 injury was a mild strain that resolved quickly, and it was not a substantial factor in Employee's disability or need for treatment after the 2007 injury. (Dr. Fuller, Hearing Testimony).

175. Dr. Weiss testified that SI joint problems often overlap with low back or hip pain, and are frequently overlooked. He explained there is no truly objective test for SI joint dysfunction; diagnosis relies on a physical exam, patient history, and response to SI joint injections. Dr. Weiss did not feel Employee was malingering as she appeared anxious to return to work. He discounted the diagnosis of Munchausen's syndrome because there was no evidence Employee had tried to hurt herself. The 2003 injury could have been the origin of SI joint injury, based on Employee's reports she continued to have symptoms, but the 2007 injury was the substantial cause of Employee's SI dysfunction. When asked what changed between 2010 when he stated that Employee's SI joint fixation and fusion were secure and 2016, when he did the revision surgery, Dr. Weiss did not point to any evidence, but stated his 2010 opinion might have been different if he had examined Employee in person. (Dr. Weiss, Hearing Testimony).

176. Rebecca, Byerly, who has a PhD. in physical therapy has been Employee's physical therapist since 2015. She was also Employee's supervisor when Employee worked for Central Peninsula Hospital. Dr. Byerly considered Employee one of the best therapists at the hospital, noting that she strove to advance her education. Dr. Byerly reported "big changes" after Employee's 2016 fusion, in that she was less guarded, had a more fluid motion. She explained that although Employee was a physical therapist, she could not treat herself because the therapy requires someone to observe and analyze the patient's movements as well as assisting them. Typically physical therapy lasts less than one year,

and she could not recall anyone receiving therapy for ten years. (Dr. Byerly, Hearing Testimony).

177. Employee explained that when she injured her back in 2003, she was assisting a patient and felt a pop in her lumbar spine, but she did not have leg pain. When the pain continued she went to urgent care. Although she stopped treatment, she never fully recovered, and she was unable to sleep on her left side. At the time of the 2007 injury, she felt a strain in her back, but no sharp pain. She attempted to work, and delayed reporting the injury for seven days. When she went to the emergency room, she had pain down her whole left side, but because of her prior cervical fusions, the doctors focused on her neck. The reason she kept the diary or journal was because after her 1999 injury, doctors had given differing opinions, and she had not kept track of what she had been doing. After the first SI fusion in 2008, she felt better, but still had pain. When Dr. Lipon said she was capable of returning to work in the 2009 SIME report, she tried volunteering as a physical therapist, and in 2010, she leaned forward and felt a breaking sensation. After that, the pain got worse. (Employee, Hearing Testimony).

178. Dr. Sheorn stated she had reviewed an extensive number of Employee's medical records in connection with her evaluation, and, after examining Employee, she diagnosed factitious disorder, or Munchausen's syndrome. Dr. Sheorn explained the differences between factitious disorder, malingering, somatization, and conversion, which had been mentioned as possible diagnoses. A person with factitious disorder has a deep need to be taken care of, and consciously and intentionally feigns or produces symptoms. With malingering, there is a conscious and intentional production or exaggeration of symptoms for material gain, such a money, avoidance of work, or escape from punishment. Somatization involves multiple recurrent symptoms with no organic basis that are believed to be due to unconscious suppression of emotional conflict or stress. It does not involve conscious voluntary behavior. With conversion, symptoms are created unconsciously to avoid psychological pain; for example, a mother's arm will become paralyzed so she cannot hit her child. Dr. Sheorn ruled out somatization and conversion because she found Employee to be acting consciously. And, as between factitious disorder and malingering, she found Employee to be driven more by a need to be taken care of than by material gain. She had seen both Dr. Bock's and Dr. Craig's reports, and pointed out that Munchausen's is hard to see without a

review of all the medical records. Dr. Sheorn reviewed the warning signs for Munchausen's that were included in her EME report, pointing out examples in Employee's history. (Dr. Sheorn, Hearing Testimony).

PRINCIPLES OF LAW

AS 23.30.001. Intent of the legislature and construction of chapter. It is the intent of the legislature that

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

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

. . . .

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

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

At the time of Employee's May 28, 2003 injury, the Act provided as follows:

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

For work injuries occurring prior to the November 7, 2005 effective date of the 2005 amendments to the Alaska Workers' Compensation Act, a work injury is compensable if the employment is "a substantial factor" in bringing about the disability or need for medical care. *Ketchikan Gateway Borough v. Saling*, 604 P.2d 590, 597-98 (Alaska 1979). A work injury is a substantial factor in bringing about the disability or need for medical care if the claimant would not have suffered disability at the same time, in the same way, or to the same degree but for the work injury. *Rogers & Babler* at 532-33.

In 2005, the legislature amended AS 23.30.010. That amendment applies to Employee's January 30, 2007 injury.

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

Under the Alaska Workers' Compensation Act, coverage is established by a work connection, meaning the injury must have "arisen out of" and "in the course of" employment. If an accidental injury is connected with any of the incidents of one's employment, then the injury both would "arise out of" and be "in the course of" employment. The "arising out of" and the "in the course of" tests should not be kept in separate compartments but should be merged into a single concept of "work connection." *Northern Corp. v. Saari*, 409 P.2d 845, 846 (Alaska 1966).

> **AS 23.30.095. Medical treatments, services, and examinations.**
> (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. However, if the condition requiring treatment, apparatus, or medicine is a latent one, the two-year period runs from the time the employee has knowledge of the nature of the employee's disability and its relationship to the employment and after disablement. It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is

> indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require. . . .
>
> **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 . . . .
>
> (b) If delay in giving notice is excused by the board under AS 23.30.100(d)(2), the burden of proof of the validity of the claim shifts to the employee notwithstanding the provisions of (a) of this section.

Under AS 23.30.120(a), benefits sought by an injured worker are presumed to be compensable, and the burden of producing evidence is placed on the employer. *Sokolowski v. Best Western Golden Lion Hotel*, 813 P.2d 286, 292 (Alaska 1991). The Alaska Supreme Court held the presumption of compensability applies to any claim for compensation under the Act. *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996); *Carter* at 665. An employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski* at 292.

A three-step analysis is used to determine the compensability of a worker's claim. At the first step, the claimant need only adduce "some" "minimal" relevant evidence establishing a "preliminary link" between the injury claimed and employment. *McGahuey v. Whitestone Logging, Inc.,* 262 P.3d 613, 620 (Alaska 2011); *Smith v. Univ. of Alaska, Fairbanks,* 172 P.3d 782, 788 (Alaska 2007); *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.,* 742 P.2d 239, 244 (Alaska 1987). The evidence necessary to attach the presumption of compensability varies depending on the claim. In claims based on highly technical medical considerations, medical evidence is often necessary to make that connection. *Burgess Construction Co. v. Smallwood,* 623 P.2d 312, 316 (Alaska 1981). In less complex cases, lay evidence may be sufficiently probative to establish causation. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Witness credibility is not weighed at this step in the analysis. *Resler v. Universal Services Inc.*, 778 P.2d 1146, 1148-49 (Alaska 1989).

At the second step, once the preliminary link is established, the employer has the burden to overcome the presumption with substantial evidence. *Kramer* at 473-74, quoting *Smallwood* at

316. To rebut the presumption, an employer must present substantial evidence that either (1) something other than work was the substantial cause of the disability or need for medical treatment or (2) that work could not have caused the disability or need for medical treatment. *Huit v. Ashwater Burns, Inc.*, 372 P.3d 904 (Alaska 2016). "Substantial evidence" is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Tolbert v. Alascom, Inc*., 973 P.2d 603, 611-12 (Alaska 1999). At the second step of the analysis, the employer's evidence is viewed in isolation, without regard to the claimant's evidence. Issues of credibility and evidentiary weight are deferred until after a determination whether the employer has produced a sufficient quantum of evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051, 1054 (Alaska 1994); *Wolfer* at 869-870.

If the presumption is raised but not rebutted, the claimant prevails and need not produce further evidence. *Williams v. State*, 938 P.2d 1065, 1075 (Alaska 1997). If the employer successfully rebuts the presumption, it drops out, and the employee must prove all elements of his case by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381. At this last step of the analysis, evidence is weighed and credibility considered. To prevail, the claimant must "induce a belief" in the minds of the fact finders the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). The presumption does not apply if there is no factual dispute. *Rockney v. Boslough Construction Co.*, 115 P.3d 1240 (Alaska 2005). In *Buchinsky v. ARC of Anchorage*, (Memorandum Decision) (Alaska, May 25 ,2016), noted that it had previously rejected arguments that continuing pain following a work-related injury invariably leads to the conclusion that the work-related incident caused the pain.

> **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. When the board advises that a claim has not been controverted, but further advises that bona fide legal services have

> been rendered in respect to the claim, then the board shall direct the payment of the fees out of the compensation awarded. In determining the amount of fees the board shall take into consideration the nature, length, and complexity of the services performed, transportation charges, and the benefits resulting from the services to the compensation beneficiaries.
>
> (b) If an employer fails to file timely notice of controversy or fails to pay compensation or medical and related benefits within 15 days after it becomes due or otherwise resists the payment of compensation or medical and related benefits and if the claimant has employed an attorney in the successful prosecution of the claim, the board shall make an award to reimburse the claimant for the costs in the proceedings, including reasonable attorney fees. The award is in addition to the compensation or medical and related benefits ordered.

Attorney fees in workers' compensation cases should be fully compensatory and reasonable so injured workers have competent counsel available to them. *Cortay v. Silver Bay Logging*, 787 P.2d 103, 108 (Alaska 1990). An employee is entitled to attorney fees when the attorney is instrumental in inducing an employer to voluntarily but belatedly pay benefits. *Childs v. Copper Valley Elec. Ass'n*, 860 P.2d 1184, 1190 (Alaska 1993).

> **AS 23.30.155. Payment of compensation.**
> (a) Compensation under this chapter shall be paid periodically, promptly, and directly to the person entitled to it, without an award, except where liability to pay compensation is controverted by the employer. . . ..
>
> (b) The first installment of compensation becomes due on the 14th day after the employer has knowledge of the injury or death. On this date all compensation then due shall be paid. Subsequent compensation shall be paid in installments, every 14 days, except where the board determines that payment in installments should be made monthly or at some other period.
> . . . .
>
> (d) If the employer controverts the right to compensation, the employer shall file with the division and send to the employee a notice of controversion on or before the 21st day after the employer has knowledge of the alleged injury or death. If the employer controverts the right to compensation after payments have begun, the employer shall file with the division and send to the employee a notice of controversion within seven days after an installment of compensation payable without an award is due. . . .
>
> (e) If any installment of compensation payable without an award is not paid within seven days after it becomes due, as provided in (b) of this section, there shall be added to the unpaid installment an amount equal to 25 percent of the

> installment. This additional amount shall be paid at the same time as, and in addition to, the installment, unless notice is filed under (d) of this section or unless the nonpayment is excused by the board after a showing by the employer that owing to conditions over which the employer had no control the installment could not be paid within the period prescribed for the payment. The additional amount shall be paid directly to the recipient to whom the unpaid installment was to be paid.
> . . . .
>
> (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.

A controversion notice must be filed "in good faith" to protect an employer from a penalty under AS 23.30.155(e) or to avoid referral to the Division of Insurance under AS 23.30.155(o). *Harp v. ARCO Alaska, Inc.*, 831 P.2d 352, 358 (Alaska 1992). "In circumstances where there is reliance by the insurer on responsible medical opinion or conflicting medical testimony, invocation of penalty provisions is improper." *See also* 3 A. Larson, *Larson's Workmen's Compensation Law* § 83.41(b)(2) (1990) ("Generally a failure to pay because of a good faith belief that no payment is due will not warrant a penalty."). "For a controversion notice to be filed in good faith, the employer must possess sufficient evidence in support of the controversion that, if the claimant does not introduce evidence in opposition to the controversion, the Board would find that the claimant is not entitled to benefits." *Harp* at 358.

In *Moretz v. O'Neill Investigations,* 783 P.2d 764, 765 (Alaska 1989), the Court addressed interest in workers' compensation cases:

> The applicable rule is that "a workers' compensation award, or any part thereof, shall accrue lawful interest . . . from the date it should have been paid." *Land & Marine Co. v. Rawls,* 686 P.2d 1187, 1192(Alaska 1984). In *Rawls,* we noted that . . . "the economic fact that money awarded for any reason is worth less the later it is received" cannot be overlooked. *Id.* Judgment creditors, including workers' compensation claimants, are entitled to the time value of the compensation for their injuries. *Id.*

> **AS 23.30.180. Permanent total disability.**
> (a) In case of total disability adjudged to be permanent 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the total disability. If a permanent partial disability award has been made before a permanent total disability determination, permanent total disability

> benefits must be reduced by the amount of the permanent partial disability award, adjusted for inflation, in a manner determined by the board.
>
> **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.
>
> **AS 23.30.395. Definitions.**
> In this chapter,
> . . . .
>
> (16) "disability" means incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment;
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> (28) "medical stability" means the date after which further objectively measurable improvement from the effects of the compensable injury is not reasonably expected to result from additional medical care or treatment, notwithstanding the possible need for additional medical care or the possibility of improvement or deterioration resulting from the passage of time; medical stability shall be presumed in the absence of objectively measurable improvement for a period of 45 days; this presumption may be rebutted by clear and convincing evidence;

"Once an employee is disabled, the law presumes that the employee's disability continues until the employer produces substantial evidence to the contrary." *Runstrom v. Alaska Native Medical Center*, 280 P.3d 567, 573 (Alaska 2012) citing *Grove v, Alaska Constructors & Erectors*, 948 P.2d 454, 458 (Alaska 1997).

ANALYSIS

1. Is Employee's May 28, 2003 work injury a substantial factor in her subsequent disability or need for medical care?

The presumption analysis under AS 23.30.120 applies to the question of whether an injury is a substantial factor in an employee's disability or need for treatment. To attach the presumption, an employee must first establish a preliminary link between his or her injury and the employment. The preliminary link requires only "some," or "minimal," relevant evidence. In complex medical cases, medical evidence may be needed to establish the link, but in simpler cases lay evidence is sufficient. In determining whether the presumption is met, credibility of the evidence is not considered. If the employee successfully raises the presumption, the employer is required to produce evidence to rebut it. Again, at this stage, credibility is not considered. If employee raises the presumption and the employer does not rebut it, the employee prevails. If the employer successfully rebuts the presumption, the employee must establish his case by a preponderance of the evidence.

Without regard to conflicting evidence, and without considering credibility, Employee raised the presumption through the opinions of Drs. McIntosh and Weiss. In her March 4, 2014 chart note, Dr. McIntosh stated the 2003 injury was a substantial cause of Employee's ongoing disability and need for medical treatment. In his December 29, 2016 chart note, Dr. Weiss stated Employee was initially injured in 2003, and that injury was exacerbated by the 2007 injury, and at hearing he testified the 2003 injury could have been the origin of Employee's SI joint dysfunction.

Because Employee raised the presumption, Employer was required to rebut it. It did so with through the opinions of Dr. Fuller. In his January 2014 report and in his hearing testimony, Dr. Fuller opined the 2003 injury was a strain that resolved in four to six weeks, and it was not a substantia factor in Employee's need for medical treatment after 2007.

Because Employer rebutted the presumption of compensability, Employee had to prove by a preponderance of the evidence that the 2003 work injury remains a substantial factor in her current disability or need for medical treatment. At this step, credibility and contrary evidence are considered. Dr. McIntosh's opinion regarding the 2003 injury is given no weight, given her testimony at hearing that she had been confused the 1999 and 2003 injuries and that she could not

offer an opinion regarding the 2003 injury. Dr. Weiss's opinion is given little weight. His opinion that the 2003 injury could have been the origin of Employee's SI joint injury was based on Employee's reports she continued to have symptoms between 2003 and 2007. However, in her February 20, 2011 deposition, Employee testified she had not treated since shortly after the injury, and had not had any backaches. Dr. Fuller's January 21, 2014 report and his hearing testimony were that Employee had only a minor strain that resolved within four to six weeks. Dr. Fuller's explanation is consistent with Employee's deposition testimony, and is given the most weight. Employee did not prove the 2003 injury remained a substantial factor in her disability or need for medical treatment by a preponderance of the evidence.

2. Is Employee's January 30, 2007 work injury the substantial cause of her subsequent disability or need for medical care?

It is undisputed that Employee suffered a compensable injury on January 30, 2007; Employer accepted the claim and paid benefits. The issue is whether the injury remained the substantial cause of Employee's disability or need for medical treatment after February 28, 2008, when Employer controverted further benefits.

Without regard to conflicting evidence, and without considering credibility, Employee raised the presumption through the opinions of Drs. McIntosh, Weiss, and Humphreys. In response to Employee's March 18, 2009 letter, Dr. Weiss stated the 2007 injury was the substantial cause of her need for the SI fusion and her disability, and he restated that opinion in his hearing testimony. On August 26, 2009, Dr. McIntosh disagreed with Dr. Lipon's opinion that the SI joint dysfunction was not caused by the work injury, and on January 23, 2014, she opined the "cascade" of surgeries Employee had undergone was due to the work injury. On June 11, 2014, Dr. Humphreys stated the 2007 injury was "a substantial injury."

Because Employee raised the presumption, Employer was required to rebut it. It did so with through the opinions of Dr. Dietrich, Dr. Fuller, Dr. Lipon, and Dr. Sheorn. In his July 19, 2008 EME report, Dr. Dietrich stated Employee's low back condition was not related to the 2007 work injury. In his July 11, 2009 SIME report, Dr. Fuller stated Employee's lumbar condition was due to preexisting degenerative changes and her SI joint dysfunction was not caused by the 2007

injury. On December 10, 2007, Dr. Fuller concluded that neither Employee's low back nor SI complaints were due to the 2007 work injury. And on August 5, 2015, Dr. Sheorn opined Employee's disability and need for medical treatment was due to a preexisting psychological condition.

Because Employer rebutted the presumption of compensability, Employee had to prove by a preponderance of the evidence that the 2007 work injury remains the substantial cause of her current disability or need for medical treatment. At this step, credibility and contrary evidence are considered.

Dr. McIntosh's conclusions are given little weight. By repeatedly incorporating Employee's statements as her own chart notes, apparently without proofreading, Dr. McIntosh moved from the realm of medical provider to advocate. Additionally, Dr. McIntosh was inexplicably resistant to the recommendations of other doctors, including specialists, that Employee should have a psychological or psychiatric evaluation. Before Employee was seen by Dr. Bock, on eight occasions doctors suggested Employee had a functional overlay or there was a psychiatric component to Employee's complaints, and Employee's husband had stated there might be an emotional component to Employee's complaints. Most significantly, in 2007 Dr. Levine's testing showed such significant functional abnormalities that he wrote to Dr. McIntosh expressing his concerns, but Dr. McIntosh did nothing to follow up.

Dr. Weiss's opinions are given relatively little weight. At his 2010 deposition, Dr. Weiss explained diagnosis of SI dysfunction was based on symptoms, the patient's reports of pain. He noted that Employee's symptoms had been "hard to explain physiologically," transient, and inconsistent. Nevertheless, his decision to proceed with the 2008 SI fusion was based solely on Employee's subjective reports of pain. After reviewing Employee's CT scan in 2010, Dr. Weiss stated the fusion was solid, and the SI joints were not the source of Employee's problem. At hearing, he was unable to identify anything that had changed since 2010, yet he proceeded with the revision surgery in 2016. Additionally, Dr. Weiss appeared quite willing to revise his diagnoses at Employee's urging. On August 3, 2016, he recommended proceeding with surgery, but noted Employee exhibited a significant psychogenic overlay. On September 21, 2016 he

noted he had received Dr. Bock's and Dr. Craig's reports, presumably from Employee, and on January 11, 2017, he determined his August 3, 2016 diagnosis was in error. He gives no explanation for the delay in changing the diagnosis, and does not explain why Dr. Bock's 2011 report negates his 2016 diagnosis.

Dr. Humphreys' opinion as to causation is given little weight. His June 11, 2014 opinion on causation was made after reviewing records with Employee. He concluded that the 2007 injury was substantial because Employee had not gotten better with conservative care and "no other cause was noted." It is unknown what records Dr. Humphreys reviewed with Employee, but given his conclusion, it is unlikely the records included any of those suggesting a psychological or emotional component to Employee's complaints.

Dr. Craig's opinion is given little weight as it appears to be based on limited information. Dr. Craig reported Employee described all seven spinal surgeries after her 2000 cervical fusion as "helpful." This conflicts with the pain diagrams, which, are essentially unchanged since 1999, although they show some variations over time. It is also unclear whether Dr. Craig was told the relief was short-lived in every case. While Dr. Craig reported receiving a "fairly thick stack" of medical records, the only one he specifically identified was Dr. Bock's report. He did not mention any of the reports from providers that suspected Employee had psychological problems.

Dr. Bock's report is of little help in determining the issue of causation. She specifically stated purpose of the evaluation was to ascertain whether Employee understood the risks and potential complications of her proposed surgery; she did not indicate it was intended to diagnose any psychological or psychiatric conditions Employee may have had. Additionally, she had little of Employee's medical history. Dr. Bock notes she relied on "a" medical report from Dr. McIntosh listing Employee's diagnosed conditions and the history given by Employee. There is no indication the medical report provided by Dr. McIntosh included the fact several doctors had diagnosed psychological or functional problems. Dr. Bock's report of Employee's history omits Employee's 2008 SI fusions, and misstates Dr. Stinson's recommendations as to surgery.

Dr. Fuller's opinions are given more weight. Only he and Dr. Lipon reviewed the bulk of Employee's medical records. He noted that other than vague references to back pain, Employee did not mention low back or SI pain to her doctors until September 20017, eight months after the injury. Although Dr. McIntosh attributed the failure to mention low back pain to "masking" by Employee's cervical pain, Employee completed a pain diagram on May 8, 2007 that reported "tightness" in her jaws, but no low back or SI pain. If Employee's cervical pain did not mask tightness in her jaws, it is unlikely it masked the pain from a significant low back or SI injury. Dr. Fuller's observation is more consistent with the evidence than is Dr. McIntosh's. Dr. Fuller's observation that Employee had a pattern of switching complaints from one body part to another after testing, and the numerous tests that had been done had failed to show an organic basis for Employee's complaints is consistent with Employee's medical history.

Dr. Lipon's opinions as to Employee's physical condition are given the most weight. As the Board's expert, he is independent of the parties, and, as noted, he reviewed the bulk of Employee's medical records. In his July 11, 2009 report, after reviewing Employee's medical records, he concluded the cause of the need for treatment in her lumbar spine was preexisting degenerative changes that were not aggravated by the 2007 injury, and he ruled out the work injury at the cause of Employee's SI joint complaints given the length of time after the injury before Employee first reported pain. He reiterated other doctors' concerns of a possible functional overlay.

Dr. Sheorn's opinion is given significant weight as her diagnosis of factitious disorder or Munchausen's syndrome is highly consistent with Employee's history. An analysis shows all of the warning signs Dr. Sheorn identified are present in Employee's case:

- Dramatic but inconsistent medical history.

The record is replete with examples. Beginning in 1999, Dr. Levine noted Employee had a different presentation than her medical records indicated. In 2000, Dr. Stage noted Employee's presentation could be fibromyalgia, but her symptoms were more severe that typical and the normal fibromyalgia tender points were absent. In 2007, Dr. Levine's testing showed Employee was reporting symptoms comparable to a non-patient, but perceived herself as having a limited capacity. Even Dr. Weiss noted Employee's symptoms were hard to explain physiologically,

giving the example of pain extending into Employee's feet when there was no evidence of radiculopathy or neuropathy.

- Unclear symptoms that are not controllable, become more severe, or change once treatment has begun.

Despite a cervical fusion, two bilateral SI joint fusions, two artificial disc replacements, a three-level lumbar fusion, the pain complaints on Employee's May 31, 2017 pain diagram are essentially the same areas, but worse than as those shown on her November 30, 1999 pain diagram. Employee's symptoms have not been controlled by the surgeries. Dr. Fuller noted Employee has a pattern of switching complaints from one body part to another after testing failed to show an organic basis for the complaint.

- Predictable relapses following improvement in the condition.

Employee reported to Dr. Craig that she had felt an improvement after each of her surgeries, although she failed to tell him that in every case she had a relapse. And despite Employee's assertion the 2016 SI revision surgery provided relief, her May 31, 2017 pain diagram shows her complaints have returned.

- Extensive knowledge of hospitals and/or medical terminology, as well as the textbook descriptions of illness.

Employee is a physical therapist, who Dr. McIntosh noted has done extensive research into her conditions.

- Presence of many surgical scars.

While there is no evidence as to the scars themselves, there is abundant evidence as to Employee's many surgeries.

- Appearance of new or additional symptoms following negative test results.

As Dr. Fuller noted in his December 7, 2010 report, after Employee's cervical fusion, she switched to low back complaints. When imaging and testing were normal, she switched to her SI joints. After the 2008 SI fusion, she switched back to her lumbar spine. After two disc replacements and a three-level fusion, she switched back to her SI joints.

- Presence of symptoms only when the patient is alone or not being observed.

Although Employee reported subjective complaints to the medical providers, there was little objective evidence to support those complaints. The reports in Employee's journal, as well as

many of her reports to providers about her activities of daily living occurred while Employee was alone.

- Willingness or eagerness to have medical tests, operations, or other procedures.

On several occasions Employee asked for additional MRIs, CT scans, or discograms, either because she believed earlier ones were inaccurate or because she believed she had determined the source of her pain.

- History of seeking treatment at many hospitals, clinics, and doctors' offices, possibly in different cities.

In addition to Alaska, Employee has been seen by doctors in Seattle, Washington, Portland, Oregon, Atlanta, Georgia, Los Angeles, California, and in Germany.

The preponderance of the evidence is that the January 30, 2007 injury is not the substantial cause of Employee's disability or need for medical treatment after January 28, 2008. It is important to note that the hearing panel is not diagnosing, or confirming any diagnoses of, Employee. The panel lacks the education and training to do so. In complex medical cases, such as this one, the panel's task is to determine which medical opinion or opinions best correlate with and explain the evidence in the record.

3. If either the 2003 or 2007 work injuries is the cause of Employee's disability or need for medical treatment, to what benefits is Employee entitled?

To be entitled to benefits for an injury that occurred prior to 2005, an employee must show the injury is a substantial factor in his or her disability or need for medical treatment. To be entitled to benefits for an injury occurring after 2005, an employee must show the injury was the substantial cause of his or her disability or need for medical treatment. Employee did not establish that the 2003 injury was a substantial factor or that the 2007 injury was the substantial cause of disability or her need for medical treatment. Consequently, Employee is not entitled to further benefits.

CONCLUSIONS OF LAW

1. Employee's May 28, 2003 work injury is not a substantial factor in her subsequent disability or need for medical care.

2. Employee's January 30, 2007 work injury is not the substantial cause of her subsequent disability or need for medical care after January 28, 2008.

3. Because neither the 2003 or 2007 work injuries are the cause of Employee's disability or need for medical treatment, she is not entitled to any further benefits.

ORDER

Employee's October 22, 2008 and August 9, 2013 claims are denied.

Dated in Anchorage, Alaska on November 21, 2017.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Ronald P. Ringel, Designated Chair

/s/
Linda Murphy, 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 CHARLAYNE W. O'BRIEN, employee / claimant; v. CENTRAL PENINSULA GENERAL HOSPITAL, employer; WAUSAU UNDERWRITERS INSURANCE COMPANY, and ALASKA NATIONAL INSURANCE COMPANY insurers / defendants; Case Nos. 200308494 and 200701733; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on November 21, 2017.

/s/
Elizabeth Pleitez, Office Assistant