ALASKA WORKERS' COMPENSATION BOARD

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

JERI L. CLIFTON, Employee, Claimant,	)	FINAL DECISION AND ORDER
v.	)	AWCB Case No. 200801738
STATE OF ALASKA, Self-Insured Employer, Defendant.	)	AWCB Decision No.15-033 Filed with AWCB Anchorage, Alaska on March 17, 2015

Jeri L. Clifton's January 20, 2010 claim was heard February 25, 2015 in Anchorage, Alaska. This hearing date was selected on December 4, 2014. Ms. Clifton (Employee) appeared, represented herself, and testified. Assistant Attorney General Jayme Keller appeared and represented the State Of Alaska (Employer). No witnesses testified. The record closed at the hearing's conclusion on February 25, 2015.

ISSUES

Employer filed a petition to continue the hearing. Employee opposed a continuance and objected to Employer's late-filed medical reports. After Employee waived her right to cross-examine the authors of the medical reports, the designated chair allowed the reports into evidence and orally denied the continuance.

1. Were the oral rulings admitting the reports and denying the continuance correct?

Although the prehearing conference summary identified the specific benefits Employee is seeking as the issues for the hearing, the parties agreed that the threshold issue was whether the

February 5, 2008 work injury is the substantial cause of Employee's disability or need for medical treatment.

2. Is the February 5, 2008 work injury the substantial cause of Employee's disability or need for medical treatment?

Employee contends she is entitled to permanent total disability (PTD) benefits, medical costs after November 2, 2009, and lost wages because of the work injury. Employer contends Employee is not entitled to the requested benefits because the work injury is no longer the substantial cause of her disability or need for medical treatment.

3. If work is the substantial cause of Employee's disability and need for medical treatment, is Employee entitled to PTD benefits, medical costs, and lost wages?

FINDINGS OF FACT

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

1. On January 21, 2000, Employee was diagnosed with influenza and prescribed an antiviral medication and Percocet. (Hillside Family Medicine, Chart Note, January 21, 2000).
2. On April 4, 2000, Employee was seen for abdominal pain and was prescribed Percocet. Although it is unclear when first prescribed, on July 11, 2000, her prescription of Vicodin was renewed. On August 1, 2000, she was again given a prescription for Percocet. The abdominal pain resolved after removal of Employee's gall bladder in August, 2000. (Hillside Family Medicine, Chart Notes, April 4, July 11, August 1, and December 14, 2000).
3. On March 12, 2001, Employee reported she had painful tingling (paresthesia) in her left hand and face for about two weeks. (Hillside Family Medicine, Chart Notes, April 4, 2001). She was diagnosed with a right thalamic infarct (a stroke). (Neurological Consultants, Chart Note, April 11, 2001).
4. On January 1, 2002, Employee was pulled forward when walking her dog. She was diagnosed with low back strain and prescribed Vicodin. (First Care, Chart Note, January 3, 2002).

5. On February 5, 2004, Employee broke her ankle in a fall from a pickup truck. Employee underwent open reduction internal fixation surgery at Providence Alaska Medical Center (PAMC), in which plates and screws were implanted to secure the fracture. (PAMC, Procedure Report, February 5, 2005). Employee was prescribed Percocet and Oxycodone. (PAMC, Physician's Orders, February 5, 2004).
6. On February 16, 2004, Employee followed up with her surgeon, Jeffrey Moore, M.D., who noted Employee still suffered discomfort that improved somewhat with pain pills. Dr. Moore released Employee to light-duty work. (Dr. Moore, Chart Note, Work Release, February 16, 2004).
7. On March 15, 2004, Dr. Moore extended the light-duty work restriction and renewed the prescription for Employee's pain medication. (Dr. Moore, Work Release, Prescriptions, March 15, 2004).
8. On April 26, 2004, Dr. Moore released Employee to work without restriction. (Dr. Moore, Work Release, April 26, 2004).
9. On May 24, 2004, Employee reported persistent pain in her ankle, and was prescribed Vicodin. (Hillside Family Medicine, Chart Note, May 24, 2004).
10. On August 11, 2004, Employee returned to Dr. Moore, reporting significantly increased pain in the last two weeks. She reported taking Motrin for the pain with minimal relief. (Dr. Moore, Chart Note, August 11, 2004).
11. Also on August 11, 2004, Employee was seen at Hillside Family Medicine where she was prescribed Vicodin for the ankle pain. (Hillside Family Medicine, Chart Note, April 11, 2004).
12. On October 18, 2004, Employee underwent surgery to remove the hardware from her ankle. (Alaska Surgery Center, October 18, 2004).
13. On November 11, 2004, Employee was diagnosed with acute withdrawal from narcotics, and it was noted she had a similar problem ten years earlier. (Hillside Family Medicine, Chart Note, November 11, 2004).
14. On December 12, 2004, Employee went to PAMC emergency room stating she had twisted her right ankle the day before. There was a little bit of bruising and no swelling. She was given morphine in the emergency room and a prescription for Percocet. (PAMC, Emergency Room Report, December 12, 2004).

15. On January 8, 2005, Employee returned to Hillside Family Medicine to discuss stress and sadness. She stated she had struggled with various medical conditions including "an addiction to pain medication." She was diagnosed with severe depression and referred to Anne Marie Zack, ANP. (Hillside Family Medicine, Chart Note, January 8, 2005).
16. On June 3, 2005, Employee's daughter called ANP Zack concerned about Employee's alcohol abuse. (Zack, Progress Note, June 3, 2005).
17. On August 2, 2005, Employee was hospitalized after an attempted suicide. Employee was unresponsive, but was accompanied by her daughter, who reported Employee had a problem with prescription pain medications and had shown narcotic seeking behavior as long as the daughter could remember. Employee had ingested multiple psychiatric medications and alcohol. (PAMC, History and Physical, August 2, 2005).
18. Employee declined the inpatient care recommended by her doctor. (Employee letter to Eric Taylor, M.D., August 4, 2005). Employee was discharged on August 8, 2005 and instructed to take no narcotics and no alcohol. (PAMC, Discharge Instructions, August 8, 2005).
19. On November 18, 2006, Employee lost her balance and fell while walking her dog, landing on her buttocks. An x-ray and a CT scan showed a burst fracture of the T-12 vertebra. (PAMC Emergency Admit Report, November 18, 2006). The x-ray report makes no mention of Employee's coccyx. (PAMC, Radiology Consult, November 18, 2006). Employee was given narcotics while hospitalized and was fitted with a TLSO (Thoracic-Lumbar-Sacral Orthosis). (PAMC, Notes, November 18 – 24, 2006). On discharge, Employee was prescribed Percocet. (PAMC, Discharge Instructions, November 24, 2006).
20. Employee was referred to Upshur Spencer, M.D. On December 13, 2006, Dr. Spencer noted Employee had called on a number of occasions for more pain medication, but he was trying to wean her off. (Dr. Spencer, Initial Office Visit, November 29, 2006; Chart Note, December 13, 2006).
21. On March 14, 2007, Employee was seen by William Campbell, M.D., for a psychiatric disability evaluation for Social Security. She was diagnosed with major depressive disorder and dependent personality disorder. (Dr. Campbell, Disability Evaluation, March 14, 2007).
22. On March 16, 2007, Employee returned to Dr. Spencer for a follow-up exam. She complained her left shoulder had been painful for a couple of months. Dr. Spencer determined the T-12 burst fracture was stable and likely healed. He diagnosed left shoulder

arthritis. Dr. Spencer noted Employee requested narcotic pain medicines, and he told her he did not want her taking them for a variety of reasons. (Dr. Spencer, Chart Note, March 16, 2007).

23. On February 5, 2008 while working for Employer, Employee tripped over a purse in her work area, fell back against a desk and landed on the floor. She worked the remainder of the day. Employee was age 57 at the time of the injury. (Report of Injury, February 13, 2008).
24. On February 7, 2008 Employee went to the PAMC emergency room. She stated she had mild chronic back pain since the T-12 burst fracture, but since her fall two days before, the pain was worse. She described the pain as being in her lower lumbar region. She was given morphine, and x-rays were taken and compared with earlier x-rays. No new abnormalities were noted. Employee was discharged with Vicodin. (PAMC, Emergency Report, February 7, 2008).
25. On March 3, 2008, Employee returned to Hillside Family Medicine for follow-up. She was prescribed Vicodin. (Hillside Family Medicine, Chart Note, March 3, 2008).
26. On March 24, 2008, Employee was again referred to Dr. Spencer. (Hillside Family Medicine, Chart Note, March 24, 2008).
27. On March 31, 2008, Employee was seen by PA-C Colin Hickenlooper. Employee reported that after her fall on February 5, 2008, she had left-sided pain from her low back through her left hip and thigh to the back of her knee. (Orthopedic Physicians Anchorage (OPA), Chart Note, March 31, 2008). An MRI of Employee's thoracic and lumbar spine showed no acute traumatic changes. (Diagnostic Imaging of Alaska, MRI Report, March 31, 2008).
28. On April 3, 2008, Employee went to PAMC emergency room with complaints of left back and buttock pain. She explained the February 5, 2008 fall and that she was taking Vicodin. She was given Dilaudid for the pain and discharged. (PAMC, Emergency Report, April 3, 2008).
29. On April 4, 2008, Employee returned to PA-C Hickenlooper, who prescribed physical therapy and renewed Employee's Vicodin prescription. (OPA, Chart Note, April 4, 2008).
30. On April 23, 2008, Employee completed a pain diagram for the physical therapist. The diagram shows pain from the left buttock down the back of the leg to the ankle, but does not

indicate any pain in the area of the coccyx (tailbone). (United Physical Therapy, Intake Sheet, April 23, 2008).

31. Employee was referred to Advanced Medical Centers of Alaska by PA-C Hickenlooper. On May 5, 2008, she filled out a pain diagram that showed aching pain in her shoulders and upper back, a slight burning pain in the area of her tailbone, and significant stabbing pain from just above her left buttock down the left leg to the ankle. (Advanced Medical Centers of Alaska, Patient Information, May 5, 2008). Employee was seen by ANP Deborah Kiley, who diagnosed a bulging disc alt L4-L5. (Advanced Medical Centers of Alaska, Chart Note, May 5, 2008).
32. On May 12, 2008, Employee was seen by Lawrence Stinson, M.D., at Advanced Pain Centers of Alaska. Employee completed another pain diagram that again showed significant stabbing pain above her right buttock radiating down her right leg, but no tailbone pain. Dr. Stinson diagnosed lumbar degenerative disc disease and coccydynia (tailbone pain). He discussed epidural steroid injections with Employee. (Advanced Pain Centers, Progress Note, May 12, 2008).
33. On May 14, 2008, Dr. Stinson performed a caudal epidural steroid injection, a sacrococcygeal ligament injection and a ganglion impar injection. (Advanced Medical Centers of Alaska, Procedure Note, May 14, 2008).
34. On May 20, 2008, Employee went to the PAMC emergency room. She complained her pain had been much worse since the injections six days before. She had taken oxycodone without improvement. She was given a Demerol injection and told to follow up with Dr. Stinson. (PAMC, Emergency Report, May 20, 2008).
35. On June 2, 2008, Employee returned to Dr. Stinson. She explained that her pain had increased after the injections, but she now had less back pain with significantly less leg and tailbone pain. She reported that the TENS (transcutaneous electrical nerve stimulation) unit the physical therapist provided had helped with her back pain. Employee completed another pain diagram showing significantly less back and leg pain, but substantial pain in her tailbone. (Advanced Pain Centers, Progress Note, June 2, 2008).
36. On June 23, 2008, Employee was again seen by Dr. Stinson. She reported that although her symptoms had somewhat resolved after the injections, they had returned. She completed a pain diagram, showing significant pain in the lower back and tailbone area, and pain

radiating down her left leg. Dr. Stinson referred Employee to Anne Marie Zack. (Advanced Pain Centers, Progress Note, June 23, 2008).

37. On August 28, 2008, Employee had a pelvic CT scan that showed an old fracture at S-1. (Imaging Associates of Providence, Radiology Consultation, August 28, 2008).
38. On September 11, 2008, Employee was seen by PA-C Royce Morgan and James Eule, M.D. Both reviewed her clinical and radiographic findings, including the CT of the pelvis, and did not find any positive findings. Dr. Eule noted Employee's coccyx was significantly hooked, and may have had a previous fracture. He noted, however, that her tenderness was over the sacrum rather than the coccyx. They recommended MRIs of the brain and cervical spine and a neurological consult. (OPA, Chart Notes, September 11, 2008).
39. On November 18, 2008, Employee was again seen by Dr. Spencer. He diagnosed a potential sacrococcygeal injury secondary to the February 2008 fall, but stated the deformity in Employee's coccyx was apparent in the November 18, 2006 x-ray. He was unable to find an objective source for Employee's pain. He noted that a sacrococcygeal injury would be expected to "quiet down" over time, and Employee's injury had not. He did not recommend surgery. (Dr. Spencer, Physician's Report, November 18, 2008).
40. On March 10, 2009, Employee saw Dr. Eule. He noted Employee's pain was located in her low buttock. He stated it was unlikely the T-12 fracture was causing the pain, and she had no spinal stenosis that would account for the pain. He thought Employee might benefit from a spinal cord stimulator, and referred her to Franklin Ellenson, M.D., a neurologist. (OPA, Chart Note, March 10, 2009).
41. On April 16, 2009, Dr. Ellenson evaluated Employee. He recommended an EMG (electromyogram) and a nerve conduction study. He performed the tests on April 28, 2008. The EMG results were normal, but the nerve conduction studies showed mild peripheral neuropathy and peroneal nerve compression in the left ankle, but were otherwise normal. (Dr. Ellenson, Chart Notes, April 16 and April 28, 2008).
42. On May 5, 2009, Employee returned to Dr. Eule. He noted Dr. Ellenson's testing revealed nothing significant. Because of Employee's reaction to the metal implanted to repair her broken ankle, Dr. Eule expressed concerns about a spinal cord stimulator. (OPA, Chart Note, May 5, 2009).

43. On August 4, 2009, Employee was seen by Steven Johnson, M.D., a pain management specialist at AA Spine & Pain Clinic, for evaluation for a spinal cord stimulator. Dr. Johnson recommended a caudal block and bilateral sacroiliac injections before proceeding with a spinal cord stimulator. (Dr. Johnson, Chart Note, August 4, 2009).
44. The caudal block and sacroiliac injections were done on September 11, 2009. (Alaska Spine Center, Procedure Note, September 11, 2009).
45. On September 16, 2009, Employee called Dr. Johnson's office and reported she was having increased pain since the injections, and it felt like when she broke her back. She also had weakness in her legs, leading to falls. (Dr. Johnson, Message and Note, September 16, 2009).
46. On September 18, 2009, Dr. Johnson saw Employee. Employee stated she had doubled up on her pain medications. Dr. Johnson noted it was not clear whether Employee's pain was causing her falls or if the falls were causing the pain. He referred her for MRIs. (Dr. Johnson, Chart Note, September 18, 2009).
47. On September 21, 2009, Employee had the MRIs. The MRI of her pelvis showed her bones, joints and soft tissues were normal other than some minimal degenerative changes in her right hip. The MRI of her spine showed no changes since the March 31, 2008 MRI. (Diagnostic Health, MRI Reports, September 21, 2009).
48. Employee returned to Dr. Johnson on October 1, 2009. He reviewed the MRIs and continued Employee's prescription for Percocet. (Dr. Johnson, Chart Note, October 1, 2009).
49. On October 19, 2009, Employee was seen by orthopedic surgeon Douglas Bald, M.D., for an employer's medical evaluation (EME). Dr. Bald reviewed Employee's medical records since the February 5, 2008 injury. He stated her subjective pain complaints dramatically exceed the objective findings. He concluded Employee had suffered only a tailbone contusion and a musculoskeletal strain in the February, 5, 2008 injury, and she had reached medically stability. He opined the substantial cause of her current need for treatment was a combination of psychiatric/psychological factors. (Dr. Bald, EME Report, October 19, 2009).
50. On October 20, 2009, Employee was evaluated by Ronald Turco, M.D., for a psychiatric EME. Dr. Turco diagnosed major depressive disorder, chronic anxiety disorder, and passive

dependent personality disorder, all of which long predated and were unrelated to the February 5 2008 injury. Consequently, he concluded the work injury was not the substantial cause of her current need for treatment. (Dr. Turco, EME Report, October 22, 2009).

51. On October 21, 2009, Employee called Dr. Johnson's office stating she had increased pain from traveling to the EMEs, and requesting an early refill of her pain medication. (Dr. Johnson, Messages and Notes, October 21, 2009).
52. On November 3, 2009, Employer filed a controversion notice denying further medical treatment and disability benefits. The controversion was based on Dr. Bald's and Dr. Turco's EME reports. (Controversion Notice, November 2, 2009).
53. On November 19, 2009, Employee saw Dr. Johnson. He reviewed Dr. Bald's EME report and did not agree with his conclusions. He stated that even though the tailbone abnormality may have appeared on earlier x-rays, it was not causing any problems until the February 2008 work injury. Whether it resulted in a fracture or soft tissue injury, the fall in February 2008 resulted in ongoing pain. (Dr. Johnson, letter to Employer's adjuster, November 19, 2009).
54. On February 1, 2010, Employee filed a claim seeking a compensation rate adjustment and alleging Employer had unfairly or frivolously controverted benefits. (Claim, January 20, 2010).
55. On March 29, 2010, Dr. Johnson noted the pharmacy had called concerned about Employee's medications, and Employee had made an appointment because she was "self-escalating" and needed to change her pain medications. He called in a prescription to treat opioid withdrawal. (Dr. Johnson, Messages and Notes, March 29, 2010).
56. On March 31, 2010, Employee saw Dr. Johnson. She stated that due to her pain level she had increased her consumption of pain medications and asked if the prescribed dosage could be increased. Her prescription for OxyContin was increased, and her Percocet prescription was renewed. (Dr. Johnson, Chart Note, March 31, 2010).
57. On April 27, 2010, a prehearing conference was held. Employee amended her January 2010 claim to include medical costs and permanent total disability (PTD) benefits. Employee withdrew her claim for an unfair or frivolous controversion, and the parties resolved the compensation rate issue. (Prehearing Conference Summary, April 27, 2010).

58. On July 28, 2010, Employee forgot to take a pain pill and became increasingly anxious. Her husband noticed a left-sided facial droop and Employee had left shoulder pain that lasted about 15 minutes. He took her to the PAMC emergency room, where she was diagnosed with extreme anxiety and transient left facial weakness. She was given morphine and an anti-anxiety medication and referred to a neurologist. (PAMC Emergency Report, July 28, 2010).
59. On August 1, 2010, Employee was admitted to the PAMC psychiatric emergency department where she was diagnosed with acute onset psychosis and anxiety. Employee reported she had again missed her pain medication. She was placed in psychiatric observation and discharged the next day. (PAMC, Admission Order and Consult Report, August 1, 2010; PAMC, Discharge Instructions, August 2, 2010).
60. On August 19, 2010, Employee became quite agitated at ANP Zack's office, and was taken by paramedics to the PAMC emergency room. Employee's husband reported that Employee had been increasingly paranoid, making several calls to the police. She was diagnosed with psychosis and placed in psychiatric observation. (PAMC, Consult Report and Emergency Report, August 19, 2010).
61. An examination on August 20, 2010 concluded Employee's episodes of confusion, memory difficulties, paranoid ideation, and combativeness may be related to her pain medications. (PAMC, Consult Report, August 20, 2010).
62. On August 28, 2010, Employee became angry and agitated because she wanted her immediate release oxycodone to be given more frequently than prescribed. (PAMC, Progress Note, August 28, 2010).
63. On September 2, 2010, Laura Swogger, M.D. at PAMC spoke to Dr. Johnson. Dr. Johnson stated it was possible the opioid medications were contributing to her mental status changes. Dr. Swogger prescribed gabapentin, a non-opioid, as it can be used to treat chronic and neuropathic pain as well as anxiety. (PAMC, Progress Note, September 2, 2010).
64. Employee continued to take gabapentin until her discharge from PAMC on September 7, 2010 when she was given a 30 day supply. (PAMC, Discharge Record, September 27, 2010). No medical records indicate Employee had an allergy or other adverse reaction to the gabapentin. (Observation).

65. On September 21, 2010, Employee returned to Hillside Family Medicine where she was seen by Julie Wilson, M.D. Employee stated she was there for follow-up after her hospitalization in August and had been discharged a couple of weeks earlier. She stated she had been admitted for a stroke and had residual left-sided weakness and an inability to find words. After talking to Employee, Dr. Wilson reviewed the PAMC discharge summary and found she had been admitted for depressive psychosis and acute anxiety. Dr. Wilson concluded Employee's statement to her "was almost complete confabulation." (Hillside Family Medicine, Chart Note, September 21, 2010).
66. On September 27, 2010, Employee saw Dr. Johnson. She reported having some TIAs (transient ischemic attacks) and ended up in the hospital with what Dr. Johnson stated "sounds like perhaps being over medicated." Employee stated that on withdrawing from her medication in the hospital she had a stroke. Dr. Johnson continued Employee's prescription for MS Contin 100 mg, and Roxicodone, and added MS Contin 60 mg. There is no indication that Dr. Johnson reviewed any of the records from Employee's hospitalization. (Dr. Johnson, Chart Note, September 27, 2010).
67. On November 22, 2010, Dr. Johnson increased employees Roxicodone from two per day to three per day, and increased her MS Contin dosage from 260 mg per day to 300 mg per day. (Dr. Johnson, Chart Note, November 22, 2010)
68. On June 20, 2011, Employee was seen by Thomas Gritzka, M.D., an orthopedic surgeon, for a board-ordered second independent medical evaluation (SIME). Dr. Gritzka reviewed 2,152 pages of Employee's medical records going back to 1995. The only medical allergy disclosed by Employee was to penicillin. Relative to the February 2008 work injury, Dr. Gritzka diagnosed chronic sacroiliac joint sprain or fracture, chronic bilateral sacroiliac area pain, chronic pain syndrome, and psychological factors affecting Employee's physical condition. He explained that Employee's sacroiliac and sacrococcygeal pain was initially caused by the February 2008 accident, and the current pain was more probably than not due to either neuropathic pain or psychological factors. He noted Employee had a normal anatomic variant at the sacrococcygeal joint that preexisted the February 2008 accident. However, the accident aggravated and combined with the preexisting condition as the substantial cause of Employee's sacroiliac pain, which was, in turn, amplified by her psychiatric status. Dr. Gritzka noted, however that the best way to diagnose bilateral active

sacroiliitis and active coccydynia were with radioactive bone scans, and if the Employee had a radioactive bone scan that did not show increased activity it could be concluded she did not have active sacroiliitis. (Dr. Gritzka, SIME Report, June 20, 2011).

69. On September 30, 2011, Employee underwent surgery to have a spinal cord stimulator implanted. (PAMC, Operative Note, September 30, 2011).
70. On February 12, 2012, Employee had the radioactive bone scan suggested by Dr. Gritzka. (PAMC, Imaging Result Report, February 17, 2012).
71. On May 15, 2012, Dr. Gritzka revised his SIME report after reviewing the results of the February 12, 2012 bone scan. He stated the bone scan suggested Employee's tailbone and sacroiliac joints should no longer be causing pain. He no longer believed Employee had active sacroiliitis or active coccydynia, and concluded Employee had a chronic widespread pain or neuropathic pain independent of any sacroiliac or sacrococcygeal injury. (Dr. Gritzka, Supplemental SIME Report, May 15, 2012).
72. At some point Employee was prescribed a CPAP (continuous positive airway pressure) device for sleep apnea. (Alaska Medicare Clinic, Encounter Note, April 16, 2013).
73. On May 29, 2013, Employee was seen at AA Spine & Pain Clinic by Derek Hagen, D.O. She reported she would be going to her dentist for an extraction and root canal, but had breakthrough pain medication, and would inform her dentist of her pain management medications before any sedation was started. (Dr. Hagen, Chart Note, May 29, 2013).
74. On June 25, 2013, Employee reported she had had the dental surgery. (Alaska Medicare Clinic, Encounter Note, June 25, 2013).
75. On July 17, 2013, Employee was seen by Terri Berndt, PA-C, at the Lung and Sleep Clinic of Alaska to follow up on her sleep apnea. PA-C Berndt reported Employee was having a difficult time staying awake to answer questions. PA-C Berndt was able to determine Employee was not using her CPAP, and obtained a list of 15 medications Employee was taking. The list does not include Halcion, a sedative. Employee stated she had critical allergies to penicillin and gabapentin. PA-C Berndt's physical examination showed Employee's teeth were in good repair. PA-C Berndt and William Lucht, M.D., spoke with Employee and explained that with her pain medications and failure to use the CPAP, she could die in her sleep. Employee kept falling asleep as they were explaining this. (Alaska Lung & Sleep Clinic, Chart Note, July 18, 2013).

76. On July 17, 2013, PA-C Berndt called AA Spine & Pain Clinic, to inform them of Alaska Lung & Sleep Clinic's concerns that Employee was on too high a dosage of pain medications, and with her failure to use the CPAP, that she could die in her sleep. (AA Spine & Pain Clinic, Call Note, July 17, 2017).
77. On July 18, 2013, AA Spine & Pain Clinic called Employee to schedule an appointment to address PA-C Berndt's concerns. Employee was unable to come in that day because she had a dental appointment scheduled. (AA Spine & Pain Clinic, Call to Patient, July 18, 2013).
78. On July 25, 2013, Employee was seen by PA-C Jane Sonnenberg at AA Spine & Pain Clinic. PA-C Sonnenberg discussed the note from PA-C Berndt. Employee explained the dentist had given her Halcion to take before the procedure, which sedated her significantly. PA-C Sonnenberg discussed Employee's medications with Dr. Johnson, and switched to a lower dosage of OxyContin. (AA Spine & Pain Clinic, Progress Note, July 25, 2013). The medical records indicate Employee's dental surgery was in May 2013, and while she may have had a dental appointment on July 18, 2013, there is no indication she had oral surgery on July 17, 2013. (Observation).
79. On August 22, 2013, Employee returned to PA-C Sonnenberg. She was very upset with the reduction in her OxyContin. She stated she had withdrawal symptoms and was so miserable with pain she had not moved much from the couch. Her prescriptions for MS Contin and Roxicodone were increased. (AA Spine & Pain Clinic, Progress Note, August 22, 2013).
80. On November 11, 2013, Employee was again seen by PA-C Sonnenberg. Employee reported she had recently been taking more medication than prescribed. (AA Spine & Pain Clinic, Progress Note, November 11, 2013)
81. On December 9, 2013, Employee was seen by William Campbell, M.D., for a psychiatric SIME. Dr. Campbell reviewed Employee's medical history, noting the pain and psychological medications prescribed, and pointing out that at one point Employee was taking 300 mg per day of MS Contin, a very high dose. He diagnosed pain disorder associated with psychological factors and a medical condition, opiate dependence, sleep apnea, depressive disorder, and dependent personality disorder. He concluded the February 5, 2008 injury was not the substantial cause of Employee's disability or need for medical treatment. Her dependent personality disorder, opiate dependence, depression, and pain

disorder pre-existed the February 2008 injury, and the injury did not aggravate, accelerate, or combine with the preexisting conditions. He opined that psychological factors were causing 95 percent of Employee's pain disorder, and the February 2008 work injury was causing five percent. (Dr. Campbell, SIME Report, December 7, 2013).

82. On March 19, 2014, AA Spine & Pain Clinic received a telephone call from Alaska Medicare Clinic asking if they were aware Employee was overusing her medications. Employee's personal care assistant had done a pill count, and Employee was very low on the prescriptions she had recently refilled. (AA Spine & Pain Clinic, Overuse Phone Call, March 19, 2014).
83. On March 21, 2014, Employee called AA Spine & Pain Clinic stating she had been experiencing increased pain and had to take more of her medication. Employee asked for an appointment. (AA Spine & Pain Clinic, Note, March 21, 2014).
84. On May 14, 2014, Employee went to the PAMC for the third time in a week for nausea, diarrhea, and opioid withdrawal. (PAMC, Admission History, May 14, 2014). While in the emergency room, Employee refused a different opioid "tearfully stating 'I want to take my morphine. No one understands how serious this is, I can't eat, I can't sleep, I fall down because the pain so out of control.'" (PAMC, Emergency Notes, May 14, 2014).
85. On June 17, 2014, Employee was seen by Dr. Ellenson for a neurological SIME. In his review of Employee's medical records, Dr. Ellenson made no mention of his April 16, 2009, evaluation of Employee or the results of the EMG and nerve conduction study he performed on April 28, 2008. In his review of the medical records, Dr. Ellenson discussed Dr. Gritzka's June 20, 2011 SIME report, but made no mention of the subsequent bone scan or Dr. Gritzka's supplemental report. Dr. Ellenson's discussion did not address Employee, but referred to a 30 year old woman, who was treated at the Yukon-Kuskokwim Health Corporation for a stroke in 2011. Dr. Ellenson concludes the February 5, 2008 injury was the substantial cause of Employee's sacrococcygeal and bilateral sacroiliac joint pain. He stated she became medically stable when the spinal cord stimulator was implanted on September 30, 2011. (Dr. Ellenson, SIME Report, June 17, 2014).
86. On June 24, 2014, Employee's personal care assistant reported to AA Spine & Pain Clinic that Employee had been over-taking her medication. The personal care assistant had been concerned for some time about Employee's "pill-popping," and wanted to know why AA

Spine & Pain Clinic had not addressed the issue. (AA Spine & Pain Clinic, Telephone Note, June 24, 2014).

87. On November 10, 2014, Employee filed an affidavit of readiness for hearing (ARH) on her January 2010 claim. (ARH, November 5, 2014).
88. On December 4, 2014, a prehearing conference was held to schedule a hearing and to identify the issues. The issues for hearing were PTD, medical costs, and "lost wages." The hearing was set for February 25, 2015, and the parties agreed to file evidence by February 5, 2015, as required by 8 AAC 45.120. (Prehearing Conference Summary, December 4, 2014).
89. On December 22, 2014, Employer's adjuster wrote to Employee informing her that EMEs had been scheduled for January 10, 12, and 14, 2015. (Employer Letter to Employee, December 22, 2014).
90. On January 6, 2015, Employee filed a petition for a protective order asking that she not be required to attend the EMEs. (Petition, January 6, 2015).
91. On January 7, 2015, Employer filed an "emergency" request for a prehearing to address Employee's petition for protective order. (Prehearing Conference Request, January 7, 2015).
92. On January 12, 2015, Keyhill Sheorn, M.D., performed a psychiatric record review EME. She did not examine Employee. In her review, Dr. Sheorn counted the doses of opiates and psychiatric medications that had been prescribed to Employee: In 2008, Employee was prescribed 3,308 doses; in 2009, 4,240 doses; in 2010, 2,896 doses, in 2011, 3,464 doses; in 2012, 2,340 doses; in 2013, 3,000 doses; and in 2014, 2,823 doses. Dr. Sheorn noted that in January 2008, prior to the work injury, Employee had been prescribed 210 doses. She stated the most significant factor in Employee's need for treatment was drug abuse. (Dr. Sheorn, EME Report, January 12, 2015).
93. On January 14 2015, Dr. Bald performed a record review EME, examining Employee's medical records since his October 9, 2009 EME. He did not examine Employee. Dr. Bald's diagnoses remained unchanged, although he stated that with the later psychological evaluations, Employee's psychiatric disorders were better clarified. His opinion was that Employee's psychiatric disorder was by far the substantial cause of her disability and need for medical treatment. (Dr. Bald, EME Report, January 14, 2015).

94. Also on January 14, 2015, Lynne Bell, M.D., a neurologist, performed a records review EME. Dr. Bell diagnosed a history of T-12 burst fracture, history of cerebrovascular accident, multilevel lumbar degenerative disease, sacrococcygeal deformity, psychiatric history of depression and anxiety, and misuse of prescription narcotics/drug dependency, all of which preexisted the February 5, 2008 injury. She also diagnosed a lumbar strain and tailbone contusion related to the February 2008 work injury. She opined Employee had fully recovered from the work injury, and was medically stable by the time of Dr. Bald's EME on October 19, 2009. The substantial causes of her chronic pain were drug dependency or the inappropriate use of prescription medication to treat her emotional distress. (Dr. Bell, EME Report, January 14, 2015).
95. On January 20, 2015, a hearing was held on Employee's petition for protective order. (Record). On February 3, 2015, a decision and order was issued, affirming Employer's right to conduct the EMEs, denying Employee's petition and ordering her to attend the EMEs. The order directed the parties to confer on the scheduling of the EMEs. (*Clifton v. State of Alaska,* AWCB Decision No. 15-0016 (February 3, 2015).
96. It is not feasible to schedule, arrange travel for, conduct, and receive the written reports from three EMEs in two days. (Experience, Judgment).
97. On February 6, 2015, Employer filed Dr. Sheorn's January 12, 2015 EME report and Dr. Bald's January 14, 2014 EME report. (Record).
98. On February 11, 2015, Employer filed a petition to continue the February 25, 2015 hearing. Employer contended that although it had obtained record review EMEs, the date of the February 3, 2015 decision and order did not allow it to obtain the "physical examination" EMEs ordered in the decision. (Petition and Memorandum, February 11, 2015).
99. On February 13, 2015, Employer filed Dr. Bell's EME report. (Record).
100. On February 24, 2015, Employee filed an objection to any continuance of the February 25, 2015 hearing and to the consideration of any evidence filed after February 5, 2015. (Objection, February 24, 2015).
101. Employer's petition for a continuance and Employee's objection to the late-filed evidence were considered at the beginning of the February 25, 2015 hearing. Employer stated it was only seeking a continuance if the late-filed EME reports could not be considered, and contended the reports were not timely filed because of the delay due to Employee's petition

for protective order and the time required to issue the decision and order. The designated chair explained that under 8 AAC 45.120(i), the late-filed EME reports could only be considered if Employee waived her right to cross-examine the authors of the reports. After Employee waived her right to cross examine the EME doctors, the designated chair ruled the EME reports were admissible, and denied the continuance. (Record).

102. At the February 25, 2015 hearing, Employee testified she did have a preexisting tailbone condition, but had no pain and had been able to work regularly before the February 5, 2008 injury, and had pain since that time. She stated Dr. Spencer agreed the "hook" in her tailbone was worse than after her 2006 back injury. She agreed she is addicted to pain medication, but because the medication is necessary to treat her pain, addiction is unavoidable. She testified she has reduced her use of pain medication by almost half since the spinal cord stimulator was implanted. She contended that while Dr. Sheorn pointed out all the times she was given pain medication, Dr. Sheorn did not cite the times Employee asked the doctors not to give her pain medications. She contended that as Dr. Johnson has treated her for five years, his opinion that the pain is real should be given the greatest weight. Employer clarified it was not contending that Employee's pain was not real, only that the preponderance of the evidence showed the February 5, 2008 work injury was not the substantial cause of her pain. (Record).

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).

> **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.

> **AS 23.30.095. Medical 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. . . .
>
> (e) The employee shall, after an injury, at reasonable times during the continuance of the disability, if requested by the employer or when ordered by the board, submit to an examination by a physician or surgeon of the employer's choice authorized to practice medicine under the laws of the jurisdiction in which the examination occurs, furnished and paid for by the employer. The employer may not make more than one change in the employer's choice of a physician or surgeon without the written consent of the employee. Referral to a specialist by the employer's physician is not considered a change in physicians. An examination requested by the employer not less than 14 days after injury, and every 60 days thereafter, shall be presumed to be reasonable, and the employee shall submit to the examination without further request or order by the board. Unless medically appropriate, the physician shall use existing diagnostic data to complete the examination. Facts relative to the injury or claim communicated to

> or otherwise learned by a physician or surgeon who may have attended or examined the employee, or who may have been present at an examination are not privileged, either in the hearings provided for in this chapter or an action to recover damages against an employer who is subject to the compensation provisions of this chapter. If an employee refuses to submit to an examination provided for in this section, the employee's rights to compensation shall be suspended until the obstruction or refusal ceases, and the employee's compensation during the period of suspension may, in the discretion of the board or the court determining an action brought for the recovery of damages under this chapter, be forfeited. . . . .
>
> (k) In the event of a medical dispute regarding determinations of causation, medical stability, ability to enter a reemployment plan, degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's independent medical evaluation, the board may require that a second independent medical evaluation be conducted by a physician or physicians selected by the board from a list established and maintained by the board. The cost of an examination and medical report shall be paid by the employer. The report of an independent medical examiner shall be furnished to the board and to the parties within 14 days after the examination is concluded. A person may not seek damages from an independent medical examiner caused by the rendering of an opinion or providing testimony under this subsection, except in the event of fraud or gross incompetence.
>
> **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; . . . .

Under AS 23.30.120(a)(1), benefits sought by an injured worker are presumed to be compensable. *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996). The presumption of compensability is applicable to any claim for compensation under the workers' compensation statute, including medical benefits. *Municipality of Anchorage v. Carter*, 818 P.2d at 665; *Meek*, 914 P.2d at 1279; *Moretz v. O'Neill Investigations*, 783 P.2d 764, 766 (Alaska 1989); *Olson v. AIC/Martin J.V.*, 818 P.2d 669, 675 (Alaska 1991).

Application of the presumption involves a three-step analysis. To attach the presumption of compensability, an employee must first establish a "preliminary link" between his or her injury and the employment. *See, e.g., Tolbert v. Alascom, Inc*., 973 P.2d 603, 610 (Alaska 1999).

Medical evidence may be needed to attach the presumption of compensability in a complex medical case. *Burgess Constr. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). However, an employee "need not present substantial evidence that his or her employment was a substantial cause of his disability." *Fox v. Alascom, Inc.*, 718 P.2d 977, 984 (Alaska 1986) "In making the preliminary link determination, the Board may not concern itself with the witnesses' credibility." *Excursion Inlet Packing Co. v. Ugale*, 92 P.3d 413, 417 (Alaska 2004).

If the employee establishes the preliminary link, then the employer can rebut the presumption by presenting substantial evidence that demonstrates that a cause other than employment played a greater role in causing the disability or need for medical treatment or by substantial evidence that employment was not the substantial cause. *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 (Mar. 25, 2011) at 7); *Atwater Burns Inc. v. Huit*, AWCAS Decision No. 191 (March 18, 2014). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Fireman's Fund Am. Ins. Companies v. Gomes*, 544 P.2d 1013, 1015 (Alaska 1976). The determination of whether evidence rises to the level of substantial is a legal question. *Id*. Because the employer's evidence is considered by itself and not weighed at this step, credibility is not examined at this point. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 869-870 (Alaska 1985).

If the presumption is raised and not rebutted, the claimant need produce no further evidence and prevails solely on the raised but un-rebutted presumption. *Williams v. State*, 938 P.2d 1065 (Alaska 1997). "If the employer rebuts the presumption, it drops out, and the employee must prove, by a preponderance of the evidence, that in relation to other causes, employment was the substantial cause of the disability, need for medical treatment, etc. Should the employee meet this burden, compensation or benefits are payable." *Runstrom* at 8.

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

The board's finding of credibility "is binding for any review of the Board's factual findings." *Smith v. CSK Auto, Inc.*, 204 P.3d 1001, 1008 (Alaska 2009). The board has the sole power to determine witness credibility, and its findings about weight are conclusive even if the evidence is conflicting. *See, e.g.*, *Harnish Group, Inc. v. Moore*, 160 P.3d 146, 153 (Alaska 2007); *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249, 1253 (Alaska 2007); *Municipality of Anchorage v. Devon*, 124 P.3d 424, 431 (Alaska 2005). The board has the sole discretion to determine the weight of the medical testimony and reports. When doctors' opinions disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.*, AWCAC Decision No. 087 (August 25, 2008) at 11.

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.

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;

8 AAC 45.070. Hearings
(a) Hearings will be held at the time and place fixed by notice served by the board under 8 AAC 45.060(e). A hearing may be adjourned, postponed, or continued from time to time and from place to place at the discretion of the board or its designee, and in accordance with this chapter.

(b) Except as provided in this section and 8 AAC 45.074(c), a hearing will not be scheduled unless a claim or petition has been filed, and an affidavit of readiness for hearing has been filed and that affidavit is not returned by the board or designee nor is the affidavit the basis for scheduling a hearing that is cancelled or continued under 8 AAC 45.074(b). The board has available an Affidavit of Readiness for Hearing form that a party may complete and file. The board or its designee will return an affidavit of readiness for hearing, and a hearing will not be set if the affidavit lacks proof of service upon all other parties, or if the affiant fails to state that the party has completed all necessary discovery, has all the necessary evidence, and is fully prepared for the hearing.
. . . .

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

8 AAC 45.074. Continuances and cancellations
(a) A party may request the continuance or cancellation of a hearing by filing a

(1) petition with the board and serving a copy upon the opposing party . . . .

(b) Continuances or cancellations are not favored by the board and will not be routinely granted. A hearing may be continued or cancelled only for good cause and in accordance with this section. For purposes of this subsection,

(1) good cause exists only when
. . . .

(N) the board determines that despite a party's due diligence, irreparable harm may result from a failure to grant the requested continuance or cancel the hearing;

8 AAC 45.120. Evidence
. . . .

(f) Any document, including a compensation report, controversion notice, claim, application for adjustment of claim, request for a conference, affidavit of readiness for hearing, petition, answer, or a prehearing summary, that is served upon the parties, accompanied by proof of service, and that is in the board's possession 20 or more days before hearing, will, in the board's discretion, be relied upon by the board in reaching a decision unless a written request for an opportunity to cross-examine the document's author is filed with the board and served upon all parties at least 10 days before the hearing. The right to request cross-examination specified in this subsection does not apply to medical reports filed in accordance with 8 AAC 45.052; a cross-examination request for the author of a medical report must be made in accordance with 8 AAC 45.052.
. . . .

(i) If a hearing is scheduled on less than 20 days' notice or if a document is received by the board less than 20 days before hearing, the board will rely upon that document only if the parties expressly waive the right to cross-examination or if the board determines the document is admissible under a hearsay exception of the Alaska Rules of Evidence.

ANALYSIS

1. Were the oral rulings admitting the reports and denying the continuance correct?

The February 3, 2015 decision and order affirmed Employer's right to conduct the three EMEs it had requested and ordered Employee to attend. The deadline under 8 AAC 45.120(f) for submission of evidence for the February 25, 2015 hearing was only two days later. It is not feasible that Employer could arrange for, conduct, and receive the written reports for the EMEs in two days. A continuance of the February 25, 2015 hearing would have been appropriate under 8 AAC 45.074(b)(1)(N). However, Employer was willing to forgo the continuance if the late-filed record review EME reports could be admitted. The designated chair explained to Employee that under 8 AAC 45.120(i), the late-filed EME reports could only be admitted if she waived her right to cross-examine the doctors. Employee elected to waive her right to cross-examine the doctors to avoid a continuance. Because Employee waived her right to cross-examine the doctors, the reports were properly admitted. Because the reports were admitted, the continuance was properly denied.

2. Is the February 5, 2008 work injury the substantial cause of Employee's disability or need for medical treatment?

Employee contends the work injury was the substantial cause of her disability and need for medical treatment. This is a factual question to which the presumption of compensability applies. Because Employee was paid benefits prior to Employer's November 3, 2009 controversion, only benefits after that date are at issue. Employee needed only "some," or "minimal," relevant evidence to raise the presumption. In determining whether the presumption is met, credibility is not considered nor is the evidence weighed against competing evidence. Employee's testimony that her tailbone pain began with the work accident, combined with Dr. Johnson's November 19, 2009 opinion that her fall caused the ongoing pain, Dr. Ellenson's SIME report, and Dr. Gritzka's June 20, 2011 SIME report stating the accident was the substantial cause of her pain are are sufficient to raise the presumption.

To rebut the presumption, Employer was required to present substantial evidence demonstrating employment was not the substantial cause or that a cause other than employment played a greater role in causing Employee's disability and need for medical treatment. Again, credibility is not

considered nor is the evidence weighed against competing evidence at this step. Employer successfully rebutted the presumption through Dr. Bald's two EME reports, and the EME reports by Dr. Turco, Dr. Sheorn, and Dr. Bell as well as Dr. Gritzka's supplemental SIME report and Dr. Campbell's psychiatric SIME report Because Employer rebutted the presumption, Employee needed to prove by a preponderance of the evidence that the work injury was the substantial cause of her disability or need for medical treatment

It is beyond doubt that Employee is experiencing significant pain. The question, however, is whether the February 2008 injury remains the substantial cause of her pain after Employer's November 3, 2009 controversion. In answering that question, relatively less weight is given to the medical reports supporting Employee's position. Dr. Gritzka's June 20, 2011 report concluded the February 2008 injury was the substantial cause that aggravated or combined with Employee's preexisting condition, causing the pain. However, he also stated the best diagnostic tool was a radioactive bone scan, which had not been done. After he bone scan was done, Dr. Gritzka reviewed the result and changed his opinion. Because it is based on more evidence, including what he described as the best diagnostic tool, more weight is given to Dr. Gritzka's later opinion.

Little weight is given to Dr. Ellenson's SIME report. In reviewing Employee's medical records, Dr. Ellenson failed to mention the EMG and nerve conduction study he had done on April 28, 2008, which showed a problem with Employee's ankle, but not her sacroiliac or tailbone. That failure raises questions as to the thoroughness of his review. Additionally, because Dr. Ellenson's report includes a discussion of someone other than Employee, his conclusions are questionable at best.

Although Dr. Johnson has treated Employee for several years, his November 19, 2009 letter disagreeing with Dr. Bald is given less weight as well. At the time of the letter, he had been treating Employee for just over three months. There is no indication he reviewed any of Employee's medical records other than his own, and his opinion is essentially that the work injury must be the cause because Employee did not have the pain prior to that, but there is no indication that he considered whether the psychiatric or psychological factors diagnosed by Dr.

Bald had any role in Employee's pain. Additionally, while Employee may have reported pain since the injury, the nature or source of the pain is suspect. In the pain diagrams completed before Dr. Stinson diagnosed coccydynia, Employee reported significant pain in her lower back, buttock, and legs, with only one report of minor pain near her tailbone. It was only after Dr. Stinson's diagnosis that Employee began reporting significant pain in her tailbone. For those reasons, Dr. Johnson's opinion is given less weight.

Employee also suggests Dr. Eule and Dr. Spencer support her position. Although they discuss the deformity in her coccyx, they do not, however, give an opinion as to the causation of her pain. Dr. Eule noted Employee's coccyx was "significantly hooked," and may have been fractured. He does not state that the fracture occurred in the February 2008 fall, or that it was the cause of Employee's pain. Dr. Spencer stated the injury to Employee's coccyx was visible in a 2006 x-ray. He does not indicate there was any change or worsening of the deformity after the injury, and clearly states he was unable to fine an objective source for Employee's pain. Neither Dr. Eule's nor Dr. Spencer's reports suggest the February 2008 injury is the substantial cause of Employee's pain.

Dr. Bald's two EME reports, and the EME reports by Dr. Turco, Dr. Sheorn, and Dr. Bell as well as Dr. Gritzka's supplemental SIME report and Dr. Campbell's psychiatric SIME report are given greater weight. Although there are some differences, the diagnoses are generally consistent. Dr. Bald twice opined the substantial cause was psychiatric or psychological, not the work injury. Dr. Turco opined the substantial cause was psychological disorders that predated the February 2008 injury. Dr. Gritzka stated the substantial cause was chronic or neuropathic pain independent of the work injury. Dr. Campbell opined a pain disorder with psychological factors and opiate dependence was far more significant than the February 2008 injury. Dr. Sheorn stated drug abuse was the most significant factor. And Dr. Bell stated drug dependency or inappropriate use of prescription medication to treat Employee's emotional distress were the substantial cause of Employee's chronic pain. These opinions are particularly persuasive given the medical records show no clear objective findings that would account for Employee's continued pain, while repeatedly showing Employee has psychological or psychiatric problems and a history of abusing prescription medication. The preponderance of the evidence proves the

February 5, 2008 work injury is not the substantial cause of Employee's disability or need for medical treatment after November 3, 2009.

3. If work is the substantial cause of Employee's disability and need for medical treatment, is Employee entitled to PTD benefits, medical costs, and lost wages?

Because this decision determined the work injury was not the substantial cause of Employee's disability or need for medical treatment, she is not entitled to PTD benefits, medical costs, or lost wages.

CONCLUSIONS OF LAW

1. The oral rulings admitting the reports and denying the continuance were correct.

2. The February 5, 2008 work injury is not the substantial cause of Employee's disability or need for medical treatment.

3. Because the work injury is not the substantial cause of Employee's disability and need for medical treatment, Employee is not entitled to PTD benefits, medical costs, or lost wages.

ORDER

1. Employee's January 20, 2010 claim is denied.

Dated in Anchorage, Alaska on March 17, 2015.

ALASKA WORKERS' COMPENSATION BOARD

_____

Ronald P. Ringel, Designated Chair

_____

Stacy Allen, Member

_____

Michael O'Connor, 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 JERI L. CLIFTON, employee / claimant; v. STATE OF ALASKA, a self-insured employer; defendant; Case No. 200801738; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on March 17, 2015.

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Pamela Murray, Office Assistant