ALASKA WORKERS' COMPENSATION BOARD

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

DICK PHILLIPS, Employee, Claimant, v. BILIKIN INVESTMENT GROUP, INC., Employer, and REPUBLIC INDEMNITY CO. OF AMERICA (RIG), Insurer, Defendants.	)	FINAL DECISION AND ORDER AWCB Case No. 200813169 AWCB Decision No. 15-0080 Filed with AWCB Anchorage, Alaska On July 17, 2015

Dick Phillips' (Employee) September 23, 2010 claim was heard on June 2, 2015, in Anchorage, Alaska, a date selected on February 11, 2015. Attorney Richard Harren appeared and represented Employee who appeared and testified. Attorney Richard Wagg appeared and represented Bilikin Investment Group, Inc., d/b/a Midas (Midas or Employer). Laurie Phillips appeared and testified for Employee. Other witnesses, all of whom testified by telephone for Employee, included Christopher Krieg, Damian Phillips and Colton Lockhart. Near the hearing's conclusion, Employee sought an order keeping the hearing record open so he could enforce subpoenas and depose a medical witness and the insurance carrier's adjuster. An oral order sustained Employer's objection to this request. The record closed on July 17, 2015, when the panel met to deliberate. This decision examines the oral order and addresses Employee's claim on its merits.

ISSUES

Employee contended the hearing record should be left open so he could obtain testimony from a medical witness who, though under subpoena, was unable or unwilling to attend the hearing. He further contended the insurer's adjuster had been subpoenaed but refused to appear.

Employer contended Employee did not make proper arrangements to obtain the physician's testimony even though a prior decision gave him 45 days to do so. Employer contended Employee had not listed the adjuster on his witness list and had only subpoenaed her the day prior to hearing. Further, Employer contended a prior decision had "frozen" the evidence and Employee was not entitled to submit additional evidence. The panel sustained Employer's objection and declined to leave the record open.

1) **Was the oral order declining to leave the hearing record open correct?**

Employee contends his August 15, 2008 injury arose out of and in the course of his employment with Employer, and is compensable. He contends his injury with Employer remains the substantial cause of his disability and need for medical treatment for his back.

Employer contends Employee's August 15, 2008 injury was a temporary lumbar strain. It contends the work injury was not the substantial cause of Employee's continuing disability and need for medical treatment to his back after October 10, 2008. Thus, Employer contends the work injury was no longer compensable after October 10, 2008.

2) **Does Employee's August 15, 2008 injury remain compensable after October 10, 2008?**

Employee contends he is entitled to various benefits including temporary total disability (TTD) from November 23, 2008 through January 1, 2012, permanent partial impairment (PPI) based on a 30 percent PPI rating, permanent total disability (PTD) from January 2, 2012, and continuing and medical costs and related transportation expenses.

Employer contends it does not dispute Employee's disability or impairments status, medical expenses subject to adjustment by the fee schedule and work-related transportation expenses.

However, Employer contends it is not liable for any such benefits under the Act, because Employee's work-related disability and need for medical care ended effective October 10, 2008. It also contends statutory offsets may reduce any liability.

3) Is Employee entitled to additional benefits?

Employee contends he is entitled to attorney's fees, costs and interest if he prevails. Employee contends he should be awarded statutory minimum attorney's fees.

Employer contends Employee should not prevail on the causation issue. Therefore, it contends he is entitled to no additional benefits and his request for statutory minimum attorney's fees, costs and interest should also be denied.

4) Is Employee entitled to statutory attorney's fees, costs and interest?

FINDINGS OF FACT

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

1) On November 5, 2003, Employee injured his "right back" in case 200319045 while unloading 100 pound sand bags while employed by NAPA. (Report of Occupational Injury or Illness, November 6, 2003).

2) On November 5, 2003, Employee went to AIC Urgent Care (AIC) and saw Scott Peterson, PA-C. Employee had back pain after feeling a sudden pop and "a twinge" while picking up a sand-filled sack at work. PA-C Peterson assessed "back pain" and released Employee to return to work effective November 6, 2003, with a 10 pound lifting limit and referred him to his normal physician. (Peterson chart note; Work-Related Injury Instructions, November 5, 2003).

3) On November 6, 2003, Employee told an AIC nurse he had right "rib pain" which started when he picked up a sand sack and felt a pop. Employee said it hurt to breathe and move and the pain radiated to his right side. (AIC Nursing Assessment, November 6, 2003).

4) On November 7, 2003, Employee saw Robert Neubauer, M.D., at AIC. Dr. Neubauer diagnosed a "back strain." (AIC report, November 7, 2003).

5) On November 10, 2003, Employee saw Dr. Neubauer at Valley Hospital for evaluation. Dr. Neubauer restricted Employee from work with NAPA from November 6, 2003 through

November 10, 2003, and released him to return to work without any restrictions effective November 11, 2003. (Valley Hospital work restriction form, November 10, 2003).

6) On November 11, 2003, NAPA paid Employee $51.14 for two days' TTD benefits. (Compensation Report, November 12, 2003).

7) The agency file for case 200319045 does not show Employee incurred any additional medical care or time loss resulting from the 2003 injury. (ICERS database, accessed January 20, 2015).

8) On December 9, 2004, Employee was moving an oxygen bottle in case 200422089 while working as a delivery driver for Valley Transport & Storage (Valley), when he developed pain in his low back. He received medical treatment and Valley paid him TTD for 20 weeks through April 28, 2005. (Compromise and Release Agreement, approved February 8, 2006).

9) On December 21, 2004, Employee underwent a lumbar spine magnetic resonance imaging (MRI) scan. His history included low back pain with a "right-sided radiculopathy." At L2-3, there was minimal, broad posterior disc bulging which anatomically appeared "inconsequential." At L3-L4, there were no significant abnormalities. At L4-5, Employee had mild, broad posterior disc bulging along with bilateral facet hypertrophy, which resulted in moderate, bilateral, lateral recess stenosis symmetrically encroaching on the descending L5 nerve roots. At L5-S1, there was bilateral facet osteoarthritis with marginal hypertrophy, which resulted in mild to moderate bilateral foraminal stenosis that appeared to encroach on the descending S-1 nerve roots. There was also a small, posterior, central disc bulge measuring approximately 8 mm by 8 mm by 3-4 mm, which did not appear to be "anatomically consequential." This finding was, however, associated with an arcuate zone of increased signal on the right posterior central annulus fibrosis consistent with a small, annular tear. The radiologist opined this latter finding could be contributory to nonspecific low back pain symptoms. (MRI, December 21, 2004).

10) On March 11, 2005, Susan Klimow, M.D., reviewed Employee's lumbosacral back pain and other issues. Noting Employee's symptoms did not resolve with injection therapy, Dr. Klimow determined his injury was "consistent with a strain," although there may be a facet component. Dr. Klimow did not think Employee was a surgical candidate. (Klimow report, March 11, 2005).

11) On April 5, 2005, Valley sent Employee to Steven Schilperoort, M.D., for an employer's medical evaluation (EME). Dr. Schilperoort reviewed Employee's medical records beginning in 1986 through March 2005. He also performed a physical examination and took Employee's

history. Dr. Schilperoort diagnosed: multilevel lumbar spine spondylosis degenerative arthritis mixed with L4-5 and L5-S1 facet degenerative arthritis, evolutionary and degenerative, pre-existing and not related to the December 9, 2004 injury; possible minor symptomatic exacerbation of preexisting spine degenerative arthritis associated with the Valley injury, resolved as of January 11, 2005; "prior history of polysubstance abuse necessitating inpatient detoxification treatment"; current history of drug-seeking behavior, violation of pain contract; and malingering. Giving Employee "every available benefit of the doubt," Dr. Schilperoort determined Employee may have sustained a minor, symptomatic aggravation of his preexisting degenerative arthritis. When asked to describe alternative causes for Employee's then-current "condition," Dr. Schilperoort concluded "only drug-seeking behavior as the motivation for seeking medical treatment and for his current statement of symptoms." Dr. Schilperoort opined Employee was medically stable effective January 11, 2005, needed no further medical treatment, and was capable of full, unrestricted work. (Schilperoort EME report, April 5, 2005).

12) On September 20, 2005, Dr. Roderer performed an L5-S1 lumbar epidural steroid injection to address Employee's continuing low back pain. (Procedure note, September 20, 2005).

13) On October 25, 2005, Employee had another epidural steroid injection and completed a pain drawing for Dr. Roderer with no buttock or lower extremity complaints marked on the drawing. Employee told Dr. Roderer he had several weeks' relief from pain following his injection. (Pain drawing, October 25, 2005).

14) On November 22, 2005, Employee told Dr. Roderer his second epidural steroid injection provided relief for about two weeks after which he had a gradual return to his typical pain levels. Dr. Roderer suggested a provocative discogram to determine the source of Employee's pain. (Roderer report, November 22, 2005).

15) On December 8, 2005, Dr. Roderer performed a discogram on Employee, which revealed positive provocation at L4-5 for similar and concordant pain, as well as at L5-S1 with exact symptom duplication. (Discogram report, December 8, 2005).

16) On December 8, 2005, Dr. Roderer ordered a computerized tomography (CT) scan, which showed a normal L3-4 disc but severe disc degeneration at L4-5 and L5-S1. (CT scan report, December 8, 2005).

17) On December 12, 2005, Dr. Roderer referred Employee to Davis Peterson, M.D., for an orthopedic surgical evaluation. (Roderer report, December 12, 2005).

18) On December 27, 2005, Employee returned to Dr. Roderer stating he had seen Dr. Peterson, who reviewed his records and did not believe Employee was a surgical candidate. (Roderer report, December 27, 2005).

19) On January 27, 2006, Employee saw Sanford Lazar, M.D., for a second independent medical evaluation (SIME) in the Valley case. On examination, Employee walked without a limp or any obvious discomfort. His lumbar range of motion was markedly restricted with pain complaints in the lower lumbar midline at the extreme of all movements. Dr. Lazar found no muscle spasm or evidence of any motor weakness or sensory loss in the lower extremities. Dr. Lazar reviewed Employee's medical records and diagnosed symptomatic, multiple-level lumbar degenerative disc disease without radiculopathy; chronic pain syndrome; and narcotic habituation. Dr. Lazar opined Employee likely has an addictive personality as evidenced by his alcohol and drug usage issues in the past. He stated Employee had shown drug seeking behavior. Dr. Lazar also noted Employee had "weakened to absent" ankle reflexes, which Dr. Lazar opined represented some first sacral compression or other abnormality, which conformed to the MRI findings at L5-S1 and comported with Employee's discogram results. Dr. Lazar concluded the December 2004 Valley incident aggravated the underlying degenerative process which was "relatively quiescent" before the injury. He also opined the 2004 Valley injury was a substantial factor in bringing about Employee's then-current "conditions." Notably, Dr. Lazar opined Employee was not a surgical candidate because he had multiple-level disc disease and operating on the worst levels, L4-5 and L5-S1, would not prevent higher disc levels from progressively worsening causing Employee future problems. Furthermore, Employee was a "heavy smoker" and smokers and people exhibiting drug-seeking behavior are likely to have poor surgical results. Dr. Lazar recommended aggressive home exercise, weight loss and a lumbar corset trial. In his view, Employee had received more medication than most patients with similar symptoms and findings due in part to his drug-seeking behavior which complicated his diagnosis and treatment. Dr. Lazar stated Employee had been medically stable since December 1, 2005. He did not believe Employee could return to work as a truck driver or delivery person given his back pathology and needed to be retrained. In short, Dr. Lazar opined Employee had not returned to his pre-injury baseline and had a chronic pain syndrome making it difficult for him to be evaluated and for him to recover. (Lazar SIME report, January 27, 2006).

20) On February 8, 2006, Employee and Valley settled their disputes through a board-approved C&R. This settlement agreement waived Employee's rights to all benefits under the Alaska Workers' Compensation Act (Act) against Valley. (Compromise and Release Agreement, approved February 8, 2006).

21) As part of his settlement with Valley, Employee completed an affidavit for submission to the board in support of his request for settlement approval. Among other things, Employee testified "I have discussed this settlement with my lawyer at length, and it is my belief that this settlement is in my best interest." Employee further acknowledged: "I have a convoluted medical history and it is entirely possible that the SIME that was performed in January may be against my interests." Employee also acknowledged he discussed the settlement at length with his wife before signing the agreement. (Affidavit of Employee, February 1, 2006).

22) There is no evidence Employee or his then-attorney in the Valley case had received or reviewed Dr. Lazar's SIME report before submitting the settlement agreement for board approval and before the board approved it. Available evidence shows they were not aware of Dr. Lazar's opinions. (Experience, judgment and inferences drawn from the above).

23) On February 20, 2006, Employee told Dr. Roderer his low back pain was "8/10" with stabbing and radiation into the right buttock. Activity made it worse while relaxation and pain medications made the pain better. Employee's pain drawing was relatively benign with minimal pain markings in the low back region and minimal numbness markings in the right posterior thigh just below the buttock. (Roderer report; pain drawing, February 20, 2006).

24) On March 2, 2006, Patty Nelson performed a physical capacities evaluation on Employee. Nelson concluded Employee was capable of "medium" level work, but not sustained medium level work for an eight hour day. He could tolerate an eight hour workday at the "light" exertional level. Nelson opined Employee needed conditioning but participated fully in all required tasks. (Physical Work Performance Evaluation Summary, March 2, 2006).

25) On March 20, 2006, Employee told Dr. Roderer the addition of methadone to his treatment regimen had increased his ability to function at higher levels and sleep through the night. Employee's pain drawing was similar to the February 20, 2006 pain drawing with some additional numbness in the right buttock noted. (Roderer report; pain drawing, March 20, 2006).

26) On April 24, 2006, Employee told Dr. Roderer for the last "2 to 3 weeks" he had been "losing control of his bodily functions per his report." Employee's pain level was at "8/10" with

radiation to the right lower extremity. Employee could perform heel and toe walking "with difficulty." Dr. Roderer noted worsening pain symptoms and a "question of fecal incontinence." Dr. Roderer ordered another MRI and referred Employee to James Eule, MD, orthopedic surgeon. Employee's pain drawing was similar to the March 20, 2006 pain drawing except the right buttock numbness had moved to the center. (Roderer report; pain drawing, April 24, 2006).

27) On April 26, 2006, Employee had another lumbar MRI. It was not compared to the prior study. The radiologist found no focal disc protrusions at L2-3 and the L3-4 disc was "unremarkable." There was no significant spinal stenosis. The L4-5 disc had a small central protrusion measuring approximately 3 mm. There were prominent bulging discs at L4-5 and L5-S1. Employee's posterior facets were unremarkable but L5-S1 showed a small, 3 mm protrusion without spinal stenosis. The overall impression included 3 mm central disc protrusions at L4-5 and L5-S1; no significant neuro-foraminal stenosis; and mild degenerative changes involving the left posterior facet at L5-S1. (Lumbar MRI, April 26, 2006).

28) By June 26, 2006, Employee had pain increasing to "9/10" in his lower back with radiation to his posterior and anterior legs down to his ankles. His pain drawing was more dramatic than the April 24, 2006 version. (Roderer report; pain drawing, June 26, 2006).

29) On June 27, 2006, Employee saw Dr. Eule for surgical evaluation. Dr. Eule reported, "He says he has significantly more back pain than leg pain." Employee reported occasional leg weakness, inability to feel a bowel movement and subsequent wiping and said his penis was numb. This had been going on for several months by his report. Dr. Eule noted Employee was a smoker and smokers' discs wear out faster, smokers have more back pain, and smokers are three to four times more likely to have a failed fusion. Dr. Eule wanted to review Employee's discogram results for clear, concordant pain reproduction. Noting Employee had some positive Waddell signs, Dr. Eule was not sure he was going to be able to assist him through surgery. (Eule report, June 27, 2006).

30) By August 28, 2006, Employee reported to Dr. Roderer his pain was at "10 out of 10." Employee's pain drawing showed stabbing and aching pain in the lower back and both posterior lower extremities. (Roderer report; pain drawing, August 20, 2006).

31) On September 26, 2006, Employee had nerve conduction studies and electromyography in the lower extremities. The study was abnormal. There were chronic neurogenic changes in L-5 and S-1 myotomes on the left, and on the right at L4 and L5. There was also severe axonal

sensory fiber neuropathy and severe debilitating motor neuropathy in the lower extremities. Jeffrey Sponsler, M.D., who performed the tests, listed numerous medical conditions that could cause these findings, including diabetes, and said such findings were more highly correlated with Employee's clinical symptoms than with his MRI. (Sponsler report, September 26, 2006).

32) On October 24, 2006, Employee saw Dr. Eule who reviewed prior electromyography results and determined it looked "fairly clearly evident" Employee had "multilevel peripheral neuropathy," which explained the numbness in his bilateral arms, legs and groin area. Dr. Eule surmised the peripheral neuropathy possibly arose from Employee's chronic hepatitis. Dr. Eule also diagnosed discogenic back pain, confirmed by discograms. Because Employee was a smoker and had positive Waddell signs, Dr. Eule did not think he had better than a 50 percent chance of improvement with a two-level fusion. Dr. Eule opined there was nothing he could do surgically to help Employee's symptoms. (Eule report, October 24, 2006).

33) On December 5, 2006, Employee saw Dr. Roderer to follow-up on degenerative disc disease with lumbar radicular symptoms. Dr. Roderer continued Employee on his "pain medication regimen" including methadone 10 mg three times per day and hydrocodone 10 mg/325 mg three times per day for breakthrough pain, which was increased to six times per day for postoperative pain from recent carpal tunnel surgery. Dr. Roderer also increased Employee's Lyrica from 50 mg twice per day to 100 mg twice per day to see if it would help with Employee's "lower extremity pain symptoms." Employee's pain drawing showed numbness in his anterior and posterior thighs and stabbing pain beginning just above the knees and extending into the calves bilaterally. (Roderer report; pain drawing, December 5, 2006).

34) On January 15, 2007, Employee saw Dr. Roderer for low back pain which radiated into the buttocks and lower extremities. Employee rated his pain as "7/10" in the lumbar spine made worse by prolonged activity and made better by medications and relaxation. Employee could perform heel and toe walking with "minimal difficulty." Dr. Roderer diagnosed degenerative disc disease in the lumbar spine. (Roderer report, January 15, 2007).

35) Employee's March 26, 2007 visit with Dr. Roderer was similar to his January visit. Employee was working full-time at a liquor store, was using his medications appropriately and was able to work. Employee's pain drawing was also similar to the previous one, though Employee marked only the posterior view. (Roderer report; pain drawing, March 26, 2007).

36) On May 21, 2007, Employee said he had been to the emergency room for a swollen knee. His back pain was "6/10 to 8/10" in the lumbar spine with radiation into the right buttock and was "continuous." Dr. Roderer opined Employee had used his pain medications appropriately. His pain drawing was similar to the prior one, except Employee added numbness and stabbing pain to the anterior right lower extremity. (Roderer report; pain drawing, May 21, 2007).

37) On July 23, 2007, Employee told Dr. Roderer his pain was "6/10" in the lumbar spine with aching, stabbing, numbness, and pins and needles radiating into the buttocks and into the lower extremities, continuously. His symptoms were made worse by bending and twisting and made better by relaxation and pain medications. Employee's pain drawing showed bilateral, anterior symptoms going down both legs, and posterior left buttock and thigh numbness with right buttock and thigh numbness with aching pain beginning just above the posterior knee descending down the right lower extremity. (Roderer report; pain drawing, July 23, 2007).

38) On or about September 14, 2007, Employee began working for Employer. (Report of Occupational Injury or Illness, August 18, 2008; Employee).

39) On October 1, 2007, Employee's visit with Dr. Roderer was very similar to his prior visit in July. But, he could perform heel and toe walking "without difficulty." His motor power was "5/5" in his lower extremities. Employee's pain drawing showed more moderate symptoms in his thighs and lower extremities. (Roderer report; pain drawing, October 1, 2007).

40) On October 29, 2007, Employee reported to Mat-Su Regional Medical Center emergency room stating he had "turned and twisted" his back suffering "gripping pain" radiating into his leg. Employee told James Lord, M.D., he had well-controlled chronic back pain until he turned and twisted and his normal chronic pain medications did not cover his pain. His "original injury" occurred when he lifted an oxygen bottle. Dr. Lord assessed a chronic low back pain exacerbation and told Employee to follow-up with Dr. Roderer. This visit began around 2:30 PM on a Monday. The record does not disclose where the event giving rise to this visit happened. (Emergency room report, October 29, 2007; observations).

41) On December 10, 2007, Employee saw Dr. Roderer again. Employee's pain drawings show upper back pain but minimal lower back pain, and numbness in his anterior and posterior thighs. (Roderer report; pain drawing, December 10, 2007).

42) On February 11, 2008, Employee told Dr. Roderer his low back pain was "7/10" with some radiation into his lower extremities, continually. Dr. Roderer continued Employee's pain

medication regimen. Employee's pain drawing showed low back stabbing pain with decreased numbness only in the posterior thighs. (Roderer report; pain drawing, February 11, 2008).

43) On April 28, 2008, Employee returned to Dr. Roderer who noticed Employee's last blood screen was positive for marijuana. Employee agreed to stop smoking marijuana. His gait was within normal limits as was his physical examination. Employee rated his pain as "7/10" located in the lower back and described as aching, with numbness radiating into the lower extremities. Dr. Roderer said Employee was using his pain medications appropriately and renewed his prescriptions. Employee's pain drawing showed reduced lumbar spine stabbing pain, and numbness beginning in the thighs and descending into both lower extremities. (Roderer report; pain drawing, April 28, 2008).

44) On June 23, 2008, Employee told Dr. Roderer he had been actively walking and wearing a lumbar brace while working. His pain remained at "7/10" in the lower back with radiation into his lower extremities. Dr. Roderer continued Employee's pain medications. Employee's pain drawing showed aching and stabbing mid-back pain and numbness beginning on the bilateral thighs and descending down both extremities. (Roderer report; pain drawing, June 23, 2008).

45) On July 8, 2008, Employee returned to the emergency room stating he had chronic low back pain but was "fine" until about 3:00 AM when he stood up and turned. Employee developed abrupt, severe left lower thoracic tenderness. The emergency room physician diagnosed a left lower thoracic paraspinal muscle strain and told him to follow-up with Dr. Roderer. (Emergency room report, July 8, 2008).

46) On July 21, 2008, Employee returned to Dr. Roderer. Employee's pain was at "7/10" and included lower back numbness radiating into his lower extremities, continuously. It was made worse by sitting and working and improved with medications and massage. Dr. Roderer continued Employee on his pain regimen. Employee's pain drawing was similar to his June pain drawing in Dr. Roderer's office. (Roderer report; pain drawing, July 21, 2008).

47) On August 15, 2008, Employee was injured while working for Employer when a large, heavy trash barrel he was trying to empty into a dumpster hit the dumpster and fell onto him, causing a low back injury. Employer accepted the injury and paid benefits. (Report of Occupational Injury or Illness, August 18, 2008; ICERS database, accessed July 15, 2015).

48) On August 15, 2008, Employee went to the emergency room and reported chronic low back pain. He reportedly said he had lifted a "250 pound" barrel at work at Midas and had

injured his low back. Employee reported feeling a "pop" with radiating pain down his left buttock and left posterior thigh. He related his then-current pain medications and advised Dr. Roderer was his normal pain doctor. Concerned about the heavy weight involved, the physician performed x-rays which showed "slight wedging" at the L1 vertebra. The physician could not say whether this was "an acute fracture or not." The final assessment was: "Lumbar strain with radicular symptoms, possible early herniated nucleus pulposus," and Employee was referred to Dr. Roderer. (Emergency room report, August 15, 2008; Physician's Report, August 18, 2008).

49) On August 18, 2008, Employee saw a medical provider at Mat-Su Health Services because he could not get in to see Dr. Roderer right away. Though the record contains a typographical error and says the injury happened "7/15/08," Employee said he lifted a heavy garbage can at work and tried to swing it over a dumpster to empty the can. The can hit the dumpster, swung back and hit him in the stomach making him fall onto his buttock. Employee again recounted his then-current pain medications and said he had shooting pain in his upper low back, radiating down his left buttock behind his left knee. Employee was in moderate discomfort with antalgic gait. The emergency room physician advised Employee to see Dr. Roderer as soon as possible, but would not provide additional pain medications. (Emergency room report, August 18, 2008).

50) Later on August 18, 2008, Employee saw Dr. Roderer. He reported having a work-related injury when trying to place a barrel into a dumpster. Dr. Roderer said Employee "had an acute exacerbation of his low back and lower extremity pain. . . ." Employee was still in "moderate distress" and had difficulty maintaining a single position either sitting or standing and had to move frequently. Employee's gait was still antalgic and Dr. Roderer noted muscle spasms throughout the thoracic and lumbar spine and paraspinal musculature. Dr. Roderer's assessment was: "Exacerbation of pain symptoms with radicular pain to the left groin area after work related injury." Dr. Roderer recommended physical therapy and an MRI to compare with his previous MRI study. Heel and toe walking was accomplished with "moderate difficulty." Employee was not able to return to work and was "essentially incapacitated currently." (Roderer report; physical therapy referral, August 18, 2008).

51) On August 18, 2008, Employee completed a pain drawing for Dr. Roderer. This drawing was in many ways similar to some of his pre-Midas injury pain drawings. However, at the bottom, Employee stated his medications had not changed since his last visit, "But I sure hope the[y] give me something stronger at least for this month." (Pain drawing, August 18, 2008).

52) On August 18, 2008, Dr. Roderer said Employee was totally incapacitated for work and would be reevaluated on September 15, 2008. (Roderer Return to Work Recommendations, August 18, 2008).

53) On August 23, 2008, Employee underwent a thoracic spine MRI which showed degenerative disc disease with desiccation and discogenic endplate changes at the T7-T8 level. There was no previous MRI study with which to compare. (Thoracic MRI, August 23, 2008).

54) On August 23, 2008, Employee also had a lumbar spine MRI which was compared to lumbar MRIs performed December 21, 2004 and April 26, 2006. The radiologist interpreted this MRI to show the "essentially unchanged" small, fusiform lipoma of the terminal filum measuring roughly 4.5 cm by 2 mm. At L2-3, and L3-4 there were mild, broad-based disc bulges. At L4-5, the radiologist found disc desiccation and a broad-based disc bulge with mild, bilateral facet and ligamentum flavum hypertrophy resulting in relative spinal cord narrowing. At L4-5, there was a small posteromedian disc protrusion less conspicuous than in the prior examinations. The radiologist also found mild, bilateral hypertrophic ligamentum flavum and facet degenerative changes at this level. Similarly, the L5-S1 annulus defect was not as conspicuous as in previous studies, but may represent a chronic annular tear. The reason for this test was: "BACK PAIN AFTER LIFTING INJURY." The radiologist's final impressions were: minimal chronic degenerative changes at L4-5 and L5-S1; stable lipoma at the terminal filum; subtle suggestion of residua of chronic posteromedian annular tear at L4-5 which was better seen on the December 21, 2004 MRI study. (Lumbar MRI, August 23, 2008).

55) Shortly after his Midas injury, Employee and his family left the state on a pre-planned vacation, which turned into a month-long family emergency when a relative passed away. (Employee; Laurie Phillips).

56) On September 29, 2008, Employee returned to Dr. Roderer and described his low back pain as "8/10" with stabbing, burning, and numbness radiating into his right buttock and right lower extremity. Employee's pain was continuous and made worse by sitting, moving, and standing and nothing currently made it better. Employee continued to have an antalgic gait and had decreased right leg strength. Dr. Roderer reviewed the thoracic spine MRI but did not mention the lumbar spine MRI at this visit. He recommended physical therapy and a right lower extremity electromyography to determine if radiculopathy accounted for Employee's leg weakness. Employee was unable to heel or toe walk with his right foot. His motor power was

"5/5" in the lower extremities, except for his right plantar flexion which was "4/5." Employee's pain drawings had fewer markings than on previous iterations. His pain medication regimen continued. (Roderer report; pain drawing, September 29, 2008).

57) On October 3, 2008, Employee reported to the emergency room and described his work injury with Employer. He had low back pain since the injury and now reported loss of bladder control over the past three weeks and a numb penis. The diagnosis was "acute on chronic back pain." (Emergency room report, October 3, 2008).

58) On October 6, 2008, Employee returned to physical therapy where he reported low back and right leg pain at "9/10." (Physical therapy note, October 6, 2008).

59) On October 9, 2008, Employee returned to Dr. Roderer, who performed a right L5 transforaminal epidural steroid injection to address Employee's right lumbar radicular pain secondary to his lumbar disc protrusion. (Roderer report, October 9, 2008).

60) On October 10, 2008, Employee underwent a right lower extremity electromyography which Franklin Ellenson, M.D., read as normal. (Ellenson report, October 10, 2008).

61) On October 27, 2008, Employee followed up with Dr. Roderer and said the epidural steroid injection had provided no relief. Employee's low back pain was rated at "7-8/10" and his right lower extremity was rated at "8-9/10" and nothing currently improved his symptoms. Dr. Roderer's assessment was: "Low back and right lower extremity pain in a patient status post work-related injury." Dr. Roderer concluded Employee had not benefited from conservative measures including physical therapy and an epidural steroid injection. His injury was approximately two months old and Dr. Roderer thought lumbar traction might help but nonetheless referred Employee to Eric Kohler, M.D., for surgical evaluation. Dr. Roderer noted Employee had a history of degenerative disc disease with a positive discography at L4-5 and L5-S1 from December 2005. However, Employee's prior pain symptoms were low back with some mild pain into his lower extremities with numbness. "Now, he has severe right lower extremity pain after the work-related injury." Heel and toe walking was accomplished "with difficulty on the right side." Employee's pain drawing showed low back pain and predominantly right lower extremity burning, stabbing pain and numbness and no other markings. Dr. Roderer increased Employee's breakthrough pain medication. (Roderer report; pain drawing, October 27, 2008).

62) Knowing Employee's past history, and Employee having failed conservative measures, Dr. Roderer would not have referred him to Dr. Kohler for a surgical evaluation if he did not think Employee might need surgery. (Experience, judgment and inferences drawn from the above).

63) On November 6, 2008, Employee saw Dr. Kohler and generally described his injury "on the job four years ago" and his work injury with Employer "when attempting to shove a 55 gallon [barrel] of debris into the back of a dumpster, and to the back of a truck." Dr. Kohler reviewed Employee's past history including chronic lumbar pain and "intense centralized low back pain that was effecting [sic] all elements of his life." Following the Midas injury, Employee described "new burning dysesthesias in his left thigh," which was "pushing him to the point he is unable to work and unable to take part in most daily activities without severe pain and discomfort." Later in his report, Dr. Kohler clarified the neuropathic pain was in Employee's "right anterior thigh." Reviewing the August 23, 2008 lumbar MRI, Dr. Kohler noted Employee's symptom onset was "acute" with progression, which had been "acute and severe" presenting primarily "in the center to the back and then in a very distinct L4 pattern." His gait was markedly antalgic. Dr. Kohler was aware Employee had a four-year history "of severe low back pain" beginning with a work injury, "followed by a second on the job injury that resulted in exacerbation of centralized low back pain and the onset of pain and numbness in L4 and 5 distribution with neuropathic symptoms in the L4 distribution." Dr. Kohler noted Employee said he had "some incontinence" since his August 15, 2008 injury. Employee noted back pain for four years but leg pain for about two months. Dr. Kohler concluded:

> PLAN: The risks, benefits and alternatives to continue conservative therapy, use of artificial disc even though this would be off-label, and/or posterior lumbar interbody fusion with careful mobilization and inspection of the right L4 and L5 nerve roots, it was felt to be the best option for him at this time. Because he does have significant neuropathic pain, consideration for placement of spinal cord stimulator will be discussed with his primary care physician, Dr. Doty and chronic pain management physician, Dr. Roderer. (Kohler report, November 6, 2008).

64) The "second on the job injury" to which Dr. Kohler referred was the August 15, 2008 injury with Employer. (Experience, judgment and inferences from the above).

65) On November 6, 2008, Dr. Kohler's office scheduled Employee for a proposed posterior lumbar interbody fusion at L4-5 and L5-S1 with interbody Synthes PEEK graft, Synthes Pangaea

screws and rods and possible spinal cord stimulator placement, on December 1, 2008. (Kohler report, November 6, 2008).

66) On November 10, 2008, Dr. Kohler wrote to Drs. Roderer and Doty and recounted Employee's work injury approximately four years earlier. Dr. Kohler stated Employee had been treated extensively and was "able to continue functioning until he re-injured himself several months ago while thrusting a 55 gallon drum into the back of a truck, having the drum bounce back, strike him in the chest and cause him to land on his back with the drum on top of him." Dr. Kohler opined this caused a "severe flareup" of centralized low back pain with "new onset of L4 and to some extent, L5 neuropathic pain" that made Employee's work impossible. Dr. Kohler recommended various options but settled on a posterior fusion and inspection of L4 and L5 nerve roots during surgery. (Kohler letter, November 10, 2008). The surgical procedures Dr. Kohler recommended are within the realm of medically accepted options to treat Employee's symptoms. (Experience, judgment and inferences drawn from the above).

67) It is difficult to tell from Dr. Kohler's November 6 and November 10 reports if he was aware Employee had pain and numbness radiating into his right lower extremity before the work injury with Employer. The reports could be read as saying Employee said he had initial "onset" of symptoms in his right leg, which would clearly not be correct, or it could be read to say the onset of Employee's increased symptoms were new and causing more distress than they did previously. (Experience, judgment and inferences drawn from all the above).

68) Dr. Kohler recommended surgical intervention to address Employee's symptoms from his August 15, 2008 injury with Employer within two years of the injury. (Official notice).

69) On November 17, 2008, Employee saw Lea Anne Abernathy, ANP, for a pre-operation physical. Employee's injury description in his "own words" was, "Injured 11/04 reinjured 8/08." (Abernathy report, November 17, 2008).

70) On November 18, 2008, Employer's adjuster received Dr. Kohler's November 6, 2008 reports according to the "received" stamps. (*Id.*).

71) On November 20, 2008, and November 22, 2008, Employee attended an EME for his August 15, 2008 work injury, with Douglas Bald, M.D., orthopedic surgeon, and Lynn Adams Bell, M.D., neurologist. Employee stated on the injury date he was emptying a 55 gallon trash drum into a dumpster. As he lifted the barrel, it hit the dumpster and bounced back. Employee lost his balance and fell backwards landing on his back with the drum landing on him. He completed his work and

drove home where he had difficulty exiting his vehicle. At the emergency room, physicians noted Employee was already on a pain contract with Dr. Roderer but gave him a pain injection, without much improvement. Employee told the EME physicians he had pain at level "8" which would occasionally go to a "10" when he moved. Employee noted bowel and bladder control issues on four or five occasions since his work injury with Employer. His symptoms were mostly in his lower back with a constant burning type component down his right leg. The EME physicians reviewed Employee's medical records and, discussing the 2004 work injury, noted Employee had complained of lower back pain and paresthesia in his right anterior thigh in the L1 and L2 nerve root distribution with some symptoms on the left side in the S1 nerve root distribution. The EME physicians also referenced Dr. Schilperoort's April 5, 2005 EME report, which offered a diagnosis of multilevel, degenerative spondylosis at L4-5 and L5-S1 with secondary facet degenerative arthritis, not related to the December 2004 work injury. They noted Dr. Schilperoort opined Employee had suffered a temporary symptom aggravation, which had resolved. After performing a physical examination, the EME doctors diagnosed lower lumbar degenerative disc disease and secondary facet arthropathy at L4-5 and L5-S1, preexisting; lumbar strain secondary to the August 15, 2008 injury, which had resolved; past history of alcohol and drug abuse requiring detoxification; and probable malingering. The adjuster asked the EME physicians to identify "all causes of the condition" they diagnosed and whether the August 15, 2008 work injury was "the substantial cause of any condition." However, the adjuster also provided the statutory requirements under AS 23.30.010(a). In responding to the above-referenced question, the EME physicians stated Employee's persistent pain complaints and "self-imposed physical limitations" were the result of "a combination of non-injury related factors as noted in the diagnoses." Also included in "different causes" were Employee's "significant evidence of pain behavior and symptom magnification" and "an element of malingering," which were "felt to be the major cause of his persistent subjective complaints." The EME physicians did not believe any preexisting physical condition was aggravated or affected by the work injury. Subsequently, the EME stated:

> In our joint medical opinion, by far the substantial cause of Mr. Phillips' current condition is a result of nonphysical factors related to a combination of pain behavior, symptom magnification, and out-and-out malingering, in combination with his lower lumbar degenerative disc disease.

The EME physicians opined Employee's subjective complaints were "completely out of line" with objective findings. They recommended no further diagnostic studies or tests, found Employee was medically stable effective October 10, 2008, provided a zero percent PPI rating and stated Employee needed no further medical treatment. The examiners also said Employee had no physical restrictions resulting from the August 15, 2008 injury and could perform his usual and customary job but his preexisting degenerative disc disease would likely restrict him to the medium/heavy job capacity with lifting up to 75 pounds. (EME report, November 20, 2008).

72) On November 24, 2008, Employee returned to Dr. Roderer and advised he was scheduled for lumbar fusion surgery on December 1, 2008, with Dr. Kohler. His pain level was rated at "8/10" in the lumbar spine with radiation to the lower extremities greater on the right, made worse by "everything" and made better by "nothing." Employee discussed with Dr. Roderer a trial spinal cord stimulator prior to surgery, but decided not to pursue the stimulator at that time. Employee's pain drawing showed numbness in the buttocks, stabbing pain in the low back, and stabbing pain and burning down the right leg primarily in the right thigh. Employee drew no symptoms on his left lower extremity. (Roderer report; pain drawing, November 24, 2008).

73) On December 1, 2008, Dr. Kohler performed a posterior, lumbar interbody fusion at L4-5 and L5-S1 on Employee. (Operative report, December 1, 2008).

74) On December 2, 2008, Employee had post-surgical lumbar x-rays compared to x-rays taken on August 15, 2008. The radiologist found grade 1 spondylolisthesis of L5 on S1 measuring approximately 5 mm, which was a new finding from the comparison films from August 15, 2008. (X-ray report, December 2, 2008).

75) By January 5, 2009, one month after his surgery, Employee reported a decrease in back pain. However, his right lower extremity numbness was about the same and his right lower extremity pain may have been slightly worse since his surgery. (Roderer report, January 5, 2009).

76) Dr. Kohler's surgery was initially effective in reducing Employee's low back pain. (Employee).

77) On January 13, 2009, Employee told Dr. Kohler he still had burning, stabbing and aching pain radiating down his right leg and some aching and numbness in his left leg. He was getting a "jolt feeling" in his right leg. Employee had right leg weakness and his leg would "give out" occasionally. Dr. Kohler suggested a trial spinal cord stimulator through Dr. Roderer. (Kohler report, January 13, 2009).

78) Dr. Kohler's recommendation for a spinal cord stimulator to address Employee's symptoms occurred within two years of his work injury with Employer. (Official notice).

79) A spinal cord stimulator is within the realm of medically accepted options to treat Employee's symptoms. (Experience, judgment and inferences drawn from the above).

80) By April 13, 2009, Employee decided he wanted to try a spinal cord stimulator to control his low back and lower extremity pain. (Roderer report, April 13, 2009).

81) On May 19, 2009, Dr. Roderer installed a trial spinal cord stimulator. (Roderer report, May 19, 2009).

82) Dr. Roderer concurred with Dr. Kohler's recommendation for a spinal cord stimulator. (Roderer report, January 13, 2009).

83) On May 21, 2009, Employee returned to Dr. Roderer and reported good pain relief for his right lower extremity but not his lower back. Dr. Roderer decided to move the stimulator leads slightly to obtain better coverage into the lower back area. (Roderer report, May 21, 2009).

84) Dr. Roderer's spinal cord stimulator implantation was initially effective in reducing Employee's lower extremity symptoms. (Employee).

85) On August 14, 2009, Dr. Roderer fired Employee as a patient for violating his pain contract. (Roderer letter, August 14, 2009).

86) On August 29, 2009, Dr. Kohler operated on Employee to place a surgical spinal cord stimulator lead at T8-9 and a left gluteal battery pack. (Operative Report, August 29, 2009).

87) On September 10, 2009, Employee told Dr. Kohler he still had difficulty controlling his low back pain with the stimulator. (Kohler report, September 10, 2009).

88) On October 6, 2009, Employee told Dr. Kohler the stimulator and fusion surgery were not improving his situation. (Kohler report, October 6, 2009).

89) On October 15, 2009, Dr. Kohler reviewed Employee's recent x-rays and his symptoms and decided an adjustment to a stimulator lead was necessary to provide coverage for Employee's low back, right hip and right leg pain. (Kohler report, October 15, 2009).

90) On December 30, 2009, Dr. Kohler performed another surgical procedure to relocate Employee's stimulator paddles. (Operative Report, December 30, 2009).

91) On January 1, 2010, Employee told hospital staff he could not feel anything from his waist down. Dr. Kohler performed emergency surgery to address Employee's paraplegia, remove a blood

clot and reduce pressure on Employee's spinal cord. (Physical Therapy Daily Chart Note; Operative Report, January 1, 2010).

92) On January 6, 2010, Dr. Kohler reevaluated Employee's situation and noted he developed a hematoma at his operative site, which resulted in bilateral lower extremity paralysis and emergency surgery to remove the hematoma. (Transfer Summary, January 6, 2010).

93) Dr. Kohler initially performed surgery on Employee to address increased and persistent symptoms arising from the August 15, 2008 work injury with Employer, and later to further address surgical complications from the December 30, 2009 surgery. Nothing in the medical records suggests the January 1, 2010 surgical consequences had anything to do with Employee's preexisting degenerative disc disease, prior addictions, prior injuries, drug seeking behavior, smoking, malingering or any other Employee behavior. (Experience, judgment, observations).

94) On January 8, 2010, Dong Cho, M.D., opined Employee was "without a doubt" totally disabled and could not return to work or training for at least a year. (Cho report, January 8, 2010).

95) On or about October 21, 2010, Employee filed a claim against Employer seeking TTD, PTD, medical and transportation costs, interest and attorney's fees and costs. (Workers' Compensation Claim, September 23, 2010).

96) On August 16, 2013, Edward Tapper, M.D., performed an SIME on Employee. He opined the August 15, 2008 injury aggravated, accelerated and caused Employee's disability and need for treatment. However, he also said it was not "the substantial cause," a title he attributed to "preexisting injuries and drug dependency." Dr. Tapper also said the work injury with Employer produced a temporary aggravation but "it became a permanent change after the surgical complications." When asked the "the substantial cause" question in another way, Dr. Tapper stated "yes and no," the August 15, 2008 work injury was the substantial cause in Employee's disability and need for medical treatment to his back. Dr. Tapper further opined the medical treatment Employee had following his August 15, 2008 work injury with Employer was "probably reasonable," though the necessity "might be questionable," but Dr. Tapper could understand how and why the decision regarding surgery was made. "It was not necessarily inappropriate," but in hindsight it might be considered "controversial." In short, Dr. Tapper said the surgery was reasonable but the spinal cord stimulator complications were "questionable." (Tapper SIME report, August 16, 2013).

97) In his deposition, SIME Dr. Tapper said he tried to address "the substantial cause of Mr. Phillips[']s condition . . . and what was the need for his medical care." (Tapper deposition, February 7, 2014, at 9). Dr. Tapper stated:

> Well, substantial cause is greater than 50 percent as I understand it and I felt the substantial cause was not the injury of August 2008 but everything that preceded it. At the time of the August 2008 injury, he was under treatment for prior injuries and taking narcotic medications. And everything that he complained of, and even his MRI studies after the 2008, were unchanged from prior studies. So that's what I based my decision on. (*Id*. at 9).

98) Dr. Tapper said he was asked whether the 2008 injury aggravated or accelerated Employee's preexisting complaints; he said "it did." But, if Dr. Tapper had to say "one or the other," the "weight was more on all the prior things rather than the 2008. But the 2008, you know, certainly did aggravate his problems." (*Id*. at 10). Dr. Tapper could not really say whether or not Employee's 2008 injury with Employer would have been a "temporary aggravation," even though he mentioned that possibility in his written report. (*Id*.). Dr. Tapper said that prior to the 2008 Midas injury, Employee had chronic back pain dependent on narcotics and had imaging studies, which showed "nothing terrible" but "some discs" at two levels in his lumbar spine. He was taking a "fairly high amount" of narcotics prior to the Midas injury. (*Id*. at 11). Dr. Tapper agreed Employee, from at least his 2004 injury, always complained of severe low back pain and leg involvement and sought multiple drugs to relieve his pain. He consistently assessed his pain level at seven out of 10 or greater. Dr. Tapper opined there were no changes in Employee's imaging studies before and after the 2008 Midas injury and his pain complaints were consistent. (*Id*. at 12-13). Dr. Tapper questioned Employee's truthfulness given his various weight estimates on the barrel he was lifting when injured at Midas. (*Id*. at 13). Dr. Tapper said the only objective evidence were Employee's pre-and post-Midas-injury MRI studies, which in his view were unchanged. When asked to describe all different causes for Employee's need for low back treatment and then evaluate the relative contribution of each, Dr. Tapper stated:

> Well, if you go to the 2008 injury and then the, uh -- you could lump all the prior injuries, 2003, 1998, some other things, it's really close to 50/50. But you, you know, sort of make me say is substantial and so I think it's maybe 51/49; the substantial one being all the preexisting. (*Id*. at 15).

Dr. Tapper's relative contribution analysis was "colored by the fact that this time he had surgery and that was a disaster." Dr. Tapper does not fault or criticize Dr. Kohler's surgery in an attempt to help relieve Employee's symptoms. (*Id*. at 16-17). When revisiting his "51/49" relative contribution split, Dr. Tapper said he gave more weight to the 2008 injury because there is no way to separate the substantial cause of the need for surgery as opposed to the surgical outcome. (*Id*. at 19). Dr. Tapper explained:

> The 2008 injury led Dr. Kohler to think surgery was indicated and he could help him. But he's a different doctor than those who had seen him before. And I repeat that I really am colored by the outcome of the surgery so I would give the 2008 injury a little bit more weight. (*Id*. at 20).

Dr. Tapper further stated had Employee never had the surgery which led to paralysis, Dr. Tapper would have attributed "very little" weight to his 2008 Midas injury. (*Id*. at 22).

99) On cross-examination, Dr. Tapper conceded that prior to 2008, no physician had ever suggested Employee undergo back surgery. (*Id*. at 26). Dr. Tapper agreed a year's worth of work at Midas would have been one of the things that caused Employee to seek more narcotics. (*Id*. at 51-52). Dr. Tapper opined Employee probably would have had surgery "anywhere along the way if somebody had told him to." (*Id*. at 58). He agreed Dr. Kohler's decision to schedule surgery three weeks after first seeing Employee was "hasty." (*Id*. at 60). Again revisiting the relative contribution analysis, and asked to describe which injury predating August 15, 2008, was the substantial cause of Employee's need for medical care, Dr. Tapper said:

> I don't think there is one. I mean, you go back, he's had -- I lost track of how many in the early 1990s -- lifting a motor that wasn't a reported injury. In 2003 there were a number of them. So I don't think there is one I can say is the substantial. (*Id*. at 63).

100) Dr. Tapper opined Employee's narcotic addiction colors everything including his pain perception. (*Id*. at 63-64). He agreed Employee's addictive personality traits were a factor "in his present condition." (*Id*. at 71). Employee's degenerative disc disease was "not so much" a factor in his disability. (*Id*. at 72). Dr. Tapper agreed the August 15, 2008 incident along with a year's worth of work at Midas "probably did" aggravate Employee's prior injuries and his narcotic usage. (*Id*. at 86). Dr. Tapper agreed diabetes, peripheral neuropathy, and carpal tunnel

syndrome could complicate Employee's situation, cause symptoms, and result in many marks on Employee's pain drawings prior to the Midas injury. (*Id*. at 88-89).

101) On re-direct examination, Dr. Tapper opined, based solely on the MRI reports, Employee's low back was never a surgical situation. (*Id*. at 80-81). It was Dr. Tapper's conclusion that Employee's "condition prior to August of 2008" is what necessitated his need for medical treatment after the work injury. (*Id*. at 82-83).

102) In his deposition, Employee described his Valley injury while unloading an oxygen bottle and putting it on his shoulder. Employee felt something in his back "pop," promptly reported the injury and knew his back was "definitely hurt." (Employee deposition at 13, January 14, 2014). He never returned to work for Valley after this injury, hired an attorney, filed a claim and eventually settled his case. (*Id*. at 13-14). Employee has had ongoing medical care for his back since the Valley injury to the present. (*Id*.). Employee never had any low back or leg injuries and no medical care for these body parts prior to the Valley injury. (*Id*. at 18). When Employee settled his Valley claim, he still had "ongoing" back issues. (*Id*. at 23). His ongoing back issues included "constant pain" in the "small of my back" up to his mid-back. Employee had these symptoms on a daily basis and had "slight" leg pain mostly on the right. (*Id*. at 23-24). Prior to the Midas injury, from 2004 to 2008, Employee saw Dr. Roderer on a regular basis. Dr. Roderer performed injections and after the Midas injury installed a trial spinal cord stimulator. Dr. Roderer also regularly prescribed pain medication, which helped to some degree. (*Id*. at 25). Dr. Roderer never discussed possible surgery prior to the Midas injury. Employee saw Dr. Eule one time after the Valley injury but he did not recommend surgery. (*Id*. at 26). Employee also worked for about a year at a liquor store before he worked at Midas. He admitted "ongoing" back symptoms on a daily basis and leg symptoms, which impacted his activity level while he was working at the liquor store. If, for example, he moved beverage cases, he would have "sharp, burning pain." (*Id*. at 26-27). Employee conceded the symptoms had never gone away completely following the Valley injury, but had decreased somewhat. (*Id*. at 27). Prior to his Midas job, Employee's pain level was frequently a seven out of 10. (*Id*. at 30). When Employee began working for Midas, he was continuing to have back problems on a daily basis. It was "more manual" than his work at the liquor store because he did a lot of "heavy lifting" at Midas. Mounted tires weighed between 30 to 75 pounds and garbage barrels ranged between 65 to 160 pounds. (*Id*. at 31). On the Midas injury date, Employee picked up a heavy garbage barrel and

swung it into the dumpster. The barrel caught the dumpster lid and came back on top of Employee pinning him to the ground. (*Id*. at 32). Employee finished his shift but never returned to work thereafter. (*Id*.). After his wife's friend told him about Dr. Kohler, Employee made an appointment and Dr. Kohler suggested and performed a surgical fusion, which helped as Employee's back pain was better but his legs hurt more. (*Id*. at 35). Dr. Kohler subsequently installed a spinal cord stimulator, which relieved leg pain considerably but did not affect his back. A paddle had come off the stimulator and needed to be replaced to properly address the lower back. Dr. Kohler performed another surgery to replace the paddle, and Employee woke up paralyzed from his chest down. (*Id*. at 35-36). Employee correctly and honestly completed pain drawings at all times when he saw his physicians. (*Id*. at 43-44). Employee spoke with Dr. Roderer before he took the Midas job and Dr. Roderer told him "it would be all right" so long as he was careful with what he was doing. (*Id*. at 45-46). When he took the job at Midas, Employee felt capable of performing it. (*Id*. at 46).

103) On February 12, 2014, Employee filed a witness list for the February 18, 2014 hearing. Employee's witness list did not include the insurer's adjuster. (Employee's Final Witness List, February 12, 2014).

104) At hearing, Employee conceded he had a struggle with drugs and was addicted to cocaine in the early 1980s. Employee put himself through drug rehabilitation and last used cocaine in the early 1980s. He also drank alcohol excessively until he stopped heavy drinking in the early 1980s, though he occasionally has a drink. Employee has smoked cigarettes since he was 14 years old. Eventually, Employee went to work for NAPA as a delivery driver. In November 2003, while working at NAPA, Employee had a back injury while lifting garnet sand bags, used for sandblasting. In December 2004, Employee had a back injury with Valley when he lifted a heavy tank. Valley sent Employee to an EME who said Employee had not injured his back in the tank lifting event. Fearing he would not win at hearing, Employee settled the 2004 case in early February 2006. (Employee).

105) Employee understood he was not released to return to medium level work following the 2004 work injury. Subsequent to the 2004 injury, Employee had assistance from the Alaska Division of Vocational Rehabilitation to find employment. This effort was not successful but he returned to work at a liquor store. (*Id*.).

106) In late 2007, while working at the liquor store, Employee met a person he had once hired in a previous job. Employee's old friend was managing Midas' Wasilla store and offered Employee a job as a counterman. However, Employee was not "computer literate" so his friend hired Employee as a "tire man" and janitor. At Midas, Employee also drove customers to and from work and ran for parts. Eventually, Employee did shop work at Midas including oil and tire changing, brake repairs and he occasionally mowed the lawn. During Employee's Midas employment, he did considerable "medium to heavy" work full-time and during tire season he regularly worked over 40 hours per week. During tire season, Employee did what he described as "heavy" work. (*Id*.).

107) On the injury date, Employee was performing shop cleanup at Midas. He grabbed the trash barrel, put it on a dolly and rolled it outside to the dumpster. Employee grabbed the barrel and tried to empty it into the dumpster but it bounced off the dumpster and fell on him. Employee grabbed the barrel again, hefted it up to the dumpster and emptied it. As he was done working, Employee got into his truck and went home. Employee realized he had injured himself when he had difficulty getting out of his truck upon arriving home. (*Id*.).

108) When he got home, Employee could barely get out of his truck and had to crawl. His wife and son assisted him getting back into a vehicle and his wife took him to the hospital. (*Id*.).

109) Employee loved working for Midas and had a good relationship with his old friend "Jeff," the manager who had hired him. (*Id*.).

110) Employee's physician-patient relationship with Grant Roderer, M.D., began after his 2004 Valley injury and continued past the Midas injury. Dr. Roderer had filled prescription pain medications for Employee for years. Employee did not think he could have continued working at Midas but for Dr. Roderer's prescription pain medication, because on some occasions he had difficulty moving while at work at Midas. (*Id*.).

111) On February 19, 2014, *Phillips v. Bilikin Investment Group, Inc*., AWCB Decision No. 14-0020 (February 19, 2014) (*Phillips I*) declined to consider medical reports from Employee's hired medical expert, gave Employee 45 days to depose authorized medical providers, and continued the February 18, 2014 hearing subject to the parties' stipulation to "freeze" the parties' hearing preparation in the *status quo* so Employee could not use the continuance to his advantage to fortify his position. (*Phillips I* at 12).

112) On May 26, 2015, Employee filed another witness list. Employee's witness list did not include the insurer's adjuster Jessica Rush. (Employee's Final Witness List, May 26, 2015).

113) On May 29, 2015, Employee subpoenaed Grant Roderer, M.D., to attend the June 2, 2015 hearing. Dr. Roderer's attorney contacted Employee's lawyer and said Dr. Roderer had a full schedule and was not available. (Employee's hearing statements).

114) On June 1, 2015, Employee subpoenaed Jessica Rush, Employer's insurance company's adjuster, to appear at the June 2, 2015 hearing. Employee's attorney said Employer's attorney advised Rush to disregard the subpoena as she was not listed on Employee's witness list and the evidentiary record had been previously frozen. Employer did not dispute this account. (Employee's hearing statements).

115) At hearing, Employee said up to August 15, 2008, he had been doing "fairly well," and had been golfing, fishing, walking and could do his job at Midas. After the August 15, 2008 work injury, he could "hardly move." Employee never returned to the way he was before the work incident. Employee thought he had suffered a new injury on August 15, 2008. (Employee).

116) At some point after the Midas injury, Employee's wife's friend told him about Dr. Kohler, and Employee saw him for a second opinion on Dr. Roderer's referral. Employee thought Dr. Kohler was "absolutely awesome." In Employee's view, Dr. Kohler, within 15 minutes after examining his MRI films, had diagnosed the specific place in Employee's spine which was causing him difficulty. Employee was delighted he had finally found somebody who "believes what I'm saying." Employee was uncertain if he would have ever seen Dr. Kohler but for his Midas injury. He thought he could have continued doing the things he did before but for the August 15, 2008 injury with Employer. Even before the work injury, if Employee was active and moving around, his pain would increase. This explained why on some occasions, when he saw Dr. Roderer before his Midas injury, Employee's pain level was at an eight or nine on a 10 scale. While working for Midas, it was "pretty rough" if he had been changing tires. (*Id.*).

117) On cross-examination, Employee said his pre-Midas injury medical reports and pain drawings accurately recorded his pain complaints. Employee conceded that after his Valley injury, his back never "fully" recovered. He relied "somewhat" on pain medication to function thereafter. Employee admitted, following the Valley injury, whenever he did anything strenuous it would cause low back pain. He further agreed when he found Dr. Kohler, Employee had finally found someone who said he could fix what ailed his back. Had Dr. Eule recommended

surgery earlier, Employee would have had surgery. Employee's back and leg pain existed before his Midas injury, but not to the same extent. Employee does not believe the pre- and post-Midas medical records and pain drawings show equal pain locations and degrees. When reviewing an October 27, 2008 pain drawing, Employee agreed it was an accurate description of his pain on that date. Reviewing a June 26, 2006 and November 6, 2006 pain drawing as related to his low back and legs, Employee conceded the pre-Midas pain drawings had many more marks on them then the post-Midas drawing. Employee agreed he had been hoping for a cure to his back ever since the Valley injury. (*Id*.).

118) On re-direct examination, Employee explained he had not been working for over two months when he completed his October 27, 2008 pain drawing. He implied this is why the pre-Midas pain drawings had more marks on them than his post-Midas pain drawing. Employee said no physician ever discouraged him from having lumbar surgery after his Midas injury. Dr. Eule did not tell him to have surgery or to not have surgery. The symptoms down Employee's right leg existed to some extent prior to the Midas injury but not as much as they did thereafter. (*Id*.).

119) Christopher Krieg grew up next to Employee's home and has known him since Krieg was about 11 years old. Krieg was best friends with Employee's son Damian. Employee's family was like a second family to Krieg. Before his Midas injury, Employee frequently participated in activities with Krieg and Damian such as fishing, go-carting, walking dogs and felling trees. Krieg was aware Employee had worked at Midas. He often saw Employee working on an old white Camaro. He also observed Employee frequently walking his dogs. Krieg believed he had never seen anybody walk as often and as far as Employee. However, after the Midas injury, he spoke with Employee who told him a physician recommended he walk regularly. Krieg said this explained why Employee walked frequently. To Krieg's knowledge, before his Midas injury Employee worked hard and was never without a job. After the Midas injury, Employee increased his walks but never went golfing or fishing with Krieg. (Krieg).

120) Damian Phillips is Employee's son. He moved out of the family home in 2009. Damian was present when Employee came home from the Midas work injury. Employee was in significant pain and was crying. He crawled out of his Jeep and Damian's mother took him to the emergency room. Damian described his father's work ethic as "excellent." He wanted to emulate his father. Damian did not notice any specific improvement in his father's condition until after the surgery when a spinal cord stimulator was implanted. In Damian's opinion, it did

not seem Employee ever got back to "100 percent his old self" when it came to moving and working following the Midas injury. Damian occasionally visited Employee while he was at work at Midas and Employee seemed to really enjoy himself. Prior to the Midas injury, he and Employee would fish and golf frequently. After the work injury, Employee did not fish anymore and golfed perhaps once. (Damian Phillips).

121) Laurie Phillips and Employee were together for about six years before they married in 1990. She is aware Employee has had several work injuries. Phillips recalled the Valley injury where Employee injured his back lifting a heavy tank. This injury resulted in a one-year "struggle with workers' compensation." Doctors at the time were not able to help him and just wanted to "throw pain meds" at him. Employee had a pain contract with Barbara Doty, M.D., the family doctor. He had a similar pain contract with Dr. Roderer. Dr. Roderer fired Employee for violating the pain contract. Phillips thinks this was based upon a miscommunication and misunderstanding because some prescription drugs were difficult to obtain in "the Valley" and Dr. Doty switched his prescription from a higher milligram per pill dosage to a lower one, but had to double the number of pills. Dr. Roderer never discussed the matter with Employee and simply terminated their physician-patient relationship. She thought Employee was "crazy" for settling the Valley case and thought he should have tried surgery. Phillips did not want Employee to be on narcotics. Yet several doctors including Dr. Eule told Employee he was not a surgical candidate. In Phillips' opinion, Employee has always had an excellent work ethic. (Laurie Phillips).

122) During the time Employee worked at Midas before his injury, he never complained to Phillips about Employer or his job. Employee would sometimes come home from work at Midas "stiff and sore" if he had done some heavier lifting, but never like he was the day he came home from work on August 15, 2008. She had never seen him in so much pain. She does not know how Employee got out of his Jeep, but when she saw him, he was crawling on the ground and crying. Phillips asked Employee what happened, and he recounted the trash can and dumpster incident. She accompanied Employee to the emergency room and to many subsequent doctors' appointments. (*Id.*).

123) Shortly after the Midas, Employee went on a previously planned family vacation. Physically, Employee was "not great" during this trip and was in considerable pain. (*Id.*).

124) Phillips heard about Dr. Kohler from a friend at work. She was impressed with his ability to discern what was wrong with Employee's back within 15 minutes. Phillips and Employee were very happy Dr. Kohler had determined what was wrong with Employee and how to fix it. They both wondered why no other physician had done so previously. (*Id*.).

125) To this point, Employer had paid for Employee's medical care. However, Employer refused to pay for Dr. Kohler's recommended surgery so Phillips called her health insurer which said it would pay for the surgery. Her health insurer, Blue Cross, never questioned whether it was reasonable and necessary for Employee to get his December 2008 low back surgery. (*Id*.).

126) Following his surgery after the Midas injury, Employee never returned to his former self physically in Phillips' view. In Phillips' lay opinion, but for the August 15, 2008 injury, Employee would have continued working at Midas because he loved his job. (*Id*.).

127) Phillips reviewed Employee's prescription medications and noted he did not take anti-nausea medication before his work injury. Similarly, he was not diagnosed with diabetes or high blood pressure until after his work injury with Midas. Employee now takes numerous medications he did not take before his Midas injury. (*Id*.).

128) Phillips did not think her husband was a malingerer. She first noticed he appeared depressed after his emergency surgery and paralysis. Phillips at some point reviewed the SIME report from the Valley case and felt strongly Employee should not have settled his case especially for the money offered. Thereafter, Employee actively sought surgical intervention because Phillips and he wanted a cure. Employee's symptoms were similar before and after the Midas injury. However, his symptoms following the Midas injury were "more severe" and Phillips had never before seen her husband in pain like he had on August 15, 2008. (*Id*.).

129) Colton Lockhart is Damian Phillips' friend. Lockhart has known Employee since about 2006. He knew Employee worked at Midas and would occasionally visit him there with Damian. Lockhart lived at Employee's home from around September 2007 through May 2008. He observed Employee on a regular basis. In Lockhart's view, Employee was active and Lockhart never noticed anything out of the ordinary with Employee physically. Employee occasionally helped Lockhart work on his automobile. Lockhart never observed Employee having any obvious difficulty with drug or alcohol abuse. Damian Phillips told Lockhart about Employee's work injury at Midas. After the Midas injury, Lockhart saw Employee lying around on his bed frequently. Lockhart was not aware Employee was taking any medications or was

obtaining any medical treatment before his Midas injury. Employee had always been honest with Lockhart. (Lockhart).

130) At hearing on June 2, 2015, Employer stipulated Employee was temporarily totally disabled from November 23, 2008, through January 1, 2012; had a 30 percent PPI rating; and was permanently totally disabled since January 2, 2012, and continuing until such time as he is retrained or returns to appropriate employment. Employer had no objection to Employee's medical expense accounting for his work injury subject to adjustment by the fee schedule should Employee prevail, or to his transportation costs. However, Employer denied liability for any additional benefits based on its basic defense that the August 15, 2008 work injury with Employer was not the substantial cause of Employee's disability or need for medical treatment after October 10, 2008. (Employer's hearing statements).

131) Employee contends the year prior to his August 15, 2008 injury, he incurred around $4,000 in medical expenses. He contends, but for the August 15, 2008 injury, Employee's medical care would have continued to be about $4,000 - $5,000 per year. Employee contends his highest pre-injury medical expenses totaled $31,999.01 between August 15, 2006 and August 14, 2007. He further contends his medical billings from August 15, 2008 through August 14, 2009 total $268,864.05 and the year following medical costs ballooned to $315,512.71. Employee contends this evidence shows there was a dramatic change in his medical condition following his work injury with Employer. (Employee's hearing arguments).

132) Employee contends Dr. Tapper's SIME report and deposition, properly interpreted, support his position. He contends Dr. Tapper found the work injury with Employer constituted a 49 percent causative factor. Employee further contends Dr. Tapper erroneously combined all other causes into one cause equaling 51 percent and incorrectly opined this exceeded 49 percent making the work injury not the substantial cause of Employee's disability and need for medical treatment. (*Id*.).

133) Employer contends the primary issue is "what is the substantial cause of Mr. Phillips' condition, and primarily that means what is the substantial cause of the surgeries that Dr. Kohler did. . . ." Employer contends Employee has no medical evidence to even attach the statutory presumption of compensability. It contends no medical doctor said the August 15, 2008 injury is the substantial cause of anything other than a back strain. Even if the presumption is raised and attached, Employer contends substantial medical evidence rebuts the presumption and shows

Employee had nothing more than a back strain on August 15, 2008, which has long ago resolved. Employer also relies on Dr. Tapper's SIME opinion to support its position. Employer contends the last injurious exposure rule and any "egg shell plaintiff" principles do not apply in this case. Employee further contends Employee's lay evidence is not consistent with Employee's medical records. For example, Employer contends medical records show Employee had leg symptoms well before the August 15, 2008 injury and frequently complained of "9 out of 10" and "10 out of 10" pain when requesting narcotics. Employer contends two months following the work injury, Employee's lower extremities appeared normal. But, Employee then discovered Dr. Kohler who offered him surgery, which turned out to be disastrous, a result that supported prior physicians' opinions stating Employee should not have lumbar surgery. Employer further contends Dr. Tapper's deposition explains his report and demonstrates Dr. Tapper actually does not support Employee's position. Specifically, Employer contends Dr. Tapper weighed the 2008 injury at 49 percent solely because of the surgery, which turned out badly for Employee. Employer contends Employee and his wife both testified he was looking for a physician to perform surgery to make him better after the Valley injury. Thus, Employer contends Dr. Tapper concluded Employee had a significant, continuing low back problem amenable to surgery after the 2004 Valley injury. Employer contends all attending physicians, EME and SIME doctors agree the 2008 work injury was not the substantial cause of Employee's need for medical care and any resultant disability after the low back strain injury resolved. (Employer's hearing arguments).

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 . . . to ensure . . . quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to . . . employers who are subject to the provisions of this chapter;

The board may base its decision not only on direct testimony 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). A finding employment was a cause of the Employee's

disability and impose liability is, "as are all subjective determinations, the most difficult to support." *Id*. at 534. The court has "no reason for supposing, however, that the members of the Board who found it so are either irrational or arbitrary." The court further noted "the fact that some reasonable persons may disagree with a subjective conclusion does not necessarily make that conclusion unreasonable. . . ." *Id*.

> **AS 23.30.005. Alaska Workers' Compensation Board**. . . .
> . . . .
>
> (h) . . . Process and procedure under this chapter shall be as summary and simple as possible. . . .
>
> **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 the need for medical treatment of an employee if the disability . . . 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 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 the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the . . . 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 . . . 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 the need for medical treatment. Compensation or benefits under this chapter are payable for the disability . . . or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability . . . or need for medical treatment. . . .

Effective November 7, 2005, the legal "causation" definition changed to "contract" the Act's coverage. For injuries occurring on or after November 7, 2005, the board must evaluate the relative contribution of all causes of disability and need for medical treatment and will award benefits if employment is, in relation to all other causes, "the substantial cause" of the disability or need for medical treatment. *City of Seward v. Hansen,* AWCAC Decision No. 146 at 10 (January 21, 2011). Expanding on AS 23.30.010(a), *Hansen* said:

> The penultimate sentence indicates that the board is to determine 'the relative contribution of different causes' of the disability, death, or need for medical treatment, that is, the statutory language provides that the board is to compare

> causes. Furthermore, the legislature's use of the word 'the' in the phrase 'the substantial cause,' is suggestive of a limitation. Typically, the definite article 'the' particularizes the subject which it precedes and 'is a word of limitation as opposed to the indefinite or generalizing force of [the indefinite articles] 'a' or 'an.'' (Footnote omitted). Also, the legislature's inclusion of the phrase 'in relation to other causes' in the last sentence, preceding the phrase 'the substantial cause,' imparts to us the concept that, when causes are compared, only one cause can be 'the substantial cause.' Thus, the language in the last two sentences of AS 23.30.010(a) connotes to the commission that, compensation or benefits are payable under the Act if, in comparing the relative contribution of different causes, the employment, in relation to other causes, is the substantial cause of the employee's disability . . . or . . . need for medical treatment. . . . (*Id*. at 6).

In *DeYonge v. NANA/Marriott*, 1 P.3d 90 (Alaska 2000), the Alaska Supreme Court addressed a board decision finding a doctor's report constituted affirmative evidence DeYonge's condition was not "aggravated or accelerated by her work." *Id*. at 96. In his report, a physician suggested Ms. DeYonge's arthritic condition had "probably been developing slowly for years and . . . was not specifically caused by her job." *Id*. He also suggested "any stressful use of her knees would have increased her symptoms." *Id*. These statements tend to show a non-work-related factor, "DeYonge's genetic predisposition for arthritis and its natural degenerative progression," caused DeYonge's "underlying impairment." *Id*. The board found:

> We find Dr. Frost states that the employee may have an increase in symptoms. We do not find any evidence to support a conclusion that an increase in symptoms is the equivalent of a *permanent* aggravation or acceleration of the preexisting condition. We find that the employee temporarily experienced an increase in her symptoms, i.e., discomfort while working. In summary, we find no acceleration of the employee's preexisting degenerative condition and we find no *permanent* worsening of her knee condition. We find no indication of work-related disability from this discomfort. We conclude the employee was not disabled by her work with the employer; therefore we must deny and dismiss her claims for benefits. (Emphasis in original) (*Id*. at 97).

The Alaska Supreme Court in *DeYonge*, on the other hand, said:

> But we have established 'that a preexisting . . . infirmity does not disqualify a claim under the work-connection requirement if the employment aggravated, accelerated, or combined with the . . . infirmity to produce the . . . disability for which compensation is sought.' (Footnote omitted). Dr. Frost's explanation does not exclude DeYonge's employment as a substantial factor in the aggravation of her arthritis. On the contrary, Dr. Frost believed that DeYonge's employment with NANA/Marriott did worsen her symptoms: 'Certainly the type of duties

> which she performed as a housekeeper . . . would have been a substantial factor in increasing her symptoms.' (*Id*.).

DeYonge cited *Hester v. Public Employees' Retirement Board*, 817 P.2d 472, 476 n. 7 (Alaska 1991) where the court explicitly declined "to differentiate between the aggravation of symptoms and the aggravation of an underlying condition in the context of a claim for occupational disability benefits." *DeYonge*, 1 P.3d at 96. *DeYonge* further noted though *Hester* arose under occupational disability statutes rather than the Alaska Workers' Compensation Act, its stated principle, "worsened symptoms may be compensable," is "equally persuasive in the context of workers' compensation." *Id.* DeYonge had only brought claims for medical benefits and TTD. With respect to both of these claims, the court only requires "the employment cause a temporary increase in symptoms aggravating the disability." *Id*. at 97. *DeYonge* held because the board failed to recognize the *Hester* principle, "it erred in concluding that NANA/Marriott rebutted the presumption of compensability through Dr. Frost's report." *Id*. The court concluded DeYonge was "entitled to TTD for the period during which she suffered debilitating work-related symptoms." *Id*. at 98.

In *Smith v. University of Alaska, Fairbanks*, 172 P.3d 782 (Alaska 2007), the board said in its decision, "No physician has stated, on a more probable than not basis, the employee's work caused his need for surgery and continuing treatment. Therefore, we find the employee cannot prove his claim by a preponderance of the evidence." The Alaska Supreme Court in *Smith* however stated:

> A statement by a physician using a probability formula is not required to establish employer liability in workers' compensation. As Larson remarks:
>
> > The compensation process is not a game of 'say the magic word,' in which the rights of injured workers should depend on whether a witness happens to choose a form of words prescribed by a court or legislature. What counts is the real substance of what the witness intended to convey, and for this purpose there are more realistic approaches than a mere appeal to the dictionary.

Smith also noted a physician's reliance on the injured worker's statements in forming an opinion is "not unique." The court cited to an earlier decision in which the doctor upon whom the board had relied said the best way to establish a connection between two injuries would be to "ask the patient how much back pain he had in the interim period." *Id.* at 790, n. 34. The Alaska Supreme Court

came to a similar conclusion in *Williams v. State, Department of Revenue*, 938 P.2d 1065 (Alaska 1997) where the court said absent "semantical confusion," a physician's testimony unequivocally supported the claim. The physician had repeatedly said the work was "a major factor" contributing to the injured worker's medical condition but was not "a substantial factor." *Id*. at 1073.

A disability is fully compensable even if stemming from a preexisting disease or infirmity, if a work-related accident "aggravated, accelerated or combined with the disease or infirmity" in producing the disability. *Hawkins v. Green Associated*, 559 P.2d 118, 119 (Alaska 1977). In addition, aggravation of a preexisting condition may be found absent any specific traumatic event. *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528 (Alaska 1987).

In the *State of Alaska, Department of Corrections v. Dennis*, AWCAC Decision No. 036 (March 27, 2007), the Alaska Workers' Compensation Appeals Commission said the "last injurious exposure rule" still applies after the legislature amended the Act in 2005 to change coverage standards.

Professor Larson sets forth the law concerning compensable consequences of medical treatment:

> The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.
>
> The simplest application of this principle is the rule that all the medical consequences and sequelae that flow from the primary injury are compensable. . . . (1 Arthur & Lex Larson, *Larson's Workers' Compensation Law*, §10.01 (2008)).

Ribar v. H&S Earthmovers, 618 P.2d 582 (Alaska 1980) (complications from surgery for work-related injury are still compensable even if surgery was done negligently).

In *Rodriguez v. Fluor Alaska Inc*., AWCB Decision No. 14-0080 (June 11, 2014), the board addressed a situation where the injured worker had two work injuries with one employer, and returned to work thereafter for numerous joined employers. He eventually became disabled when the last of serial epidural steroid injections offered as ongoing treatment for the two injuries with the first employer caused catastrophic consequences requiring extensive surgery and subsequent disability. *Rodriguez* applied the last injurious exposure rule but found only

temporary symptomatic aggravations and no specific injury with any subsequent employer. Therefore, the first employer was found liable for Rodriguez's ultimate disability and continuing need for medical treatment.

> **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. . . .

In *Philip Weidner & Associates, Inc. v. Hibdon*, 989 P.2d 727 (Alaska 1999), the Alaska Supreme Court addressed §095(a) and said medical treatment must be reasonable and necessitated by the work-related injury. *Hibdon* states "when the Board reviews an injured employee's claim for medical treatment made within two years of an injury that is undisputably work-related, its review is limited to whether the treatment sought is reasonable and necessary." *Id*. at 731. The Alaska Supreme Court in *Turner v. Municipality of Anchorage*, 171 P.3d 180 (Alaska 2007), said medical care can be considered reasonable when the plaintiff presents credible evidence from her treating physician that the treatment is reasonably effective and necessary, other medical experts corroborate the evidence, and the treatment falls "within the realm of medically accepted options." *Turner*, 171 P.3d at 185.

> **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. (*Id*.; emphasis omitted). The presumption application involves a three-step analysis. To attach the presumption of compensability, an employee must first establish a "preliminary link" between his injury and the employment. *Tolbert v. Alascom, Inc*., 973 P.2d 603, 610 (Alaska 1999). For injuries occurring after the 2005 amendments to the Act, if an employee establishes the link, the presumption may be overcome at the second stage when the employer presents substantial evidence, which demonstrates a cause other than employment played a greater role in causing the

disability or need for medical treatment. *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 (March 25, 2011) at 7.

If the board finds the employer's evidence is sufficient to rebut the presumption, it drops out and the employee must prove his case by a preponderance of the evidence. He must prove that in relation to other causes, employment was "the substantial cause" of the disability or need for medical treatment. *Runstrom*, AWCAC Decision No. 150 at 8. This means the employee 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). In the third step, the evidence is weighed, inferences are drawn from the evidence, and credibility is considered.

> **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 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). When doctors' opinions disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.*, AWCAC Decision. No. 087 at 11 (August 25, 2008).

> **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 . . . may not be less than 25 percent on the first $1,000 of compensation . . . and 10 percent of all sums in excess of $1,000 of compensation. . . .
>
> **AS 23.30.155. Payment of compensation**. . . .
> . . . .
>
> (p) An employer shall pay interest on compensation that is not paid when due. . . .
>
> **AS 23.30.395. Definitions.** In this chapter,
> . . . .
>
> (24) 'injury' means accidental injury . . . arising out of and in the course of employment. . . .

8 AAC 45.142. Interest. . . .
. . . .

(b) The employer shall pay the interest

(1) on late-paid time-loss compensation to the employee. . . .
. . . .

(3) on late-paid medical benefits to

(A) the employee . . . If the employee has paid the provider or the medical benefits;
(B) to an insurer, trust, organization, or government agency, if the insurer, trust, organization, or government agency has paid the provider of the medical benefits; or
(C) to the provider if the medical benefits have not been paid.

8 AAC.45.180. Costs and attorney's fees. . . .
. . . .

(f) The board will award an applicant the necessary and reasonable costs relating to the preparation and presentation of the issues upon which the applicant prevailed at the hearing on the claim. The applicant must file a statement listing each cost claimed, and must file an affidavit stating that the costs are correct and that the cost were incurred in connection with the claim. . . .

ANALYSIS

1) Was the oral order declining to leave the hearing record open correct?

On February 19, 2014, Phillips I gave Employee 45 days to depose any authorized physician who had seen or treated him. At hearing on February 18, 2014, Employee stipulated to otherwise "freeze" his hearing preparation in exchange for a hearing continuance. Without a continuance, the February 18, 2014 hearing would have proceeded notwithstanding an oral order refusing to consider any evidence from Employee's independent medical expert, upon whom he intended to rely. Nevertheless, at the June 2, 2015 hearing Employee requested an order leaving the record open so he could depose Dr. Roderer and the insurer's adjuster. Employer objected.

If Employee had difficulty securing Dr. Roderer's deposition in 2014, he could have petitioned well before the June 2, 2015 hearing for an extension of the 45 days allowed in *Phillips 1* to

depose Dr. Roderer. Instead, Employee waited until the Friday before the Tuesday hearing to subpoena him to testify at hearing. Not surprisingly, Dr. Roderer was unavailable on such short notice. Employee provided no compelling reason why the record should be left open so he could depose Dr. Roderer 16 months after *Phillips I* gave him 45 days to do so. As for deposing the insurer's adjuster, Employer correctly noted she was not on Employee's 2014 witness list. Therefore, allowing the record to remain open so Employee could depose the adjuster would "thaw" Employee's hearing preparation without good cause and violate *Phillips I*. Furthermore, as the issues at hearing were causation and continued compensability, it is unclear what relevance the adjuster's testimony would have had. Lastly, Employee did not list the adjuster on his 2015 witness list either and subpoenaed her the day prior to the hearing, which is not appropriate notice notwithstanding the other infirmities in Employee's request to leave the hearing record open. Therefore, for all these reasons the oral order declining Employee's request to leave the hearing record open to obtain depositions was correct. AS 23.30.005(h).

2) Does Employee's August 15, 2008 injury remain compensable after October 10, 2008?

Employee had extensive, preexisting lumbar spine medical conditions and had treated for these conditions and related symptoms extensively prior to his August 15, 2008 injury with Employer. It is undisputed Employee had an accidental "injury" while working for Employer on August 15, 2008. AS 23.30.395(24). Employer paid him disability and medical benefits. However, the disagreement arises over whether Employee's August 15, 2008 work injury continued to disable him and cause the need for additional medical treatment after Employer's EME, which opined Employee's work injury was merely a temporary strain from which he recovered, and which became medically stable by October 10, 2008. This question creates a factual dispute to which the statutory presumption analysis must be applied. AS 23.30.120; *Meek*.

Employee's work injury with Employer and his pre- and post-injury lumbar spine medical conditions are not medically complex. In particular, his Valley injury and his injury with Employer are not unusual and a reasonable person could conclude Employee could have been seriously injured hefting either a compressed air bottle or a heavy garbage can. Therefore, medical evidence is not needed to raise the presumption. *Meek*.

Nonetheless, contrary to Employer's assertion and without regard to credibility, Employee raises the statutory presumption through his own testimony, Dr. Roderer's August 18, 2008 and October 27, 2008 reports, and Dr. Kohler's November 6, 2008 and November 10, 2008 records. Employee states he suffered a new injury on August 18, 2008, and his preexisting symptoms increased thereafter. Employee's injury could conceivably cause low back and lower extremity symptoms. On August 18, 2008, Dr. Roderer, referring to the 2008 Midas injury, said Employee had "exacerbation of pain symptoms . . . after work related injury." On October 27, 2008, he said Employee had low back and right lower extremity pain "status post work-related injury." On November 6, 2008, Dr. Kohler, also referring to the 2008 Midas injury, said Employee had a "second injury" that resulted in "exacerbation of centralized low back pain and the onset of pain and numbness in L4 and 5 distribution with neuropathic symptoms in the L4 distribution." On November 10, 2008, Dr. Kohler said Employee "re-injured himself" while lifting a 55 gallon drum. This evidence raises the presumption and shifts the burden to Employer. *Tolbert*.

Without regard to credibility, Employer rebuts the raised presumption with Drs. Bald's and Bell's November 20, 2008 EME report in which they state the Midas injury caused Employee only a lumbar strain, which had resolved, and with their opinion Employee was malingering. *Runstrom*. The statutory presumption therefore drops out and Employee must prove his claim by a preponderance of the evidence. *Saxton*.

Employer contends the primary issue is "what is the substantial cause" of Employee's "condition, and primarily that means what is the substantial cause of the surgeries that Dr. Kohler" performed. Employer is only partly correct. The law does not require employment or a work injury to be the substantial cause of an underlying medical "condition." In many cases, an employment injury can cause the underlying medical condition, as in the case where a worker falls and breaks a bone. But the word "condition" does not appear in the applicable statute. AS 23.30.010(a). As Employer correctly argued, the law requires this decision to evaluate the "relative contribution" of all causes of Employee's disability and need for medical treatment. This decision must determine if his Midas employment or the work injury in this instance, in relation to all other causes, remains "the substantial cause" of Employee's disability or need for medical treatment after October 10, 2008. *Hansen*.

It is undisputed Employee had a serious work injury with Valley in 2004. AS 23.30.395(24). He treated extensively and continued to treat for it after he went to work for a liquor store and eventually for Employer. If Employee's pain drawings were the only evidence in this case, and the number of markings he put on each drawing was dispositive, the drawings would present a compelling picture suggesting Employee's injury with Employer actually improved his situation and made him feel better. For the most part, Employee's post-Midas-injury pain drawings have far fewer symptom markings than those preceding his injury with Employer. But pain drawings are not the only evidence in this case.

A) The evidence discloses numerous, possible contributing causes to Employee's disability and need for medical treatment after October 10, 2008.

The medical records and testimony suggest the following are possible contributing causes to Employee's disability and need for medical treatment after October 10, 2008: His preexisting lumbar condition; his 2003 NAPA injury; his 2004 Valley injury; a "combination" including pain behavior, symptom magnification and malingering; drug seeking behavior; and his 2008 injury with Employer.

B) Only one cause can be "the substantial cause" for Employee's disability and need for medical treatment after October 10, 2008.

The possible contributing causes for Employee's disability and need for medical treatment after October 10, 2008, will be addressed in order. The law requires this decision to evaluate "the relative contribution" of all different causes of disability or need for medical treatment. *Hansen*. A claim is compensable, or in other words benefits are payable, if in relation to other causes, the work injury is "the substantial cause" of the disability or need for medical treatment. Nothing in the statute or case law suggests all causes other than a work injury can be lumped together to constitute one gigantic "cause" and then weighed against the work injury as an individual cause. AS 23.30.010(a); *Runstrom*. The opposite is true. The relative contribution of each individual cause must be considered. *Hansen*.

(i) Employee's preexisting lumbar condition is not the substantial cause.

Experience shows lumbar discs begin a lifelong degenerative process beginning at a fairly early age. *Rogers & Babler*. EME physicians Drs. Bald and Bell support the notion that Employee's

lumbar degenerative disc disease, in "combination" with other "non-industrial" issues, was the substantial cause of his 2008 "condition." Notably, Dr. Schilperoort said the 2004 Valley injury caused only a minor, "symptomatic aggravation" of Employee's preexisting arthritis. He also released Employee to return to work to full duty in 2005. Drs. Bald and Bell adopted Dr. Schilperoort's reasoning in respect to the 2008 injury with Employer and their diagnoses are very similar, including reference to Employee's "lower lumbar degenerative disc disease." EME Drs. Bald and Bell and SIME Dr. Tapper do not state Employee's preexisting lumbar condition alone is the substantial cause of his disability or need for medical care after October 10, 2008.

By contrast, without regard to physicians saying "magic words," or to semantics, the real substance of Drs. Roderer's August 18, 2008 and October 27, 2008, and Kohler's November 6, 2008 and November 10, 2008 reports is that Employee suffered a new injury on August 18, 2008, which caused increased and persistent symptoms, which disabled him and prompted their medical care. *Smith*; *Williams*. This also comports with Employee's credible, uncontradicted account of his August 15, 2008 trash can injury, which a reasonable mind could conclude was a relatively serious accident. AS 23.30.122; *Smith*. Further, SIME Dr. Tapper said the 2008 injury aggravated and accelerated Employee's preexisting complaints. However, not understanding the medical-legal test, Dr. Tapper had to "lump" together all the previous injuries and "some other things," presumably including Employee's preexisting condition, including lumbar degenerative disc disease, to make "all the preexisting" injuries and conditions "the substantial cause" for Employee's disability and need for low back treatment. Though Employee's preexisting lumbar spine condition was a contributing factor, the lay and medical evidence does not support a finding that Employee's preexisting condition, alone, when compared to his August 15, 2008 work injury, is the substantial cause for Employee's disability and need for medical treatment after October 10, 2008. *Runstrom*.

(ii) Employee's 2003 NAPA injury is not the substantial cause.

EME Drs. Bald and Bell do not include Employee's 2003 NAPA injury in their "the substantial cause" analysis. Thus, their report cannot form a basis to find Employee's 2003 NAPA injury alone, when compared to his August 15, 2008 work injury with Employer, was the substantial cause of disability and need for medical care for his low back after October 10, 2008. SIME Dr.

Tapper expressly includes the NAPA injury in his opinion that "all the preexisting" is "the substantial cause." But, as discussed above, Dr. Tapper did not perform the analysis properly.

Evaluating Employee's 2003 NAPA injury shows NAPA paid Employee two days' disability. He incurred no significant medical expenses. Dr. Neubauer released Employee to full duty work without restriction in 2003. Though the 2003 NAPA injury contributed minimally to Employee's lumbar spine symptoms, the evidence shows, when compared to his August 15, 2008 work injury, it was not the substantial cause of his disability or need for medical care after October 10, 2008. AS 23.30.122.

(iii) Employee's 2004 Valley injury is not the substantial cause.

EME Drs. Bald and Bell were asked to identify "all causes of the condition" they diagnosed and were asked whether they thought the August 15, 2008 work injury was "the substantial cause of any condition." Notwithstanding the adjuster's incorrectly worded question, these physicians were given the appropriate statutory language for "coverage" under AS 23.30.010(a). They concluded "by far the substantial cause" of Employee's "current condition" were nonphysical factors "related to a combination" including pain behavior, symptom magnification, and malingering all in combination with his preexisting lower lumbar degenerative disc disease. These EME physicians gave significant weight to Dr. Schilperoort's prior EME report from the 2004 Valley injury and gave no weight to Employee's 2004 Valley injury as even a contributing factor, much less the substantial cause for any disability or need for additional medical care.

Similarly, though Dr. Tapper did not expressly include the 2004 Valley injury in his causation analysis, it is reasonable to assume he included it in "all the preexisting" which he said was the substantial cause. Again, as already discussed, it is not appropriate to lump all possible causes into one giant cause and weigh it against the work injury. AS 23.30.010(a); *Runstrom*; *Hansen.*

Employee received only 20 weeks TTD for the 2004 Valley injury. Dr. Peterson said Employee was not a surgical candidate from this injury. Dr. Klimow said he had only a lumbar strain. Dr. Schilperoort said Employee had a minor, symptomatic aggravation of his preexisting degenerative condition and returned him to work without any restrictions. Even SIME Dr. Lazar

said Employee was not a surgical candidate and simply needed a trial lumbar corset. None of these medical reports support a finding that Employee's 2004 Valley injury alone, when compared to his August 15, 2008 work injury with Employer, was the substantial cause of his disability and need for medical treatment after October 10, 2008. Dr. Roderer's continued medical treatment and prescription medications demonstrate the 2004 Valley injury contributed to Employee's continuing, subjective complaints. Nevertheless, Employee returned to work at the liquor store and then worked at Midas with regular symptomatic aggravations, but no surgical recommendations. The 2004 Valley injury was a greater cause than most other causes, but not as great as Employee's August 15, 2008 work injury with Employer. AS 23.30.122.

(iv) A "combination" including pain behavior, symptom magnification and malingering is not the substantial cause.

As already discussed, the "combination" theory is not legally correct. AS 23.30.010(a); *Runstrom*; *Hansen*. EME Drs. Bald and Bell emphatically stated "by far the substantial cause" of Employee's current "condition" was a result of "nonphysical factors" related to a combination including pain behavior, symptom magnification and malingering. They further combined this combination with his lower lumbar degenerative disc disease to form "the substantial cause." Drs. Bald and Bell failed to compare the relative contribution of each cause and weigh them against the work injury to see if the work injury was the substantial cause. Without the "out-and-out malingering" opinion, their report would not even overcome the presumption because it addresses the substantial cause of Employee's "condition," not the substantial cause of his disability and need for medical treatment. AS 23.30.010(a). Had this decision agreed Employee was malingering based upon the 2008 EME report, Employee would not be able to prove his claim by a preponderance of the evidence. *Saxton*. Malingering as a cause is discussed below.

Dr. Tapper's report has a similar problem. He lumps together "all the prior injuries . . . some other things" and decides all these combined are "the substantial cause." Dr. Tapper does not suggest Employee was malingering. Only the EME from the 2004 injury and the two EME physicians from the 2008 injury with Employer have ever suggested Employee was malingering. Dr. Roderer treated Employee for years and never suggested he was malingering. It is unlikely Dr. Roderer would have continued to treat Employee and prescribe medication if he thought

Employee was malingering. Less weight is given to the EME reports on the malingering issue and greater weight is given to Dr. Roderer and the lay evidence. Employee is not malingering. AS 23.30.122; *Smith*. The credible medical evidence and the law do not show that any "combination" of contributing causes is the substantial cause of Employee's disability and need for medical treatment after October 10, 2008. AS 23.30.010(a).

(v) Employee's drug seeking behavior is not the substantial cause.

EME Drs. Bald and Bell commented on Employee's drug usage but did not expressly include "drug seeking behavior" in their "combination" theory, unless it means the same to them as "pain behavior," which is addressed above. SIME Dr. Tapper also referenced Employee's drug seeking behavior. Though it is not mentioned expressly in his "lumping" method, Dr. Tapper suggested drug seeking behavior was part of "all the preexisting" causes, which lumped together comprised 50 percent cause, and thus was "the substantial cause" of Employee's continuing disability and need for medical treatment in Dr. Tapper's opinion. There is no question Employee has ingested considerable pain medications. But he was able to work successfully at the liquor store and for nearly a year for Employer all the while taking narcotics and other prescription medications. There is no medical evidence suggesting drug seeking behavior alone is the substantial cause of Employee's disability or need for medical care after October 10, 2008. Therefore, when compared to Employee's August 15, 2008 injury with Employer, this cannot be the substantial cause.

(vi) Employee's 2008 Injury with Employer is the substantial cause.

The fact none of the above, when viewed separately in relation to other causes, is the substantial cause does not necessarily mean the work injury is the substantial cause. Employer contends Employee has no evidence from any physician suggesting the August 15, 2008 work injury is the substantial cause of his disability and need for medical treatment after October 10, 2008. Physicians typically offer opinions on this ultimate issue. But the fact-finders review the evidence, evaluate the relative contribution of all different causes of Employee's disability and need for medical treatment, and the fact-finders decide if "the employment" including in this case the August 15, 2008 work injury is the substantial cause of disability and need for medical

treatment. AS 23.30.010(a). It is an administrative decision. Considerable lay and medical evidence points to the August 15, 2008 work injury as the substantial cause.

(a)The uncontradicted lay testimony supports Employee's position.

Employee presented testimony from five lay witnesses. Employee testified about a relatively dramatic work injury with Employer. A reasonable person could conclude that Employee suffered a serious back injury with attendant symptoms after lifting a 55 gallon barrel full of repair shop refuse into a dumpster, having the barrel bounce off the dumpster, hitting him in the chest and knocking him to the ground. *Rogers & Babler*. Though Employee was the only witness to the event, Employer never contradicted or refuted his account. Employee, his wife Laurie and his son Damian all convincingly testified Employee crawled out of his truck at home after the work injury on August 15, 2008, and had to be assisted to a vehicle to take him to the emergency room. Employee believed he had suffered a new injury.

The exact weight of the barrel which bounced off the dumpster, hit Employee and knocked him to the ground is immaterial. Employee's weight estimates range from 100 to 250 pounds according to the medical records. The record in which Employee purportedly said it weighed 250 pounds is an outlier and could be accurate or could simply be the result of Employee's understandable hyperbole or a dictation or typographical error. Regardless, Employer does not dispute the injury occurred as Employee stated and provided no contrary evidence suggesting the trash barrel was anything but "heavy." Employee's injury account is uncontradicted and is credible. AS 23.30.122; *Smith*.

Further, at hearing Employee was forthcoming about his prior cocaine addiction, addictive personality and other issues. In particular, his acknowledgment he would have agreed to have surgery before the August 15, 2008 injury had a surgeon offered it to him speaks to his credibility. Employee's account of how he obtained his job with Employer was also compelling and uncontradicted. Employee believed he could perform the required work. He acknowledged that but for Dr. Roderer's narcotic prescriptions, Employee might not have been able to continue working at Midas because tasks such as lifting mounted tires aggravated his preexisting low back symptoms. Employee further stated, notwithstanding his preexisting symptoms, before August

15, 2008, he had been doing fairly well and had gone golfing, fishing, walking and could perform his job with Employer. Employer offered no contrary evidence. Employee never physically returned to the way he was before the dumpster incident. Employee is credible. AS 23.30.122; *Smith*.

Employee, post-injury, had gone through normal conservative care for his increased low back pain and lower extremity symptoms including physical therapy and epidural steroid injections. *Rogers & Babler*. Unlike after previous injuries, these methods did not improve Employee's situation sufficient for him to return to work. Employee saw Dr. Kohler just a few months after his work injury with Employer. Employee thought Dr. Kohler was "absolutely awesome" because it only took him 15 minutes to determine Employee's problem and propose surgical correction. A reasonable person in Employee's situation could be expected to accept Dr. Kohler's recommended surgery. *Rogers & Babler*.

Krieg has known Employee since Krieg was a child. Krieg frequently participated in physical activities with Employee and his son Damian before Employee's injury with Employer. To Krieg's knowledge, before his Midas injury Employee worked hard whereas after the injury Employee increased his walks but never participated in physical activities again with Krieg. Krieg's testimony is credible, uncontradicted and is given considerable weight on Employee's physical abilities before and after his work injury with Employer. AS 23.30.122; *Smith*.

Employee's son Damian testified he was present when Employee came home on August 15, 2008, and saw him crying and in significant pain. Damian had observed Employee both before and after his injury with Employer. In Damian's view, Employee never returned to his "old self" after the injury. Damian's testimony is credible, uncontradicted and is given some weight, but less weight than Krieg's testimony because Damien is Employee's son. AS 23.30.122; *Smith*.

Employee's wife Laurie has known Employee since 1984, and is aware of his work injuries. She confirmed several physicians told Employee he was not a surgical candidate prior to his injury with Employer. While working at Midas, Employee would sometimes come home at night and be "stiff and sore" if he had done additional lifting, but Laurie never saw him like he was on

August 15, 2008. She had never seen him in so much pain. Laurie and Employee saw Dr. Kohler together and were immediately impressed with his seeming ability to diagnose Employee's problem and suggest a surgical solution. Employee and his wife were reasonable in relying upon Dr. Kohler's surgical recommendation, and subsequent recommendation for a spinal cord stimulator. Unfortunately, the second to last surgery went awry with catastrophic results. In Laurie's view, Employee never returned to his "former self" following his surgeries after the injury with Employer. Laurie conceded Employee's pre- and post-Midas injury symptoms were "similar," but after the work injury with Employer his symptoms were "more severe." Laurie's testimony is credible, uncontradicted and is given some weight, but less weight than Krieg's testimony because Laurie is Employee's wife. AS 23.30.122; *Smith*.

Lockhart has known Employee since 2006. He lived at Employee's home from around September 2007 through May 2008. He observed Employee on a regular basis and said he was "active." Lockhart never noticed anything out of the ordinary with Employee physically before the injury with Employer. Lockhart never observed Employee abusing drugs or alcohol. Following the Midas injury, Lockhart saw Employee lying around on his bed. He had no reason to question Employee's honesty. Lockhart's testimony is credible, uncontradicted and is given considerable weight. AS 23.30.122; *Smith*.

The fact Employee's lay witnesses were unaware Employee had been using narcotic medication and had similar symptoms prior to his injury with Employer is immaterial. Their testimony was not offered to provide medical diagnoses. It was offered to show a contrast and comparison in his appearance, symptoms and physical activity pre- and post-injury with Employer. Employee's lay evidence supports a finding that the August 15, 2008 work injury is the substantial cause of Employee's disability and need for medical care continuing from that day forward, because the lay evidence demonstrates Employee's pre- and post-injury symptoms and physical activity dramatically changed after his work injury with Employer and never returned to their pre-injury levels. *Rogers & Babler*.

(b) The credible medical evidence supports Employee's position.

As Employee pointed out at hearing, marks on pain drawings do not tell the entire story. His medical records show that at most times prior to his injury with Employer, Employee was working or had concurrent medical conditions, including hepatitis C, which Dr. Eule said could account for his widespread peripheral neuropathy. This unrelated medical condition accounts for some markings on Employee's pain drawings prior to his work injury with Employer. Employee and his wife testified that when Employee was physically active or worked hard, such as when he lifted liquor cases or changed tires at work before his injury with Employer, his preexisting pain and radicular symptoms increased. These increased symptoms are also reflected on Employee's pre-injury pain drawings. His pre-injury medical records show medication and rest or relaxation usually "improved" his symptoms. After his injury with Employer, Employee ceased working altogether and either maintained or increased his pain medications. Even without work and with increased medication, unlike most pre-injury records, most post-Midas-injury medical reports record "nothing," relieved his post-injury symptoms. Fewer markings on Employee's post-injury pain drawings reflect less physical activity post-injury. His post-Midas-injury physical examinations show Employee could either not "heel or toe walk" at all, or could do so with great difficulty especially on the right. Prior to his work injury with Employer, Employee typically had little difficulty performing the heel and toe walking maneuver.

Employee and his wife testified had a physician offered surgery to Employee before his injury with Employer, they probably would have gone forward with surgery. Employee's preexisting symptoms were exasperating to him, and he and his wife were looking for "a cure." But the medical evidence shows no physician recommended lumbar surgery before Employee's injury with Employer. The fact Employee could have or would have had surgery prior to his work injury with Employer is immaterial. *Hawkins*. A preexisting condition does not disqualify his claim if Employee's employment with Employer aggravated, accelerated or combined with the infirmity to produce disability or the need for medical treatment. *DeYonge*. Worsened symptoms alone are compensable under the Act so long as the work injury is the substantial cause of disability or need for medical care. AS 23.30.010(a); *Hester*; *Runstrom*; *Hansen*.

Dr. Roderer, well familiar with Employee's history, nonetheless concluded Employee post-injury had "severe right lower extremity pain after the work-related injury." Dr. Roderer increased Employee's pain medication in response to this injury. It was reasonable for Dr. Roderer to refer Employee to an orthopedic surgeon, given Employee's failure at conservative measures. *Rogers & Babler*. In October 2008, Dr. Roderer referred Employee to Dr. Kohler for surgical evaluation. SIME Dr. Tapper understood how this referral and surgical recommendation came about and did not fault or criticize either Dr. Roderer or Dr. Kohler.

Dr. Kohler's surgical recommendation fell well within the two year post-injury period during which this decision has no discretion to second-guess Employee's physicians. *Hibdon*. Dr. Roderer thought Dr. Kohler could help Employee and referred him for a surgical consult. Dr. Kohler believed he could help Employee. Dr. Kohler thought Dr. Roderer could help Employee with a spinal cord stimulator and referred him back. The lumbar fusion initially relieved Employee's low back pain. The spinal cord stimulator initially relieved some of Employee's lower extremity symptoms. Both procedures were somewhat effective. *Turner*. Drs. Kohler and Roderer thought they were reasonable and Dr. Tapper did not criticize the surgical decision and understood how it came to be recommended. *Hibdon*.

Physicians who said Employee was not a surgical candidate either gave their opinions before his August 15, 2008 work injury with Employer, or based their opinion on the fact Employee had an addictive personality, smoked or had positive Waddell signs. There is no evidence in the medical records or testimony showing these concerns played any role in the blood clot which ultimately resulted in catastrophic consequences to Employee following his second to last surgery. Therefore, Employee's decision to undergo surgical intervention was reasonable. Employee had a lengthy pre- and post-injury battle with low back and lower extremity symptoms and failed to respond to continued conservative treatment after the Midas injury. Dr. Kohler's confidence surgery could relieve his symptoms, his surgical recommendation, Drs. Koehler's and Roderer's spinal cord implant prescription and Employee's decision to have surgery makes surgery and a spinal cord stimulator both necessary and reasonable to address Employee's increased symptoms following the Midas injury. *Rogers & Babler*; *Turner*; *Hibdon*.

Putting aside "magic words," semantics and Dr. Tapper's misunderstanding of the proper legal analysis, his report and deposition testimony can only be read to support Employee's causation and compensability position. *Smith; Williams*. If Dr. Tapper's confusion about "lumping together" or "combining" all non-work-related causes for Employee's disability and need for medical treatment, are also put aside, he opines the August 15, 2008 work injury comprises 49 percent of the cause, which makes it the substantial cause when compared with the relative contributions of every other individual cause standing alone. AS 23.30.010(a). Since this decision finds Employee's post-injury surgeries reasonable and necessary, it also gives greater weight and credibility to Dr. Tapper's 49 percent causation opinion, which includes these surgeries and the unfortunate consequences from one procedure. AS 23.30.122; *Smith*; *Moore*.

The Alaska Supreme Court in *Smith* credited the age-old method for a physician to determine the connection between two injuries by asking the patient "how much back pain he had in the interim period." *Smith*, 172 P.3d 782 at 790, n. 34. Employee said he had greater pain and other symptoms following the work injury with Employer, and Drs. Roderer and Kohler accepted this statement, which is supported by Employee's medical records and his lay witnesses. Further, there is no reason to suspect that had Dr. Kohler reviewed Employee's pre-injury medical records and knew, for a certainty, that Employee had similar, though lesser, pre-injury symptoms, he would not have still offered surgery. Dr. Tapper expressly stated Employee's work injury with Employer aggravated his preexisting lumbar condition. He also said the "magic words" and opined the work injury with Employer was a 49 percent cause, which makes it the substantial cause relative to contributions from other identified possible causes. An aggravation can be found absent a specific, traumatic event. *Rogers & Babler*. Here, Employee had an undisputed, fairly dramatic work injury with Employer. It was the last injurious exposure. *Dennis*. This case is distinguishable from *Rodriguez* because unlike the claimant in *Rodriguez*, Employee had a specific, traumatic injurious event with Employer, which gave rise to surgery, which surgery caused additional disability and more need for medical treatment. *Rogers & Babler*.

Credible lay and medical evidence demonstrate Employee aggravated his lumbar condition on August 15, 2008, in the described injury, and his symptoms never reverted to the level at which

he was functioning prior to this injury. *Hester*. The surgery, which ultimately went awry, was performed to address Employee's symptoms following the August 15, 2008 work injury with Employer. The unfortunate consequences of Employee's second to last surgery are compensable because they resulted from reasonable and necessary medical treatment to address a primary work injury and are permanent. 1 *Larson's Workers' Compensation Law* §10.01; *Ribar*.

Had Employee not had surgical intervention after his work injury with Employer, it is possible his symptoms may have returned to the same level as before his August 15, 2008 injury. It is equally possible he may have returned to work for Employer. But at this point, these possible results are mere speculation and unknowable because his post-injury surgeries changed everything. This decision has carefully considered all possible causes for Employee's disability and his need for medical care after October 10, 2008. It has evaluated the relative contribution of every alleged cause of Employee's disability and need for medical treatment beginning October 10, 2008, and continuing. A preponderance of credible lay and medical evidence shows Employee's August 15, 2008 work injury with Employer, including all subsequent surgeries performed to address his increased and persisting symptoms thereafter, was the substantial cause of his disability and the need for such medical treatment. Therefore, Employee's August 15, 2008 work injury with Employer was and is compensable. AS 23.30.010(a); *Ribar*; *Saxton*.

3) Is Employee entitled to additional benefits?

This decision finds Employee's August 15, 2008 work injury with Employer continues to arise out of and in the course of his employment, continues to be the substantial cause of his disability, impairment and need for medical treatment, and thus continues to be a compensable injury. AS 23.30.010(a). Therefore, Employee is entitled to benefits as the parties stipulated at the June 2, 2015 hearing, subject to any PPI or other valid offsets from his TTD or PTD entitlements.

4) Is Employee entitled to statutory attorney's fees, costs and interest?

Employee did not file an attorney's fee affidavit. He requests statutory minimum attorney's fees on all benefits to which he is now entitled. The parties stipulated to his disability and impairment status. Employer further stipulated to medical costs and related transportation benefits in accordance with the Act, subject to adjustment under the medical fee schedule. As

the record does not disclose the exact amount of all benefits to which Employee may be entitled, and statutory interest has not yet been calculated, this decision will not award a specific statutory attorney's fee amount. However, Employee prevailed on the main issues in this case, continued "causation" and "compensability," and his request for a statutory minimum attorney's fee award will be granted. AS 23.30.145(a). If the parties cannot agree on the attorney's fee award, they can bring this issue back for a subsequent hearing.

Employee did not file a cost statement and affidavit. The cost regulation does not set forth a specific time for an injured worker to file his cost statement and affidavit. 8 AAC 45.180(f). Employer did not object to Employee's cost request, but in general objected to continued causation and compensability. Therefore, Employee's request for costs will be granted, subject to him filing a cost statement and affidavit within seven days from this decision's date. Employer will have seven days thereafter, or seven days from the date it receives the itemization, whichever is shorter, to review the statement and affidavit, and file any objections. If the parties cannot agree on a cost award, they can bring this issue back for a subsequent hearing.

Interest is mandatory. As Employee has prevailed in his claim, he and his medical providers or third-party insurers are entitled to statutory interest on all past-due benefits in accordance with the Act. AS 23.30.155(p); 8 AAC 45.142. Given the PPI and other possible offsets, it may take the parties time to determine the exact benefits to which Employee is entitled. The parties will be directed to calculate all benefits to which Employee is entitled and Employer will be directed to pay these benefits and related statutory attorney's fees and interest promptly in accordance with the Act to avoid penalty for late payment.

CONCLUSIONS OF LAW

1) The oral order declining to leave the hearing record open was correct.
2) Employee's August 15, 2008 injury remains compensable after October 10, 2008.
3) Employee is entitled to additional benefits.
4) Employee is entitled to statutory attorney's fees, costs and interest.

ORDER

1) Employee's September 23, 2010 claim as amended is granted.

2) Employee is awarded TTD, PPI, PTD, medical and related transportation costs, interest and statutory minimum attorney fees in accordance with this decision and the parties' agreement.

3) Employee is directed to file a cost statement and affidavit within seven days from this decision's date.

4) Employer has seven days from the date it receives Employee's cost statement and affidavit to file a written objection.

5) The parties are directed to calculate the benefits to which Employee, his medical providers, Medicaid or his third-party insurer are entitled pursuant to this decision promptly, and Employer is ordered to pay all benefits within the time constraints set forth in the Act in accordance with this decision and order.

Dated in Anchorage, Alaska on July 17, 2015.

ALASKA WORKERS' COMPENSATION BOARD

_____
William Soule, Designated Chair

_____
Michael O'Connor, Member

If compensation is payable under terms of this decision, it is due on the date of issue. A penalty of 25 percent will accrue if not paid within 14 days of the due date, unless an interlocutory order staying payment is obtained in the Alaska Workers' Compensation Appeals Commission.

If compensation awarded is not paid within 30 days of this decision, the person to whom the awarded compensation is payable may, within one year after the default of payment, request from the board a supplementary order declaring the amount of the default.

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 Dick Phillips, employee / claimant v. Bilikin Investment Group Incorporated., employer; Republic Indemnity Company of America (RIG), insurer / defendants; Case No. 200813169; 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 July 17, 2015 .

_____

Elizabeth Pleitez, Office Assistant