ALASKA WORKERS' COMPENSATION BOARD

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

SCOTT A. HAHN,	)	
Employee,	)	
Claimant,	)	FINAL DECISION AND ORDER
	)	
v.	)	AWCB Case No. 200917867
	)	
ARCTEC ALASKA,	)	AWCB Decision No. 15-0081
Employer,	)	
	)	Filed with AWCB Fairbanks, Alaska
and	)	on July 14, 2015
	)	
ARCTIC SLOPE REGIONAL CORP.,	)	
Insurer,	)	
Defendants.	)	
	)	

Scott Hahn's (Employee) March 12, 2013 claim was heard on May 21, 2015, in Fairbanks, Alaska, a date selected on March 10, 2015. Attorney Christopher Beltzer appeared and represented Employee. Attorney Robert Bredesen appeared and represented Arctec Alaska and Arctic Slope Regional Corp. (Employer). Employee appeared and testified, and James Eule, M.D., through deposition, testified on Employee's behalf. Dennis Chong, M.D., appeared and testified on Employer's behalf. Peter Diamond, M.D., testified through deposition. The record remained open at the hearing's conclusion for Employee's supplemental fee affidavit and Employer's objections. After deliberations, the record closed when the board next met on June 11, 2015.

ISSUES

Employee contends there is no dispute Employee was injured from the fall from a ladder while working on December 3, 2009, and all physicians agree Employee sustained an injury from the

fall except Dr. Chong. Employee contends a medical determination must be made regarding whether his claim for continued medical and temporary total disability (TTD) benefits and an eligibility evaluation for reemployment benefits is compensable. Employee contends the greatest weight should be given James Eule, M.D.'s opinions because he has treated Employee's lumbar spine from the onset of treatment. Employee further contends reliance upon Dr. Eule's opinions is in accord with "Ockham's Razor" principle, which holds that among competing opinions that predict equally well, the one with the fewest assumptions should be relied upon.

Employer contends no one disputes Employee has a low back condition, or that Employee fell from a ladder while working on December 3, 2009. Employer contends, however, Employee's medical record includes numerous chart notes for other conditions following the December 2009 incident, however, none reflect any low back symptoms until a year later. Employer contends greater weight should be given the opinions of Dr. Diamond and Dr. Chong, the only physicians to have reviewed the entire medical record, upon which they both relied to conclude the December 2009 work incident is not the substantial cause of Employee's disability or need for medical treatment.

1) **Is the December 3, 2009 work injury the substantial cause of Employee's disability and need for medical treatment for his low back?**

2) **Is Employee entitled to attorney fees and costs?**

FINDINGS OF FACT

1) On September 4, 1981, Employee injured his neck and back while working for Cascade Diesel. Employee was a mechanic and did heavy lifting. His spinal motion was restricted on flexion and extension, and he had muscle spasms caused by cervical dorsal lumbar spine subluxation. Employee was released to return to work on June 1, 1982, but continued to treat with Gary Davis, D.C., who noted Employee's work as a diesel truck mechanic caused continual intermittent exacerbations of neuropathic subluxation of Employee's cervical dorsal lumbar spine. (Washington Labor & Industries Accident Report Claims Section, September 9, 1981; Medical Progress Reports, Dr. Davis, December 1, 1981 and June 1, 1982; Sixty Day Report, Dr. Davis, August 19, 1982.)

2) On December 15, 1982, during a State Special Examination, history of Employee's back injuries was recorded. He first injured his low back in a diving accident when he was a senior in high school, which improved after chiropractic manipulations. He had a second back injury, which was industrial, his back improved and his Washington Labor and Industry claim was closed. The September 4, 1981 injury was his third back injury. X-rays revealed lumbar hyper lordosis, but were otherwise normal. John Dunn, M.D., diagnosed chronic lumbar strain, and found no specific treatment was necessary, Employee was able to work, and his claim should be closed. Dr. Dunn placed Employee in Category One for Permanent Lumbosacral Impairments. (State Special Examination Report, Dr. Dunn, December 15, 1982.)

3) On August 23, 1984, Employee reported an injury to his spine when he lifted a truck tire and hub assembly. The subjective findings included 1/2 inch right leg contracture, pelvic imbalance, shoulder imbalance, head tilt, and restriction of cervical and lumbar motion. X-rays revealed displacement of vertebral bodies anatomically in both the cervical and lumbar spine. Employee was diagnosed with displacement cervical disc, lumbar intervertebral disc syndrome, and low back pain. (Chart Note, Joseph Howells, D.C., August 27, 1984.)

4) On November 27, 1984, Employee was treated for a November 16, 1984 work accident that caused motion restriction and moderate pain in Employee's cervical and lumbar spine. (Letter to Washington Department of Labor & Industries, Joseph Howells, D.C., November 27, 1984; Washington Labor & Industries Accident Report Claims Section, November 29, 1984.)

5) On November 23, 1997, Employee submitted an incident report while working for Valley Freightliner, Inc. When he removed a transmission and took down the clutch he hurt his back or hips on November 16, 1997. (Incident report, November 23, 1997.)

6) On December 3, 2009, while working for Employer, a support timber fell and hit the ladder Employee was on, causing Employee to fall. He complained of injuries to his "low back / left upper back and left shoulder." (Accident / Incident Report, December 3, 2009.)

7) On December 9, 2009, a report of occupational injury was filed. (Report of Occupational Injury or Illness, December 9, 2009.)

8) On December 23, 2009, Employee was treated for bronchitis, dermatitis, eczema, cellulitis and finger abscess. The skin conditions erupted after Employee worked with antifreeze several months prior. The medical history taken did not include low back, left upper back or left

shoulder injuries, but did include "trauma resulting from being run over by a truck twice." (Chart Note, Hillside Family Medical, Rachel Coleman, PA, December 23, 2009.)

9) On January 7, 2010, Rachel Coleman, PA, performed a Fit for Duty Exam – Station Mechanic and identified no issues with Employee's muscular and skeletal systems. Employee was found fit for the duties of Station Mechanic and released to return to work and instructed to keep his hands dry, not to wear gloves for a week and then only latex free gloves. During this appointment, Employee did not complain of leg, hip, or low back pain. (Chart Note, Hillside Family Medical, Rachel Coleman, PA, January 7, 2010.)

10) On April 2, 2010, Employee reported that while lifting five gallon buckets of fuel, he slipped off a PP2 fuel tank, grabbed the ladder and his elbow "popped again." The first left elbow pop occurred on March 28, 2010, when he lifted a heavy box. The medical history mentions Employee fell off a ladder in January. Employee was diagnosed with tendinitis and taken off work for one week. (Medical Report of Injury (Illness), April 2, 2010; Physician's Report, April 2, 2010; Chart Note, Patients First Medical Clinic, April 2, 2010.)

11) An April 9, 2010 left elbow MRI's findings suggested a partial complex tear with tendinitis developing at the biceps insertion. X-rays found no evidence of acute left elbow skeletal injury but revealed degenerative changes of the humero-ulnar and radiocapitellar joints. (MRI Report, April 9, 2010; X-ray Report, April 9, 2010.)

12) On April 15, 2010, Robert Thomas, PAC, and Michael McNamara, M.D., diagnosed a torn left distal bicep and recommended surgery, which occurred on April 30, 2010. Employee did not mention low back, leg, or hip pain. (Chart Note, April 15, 2010; Operative Report, Dr. McNamara, April 30, 2010.)

13) On August 11, 2010, employee was discharged from physical therapy after 21 visits. Employee did not complain of low back, leg, or hip pain during any of his physical therapy sessions. (Discharge Report, Alaska Hand Rehabilitation, August 11, 2010; record.)

14) On September 30, 2010, Employee's left distal bicep was medically stable and he was referred for a permanent partial impairment (PPI) rating. Employee was released to full duty work with no restrictions beginning October 22, 2010. (Patient Visit Note, Dr. McNamara, September 30, 2010; Work Status, Dr. McNamara, September 30, 2010.)

15) On October 22, 2010, Kurt Mentzer, M.D., rated Employee's PPI as four percent using the American Medical Association Guides to the Evaluation of Permanent Impairments, Sixth Edition. (Patient Visit Note, Dr. Mentzer, October 22, 2010.)

16) On December 9, 2010, Employee complained of a head cold moving down to his chest and hip pain. The provider at Patients First Medical Clinic noted Employee had chronic intermittent hip pain for the last year, and Employee had not reported the pain. (Chart Note, Patients First Medical Clinic, December 9, 2010.)

17) On December 9, 2010, x-rays of Employee's lumbar spine revealed degenerative changes including a 16 degree levoconvex curvature, disc degeneration and endplate sclerosis at L2 – L3, L5 – S1, posterior facet degeneration, and L1 anterior wedging. X-rays of Employee's hip showed mild right sacroiliitis, spurring at the pubic symphysis and lower lumbar spine. No hip fracture or dislocation was evident. (Lumbar Spine X-ray Report, December 9, 2010; Pelvis and Hip X-ray Report, December 9, 2010.)

18) On January 14, 2011, Employee's dermatitis cellulitis, and abscesses on his upper arm and forearm reoccurred. Employee believed "there is a problem with his workplace that is causing these repeated issues." (Chart Note, Miriam Nolte, M.D., January 14, 2011.)

19) On January 20, 2011, Employee complained of stomach pain and hip or lumbar pain, indicating he had a history of both. Employee was referred to the Alaska Spine Institute. (Chart Note, Patients First Medical Clinic, January 20, 2011.)

20) On January 28, 2011, Employee completed a general questionnaire describing his problem as, "Well got ran over by Mack Log trk at work by driver 10-14-84, claim #J655015. Fell off a ladder 2009 onto ice boulders at work." He described his pain to include numbness and aching and indicated on a scale of 0 to 10 his pain severity was 10, but varied in intensity from 1 to 10. He listed the fall off the ladder in 2009 as a previous serious injury but indicated no treatment was necessary. The other previous serious injury he included was crushed torso and traumatic brain injury. He indicated he had exploratory surgery and was off work for four to five years. (Questionnaire, Scott Hahn, January 28, 2010.)

21) On January 31, 2011, Sean Taylor, M.D., on referral from Bennett Jackson, ANP, diagnosed the following:

a. Chronic Lumbosacral back pain with left lower extremity referral.
b. Remote history of crush injury to the torso on 10/14/1985, with 5% whole person impairment.

c. Lumbar spondylosis with anterior wedging of L1.
d. History of tobacco abuse.

Dr. Taylor ordered laboratory work and imaging studies to evaluate for neural impingement and indicated if there were no contraindications Employee would be treated with physical therapy. (Consultation Report, Dr. Taylor, January 31, 2011.)

22) On February 2, 2011, lumbar spine MRI showed severe degenerative changes throughout Employee's spine with stenosis of the left lateral recess and left neural foramen at L4-5, which was the most severe abnormality. In addition, there was "some" foraminal stenosis at L5-S1, left greater than right, and not as severe as L4-5; however, it was noted either of these could correlate with Employee's symptoms. There was also mild to moderate central spinal stenosis at L3-4. (MRI Report, Harold Cable, M.D., February 2, 2011.)

23) On February 8, 2011, x-rays of Employee's spine with flexion and extension showed diffuse disc space narrowing, heavy endplate sclerosis with osteophytes, and minimal subluxations with positional movement. (X-ray Report, University Imaging Center, February 8, 2011.)

24) On February 16, 2011, Dr. Taylor notified Employee there were multiple laboratory work abnormalities and directed Employee to follow-up with his primary care physician. The treatment plan for Employee's back was over-the-counter ibuprofen as needed for pain and physical therapy for four weeks. (Chart Note, Dr. Taylor, February 16, 2011.)

25) On February 24, 2011, Dr. Taylor indicated Employee could return to sedentary work that allowed for position change every 20 minutes. (Attending Physician's Return to Work Recommendations, Dr. Taylor, February 24, 2011.)

26) On March 25, 2011, Dr. Taylor advised Employee his thyroid function must be in normal range and he must be infection free for a week prior to receiving an epidural steroid injection. (Chart Note, Dr. Taylor, March 25, 2011.)

27) On April 11, 2011, Employee was clinically stable, free of infection and scheduled for a caudal epidural steroid injection, which he received on May 3, 2011, for lumbar spinal stenosis. (Chart Note, Dr. Taylor, April 11, 2011; Procedure Report, Larry Levine, M.D., May 3, 2011.)

28) On July 28, 2011, Matthew Provencher, M.D., evaluated Employee at Employer's request. Dr. Provencher diagnosed the following:

a. Lumbar strain related to the incident on a more-probable-than-not basis, not yet medically stable.
b. Pre-existing degenerative changes in the lumbar spine, temporarily exacerbated by the industrial injury.
c. Lumbar spinal stenosis and degenerative changes, most noted at L4-L5 and L5-S1, pre-existing but temporarily exacerbated by the industrial injury.

Dr. Provencher opined the December 2, 2009 work injury was the substantial cause of temporary exacerbation of Employee's significant pre-existing lumbar condition. He recommended additional diagnostic treatment, including one additional selective nerve root block, as well as an additional six weeks of physical therapy two times per week. Dr. Provencher anticipated medical stability in three months. He also found Employee disabled from performing his position's duties, but found Employee could perform sedentary work with no lifting more than 10 pounds, no bending, no crawling, no ladders, and no stooping. Dr. Provencher believed Employee could be released to return to work as a station mechanic in three months. (EME Report, Dr. Provencher, July 28, 2011.)

29) On July 29, 2011, Employee received a second selective nerve root block epidural steroid injection at L4 and L5 on the left for low back pain, lumbar radiculopathy, and lumbar spinal stenosis. (Procedure Report, Dr. Levine, July 29, 2011.)

30) On August 25, 2011, James Eule, M.D., concluded Employee had not improved after extensive conservative treatment, diagnosed multilevel level lumbar spinal stenosis with significant neurogenic claudication, and opined Employee would benefit from an L3 to S1 decompression and possibly decompression on the right side and at the L2 – 3 level. (Chart Note, Dr. Eule, August 25, 2011.)

31) On November 9, 2011, Dr. Eule, M.D., performed decompression at L3-L5 and L5-S1. Both the pre and post-operative diagnoses were lumbar spinal stenosis of the lumbar region. (Alaska Regional Hospital Operating Room Medical Record, November 9, 2011; Attestation Statement, October 28, 2011.)

32) On November 15, 2011, Dr. Eule reported Employee had dramatic improvement in his left leg symptoms postoperatively; however, a bit of irritation returned to Employee's left leg. (Dr. Eule report, November 15, 2011.)

33) On November 22, 2011, James Glenn, PA-C, noted Employee continued to have left leg symptoms. Mr. Glenn noted Employee admitted he had been overdoing it; he was moving out of

his house and had been moving small items, but was letting friends do the majority of heavy lifting. Mr. Glenn reminded Employee he needed to take it easy over the next six to eight weeks to heal. Because Employee continued to have radicular symptoms Gabapentin was prescribed. (Chart Note, PA-C Glenn, November 22, 2011.)

34) On December 22, 2011, six weeks status post L3 – S1 decompression, Employee was greatly improved. "He is incredibly happy and says he's incredibly blessed and gave me a hug that he is doing so well and not having any of the pinching or pain. He said his sexual function has improved as well." Dr. Eule ordered physical therapy. (Chart Note, Dr. Eule, December 22, 2011.)

35) On January 3, 2012, Employee commenced physical therapy. Employee's main complaint was weakness. He had no leg pain. Low back pain was activity related. Treatment's main goal was to decrease nerve root irritation and strengthen Employee's low back so he could return to work. (Alaska Physical Therapy Specialists Initial Evaluation, James Halfpenny, PT, January 3, 2012.)

36) On February 13, 2012, Employee was evaluated for work conditioning ordered by Dr. Eule. He began the program on February 14, 2012, and was discharged on March 30, 2012. On March 26, 2012, Employee appeared to have gained enough overall strength and stability to return to work and his aerobic tolerance had improved. His positional tolerance and repetitive motions were still somewhat limited. On March 27, 2012, Employee was ready for a functional capacity evaluation to assess his readiness to return to work. On March 30, 2012, Employee was found able to return to work full duty with paced activities and possible restrictions of vibratory equipment, following completion of a functional capacity evaluation and a release by his physician. (Plan of Care, Cathy Trout, PT, February 13, 2012; Daily Notes, Cathy Trout, PT, February 14 – March 30, 2012.)

37) On April 5, 2012, a physical capacities evaluation placed Employee in the medium heavy physical capacity demand classification. (PCE, April 5, 2012.)

38) On April 10, 2012, Dr. Eule noted Employee completed work hardening, had been working out and doing "a lot of exercises," and had a functional capacity exam, which indicated he has the ability to return to his "regular job." Neurologically, Employee was grossly intact. Employee was released back to work, was medically stable, and could receive his permanent partial impairment (PPI) rating. (Chart Note, Dr. Eule, April 10, 2015.)

39) On April 25, 2012, Michel Gevaert, M.D., rated Employee's PPI based upon the AMA Guides to Evaluation of Permanent Impairment, 6th Edition, which was 14 percent of the whole person. (Letter to Dr. Eule from Dr. Gevaert, April 25, 2012.)

40) On November 15, 2012, Employee returned to Dr. Eule and reported he was not allowed to return to work with Employer. Employee had burning into his left leg and felt out of shape. Dr. Eule kept Employee on Mobic, gave samples of Lyrica for burning in his left leg, and ordered a reconditioning program to permit Employee to return to work with limitations. (Chart Note, Dr. Eule, November 15, 2012.)

41) On December 3, 2012, Lynn Palazzotto, Workers' Compensation Unit Supervisor for Employer, notified Dr. Eule the reason Employee had not been rehired was because he had not applied for the necessary security clearance. She said Employee had been sent many reminders and had yet to respond. Further, Ms. Palazzotto understood because Employee was a union member, he could have been dispatched out for many positions had he registered. Employee asked to be placed back on time loss benefits because Dr. Eule referred him to physical therapy, and the amount of time in physical therapy would not allow him to work. Ms. Palazzotto inquired if Dr. Eule considered Employee disabled from work and he responded Employee was disabled from work effective November 15, 2012. (Dr. Eule's Response to Memorandum from Lynn Palazzotto, December 6, 2012.)

42) On January 15, 2013, Dr. Eule identified pain in the sciatic notch on Employee's left side descending into his lower leg but not into the foot. Dr. Eule indicated a return of radicular symptoms and ordered an MRI. He was hopeful Employee was having a minor flare up, which could be controlled with an epidural injection. (Chart Note, Dr. Eule, January 15, 2013.)

43) On January 15, 2013, an MRI with and without contrast of Employee's lumbar spine revealed no new areas of central stenosis, marked enhancement of soft tissues, likely reflecting postoperative scar formation and healing. There was an extruded disc fragment which had arisen from L4 – 5 and migrated below the disc space causing mass effect on the left L5 nerve at the lateral recess. At L4 – 5 there was diffuse annular bulging with high-grade mass effect on the intracanalicular L4 nerve. There was also diffuse annular bulging at L4 – S1 with contact at both intracanalicular L5 nerves, left greater than right. Enhancement of the endplates at L3 – 4 and L4 – 5 with no associated enhancement of the discs likely reflected osteitis rather than

osteomyelitis. Finally, there was no evidence of arachnoiditis. (MRI Report, John McCormick M.D., January 15, 2013.)

44) On January 18, 2013, Dr. Eule stated the MRI showed a left-sided L4 – 5 disc herniation and foraminal stenosis at that level, consistent with Employee's pain. (Chart Note, Dr. Eule, January 18, 2013.)

45) On February 13, 2013, at Employer's request, Dennis Chong, M.D., examined and evaluated Employee (EME). Employee presented with pain to the mid-back, bilateral low back, bilateral groins, bilateral flies, and bilateral anterior tibial distribution with constant burning pain. Additionally, Employee noted symptoms to his left anti-cubital aspect. During the examination, Dr. Chong observed behavior he characterized as symptom magnification when Employee stood to be assessed, indicated he had back pain, and leaned forward in a flexed position. Dr. Chong instructed Employee to return back to the examination table and observed Employee transfer from standing to seated with no difficulty. When transferring to seated, Employee forward flexed at least 45 degrees, the same position he had taken when leaning over the examination table with pain behavior. Dr. Chong also observed even when not specifically instructed, Employee would move around the room fluidly; Employee was limber and had dexterity. However, when specifically requested to move, Dr. Chong observed "profound florid pain behavior from facial and verbal responses." Dr. Chong described his interaction with Employee and Employee's behavior when Dr. Chong entered the examination room. After changing into shorts, Dr. Chong found Employee lying on the examination table and a left lateral decubitus position. Dr. Chong reported Employee said he was paralyzed with pain and could not move. Dr. Chong proceeded to excuse himself and said the examination should be deferred if Employee was in such severe agony, at which point Employee rapidly sat up and stated the examination should continue "but then resumed the florid pain behavior in a seated position." Despite Employee's pain behavior, Dr. Chong found diminished sensation to light and sharp touch in all dermatomes of bilateral limbs and symmetrically diminished reflexes at L4 – 5 and S1. (EME Report, Dr. Chong, February 13, 2013.)

46) Dr. Chong's diagnoses are lumbar strain, related to be December 3, 2009 work injury; pre-existing degenerative changes in the lumbar spine with spinal stenosis; status post multilevel L3 to S1 bilateral laminectomies with decompression on November 9, 2011. Dr. Chong noted the bilateral laminectomies were "performed under the auspices of his claim;" and extruded disc

fragment from L4 – 5, likely a progression since February 3, 2011, which occurred in the absence of work activity and after Employee was determined to be medically stable. Dr. Chong stated the extruded disc fragment is unrelated to the December 3, 2009 work injury. Dr. Chong stated "the mechanism of injury was consistent with development of back pain complaints;" however, "it is not consistent with the examinee's current multiple diffuse, and not localized musculoskeletal pain complaints." In his opinion, the December 3, 2009 work injury is not the substantial cause of Employee's new disc herniation at L4 – 5; rather, in the absence of work activity, it is a natural progression of Employee's pre-existing condition. Dr. Chong found no explanation for Employee's widely dispersed musculoskeletal pain complaints, which are not localized to specific left L4 – 5 distribution, other than "florid profound" symptom magnification. Dr. Chong specifically stated Employee's "subjective complaints overwhelm the objective findings" and "there is tremendous symptom magnification." (*Id.)*

47) Dr. Chong found the treatment Employee received after April 25, 2012, was reasonable but not related to the December 3, 2009 work injury. No additional diagnostic studies or medical treatment for the December 3, 2009 work injury were recommended. Dr. Chong noted Employee was released to full duty in April 2012, and notwithstanding he had not returned to work, there has been a progression of Employee's pre-existing left L4 – 5 disc protrusion and it is now an extrusion, which limits Employee's work ability. Dr. Chong indicated Employee should be working in a light-duty capacity, had reached medical stability for his work injury, and there was no change in the April 2012 PPI rating. (*Id.*)

48) On February 15, 2013, Employee received a left L4 – 5 transforaminal epidural steroid injection. Dr. Levine notified Dr. Eule Employee has a "significantly low pain threshold or is quite problematic in relation to even local anesthetic and jumps around a fair amount." Dr. Levine offered he was hesitant to reconsider further injections because of Employee's fair amount of movement, which posed a safety concern. (Chart Note, Dr. Levine, February 15, 2013; Letter to Dr. Eule from Dr. Levine, February 16, 2013.)

49) On February 21, 2013, Dr. Eule explained to Employee "he has a very challenging, complicated problem." Dr. Eule explained:

> a. He has multilevel degenerative changes in his back, some early degenerative scoliosis as well and severe foraminal stenosis, basically L3 - 4, L4 – 5 and L5 - S1, left > right. We talked to him about the fact that with the significant foraminal stenosis and significant degenerative

changes in early degenerative scoliosis this is much more complicated than just the decompression that we did before and we have to remember there are more issues with this and that possibly we could consider doing a foraminal decompression, maybe use Baxano and really Roto-Rooter out those foramen for him and avoid the fusion, although most definitively would be a multilevel fusion that is clearly going to make him pretty stiff and not as active as what he is now. There is no easy, simple "fix" for him.

b. At this point were going to see how he does from his shot. We will discuss this a little bit more. We will talk with his Workmen's Compensation and we will proceed accordingly.

(Chart Note, Dr. Eule, February 21, 2013.)

50) On February 22, 2013, Employer controverted all benefits based on Dr. Chong's report. (Controversion Notice, February 20, 2013.)

51) On March 12, 2013, Employee filed a claim seeking temporary total disability (TTD), medical, transportation, PPI, interest, attorney fees, and costs, and "other." (Claim, March 12, 2013.)

52) On March 26, 2013, Employee was discharged from a reconditioning program that began on November 16, 2012, because orders expired; there were insurance limitations; and possible additional interventions. (Select Physical Therapy Initial Evaluation and Daily Notes, November 16, 2012 to February 14, 2013; Discharge Summary, March 26, 2013.)

53) On April 8, 2013, Dr. Eule stated he did not agree with Dr. Chong's February 13, 2013 opinion that Employee's December 3, 2009 work injury was not the substantial cause of the left L4 – 5 disc herniation because "this is ongoing from his original problem." In relation to all possible causes, Dr. Eule stated the December 3, 2009 work injury is the substantial cause of Employee's disability and need for medical treatment, he needed further decompression, he was no longer medically stable, and it was unlikely he would have the permanent physical capacities to return to his job without limitations or restrictions. Dr. Eule stated Employee was no longer medically stable after the April 25, 2012 PPI rating "when he tried to go back to work and get active again." (Dr. Eule's responses to questions, April 8, 2013.)

54) On November 25, 2013, Peter Diamond, M.D., conducted a second independent medical evaluation (SIME). Dr. Diamond diagnosed the following and indicated each were contributing cause of Employee's disability or need for medical treatment:

a. History of injury in a diving accident when senior in high school.
b. Second industrial injury following diving accident.

c. Injury on September 4, 1981, while working for Cascade Diesel.
d. New injury to neck and lower back, November 16, 1984.
e. Crush injury with L5 fracture by history, 1985.
f. Low back injury following a 13 – foot fall, December 3, 2009, not noted in medical records until January 31, 2011 by Dr. Taylor.
g. Progression of L4 – 5 disc pathology to extruded L4 – 5 disc around November 2012.

(Dr. Diamond SIME Report, November 25, 2013).

55) Taking Employee's history at face value, Dr. Diamond stated, "it would seem" the December 3, 2009 injury aggravated, accelerated, or combined with Employee's pre-existing condition to cause disability and need for treatment. However, he noted confusion regarding the injury in the absence of records specifically documenting the injury and, despite multiple visits with physicians between December 3, 2009 and January 31, 2011, there was no mention of lower back pain until Dr. Taylor's January 31, 2011 note. Dr. Diamond determined the most significant findings are of chronic degenerative change of multiple levels, attributable to scoliosis, a history of trauma in 1985, and expected worsening with time. He stated it was clear Employee had significant back pathology, surgical treatment was appropriate and reasonable, "but mandated primarily by the presence of advanced degenerative changes and lateral recess stenosis, rather than acute disc injury." The substantial cause of the need for physical therapy was the December 3, 2009 injury and was precipitated because Employee's pre-existing condition was symptomatically aggravated. However the substantial cause of the need for surgical treatment is Employee's underlying pre-existing multilevel, degenerative condition. Dr. Diamond indicated Employee continues to be disabled and although the December 3, 2009 injury is a contributing factor, it is not the substantial cause given Employee's multiple injuries, the presence of advanced degenerative changes at the time of the initial imaging studies following the December 3, 2009 injury, Employee's lack of symptoms following the injury, and the clear progression of the condition at L4 – 5 following surgical treatment during the period Employee was not working. Though Employee had not shown signs of improvement within the last 45 days, Dr. Diamond expected surgery would result in objectively measurable improvement and Employee would be medically stable one year from the date of surgery. Dr. Diamond agreed with Dr. Eule further treatment would be surgical, decompression rather than fusion. Dr. Diamond did not feel Employee was able to work without restrictions, and was unable to determine with certainty

what specific restrictions would be necessary, but thought it likely restrictions would be in the sedentary or light range. Treatment through the time of the left L4 and L5 selective nerve blocks in late January 2011, were primarily attributable to the work injury. "Beyond that, the surgical treatment would be based primarily on the presence of severe stenotic effect of the degenerative changes." *(Id.)*

56) On February 20, 2014, Employee filed an affidavit of readiness for hearing, to which Employer filed an affidavit of opposition on February 26, 2014. (Affidavit of Readiness for Hearing, February 18, 2014; Affidavit of Opposition, February 24, 2014.)

57) On September 30, 2014, Dr. McNamara testified via deposition. Dr. McNamara cares for a number of workers' compensation patients, each of whom completes an intake form / questionnaire, which gives Dr. McNamara the patient's history and notes past problems or issues. The form contains an orthopedic section, where patients indicate back or neck pain or some other issue causing symptoms. Dr. McNamara indicated Employee's form did not disclose a low back injury in December 2009, or burning radiating into his legs; in fact, Employee's form was marked as "no additional problems." Dr. McNamara stated he is compulsive about documenting what patients say when they are injured, as are the therapists. A review of Employee's chart revealed no comment about back or neck pain. Had Employee mentioned an ongoing low back problem or problems in his leg, Dr. McNamara would have documented the issues and, if it was something he was unable to treat, made a referral. Employee came to Dr. McNamara, and was initially evaluated by his PA Robert Thomas. Employee complained of left interior elbow pain sustained March 28, 2010, and reported to PA Thomas his injury occurred when he lifted a gas can, and when he threw it into the back of a truck with his palm up he felt a snap in his elbow.

58) Dr. McNamara believes his PA, who worked for him for 10 years, is even more compulsive about documentation than Dr. McNamara, as PA Thomas is primary care trained, in addition to orthopedics. According to Dr. McNamara, PA Thomas' documentation practice is because of his training as a generalist; he "pays attention to all the other things that may be going on in any patient's life." Being a specialist, Dr. McNamara tends to focus on the patient's primary complaints. After surgery, Employee underwent therapy at Alaska Hand Rehabilitation, an organization Dr. McNamara uses on a regular basis. Dr. McNamara's opined Alaska Hand Rehabilitation therapists are very good, and compulsive about documenting "other" complaints

patients may have. Often, the therapist will ask, "did you know they're having this pain and should you refer them to someone to check and treat them?" If Dr. McNamara makes a referral because an Alaska Hand Rehabilitation therapist brings an issue outside of Dr. McNamara's expertise to his attention, it is documented. There is no documentation in Dr. McNamara's record to suggest he was approached by a therapist at Alaska Hand Rehabilitation about Employee complaining of low back or lower extremity issues. Employee was released to full duty on November 24, 2010. When Dr. McNamara releases a patient to return to work he does not ask if the individual has any other problems; however, if he were aware of another problems such as a low back injury, he would specifically state the individual is released to full duty for the upper extremity, but would require additional release for the low back. He would need to be aware something else was going on that could interfere with the individual's return to work. (Michael McNamara, M.D., Deposition, September 30, 2014.)

59) On October 24, 2014, Dr. Diamond testified via deposition. Dr. Diamond is a board certified orthopedic surgeon. He has been in practice in Hawaii since 1979, and has been conducting independent medical evaluations on and off since 1980. Dr. Diamond also has a clinical practice. Although he was trained as a spine and children's orthopedic surgeon, for the last 10 to 15 years his clinical practice has focused on arthroscopic surgery to shoulders and knees. Dr. Diamond's report includes a section on Employee's past medical history; it is based on Employee's recollection and presentation to Dr. Diamond, not on a records review. After Employee's evaluation, Dr. Diamond was provided additional records which included a report of occupational injury or illness and an attached accident report and lumbar x-ray report dated December 9, 2010, and the depositions of Dr. McNamara and Employee. Dr. Diamond stated it is not uncommon for patients to inaccurately recall their medical history; specifically, "It's not unusual for patients to either - - to have selective memory or to have a retroactive memory of an event that didn't occur the way they thought it occurred." Dr. Diamond includes a patient's history in his evaluation of the patient and proceeds with a working assumption the patient is giving a reasonably accurate picture of events. Additionally, he "plugs" in the patient's personality, which often tends to overdramatize or minimalize the history. Dr. Diamond found Employee's personality was "a little bit overly dramatic." Dr. Diamond was aware of Employee's low back issues before 1985, and the 1985 incident. Relying on the imaging studies, Dr. Diamond found Employee had "a combination of degenerative change and disk problems,

disk protrusions. Disk protrusions can also be degenerative in etiology." Employee has scoliosis and significant degenerative change in the joints at the back of his spine. Imaging studies showed changes between February 2, 2011 and January 15, 2013. On both, Employee had a combination of degenerative change and disk protrusions at several levels. On the second study, Employee had a L 4 – 5 disk extrusion, which is a piece of disk in the spinal canal. On the first study, this was just a protrusion. The 2013 study also showed Employee had bilateral laminectomies at multiple levels L3 to S1, also known as decompression. Dr. Diamond neither expected nor precluded worsening of Employee's L4 – 5 because he had decompression, but also stated decompression would not prevent the worsening either. Extrusions can be caused traumatically or through degeneration, either or both. Dr. Diamond was aware Employee had a crush injury in 1985, which resulted in a compression fracture at L1.[1] Dr. Diamond testified:

> I would say that a significant portion of my decision to ascribe the need for surgery and the subsequent continuing problems with the back to the preexisting condition is based on the fact that even if he had lumbar complaints following the 2009 injury, they were not of sufficient magnitude to warrant treatment or discussion with any of his treating doctors.

60) Even if Employee's recollection of the December 2009 incident is accurate, that incident is not the substantial cause of Employee's need for treatment in 2011 and thereafter. Dr. Diamond did not question Employee's veracity or motivation. It is not uncommon that patients have inaccuracies in their history or recollections. Physicians have to rely on medical records to a great extent for the basis of their decisions because of the "notorious inaccuracy". Dr. Diamond found Employee's mechanism of injury on December 3, 2009 consistent with an injury; however, he thought it unlikely an acute disc herniation occurring as a result of that injury would remain "relatively non-symptomatic" and despite Employee's multiple contacts with physicians, go unmentioned. Dr. Diamond concluded the December 3, 2009 injury aggravated Employee's pre-existing condition, but did not produce sufficient "incremental injury, anatomic or neurologic, to precipitate the need for surgery." Dr. Diamond based his conclusion on Employee's history, the physician's evaluations of Employee's back condition, and on the procedure performed, a posterior decompressive multi-level laminectomy, which is the procedure done for "classical lumbar spinal stenosis." Dr. Diamond was influenced by the fact

[1] Dr. Diamond noted a typographical error in his report. The report identifies the compression fracture at L5, and it was at L1.

Dr. Eule did not perform a discectomy and did not focus on any single disk as the result of the injury. The 2011 MRI revealed degenerative changes far more advanced than Dr. Diamond would expect for someone Employee’s age. Dr. Diamond admitted it was within the realm of possibility Employee’s symptoms could have persisted from December 2009, until December 2010, when he began to treat and the work injury was the substantial cause of Employee’s symptoms; however, it was not within the realm of possibility to a reasonable degree of medical probability. Employee’s symptoms at any point in time are the combination of the effect of the fall, the preexisting condition, and the expected progression with time of the preexisting condition. Dr. Diamond’s testimony is credible. (Dr. Diamond Deposition, October 24, 2014.)

61) On November 3, 2014, Employee testified at a videotaped deposition. After his claim was controverted, he applied and was found eligible for Social Security disability benefits and is also eligible for Medicare. The reason there is no mention of low back problems in Dr. McNamara’s records for Employee's bicep reattachment is because employee was on pain pills and the only concern he experienced was a burning sensation in his lower calf. Dr. McNamara and Dr. Gevaert both focused on Employee’s bicep. Employee thought the burning was caused by cancer and went to his primary care physician instead of mentioning it to Dr. McNamara. Employee sought psychiatric counseling for depression and pain after his claim was controverted. (Scott Hahn Deposition, Volume II, November 3, 2014.)

62) On December 4, 2014, Dr. Eule testified via deposition. Dr. Eule is an orthopedic surgeon and, other than trauma call obligations, his work is exclusively spine surgery. He has worked in Alaska for the last 12 years. He performs between 200 and 300 spine surgeries a year, and has done so for 12 years. As part of Dr. Eule’s treatment of Employee, he did not review any records regarding prior accidents or injuries involving Employee’s back. He “generally” takes his patient’s word regarding prior accidents or injuries. Dr. Eule admitted he often misremembers his own medical history. As he had not seen these records before, records of Employee’s 1981, 1984, and 1997 injuries were shared with Dr. Eule. Dr. Eule stated it was unlikely the 1984 incident was a possible cause of Employee’s disability and need for medical treatment in 2011, because Employee “had a pretty extensive work history in between that, as far as my knowledge is of the situation.” In 2011, Dr. Eule noted evidence of discs with “quite a bit of wear and tear." He stated these changes clearly did not occur in a very short period of time before the 2011 film study. Dr. Eule finds an individual’s preinjury work history and work abilities relevant when he

assesses the relationship of the individual's pre-existing condition to their ability to work. Based upon his knowledge of Employee and Employee's history, including the fact Employee was working before the injury, Dr. Eule stated the work injury was the substantial cause and need for Employee's surgery and his inability to perform his job. The deciding factor in making this determination, which Dr. Eule always uses, is whether Employee was working before, had a "big" injury and could not go back to preinjury work. Dr. Eule stated he knew no cause of Employee's disability and need for medical treatment which is more substantial than the reported work injury. Dr. Eule believes the disc herniation at L4 – 5 is a continuation of Employee's original problem, and not a new injury, making the work injury the substantial cause of Employee's ongoing disability and need for medical treatment. Dr. Eule explained there are three types of stenosis: central, lateral recess, and foraminal. Dr. Eule found all three when operating on Employee. The central stenosis was the least severe; at L2 – 3 Employee had "pretty significant lateral recess stenosis"; at L3 – 4, he had moderate central stenosis; at L4 – 5, there was "probably" bilateral foraminal stenosis; and at L5 – S1, "very severe left-sided, and some central stenosis" and "kind of" lateral recess stenosis. Dr. Eule stated right-sided foraminal stenosis at L2 – 3 and L5 – S1 was "probably the worst," and there was a little bit at L3 – 4. Left-sided foraminal stenosis was severe at L4 – 5 and L5 – S1, and "not as bad" at L2 – 3 and L3 – 4. Dr. Eule characterized the overall severity of Employee's spine as "moderate, moderate to severe." Dr. Eule stated there are degenerative changes, central stenosis is caused by a combination of things, but the problem is Employee has disc bulge/herniations at most every level, particularly L4 – 5, "which is the worst." Dr. Eule explained bulging can occur from wear and tear changes made acutely worse by a spine injury and, usually, most herniations are acute. He stated, "You don't have a chronic, slowly progressive herniation." Clearly, Employee "had significant underlying degenerative changes that -- probably had some, you know, the tipping points were these areas of bulging discs in herniations that -- usually what gets these people into their predicament." (Dr. Eule Deposition, December 4, 2014.)

63) Employee testified at hearing. He was a heavy-duty diesel mechanic since the 1970s; very physical, dirty work. In 1981, he "tweaked" his back, saw a chiropractor for one year, but missed no work. He does not recall what occurred in 1984, but he saw a chiropractor, Dr. Howell, once or twice for a strained neck. In 1985, he was run over by a logging truck and needed extensive treatment. He had a traumatic brain injury. He did not require surgery. He

received lumbar injections and speech therapy. He was off work for about five years. He recalled receiving a PPI rating on his hip, not his back. In 1997, while working in Washington, a truck dropped on his right wrist, which required surgery. He also had a neck sprain and back strain, but went back to work. Employee had no treatment from 1997 until 2009. He worked consistently through that period. Other than not wanting to lift the clutch alone, he did his work. He began work for Employer in 2008. His pre-employment physical revealed no problems with his back. He worked full-time at remote sites, including Barrow and McGrath, for up to 3 1/2 months, six, sometimes seven, days per week. When he came home he would go back out to work a couple days later. As a general mechanic, he did all repairs on-site. His coworkers thought highly of him, considered him a team player who got work done. His financial situation was good. On December 3, 2009, Employee fell off the ladder which a coworker had accidentally kicked. The fall "really bruised me up" and stretched something in Employee's bicep, but he felt he could work through it. He first felt like a butterfly was crawling up his leg, but didn't pay much attention to it because his shoulder was the main issue. His back was stiff, but had been stiff before. He did a lot of stretching and took anti-inflammatories. After the December 3, 2009 fall, he was stiff and sore with the tickling down his leg, which he didn't know was related to his back. He was all right working, but was stiff, with "a little bit of pinch." The tickling was new and intermittent on his shin. He went back to work after recovering from his biceps tear. The sensation then went from tickling in his shin to burning, "like someone shot me in the ass with a 22. It was excruciating." Employee thought it was about six weeks after he returned to work when he decided to seek formal treatment for his back; however, he did not know it was his back, he thought it was his leg that was injured. In August or September Employee reported to Tracy Davis, R.N., he had "pain inside my leg, not inside leg pain." When Employee saw a dermatologist on December 23, 2009, for infection in his finger, he did not report his leg pain because it was a different issue. Likewise on January 7, 2010, when he treated for his hand, Employee felt it was not the place to mention his back issue. He does not recall if he reported he was taking ibuprofen. On April 2, 2010, Employee completed a pain drawing and listed arm pain only because he was there for his bicep injury and his leg sensation was still "just a tickling." Despite surgery, Employee never returned to preinjury status. Employee has not worked since the 2013 controversion. He went on food stamps, sold

everything, and is now on Social Security disability benefits and receives Medicare. Employee loved his job with Employer, "serving my country working on radar sites." (Employee.)

64) Dr. Chong testified at hearing. He trained in Canada at the University of Calgary in family medicine, physical medicine and rehabilitation, and physiatry, which is nonsurgical orthopedics with a focus on rehabilitation. He moved to the United States in 1993, taught, saw patients, and published. In 1999, he obtained licenses in Washington and Alaska. He worked at Swedish Hospital in its outpatient rehabilitation unit with a focus on patients' musculoskeletal system injuries. He has been doing employer medical evaluations (EME) since the 1990s. Each week he sees between 40 and 50 patients for treatment and performs 15 EMEs. When conducting EMEs, Dr. Chong reviews records, interviews injured workers, provides a diagnosis and opinion regarding causation, and makes treatment recommendations. It is his practice to review medical records on the day of the evaluation. During the records review for Employee's EME, Dr. Chong noted a typographical error in Dr. Provencher's July 28, 2011 EME report; x-rays were taken in December of 2010, not 2009. According to Dr. Chong, this date makes a "big difference." Dr. Chong was struck by the fact records regarding Employee's back condition were silent for 12 months. The history of present illness section of Dr. Chong's report was taken during Employee's evaluation. Dr. Chong asked Employee to share what happened. Employee told Dr. Chong onset of symptoms was in December 2009, when he fell from the ladder and two weeks was the longest injections were effective to relieve pain. Dr. Chong stated injections should provide relief for two to three months. He did, however, consider Employee's report a relevant data point because epidural steroid injections are given to address an inflammatory response. If the injections Employee received were not effective, Dr. Chong concludes there was not a worsening of Employee's condition. If there had been a worsening of Employee's condition, there would have been an inflammatory response and the injection would have provided greater relief. Dr. Chong admitted he has misremembered his own medical history and stated this is very common. He stated there was a great deal of variability about when Employee's symptoms first started. Dr. Chong attributed this to the natural tendency for individuals' memories to fade and recollections to change over time. Therefore, if Dr. Chong needs a precise history he seeks out the primary records to ensure accuracy. In the current complaint section of Dr. Chong's report, he records what is happening, generally, around the time of evaluation. Taking Employee's report of symptoms, combined with a review of

Employee's medical history and the physical examination Dr. Chong conducts, he is able to explain the set of symptoms and come to a diagnosis "by tying it all together in a package that makes sense with respect to his objective findings on physical examination and the objective findings on diagnostic imaging, in this case MRI." Dr. Chong found Employee's report of constant burning pain in the areas Employee described did not correlate with a specific physiological injury. Dr. Chong could not come to a diagnosis that explains Employee's set of symptoms, nor could Employee's symptoms be explained by left L4 – 5 extrusion. Dr. Chong concluded there was not a correlation between Employee's subjective complaints and the objective findings. Dr. Chong decided not to proceed with further testing of Employee's motions, which would have been informative regarding how Employee moves, and his postures, which provides information on Employee's ability to perform daily activities. Because that part of the exam was not sufficiently complete, Dr. Chong came to "a more cautious opinion" Employee should be restricted to light duties. Dr. Chong based his opinion upon an anatomical finding on the MRI, which shows an extrusion, as opposed to his clinical examination, which did not verify the extrusion was causing functional deficits. Neurological testing conducted by Dr. Chong to determine if the extrusion was causing damage to a nerve, which would present as pain, sensory changes, and weakness confirmed the extrusion was not compromising the nerve. Dr. Chong also evaluated Employee's proximate presentation and temporal presentation to determine causation. Dr. Chong found the mechanism of injury, which was Employee's fall from the ladder, sufficient and necessary force to cause injury. However, there was no proximate symptom presentation; had the fall caused Employee's symptoms, an immediate presentation of disabling pain would have manifested right away. Employee's temporal presentation was progression of symptoms he attributed to a trauma that went untreated for a year. Dr. Chong did not find a proximate / temporal relationship sufficient to attribute the December 3, 2009 work injury as the cause of Employee's disability and need for medical treatment. Dr. Chong noted Employee was belligerent and aggressive; he exhibited excessive pain behaviors throughout the evaluation including moaning, shouting, and vulgarities. However, Dr. Chong did not arrive at his medical conclusions based upon Employee's personality or manners. Dr. Chong opined Employee's report of "tickling" in his shin is not explainable as an injury. Dr. Chong explained that an injury to the lumbar spine creates abnormal sensations from a nerve supplying a particular part of the body; it would have a certain distribution and the distribution would not be

in isolation to a shin. The L4 dermatome is the nerve that supplies sensation to the shin. It follows the region coming down the back to slightly outside the thigh, across the knee to the shin, and terminating at the inside ankle. If Employee had a nerve injury to L4 his abnormal sensations would follow this pattern. Employee would not have to report an absolute "classic" pattern, but there must, at least, be a pattern that explains an L4 distribution. Tickling isolated to just the shin is not L4. Further, the MRI objectively showed it was not Employee's L4 disc, but rather L5. Subjectively, Employee did not report the correct dermatome presentation and objectively, the abnormal sensation presentation was for the wrong disc. Dr. Chong unequivocally agrees with Dr. Diamond's conclusion to ascribe the need for surgery and subsequent continuing problems with Employee's back to Employee's pre-existing condition. Dr. Chong also agrees with the basis for Dr. Diamond's conclusion; specifically, if Employee had lumbar back complaints following the 2009 injury, they were not of sufficient magnitude to warrant treatment or discussion with any of Employee's treating physicians. Dr. Chong is credible. (Dr. Chong.)

65) Employee's total attorney fees are $51,150.00 and costs are $4,029.01. Attorney Chris Beltzer bills at $300.00 per hour. (Affidavit of Attorney Fees and Costs, May 23, 2015.)

66) On May 29, 2015, Employer filed a limited objection to Employee's attorney fee claim. Employer did not object to Employee's costs claim for $4,029.01. Employer did not object to attorney Beltzer's $300.00 hourly rate. However, Employer asserted the 170.5 hours claimed "is mildly unreasonable" and raised large amounts of time billed for single events and its suspicion three hours billed on April 29, 2015, for travel to and from Wasilla to meet with providers was a time entry for a different case inadvertently posted to Employee's. Employer requested Employee's fee claim be reduced by a modest amount in light of the factors applicable under AS 23.30.145(a).

67) On June 1, 2015, Employee filed a response to Employer's objections over fees respectfully disagreeing with Employer's position. Employee asserted this is a long, complicated case spanning over two years, with hundreds of medical and nonmedical records. It was necessary to revisit these records on occasion to prepare for depositions and hearing. Employee acknowledged his past providers are in Anchorage; however, asserted his disability is ongoing and his current physician is in Wasilla and was interviewed to prepare for hearing and ongoing representation of Employee.

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 reasonable persons would find 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 and we cannot say that it is so in this case." *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 death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes

> of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.

Effective November 7, 2005, the legal "causation" definition changed to narrow 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. Hanson*, AWCAC Decision No. 146 at 10 (January 21, 2011).

> **AS 23.30.045. Employer's liability for compensation.** (a) An employer is liable for and shall secure the payment to employees of the compensation payable under AS 23.30.041, 23.30.050, 23.30.095, 23.30.145, and 23.30.180 - 23.30.215….
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> **AS 23.30.095. Medical treatments, services, and examinations.** (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. However, if the condition requiring the treatment, apparatus, or medicine is a latent one, the two-year period runs from the time the employee has knowledge of the nature of the employee's disability and its relationship to the employment and after disablement. It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require. . . .
> . . .

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

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

> **AS 23.30.120. Presumptions.** (a) In a proceeding for the enforcement of a claim for compensation under this chapter it is presumed, in the absence of substantial evidence to the contrary, that
>
> (1) the claim comes within the provisions of this chapter;
> (2) sufficient notice of the claim has been given;
>
> (3) the injury was not proximately caused by the intoxication of the injured employee or proximately caused by the employee being under the influence of drugs unless the drugs were taken as prescribed by the employee's physician;
>
> (4) the injury was not occasioned by the willful intention of the injured employee to injure or kill himself or another. . . .

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 findings of the board are subject to the same standard of review as a jury's finding in a civil action.

The board's finding of credibility "is binding for any review of the Board's factual findings." *Smith v. CSK Auto, Inc.,* 204 P.3d 1001, 1008 (Alaska 2009). The board has the sole power to determine witness credibility, and its findings about weight are conclusive even if evidence is conflicting. *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249, 1253 (Alaska 2007). 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 the fees may not be less than 25 percent on the first $1,000 of compensation or part of the first $1,000 of compensation, and 10 percent of all sums in excess of $1,000 of compensation. When the board advises that a claim has been controverted, in whole or in part, the board may direct that the fees for legal services be paid by the employer or carrier in addition to compensation awarded; the fees may be allowed only on the amount of compensation controverted and awarded. When the board advises that a claim has not been controverted, but further advises that bona fide legal services have been rendered in respect to the claim, then the board shall direct the payment of the fees out of the compensation awarded. In determining the amount of fees the board shall take into consideration the nature, length, and complexity of the

> services performed, transportation charges, and the benefits resulting from the services to the compensation beneficiaries.
>
> (b) If an employer fails to file timely notice of controversy or fails to pay compensation or medical and related benefits within 15 days after it becomes due or otherwise resists the payment of compensation or medical and related benefits and if the claimant has employed an attorney in the successful prosecution of the claim, the board shall make an award to reimburse the claimant for the costs in the proceedings, including a reasonable attorney fee. The award is in addition to the compensation or medical and related benefits ordered. . . .

ANALYSIS

1) Is the December 3, 2009 work injury the substantial cause of Employee's disability and need for medical treatment for his low back?

This is a factual question to which the presumption of compensability applies. AS 23.30.120. Employee raises the presumption with an incident report and his report of injury stating he injured his low back, left upper back, and left shoulder, and with his testimony. Falling off a ladder and injuring one's back is not a medically complex event. Therefore, medical evidence is not necessary to establish the preliminary link and raise the presumption. *Meek.* Employer rebuts the presumption with Dr. Chong's EME report. The burden of production now shifts to Employee, who must prove his claim by a preponderance of the evidence. *Saxton.*

Employee's medical records are troubling. Shortly after Employee's December 3, 2009 fall from the ladder, he was treated by various medical providers for several conditions, none of which were his low back. There were no contemporaneous medical records post-injury that mention Employee's low back complaints, or even hip or leg complaints. The first medical provider Employee saw after his injury was on December 23, 2009, for a finger abscess caused by exposure to antifreeze at work. The medical history taken did not include mention of hip, leg, or back pain. Likewise, a fit for duty exam on January 7, 2010, made no mention Employee had hip, leg, or back pain. On April 2, 2010, Employee was released from work for a week due to tendinitis. This diagnosis lead to an MRI which revealed Employee's bicep was torn. During treatment for the torn bicep, at no time did Employee mention hip, leg, or back pain. The absence of medical records documenting pain associated with Employee's low back is a critical component in determining if the work incident is the substantial cause of Employee's disability and need for a second decompression surgery. Dr. Levine noted Employee has an extremely low

pain threshold, so low, in fact, it made treatment with further injections problematic and posed a safety concern. Dr. Levine's report is given great weight. AS 23.30.122. Employee went through a long course of physical therapy after his bicep repair. During 21 physical therapy sessions, Employee did not mention hip, leg, or back pain. Employee testified he did not mention hip, leg, or back pain because he was receiving treatment for other ailments. Employee is not credible. AS 23.30.122.

Three physicians gave opinions on whether work was the substantial cause of Employee's disability and need for a second surgical procedure. Dr. Provencher's opinion was not sought to determine the substantial cause of Employee's disability and need for a second surgical procedure. However, prior to Employee's decompression surgery, Dr. Provencher, found the work injury was a lumbar strain, and Employee's pre-existing degenerative lumbar spine changes and stenosis were temporarily exacerbated by the work injury. The treatment he found necessitated by the work injury was only one additional injection and an additional six weeks of physical therapy. Drs. Eule, Diamond, and Chong provided opinions on the substantial cause of Employee's disability and need for a second decompression surgery.

Dr. Eule did not review any of Employee's medical records regarding prior accidents or injuries to Employee's back prior to treating Employee. In 2011, Dr. Eule was aware Employee's discs had degenerated and acknowledged these changes did not occur in a very short period of time before the 2011 MRI. Dr. Eule determined Employee's work injury was the substantial cause of the need for the second surgery and Employee's inability to perform his job because Employee was working before, had a "big" injury, and then was unable to return to work. There was no cause for Employee's disability and need for the second surgery more substantial than the work injury. The disc herniation at L4 – L5, in his opinion, is a continuation of Employee's original problem and not a new issue. Employee has disc bulges at most every level from wear and tear. Dr. Eule holds these degenerative changes were made acutely worse by the work injury because herniations do not manifest from a slow, chronic, progressive process. Dr. Eule applies a formulaic approach to determine work is the substantial cause of Employee's disability and need for medical treatment. Employee worked consistently before the injury, but did not work after; therefore, work is the substantial cause. Dr. Eule did not consider the contribution of the work incident in relation to all other causes. *Runstrom.*

Dr. Diamond determined the only reasonable and necessary treatment for Employee's December 3, 2009 work injury was that received through the selective nerve blocks in late January 2011. Any treatment beyond that, including the decompression surgery and the second decompression surgery recommended by Dr. Eule, are due to Employee's severe stenosis and degenerative changes. In making this determination, Dr. Diamond noted the absence of medical records documenting the injury or lower back pain for more than a year from the day Employee fell off the ladder. Dr. Diamond concluded even if Employee had lumbar complaints following the 2009 work injury, they were not of sufficient magnitude to warrant treatment or even discussion with any of his many medical providers. Like Dr. Provencher, Dr. Diamond determined Employee's pre-existing condition was aggravated, but it did not sufficiently advance Employee's pre-existing condition to be the substantial cause of Employee's need for either the first or recommended second surgery. Dr. Diamond's opinion was influenced by not only Employee's failure to mention issues with his leg, hip or back to providers following his fall from the ladder for over a year, but also by the actual procedure performed by Dr. Eule, which was not a discectomy and not focused on any single disk. It was a posterior decompressive multi-level laminectomy, the procedure done for classic lumbar spinal stenosis. Dr. Diamond also found the 2011 MRI revealed degenerative changes far more advanced than expected in someone Employee's age.

Likewise, Dr. Chong ascribes Employee's disability and the need for surgery to Employee's pre-existing condition. Dr. Chong bases his determination opinion on several considerations. The first was his finding Employee's condition had not worsened when Employee fell from the ladder. If it had, there would have been an inflammatory response and an epidural steroid injection would have provided relief greater than two weeks. Dr. Chong, however, does not rely solely upon Employee's recollections; to ensure accuracy he relies on primary records, Employee's report of symptoms, and physical examination. Second, Dr. Chong did not find a correlation between those areas Employee reported were constantly burning and any specific physiological injury or between Employee's subjective complaints and the objective MRI findings. Employee's reported symptoms cannot be explained by a left L4 – 5 extrusion. Employee's reported symptoms were not the correct dermatome presentation and objectively, the abnormal sensation Employee described was for the wrong disc. Dr. Chong was able to confirm the extrusion was not compromising Employee's nerve. Finally, and consistent with Dr.

Diamond's opinion, Dr. Chong found had the fall caused Employee's symptoms, Employee would have experienced immediate disabling pain.

Dr. Eule's opinion is given less weight than Dr. Diamond's and Dr. Chong's. Dr. Eule applied a simple formula to determine work was the substantial cause of Employee's disability and need for the second surgery. Although he acknowledged Employee's discs had "wear and tear," because Employee could work before his fall from the ladder and could not work thereafter, Dr. Eule determined work was the substantial cause of Employee's disability and need for a second decompression. Dr. Diamond and Dr. Chong were both influenced by the lack of medical evidence documenting Employee's pain complaints after the December 3, 2009 fall from the ladder. This is compelling and entitled to great weight. When Employee was treated and underwent physical therapy for his bicep tear repair and his permanent partial impairment was rated, if he had experienced sufficient leg, hip, or back pain to prevent him from returning to work, it is not credible he did not report it because his treatment and evaluations were only for his bicep tear. Dr. Diamond and Dr. Chong's opinions are strengthened because neurological testing to determine if the extrusion was causing damage to Employee's nerve did not reveal associated or correlating pain, sensory changes, or weakness. Employee has multilevel lumbar spinal stenosis with advanced degenerative changes, present on the first MRI after the December 3, 2009 injury.

Continuing disability and the decompression surgery recommended is for Employee's underlying pre-existing severe multilevel lumbar spinal stenosis, and advanced degenerative condition, rather than an acute disc injury or for repair of a herniated disc or extrusion at L4 – 5. Work is not the substantial cause of Employee's disability and need for surgery. Employee's disability and need for further medical treatment are not compensable, and his claim will be denied.

2) Is Employee entitled to attorney fees and costs?

This decision does not award Employee any additional benefits. Therefore, he is not entitled to an associated attorney fees and costs award. Employee's attorney fees and costs claim will be denied.

CONCLUSIONS OF LAW

1) The December 3, 2009 work injury is not the substantial cause of Employee's disability and need for medical treatment for his low back.
2) Employee is not entitled to attorney fees and costs.

ORDER

Employee's March 12, 2013 claim is denied.

Dated in Fairbanks, Alaska on July 14, 2015.

ALASKA WORKERS' COMPENSATION BOARD

/s/______________________________
Amanda Eklund, Designated Chair

/s/______________________________
Sarah Lefebvre, Member

/s/______________________________
Lake Williams, Member

APPEAL PROCEDURES

This compensation order is a final decision. It becomes effective when filed in the office of the board unless proceedings to appeal it are instituted. Effective November 7, 2005 proceedings to appeal must be instituted in the Alaska Workers' Compensation Appeals Commission within 30 days of the filing of this decision and be brought by a party in interest against the boards and all other parties to the proceedings before the board. If a request for reconsideration of this final decision is timely filed with the board, any proceedings to appeal must be instituted within 30 days after the reconsideration decision is mailed to the parties or within 30 days after the date the reconsideration request is considered denied due to the absence of any action on the reconsideration request, whichever is earlier. AS 23.30.127.

An appeal may be initiated by filing with the office of the Appeals Commission: 1) a signed notice of appeal specifying the board order appealed from and 2) a statement of the grounds upon which the appeal is taken. A cross-appeal may be initiated by filing with the office of the Appeals Commission a signed notice of cross-appeal within 30 days after the board decision is filed or within 15 days after service of a notice of appeal, whichever is later. The notice of cross-appeal shall specify the board order appealed from and the ground upon which the cross-appeal is taken. AS 23.30.128.

RECONSIDERATION

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

MODIFICATION

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

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of SCOTT A HAHN, employee / claimant; v. ARCTEC ALASKA, employer; ARCTIC SLOPE REGIONAL CORP., insurer / defendants; Case No. 200917867; dated and filed in the Alaska Workers' Compensation Board's office in Fairbanks, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on July 14, 2015.

/s/______________________________

Darren Lawson, Workers' Compensation Technician