ALASKA WORKERS' COMPENSATION BOARD

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

STEVEN C. BARNETT, Employee, Claimant, v. LEE E. RAYMOND, Employer, and INSURANCE CO. NORTH AMERICA, Insurer, Defendants.	FINAL DECISION AND ORDER AWCB Case No. 199028161 AWCB Decision No. 15-0135 Filed with AWCB Anchorage, Alaska on October 13 , 2015.

Steven Barnett's (Employee) May 22, 2012 claims for medical costs and attorney fees and costs were heard on the written record on August 27, 2015, in Anchorage, Alaska, a date selected on June 10, 2015. Attorney Jonathan Hegna represented Employee. Attorney Robin Gabbert represented Lee E. Raymond, and its insurer (Employer).

ISSUES

Employee contends he is entitled to cervical spine medical treatment. He seeks an order awarding past and ongoing cervical spine medical care.

Employer contends because Employee's need for cervical spine medical treatment is not work-related, Employee is not entitled to further benefits.

1) Is Employee entitled to cervical spine medical benefits?

Employee contends his attorney provided valuable legal services in a complex case. Employee contends he is entitled to actual attorney's fees under AS 23.30.145(b).

Employer contends Employee is not entitled to any additional benefit, and is thus not entitled to an attorney's fees and costs award.

2) Is Employee entitled to an attorney's fees and costs award?

FINDINGS OF FACT

The record establishes the following relevant facts and factual conclusions by a preponderance of the evidence:

1) On March 22, 2000, the board approved the parties' compromise and release agreement (C&R) settling all of Employee's claims related to his October 25, 1990 work injury, except for future medical benefits. Employee did not waive his entitlement to reasonable and necessary medical benefits attributable to the work injury. (C&R, March 22, 2000).

2) On May 22, 2012, Employee filed a claim requesting cervical spine medical and related transportation benefits, attorney's fees, and interest. (Claim, May 22, 2012).

3) At a June 10, 2015 prehearing conference, the parties scheduled an August 27, 2015 written record hearing on the issues of medical costs and attorney fees and costs. (Prehearing Conference Summary, June 10, 2015).

4) On August 10, 2015, the parties filed a stipulation of facts, which is incorporated herein in its entirety;

> 1. Steven C. Barnett (hereinafter EE) was a 35-year-old carpenter/laborer when he had an injury to his left shoulder, arm, neck, and upper back after slipping on an icy roof moving bundles of shingles on 10/25/90 while employed with Lee's Custom Designs (hereinafter ER).
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> 2. EE initially treated with Samuel Schurig, D.O., with complaints of upper back pain and left arm numbness. Cervical spine x-rays showed mild spurring, and an MRI on 11/02/90 showed evidence of a C6 - 7 herniated disc central and to the left.
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> 3. On referral from Dr. Schurig, EE began treatment with neurosurgeon Louis Kralick, M.D., on 11/29/90. On 12/05/90, he underwent an anterior cervical discectomy and

fusion (ACDF) at the C6-7 level. Dr. Kralick deemed him medically stable on 03/05/91 and gave him a PPI rating of 9% on 04/02/91.

4. On 08/05/91, EE saw Dr. Kralick with complaints only of occasional intermittent muscle spasm in both upper extremities.

5. The parties' next record of medical treatment for EE is Dr. Schurig's 04/25/95 report, almost four years later. EE complained that his symptoms had now gone over to the right side of his body, including cramping in the hands, muscle spasms, and pain in the arms and chest.

6. In his deposition of 10/29/98, EE testified that he returned to his hometown in Nebraska from September 1991 until April 1995. He testified he noticed problems developing on the right side of his body while working for a design and construction company using hand tools, sanders, routers, and other small equipment while in Nebraska. He was employed with this company full time from September 1991 to November or December 1992. He said he left his employment with the company because of the problems on the right side of his body.

7. EE testified that, while working for this construction company, he also had occasional left arm and hand spasms but noted these were milder and much less than what he was experiencing on the right.

8. When asked why he did not contact the insurance company in 1992 if he was having problems relating to his work injury, EE testified it was because of confusion brought on by his alcohol abuse and "denial of pain," that he did not seek treatment or contact anyone until 1995.

9. EE admitted that during the winter of 1993/1994 while crossing an icy road, he slipped and fell and slid onto his left side, falling onto his left elbow and knee. He said he just got up, went on his way, and had no medical treatment following that incident.

10. EE returned to Dr. Kralick on 06/08/95 complaining of neck pain, extremity spasms, and pain in a radicular-type distribution in both upper extremities, tending to fluctuate from left to right. Dr. Kralick also indicated that EE reported one instance of "falling on a stable surface" which "may have contributed to his problem." Dr. Kralick thought there was some motion present at the C6-7 fusion site and diagnosed delayed symptomatic "pseudoarthrosis" at C6-7 and apparent progression of degenerative disc changes at C5-6. Dr. Kralick recommended surgery, which he related to the 10/25/90 work injury.

11. On 08/04/95, Dr. Kralick did an anterior disc excision at C5-6, dissection of the pseudoarthrosis, and an anterior fusion at the C6 - 7 levels.

12. Following surgery, EE had physical therapy from which he was discharged on 11/30/95 with the comment that all goals had been met. His pain at that point was one on a scale of ten.

13. On 02/29/96, Dr. Kralick again deemed EE medically stable, and on 03/06/96, Dr. Carlsen gave EE an additional 12% PPI rating.

14. On 04/15/96, the Alaska Workers' Compensation Board (hereinafter Board) approved a Partial Compromise and Release (hereinafter C&R) between the parties, wherein the EE exchanged his entitlement to reemployment benefits for a lump sum payment of his PPI or $16,200.00.

15. X-rays taken on 01/07/97 showed a plate fusion between C6-7 and at least a partial fusion between CS-6.

16. EE testified that, following the second surgery, he was almost immediately disappointed with the result and only continued to get worse. Following the second surgery, EE testified that he returned to Nebraska and lived with his parents but did not return to work.

17. EE returned to Alaska and was seen by Dr. Kralick in follow up on 03/25 and 03/27/97. An MRI done on 03/2 5/97 showed spurring from C3-C6, which was said to produce mild neural foraminal encroachment on the right "similar to previous exams." No focal disc herniations or protrusions were seen.

18. Dr. Kralick opined on 03/27/97 the MRI showed no obvious evidence of any abnormality other than expected changes consistent with the fusion at two levels, which appeared to be complete. He said there were no further treatment recommendations from a neurosurgical standpoint.

19. EE continued to treat with Dr. Schurig complaining of headaches and swelling of his hands. Dr. Schurig recommended a CT scan, but Dr. Kralick felt that a follow-up CT scan was not indicated.

20. A bone scan done 04/01/98 was normal, and a CT scan of the same date evidenced a solid anterior interbody fusion at all levels. An MRI done on 04/01/98 showed an essentially stable fusion of C5-6-7 and a mild central disc protrusion, hypertrophy, and mild spinal stenosis at the C4-5 levels.

21. EE was evaluated by internist Harbir Makin, M.D., on 04/22/98 for an SSI determination. At that time, EE complained of right-sided headaches radiating to the right temple and the right eye associated with blurred vision, wavy lines, scatomas in the visual fields, and nausea. The headaches were said to be so debilitating that he was unable to function and had to lie down in a dark, quiet room. Dr. Makin's impressions included probable early RSD of the right hand and vascular headaches.

22. On 05/29/98, Dr. Schurig recommended that the EE have an additional neurosurgical consultation. Dr. Schurig referred him to Dr. Donn M. Turner, a neurosurgeon at the Front Range Brain & Spinal Institute in Colorado.

23. EE was seen by Dr. Turner in Colorado on 06/19/98. His chief complaints were chronic muscle cramping and spasm in the right arm and right pectoral region, tremors in both upper extremities, and severe neck pain, particularly on the right side. Dr. Turner opined that EE was "basically stabilized" and that no further surgical intervention was indicated. He offered some alternative medication options for treatment of the spasms.

24. In a Decision and Order (hereinafter D&O) of 01/28/99, the Board approved the parties' stipulation that **EE** was permanently and totally disabled (PTD). D&O No. 99-0020. At that time, EE was represented by attorney Chancy Croft.

25. EE went for a panel IME in March 1999 by an orthopedic surgeon, Dr. John Lavorgna; a psychiatrist, Dr. Carroll Brodsky; and a neurologist, Dr. Richard Cuneo. The panel's findings are summarized in Dr. Cuneo's detailed report of 05/20/99. The IME physicians, giving EE the benefit of the doubt, concluded that the work injury was a substantial factor in causing or significantly worsening EE's condition. They also concluded there was some level of symptom magnification and that the work injury was not a substantial factor in causing or significantly worsening his complaints of headache and right eye pain or his alcohol abuse and dependence. Dr. Cuneo concluded that EE had been medically stable since 08/04/96, one year out from his cervical spine fusion. He recommended that EE be treated with non-steroidal anti-inflammatory medications and be tapered off narcotics and tranquilizers. This panel of physicians also concluded that EE was capable of modified work, if he were so motivated. They did not think that **EE** would benefit from a structured pain clinic. Lastly, they strongly recommended against any further cervical spine surgery short of a “striking change” in EE’s condition in the future. Dr. Cuneo found no evidence of RSD.

26. On 07/08/99, the Board, in D&O No. 99-0146, ruled on multiple issues related to ER’s entitlement to a Social Security disability offset under AS 23.30.225(b). Included for consideration by the Board was the employer’s 1) entitlement to reduce employee’s compensation rate below the statutory minimum; 2) right to a retroactive offset of social security benefits; 3) right to a reduction of permanent total disability compensation payments to reimburse the ER for voluntary payment of permanent partial impairment benefits; 4) right to a reduction of permanent total disability compensation payments to reimburse the ER for consideration paid to employee under a partial compromise and release; and 5) whether the ER should be permitted to withhold more than 20 percent of compensation due in the future to reimburse the ER for past payment of permanent partial impairment and/or overpayment of compensation. The Board granted the **ER** a retroactive offset for EE’s receipt of SSD benefits and set his compensation rate after offset at $54.18 per week even though this was below the statutory minimum. The Board also authorized the ER to reduce its future permanent total disability compensation for its voluntary payment of PPI in 1991. The Board did not allow the social security disability offset against the funds paid under the Partial C&R of 04/15/96 which it found was primarily for purposes of obtaining a waiver of reemployment benefits.

27. EE saw Dr. Schurig complaining of neck and shoulder pain on 02/15/00 after falling twice within three days.

28. The parties reached a complete settlement of EE's entitlement to all non-medical benefits, which was approved by the Alaska Workers' Compensation Board on 03/22/00. He was paid $45,000.00 in exchange for which he waived entitlement to all benefits, with the exception of medical benefits, in accordance with the Alaska Workers' Compensation Act.

29. EE continued to treat periodically for neck and back pain in 2000 and 2001. An MRI of the cervical spine on 04/17/01 was read as stable since the previous MRI in April 1998.

30. On 03/06/02, **EE** reported to Dr. Schurig that he fell on his right side on 02/26/02 when a gust of wind knocked him off his feet on the ice. He felt a "pop" in his right neck, and a filling was knocked out. Dr. Schurig said he did not think there was a lot that could be done treatment wise for EE and did not anticipate the need for surgery any time soon.

31. In June 2002, EE began treating with nurse practitioner Jessica Spayd for pain management on referral by Dr. Schurig.

32. On 08/22/02, Dr. Schurig wrote a letter to update the Social Security Administration. His assessment was severe chronic pain syndrome. He did not believe he was a surgical candidate at that time.

33. EE reported to Ms. Spayd on 09/18/02 that two boards fell on his head "while working around house."

34. According to Ms. Spayd's report of 01/02/03, her diagnoses included cognitive impairment from multiple traumas due to multiple previous head injuries. In follow up on 02/25/03, Ms. Spayd stated that EE had a long-standing memory problem secondary to a head injury.

35. An MRI of the thoracic spine on 04/03/03 showed a small to moderate T6-7 posterior central disc protrusion and small to moderate T7-8 right paracentral disc protrusion.

36. EE saw Dr. Davis Peterson at Anchorage Fracture and Orthopedic Clinic on 04/10/03. He was seen by Dr. Peterson at the request of Jessica Spayd for complaints of chronic low back pain and right greater than left radiating leg pain. He related the date of onset of back and leg complaints to April 2001. Based on then current data, Dr. Peterson did not recommend low back surgery.

37. Dr. Michael James of Alaska Spine Institute (ASI) wrote a letter to Dr. Peterson on 05/13/03 regarding his electrodiagnostic testing of EE. It indicates EE had complaints of low back and right lower extremity pain for the past 2-1/2 years. Dr. James' impression was chronic right S1 radiculopathy, mild peripheral neuropathy, and multilevel DDD with evidence of an annular tear at multiple levels.

38. EE was seen in follow up by Dr. Peterson on 06/17/03 following electrodiagnostic testing. Dr. Peterson felt it reasonable for him to undergo discography and possibly intradiscal electrothermal therapy.

39. EE underwent a four-level discogram on 08/12/03, which was positive at L5 – S1, discordant pain located at L3-4, and concordant pain at L2-3. A lumbar spine IDET procedure was recommended by Dr. James.

40. EE was treated at Providence Hospital emergency room on 10/18/03 following a motor vehicle accident. At triage, EE was complaining of pain over his entire spine. He reported only middle and upper back discomfort to the physician after being t-boned by another vehicle.

41. On 11/05/03, EE underwent an MRI of the thoracic spine, which showed a central disc protrusion, T6-7, without cord compromise, and a right paracentral disc protrusion/extrusion at T7-8, which does not cause central canal stenosis but may compromise the emerging nerve rootlet.

42. Per EE's report to Shawna Wilson, a nurse practitioner at Alaska Spine Institute, on 11/25/03, his truck sustained $5,500.00 in damage from the MVA.

43. EE underwent the lumbar IDET on 01/13/04 with temporary resolution of his lumbar symptoms for about three months.

44. EE picked up treatment again with Jessica Spayd on 05/27/04 complaining of increased neck pain. He was told he would need to be seen every two weeks in order to obtain narcotic medications due to his use of marijuana. He said that it helped him to maintain an appetite, otherwise, he would lose weight.

45. Per Ms. Spayd's report of 07/14/04, EE reported that generic OxyContin was not efficacious for pain. Two weeks later, on 07/27/04, he reported that his pain was considerably increased following a recent move.

46. Dr. Edward Voke initially saw EE on 09/02/04, on referral by Ms. Spayd, for complaints of low back pain, which began in April 2001 when he lifted a car battery.

47. A lumbar MRI was ordered by Dr. Voke and carried out on 09/10/04. It was unchanged from a prior lumbar MRI on 01/31/03. It showed degenerative disc disease and facet hypertrophy at several levels and a small central disc protrusion at L5-S1 possibly contacting the exiting nerve roots.

48. Treatment continued in 2005, and EE's neck pain was said to have increased again on 03/08/05 while again attempting another move.

49. On 08/08/05, EE complained of increased low back symptoms after taking a bad fall. He said his right leg spasms and then gives out on him.

50. On 09/22/05, Shawna Wilson stated that she did not find any new problems following the fall and that she did not feel he was a good surgical candidate.

51. While seeing Dr. James on 11/10/05 for low back pain, EE complained of an incremental increase in neck pain and paresthesias and weakness of the right arm over the past six months.

52. Another fall was reported to Dr. James on 12/09/05.

53. An MRI of the cervical and thoracic spine was done on 04/17/06 showing disc degeneration at T6 - 7 and small protrusions, which did not stenose the spinal canal or compromise the cord, nerve roots, or neural foramina. The cervical spine showed significant disc degeneration at C4-5. There was a marked disc protrusion posteriorly slightly effacing the cord. The major abnormality was the impingement on the right neural foramen due to a disc protrusion.

54. Trigger point injections (TPIs) were given by Ms. Spayd for neck pain on 01/17/06.

55. Dr. James carried out a lumbar radiofrequency ablation procedure of the lumbar spine on 04/24/06.

56. EE underwent a neuropsychological evaluation by Dr. Keith Youngblood on 05/31 and 06/08/06. EE reported that he tended to fall and lived alone in a camper trailer. He admitted a history of drinking abusively but stated his drinking at the time was limited to some beers. He said he ceased using marijuana as part of an agreement with the provider of his treatment for pain. Dr. Youngblood opined that EE presented with moderate to severe chronic neuropsychological dysfunction. The primary cause was unclear. EE reported a number of falls that included head trauma, including episodes of unconsciousness. He was also taking medications that could impact cognitive functioning.

57. EE underwent TPIs to his trapezius muscles by Ms. Spayd on 10/12/06 for myofacial pain syndrome.

58. TPIs were again given by Ms. Spayd on 02/15/07 and 03/01/07.

59. On 04/17/07, EE saw Dr. James with complaints of low back pain and bilateral leg pain.

60. A repeat radiofrequency ablation procedure of the lumbar spine was carried out by Dr. James on 04/23/07.

61. An MRI of the cervical spine on 07/17/07 showed 1) moderate central spinal stenosis at C4-5 and high grade bilateral C4 - 5 foraminal stenosis at C4 - 5; 2) status past anterior interbody fusion at CS-6-7 with solid fusion; and 3) the cord was intrinsically normal and there was no evidence of myelomalacia.

62. An MRI of the lumbar spine was also carried out on 07/17/07. It showed 1) focal hyperintensity in the L5-Sl area, consistent with an annular tear; 2) midline protrusion at the L2–3 area with disc space narrowing and moderate central stenosis at this level; and 3) mild diffuse annular bulging at L4-5, mild to moderate central stenosis at this level, and mild bilateral foraminal stenosis at this level.

63. On 07/27/07, Shawna Wilson opined that EE should get a neurosurgical consult for the C-spine and that he also needed treatment for the lumbar spine. EE declined referral to a neurosurgeon at that time, indicating he wanted to seek treatment outside of Alaska.

64. EE underwent more TPIs by Ms. Spayd on 08/16/07 for myofascial pain syndrome.

65. Another MRI of the cervical spine was done on 04/29/08. The impression was 1) spinal cord deviation, with mild to moderate spinal stenosis, and moderate right and. mild left foraminal stenosis at C4-5; 2) spinal cord deviation, with mild spinal stenosis, and moderate to severe right and moderate left foraminal stenosis at C4-S.

66. To Dr. Erik Kohler (Alaska Neurological Surgery) on OS/22/08, EE reported a history of working physically demanding jobs all of his life. He also recalled significant episodes of trauma in his upbringing. Per the history given to Dr. Kohler, he was working on construction and began developing cervical pain, leading to his fusions. Dr. Kohler assessed multiple sources of musculoskeletal pain; the most significant likely being adjunctional cervical stenosis at C4 -S, above his CS-6-7 fusion, with probable degenerative changes noted at the C3-4 level. An MRI of the head/brain ordered by Dr. Kohler was normal.

67. An EMG done by Dr. James on 06/10/08 showed, in part, chronic right CS - 6 radiculopathy, moderate right carpal tunnel syndrome, and mild left carpal tunnel syndrome. Lower extremity NCV studies done by Dr. James on 06/24/08 showed mild left L4 versus LS chronic radiculopathy. At that visit, EE complained of extreme pain from lower back to feet and "cannot trust legs for walking without falling a few hundred feet."

68. A discogram of the lumbar spine was carried out by Dr. James on 08/04/08. It was said to be negative at the L2 through S1 levels. The impression was DDD of L2 through Sl.

69. Cervical, thoracic, and lumbar spine CT scans were done on 09/24/08. Significant degenerative spine and facet arthritis was shown in all areas of the spine. On follow up with Dr. Kohler on 12/03/08, EE said his primary concern was his lumbar, followed by thoracic, and then cervical symptoms.

70. A controversion of medical treatment for the thoracic and lumbar spine was filed by the ER on 11/12/08 on the basis that EE's work injury was to the cervical spine only and that no medical evidence linked the thoracic or lumbar spine to the work injury of 10/25/90.

71. Dr. Kohler reported on 12/03/08 that the cervical spine CT scan showed significant spondylosis above his C5 - 6-7 fusion with severe loss of disc height, which was the likely source for his mechanical and radicular pain.

72. An NM Bone SPECT of the cervical spine was done on 02/23/09, which showed focal uptake of radiopharmaceutical overlying the expected location of the left C4-5 and cervical facets corresponding to exuberant degenerative changes of same.

73. On 06/16/09, EE wanted to discuss placement of a spinal cord stimulator and was told by Dr. Kohler to follow up with Dr. James on this but a neuropsychological evaluation was recommended prior to the decision on the stimulator.

74. On 08/04/09, Dr. Kohler strongly recommended a trial spinal cord stimulator and completion o f a neuropsychological evaluation.

75. On 10/01/09, Ms. Spayd stated she had been treating EE in excess of seven years and that he was generally compliant with his opioid medication and plan of care. She did not believe there was any abuse of opioid medication.

76. On 10/02/09, EE underwent a psychiatric assessment by Dr. Ellen Halverson at Providence Behavioral Health for possible placement of a spinal cord stimulator. He wanted Dr. Halverson's assistance with the appeals process of getting the spinal cord stimulator. He was upset that Dr. Nassar (another psychiatrist) did not feel that the spinal cord stimulator was appropriate for him. EE admitted prior issues with alcohol and marijuana use to Dr. Halverson but said he only drinks socially 1-2 drinks per month, and he discontinued the use of marijuana. Dr. Halverson did not see a specific psychiatric contraindication for pursuing a spinal cord stimulator.

77. EE ultimately did not have a spinal cord stimulator implant.

78. An orthopedic surgeon, Dr. James Eule, provided a surgical consultation on referral by Medicaid on 12/03/09. Dr. Eule stated that EE had developed significant incapacitating neck pain, back pain, and leg pain. Dr. Eule stated that EE likely had ongoing significant spinal cord compression and may need further surgery. He thought it was unlikely that EE would ever get off his pain medication, which made it exceedingly difficult to do surgery on him.

79. Another MRI of the cervical spine was done on 12/08/09, which again showed a solid appearing interbody fusion at CS-6-7, disc degeneration with focal protrusion slightly narrowing the left neural foramen at C7-Tl, with the most severe abnormality at

C4-5, where there was a circumferential disc protrusion slightly effacing the central surf ace of the cord and causing marked stenosis of the right neural foramen.

80. On 12/08/09, a lumbar spine MRI was done showing degenerative disc disease at L2-5 and annular tears at L2 and LS. There were disc protrusions at L4 – S1 and foraminal stenosis at L2–3 causing bilateral effacement of the nerve roots.

81. On 01/07/10, Dr. Eule concluded there was a definite need to plan on at least a C4 -5 decompression and fusion with consideration of the C3-4 levels as well.

82. On 04/05/10, an IME was done by Dr. Marilyn Yodlowski. She opined that EE was medically stable on 02/29/96 when he was found stable by his treating surgeon, Dr. Kralick. From that point forward, the work injury was no longer a substantial cause in the need for medical treatment. In her opinion, EE no longer required narcotic pain medication and had no specific neurologic deficits. Dr. Yodlowski said the deterioration and degeneration of the cervical spine was due to employee's preexisting condition and aging. She felt EE's preexisting history of nicotine and alcohol use and possibly addictive personality may have contributed to his ongoing extensive use of narcotic pain medication. She further stated that the surgery recommended by Dr. Eule was not reasonably effective and necessary for the process of recovery from the 1990 work injury. She noted EE has a long history of subjective pain complaints and extensive procedures, none of which have provided significant relief. EE did not evidence clear isolated objective findings. Rather, she said that for the last ten plus years, he has had debilitating complaints of neck pain requiring ever increasing chronic doses of narcotic pain medication. In the absence of very clear, objective findings of focal neurologic deficit, surgery would not be recommended. She felt he was at significant risk for a potentially fatal respiratory depression due to the amount of narcotics prescribed by ANP Spayd every two weeks.

83. ER filed a controversion on 07/27/10 denying medical and related benefits for treatment of the cervical spine, including the surgery proposed by Dr. Eule, based on the IME of Dr. Yodlowski.

84. Per Ms. Spayd's 03/22/12 report, EE's primary problem seemed to be more his worsening lumbar pain and bilateral burning leg pain than his cervical pain, although it persisted. He was continuing to work toward smoking cessation. It was noted he lives in a handicapped apartment in a retirement community.

85. On 05/17/12, EE reported to Ms. Spayd that he had fallen while showering, and he was slowly recovering from the fall. On 05/31/12, he was complaining of right leg weakness since the fall. Follow up with Dr. Eule was recommended.

86. On 08/01/12, Dr. Eule responded to a letter from EE's counsel dated 05/22/12. Dr. Eule continued to recommend surgical decompression and fusion at C4-5 opining the 10/25/90 work injury was a substantial factor in the need for the surgery. He said his

opinion was based on EE's history due to the "significant lag in time from injury to my initial evaluation." Dr. Eule has never reviewed the employee's entire medical file.

87. A second deposition of EE was taken on 09/28/12. He testified that, among other things:

-His problems with memory loss started in 2004 or 2005 and affected both his long- and shorter: n memory.

-He was down to smoking four packs of cigarettes per week but admitted he would use marijuana once in awhile.

-He said he does not drink alcohol and has not for years, but treatment for alcohol abuse had been recommended back in 1997.

-When asked about his low back problems, he related an injury while working for the railroad in 1974 when he took “a slight impact while dropping a rail car.” He was in the hospital for three to four days "in traction" with a "weight at the end of the hospital bed." Ee was off work after this injury but could not recall for how long. He did not recall for how long he had treatment but said his low back would be irritated if he strained it or overworked, after that.

-In the summer of 1984, he twisted and wrenched his low back using a torque gun. He said he climbed down and was in so much pain he had to lie down.

-At age 14-15 he "wiped out on a mini-bike" and had a broken collar bone; he thinks on the right side. He was in a body cast, he says, because he waited too long to seek treatment, and they did not want to re-break it. He was seen at Providence Emergency Room and saw Dr. Mills at Alaska Medical & Surgical.

-He also had a motorcycle accident at age 16. He went into a ditch to avoid a head-on collision. The speedometer on the bike hit and split his forehead below the lip of the helmet. He said there was an imprint from the speedometer on his forehead. His lip was also split and required stitches and some type of mesh in order to repair it.

- EE also recalled a slip and fall on an icy road while living in Nebraska in the 1990s.

-He admitted to "severe" alcohol abuse between 1993 and 1997. He admits he is still not completely sober. He has a beer once in awhile but said he has had no "overuse" since the 1990s.

-When asked about the report of 02/15/00 stating he had "a fall today and two days ago and is feeling pain in neck and shoulders...,” he said he was on a hike and fell in wet grass and "wound up down the hill."

-When questioned regarding a reported fall on 02/26/02, when the medical records indicate a gust of wind knocked him off his feet on the ice and his neck popped and about the time two boards fell on his head around 09/18/02, he did not recall either of those incidents.

-He also did not recall seeing Dr. Wayne Downs for evaluation of head injuries or that Ms. Spayd had referred him there on 01/02/03 for cognitive problems.

-He could not recall what he was referencing when he told orthopedic surgeon Davis Peterson on 04/10/03, that his low back pain and right leg pain had started 2-1/2 years prior.

-EE did recall his MVA on 10/18/03. He said he was uninjured but did get an MRI the next day "just in case." The emergency room records note he gave a history of "disc problems L5-81" and "degenerative disc disease."

-He also related another MVA when he hit a berm with the front tire of his truck while on a dirt road in Big Lake, which caused his truck to flip onto the driver's side, but he denied any injury.

-EE testified his current treatment remained seeing ANP Jessica Spayd every two weeks for medication management. He said his low back and right buttock pain down to his foot had been worsening and that balance is an issue. He walks with a cane. He also had pain above the knee down to his toes on the left leg. He still wanted to have the surgery proposed by Dr. Eule on 01/11/11.

88. To Ms. Spayd on 1 1/01/12, EE complained of sharp, shooting, stabbing, lumbar pain which was becoming burning and radiating into both legs. Cervical pain was the same, not as painful as the lumbar. He reported falling in the shower. He said he had better control of his pain with increased medication.

89. On 11/05/12, Dr. Yodlowski issued a second IME report. She opined that the 1990 work injury had long since resolved and no longer represented any current condition. She said the diffuse changes in EE's cervical and lumbar spine, spondylosis, are a degenerative condition and are due to a combination of hereditary factors and age-related changes. She said the decompression and fusion surgery recommended by Dr. Eule was due to the underlying, genetically-based, and age- related degenerative changes, and the work injury of 1990 was not a substantial factor in the need for the recommended surgery. She also said such surgery was neither reasonably effective nor necessary for the process of recovery from the 1990 work injury and that there was no basis for attributing any need for a fusion to the work injury. She felt **EE** had long been medically stable requiring no further treatment and that there was no need for the ongoing and ever increasing opioids and benzodiazepines, and no basis for employee being deemed unable to work due to the injury. Dr. Yodlowski opined that EE's current condition leading to his ongoing treatment was that of subjective pain complaints, likely worsened by his

prolonged and ever increasing use of opioids and benzodiazepines, possibly leading to both physical and psychological addiction/dependence.

90. EE continued to treat every two weeks with Ms. Spayd for medication/pain management but reported his pain with medications was still in the 7/10-9/10 range.

91. From 2012 to present, employee has also treated with John Boston, D.O., for primary care. His assessment has been: Peripheral neuropathy, multifactoral; multiple joint pain; at risk for falls; lumbar radiculopathy; current everyday smoker; and alcohol dependence. Lyrica was prescribed for the neuropathy.

92. On 04/03/13, a controversion was filed by the ER of medical and related benefits for treatment of the cervical spine, including surgery proposed by Dr. Eule based on the 11/05/12 IME opinion of Dr. Marilyn Yodlowski.

93. Dr. Eule was asked by ER if he concurred with Dr. Yodlowski's report. On 04/08/13, he responded indicating that he disagreed with Dr. Yodlowski's opinion on causation because, "it seems like all his problems have been ongoing since 1990." He also disagreed with Dr. Yodlowski's opinions that the 1990 injury was not a substantial factor in his need for the surgery Dr. Eule proposed and that it was not reasonable and necessary for the process of recovery from that injury. He disagreed with Dr. Yodlowski that employee’s ongoing treatment was related to subjective complaints and might be worsened by his use of opioids and benzodiazapines; but he said that EE ' s chronic pain and opioid use "complicates his condition."

94. On 11/01/13, EE saw neurosurgeon Bruce McCormack, M.D., for a second independent medical evaluation (SIME). Based on notes from Dr. Boston and Ms. Spayd, EE was provided a first-class airline seat and a companion to accompany him to the SIME.

95. Per Dr. McCormack's report of same date, his diagnoses for EE for complaints after 02/29/96 are: Chronic pain; narcotic dependent; tobacco dependent; symptomatic cervical, thoracic and lumbar disc disease; lumbar facet mediated pain; L2 pars defect;
L5-Sl disc herniation; dementia; depression; marijuana use; and peripheral neuropathy. He further opined that the work injury was "a substantial factor only for a permanent aggravation of cervical disc disease that led to fusion C5-C7." He noted EE had chronic pain in almost all body parts treated with heavy narcotics over decades with unfortunate psychosocial circumstances and little personal effort to improve his situation. He is passive and content to see a nurse and use heavy narcotics and occasional marijuana, per Dr. McCormack, who felt his cervical and lumbar conditions were minor in terms of his overall disability. Dr. McCormack further opined that:

-EE's treatment since 07/27/10 has not been reasonable and necessary for "the process of recovery" from the work injury and that the work injury was not a substantial factor in EE's need for treatment since 07/27/10.

-He disagreed with Dr. Eule's recommendation for surgical decompression and fusion surgery at the C4-5 and possibly C3-4 level as reasonable and necessary for the process of recovery.

-He felt the results of the two prior procedures were failures for pain control noting chances of success in this case were "nil" and that EE's pain covers multiple body parts.

-He said there was no medical evidence that C3-4 or C4-5 are causing him pain, or any symptoms whatsoever. He said radiographic findings were not impressive for decompression.

-The 1990 injury is not a factor or a substantial factor in the need for lumbar disc surgery.

-The cervical fusion proposed by Dr. Eule is not medically indicated or substantially related to the industrial fusion.

-Degenerative changes at the cervical levels in question are predominately due to aging and hereditary factors versus adjacent segment disease given that accelerated degenerative changes were not present on cervical studies in '03 and '08. Spurs at C4-5 are similar to age-related findings at other spinal segments.

-Peripheral neuropathy is unrelated to the 1990 work injury.

96. On 01/30/14, Dr. Eule noted EE just had his SIME and "They say it is not related to his work related injury, but from his standpoint we have been wanting to do his cervical spine first because we are concerned about cervical myelopathy." On the other hand, EE said his right leg pain is "just killing him" and he wants to get something done. On PE, EE was horribly off balance and had signs and symptoms of chronic ongoing myelopathy. Dr. Eule determined to proceed with treatment, and Medicare/Medicaid should cover the medical expenses.

97. On 03/24/14, Dr. Susan Bertrand provided a pain management consult to establish a plan for post-op pain management while EE is in the hospital for surgery. EE reported he had been in bed for most of the prior three years due to pain. EE also reported that the 80 mg Oxycontin he was taking put him in "respiratory arrest," so he was weaned down to 40 mg bid.

98. A CT of the cervical spine on 03/24/14 showed 1) multilevel degenerative changes throughout, most pronounced at C4 - 5; 2) less pronounced neural foraminal stenosis at multiple levels, most pronounced on right at C3 - 4; 3) no severe osseous canal stenosis; and 4) solid fusion at C5 - 6 and C6 - 7. The C6–7 hardware appeared unremarkable.

99. The same day a CT of the lumbar spine showed 1) nondisplaced pars defects bilaterally at L2 resulting in minimal anterolisthesis of L2 on L3; 2) hyperdense appearance at the posterior margins of most disc bulges throughout, somewhat narrow AP canal diameter throughout and multilevel mild and moderate neuralforaminal stenoses, underlying congenital short pedicles may contribute to this finding; and 3) neural foraminal stenosis is most pronounced bilaterally at L2-3.

100. An MRI of the cervical spine on 04/10/14 showed continued findings of a cervical fusion at C4-5, 5 - 6, and 6-7 levels with further degenerative disc disease changes at C3-4 and 4 -5 with spinal stenosis secondary to diffuse bulging of the annulus of the disc and some hypertrophic changes of the facet joints . Disc material impinges upon the anterior aspect of the cord at these levels. There is bilateral foraminal stenosis at these levels.

101. Also on 04/10/14, an MRI of the lumbar spine showed 1) resolution of the large right disc herniation at L5-Sl; 2) degenerative changes at the L2 - 3 level, but no disc herniation or stenosis; and 3) combination of findings at the 4-5 level creating mild bilateral foraminal stenosis and central canal stenosis.

102. That day Dr. Eule issued a letter recommending surgery of EE's neck for significant spinal stenosis compressing the spinal cord causing myelopathy and longstanding multiple significant nerve root compression and weakness and numbness in the lower extremities.

103. On 04/11/14, Dr. Eule stated that EE’s lumbar spine is more complicated and unusual in that he has a little bit of listhesis and instability at L2-3 with a severe degenerative disc and some foraminal narrowing at that level, which could be causing significant back pain. Dr. Eule speculated that the timing of when this occurred is difficult to say, but it could be related to his work injury.

104. EE underwent a total of 12 procedures to his neck and low back by Dr. Eule on 04/30/14. In summary, EE underwent 1) anterior cervical discectomy and fusion at C3-4 and C4-5; 2) transforaminal lumbar interbody fusion at L2-3; and 3) lumbar decompression at L2-Sl.

105. EE was reportedly healing nicely at his first post-op visit with Glenn James, PA-C, on 05/08/14. It was reported on 05/15/14, that EE was doing better than expected.

106. At follow up with Dr. Eule on 06/03/14, EE reported doing reasonably well with good feeling in his hands. He was doing some things on his own and getting by after losing his PCA due to an injury. His neck brace was changed to a soft collar.

107. By 06/05/14, EE reported to Ms. Spayd that pain control was adequate and on 07/17/14, Ms. Spayd reported it was time to start the tapering process ASAP.

108. Dr. Eule reported on 08/05/14 that EE decreased some of his medications, his neck was getting better, and he was happy to be out of the brace. Every three days, EE noticed

some type of improvement. He was now able to walk with a cane instead of a walker. The soft collar was removed.

109. On 08/14/14, Ms. Spayd discussed with EE the high dose of medication he was taking and trying to organize his medication into two types. EE stated he was willing to make the changes, along with an overall reduction. Tapering was instituted.

110. Ms. Spayd issued a letter on 10/13/14 requesting a PCA help transport EE to his appointments for pain management due to his low back pain.

111. Dr. Eule reported on 11/04/14 that EE's neck was doing great, and his leg pain had gotten completely better. His back still bothered him but was quite a bit better. EE was reportedly undergoing physical therapy.

112. At last follow up with Dr. Eule on 04/30/15, EE said his neck was doing good, and he did not have any pain except for an occasional twinge. His back was better, but he still had some back pain and was taking pain medication for that. Overall, he felt dramatically better. EE's L2 - 3 level was solidly fused, but Dr. Eule had a slight concern that EE has started to develop a spondylolisthesis at L3-4 below the fusion. Per EE, he wants to get off Dilaudid and take only Hydrocodone and Oxycodone, which Dr. Eule thought reasonable.

113. At a prehearing conference held on 06/10/15, the parties requested a hearing on the issues of medical costs and attorney's fees and costs. A hearing on the written record was scheduled for 08/27/15.

114. The parties agree that the statements made in this Stipulation are an accurate representation of EE's relevant medical history and facts of this case, and the Stipulation may be used by the Board for purposes of rendering its decision on the written record.

5) On December 10, 2013, the parties filed a compromise and release agreement (C&R) settling Employee's claim for all past and future indemnity benefits related to his December 3, 2008 work injury. Employee did not waive his entitlement to reasonable and necessary medical benefits attributable to the work injury. The agreement did not require board approval and became effective upon filing. (C&R, December 10, 2013).

PRINCIPLES OF LAW

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

At the time of Employee's 1990 injury, the Act provided as follows:

> **AS 23.30.010. Coverage.** Compensation is payable under this chapter in respect of disability or death of an employee.
>
> **AS 23.30.095. Medical examinations.** (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. . . .
>
> **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 . . . reasonable cost to . . . employers . . . subject to . . . this chapter; . . . .

"Process of recovery" language allows the board to authorize continuing care beyond two years from the date of injury. *Municipality of Anchorage, v. Carter,* 818 P.2d 661, 665-66 (Alaska 1991). However, such language also means the board may disallow a claimant's claim for continuing care if it does not promote recovery from the original injury. In *Carter,* the court held the Act does not require the board to provide "continuing or palliative care in every instance. Rather, the statute grants the board discretion to award such 'indicated' care 'as the process of recovery may require.'" *Id.* at 664.

> **AS 23.30.120 Presumptions**. (a) In a proceeding for the enforcement of a claim for compensation under this chapter it is presumed, in the absence of substantial evidence to the contrary, that
>
> (1) the claim comes within the provisions of this chapter. . . .

Under AS 23.30.120(a)(1), benefits sought by an injured worker are presumed to be compensable. *Meek v. Unocal Corp.*, 914 P.2d 1276, 1279 (Alaska 1996). The presumption of compensability is applicable to any claim for compensation under the workers' compensation

statute, including medical benefits. *Carter,* 818 P.2d at 665; *Meek*, 914 P.2d at 1279; *Moretz v. O'Neill Investigations*, 783 P.2d 764, 766 (Alaska 1989); *Olson v. AIC/Martin J.V.*, 818 P.2d 669, 675 (Alaska 1991).

The application of the presumption involves a three-step analysis. To attach the presumption of compensability, an employee must first establish a "preliminary link" between his or her injury and the employment. *See, e.g., Tolbert v. Alascom, Inc.*, 973 P.2d 603, 610 (Alaska 1999). If the employee establishes the link, the presumption may be overcome when the employer presents substantial evidence the injury was not work-related. *Id.* at 611. An employer may rebut the presumption of compensability with an expert opinion the claimant's work was probably not a substantial cause of the disability or need for medical treatment. *Gillispie v. B&B Foodland*, 881 P.2d 1106, 1110 (Alaska 1994). Because the board considers the employer's evidence by itself and does not weigh the employee's evidence against the employer's rebuttal evidence, credibility is not examined at this point. *Veco, Inc. v. Wolfer*, 693 P.2d 865, 869-870 (Alaska 1985). If the board finds the employer's evidence is sufficient, the presumption of compensability drops out and the employee must prove his or her case by a preponderance of the evidence. *Miller v. ITT Arctic Services*, 577 P.2d 1044, 1046 (Alaska 1978). This means the employee must "induce a belief" in the minds of the board members the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). At this point, the board weighs the evidence, determines what inferences to draw from the evidence, and considers credibility.

For work injuries occurring prior to the November 7, 2005 effective date of the 2005 amendments to the Alaska Workers' Compensation Act, a work injury is compensable where the employment is "a substantial factor" in bringing about the disability or need for medical care. *Ketchikan Gateway Borough v. Saling*, 604 P.2d 590, 597-98 (Alaska 1979). A work injury is a substantial factor in bringing about the disability or need for medical care if the claimant would not have suffered disability at the same time, in the same way, or to the same degree but for the work injury. *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 532-33 (Alaska 1987).

> **AS 23.30.122. Credibility of witnesses**. The board has the sole power to determine the credibility of a witness. A finding by the board concerning the

> weight to be accorded a witness's testimony, including medical testimony and reports, is conclusive even if the evidence is conflicting or susceptible to contrary conclusions. The findings of the board are subject to the same standard of review as a jury's finding in a civil action.

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

AS 23.30.145(b) requires an employer to pay reasonable attorney's fees when the employer delays or "otherwise resists" payment of compensation and the employee's attorney successfully prosecutes his claim. *Harnish Group, Inc.*, 160 P.3d at 150-51.

Alaska workers' compensation regulations currently provide:

> **8 AAC 45.050. Pleadings.**
> ...
>
> (f) Stipulations.
>
> ...
>
> (2) Stipulations between the parties may be made at any time in writing before the close of the record, or may be made orally in the course of a hearing or a prehearing.
>
> (3) Stipulations of fact or to procedures are binding upon the parties to the stipulation and ha\e the effect of an order unless the board, for good cause, relieves a party from the terms of the stipulation ....
>
> **8 AAC 45.180. Costs and attorney's fees**.
> . . .
>
> (b) A fee under AS 23.30.145(a) will only be awarded to an attorney licensed to practice law in this or another state. An attorney seeking a fee from an employer for services performed on behalf of an applicant must apply to the board for approval of the fee; the attorney may submit an application for adjustment of claim or a petition. An attorney requesting a fee in excess of the statutory minimum in AS 23.30.145(a) must (1) file an affidavit itemizing the hours expended, as well as the extent and character of the work performed, and (2) if a hearing is scheduled, file the affidavit at least three working days before the hearing on the claim for which the services were rendered; at the hearing, the attorney may supplement the affidavit by testifying about the hours expended and the extent and character of the work performed after the affidavit was filed. If the request and affidavit are not in accordance with this subsection, the board will deny the request for a fee in excess of the statutory minimum fee, and will award the minimum statutory fee.
>
> (c) Except as otherwise provided in this subsection, an attorney fee may not be collected from an applicant without board approval. A request for approval of a fee to be paid by an applicant must be supported by an affidavit showing the extent and character of the legal services performed. . . .

> (d) The board will award a fee under AS 23.30.145(b) only to an attorney licensed to practice law under the laws of this or another state.
>
> > (1) A request for a fee under AS 23.30.145(b) must be verified by an affidavit itemizing the hours expended as well as the extent and character of the work performed. . . . Failure by the attorney to file the request and affidavit in accordance with this paragraph is considered a waiver of the attorney's right to recover a reasonable fee in excess of the statutory minimum fee under AS 23.30.145(a), if AS 23.30.145(a) is applicable to the claim, unless the board determines that good cause exists to excuse the failure to comply with this section.
> >
> > (2) In awarding a reasonable fee under AS 23.30.145(b) the board will award a fee reasonably commensurate with the actual work performed and will consider the attorney's affidavit filed under (1) of this subsection, the nature, length, and complexity of the services performed, the benefits resulting to the compensation beneficiaries from the services, and the amount of benefits involved.
>
> . . .
>
> (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 costs were incurred in connection with the claim…

ANALYSIS

1) Is Employee entitled to cervical spine medical benefits?

This is a factual question to which the presumption of compensability applies. Employee raises the presumption he is entitled to cervical spine medical benefits with Dr. Eule's opinion Employee's need for cervical spine medical treatment is related to the October 25, 1990 work injury.

One the presumption is raised, Employer must rebut the presumption with substantial evidence, which is viewed in isolation and without a determination of credibility. Employer relies on the opinions of EME physician Dr. Yodlowski and SIME physician Dr. McCormack. Dr. McCormack opined Employee's 1990 work injury has not been a substantial factor in his need for treatment since July 27, 2010. Dr. McCormack opined that Employee was medically stable on February 29, 1996, when he was found stable by his treating surgeon, Dr. Kralick. Dr. McCormack stated from

that point forward, the work injury was no longer a substantial factor in the need for medical treatment.

Once Employer rebuts the presumption of compensability, Employee must prove his claim by a preponderance of the evidence. Employee is unable to meet this burden. There is clearly disagreement among the physicians regarding Employee's need for cervical spine medical treatment. A finding reasonable persons would find employment was a cause of Employee's need for medical treatment and impose liability is a subjective determination. *Rogers & Babler*, 747 P.2d at 534. The board has the sole discretion to determine the weight of the medical testimony and reports. When doctors' opinions disagree, the board determines which has greater credibility. *Harnish Group, Inc.*, 160 P.3d at 153; *Moore v. Afognak Native Corp.*, Alaska Workers' Comp. App. Comm'n Dec. No. 087 at 11.

Dr. Eule has never reviewed Employee's entire medical file, and consequently his opinion is given less weight on the issue of Employee's need for cervical spine medical treatment. Drs. Yodlowski and McCormack's credible and clear opinions are the most persuasive and probative evidence on the issue of whether Employee's October 1990 work injury is a substantial factor in his need for cervical spine medical treatment. Evaluation of the medical evidence shows it is more likely than not the work injury is not a substantial factor in Employee's need for cervical spine medical treatment. Employee's claim for cervical spine medical benefits will be denied.

2) Is Employee entitled to an attorney's fees and costs award?

Employee failed to meet his burden of proving his ongoing complaints and symptoms are work-related. The foundation for Employee's claims for an award of attorney's fees and costs was the work-relatedness of his conditions and symptoms. In the absence of adequate proof of work-relatedness, Employee is not entitled to these benefits. The evidence does not support an award of additional benefits for the reasons stated in section one, above. Therefore, he is not entitled to an attorney's fees or costs award.

CONCLUSIONS OF LAW

1) Employee is not entitled to cervical spine medical benefits.

2) Employee is not entitled to an attorney's fees and costs award.

ORDER

1) Employee's claim for cervical spine medical costs is denied.
2) Employee's claim for an attorney's fees and costs award is denied.

Dated in Anchorage, Alaska on October 13, 2015.

ALASKA WORKERS' COMPENSATION BOARD

Amanda Eklund, Designated Chair

Pat Vollendorf, 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 STEVEN C BARNETT, employee / claimant; v. LEE E RAYMOND, employer; INSURANCE CO NORTH AMERICA, insurer / defendants; Case No(s). 199028161; 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 October 13, 2015.

Pamela Murray, Office Assistant