6/ALASKA WORKERS' COMPENSATION BOARD

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

MICHAEL R. BARKER, Employee, Claimant, v. STATE OF ALASKA, Self-Insured Employer, Defendant.	)	FINAL DECISION AND ORDER AWCB Case No. 201407990 AWCB Decision No. 19-0071 Filed with AWCB Fairbanks, Alaska on June 25, 2019

Michael R. Barker's (Employee) December 10, 2015 claim was heard on the written record on May 23, 2019 in Fairbanks, Alaska, a date selected on January 15, 2019. A December 12, 2018 affidavit of readiness for hearing request gave rise to this hearing. Attorney Joseph Kalamarides represented Employee. Attorney Adam Franklin represented State of Alaska (Employer). The record closed after deliberations on May 30, 2019.

ISSUES

Employee contends the work injury is the substantial cause of his need for cervical and lumbar spine, bilateral shoulders, double vision and vertigo medical treatment. He acknowledges his physician does not recommend any further treatment for his right shoulder and neck and that his lower back is medically stable. Employee seeks continuing medical treatment for his double vision and vertigo. He requests an order awarding medical benefits for his cervical and lumbar spine, bilateral shoulders and double vision. Employee requested medical treatment for any future ongoing vertigo problems.

Employer concedes the work injury is the substantial cause of Employee's need for prism glasses and an examination by a neuro-ophthalmologist for his double vision and mild over-the-counter analgesics for his cervical spine. It contends the work injury is not the substantial cause of his need for lumbar spine and bilateral shoulders medical treatment, for degenerative cervical spine disease or for ear or eye medical treatment. Employer contends the substantial causes of his continuing need for lumbar spine and right shoulder medical treatment for his are preexisting conditions. It contends the substantial cause of his continuing need for left shoulder medical treatment is degenerative changes. Employer seeks an order denying Employee's claim for medical benefits for his lumbar spine, bilateral shoulders and degenerative cervical spine condition.

1) **Is the work injury the substantial cause of Employee's need for medical treatment for his past and/or continuing cervical and lumbar spine, bilateral shoulders, double vision and vertigo, and if so, to what benefits is Employee entitled?**

Neither Employer nor Employee addressed attorney fees and costs in their written briefs. Employee did not file an affidavit of attorney fees and costs.

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

FINDINGS OF FACT

A preponderance of the evidence establishes the following facts and factual conclusions:

1) On August 19, 2011, Employee reported severe lumbosacral pain with right leg weakness. He had a persistent right foot drop and right sided sciatica. Employee used two to three Vicodin daily for chronic pain and a narcotic contract was completed. (Mary Gannett, M.D., chart note, August 19, 2011).

2) On July 23, 2012, Employee complained of back pain. He used Vicodin twice a week and Valium for nocturnal sciatica. (Charles Steiner, M.D., chart note, July 23, 2012).

3) On October 26, 2012, Employee visited Victor Bartling, D.O., for chronic back pain. His ongoing pain worsened with his current job delivering propane and hauling hoses. Employee used four Vicodin tabs daily. Dr. Bartling prescribed Cymbalta and Vicodin for chronic pain. (Bartling chart note, October 26, 2012).

4) On January 4, 2014, Employee reported chronic back pain with difficulty sleeping and taking deep breaths and rated his pain as "9/10." An x-ray revealed diffuse mild to moderate spondylosis most apparent at the L4-5 level. Dr. Bartling prescribed muscle relaxants and pain medications and recommended physical therapy (PT) and a lumbar spine magnetic resonance imaging (MRI). (Bartling chart note, January 4, 2014; X-Ray report, January 4, 2014).

5) On January 6, 2014, an MRI revealed disc space narrowing at L4-5. (MRI report, January 6, 2014).

6) On April 28, 2014, Employee operated a street sweeping machine while working for Employer and a co-worker driving another street sweeping machine rear-ended him. The back of his head hit the back windshield but he did not lose consciousness. Employee reported his neck hurt and he felt lightheaded. He denied any new numbness, tingling or weakness to any extremity. Employee was diffusely tender midline in his neck, particularly lower on C4-5 but was not tender over his thoracic or lumbar spine. A cervical computerized tomography (CT) scan showed no acute injuries but revealed spondylosis and facet degeneration most evident at C3-4. He was diagnosed with an acute closed head injury and acute neck pain and was restricted from working for the next few days. (Fairbanks Memorial Hospital Emergency Room Report, April 28, 2014; CT report, April 28, 2014).

7) On May 2, 2014, Employee believed he experienced a brief loss of consciousness because the first thing he recalls after the impact was someone at his window to help him. Employee's wife stated his cognition was not as sharp as usual. Employee reported headaches in the back of his head, pressure in his forehead and face, dizziness and slow thoughts; sometimes he lost focus and had to concentrate to see. His left shoulder and elbow pain were worse than before the accident and probably reflected myofascial strains at those joints. Employee's back was forcefully extended against the seat belt restraint worsening his chronic lumbago. Charles Steiner, M.D., diagnosed concussion without loss of consciousness, cervical spine strain, shoulder joint pain and lumbago. He referred Employee for PT for whiplash, shoulder pain and low back pain and prescribed medication for dizziness. (Steiner medical report, May 2, 2014).

8) On May 7, 2014, Employee was evaluated for PT. He stated he had bad headaches for the last few days, dizziness and nausea, neck, pain, left shoulder pain and lower back pain. Employee's neck and head were the most painful. He rated his lower back pain as "7/10." Under "Surgical Histories," it listed 2000 L4-5 discectomy, 2000 left shoulder bur removal and right extremity

surgeries after a fracture in 1978 which required 13 surgeries. Employee had limited range of motion in his cervical and lumbar spine and less but notable shoulder limitation. (Jack Fry, D.P.T, PT Evaluation, May 7, 2014).

9) On May 20, 2014, Employee followed up with Dr. Steiner for neck and back pain. He continued to have limited cervical spine range of motion, vertigo and diplopia. Dr. Steiner referred him for a neurological evaluation and brain MRI and restricted Employee from working until June 18, 2014. (Steiner medical report, May 20, 2014; Steiner Work Ability Report, May 20, 2014).

10) On May 27, 2014, Employee's brain MRI revealed volume loss greater than expected for age, a probable old right thalamic lacunar infarct and a left mastoid effusion. (MRI report, May 27, 2014).

11) On June 3, 3014, Employee visited James Foelsch, M.D., a neurologist, upon referral from Dr. Steiner. He showed Dr. Foelsch pictures of the broken front window and back window. His head hit the front window and then rebounded back and struck the back window. Afterwards, Employee complained of significant neck and low back pain and dizziness with nausea. He has residual right arm weakness due to multiple surgeries for a prior injury and residual right leg weakness after prior lumbar surgery at L5-S1 and L4-5 in 2000. Employee had vision problems primarily when he tried to use his near vision, occasional diplopia and blurry vision. Dr. Foelsch reviewed the brain MRI and concluded it showed no significant changes related to trauma. He diagnosed a concussion on April 28, 2014, with post-concussive symptoms consistent with posttraumatic vertigo as well as accommodation insufficiency, and flexion and extension injury to the cervical and lumbar spine without radiculopathy or myelopathy. Dr. Foelsch believed Employee's dizziness and imbalance were related to dysfunction of his peripheral vestibular system association caused by trauma and his visual complaints were also consistent with an accommodation disorder often seen after concussions. He recommended Employee continue with PT and begin vestibular exercises when his spine was able to tolerate them. If necessary, Dr. Foelsch could refer him to the pain clinic for more aggressive treatment. (Foelsch medical report, June 3, 2014).

12) On June 17, 2014, Employee experienced persistent vertigo, continuing neck pain with decreased range of motion and sore shoulders. The day before Employee stayed in bed at home because he had a bad spell of vertigo. Dr. Steiner referred him for osteopathic manipulative treatment (OMT). (Steiner chart note, June 17, 2014).

13) On July 3, 2014, Employee's vertigo persisted and his cervical spine range of motion was still reduced. He had bad vertigo that morning but it was the first time he had it in a week. Employee's mental activity was normal. Dr. Steiner noted he continued to be unable to drive for work because of his neck but he could do other work if employers had any available. He referred Employee to PT and OMT. (Steiner chart note, July 3, 2014).

14) On July 28, 2014, Employee felt the PT and OMT helped his cervicalgia considerably and he was able to drive his personal vehicle using mirrors but was not able to perform other aspects of his job, including maintenance and minor repair on heavy equipment. He still experienced vertigo and nausea two to three times per week. Dr. Steiner recommended continuing PT and OMT and taking medication for vertigo and nausea. (Steiner chart note, July 28, 2014).

15) On August 8, 2014, Ilmar Soot, M.D., examined Employee for an Employer's Medical Evaluation (EME). Employee reported a motor vehicle accident in 2000 which injured his lower back and he underwent surgery to relieve the pressure at L4-5 and L5-S1. Afterwards, he had residual difficult with right ankle and calf weakness. Employee also reported a work-related shoulder injury in 2001. Dr. Soot reviewed the April 28, 2014 emergency room report, the May 2, 2014 medical report, the May 27, 2014 brain MRI scan and the April 28, 2014 cervical spine CT scan. He noted it was difficult to diagnose Employee without having lumbar spine or left shoulder imaging studies. Dr. Soot diagnosed cervical strain secondary to the work injury, history of cervical degenerative spondylosis, suspected lumbar spondylosis with lumbar sprain, history of L4-5 and L5-S1 decompression with residual right leg loss and left shoulder pain of undetermined etiology. He opined the work injury was not the substantial cause of Employee's left shoulder symptoms. Dr. Soot recommended home cervical traction treatments. He opined Employee's neck and lower back were not medically stable but his left shoulder was. (Soot EME report, August 8, 2014).

16) On September 8, 2014, Dr. Steiner released Employee to light duty work. (Steiner Work Ability Report, September 8, 2014).

17) On September 10, 2014, Dr. Steiner referred Employee to Michael Weber, PA-C, for an orthopedic evaluation of his left shoulder pain, which was worse since the work injury and had not abased with PT and time, and for sciatica, which was a new symptom after the work injury and had not abated. He recommended continued PT and OMT for concussion. Dr. Steiner referred Employee for an otolaryngology consultation. (Steiner chart note, September 10, 2014).

18) On September 29, 2014, Richard Raugust, M.D., an otolaryngologist, after an audiometric evaluation, diagnosed Employee with bilateral high frequency sensorineural hearing loss with tinnitus and disequilibrium episodes, which he assumed were related to the work injury because Employee never complained of it previously, and mild double vision, which could be post-concussive. Dr. Raugust recommended Employee see an eye doctor for the double vision and a videonystagmography (VNG) to test the vestibular portion of his inner ear. (Raugust medical report, September 29, 2014).

19) On October 10, 2014, Dr. Steiner stated Employee could not return to work because of the vertigo, diplopia and cervical strain. He recommended Employee continue PT, OMT and treatment for diplopia and vertigo. (Steiner chart note, October 10, 2014; Steiner Work Ability Report, October 10, 2014).

20) On November 5, 2014, Employee's VNG test demonstrated abnormal vestibular function bilaterally with decreased vestibular function in Employee's left ear. Dr. Raugust stated he was a candidate for vestibular rehabilitation. He prescribed diazepam to suppress the abnormal vestibular responses. Dr. Raugust stated if the diazepam helped it would indicate the condition was vestibular in origin as opposed to originating in the central nervous system. (Raugust chart note, November 5, 2014).

21) On December 3, 3014, Employee followed up with Dr. Raugust. He reported a quarter of a tablet of diazepam worked better than meclizine. Dr. Raugust stated it would be dangerous for Employee to go back to work driving a bus because of his severe neck and back pain, disequilibrium and uncorrected diplopia. He opined it will likely take Employee several years to continue to recover from his injury and he may never attain full recovery due to the extent of the trauma. Dr. Raugust referred him for a neurological evaluation of his neck and concussion. (Raugust chart note, December 3, 3014; Raugust letters, December 3, 2014).

22) On January 12, 2015, Employee's cervical spine x-ray was compared to an April 20, 2014 cervical spine CT. The x-ray revealed no acute bone injuries but showed static-appearing C6-7 anterolisthesis without suspected instability. (X-ray report, January 12, 2015).

23) On January 20, 2015, Employee complained of cervical pain with radiculopathy, vertigo and diplopia. The radiculopathy radiates down his left arm and intermittently into his right arm. He also reported left radiculopathy to the posterolateral aspect radiating down to his foot in an S1

distribution. PA-C Sherrie McCoy recommended a cervical MRI. (McCoy chart note, January 20, 2015).

24) On February 11, 2015, a cervical spine MRI showed C3-4 mild left foraminal narrowing, uncovertebral joint spurring and no disc herniation or central canal compromise. (Cervical MRI report, February 11, 2015). A lumbar spine MRI revealed left paracentral disc herniation at L4-5 mildly narrowing the spinal canal, mild mass effect and edema involving the left L3 nerve root and early L3-4 spondylosis with mild posterior disc bulge and minimal spinal canal narrowing. (Lumbar MRI report, February 11, 2015).

25) On February 16, 2015, Employee had left leg weakness upon examination. PA-C McCoy noted the L4-5 herniated nucleus pulposus with L5 radiculopathy was a new finding since his work injury and most likely due to his work injury. PA-C McCoy recommended surgery because of Employee's left leg weakness. (McCoy chart note, February 16, 2015).

26) On March 17, 2015, Employee complained of right shoulder plain to PA-C Weber. He discontinued PT in December because it irritated his shoulders. Pain radiated down his arm to his hand and awakened him at night. PA-C Weber diagnosed post-traumatic adhesive capsulitis. He referred Employee to Daniel Johnson, D.O., for consideration of right shoulder manipulation and prescribed Norco. (Weber chart note, March 17, 2015).

27) On March 18, 2015, Employee complained of constant burning, sharp right shoulder pain and stiffness. Moving his shoulder made it worse. Dr. Johnson assessed right shoulder point pain and unspecified disorders of bursae and tendons in his shoulder. He referred him for an MRI. (Johnson chart note, March 18, 2015).

28) On March 30, 2015, a right shoulder MRI revealed supraspinatus tendinopathy with suspected small partial tearing at the insertion, edema in the anterior supraspinatus and posterior subscapularis fibers suggesting muscle injury and a possible superior labrum from anterior to posterior (SLAP) lesion. (MRI report, March 30, 2015).

29) On April 6, 2015, Dr. Johnson referred Employee to Mark Wade, M.D., for frozen shoulder and impingement syndrome. (Johnson chart note, April 6, 2015).

30) On April 9, 2015, Dr. Wade diagnosed Employee with right shoulder adhesive capsulitis and right tendonitis or bursitis with suspected partial tear of supraspinatus insertion. He recommended PT for aggressive range of motion exercises. (Wade chart note, April 9, 2015).

31) On April 27, 2015, John Lopez, M.D., performed a left L4-5 microdiscectomy, left L5-A1 foraminotomy, fluoroscopy and microscopy. (Lopez operative report, April 27, 2015).

32) On May 14, 2015, Employee's right shoulder adhesive capsulitis was improving but he continued to have pain. Dr. Wade recommended Employee continue PT and surgical intervention if he was still in significant pain in six weeks. (Wade chart note, May 14, 2015).

33) On July 23, 2015, Employee elected to proceed with a diagnostic arthroscopy with a possible right acromioclavicular joint resection and evaluation of the rotator cuff for tendinitis versus a tear. (Wade chart note, July 23, 2015).

34) On August 25, 2015, James Rockwell, M.D., an otolaryngologist, examined Employee for an Employer's Medical Evaluation (EME). He stated Employee had absolutely no vestibular nerve injury that would explain his subjective complaints of dizziness because at the time of the work injury, there was no evidence of any other significant head and neck trauma. (Rockwell EME report, August 25, 2015).

35) On August 25, 2015, Eugene Wong, M.D., a neurologist, examined Employee for an EME. Employee reported his prior low back pain stemmed from a non-work related motor vehicle accident in 2000 and he underwent back surgery in December 2000. Dr. Wong assessed head contusion and whiplash injury or cervical strain causally related to the work injury, lumbar sprain casually related to the work injury, status post left-sided L4-5 and L5-S1 decompression surgery not casually related to the work injury and preexisting status post low back surgery not casually related to the work injury. He opined it was reasonable to relate the vertigo to the work injury and it probably resulted from a combination of the direct blow to his head and the whiplash injury. Dr. Wong stated there was no causal temporal relationship of the onset of lumbar radiculopathy to the work injury and no objective evidence to support a subjective complaint of left foot drop because his examination revealed considerable give-way and collapse weakness involving all of the musculature of the left lower extremity. Employee reached medical stability as of August 25, 2015, on a neurological basis irrespective of cause, his need for medical treatment ended as of August 25, 2015, and there was no ratable impairment. (Wong EME report, August 25, 2015).

36) On August 26, 2015, Richard Bensinger, M.D., an ophthalmologist, examined Employee for an EME. Employee reported a head on motor vehicle accident in 2000 which required surgical repair of a lumbar disc. Dr. Bensinger opined the work injury resulted in some disturbance of Employee's eye muscle coordination center causing double vision. Employee was stable and not

expected to improve. Wearing prism incorporated glasses allowed him to function. He reached medical stability six months ago. Dr. Bensinger rated him under the 4th Edition of the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment with an 11 percent impairment because the 6th Edition did not define double vision. He opined Employee will need prism glasses but no other specific treatment and he can return to fulltime work with the use of prism glasses. (Bensinger EME report, August 26, 2015).

37) On August 27, 2015, Dennis Chong, M.D., a physiatrist, examined Employee for an EME. Employee reported a work injury to his right forearm resulting in multiple surgeries and a left shoulder work injury in 1999 which required surgery in 2000. Dr. Chong diagnosed a resolved cervical sprain or strain substantially caused by the work injury, resolved left shoulder pain substantially caused by the work injury, non-work related right shoulder pain, non-work related preexisting lumbar spine multilevel degenerative disease and spondylosis, and non-work related preexisting cervical spine degenerative disease with spondylosis at C3-4. Dr. Chong opined the substantial cause of Employee's right shoulder pain was age-related degenerative disease. Employee's lumbar spine degenerative disease and spondylosis was a natural progression of a chronic degenerative process and his cervical spine disease was preexisting because it was present on the April 28, 2014 cervical spine CT scan. Employee's right shoulder was not medically stable, the cervical sprain or strain, left shoulder pain and lumbar spine condition reached medical stability in August 2014. No further medical treatment was necessary for the work injury. Dr. Chong assessed no left shoulder impairment rating, a 1.7 percent impairment for his cervical spine apportioned to his preexisting condition, and a one percent impairment for his right shoulder apportioned to his preexisting condition. (Chong EME report, August 25, 2015).

38) On October 27, 2015, Dr. Wong opined it was reasonable to causally relate Employee's double vision to a head contusion injury with the work injury. He stated the substantial cause of Employee's head contusion is the work injury but it cannot be determined whether he suffered a brain contusion. (Wong addendum EME report, October 27, 2015).

39) On October 8, 2015, Employer controverted neurological treatment after August 25, 2015, left shoulder and back PT after August 2014, all medical treatment for Employee's right shoulder, temporary total disability (TTD) after August 25, 2015, and permanent partial impairment (PPI) benefits "pending a rating rendered per the AMA Guides 6th Edition" based upon Drs. Wong and Rockwell EME reports. It contended Employee reached medical stability on August 25, 2015 and

Dr. Bensinger assessed an 11 percent PPI rating per the AMA Guides 4th Edition. Employer contended "all evaluators" released him to work and no further treatment was recommended except prism eyeglasses. (Controversion Notice, October 8, 2015).

40) On December 10, 2015, Employee filed a workers' compensation claim seeking TTD, PPI benefits, medical costs, transportation costs, interest, attorney's fees and costs, reemployment benefits and a Second Independent Medical Evaluation (SIME) for injuries sustained to his neck, shoulder, low back, vision, head and hearing. He described the nature of the injury as neck and low back pain, whiplash, vertigo, hearing loss, concussion, shoulder pain, vision, blurred and double vision, head injury, shoulder surgery and back surgery. (Workers' Compensation Claim, December 10, 2015).

41) On December 22, 2015, Paul Craig, Ph. D., a neuropsychologist, examined Employee an EME. Employee reported he underwent 13 surgeries involving his right upper extremity after a work injury in 1978. The last surgery occurred in the 1990s. He also reported a lower back surgery after a motor vehicle accident around 2000 and that same year he had surgery in his left shoulder to treat a bone spur. Dr. Craig opined Employee demonstrated a mild vascular neurocognitive disorder and the May 27, 2014 MRI objectively supported that conclusion. Furthermore, Employee and his wife reported his cognitive functions became worse over time and that is not the cognitive change pattern anticipated for a traumatic brain injury. Rather it is the natural history of cognitive decline anticipated with a vascular neurocognitive disorder. Dr. Craig noted Dr. Steiner's July 3, 2014 chart note documented improvement in his cognitive improvement. He opined the work injury is not a substantial factor associated with Employee's cerebrovascular etiology. Dr. Craig recommended continued medical care but stated it would not be related to the work injury. (Craig EME report, December 22, 2015).

42) On January 7, 2016, Employer controverted neurological treatment after August 25, 2015, left shoulder and back PT after August 2014, all medical treatment for Employee's right shoulder, TTD after August 25, 2015, and PPI benefits "pending a rating rendered per the AMA Guides 6th Edition" based upon Drs. Wong and Rockwell EME reports. (Controversion Notice, January 7, 2016).

43) On January 25, 2016, Employee followed up with Ken Lemos, PA-C. He stated his left leg pain and discomfort was approximately 60 percent better after the left L4-5 and L5-S1 microdiscectomy and left L5-S1 foraminotomy. Employee reported occasional left foot tripping

and weakness. He had very little pain or discomfort in the lumbar spine but occasional stiffness. (Lemos chart note, January 25, 2016).

44) On September 26, 2016, the parties filed a compromise and release settlement agreement in which Employee waived all benefits except medical benefits and the parties disagreed as to the extent of his work injuries. (Compromise and Release Agreement, September 26, 2016).

45) On May 9, 2017, Lorne Direnfeld, a neurologist, examined Employee for a SIME. He diagnosed a head contusion versus concussion or mild traumatic brain injury, post-traumatic diplopia with probable left fourth cranial nerve palsy, vertigo or dizziness and cervical strain. Dr. Direnfeld explained the fourth cranial nerve is particularly susceptible to damage from head trauma, occipital and frontal impact can give rise to fourth cranial nerve palsies, and relatively minor head injuries can result in fourth cranial nerve palsy. He opined the work injury is the substantial cause of his disability and need for treatment for double-vision and imbalance, dizziness and vertigo. Employee reached medical stability no later than one year after the work injury. When asked if the treatment he received was reasonable and necessary and if treatment will help Employee recover from the injury, relieve chronic debilitating pain, promote recovery from individual episodes of pain caused by a chronic condition or reduce permanent impairment, Dr. Direnfeld said:

> Treatment provided to [Employee] for the neurologic components of his symptom complex has included the use of a prism in his spectacles.
>
> [Employee] has received treatment for problems with imbalance/dizziness/vertigo in the form of physical therapy directed toward vestibular rehabilitation. [Employee] has also receive [sic] trials of treatment with various medications including meclizine and diazepam to assist in managing these complaints.
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> [Employee] will likely continue to require the use of a prism in his spectacles indefinitely.
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> Additional formal treatment directed toward vestibular symptoms in [Employee's] case is unlikely to result in further significant symptomatic or functional improvement at this stage of [Employee's] clinical course beyond that which [Employee] can achieve by simply attempting to function as normally as possible relative to his complaints of dizziness/imbalance/vertigo.
>
> [Employee's] neurologic symptoms pertaining to the brain/central nervous system components of his symptom complex are not associated with chronic debilitating

> pain and treatment directed toward these components of his system complex are not aimed at addressing chronic debilitating pain.
>
> These treatments will not promote recovery from individual episodes of pain caused by a chronic condition.
>
> These treatments will not likely further limit or reduce permanent impairment at this stage of [Employee's] clinical course.

He stated Employee's work injuries are unlikely to benefit from invasive treatment such as surgeries or injections. However, an opinion from a skilled and knowledgeable neuro-ophthalmologist regarding the role of strabismus surgery to relieve double vision and restore binocularity is reasonable. Dr. Direnfeld opined the work injury "would not be expected to result in any lasting problems with cognitive function on a primary organic basis to a reasonable degree of medical probability." (Direnfeld SIME report, May 9, 2017).

46) On May 10, 2017, James Scoggin, M.D., an orthopedist, examined Employee for a SIME. His "Diagnostic Impression" included:

> 1. Cervical strain, industrial and attributable to the April 28, 2014 injury
> 2. Preexisting C3-C4 degenerative changes of the cervical spine
> 3. Non-industrial minor degenerative changes revealed in MRI of the cervical spine on February 11, 2015 with no fractures, no dislocations, no disc herniation
> 4. Prior severe injury to the right upper extremity due to prior injury requiring approximately 13 different prior surgeries including bone grafting from his right pelvis with residuals, pre-existing
> 5. Preexisting low back pain
> 6. Prior lumbar surgery at L4-L5 and L5-S1 with residual weakness in his right leg
> 7. Preexisting chronic low back pain
> 8. Prior documentation that the prior low back pain was getting worse, documented on January 4, 2014 in the same calendar year as Mr. Barker's industrial injury of April 28, 2014
> 9. Prior documentation of 9/10 level low back pain documented on January 4, 2014
> 10. Prior documentation of pre-existing nocturnal sciatica requiring Valium
> 11. Prior narcotic pain contract for pre-existing chronic pains
> 12. Documentation of prior use of Vicodin, four tabs daily, due to chronic preexisting pain
> 13. Prior narrowing of L4-L5 disc with hypertrophic changes, spondylosis, and disc space narrowing, pre-existing and documented on January 4, 2014 and January 6, 2014
> 14. Right shoulder pain complaints with onset documented to have been in January 2015, unrelated to the April 28, 2014 industrial injury
> 15. Pre-existing left shoulder pain, with prior left shoulder injury

Dr. Scoggin opined the work injury is the substantial cause of Employee's need for cervical spine medical care. However, his lumbosacral, right shoulder and left shoulder conditions did not result from the work injury and the work injury is not the substantial cause of his disability or need for medical treatment for his bilateral shoulders or low back. Dr. Scoggin stated Employee's work-related cervical spine disability ended by August 2014 and he reached medical stability by the middle of February 2015. He opined no additional treatment is indicated, necessary or appropriate to address the cervical spine work injury and recommended Employee continue with an independent home exercise program and take mild over-the-counter analgesics as needed for pain. Employee's need for right shoulder surgery was not the result of the work injury but was the result of degenerative changes without acute injury because there was no temporal association between the April 28, 2014 work injury and Employee's onset of right shoulder pain in early 2015 and the right shoulder MRI showed non-specific degenerative changes. Employee's lumbosacral condition and left shoulder pain preexisted the work injury. He had a significant prior history of chronic low back pain and left shoulder pain. Employee's back pain escalated prior to the work injury in January 2014 and his prior symptoms included lower extremity weakness, nocturnal sciatica and pain and he was prescribed with Valium, Vicodin and Cymbalta for those symptoms prior to the work injury. Dr. Scoggin opined there was no evidence Employee's work-related injury aggravated, accelerated or exacerbated a preexisting condition. (Scoggin SIME report, May 10, 2017).

37) On July 27, 2017, Employer controverted all medical benefits except prism glasses, examination by a neuro-ophthalmologist and over the counter mild analgesics for cervical symptoms based upon Drs. Direnfeld's and Scoggin's SIME reports. (Controversion Notice, July 27, 2017).

38) On June 20, 2018, Dr. Steiner wrote a letter to Employee's attorney stating he examined Employee and believed his right shoulder injury reached medical stability and no future therapy was needed. (Steiner letter, June 20, 2018).

39) On January 15, 2019, the parties agreed to an oral hearing on May 23, 2019 on Employee's December 10, 2015 claim seeking medical treatment and attorney's fees and costs. (Prehearing Conference Summary, January 15, 2019).

40) On April 30, 2019, the parties agreed to waive an oral hearing and requested a hearing on the written record with briefs. (Stipulation, April 30, 2019).

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).

> **AS 23.30.095. Medical treatments, services, and examinations**. (a) The employer shall furnish medical . . . treatment . . . medicine . . . 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. 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.
> . . . .
>
> (o) Notwithstanding (a) of this section, an employer is not liable for palliative care after the date of medical stability unless the palliative care is reasonable and necessary (1) to enable the employee to continue in the employee's employment at the time of treatment, (2) to enable the employee to continue to participate in an approved reemployment plan, or (3) to relieve chronic debilitating pain. A claim for palliative care is not valid and enforceable unless it is accompanied by a certification of the attending physician that the palliative care meets the requirements of this subsection. . . .

When the board reviews a claim for medical treatment made within two years of an undisputed work-related injury, its review is limited to whether the treatment sought is reasonable and necessary. *Philip Weidner & Associates, Inc. v. Hibdon*, 989 P.2d 727 (Alaska 1999). *Hibdon* addressed the issues of reasonable of medical treatment:

> The question of reasonableness is 'a complex fact judgment involving a multitude of variables.' However, where the claimant presents credible, competent evidence from his or her treating physician that the treatment undergone or sought is reasonably effective and necessary for the process of recovery, and the evidence is corroborated by other medical experts, and the treatment falls within the realm of medically accepted options, it is generally considered reasonable. (Citations omitted). (*Id*. at 732).

When reviewing a claim for continued treatment beyond two years from the date of injury, the Board has discretion to authorize "indicated" medical treatment "as the process of recovery may require." *Id*. With this discretion, the Board has latitude to choose from reasonable alternatives rather than limited review of the treatment sought. *Id*.

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

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

At the second step, once the preliminary link is established, the employer has the burden to overcome the presumption with substantial evidence. *Kramer* at 473-74, quoting *Smallwood* at 316. To rebut the presumption, an employer must present substantial evidence that either (1)

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

If the presumption is raised but not rebutted, the claimant prevails and need not produce further evidence. *Williams v. State*, 938 P.2d 1065, 1075 (Alaska 1997). If the employer successfully rebuts the presumption, it drops out, and the employee must prove all elements of her case by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381. At this last step of the analysis, evidence is weighed and credibility considered. To prevail, the claimant must "induce a belief" in the minds of the fact finders the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). The presumption does not apply if there is no factual dispute. *Rockney v. Boslough Construction Co.*, 115 P.3d 1240 (Alaska 2005).

The Alaska Supreme Court has repeatedly held the fact symptoms arose after an event is insufficient to establish causation in workers' compensation cases. *Lindhag v. State*¸123 P.3d 948 (Alaska 2005); *Rivera v. Wal-Mart Stores, Inc.*, 247 P.3d 957 (Alaska 2011); *Buchinsky v. The Arc of Anchorage*, Slip Op. S-15547 (Alaska 2016). In *Morrison v. Alaska Interstate Construction Inc.*, 440 P.3d 224 (Alaska 2019), an employee first injured his knee in 2004 and underwent arthroscopic surgery. He returned to work after the surgery and performed all of his job duties without significant problems until he injured his right knee in 2014 while working for a different employer. The employee did not see a physician for his knee from 2004 to 2014. The board decided the employee's 2014 work injury was the substantial cause of his current need for medical care. The employer appealed and the Alaska Workers' Compensation Appeals Commission remanded the case back to the board because it decided the board misapplied the compensability standard. The Alaska Supreme Court reversed, holding that the changing the compensability

standard to the "substantial cause" modified the last injuries exposure rule to allow imposition of full liability on the earlier employer because the Act requires the board to consider the different causes of the benefit sought and the extent to which each cause contributed to the need for the benefit and then identify one cause as the substantial cause or the most important or material cause. *Id*. at 238. The Court held it was not unreasonable to determine the employee's second knee injury was the most important cause of his need for medical treatment because physicians agreed symptoms were what necessitated treatment in osteoarthritis. *Id*. at 239.

> **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 credibility findings and weight accorded evidence are "binding for any review of the Board's factual findings." *Smith v. CSK Auto, Inc.,* 204 P.3d 1001, 1008 (Alaska 2009). When doctors' opinions disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.,* AWCAC Decision No. 087 (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.
>
> **AS 23.30.395. Definitions.** In this chapter,
> . . . .

(28) "medical stability" means the date after which further objectively measurable improvement from the effects of the compensable injury is not reasonably expected to result from additional medical care or treatment, notwithstanding the possible need for additional medical care or the possibility of improvement or deterioration resulting from the passage of time; medical stability shall be presumed in the absence of objectively measurable improvement for a period of 45 days; this presumption may be rebutted by clear and convincing evidence;

(29) "palliative care" means medical care or treatment rendered to reduce or moderate temporarily the intensity of pain caused by an otherwise stable medical condition, but does not include those medical services rendered to diagnose, heal, or permanently alleviate or eliminate a medical condition;

. . . .

8 AAC 45.180. Costs and attorney's fees.

. . .

(b) . . . 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. . . .

(d) . . .

(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, and, if a hearing is scheduled, must be filed at least three working days before the hearing on the claim for which the services were rendered; at hearing the attorney may supplement the affidavit by testifying about the hours expended and the extent and character of the work performed after the filing of the affidavit. 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. . . .

ANALYSIS

1) Is the work injury the substantial cause of Employee's need for medical treatment for his past and/or continuing cervical and lumbar spine, bilateral shoulders, double vision and vertigo, and if so, to what benefits is Employee entitled?

a) Cervical spine

Employee requests medical benefits for his cervical spine. AS 23.30.095(a). Employer conceded the work injury caused his need for cervical medical treatment and relies on Dr. Scoggin's SIME report to contend he reached medical stability and the only treatment reasonable and necessary is mild over-the-counter analgesics. Employee acknowledges his cervical spine is medically stable and did not request any specific medical treatment. There is no dispute to resolve concerning Employee's claim for medical benefits for his cervical spine and the presumption does not apply. Employee is entitled to mild over-the-counter analgesics for his cervical spine.

b) Double vision and vertigo

Employee requests medical benefits for double vision and vertigo. AS 23.30.095(a). Employer conceded the work injury caused Employee's need for prism glasses and a neuro-ophthalmologist evaluation due to double vision caused by the work injury. Therefore, Employer does not dispute the work injury caused Employee's need for prism glasses and a neuro-ophthalmologist evaluation for double vision. It is unclear if Employer disputed whether the work injury was the substantial cause of Employee's past and continuing need for vertigo medical treatment. However, Employer controverted all neurological treatment after August 25, 2015 and all medical benefits except prism glasses, examination by a neuro-ophthalmologist and over the counter mild analgesics for cervical symptoms. The presumption of compensability applies to this issue. AS 23.30.120; *Meek*; *Sokolowski*. Without regard to credibility, Employee raises the presumption of compensability with Dr. Direnfeld's SIME report opining the work injury was the substantial cause of his need for imbalance, dizziness and vertigo medical treatment. *Tolbert*; *Wolfer*.

Without regard to credibility, Employer rebuts the presumption of compensability with Dr. Rockwell's EME report opining Employee had no vestibular nerve injury that would explain his

dizziness and Dr. Direnfeld's opinion that no additional formal medical treatment was needed for vertigo. *Wolfer*; *Runstrom*.

Because Employer rebutted the presumption, Employee must prove all elements of his claim by a preponderance of the evidence. *Koons*. At this stage, evidence is weighed, inferences are drawn from the evidence and credibility is determined. *Saxton.* Dr. Foelsch believed Employee's dizziness and imbalance was related to peripheral vestibular system dysfunction caused by trauma and ordered a VNG study which demonstrated abnormal vestibular function. The two neurologists in the medical record, Drs. Wong and Direnfeld, opined the work injury is the substantial cause of Employee's need for imbalance, dizziness and vertigo medical treatment as the direct head blow and whiplash he sustained as a result of the work injury is known to cause neurological injury. Dr. Rockwell is less credible than Drs. Wong and Direnfeld because he is an otolaryngologist and his opinion was based on his conclusion Employee did not sustain a vestibular nerve injury. AS 23.30.122; *Smith*; *Moore*. Furthermore, Employee first treated for dizziness on May 2, 2014, and there is no record indicating Employee previously complained of vertigo prior to the work injury. The preponderance of the evidence shows the work injury was the substantial cause of his past need for imbalance, dizziness and vertigo medical treatment.

Employee requested he be allowed to treat any future ongoing vertigo problems but he has not stated what continuing vertigo medical treatment he is seeking. Employee must prove continuing medical treatment is reasonable and necessary and indicated as the process of recovery may require. AS 23.30.095(a); *Hibdon*. Dr. Direnfeld opined additional formal vertigo medical treatment was unlikely to result in further significant symptomatic or functional improvement and discouraged benzodiazepine usage. He also found Employee medically stable as of April 2015. Dr. Wong opined Employee's reached medical stability on a neurological basis as of August 25, 2015, but did not distinguish whether that applied to his lumbar radiculopathy or vertigo. No physician has recommended continuing vertigo medical treatment. No physician opined he has chronic debilitating pain, nor has a physician said he needs continuing vertigo medical treatment to enable him to return to work. AS 23.30.095(o). The medical evidence established further objectively measurable improvement from the work injury was not reasonably expected to result from additional medical care or treatment as of April 2015. AS 23.30.95(28). The preponderance

of the evidence shows Employee's vertigo became medically stable in April 2015 and additional palliative vertigo medical care is not reasonable or necessary or indicated for the recovery process. Employee's request for continuing vertigo medical benefits will be denied.

c) Lumbar spine

Employee requests medical benefits for his lumbar spine. AS 23.30.095(a). Employer denied back PT after August 2014 and contends the substantial cause of his need for lumbar spine medical treatment is his preexisting degenerative disease. Employee acknowledged his lower back is medically stable. The presumption of compensability applies to this issue. AS 23.30.120; *Meek*; *Sokolowski*. Without regard to credibility, Employee raises the presumption of compensability with Dr. Steiner's May 2, 2014 medical report diagnosing lumbago worse since the work injury and PA-C McCoy's February 16, 2015 chart note attributing Employee's L4-5 herniated pulposus with L5 radiculopathy to his work injury. *Tolbert*; *Wolfer*.

Without regard to credibility, Employer rebuts the presumption of compensability with Dr. Scoggin's opinion stating the substantial cause of Employee's need for lumbar spine medical treatment is his preexisting chronic low back pain and prior lumbar surgery at L4-5 and L5-S1. *Wolfer*; *Runstrom*.

Because Employer rebutted the presumption, Employee must prove by a preponderance of the evidence the substantial cause of his need for lumbar spine medical treatment is due to the work injury. *Koons*. At this stage, evidence is weighed, inferences are drawn from the evidence and credibility is determined. *Saxton*. Employee denied any tenderness in his lumbar spine on April 28, 2014 but on May 2, 2014, reported to Dr. Steiner his lumbago was worse than before the work injury. However, he rated his lower back pain higher in January 2014 before his work injury than after his work injury on May 2, 2014. Unlike the claimant in *Morrison*, Employee had lumbar pain prior to the work injury and was not symptom free. PA-C McCoy is the only physician in the record to attribute Employee's lumbar spine symptoms to the work injury because there was a new finding at L4-5 after the work injury on January 20, 2015. Drs. Chong and Scoggin attributed Employee's need for lumbar spine medical treatment to preexisting degenerative disease. Dr. Wong opined the work injury caused a lumbar sprain and Employee reached medical stability from

a neurological basis irrespective of causation by August 2015. The medical records show Employee had a lower back surgery prior to the work injury and underwent a subsequent surgery at the same level on April 27, 2015. The medical records also show Employee had chronic back pain requiring medical treatment before the work injury, including medications and physical therapy. He did not report left radiculopathy down to his foot until January 20, 2015. The fact Employee's left radiculopathy arose after the work injury is insufficient to establish causation. *Lindhag*. The preponderance of the evidence shows the work injury was not the substantial cause of his need for lumbar spine medical treatment. Employee's request for medical benefits for his lumbar spine will be denied.

d) Left Shoulder

Employee requests medical benefits for his left shoulder. AS 23.30.095(a). Employer denied left shoulder PT after August 2014 and contends the substantial cause of his current need for left shoulder treatment is his preexisting left shoulder pain and a prior shoulder injury. The presumption of compensability applies to this issue. AS 23.30.120; *Meek*; *Sokolowski*. Without regard to credibility, Employee raises the presumption of compensability with Dr. Steiner's May 2, 2014 medical report stating his left shoulder pain was worse than before the work injury and diagnosing a myofascial strain and Dr. Chong's EME opinion that the work injury caused left shoulder pain which resolved by August 2014.

Without regard to credibility, Employer rebuts the presumption of compensability with Dr. Scoggin's opinion stating the substantial cause of Employee's need for left shoulder treatment is a preexisting shoulder injury with pain. *Wolfer*; *Runstrom*.

Because Employer rebutted the presumption, Employee must prove his claim by a preponderance of the evidence. *Koons*. At this stage, evidence is weighed, inferences are drawn from the evidence and credibility is determined. *Saxton.* Employee first reported left shoulder pain on May 2, 2014 and Dr. Steiner diagnosed left shoulder myofascial strain and noted his left shoulder pain was hurting more than it had before the work injury. Dr. Soot opined Employee's left shoulder was medically stable on August 8, 2014 but opined the work injury was not the substantial cause of his left shoulder symptoms. On October 10, 2014, Dr. Steiner restricted Employee from

working for his vertigo, diplopia and cervical strain but did not mention Employee's left shoulder. Dr. Chong opined Employee's work-related left shoulder pain resolved by August 2014. On September 10, 2014, Dr. Steiner referred Employee to PA-C Weber for left shoulder pain but Employee followed up with PA-C Weber for right shoulder pain instead in March 2015. Dr. Scoggin relied on Employee's report of a past left shoulder surgery and Dr. Steiner's May 2, 2014 medical report to conclude he had preexisting left shoulder pain and the work injury was not the substantial cause of his need for left shoulder medical treatment. The preponderance of the evidence is that the work injury was the substantial cause of Employee's temporarily increased left shoulder pain. However, no physician recommended continuing left shoulder medical treatment after August 2014 and no physician attributed Employee's left shoulder pain to the work injury after August 2014. *Hibdon*. The medical evidence establishes further objectively measureable improvement from the work injury was not reasonably expected to result from additional medical care or treatment as of August 2014. AS 23.30.395(28). Employee's left shoulder became medically stable in August 2014. The preponderance of the evidence shows left shoulder medical treatment was not reasonable or necessary after August 2014 and no continuing medical treatment for the work injury is indicated for the process of recovery. AS 23.30.095(a); *Hibdon*. Employee's claim for left shoulder treatment prior to August 2014 is compensable, but after August 2014 will be denied.

e) Right Shoulder

Employee requests medical benefits for his right shoulder. AS 23.30.095(a). Employer contends his age-related degenerative changes is the substantial cause of his need for right shoulder medical treatment. Employee acknowledges his physician does not recommend any further treatment for his right shoulder. Therefore, the only issue to be resolved is whether the work injury was the substantial cause of his past need for right shoulder medical treatment. The presumption of compensability applies to this issue. AS 23.30.120; *Meek*; *Sokolowski*. On March 17, 2015, Employee first sought treatment for right shoulder pain, over 10 months after his work injury. There is no medical report attributing Employee's need for right shoulder medical treatment to the work injury. Employee failed to present even minimal evidence his work injury was the substantial cause of his need for right shoulder medical treatment. Therefore, he failed to attach the presumption of compensability. *McGahuey*; *Smallwood*; *Wolfer*; *Resler*.

Assuming Employee attached the presumption of compensability, Employer rebutted it with Dr. Scoggin's opinion. *Kramer*; *Huit*; *Tolbert*; *Norcon*.

Because Employer rebutted the presumption, Employee must prove his claim by a preponderance of the evidence. *Koons*. At this stage, evidence is weighed, inferences are drawn from the evidence and credibility is determined. *Saxton*. While Dr. Steiner opined Employee's right shoulder required no additional treatment on June 20, 2018, he did not address whether the work injury was the substantial cause of his prior need for treatment. Employee's right shoulder symptoms arose over 10 months after the work injury. The fact Employee's right shoulder pain symptoms arose after the work injury is insufficient to establish causation. *Lindhag*. Drs. Chong and Scoggin attributed his need for right shoulder medical treatment to age-related degenerative changes and there is no medial report attributing Employee's need for right shoulder medical treatment to the work injury. Their options are credible. AS 23.30.122. The preponderance of the evidence shows the work injury was not the substantial cause of Employee's need for right shoulder medical treatment. Employee's request for medical benefits for his right shoulder will be denied.

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

An attorney requesting a fee in excess of the statutory minimum must file an affidavit itemizing the fees at least three working days before the hearing. 8 AAC 45.180(b). If an attorney does not do so, only statutory minimum fees may be awarded. *Id*. Employee's attorney did not file a fee affidavit prior to the May 23, 2019 written record hearing even though the parties agreed the issues for hearing at January 15, 2019 prehearing conference included Employee's December 10, 2015 claim seeking attorney's fees and costs. The decision awarded Employee medical treatment for cervical pain and double vision. Because Employee's attorney did not file a fee affidavit, statutory minimum fees under AS 23.30.145(a) will be awarded based on the value of those benefits. AS 23.30.145; 8 AAC 45.180.

CONCLUSIONS OF LAW

1) Employee is entitled to mild over-the-counter analgesics for cervical pain and prism glasses and a neuro-ophthalmologist evaluation for double vision but is not entitled to continuing vertigo medical treatment, lumbar medical treatment, right shoulder medical treatment or left shoulder medical treatment after August 2014.

2) Employee is entitled to an award of statutory minimum attorney's fees based on the value of the benefits awarded in this decision.

ORDER

1) Employee's December 10, claim is granted in part and denied in part.

2) Employer is ordered to pay for mild over-the-counter analgesics for cervical pain and prism glasses and a neuro-ophthalmologist evaluation for double vision.

3) Employee is entitled to an award of statutory minimum attorney's fees based on the value of the benefits awarded in this decision.

Dated in Fairbanks, Alaska on June 25, 2019.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Kathryn Setzer, Designated Chair

/s/
Julie Duquette, Member

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

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

APPEAL PROCEDURES

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

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

RECONSIDERATION

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

MODIFICATION

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

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of Michael R. Barker, employee / claimant v. State of Alaska, self-insured employer, defendant; Case No. 201407990; dated and filed in the Alaska Workers' Compensation Board's office in Fairbanks, Alaska, and served on the parties on June 25, 2019.

/s/
Ronald C. Heselton, Office Assistant II