ALASKA WORKERS' COMPENSATION BOARD

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

RANDALL LEWIS, Employee, Claimant, v. HICKEL INVESTMENT COMPANY, Employer, and ALASKA NATIONAL INSURANCE CO., Insurer, Defendants.	FINAL DECISION AND ORDER AWCB Case No. 201514492 AWCB Decision No. 20-0089 Filed with AWCB Anchorage, Alaska on September 30, 2020

Randall Lewis' (Employee) May 11, 2016 claim, was heard on July 15, 2020, in Anchorage, Alaska, a date selected on May 13, 2020. The Alaska Workers' Compensation Appeals Commission's September 18, 2019 final decision on appeal gave rise to this hearing. Employee appeared, represented himself, and testified. Attorney Michelle Meshke appeared and represented Hickel Investment Company and its insurer (Employer). *Lewis v. Hickel Investment Company*, AWCB Decision No. 18-0044 (August 22, 2018) (*Lewis I*) excluded Employee's late-filed documents, denied his requested continuance and denied all requested benefits in his claim on their merits, including his appeal from a non-eligible finding for reemployment benefits and his request for an additional $20 million in damages. Employee appealed and *Lewis v. Hickel Investment Company*, AWCAC Decision No. 268 (September 18, 2019) (*Lewis II*) affirmed *Lewis I*'s decision denying Employee's petition to review the vocational reemployment benefit eligibility decision and his claim for $20 million in damages. However, *Lewis II* reversed the

remainder of *Lewis I* finding it had improperly denied Employee's continuance request, and remanded the case for a new hearing. Witnesses included Susan Sellers, Noah Laufer, M.D., Jody Venecia, Charles Craven, M.D., and Bruce McCormack, M.D. The record closed at the hearing's conclusion on July 15, 2020.

ISSUES

At the inception of the July 15, 2020 hearing, Employee explained he was suffering from high blood pressure and might not be able to complete the hearing. While Employer was presenting its witnesses, Employee said his blood pressure was too high, and he left the hearing. The designated chair ruled the hearing would proceed in Employee's absence.

1) ***Was the oral ruling to proceed with the hearing in Employee's absence correct?***

Employee contends his injury while working for Employer is the substantial cause of his current disability and need for medical treatment and he is entitled to benefits under the Act. Employer contends Employee suffered only a strain that has resolved, and his current disability and need for medical treatment are due to preexisting degenerative disease.

2) Is the work injury the substantial cause of Employee's current disability and need for medical treatment, and, if so, to what benefits is he entitled?

FINDINGS OF FACT

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

1) On May 27, 1999, Employee injured himself while working as a mover; he was moving a 600 pound safe and developed low back pain; since then, he had middle and low back symptoms with radiation in a non-dermatomal distribution. He was off work for two weeks. Employee said he had lumbar strains in the past but nothing on an ongoing basis. He was hit by a car five years earlier [*circa* 1994] but had no ongoing problems. He sometimes drank up to a 12-pack of beer daily; but other days he did not drink at all. The physician found spasms and splinting in the lumbar spine paraspinous muscles, diagnosed a lumbar strain and removed him from work for two additional weeks. (Mark Belza, M.D. report, June 9, 1999).

2) A September 7, 1999 thoracic spine x-ray showed degenerative changes in the thoracic spine. (X-ray report, September 7, 1999).

3) A May 10, 2002 x-ray showed mild disc narrowing at L5-S1. (X-ray report, May 10, 2002).

4) On or about July 26, 2002, Employee started having pain in his low back while at work as a mover. He took his lunch break, went back to work and finished the day and in hindsight thought this was "probably a mistake." He reported having gradually worsening pain; he had a hard time getting up from different positions; Aleve did not help. The diagnosis was low back pain in the sacral and SI joint regions. Deborah Warner, M.D., prescribed Vioxx and Percocet for pain. (Warner report, July 27, 2002).

5) Between July 26, 2002 and July 29, 2005, Employee was seen for his low pain on 55 occasions. (Medical Records).

6) On July 29, 2005, Employee reported increased back pain with bilateral radicular symptoms and weakness in his lower legs and hands to Cathrine Giessel, FNP. He appeared on a "semi-emergent basis." His back pain had been increasing for the last week; his hands had been numb and getting worse. Employee had increased hydrocodone and reported it was not working; he was taking Relafen, hydrocodone and Zanaflex. He was unemployed. Employee appeared to be in pain; his hands were trembling and he appeared disheveled and dirty. The impressions included: acute exacerbation of low back pain; acute cervical pain; upper and lower extremity tremors; and positive Waddell signs. (Giessel report, July 29, 2005).

7) July 29, 2005 was the first time Employee reported neck pain. (Observations).

8) On August 24, 2006, Employee had low back pain and presented on a "semi-emergent basis" for pain in his right leg. His overall functioning had worsened; he was still taking hydrocodone, Zanaflex and Relafen; he was still unemployed. There was a "strong smell of alcohol" in the examining room. ANP Giessel became concerned for her safety when Employee became increasingly belligerent, expressed dissatisfaction, and shouted at her. He was escorted from the clinic and discharged from care. (Giessel report, August 24, 2006).

9) On August 24, 2006, ANP Giessel certified a letter to Employee informing him that neither she nor anyone at her clinic would be providing further professional attendance to him. (Giessel letter, August 24, 2006).

10) On August 24, 2006, Employee also presented at the emergency room for chronic back pain. He reported that he had sought a medication refill from Dr. Gevaert's office, but the nurse practitioner told him there was nothing wrong with his back and would not give him any medication; he was "very upset" and came to the emergency room to document what had happened. Employee denied any new injuries to his back and said it was the same as it had always been; he denied using alcohol or drugs. When the physician tried to examine his back, Employee became "very irritable" and pushed the doctor's hand away stating he did not want his back touched. The physician provided a one-day supply of Motrin and Vicodin. The impression was: acute exacerbation of chronic back pain. (Alaska Regional Hospital Report, August 24, 2006).

11) On October 1, 2006, Employee went to the emergency room stating, "I think my ribs are broken." Employee stated one day prior he was assaulted while lying on a couch when a person came up to him and started punching him in the face. Employee complained of face and rib pain. "He denies having any neck or back pain with this." He had arrived by ambulance the day prior but left before being seen; on that occasion he had left the hospital to find the person who beat him up. Since he no longer wanted to hurt that person, Employee returned for further evaluation. He had taken two Aleve before arriving. His past medical history included a "herniated disc." He was taking no medications. Employee presented with "a slight odor of alcohol on his breath." Employee's thoracic and lumbar spine was non-tender to palpation. His blood-alcohol was .309. The physician left to attend to a different patient; when he returned, Employee had pulled out his IV and left. The impression was alcohol intoxication and blunt facial and chest wall trauma. (Alaska Regional Hospital report, October 1, 2006).

12) On October 2, 2006, Employee for the third time presented to the emergency room for right chest-wall pain. He mentioned having been there previously but left because he was "fed up with waiting." Employee denied other issues besides persistent pain in his right chest wall. He was unemployed. Employee's neck was supple and non-tender. Chest x-rays were negative; he was given a rib belt for comfort, and Vicodin. (Alaska Regional Hospital Report, October 2, 2006).

13) At this point, there is a 16 month gap in Employee's medical records. (Observations).

14) On February 22, 2008, Employee returned to Dr. Eule's office with bilateral shoulder and elbow pain when grasping items at work "for the last several months." He had difficulty

grabbing batteries and hanging onto tools at work. He occasionally felt numbness and tingling in his hands but denied any neck pain; his neck had some stiffness. He was taking ibuprofen 800 mg every eight hours with no benefit. Employee worked as a small engine technician. His neck examination was normal; he had bilateral shoulder symptoms. Based on x-rays, PA-C Jane Sonnenburg diagnosed: left shoulder AC joint osteoarthritis; bilateral epicondylitis and left elbow ulnar nerve cubital tunnel syndrome. She recommended treatment including rest, but Employee said he could not afford to not work. This was his first reported shoulder pain. (Sonnenburg report, February 23, 2008).

15) On February 27, 2008, an unidentifiable physician took Employee off work for two weeks secondary to a fibular fracture on February 24, 2008. (Disability Status form, February 27, 2008).

16) On March 4, 2008, an unidentifiable physician released Employee to return to work on March 4, 2008, as his symptoms allowed. (Disability Status form, March 4, 2008).

17) On June 13, 2009, Employee reported to the emergency room with elbow pain for 18 months since he "hit his funny bone." He was taking only Advil. His medical history included a fibula fracture and a disc herniation. Employee also reported chronic "left shoulder" and "neck pain," that was "unchanged." Elbow x-rays showed no acute disease. The diagnoses included: medial epicondylitis; and hand weakness and dysfunction possibly secondary to a nerve injury. (Alaska Regional Hospital report, June 13, 2009).

18) Here there is a 22 month gap in Employee's medical records. (Observations).

19) On April 18, 2011, Employee sought care for high blood pressure and low back pain. His main complaint was that his blood pressure had increased since a back injury about two years earlier. Employee described chronic low back pain for which he took ibuprofen daily. His neck was supple. The assessment included low back pain. (Jon Riley, PA-C report, April 18, 2011).

20) On March 11, 2012, Employee presented at the emergency room with back pain that started 10 days prior. This included "acute onset of posterior neck and bilateral shoulder pain for 10 days, no injury." He reported numbness and tingling in his left hand and bilateral feet when sitting down. Employee had lifted ice bags and felt pain in his upper right back. The next day he developed flu-like symptoms that resolved but his back pain remained. Employee also had pain with moving his right arm. His history included a herniated disc. The impression was

musculoskeletal back pain. He was prescribed Flexeril and Percocet. (David Ingraham, M.D., report, March 11, 2012).

21) On November 19, 2012, Employee told PA-C Riley he had increased arthritis pain in his back, knees and neck with lots of "popping, cracking and grinding." He was taking up to 1000 mg ibuprofen two to three times per day. He was recently laid off from his job. His neck was supple. The assessment included low back pain. He was prescribed Meloxicam for a trial. (Riley report, November 19, 2012).

22) On June 3, 2013, Noah Laufer, M.D., saw Employee for left knee pain with a history of dislocation; left shoulder pain with bone spurs, limited motion and weakness due to pain; neck pain from a motor vehicle accident in 2006 with current popping, clicking and pain with movement; and low back pain from herniated discs in 2002. He presented with "multiple arthritic complaints" and a history of "fairly significant injuries." Employee attributed his multiple injuries to his furniture moving occupation, which he held for over 15 years. He also complained of left shoulder pain and chronic neck pain. He had most recently worked for Sunshine Landscaping; he could handle this job; he also worked as a mechanic and said he did not have to do much heavy lifting. He wanted to save enough money for a left-knee MRI. Dr. Laufer diagnosed: chronic back and left knee pain for which he was taking Soma, Vicoprofen and ibuprofen. (Laufer report, June 3, 2013).

23) On July 2, 2013, Dr. Laufer prescribed Vicoprofen and Soma. (Laufer report, July 2, 2013).

24) On July 29, 2013, Employee returned to Dr. Laufer to refill high blood pressure medicine and to get additional pain medication and muscle relaxants "for chronic arthritic pain." His diagnosis included chronic back pain. His updated medication for this problem included Soma and Vicoprofen. (Laufer report, July 29, 2013).

25) On October 28, 2013, Dr. Laufer refilled Employee's Soma and Vicoprofen for chronic back pain, and addressed his chronic left knee pain. (Laufer report, October 28, 2013).

26) From September 30, 2013 through May 19, 2014, Dr. Laufer refilled Employee's Soma and Vicoprofen prescriptions; there were no related office visits. (Laufer reports, November 25, 2013 through May 19, 2014).

27) On June 16, 2014, Dr. Laufer saw Employee for chronic low back pain and known history of degenerative disc disease. He was requesting medication refills. Employee had held

four jobs in the last few months. His then-current low back pain and stiffness appeared to be exacerbated by his recent work; a chiropractor had made things worse. Impressions included: chronic back pain for which he took Advil, Soma and Vicoprofen; and arthritis. (Laufer report, June 16, 2014).

28) From July 12, 2014 through November 14, 2014, Dr. Laufer refilled Employee's Soma and Vicoprofen; there were no associated office visits. (Laufer reports, July 12, 2014 through November 14, 2014).

29) On March 2, 2015, Employee had right lower back pain that radiated to his right hip and leg with occasional numbness to his right foot, which was progressively getting worse. He had recently obtained "a very good job" as an engineering assistant at the Captain Cook Hotel. The job did not involve much heavy lifting but involved considerable walking; the walking exacerbated his low back pain. He described right leg sciatica and "grinding and burning" hip pain. "There's been no specific trauma"; he has not had any falls. Employee would like to change from Vicoprofen to minimize ibuprofen exposure. "The original injury was Workmen's Comp. injury [I] believe." The assessment included "back ache." (Laufer report, March 2, 2015).

30) On April 20, 2015, Employee still had back, right hip and left shoulder pain and obtained medication refills. His work exacerbated his pain. (Laufer report, April 20, 2015).

31) On August 12, 2015, Dr. Laufer refilled Employee's medications. He was "doing well and continues to work." His back was "doing okay," but he still took four Hydrocodone per day with occasional Oxycodone for breakthrough pain. There were no "red flags." The assessment remained backache with unspecified "arthropathy." (Laufer report, August 12, 2015).

32) Employee's August 30, and August 31, 2015 daily work lists summarize repairs and tasks he performed on those dates for his 8:00 to 4:00 and midnight to 8:00 shifts. There is no mention of any overhead work. (Engineering Department Daily Work Order list, August 30, 2015).

33) On September 3, 2015, Employee presented to Dr. Laufer with "severe neck pain, cannot move head, has gotten worse in the past week." He had a history of lumbar disc disease and presented on this occasion for "severe neck pain, likely associated with work." He has been very busy as a maintenance engineer for Employer with the recent presidential visit. Employee did considerable manual labor over a short period. Around noon on the prior Sunday, he felt a "twinge" in the right side of his neck. His symptoms progressed throughout the day and he

returned to work at midnight and experienced progressive worsening. Employee had decreased motion, and pain and spasms in his neck muscles greater on the right; he also had numbness and weakness in the right arm. He had moved furniture several days earlier at work but could not otherwise identify a specific trauma. As of this visit "he has not declared this Workmen's Comp. injury. He did report it at work." Employee was in moderate distress; his neck was tender and he had pain with motion; there was muscle rigidity. Dr. Laufer assessed neck pain with right arm radiculopathy and recommended diagnostic imaging. He added Valium to Employee's regular medications and restricted him from work until September 8, 2015, due to "an acute illness." (Laufer report, September 3, 2015).

34) The September 3, 2015 report to Dr. Laufer describes the alleged work injury that occurred on August 30, 2015, subject of this claim. (Inferences drawn from the above).

35) September 3, 2015 cervical spine x-rays showed advanced disc degenerative changes at C5-6 and C6-7 with no acute abnormalities identified. (X-rays, September 3, 2015).

36) A September 4, 2015 cervical MRI disclosed degenerative changes "at multiple levels, most severe at C5 and C6." There was left foraminal encroachment at C4, C5 and C6-7 to a lesser degree. (MRI report, September 4, 2015).

37) On September 4, 2015, Dr. Laufer reviewed Employee's diagnostic imaging and found his symptoms consistent with an overuse flare. Employee might need an epidural steroid injection or perhaps surgery. The injury was converted to workers' compensation and "paperwork is filled out by his supervisor at work." Dr. Laufer administered a Toradol injection and prescribed Morphine. (Laufer report, September 4, 2015).

38) On September 9, 2015, Dr. Laufer restricted Employee from work for "medical reasons" until September 14, 2015. (Laufer report, September 9, 2015).

39) On September 11, 2015, Dr. Laufer noted Employee required "fairly heavy medications" to control his recent, severe cervical pain with radiculopathy. He was not able to return to work and wanted a referral to a specialist. Dr. Laufer referred him to Alaska Spine Institute where he was seen previously [Dr. Gevaert] and "was happy with the care he received." He also restricted Employee from working until September 21, 2015. (Laufer report, September 11, 2015).

40) On September 14, 2015, Alaska Spine Institute sent a form letter to Dr. Laufer stating the clinic was unable to schedule Employee for an appointment because, "Patient has been withdrawn from our office 8-24-06." (Form letter, September 14, 2015).

41) On September 30, 2015, Dr. Laufer restricted Employee from work until October 13, 2015; he could work light duty with no lifting, pushing or pulling anything heavier than 10 pounds. (Laufer report, September 30, 2015).

42) On September 25, 2015, Employee completed paperwork for Alaska Spine Institute. He listed his injury date as August 30, 2015. Employee said that on that date, midway through his work shift, he started to have muscle tightening and pain just above his right shoulder blade in his neck. The pain continued during his shift. He had an eight hour turnaround and went back to work. By that point, Employee said he had lost all range of motion in his neck and could not raise his arms above his shoulders. Such movements caused the worst pain he had ever experienced in his life with severe headaches, pain in the back of his neck and arm and hand weakness. Employee had worked at building maintenance for Employer for about six months. He attributed his then-current symptoms to "overworking and trying to do too much." (Alaska Spine Institute intake documents, September 25, 2015).

43) On October 12, 2015, notwithstanding his clinic's September 14, 2015 letter, Dr. Gevaert examined Employee, reviewed imaging and noted chronic low back and neck pain in 2005. Impressions included: severe neck pain and referral into both upper extremities; sensory loss in the left upper extremity; positive Waddell signs; and a history of alcohol abuse. Dr. Gevaert recommended electrodiagnostic studies to rule out radiculopathy in the left upper extremity; he prescribed MS contin, Percocet, Norco and Valium. (Gevaert letter, October 12, 2015).

44) On October 12, 2015, Dr. Gevaert restricted Employee from work for two weeks. (Work Status Report, October 12, 2015).

45) On October 14, 2015, Dr. Laufer stated Employee's return to work "will need to be treated very delicately" because he was doing physical work with a history of neck and back injuries. (Laufer report, October 14, 2015).

46) On October 16, 2015, electrodiagnostic studies showed bilateral carpal tunnel syndrome affecting motor and sensory nerve fiber; normal ulnar nerve conduction; and no electrodiagnostic evidence of cervical radiculopathy. Dr. Gevaert recommended PT and discontinued Percocet and replaced it with Roxicodone. (Electromyography (EMG), October 16, 2015).

47) On October 23, 2015, Employee began PT. He described his work injury as "insidious onset, gradually increasing during shift." (PT report, October 23, 2015).

48) On October 27, 2015, Dr. Gevaert restricted Employee from work for one week. (Work Status Report, October 27, 2015).

49) On November 6, 2015, Dr. Gevaert restricted Employee from work through November 26, 2015, and scheduled him for epidural steroid injection. (Gevaert report; Work Status Report, November 6, 2015).

50) On November 12, 2015, Dr. Gevaert performed a C7-T1 interlaminar epidural steroid injection on Employee. (Gevaert chart note, November 12, 2015).

51) On November 25, 2015, Employee told his therapist his symptoms were steadily declining and the therapist opined it was "likely due to effective epidural." (PT report, November 25, 2015).

52) On December 2, 2015, Employee said he had a setback on Thanksgiving Day while doing the dishes; his neck locked up. Dr. Gevaert noted he had been off work for months and opined:

> I had a fairly lengthy discussion with Randall and expressed concern with regards to delayed recovery. He has been off work for four months. He remains disabled despite extensive physical therapy, appropriate pain management and one epidural steroid injection. Clinical examination shows an altered pain perception. He eventually agreed to have him go back to work at full-time for four hours a day for a maximum of five days per week. He is to continue with physical therapy and pain management. I will see him in follow-up in one week to evaluate if the strategy is effective. He was sent to the lab for random drug screen. I issued a prescription for a home traction device and Bio-Freeze as requested by his physical therapist. (Gevaert report, December 2, 2015).

53) On December 10, 2015, Dr. Laufer saw Employee for his neck pain from a work-related injury with underlying cervical and lumbar degenerative joint disease. Employee expressed concern he was released to part-time, full-duty work and "does not feel anywhere near up to this." He was frustrated that his epidural steroid injection did not work and sought a referral for another opinion; Dr. Laufer agreed to make a referral. Employee needed a physical capacities evaluation to define his capabilities clearly before he can return to work. (Laufer report, December 10, 2015).

54) On December 18 and December 30, 2015, Employee had cervical median branch block injections. He reported the procedures "took away most of the symptoms." However, now his pain was on the right side and he wanted to repeat the injections there. Dr. Kropp restricted him from work until January 7, 2016. (Kropp reports, December 18 and December 30, 2015).

55) On January 4, 2016, Employee returned to Dr. Laufer reporting success with nerve blocks. However, he continued to have pain on the right and was not taking any medication as he had run out; Dr. Kropp does not prescribe medications. On this morning, Employee was turning to reach across the table when his neck "blew up on me again." He lost neck motion and screamed out in pain. Employee reported he felt like he did prior to his treatments. Dr. Laufer opined Employee "is looking like he will be permanently disabled." He was there primarily to request medication refills; Dr. Laufer prescribed Diazepam, Norco and Morphine. (Laufer report, January 4, 2016).

56) On January 7, 2016, Dr. Kropp stated, "I'm not seeing the progress that I would like to see from the injections." He recommended a return to conservative measures such as ultrasound and chiropractic. Dr. Kropp found no evidence of substance abuse and restricted him from work until February 8, 2016. (Kropp report, January 7, 2016).

57) On January 8, 2016, Employee presented to Kanady Chiropractic Center on referral from Dr. Kropp. He reported a "very bad low back," and his August 30, 2015 work injury with Employer started after "several months of overhead work." His symptoms were in the neck, upper thoracic, mid-thoracic, left posterior shoulder, right posterior shoulder and left and right hands. Any movement and no movement at all aggravate his symptoms. "When asked what types of treatment he has had for this episode, he said nothing." The assessment included: cervical disc displacement; and dislocation left shoulder joint. Trevor Tew, DC, provided "IFC and heat" for 15 minutes followed by traction for 23 minutes at 18 pounds. (Tew report, January 8, 2016).

58) On January 11, 2016, Dr. Tew found moderate to severe muscle spasms in Employee's neck and upper thoracic area. He provided IFC and heat for 15 minutes and traction for 23 minutes at 17 pounds. (Tew report, January 11, 2016).

59) On January 12, and January 13, 2016, Dr. Tew repeated his assessment and treatment though he applied traction at 20 pounds. (Tew report, January 12, and January 13, 2016).

60) On January 14, and January 15, 2016, Dr. Tew repeated the same diagnosis and treatment but used 18 pounds traction. (Tew report, January 14, and January 15, 2016).

61) On January 18, 2016, Employee told Dr. Tew he had left anterior shoulder pain while he was sitting on the couch beginning the prior Friday after he had been home for a couple of hours after his last treatment. He reported being unable to move his left arm all weekend and having

"severe pain." Dr. Tew diagnosed cervical displacement and left shoulder joint dislocation. He took an x-ray which in his view showed an acromioclavicular (AC) separation. Employee denied any trauma to this area "even though that is the normal mechanism of injury. . . ." He referred Employee back to Dr. Laufer. (Tew report, January 18, 2016).

62) On January 18, 2016, Employee presented at an emergency room with left clavicle pain that he said began three days earlier when he had traction at his chiropractor's office. His chiropractic appointment was at 10:30 AM but Employee reported severe pain beginning a few hours later; he denied any falls or injuries. Norco and Morphine did not improve his pain. A physician reviewed an x-ray from the chiropractor's office and agreed it showed an AC (acromioclavicular) joint separation. The examiner did not provide additional narcotics as Employee was "already on numerous narcotics." (Brian Rogers, M.D., report, January 18, 2016).

63) On January 20, 2016, Employee told Dr. Laufer he had a left shoulder AC separation, which he believed was caused by traction at the chiropractor's office but his chiropractor disagreed. About four hours after his chiropractic manipulation, Employee experienced severe and worsening left shoulder pain. He could not even take his wallet out of his pocket. Employee accelerated his medication usage and was dropping items with his left hand. He was wearing a sling he got at the emergency room, had essentially no use of his left shoulder and considered the chiropractic injury part of his workers' compensation case. Dr. Laufer was concerned about possible internal derangement and Employee's capacity to return to work. (Laufer report, January 20, 2016).

64) On January 27, 2016, Employee had a left shoulder contrast injection followed by an MRI to rule out tears. Impressions included: extensive, circumferential glenoid labral tear with an anterior, inferior para labral cyst; moderate glenoid chondrosis with severe subchondral cystic change of the posterior and inferior glenoid rim; and severe acromioclavicular osteoarthritis and reactive marrow edema. (MRI report, January 27, 2016).

65) On January 27, 2016, Dr. Laufer referred Employee to Orthopedic Physicians Anchorage for a left shoulder evaluation. (Referral Order, January 27, 2016).

66) On January 28, 2016, Dr. Laufer restricted Employee from working until March 1, 2016. (Laufer report, January 28, 2016).

67) On February 5, 2016, Robert Hall, M.D., orthopedic surgeon, examined Employee's left shoulder; Employee provided a history of his neck and subsequent shoulder problems. He had improved significantly with time. Employee conceded he had a diagnosis of mild osteoarthritis in the left shoulder prior to his last chiropractic visit but said his current symptoms feel different than what he had felt in the past; he now has an AC joint separation diagnosis. Dr. Hall reviewed the MRI and found no evidence of an AC joint separation but found significant degenerative changes in the glenohumeral joint with peripheral cysts around the glenoid rims. Diagnoses included: AC joint strain; and left glenohumeral joint osteoarthritis. Dr. Hall recommended PT to get his motion back. (Hall report, February 5, 2016).

68) On February 10, 2016, Employee returned to PT primarily for his left shoulder. He reported getting cervical traction when this treatment injured his left shoulder. Employee told his therapist that initially after the subject chiropractic visit he had a severe step deformity but the joint returned to its normal position and he had been wearing an immobilization sling. (Select Physical Therapy report, February 10, 2016).

69) By February 26, 2016, Employee's symptoms were responding to PT on the neck and left shoulder. He saw, "A little light at the end of the tunnel." Dr. Laufer refilled his medications, which included Amlodipine; Carisoprodol; Diazepam; Morphine; Norco; Promethazine injection solution; and Extra Strength Tylenol. (Laufer report, February 26, 2016).

70) On February 26, 2016, Charles Craven, M.D., and Richard Rivera, DC, performed an employer's medical evaluation (EME). Employee said his neck pain began on August 29, 2015, with no particular injurious event. He had been doing ceiling work such as replacing light bulbs. On August 30, 2015, his neck "siezed" while he was replacing light bulbs and he was not able to return to work the next day. While treating for his neck pain, Employee saw a chiropractor. At his last chiropractic treatment, he was manipulated and several hours later began having pain in his left shoulder. Employee explained he had been on pain medication and when it wore off he noticed increased pain; according to his significant other, his arm was drooping that day. When the EME physicians reviewed records from 2005 through 2013, Employee did not recall a prior cervical MRI in 2005, bilateral shoulder pain in 2006 or a report to Dr. Laufer in 2015 about left shoulder pain following a motor vehicle accident in 2006. On examination, Dr. Craven noted Employee had a fine, bilateral motor tremor in both hands. Employee said this began after his shoulder incident at the chiropractor and denied he had a prior motor tremor in his hands; Dr.

Craven noted ANP Giessel's July 29, 2005 report stating Employee had a constant, fine tremor in both hands. Diagnoses included: minor non-traumatic cervical strain on August 29 and August 30, 2015; cervical spondylosis and chronic neck pain, preexisting and symptomatic prior to the work injury and not aggravated by it; preexisting symptomatic left shoulder pain and acromioclavicular osteoarthritis, not aggravated by the work injury and no objective evidence of a left shoulder AC separation occurring during chiropractic manipulation; bilateral carpal tunnel syndrome (CTS) with a normal examination; and subjective complaints that greatly outweigh objective findings. The causes of the diagnosed cervical "conditions" include Employee's preexisting cervical spondylosis, which relates to his age and degenerative spine. The causes of his left shoulder AC arthropathy include his age and degenerative process and his prior work for 15 years as a mover. Dr. Craven could not contemporaneously relate the left shoulder symptom onset, which occurred several hours after his treatment, with the chiropractic treatment. The panel opined the CTS related to Employee's age and degenerative factors and was not related to the August 30, 2015 work injury. In their view, the August 29 and August 30, 2015 work events caused a minor, non-traumatic soft-tissue cervical strain, which would have persisted for not more than six weeks and there was no permanent aggravation to his underlining cervical degenerative condition. The panel opined Employee reached medical stability by October 15, 2015, at which time all treatment applicable to his neck injury at work was complete; no treatment to his left shoulder related to the work injury. In Drs. Craven's and Rivera's opinion, Employee needs no further medical care for his work injury and there is no permanent impairment. The panel opined Employee has the physical capacities to return to his normal job with Employer in respect to his work-related diagnoses. However, considering his preexisting degenerative conditions in his neck and left shoulder, he should do no lifting, pushing or pulling greater than 20 pounds with his left upper extremity. (EME report, February 26, 2016).

71) On February 29, 2016, Employee told his therapist his left shoulder condition was improving steadily. (PT report, February 29, 2016).

72) On February 29, 2016, Dr. Laufer released Employee to return to work on March 14, 2016. (Laufer report, February 29, 2016).

73) On March 3, 2016, Employee told Dr. Hall his PT was helpful and he felt markedly improved. Dr. Hall diagnosed a left shoulder acromioclavicular joint sprain "but certainly nothing higher than that." He recommended continued PT. (Hall report, March 3, 2016).

74) On March 9, 2016, Employee's therapist assessed "slow progress if any" and he continued to have severe pain in his neck and left shoulder. (PT report, March 9, 2016).

75) On March 10, 2016, Employee's therapist discussed his slow progress and suggested there might be a "psychosocial contribution." He was agreeable to a more function-focused intervention. (PT report, March 10, 2016).

76) Employee canceled the next two PT sessions. (PT reports, March 11 and March 16, 2016).

77) On March 10, 2016, Employer asked Dr. Gevaert to review and comment on Drs. Craven's and Rivera's EME report. On March 21, 2016, Dr. Gevaert said he concurred with it. (Letter, March 10, 2016; Dr. Gevaert's response to letter, March 21, 2016).

78) On March 11, 2016, Employer asked Dr. Hall to review and comment on Drs. Craven's and Rivera's EME report. On March 18, 2016, Dr. Hall said he concurred with it. (Letter, March 11, 2016; Hall response to letter, March 18, 2016).

79) On March 14, 2016, Employer denied Employee's rights to benefits based on Drs. Craven's and Rivera's February 26, 2016 EME report. (Controversion Notice, March 10, 2016).

80) On March 21, 2016, the physical therapist discharged Employee from treatment because his case was controverted. (PT report, March 21, 2016).

81) On April 22, 2016, Dr. Laufer reviewed Employee's history and noted his recent injury to his left shoulder, which Employee "attributes . . . to chiropractic manipulation." Dr. Laufer said, "It is difficult to say where the injury occurred but he has an MRI dated 01/27/16 of the left shoulder, notable for a large labral tear, degenerative cystic changes, severe degenerative changes in the acromioclavicular joint, and acute marrow changes." Dr. Laufer did not consider him medically stable and did not think he would be able to return to his work. He asked Dr. Laufer for assistance with paperwork. (Laufer report, April 22, 2016).

82) On April 22, 2016, Dr. Laufer wrote:

> To Whom It May Concern,
>
> I had the pleasure of seeing and examining Mr. Randall Lewis in clinic today. It is my understanding that he is seeking Social Security disability. He has suffered recent acute injuries to his neck and left shoulder. He also suffers from underlying chronic debilitating disease in his lumbar spine, cervical spine, generalized osteoarthritis and chronic pain. In my opinion, he is unlikely to be able to obtain or maintain meaningful employment. Please feel free to contact me with concerns or questions. (Laufer letter, April 22, 2016).

83) On April 22, 2016, Dr. Laufer also completed a form for the State of Alaska, Division of Public Assistance requesting Interim Assistance for Employee, *i.e.*, cash payments. Diagnoses included: A "combination of injuries" including (1) cervical spondylosis with radiculopathy; (2) acromioclavicular arthritis; (3) left rotator cuff injury (clinical); and (4) chronic low back pain. Dr. Laufer did not expect Employee to recover from these conditions. He further stated Employee had a combination of "moderate to severe" cervical and lumbar degenerative disease with a non-functional left shoulder; he was unlikely, in Dr. Laufer's opinion, to obtain or be able to sustain any meaningful employment. (Laufer report, April 22, 2016).

84) On May 11, 2016, Employee filed a claim for TTD, PTD, medical costs and related transportation expenses, review of a reemployment benefit ineligibility decision, an unspecified penalty, interest; a finding Employer made an unfair or frivolous controversion; and a second independent medical evaluation (SIME). (Workers' Compensation Claim, May 11, 2016).

85) On May 11, 2016, Employee filed a petition requesting an SIME. (Petition, May 11, 2016).

86) On May 16, 2016, Dr. Hall saw Employee, reviewed his history and said, "The AC joint injury was a result of an injury with a chiropractic manipulation machine that he underwent recently." Dr. Hall explained Employee's history regarding this chiropractor incident:

> He had an injury to his neck and when he was being treated for that he was placed on some sort of distractor device that apparently did not function as intended. He was holding onto some handle and had a significant distraction force that was transmitted to his shoulder instead of to his neck. After that he had marked pain over his AC joint. . . . That pain has not improved. . . .

Dr. Hall took additional x-rays, reviewed prior x-rays, and his diagnoses included: Grade 2 AC separation of the left shoulder; and moderate osteoarthritis in the left glenohumeral joint. He discussed a possible left shoulder Mumford procedure to address the AC joint issue. Employee was going to consider surgery. Dr. Hall said, "We once again discussed that his current injury is related to his neck strain and that the treatment for his neck strain resulted in the injury to his AC joint." Employee was now covered by Medicaid. (Hall report, May 16, 2016).

87) On June 20, 2016, Employer filed a notice denying "medical, transportation, TTD/TPD, PTD, and reemployment benefits" effective October 15, 2015. It served this on Employee on June 13, 2016; the notice included the standard warning found on the second page advising

Employee he had to request a hearing before the board within two years after the controversion notice's date or he would lose his right to the benefits denied. (Controversion Notice, June 13, 2016).

88) On August 1, 2016, Social Security denied Employee's claim for Supplemental Security Income (SSI) disability benefits. He was found not disabled under Social Security rules. Social Security determined Employee's condition was not severe enough to keep him from working considering his age, education, training and work experience. (Social Security Notice of Disapproved Claims, August 1, 2016).

89) On September 14, 2016, Dr. Laufer wrote a letter "to whom it may concern," stating:

> I had the pleasure of seeing and examining Randall Lewis in my clinic today. I am not able to provide a formal disability rating, however based on my clinical experience, the combination of his degenerative cervical spine, degenerative lumbar spine, and left shoulder osteoarthritis with labral tear, he is unlikely to ever be able to establish and maintain gainful employment. Please feel free to contact me with concerns or questions. (Laufer letter, September 14, 2016).

90) On September 29, 2016, Dr. Craven reviewed updated medical records and stated his prior opinions had not changed. While he agreed a Mumford procedure would be appropriate to treat Employee's symptomatic left AC joint, the substantial cause for that procedure was Employee's preexistent symptomatic degenerative condition and not the alleged event occurring during a chiropractic manipulation. (Craven report, September 29, 2016).

91) On September 30, 2016, Employer requested cross-examination of Dr. Laufer on his September 14, 2016 medical report. (Request for Cross-Examination, September 30, 2016).

92) On March 2, 2017, the parties through counsel stipulated to an SIME. On this date, the parties had a binding stipulation for an SIME and agreed discovery with not yet complete and there was insufficient evidence available for setting the matter on for hearing. (Prehearing Conference Summary, March 2, 2017; experience, judgment and inferences drawn from the above).

93) On March 17, 2017, Employee's former attorney signed the SIME form on his behalf. The form listed medical disputes, physicians, medical records supporting the disputes and reflected the parties' stipulation to the SIME. (SIME Form, March 17, 2017; March 21, 2017).

94) On March 21, 2017, Employer's attorney signed the same SIME form and filed it with the board. (SIME Form, March 17, 2017; March 21, 2017).

95) On April 14, 2017, the division notified the parties and the SIME physician that Employee's SIME had been scheduled with Bruce McCormack, M.D., for May 31, 2017. (Harvey Pullen letters, April 14, 2017).

96) On May 31, 2017, Dr. McCormack examined Employee; his report was decidedly unfavorable to him. Dr. McCormack found three causes for Employee's disability or need for medical treatment: (1) chronic low back pain predating 2002 but aggravated by a 2002 industrial injury, with positive Waddell signs, chronic pain, narcotic dependence, escalation and credibility issues; (2) neck strain from the August 30, 2015 work injury and chronic neck pain after December 2, 2015, due to factors other than the work injury including intermittent neck pain requiring a cervical MRI in July 2005 and cervical symptoms since November 2012; (3) left shoulder arthritis and impingement unrelated to chiropractic treatments in January 2016, with a February 22, 2008 AC joint arthritis diagnosis. (McCormack report, May 31, 2017).

97) Dr. McCormack opined no treatment after December 2, 2015, was due to the August 30, 2015 work injury. He found it troubling that Employee had chronic low back pain since 2002 and increasing narcotic use from 2013 to 2015, and that Dr. Gevaert had stopped prescribing narcotics in 2006 when Employee came to his office "inebriated and belligerent." He noted Dr. Gevaert had also found positive Waddell signs and had stopped treating Employee on December 2, 2015, after a drug screen showed opioids in his system that Dr. Gevaert was not prescribing. Dr. McCormack found it "odd," despite 15 years of chronic low back pain and narcotic dependence, Employee did not even mention low back pain during his examination. He also opined there was no objective findings indicating a cervical spine injury following the August 30, 2015 incident. Employee had no additional disability from the August 30, 2015 incident, which in Dr. McCormack's view was a simple cervical strain superimposed on degenerative changes, which had resolved by December 2, 2015. Dr. McCormack agreed with Drs. Craven and Rivera but put more emphasis on the December 2, 2015 drug screen and used this date as an appropriate point to find "medical stability" and conclude industrial-related medical care. (McCormack report, May 31, 2017).

98) As for the left shoulder, Dr. McCormack opined the injury and resultant surgery was not related to the August 30, 2015 work incident and Employee needed no palliative medical care. There was no mention of left shoulder pain in treatment notes for 30 days following the injury. Dr. McCormack discounted Employee's contention that January 15 or January 18, 2016 neck

traction t caused his left-shoulder pain because, "The mechanism of shoulder injury on a cervical traction table doesn't make sense." Further, he noted Employee said he went to the emergency room the night the chiropractor injured his shoulder but the emergency room records show he had "three days of pain." Dr. McCormack did not find him "credible based on his statements to me and the totality of the medical record." (McCormack report, May 31, 2017).

99) Dr. McCormack limited Employee to medium work with a 25 pound overhead lifting limit for his left shoulder. In his view, Employee could perform his job with Employer. He attributed no PPI rating for the cervical spine; any left-shoulder PPI rating "is not industrial," and in his opinion would range somewhere between one to three percent whole person impairment. Dr. McCormack did not recommend any additional diagnostic testing to complete his SIME. (McCormack report, May 31, 2017).

100) Dr. McCormack also had problems with Employee's credibility:

> By 12/2/15 all treatment was for reasons other than the 8/30/15 incident. On 12/2/15 a drug study was positive for narcotic drugs other than prescribed. Dr. Gevaert released him to work on this date but didn't comment on the drug screen. Doctor stopped prescribing narcotic pain medication. Care after 12/2/15 was for his pre-existing pain syndrome dependent on narcotics. He escalated narcotics from 2013 to 2015 for low back pain. After 8/30/15 incident neck was focus of pain but there was no objective signs of injury on tests. Nerve studies were negative, cervical MRI revealed only age related changes. At my evaluation he doesn't mention low back pain at all. He had a 15 year history of low back pain with many years of strong narcotics and now this has resolved? I don't find Mr. Lewis credible based on his statement to me, and medical records predating the subject accident. (McCormack report, May 31, 2017).

101) On June 12, 2017, the division received Dr. McCormack's May 31, 2017 SIME emailed report, without page 29, which was missing. (McCormack report, May 31, 2017; observations).

102) On October 27, 2017, Employee called the division and spoke with a board designee. He was angry and said the SIME was "a complete fabrication" and Dr. McCormack "was out of his mind." The designee advised Employee he could request a hearing when he was ready and informed him "of his two year deadline" to request a hearing "and gave him the date of 6/20/2018." (ICERS event, October 27, 2017).

103) On April 18, 2018, Employee timely filed and served a hearing request on his May 11, 2016 claim well before June 20, 2016. (Affidavit of Readiness for Hearing, April 18, 2018).

104) On May 1, 2018, James Glenn, PA-C, took Employee's history and noted he "injured himself back on August 30, 2015, lifting some ceiling tiles." (Glenn report, May 1, 2018).

105) On May 22, 2018, the parties stipulated to a July 24, 2018 hearing on Employee's claim. The designee directed the parties to file and serve evidence by June 26, 2018, and witness lists and briefs by July 17, 2018, in accordance with administrative regulations. Other than providing the email address for filing and citing the filing format and maximum file size, the designee gave no further advice; there is no evidence Employee requested any information about filing his evidence, briefs and witness list. (Prehearing Conference Summary, May 22, 2018).

106) On June 5, 2018, Employee presented with "significant long-standing chronic neck pain." (Eule report, June 5, 2018).

107) On June 20, 2018, Shawn Taylor, M.D., performed EMG studies on Employee. There was no evidence of cervical radiculopathy, brachial plexopathy, myelopathy or peripheral polyneuropathy in Employee's left upper extremity. (Taylor report, June 20, 2018).

108) On June 25, 2018, the division noticed the parties that a hearing on Employee's claim was scheduled for July 24, 2018. (Hearing Notice, June 25, 2018).

109) On June 25, 2018, PA-C Glenn examined Employee and reviewed his recent EMG testing; it was completely normal for any significant cervical radiculopathy or peripheral changes. Nonetheless, Employee said he still had ongoing cervical spine pain, headaches, neck stiffness and "terrible neck pain." He was still taking narcotics. PA-C Glenn diagnosed severe degenerative changes including severe foraminal stenosis without cervical radiculopathy, and moderate degenerative changes at C3 through C5 with some osteoarthritis at C1-2. He discussed his recommendations with Dr. Eule who did not believe surgical intervention would be prudent since Employee's EMG studies showed no radiculopathy. Employee wanted a second opinion and PA-C Glenn referred him to Timothy Cohen, M.D. PA-C Glenn said "no further workup or visits are needed at this point." (Glenn report, June 25, 2018).

110) On July 6, 2018, Employee amended his claim to add $20 million in damages. The designee reiterated prior directives for filing and serving evidence, witness lists and briefs prior to hearing. Other than providing the email address for filing and citing the filing format and maximum file size, the designee gave no further advice; there is no evidence Employee requested any information about filing his evidence, briefs and witness list. He did not say he was not ready for the July 24, 2018 hearing. (Prehearing Conference Summary, July 6, 2018).

111) On July 20, 2018, 24 days after the June 26, 2018 evidence filing deadline, three days after the July 17, 2018 deadline for filing his brief and witness list and four days before his July 24, 2018 hearing, Employee called the division and asked about filing his brief, evidence and witness list for his hearing. The conversation with the designee is recorded as follows:

> Spent 30 mins on the phone with EE who was very angry and combative. Explained to EE that I am here to answer his questions but he needs to be civil. EE explained that he wished to file his brief, evidence and witness lists for his 7/24 hearing but does not know what these are.
>
> Explained the following:
>
> Evidence: Any documents that the parties intend to rely upon at hearing should be filed with the Board and served upon the opposing parties 20 calendar days prior to the hearing. A Medical Summary form is available on the Board's website.
>
> Briefs: A brief is a document submitted by the parties prior to a hearing which outlines the issues in dispute, the party's positions on those issues, as well as why they believe their position is correct. Important supporting evidence referred to in a brief is often attached at the end of the brief. These supporting documents are called exhibits. Briefs may not exceed 15 pages, excluding exhibits. Briefs must be filed with the Board and served upon the opposing parties at least five working days prior to a hearing.
>
> Witness Lists: If a party intends to rely upon witness testimony, they must file a witness list that includes any possible witnesses that they may call at hearing. According to 8 AAC 45.112 "A witness list must indicate whether the witness will testify in person, by deposition, or telephonically, the witness's address and phone number, and a brief description of the subject matter and substance of the witness's expected testimony." Witness lists must be filed with the Board and served upon the opposing parties at least five working days prior to a hearing.
>
> Advised that he file a petition to accept the late filings to all parties along with these. fml (ICERS event, July 20, 2018).

112) On July 24, 2018, the parties appeared for a hearing on the merits. As a preliminary matter, Employee contended the board should accept his late-filed evidence and witness list; alternatively, he requested a continuance so he could continue treatment and further prepare for hearing. Employer stipulated to admitting Employee's medical records but opposed admitting his other late-filed evidence and witness list. The panel issued an oral order that it excluded the late-filed witness list and evidence and denied the continuance request, citing manifest injustice

to Employer and the possibility Employee's claim could be denied under AS 23.30.110(c). Eventually, Employee left the hearing room before the hearing was completed. (Hearing before the Alaska Worker's Compensation Board, July 24, 2018).

113) On August 22, 2018, *Lewis I* analyzed each merit issue and denied Employee's claim on all bases and denied his petition for review and modification of the rehabilitation benefits administrator designee's finding he was ineligible for vocational reemployment benefits. (*Lewis I* at 28-29).

114) On August 22, 2018, Dr. Laufer recorded that Employee said, "It's been 15 years of dealing with this" and he is "tired." (Laufer report, August 22, 2018).

115) On September 10, 2018, Employee appealed *Lewis I* to the commission. (Commission Clerk's Docket Notice, September 11, 2018).

116) On October 12, 2018, Dr. Laufer examined Employee and refilled his narcotics and other medications. Employee reported he had "always worked with my body and I'm paying for it now." (Laufer report, October 12, 2018).

117) On February 4, 2019, the division received Dr. McCormack's SIME report again, this time with page 29 included. On page 29, Dr. McCormack said Employee had left shoulder surgery on April 13, 2017, and since he was only six weeks post-op, the left shoulder was not medically stable. He again agreed with Drs. Craven and Riviera, and agreed with Drs. Gevaert and Hall that Employee had not sustained a PPI rating from his August 30, 2015 work injury. An alternate explanation for Employee's ongoing complaints following the August 30, 2015 incident "is drug seeking behavior." If Employee were his patient, Dr. McCormack would wean him off narcotic medications. (McCormack report, May 31, 2017, page 29).

118) On February 6, 2019, Timothy Cohen, M.D., performed a discectomy and a fusion on Employee's neck for C5-6, C6-7 disc herniations. The pre-operation diagnosis was "cervical spondylosis." Dr. Cohen's report does not express a causation opinion on the substantial cause for the need for surgery. (Cohen report, February 6, 2019).

119) On September 6, 2019, Employee presented with right shoulder pain to Dr. Hall; he diagnosed right shoulder osteoarthritis. (Hall report, September 6, 2019).

120) On September 18, 2019, the commission issued *Lewis II*, which affirmed *Lewis I*'s decision denying Employee's request for $20 million in damages and his petition appealing the vocational reemployment benefit ineligibility finding. However, *Lewis II* remanded for a new

hearing "of the decision denying Mr. Lewis the other benefits he requested." The commission determined *Lewis I* erred in not granting Employee a hearing continuance. *Lewis II* also ordered Employee be provided direction on how to develop a witness list and how to arrange for witnesses to testify, including how to subpoena them. It noted there was no possible manifest injustice to Employer by granting the requested continuance; there was the possibility of manifest injustice to Employee "since he was unprepared for the hearing and clearly upset." *Lewis II* found Employee was seemingly unable to comprehend what he needed to do and "did not understand what a witness meant or that he needed to contact witnesses and arrange for them to testify at hearing." It also found it troubling *Lewis I* decided the case without a full medical record and testimony from Employee or his fiancée. *Lewis II* directed the board on remand to consider any new medical evidence he provided or attempted to provide at the *Lewis I* hearing. On remand, the board should also address Employee's concern about medical records prior to 2003 being included or excluded from the record and why they were or were not relevant to his claim. *Lewis II* reversed and remanded the case for action in conformance with its instructions and directed the board to schedule a new hearing as soon as possible. (*Lewis II*).

121) On September 20, 2019, Employee called the division to set a hearing based on *Lewis II*. The advice given by the board's designee is summarized as follows:

> . . . Explained to EE that we need a prehearing first so parties can agree on what hearing date. EE also wanted help with filing evidence, witness list, brief and subpoena. Explained to EE each and informed him that either [sic] after the prehearing he can talk to a technician and we can explain it further. EE was under the impression that we will set it up and gather all information for him. Explained to EE what our role is and what we can assist him with. Scheduled a prehearing. gsm (ICERS event, September 20, 2019).

122) Later on September 20 and on September 23, October 23 and October 28, 2019, Employee called the division for reasons unrelated to procedures for filing evidence and obtaining witnesses. However, he did not ask for further advice concerning obtaining evidence or witnesses, or filing evidence, his witness list or his brief. (ICERS events, September 20; September 23; October 23; and October 28, 2019).

123) On October 21, 2019, Employer petitioned the commission to reconsider *Lewis II*. (Motion for Reconsideration, October 21, 2019).

124) On October 22, 2019, the parties and the board's designee conferenced to discuss Employee's case status on remand from the commission. Since Employer had filed a petition for reconsideration with the commission, the designee continued the conference until November 26, 2019, to give the commission time to rule on the pending petition. Employee did not contend he was not ready for hearing did not ask for further advice concerning obtaining evidence or witnesses, or filing evidence, his witness list or his brief. (Prehearing Conference Summary, October 22, 2019).

125) On October 29, 2019, Employee came to the division to discuss with the designee medical record releases he had received; her advice is summarized as follows:

> EE said he received a packet of medical releases and does not have any issues with the ER having access to his medical files but that 1 year is excessive and request it be lowered to 90 day increments if needed. Filed a petition for protective order and for compel/ discovery. EE feels that the ER attorney is holding files about his case that he is not privy to. Gave the EE a new attorney list. EE said he writes stuff down that he feels is important to his case but has so much paperwork he ends up misplacing it. Told the EE if he has paperwork that he feels is pertinent to his case I encourage him to file it with the board as well as making certain that anything he files with us he must also send a copy to the other party. This would ensure that it is in his case file when he needs to refer to it. EE stated that he did not know he could do that and that it was a huge relief to know. He had his WC & You packet with him so he said the only thing else he needed was a new attorney list. EE gets very apprehensive when he starts explaining what he feels the ER attorney is doing and feels she contradicts herself with in the latest paperwork he received. The EE was calmed down quite a bit when he left and said he was very grateful to the board for assisting him completing paperwork because he has a very tough time understanding it. cac

Employee did not ask questions about obtaining evidence or witnesses or filing evidence, his witness list where a hearing brief. (ICERS event, October 29, 2019).

126) On October 30, 2019, the commission denied Employer's request for reconsideration and noted "the Act does not require that fairness be sacrificed to quick and efficient." It said self-represented litigants need advice on the means for insuring a fair hearing. The commission reiterated *Lewis I* had abused its discretion by not granting Employee's requested continuance when it was apparent he was not prepared for hearing because he did not understand how to obtain and present witness testimony. (Order on Motion for Reconsideration, October 30, 2019).

127) On October 31, 2019, Employee came to the division for assistance. The designee's advice is summarized as follows:

> EE came in with some medical documents. I explained the medical summary. EE requested some help in filing it out. I assisted him with the summary and he proceeded in filing with the board and will hand deliver to attorney Meshke's office.- ep

Other than his questions about filing medical records, Employee did not ask questions about obtaining other evidence or witnesses or filing evidence, his witness list or a hearing brief. (ICERS event, October 29, 2019).

128) On November 26, 2019, the parties conferenced again to discuss case status with the board's designee. During this meeting, Employee did not suggest he was not ready for hearing; there is no evidence he inquired about obtaining evidence or filing a brief or obtaining witnesses and filing a witness list. However, he left the prehearing conference prematurely due to medical concerns. (Prehearing Conference Summary, November 26, 2019).

129) On November 26, 2019, Employee called the division to discuss his prehearing conference held that date. The designee summarized her advice as follows:

> EE said that his blood pressure went to like 260 over 170 or something and he was not able to complete the prehearing. He stated that nothing was said about the appeal. I explained to the EE that the WC adjudications and the Appeals court are two different entities and we do not control the Appeal decisions. Told the EE that the officer has not released the PH Summary yet but we would get that out as soon as she does. EE also said that he may start attending PH telephonically so his blood pressure might do better. Told the EE that many of the participants attend by phone and that is not an issue if he would feel more comfortable attending telephonically. EE told me he felt better and appreciates my always being willing to take his calls. cac

Employee did not ask questions about obtaining other evidence or witnesses or filing evidence, his witness list or a hearing brief. (ICERS event, November 26, 2019).

130) On December 17, 2019, Employee called the division to discuss a document he had received from the appeals commission. The designee's advice is summarized as follows:

> EE received the transmittal sheet from appeals and was not sure what it meant. Explained that when the commission is done with the paperwork we send them for an appeal they return it back to us and it is put into the EE's case file and any

> evidence is returned to the evidence file. He understood once it was explained to him and said that he is glad there are people like me at the board to help when he gets confused about what is happening. cac

Employee did not ask questions about obtaining other evidence or witnesses or filing evidence, his witness list or a hearing brief. (ICERS event, November 26, 2019).

131) On January 2, 2020, Employee called the division and asked what to expect at his upcoming prehearing conference. The designee's advice is summarized as follows:

> Spoke to the EE about his PH as he was interested in what actually would be discussed or covered. I explained that since the appeals commission had remanded his appeal back to the board they would be trying to set dates for a hearing. Explained that if he has questions on what or how to file etc. he can ask those during the PH and that much of that information will also be provided in the PH summary. (ICERS event, January 2, 2020).

132) On January 3, 2020, the parties conferenced to set a March 17, 2020 hearing on Employee's claim. Employee did not contend he was not ready for hearing; rather, the parties stipulated to the hearing date and to file and serve evidence by February 26, 2020, and witness lists and briefs by March 10, 2020, in accordance with regulations. In addition, the designee, in conformance with *Lewis II*, provided the following advice to Employee:

> **Opening and Closing arguments:**
> Per 8 AAC 45.116 "Except when the board or its designee determines that unusual and extenuating circumstances exist, the amount of time at a hearing for a party's opening and closing arguments, including a statement of the issues, will be combined total of not more than 20 minutes."
>
> **Evidence:**
> Any documents, audio or video recordings that the parties intend to rely upon at hearing should be filed with the Board and served upon the opposing parties 20 calendar days prior to the hearing. Evidence may consist of medical records, other written documents, and audio or video recordings. A Medical Summary form is available on the Board's website: http://labor.alaska.gov/wc/pdf_list.htm. The deadline to file evidence for the 03/17/2020 hearing is **02/26/2020.**
>
> **Briefs:**
> A brief is a document submitted by the parties prior to a hearing which outlines the issues in dispute, the party's positions on those issues, as well as why they believe their position is correct. Copies of important supporting evidence referred

to in a brief is often attached at the end of the brief. These supporting documents are called exhibits. Briefs may not exceed 15 pages, excluding exhibits. Briefs must be filed with the Board and served upon the opposing parties at least five working days prior to a hearing. The deadline to file briefs for the 03/17/2020 hearing is **03/10/2020.**

Witness Lists:
A party may call witnesses at the hearing. If a party intends to rely upon witness testimony, they must file a witness list that includes any possible witnesses that they may call at hearing. According to 8 AAC 45.112 "A witness list must indicate whether the witness will testify in person, by deposition, or telephonically, the witness's address and phone number, and a brief description of the subject matter and substance of the witness's expected testimony." The purpose of a witness list is to allow the opposing party to prepare to question the witness. Witness lists must be filed with the Board and served upon the opposing parties at least five working days prior to a hearing. The deadline to file witness lists for the 03/17/2020 hearing is **03/10/2020.**

Filings may be submitted electronically by emailing the complete document attached in .pdf format to workerscomp@alaska.gov. Any request for a continuance, postponement, cancellation, or change of the hearing date will be reviewed in accordance with 8 AAC 45.074.

Per the AWCAC Decision No. 18-0084 issued on 09/18/2019 on remand the Board has scheduled a new hearing date. Furthermore, the AWCAC asked that the Board provide the following information:

1. Clarify any time limitations per AS 23.30.110(c)

a. As Mr. Lewis did request a hearing on his claim, he has satisfied the 110(c) requirements and a hearing is currently scheduled.

2. Provide an explanation to Mr. Lewis of the importance of timely filing witness list, how to arrange for witnesses to testify, and how to apply for a subpoena, if necessary

a. As explained above in the "Witness Lists" section of this summary, witness lists must be filed with the Board and served upon the opposing parties at least five working days prior to a hearing. The deadline to file witness lists is 03/10/2020. It is important that parties adhere to this deadline to allow the opposing parties the time to review all filings.

i. Per 8 AAC 45.112 "If a party directed at a prehearing to file a witness list fails to file a witness list as directed or files a witness list that is not in accordance with this sections, the board will exclude the party's witnesses from testifying at the hearing, except that the board will admit and consider

(1) The testimony of the party, and
(2) Deposition testimony completed, though not necessarily transcribed, before the time for filing a witness list.

b. To arrange witness testimony, the party calling said witness will need to coordinate with the individual any travel that may be required. A witness may appear telephonically by either providing their phone number or calling in to the Board at a time scheduled by the party. If a deposition is necessary, this can be arranged by and at the expense of the party requesting it.

c. To apply for a subpoena, parties can fill out the Subpoena form 07-6112 (attached) and bring the form to the board for a hearing officer's signature. The parties should note that expert witnesses may charge a fee due by the party requesting their testimony, due at the time of the expert's choosing. Subpoenas should be served will [sic] in advance of the hearing to allow witnesses time to arrange to attend the hearing.

i. Per 8 AAC 45.054(c) "The board or division will issue subpoenas and subpoenas duces tecum in accordance with the Act. The person requesting a subpoena shall serve the subpoena at the party's expense. Neither the board nor the division shall serve subpoenas on behalf of a party."

3. The Board, on remand, should also consider any new medical evidence Mr. Lewis provided or attempted to provide at the first hearing.

a. This will be for the hearing officer to review at the time of the hearing. All evidence should be filed in accordance with the "Evidence" instructions listed above.

4. Address the concern of Mr. Lewis that his medical records prior to 2003 should be excluded from the record, and explain why or why not these medical records are relevant to his claim.

a. This appears to be regarding records sent to the SIME physician, Dr. McCormack. However, at the time, these records were served on Employee's attorney Johnathan Hegna. Generally, the medical records prior to 2003 relate to Mr. Lewis's low back, the medications he received and test results show some degenerative changes and surgery in 2003. Degenerative changes to another part of the spine may be relevant to determining whether the need for treatment of Mr. Lewis's cervical spine is due to degenerative conditions or injury.

If the Employee has any further questions regarding how to prepare for the 03/17/2020 hearing, that were not addressed in this summary, he can write a letter to the designee and serve a copy to all parties. If needed the board designee can issue a supplemental prehearing summary to address these questions. The

> Employee may also contact the Board and speak to a technician by calling (907) 269-4980, if he has any other questions or concerns. (Prehearing Conference Summary, January 3, 2020).

The prehearing conference summary was not served on the parties until January 23, 2020. (*Id*.).

133) On January 7, 2020, the division noticed the parties that a hearing on Employee's claim was scheduled for March 17, 2020. (Hearing Notice, January 7, 2020).

134) On January 27, 2020, Employer asked the designee to modify the January 3, 2020 prehearing summary to include its contention that older medical records were also relevant to Employee's chronic pain and his claim for permanent total disability benefits. (Letter, January 27, 2020).

135) On February 24, 2020, Employee came to the division for advice. The designee's advice is summarized as follows:

> EE just needed something that he could give to SSI for his disability but, it was already approved. EE turned in a medical report in regard to his triple fusion. I called Kim at ER and emailed a copy to ER attorney because of the weather conditions to avoid having the EE out on the icy walks and roadway as much as possible. cac

Employee did not ask questions about obtaining other evidence or witnesses or filing evidence, his witness list or a hearing brief. (ICERS event, February 24, 2020).

136) On February 24, 2020, Dr. Craven reviewed additional medical records since his last addendum EME report. The new medical records did not change his previous opinions. He reiterated the August 30, 2015 work injury was not the substantial cause of the cervical spine symptoms or need for additional treatment beyond six weeks following the event. Rather, in his opinion, the substantial cause of this medical treatment was Employee's preexisting multilevel cervical degenerative condition and its natural progression. No physical restrictions resulted from the work injury with Employer in his opinion. (Craven report, February 24, 2020).

137) On March 6, 2020, four days before his March 10, 2020 deadline for submitting his witness list and brief and 11 days before his March 17, 2020 hearing, Employee came to the division to ask how to submit a brief and witness list. The designee's advice was as follows:

> EE was not sure how to submit a brief and witness list and when his deadline is. Deadline is next Tues. the 10th of March. Explained that the brief is his argument for his case basically. Stating details and accounts about his injury in his words.

> EE wanted to know if he calls witness who has to pay them and if he has to subpoena them. Explained that it is normally up to the party that subpoenas for a testimony on their behalf but, that especially with medical, there should be ample time because they have appointments and schedules and will be hard to arrange the time to testify and they may possibly hire an attorney to quash the subpoena. With his hearing being in 10 days it may be tough to get all the Drs. he had cards for. Explained that if the doctors have provided reports that are detrimental to his case he does have the option to attach those to his brief as exhibits. EE wanted to know about the time for his hearing and I told him they are the only one on the docket at this time but the board would contact him the day before to give him the start time as other hearings may get scheduled before then. cac (ICERS event, March 6, 2020).

138) Later on March 6, 2020, Employee called the division asking how to obtain more time to file his brief. The conversation was summarized as follows:

> EE called regarding extension of time to file briefs. I explained the petition for extension. I encouraged EE to email the petition to parties to expedite. EE stated that he will be coming in on Monday to fill out. I told EE that he should have the tech email it to ER as a courtesy, and that we would typically not serve for him, however due to the situation. I told EE that an emergency prehearing may have to be set up. –ep (ICERS event, March 6, 2020).

139) On March 10, 2020, Employee filed his brief, witness list and a petition; the division served Employer by facsimile as a courtesy to Employee. In his brief, Employee recounts his work injury with Employer and contends he is still disabled and has had shoulder surgery and a triple cervical fusion resulting from his work injury. He contends his life will never be the same because of his neck injury and he will never be able to work again. Employee faults Dr. Gevaert's treatment as ineffective and implies he never should have released Employee to return to work. He contends he called his supervisor Isaiah and told him he had been released to return to work for four hours a day. Employee contends Carver told him that was not adequate and he had to be 100 percent to return to work for Employer. He also explained how, in his view, Dr. Tew injured his left shoulder while trying to apply pressure to his neck while Employee was on a cervical traction table. Employee attached as exhibits to his brief, and relies on for support: Dr. Laufer's August 12, 2015 and September 4, 2015 chart notes; Dr. Laufer's April 22, 2016 and September 14, 2016 letters; and Dr. Cohen's February 6, 2019 operative report. Employee contends Employer's benefit denial caused him and his fiancée financial distress. The petition requested an extension of time to request a hearing under AS 23.30.110(c). Employee's petition

appears to be a hearing continuation request because the reason for the petition includes, "Heart doctor appointment. Covid 19 to avoid public, the time for witness available after the 17th." (Hearing Brief, 03/17/2020; Witness List Hearing 03/17/2020; Petition, March 10, 2020).

140) At the inception of the March 17, 2020 hearing, the designated chair disclosed he had treated with Dr. Laufer in the past, but felt he could be impartial. Employer objected to his participation in the hearing, and the remaining panel members determined the designated chair should be recused. The hearing was continued so that another chair could be selected. (Record).

141) A prehearing conference was held on May 13, 2020 to reschedule the hearing. The parties agreed to a hearing on July 15, 2020 and stipulated to file evidence on or before June 25, 2018 and witness lists and hearing briefs on or before July 8, 2020.

> 2. Evidence
> Any document or recording that a party intends to rely on at hearing should be filed with the board and served upon the opposing party 20 calendar days prior to the hearing. Employee confirmed he understood these rules.
>
> 3. Brief
> This is a written document in which a party explains the issues in dispute, his or her positions on those issues, and why his or her position is correct. Supporting evidence may be attached at the end of the brief as exhibits. A brief may not exceed 15 pages, excluding exhibits, and must be filed with the board and served upon the opposing parties at least five working days prior to a hearing. Employee confirmed he understood these rules.
>
> 4. Witness Lists, Witness Fees, and Subpoena
> If Employee intends to rely on witness testimony, he must file a document that lists any possible witnesses to be called at hearing. This list must state whether the witness will testify in person, by deposition, or telephonically, the witness's address and phone number, and a brief description of the witness's expected testimony. A witness list must be filed with the board and served upon Employer at least five working days prior to a hearing.
>
> Filing a witness list with the board will not cause the witnesses in the list to appear at hearing. Employee should either (1) contact his witness for voluntary appearance or (2) compel appearance and/or tender documents by serving a subpoena.
>
> Employee should fill out Form 07-6112, "Subpoena" (see https://labor.alaska.gov/wc/forms/wc6112.pdf), contact the board for issuance, and serve the subpoena to the witness. Employee should also provide witness fee to the witness. The designee explained about Alaska Court Rules, Rules of Civil

> Procedure, Rule 45(c) (witness fees); Alaska Court Rules, Rules of Administration, Rule 7 (fee amount); and Alaska Court Rules, Rules of Administration, Rule 8, (reasonable fees for medical expert opinion). Employee confirmed he understood these rules.
>
> 5. What Employee needs to prove at hearing
> The designee explained benefits sought by Employee are presumptively compensable, and this presumption applies to any claim under the Act. The presumption's application involves a three-step analysis: Employee's preliminary link, Employer's substantial evidence, and Employee's preponderance of the evidence.
>
> First, to attach the presumption, Employee must first establish a "preliminary link" between his injury and the employment. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 610 (Alaska 1999).
>
> Once the presumption attaches, Employer must rebut the raised presumption with "substantial evidence." Credibility is not weighed at this stage.
>
> If Employer's evidence rebuts the presumption, it drops out and Employee must prove his case by a preponderance of the evidence. This means Employee must "induce a belief" in the panel members' minds that the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). In the third step, evidence is weighed, inferences drawn and credibility considered. *Wolfe*r. Employee confirmed he understood these steps to prove his case. (Prehearing Conference Summary, May 13, 2020).

142) On June 23, 2020, Employee asking about filing evidence. The conversation was summarized as follows:

> EE was not sure of the time frame for his evidence and has a letter that he needs to get from a doctor that is out of state. I told the EE that according to the PH summary "Any document or recording that a party intends to rely on at hearing should be filed with the board and served upon the opposing party 20 calendar days prior to the hearing. The hearing is set for July 15th. EE said if he can't get the letter in time he will have to come in and request an extension by filing a petition. Cac (ICERS event, June 23, 2020).

143) On June 26, 2020, Employee filed his hearing brief and a witness list, naming Dr. Laufer, Dr. Cohen, Dr. Hall, and Susan Sellars. (Employee, Brief and Witness List, June 26, 2020).

144) On June 26, 2020, Employee also filed letters from Dr. Cohen and Dr. Hall opining on his injury. (Employee, Evidence, June 26, 2020).

145) On July 2, 2020, Employer filed a request for cross-examination of Drs. Cohen and Hall regarding the letters filed on June 26, 2020. (Employer, Request for Cross-Examination, July 2, 2020).

146) At the inception of the July 15, 2020 hearing, Employee stated his blood pressure was quite high, and if it continued to go up, he would not be able to continue, but that didn't mean the hearing couldn't continue. The chair informed him that if he needed to take a break at any time, all he had to do was ask. (Record).

147) At the July 15, 2020 hearing, Employee testified that prior to the work injury he had never had treatment for his neck; one time in 2005 he reported his neck was sore and the PA ordered an MRI that did not show anything. He was receiving a course of chiropractic treatment for his neck after the work injury. During the fifth treatment, he was placed on a table that tilted while he held onto handgrips. He was not given a "kill switch," and he believes a bumper was out of adjustment. He did not notice any trauma, completed the treatment, and returned home where his significant other noted his left shoulder was lower than his right. After a day or so, his shoulder pain increased. An x-ray showed an AC separation. During his cross-examination, Employee said his blood pressure was too high, and he asked Employer's attorney to hurry because he would not be able to continue. (Employee).

148) Susan Sellars, Employee's significant other, testified that when Employee came home from work his neck hurt so bad he could not move it; he could not turn his neck to drive, and he was unable to move it until he had surgery three years later. When he came home from the chiropractic treatment, his left shoulder was three inches lower than his right. Employee was severely debilitated by the pain after the work injury. (Sellars).

149) Dr. Laufer testified he had previously treated Employee for low back pain, but on September 3, 2015, Employee presented with limited range of motion and neck pain after a work injury three days before. Employee reported he had been very busy with lots of manual labor over a short period of time and he felt a sharp twinge of pain in the right side of his neck, but he stated there had been no specific injury. He continued working, but the symptoms got worse throughout the day. An MRI showed multilevel severe degenerative disc disease and pinched nerves. He had not reviewed all of Employee's records, but had reviewed the Drs. Craven and Rivera EME reports and Dr. McCormack's SIME reports. When asked about the cause of Employee's neck injury, Dr. Laufer explained that if a person has arthritis in their neck they may

be pretty functional but a couple days of heavy lifting, would cause compression that would cause pain. When asked why the work injury was a greater cause than Employee's preexisting neck condition, Dr. Laufer explained he tended not to worry so much about causation as about helping the person. Any number of things could have contributed. The MRI showed his neck was "beat up," before the injury, but the injury was the straw that broke the camel's back. (Dr. Laufer).

150) Dr. Craven testified he had reviewed Employee's medical records, consisting of about 1,300 pages, on several occasions. He explained that while the July 29, 2005 MRI did not show any nerve compromise or disc problems, it showed degenerative disc disease, primarily at C5-6. The changes are typical of arthritis, which progresses over time. Dr. Craven also pointed out that on June 3, 2013, Employee told Dr. Laufer he had neck pain from a 2006 motor vehicle accident with current popping, clicking and pain with movement; Dr. Craven explained the popping and clicking were related to arthritis and show the progression of the arthritis since the 2005 MRI. Dr. Craven had reviewed the September 3, 2015 chart note, which was the first medical record after the date of the reported injury, as well as Employee's daily work orders for day of and the day before the reported injury. The work orders did not show Employee had done any work that would be consistent with a mechanism of injury to his neck, and Dr. Craven noted the September 3, 2015 chart note specifically notes there was no evidence of trauma or a specific injurious event. The September 4, 2015 MRI showed multi-level degenerative changes, most severe at that C5-6 level, together with nerve encroachment due to arthritis. The MRI shows the progression of the degenerative condition that would be expected in the 10 years since the 2005 MRI. Dr. Craven explained the January 27, 2016 MRI showed severe osteoarthritis of Employee AC and glenohumeral joints. He compared the 2016 MRI to the 2008 MRI of the same shoulder and found no change to the relative position of the acromion and the clavicle. Because there was no change, he concluded the January 15, 2016 chiropractic treatment had not caused an AC separation. (Dr. Craven).

151) About one-half hour into Dr. Craven's testimony, Employee said he couldn't continue because his blood pressure was 250/100. The designated chair asked if Employee would like to take a break; Employee responded by asking the designated chair what his blood pressure was and stated he could not take any more blood pressure medication. Employer's attorney stated she would try to move faster, and Employee continued to participate until about 50 minutes into

Dr. Craven's testimony when Employee said his blood pressure was 200/100, his blood pressure medication was not working, and he was done for the day at which point he hung up. (Employee).

152) Dr. McCormack testified he is a neurosurgeon specializing in spine surgery, and he does about 300 surgeries per year. Based on Employee's explanation he had been working overhead to change light bulbs in a ballroom on August 30, 2015, Dr. McCormack diagnosed a neck strain and temporary aggravation of his degenerative condition. Dr. McCormack found that the need for treatment due to the aggravation ended on December 2, 2015, when Dr. Gevaert released him to work. After that point, the need for medical treatment was Employee's preexisting degenerative condition. Dr. McCormack did not diagnose an AC separation, and the cervical distraction device described by Employee would not pull on his arms, and would not cause an AC separation.

PRINCIPLES OF LAW

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

> **AS 23.30.010. Coverage.**
> (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other

> causes, the employment is the substantial cause of the disability or death or need for medical treatment.
>
> **AS 23.30.095. Medical treatments, services, and examinations**. (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires. . . .

"Manifest" means obvious, open, clear, visible and unmistakable. West Publishing Co., *Black's Law Dictionary*, Abridged Fifth Edition, (1983) at 495. "Injustice" means withholding or denial of justice by the act, fault or omission of the court. *Id*. at 402. The phrase "manifest injustice" is not defined in the Act or the board's regulations. In *Sowinski v. Walker*, 198 P.3d 1134, 1158 (Alaska 2008), the court addressed this phrase from Civil Rule 16(e), which states a court may only modify pre-trial filing deadlines to prevent "manifest injustice." *Sowinski* said courts have broad discretion in determining whether a situation entails a sufficient manifest injustice to justify departure from prior orders. In making a manifest injustice determination, courts should consider: (1) prejudice to the opposing party; (2) the importance of the evidence to the party seeking to use it; and (3) whether that party could have more diligently obtained the evidence with earlier notice.

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

Under AS 23.30.120(a)(1), benefits sought by an injured worker are presumed to be compensable. *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996). The presumption of compensability is applicable to any claim for compensation under the workers' compensation statute (*id*.). The presumption application involves a three-step analysis. To attach the presumption of compensability, an employee must first establish a "preliminary link" between his injury and the employment. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 610 (Alaska 1999). Credibility is not examined at the first step. *Veco, Inc. v. Wolfer*, 693 P.2d 865, 869-70 (Alaska 1985).

If the employee's evidence raises the presumption, it attaches to the claim and in the presumption analysis' second step the burden of production then shifts to the employer. Credibility is not examined at the second step either (*id*.). If the employer's evidence is sufficient to rebut the presumption, it drops out and in the analysis' third step the employee must prove his case by a preponderance of the evidence. This means the employee must "induce a belief" in the minds of the fact finders the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). In the presumption analysis' third step, the evidence is weighed, inferences are drawn from the evidence, and credibility is considered. *Steffey v. Municipality of Anchorage*, 1 P.3d 685, 691 (Alaska 2000).

> **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). The board has the sole power to determine witness credibility, and its findings about weight are conclusive even if the evidence is conflicting. *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249, 1253 (Alaska 2007). When doctors' opinions disagree, the board determines credibility. *Moore v. Afognak Native Corp.*, AWCAC Decision. No. 087 at 11 (August 25, 2008).

> **AS 23.30.135. Procedure before the board**. (a) In making an investigation or inquiry or conducting a hearing the board is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by this chapter. The board may make its investigation or inquiry or conduct its hearing in the manner by which it may best ascertain the rights of the parties. . . .

> **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. . . . 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 23.30.180. Permanent total disability**. (a) In case of total disability adjudged to be permanent 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the total disability. . . . In all other cases permanent total disability is determined in accordance with the facts. In making this determination the market for the employee's services shall be
>
> (1) area of residence;
> (2) area of last employment;
> (3) the state of residence; and
> (4) the State of Alaska.
>
> (b) Failure to achieve remunerative employability as defined in AS 23.30.041(p) does not, by itself, constitute permanent total disability.

In *J.B. Warrack Company v. Roan*, 418 P.2d 986, 988 (Alaska 1966), the Alaska Supreme Court described PTD and stated:

> For workmen's compensation purposes total disability does not necessarily mean a state of abject helplessness. It means the inability because of injuries to perform services other than those which are so limited in quality, dependability or quantity that a reasonably stable market for them does not exist. . . . As the Supreme Court of Nebraska has pointed out, the 'odd job' man is a nondescript in the labor market, with whom industry has little patience and rarely hires. Work, if appellee could find any that he could do, would most likely be casual and intermittent. . . . (footnotes omitted).

In *Meek v. Unocal Corp*., 914 P.2d 1276, 1278 (Alaska 1996), a PTD case, the court explained:

> The concept of total disability includes an education component (citations omitted). 'Factors to be considered in making [a finding that a person's earning capacity was decreased due to a work-related injury] include not only the extent of the injury, but also age, education, employment available in the area for persons with the capabilities in question, and intentions as to employment in the future.' Thus, a person's lack of education, as much as his physical injury, may be the 'handicap' preventing him from obtaining all but 'odd-lot' jobs. (Citation omitted).
> . . . .

> If a lack of education can be overcome through vocational rehabilitation, then a disability that was once 'total' may no longer be so. This is precisely what section .041 aims to do; its goal is to retrain and educate permanently impaired employees (footnote omitted) so that they can attain 'remunerative employability' (footnote omitted).

In *Carlson v. Doyon Universal Ogden Services*, 995 P.2d 224 (Alaska 2000), the injured worker appealed denial of her PTD benefit claim. On appeal, the employer argued she failed to provide medical evidence she was PTD. *Carlson* stated this argument "oversimplifies" the total disability concept because Alaska adopted the "odd lot doctrine" in defining what constitutes permanent total disability. Under the odd lot analysis, a vocational reemployment expert's testimony demonstrated evidence of disability despite overwhelming medical evidence Carlson could perform "light duty" work. A competing vocational expert said a regular, stable labor market existed for people with Carlson's skills and capabilities. *Carlson* explained:

> To avoid paying PTD benefits, an employer must show that 'there is regularly and continuously available work in the area suited to the [employee's] capabilities, *i.e*., that [she] is not an 'odd lot' worker' (footnote omitted). The Board concluded that the three doctors' unanimous view that Carlson was not PTD and Jacobsen's testimony identifying continuous and suitable work sufficed to overcome the presumption. This evidence satisfies the 'comprehensive and reliable' requirement propounded in *Stephens* (footnote omitted). The Board considered Carlson's medical limitations and her competitiveness in the job market, specifically referring to the testimony of rehabilitation expert Jacobsen and her Anchorage area labor market survey. (*Id*. at 229).

Carlson also affirmed the board's reliance on testimony from a vocational reemployment expert who reviewed Carlson's claim file and a labor market survey. The expert identified job classifications suitable to the employee given her physical and educational limitations. (*Id*.).

> **AS 23.30.185. Compensation for temporary total disability.** In case of disability total in character but temporary in quality, 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the disability. Temporary total disability benefits may not be paid for any period of disability occurring after the date of medical stability.

In *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249, 1250 (Alaska 2007), the board heard the injured worker's claim in 2002. It found the worker's knee was initially medically stable on October 9, 2000. The board also held that once a physician recommended additional surgery on

January 25, 2001, the "knee was no longer medically stable" but also held the worker was not entitled to TTD benefits between the initial medical stability determination on October 9, 2000 and the January 25, 2001 surgery recommendation. The board based its medical stability finding on a November 2, 2000 physician's report stating he did not expect any change for 45 days and on another doctor's December 2000 report stating the knee would improve with a home exercise program. The employee appealed, arguing her knee was not medically stable and had worsened. The employer on appeal offered no argument supporting a medical stability finding between November 2, 2000 and January 25, 2001.

The court noted by the time the board made its medical stability finding in 2002, it already knew the two doctors' 2000 predictions had proven incorrect and that a doctor had recommended surgery in 2001. The court concluded that medical predictions that proved to be incorrect were not substantial evidence upon which the board could reasonably conclude a worker had achieved medical stability. The court reversed the board's determination that the injured worker had reached medical stability from November 2, 2000 to January 25, 2001. While the court's decision did not expressly discuss TTD benefit entitlement related to this issue, assuming the surgery was work-related and the surgery caused disability, the court's medical stability finding and analysis would result in TTD payable for the period during which the employee was not medically stable.

8 AAC 45.074. Continuances and cancellations

. . . .

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

(1) good cause exists only when

. . .

(C) a party, a representative of a party, or a material witness becomes ill or dies;

> (D) a party, a representative of a party, or a material witness becomes unexpectedly absent from the hearing venue and cannot participate telephonically;

ANALYSIS

1) Was the oral ruling to proceed with the hearing in Employee's absence correct?

Under 8 AAC 45.074(b)(1), a continuance may be appropriate when a party becomes ill or can no longer participate telephonically. When Employee was no longer able to continue to participate in the hearing, either of those reasons would have been good cause to continue the hearing. However, at the beginning of the hearing, Employee stated his blood pressure was quite high and he might not be able to complete the hearing, but if that occurred, the hearing should proceed. Given Employee's statement, and the fact he had presented his argument, testified, and presented his witnesses, the oral ruling to proceed in his absence was correct.

2) Is the work injury the substantial cause of Employee's current disability and need for medical treatment, and, if so, to what benefits is he entitled?

The presumption of compensability applies to the issue of causation. Without regard to conflicting evidence, and without considering credibility, Employee raised the presumption that his work for Employer was the substantial cause of his disability and need for medical treatment through his own testimony and Dr. Laufer's testimony. Because Employee raised the presumption, Employer was required to rebut it. It did so through the reports of Drs. Craven and McCormack who opined Employee's preexisting degenerative disc disease was the substantial cause of his neck pain and he had not suffered an AC separation. Because Employer rebutted the presumption, Employee was required to prove by a preponderance of the evidence his employment with Employer was the substantial cause of his disability and need for medical treatment. Employee's neck and shoulder will be addressed separately.

The Neck Injury:

The preponderance of the evidence is that the work injury is not the substantial cause of Employee's disability or need for medical treatment for his cervical spine. Employee's contention he had no problems with his neck prior to the work injury is not supported by the

medical records. He states he only reported a neck ache in 2005 and the MRI showed nothing. While the July 29, 2005 MRI did not show an acute injury, it did show he had degenerative disc disease at C5-6.

Dr. Laufer's opinion on causation is given little weight because he did not have Employee's complete medical records and applied an incorrect legal standard of causation. On June 3, 2013, Employee reported to Dr. Laufer neck pain from a motor vehicle accident in 2006 with current popping, clicking and pain with movement, and Dr. Laufer acknowledged Employee's neck was "beat up," before the injury, but the work injury was "the straw that broke the camel's back." However, AS 23.30.010(a) requires that all causes of the disability or the need for medical treatment be weighed, and an injury is compensable only if employment is the substantial cause of the disability or need for medical treatment. Here, Dr. Laufer did not weigh the effect of the work injury against Employee's preexisting cervical condition.

While Dr. McCormack applied the proper causation standard, his opinion as to the cause of Employee's neck condition is also given little weight because it is based on inaccurate information from Employee. Dr. McCormack diagnosed a neck strain that temporarily aggravated Employee's degenerative condition based on Employee's statement he had been working overhead to change light bulbs in a ballroom. Employee is a poor historian, and the evidence does not support his statement. On September 3, 2015 when Employee first saw Dr. Laufer after the work injury, he stated he had moved furniture several days earlier but could not identify a specific trauma. On September 25, 2015, when he went to Alaska Spine Institute, he attributed his symptoms to "overworking and trying to do too much." It was not until January 8, 2016, over four months after the injury, that Employee told Kanady Chiropractic Center that his August 30, 2015 work injury started after "several months of overhead work." And on May 1, 2018, Employee reported to PA-C Glenn he had injured his shoulder lifting ceiling tiles. Additionally, the work order list provided by Employer for August 30 and 31, 2015 does not show Employee was doing any overhead work on those days.

The most weight is given to Dr. Craven's opinion that the substantial cause of Employee's disability and need for medical treatment was the preexisting degenerative neck condition. He

had examined Employee and reviewed his complete medical record on several occasions. Dr. Craven noted the September 3, 2015 chart note stated there was no evidence of trauma or a specific injurious event, and he specifically compared the 2005 and 2015 MRIs of Employee's neck and explained the changes were consistent with the progression of his degenerative condition over 10 years. Dr. Craven properly considered all potential causes of Employee's disability and need for medical treatment and is consistent with the facts, and two of Employee's doctors, Dr. Hall and Dr. Cohen concurred with Dr. Craven's report.

The preponderance of the evidence is that the substantial cause of Employee's disability and the need for medical treatment of his neck was his preexisting degenerative condition, not the work injury.

The Shoulder Injury:

Because Employee raised the presumption and Employer rebutted it, Employee was required to prove by a preponderance of the evidence that his shoulder was injured during Dr. Tew's treatment on January 15, 2016. Again, he did not do so.

Based on x-rays, PA Sonnenburg diagnosed left shoulder osteoarthritis as early as February 22, 2008. On June 3, 2013, Employee reported left shoulder pain to Dr. Laufer from a motor vehicle accident in 2006. When Employee returned to Dr. Tew after the shoulder injury on January 18, 2016, he denied any trauma to his shoulder. The doctors' diagnoses of Employee's shoulder have varied. After taking an x-ray, Dr. Tew opined Employee had an AC separation. The same day, a physician at the emergency room reviewed the x-ray Dr. Tew had taken and agreed Employee had an AC separation. However, a January 27, 2016 MRI showed AC arthritis, but no separation, which Dr. Hall confirmed on February 5, 2016. On April 22, 2016, after reviewing the January 27, 2016 MRI, Dr. Laufer noted severe degenerative changes to the AC joint, and said it was difficult to say how the injury occurred. Because they lack an explanation of causation, these opinions are given little weight.

Dr. Craven's opinion is given more weight. He explained the January 27, 2016 MRI showed severe osteoarthritis of Employee AC and glenohumeral joints. He is the only physician to

compare the 2016 MRI to the 2008 x-ray of the same shoulder, and he found no change in the relative position of the acromion and the clavicle, which leads to the conclusion the January 15, 2016 treatment did not cause an AC separation.

More weight is also give to Dr. McCormack's opinion. He discounted Employee's contention the chiropractic treatment caused an AC separation, because it did not make sense that a cervical traction table could be the mechanism of a shoulder injury. He diagnosed an AC impingement that was unrelated to the work injury. Considering Dr. Craven's opinion in conjunction with Dr. McCormack's opinion further supports the conclusion the January 15, 2016 treatment for Employee's neck was not the substantial cause of Employee's disability or need for medical treatment for his shoulder.

The preponderance of the evidence is that the substantial cause of Employee's disability and the treatment of his neck was his preexisting degenerative condition, not the work injury.

Because employment was not the substantial cause of Employee's disability or the need for medical treatment of either his neck or left shoulder, he is not entitled to benefits under the Act.

CONCLUSIONS OF LAW

1) The oral ruling to proceed with the hearing in Employee's absence was correct.

2) The work injury is not the substantial cause of Employee's current disability or need for medical treatment, and he is not entitled to benefits.

ORDER

1) Employee's May 11, 2016 claim is denied.

Dated in Anchorage, Alaska on September 30, 2020.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Ronald P. Ringel, Designated Chair

/s/
Robert C. Weel, Member

/s/
Bronson Frye, 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 Randall Lewis, employee / claimant v. Hickel Investment Company, employer; Alaska National Insurance, insurer / defendants; Case No. 201514492; 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 September 30, 2020.

/s/
Nenita Farmer, Office Assistant