ALASKA WORKERS' COMPENSATION BOARD

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

JAY JESPERSEN, Employee, Claimant, v. TRI-CITY AIR, Employer, and ALASKA INSURANCE GUARANTY ASSOCIATION, Insurer, Defendants.	FINAL DECISION AND ORDER AWCB Case No. 198528817 AWCB Decision No. 21-0026 Filed with AWCB Anchorage, Alaska on March 19, 2021

Employee Jay Jespersen's January 23, 2018 claim as amended, and various preliminary objections from Employer Tri-City Air were heard on February 17 and 18, 2021, in Anchorage, Alaska, dates selected on November 17, 2020. Employee's October 21, 2020 hearing request gave rise to this hearing. Attorney Richard Harren appeared and represented Employee who appeared and testified. Attorney Vicki Paddock appeared and represented Employer and its insurer. Witnesses included Judy Jespersen and Michael Carney, DC, who testified on Employee's behalf. All participants appeared by Zoom. The panel took under advisement Employer's request to strike Employee's evidence. Oral orders granted in part Employer's request to strike Employee's witnesses, denied his request to reconsider that order and granted his request to narrow the hearing's scope. Oral orders denied Employee's request to discover Employer's attorney fees and his request for a hearing continuance and for a biomechanical

second independent medical evaluation (SIME). This decision decides Employer's evidentiary objections, examines the oral orders and the SIME request, and addresses Employee's claim on its merits. The record closed on March 1, 2021, after the parties filed their post-hearing attorney fee and cost documents and closing arguments.

ISSUES

Employer contends documents Employee filed as evidence should be stricken because they are hearsay from unreliable sources, require expert testimony to rely upon them or are irrelevant.

Employee contends the documents are for the lay panel-members' benefit, are relevant to his claim and would be relied on by witnesses at hearing. The panel took this issue under advisement.

1) Should Employer's petition to strike Employee's evidence be granted?

Employer contended Employee's non-conforming witness list should be stricken because it provided no telephone numbers or description of the subject matter or substance of the witness's expected testimony. In respect to an expert witness, it contended it had no idea what this person would say because he provided no report. Employer insisted on its due process right to a fair hearing and for an order disallowing "trial by ambush."

Employee contended Employer's request to strike his witnesses should be denied because it filed no written objection and two witnesses were necessary to rebut "junk science" presented by an employer's medical evaluator (EME). He contended Employer's lawyer had an ethical duty to point out infirmities in his witness list before hearing so he could correct them. Employee contended striking his expert would violate due process and was a litigation-ending benefit "forfeiture"; he suggested possible ways to rectify the issue. An oral order granted Employer's request in part; it allowed Employee to call three of his four requested witnesses.

2) Was the oral order striking one of Employee's four witnesses correct?

Employee contended he is not currently seeking permanent total disability or vocational rehabilitation benefits, though they are listed as issues. Thus, he contended the issue of whether or not to set aside a settlement agreement need not be heard and decided at this time.
Employer contended the set-aside issue and permanent total disability and vocational rehabilitation benefits were raised in Employee's claim and cited in the controlling prehearing conference summary as hearing issues. It contended Employee cannot alter the issues set for hearing. An oral order granted Employee's request and limited the hearing's scope.

3) Was the oral order granting Employee's request to narrow the hearing's scope correct?

Employee contended he has a right to discover Employer's attorney fees so he can re-create or verify his records and capture all time he spent on Employee's case.

Employer contended it had no duty to present evidence to support Employee's attorney fee affidavit. It further contended the attorney-client privilege and work product doctrine shielded Employer from revealing its attorney fees. An oral order denied Employee's request.

4) Was the oral order denying Employee's discovery of Employer's attorney fees correct?

Employee contends he requested medical bills from Employer's adjuster but never received them. He contends Employer simply provided billing documents from its attorney's office instead. It was unclear what relief Employee was requesting.

Employer contends it provided all medical bills in its possession even though Employee did not ask for them until after he had requested a hearing and less than 30 days prior to it. Nonetheless, Employer contends it provided the documents to Employee earlier than required by law.

5) Should Employer be ordered to provide Employee's medical bills from its adjuster?

On the second hearing day, Employee requested reconsideration of the panel's oral order from the prior day striking one of his four requested witnesses.

Employer contended the panel had no valid reason or authority to reconsider a decision that has not yet been issued. An oral order denied Employee's reconsideration request.

6) Was the oral order denying Employee's reconsideration request correct?

After one of his four requested witnesses was disallowed, Employee requested a hearing continuance. He raised various reasons including a potential attorney-client conflict-of-interest.

Employer objected to a hearing continuance, contending Employee's request was made only because he was unprepared. An oral order denied Employee's request for a hearing continuance.

7) Was the oral order denying Employee's request for a continuance correct?

Employee contends the panel should order a "biomechanical SIME" given the disputes between non-medical expert Mariusz Ziejewski, Ph.D. and other medical witnesses.

Employer did not express a position on this request. It is presumed to oppose.

8) Should there be another SIME?

Employee contends the 1985 plane crash remains a substantial factor in his need for treatment and Employer is responsible for medical care for his cervical and thoracic spine, and lumbar spine from L4 through S1, from 2016 to the present and continuing. He also claims against Employer for diabetes treatment as a prerequisite to getting care for his work-related conditions.

Employer contends the 1985 plane crash does not remain a substantial factor in his need for treatment from 2016 forward. It contends Employee's spine-related symptoms are the result of his post-1985-injury self-employment and aging. Employer further contends for this reason it has no responsibility to treat Employee's diabetes.

9) Has the 1985 work injury remained a substantial factor in Employee's need for medical care and treatment for his spine and diabetes since 2016?

Employee contends he is entitled to interest and an attorney fee and cost award. Employer contends Employee is not entitled to interest or attorney fees or costs unless he prevails and even then his fees and costs should be reduced for various reasons.

10) Is Employee entitled to interest and an attorney fee and cost award?

FINDINGS OF FACT

1) At Harren's request, Employee's chiropractor Dr. Carney transcribed chart notes for Employee from Dr. Carney's Falls Chiropractic Clinic. Pre-injury records show in 1975, the clinic adjusted Employee's cervical spine at C1, 2, 3 and 5 and thoracolumbar spine from T12 to S1, and his left hip. Later in 1975, Employee hit his head on a barn post and the clinic diagnosed a cervical strain and adjusted his neck; a recurrent cervical strain resulted in adjustments later in 1975. In April 1981, Employee had lumbosacral pain for two weeks and the clinic adjusted L2, 3, 4, 5, and both sacroiliac joints; the diagnosis was lumbosacral subluxation. According to a May 23, 1986 entry, on May 22, 1985, Employee strained his low back "pulling a man out of the lake"; Dr. Carney interpreted this difficult to read note to say "1985" but given the context it could be "1986." (Carney transcript, March 15, 2019; observations; and inferences drawn from the above).

2) Employee has a pre-work-injury history of cervical- and lumbar-spine-related pain and treatment beginning around age 12. (Inferences drawn from the above).

3) On November 16, 1985, Employee at age 22 was in a plane crash while flying in white-out conditions near Quinhagak, Alaska. He initially reported cuts, bruises, and head and back injuries. (Report of Occupational Injury or Illness, November 23, 1985).

4) On November 17, 1985, Employee received care at a local clinic; the initial physician's report said x-rays taken that day showed "no acute fractures." Radiology reports for these x-rays are not in the agency file. (Employee; Physician's Report, undated; SIME records; agency file).

5) On November 21 1985, the same physician who completed the initial physician's report said x-rays taken on November 19, 1985, showed an L5 compression fracture, but there was "no neurologic deficit." Radiology reports for these x-rays are also not in the file. (Physician's report, November 21, 1985; SIME records).

6) On March 5, 1986, Charles Helleloid, M.D., who was Employee's friend, family doctor and former employer, found Employee had right-sided rib fractures, a mild fracture at L4 and a

compression fracture at L5. No other physician's report identified a fracture at L4. (Deposition of Jay Jespersen, February 14, 2019, at 36; Helleloid report, March 5, 1986; agency file).

7) On May 12, 1986, Dr. Carney's father C. M. Carney, DC, at Falls Chiropractic Clinic, saw Employee for headaches with neck stiffness into both shoulders and back soreness. Dr. C. M. Carney found severe right lateral listhesis at C1; minimal malpositioning at C5, 6, 7 and T3; and chronic suboccipital myofibrositis. He diagnosed a lateral right L5 compression fracture; a pars interarticularis separation at L5; and well-healed fractures at ribs 9, 10, and 11. X-rays showed a completely healed L5 fracture. Dr. C. M. Carney took Employee off work for at least one more month and his prognosis was "somewhat guarded." Dr. C. M. Carney's notes and Dr. Carney's more recent transcript do not mention any early degenerative changes at L5-S1 on x-rays. (C. M. Carney notes May 12, 1986; Carney transcript; May 19, 1986).

8) By August 5, 1986, Employee's headaches had resolved, his lower back had stabilized and he was doing moderate physical activity without any aggravation or exacerbation. He still had recurrent cervical myofibrositis on the right neck. These findings were gradually and steadily stabilizing under chiropractic care. Dr. C. M. Carney opined Employee had made "a remarkable recovery" in both the cervical and lumbosacral spine. (C. M. Carney letter, August 5, 1986).

9) On October 31, 1986, Employee was able to lift 25 pounds without any issues. He was unable to twist and lift, duties associated with his pilot job. His primary complaint was neck pain after routine physical activities for two hours. He was unable to return to work as a pilot at that time; his prognosis "for a complete recovery" was poor although Dr. C. M. Carney hoped he could return to work as a pilot within four to six months. (C. M. Carney letter, October 31, 1986).

10) On February 26, 1987, orthopedic surgeon Duane Person, M.D., took x-rays and evaluated Employee for an impairment rating and obtained a history including neck and low back injuries when Employee crashed in an airplane on November 16, 1985. His left-sided neck pain was constant and aching and he had bilateral shoulder pain, worse on the right. His low back pain was steady and sharp on the right with right buttock pain but no leg pain; he had occasional numbness and tingling in both legs. Employee's history included a sore neck in 1975 when he was 12 years old; he saw a chiropractor several times and improved with no neck pain until the plane crash. His cervical motion was reduced by 20 percent; he had tenderness from L3 to S1 with right sacroiliac and buttock tenderness. His lumbar spine listed to the left and lumbar

motion was reduced. There were no nerve problems in his upper or lower extremities. Employee's cervical x-rays were normal; lumbosacral x-rays showed a healed L5 compression fracture; rib x-rays showed healed fractures on eight thru 12. Dr. Person diagnosed a chronic cervical strain; chronic lumbosacral strain superimposed on a healed L5 compression fracture; healed, fractured ribs eight thru 12 on the right; and a broken nose. Though Employee was able to work, Dr. Person limited lifting to 20 pounds, no repetitive lifting, and no crouching or working in a cramped position for more than two or three minutes and no working at height. He could return to work as a pilot but not as a "bush pilot, which requires loading and unloading airplanes." Dr. Person said Employee was medically stationary, estimated he could probably return to work as a Bush pilot in six to eight months and had a 15 percent permanent physical impairment of his spine. Dr. Person did not identify any early degenerative disc disease or changes at L5-S1. (Person report, February 26, 1987).

11) On February 26, 1987, radiologist J. Magnuson, M.D., found a "slight compression" fracture at L5, did not mention any early degenerative disc disease or changes at L5-S1 and found the lumbar spine "otherwise negative." (Magnuson report, February 26, 1987).

12) Dr. C. M. Carney continued to adjust Employee's cervical and lumbar spine thru May 1987. (Carney transcript, March 15, 2019).

13) On June 16, 1987, Dr. Carney continued Employee's off-work status, though he could fly a plane; his lifting was restricted to 30 pounds when in awkward positions. He identified "early degenerative disc disease of L-5" based on May 15, 1987 x-rays; this observation was 78 days after Drs. Person and Magnuson did not report any degenerative disc disease at L5-S1 and found Employee's lumbar spine negative but for the healed L5 compression fracture. Dr. Carney opined Employee had a 20 percent "permanent-partial disability." (Carney letter, June 16, 1987).

14) On June 24, 1988, the board approved a settlement between the parties. Though they dispute what was and was not waived in that settlement, the parties agree future medical care for the work injury was not waived. (Compromise and Release, June 24, 1988; record).

15) There is a 20-year gap in Employee's medical records from June 16, 1987, until August 29, 2007. (Agency file; SIME records).

16) On August 29, 2007, Owen Hanley, M.D., saw Employee for pneumonia. His report does not mention the 1985 crash or any orthopedic symptoms. (Handley report, August 29, 2007).

17) On August 31, 2007, William Lange, M.D., saw Employee for his lungs and diagnosed diabetes: "He apparently had been taking relatively high-dose steroids off and on since approximately January of this year, which were prescribed by an 'arthritis doctor' in Arizona." The report does not mention the 1985 injury or any spine complaints; the "arthritis doctor" is not otherwise identified. (Lange report, August 31, 2007).

18) There is a seven-year gap in Employee's medical records from August 31, 2007, until September 7, 2014. In subsequent records, Employee reported a right ankle fusion in 2010 after he fell while standing on a "five-gallon bucket." His agency file contains no contemporaneous records describing this event and surgery. (New Patient Intake Form, February 18, 2016; Sidney Levine, M.D. SIME report, March 20, 2020; SIME records).

19) Beginning in 2014, Employee started having bilateral leg issues. "I was having problems with my left -- well, my legs weren't keeping up with me. I was kind of falling down." (Deposition of Jay Jespersen, February 14, 2019, at 21).

20) On September 7, 2014, Employee went to Fairbanks Memorial Hospital emergency room; his complaints were bilateral leg numbness and weakness, and coughing up blood.

> The patient states that for 3 weeks now he has had a mostly dry cough with traces of hemoptysis [coughing up blood]; however, this morning he became abruptly worse. After a significant coughing spell, he coughed up blood several times in a row. He states the total amount was approximately half a cup. This seemed to resolve. He also states that over the course of the last week, he has had a sensation of weakness in his bilateral lower legs, but has been able to get around without any significant difficulty. Today, he began walking outside into the yard and progressively suddenly felt both of his legs giving out. He ended up falling on the ground. He states that he laid on the ground for approximately 30 minutes, unable to move or feel his legs from approximately the waist down. He has never had this happen before. . . .

Employee's medical history at this visit did not include his 1985 plane crash. Heart testing suggested a differential diagnosis including a transient ischemic attack [mini-stroke] caused by blood flow issues to the spinal cord. Maria Mandich, M.D., recommended a cervical and thoracic MRI. (Mandich report, September 7, 2014).

21) On September 7, 2014, Employee had a lumbar spine MRI for "transient complete numbness and weakness to bilateral lower extremities." Janice Chen, M.D., found: No lower thoracic or lumbar cord compressing lesions; a central disc protrusion at L5-S1 that caused mild

to moderate bilateral foraminal narrowing without significant central canal narrowing; and mild degenerative changes including "disc desiccation" at all levels and three bulging disks in the lower thoracic and upper lumbar levels. His recorded medical history included diabetes and high blood pressure but not his 1985 plane crash. (Chen report; MRI Contrast Consent Form, September 7, 2014).

22) On September 8, 2014, Employee had MRI "safety screening" for cervical and thoracic spine MRIs to address transient paralysis and numbness to bilateral lower extremities that lasted 30 minutes. His history included metal in his right ankle and "coughing up blood" but not the 1985 work injury. (Fairbanks Memorial Hospital records, September 8, 2014).

23) On September 8, 2014, Employee had a thoracic spine MRI for an "episode of profound bilateral lower extremity paralysis and hemoptysis." Mark Burton, M.D., found "age-appropriate" spondylosis in the thoracic spine; he assessed scoliosis and "small disc protrusions" and suggested a chest CT scan. (Burton report, September 8, 2014).

24) Employee's September 8, 2014 cervical MRI showed "mild annular bulging" in the C4-5 disc. (Burton report, September 8, 2014).

25) On September 24, 2014, Employee reported dizziness, weakness and transient vision loss. Another cervical MRI for vascular evaluation disclosed clinically insignificant issues involving the carotid and vertebral arteries. (Jessica Panko, M.D., report, September 24, 2014).

26) On January 8, 2015, Lorie Loreman, D.O., with Arizona Pulmonary Specialists, saw Employee for a lung problem, "Valley Fever." His musculoskeletal system review was described as "normal" and his history did not record the 1985 plane crash or any cervical or lumbar symptoms. (Loreman report, January 8, 2015).

27) On January 16, 2015, Dr. Loreman saw Employee again for his lung problem. Her report describes Employee's musculoskeletal system as "normal." (Loreman report, January 16, 2014).

28) Employee continued to see Dr. Loreman off and on through 2015, for his lung condition. Her reports never mention cervical or lumbar symptoms or his 1985 work injury, and Dr. Loreman recorded no musculoskeletal abnormalities. (Loreman records).

29) On January 21, 2016, Dr. Loreman recorded for the first time Employee's right arm difficulties and "significant back discomfort hip discomfort." The record did not mention his 1985 work injury and Dr. Loreman charted his musculoskeletal system as "normal." She

recommended a cervical and upper thoracic MRI to rule out a herniation, or brachial plexopathy secondary to his previous lung surgery. (Loreman report, January 21, 2016).

30) On February 8, 2016, Employee had a thoracic MRI to address his lung condition. Radiologist Michelle Dubbs, M.D., found mild mid- and lower-thoracic disc degeneration with shallow disc protrusions; mild thoracic facet arthrosis with foraminal narrowing mostly at the left side at T2-3, which she described as "moderate"; and postoperative changes in the right chest wall from lung surgery. (Dubbs report, February 8, 2016).

31) On February 11, 2016, Employee had a cervical spine MRI for "neck and upper back pain" for "x 2 years." Radiologist Tyler Gasser, M.D., found mild degenerative changes in the cervical spine. (Gasser report, February 11, 2016).

32) On February 18, 2016, Employee sought care at NovaSpine Pain Institute on referral from Dr. Loreman. On his New Patient Intake Form, he wrote "neck-back pain" as the reason for his visit. He described his pain as constant and ranging from six to nine on a pain scale. Though he said he had this pain for "32 yrs.," which correlates to his accident date, when asked if there was "any injury or accident," Employee checked the "Yes" box and wrote "Fell" but did not also list his 1985 airplane crash. In a later form, the person completing it stated, "Yes, the patient fell," in answer to a question asking if there was a "precipitating injury" or "event." Employee reported his pain had increased "in the last five years." Lifting made the pain worse, which affected his neck, back and both hips, with numbness or tingling in both legs. Blue Cross Blue Shield of Alaska was listed as his insurer. He had tried Flexeril, Tylenol with Codeine, Vicodin and Percocet with some relief. Employee included high blood pressure, diabetes and "stroke" in his medical history. He had his right ankle fused in 2010 and his right upper lung removed in 2015. He was then-currently working as a pilot and aircraft mechanic. (NovaSpine New Patient Intake Form, February 18, 2016).

33) It is not clear from the medical records if the "fall" to which Employee referred in the initial NovaSpine record was the fall from the five-gallon bucket in 2010, other falls he had in 2014, or the paralysis and fall in the yard in 2014. (Judgment; inferences drawn from the above).

34) On February 19, 2016, Employee reported neck and back pain, citing an airplane accident 32 years earlier as when his pain began. In 1985, he was given medication and told his neck and back were "fine." In the five years prior to this visit his pain had been increasing and he was unable to lift things or lay down comfortably; the joints in his arms also ached. He said he had

been taking Vicodin with minimal relief but had not tried therapy or injections. There was a precipitating injury or event recorded as when "the patient fell." Nikesh Seth, M.D., diagnosed cervical disc disorder with radiculopathy; cervical spondylosis; lumbar degenerative disc disease; lumbar intervertebral disc degeneration; bulging thoracic intervertebral disc; and lumbar disc disease with radiculopathy. He opined Employee's neck and mid-back pain was due to cervical spondylosis and cervical and thoracic degeneration; lumbar degeneration was causing Employee's lower extremity paresthesias. Dr. Seth recommended another lumbar MRI with a possible injection thereafter. He did not offer a causation opinion connecting these findings to the 1985 work injury. (Seth report, February 19, 2016).

35) Employee's February 19, 2016 visit with Dr. Seth was the first time any medical record in his agency file recorded the 1985 work injury since the board approved his settlement agreement on June 24, 1988, 28 years earlier. (Agency file).

36) Employee did not list Dr. Seth on his witness list. (Employee's Witness List for Hearing, February 9, 2010).

37) On February 29, 2016, a lumbar MRI disclosed approximately 50 percent disc height loss at L5-S1 with a broad-based central disc protrusion, which caused moderately severe bilateral stenosis slightly displacing the S1 nerve roots; moderate bilateral foraminal stenosis; and otherwise mild degenerative changes throughout the lumbar spine without significant canal or foraminal stenosis. (Tyler Gasser, M.D., report, February 29, 2016).

38) On March 5, 2016, Employee underwent a cervical epidural steroid injection at C7-T1 to address his cervical radiculopathy. (Seth report, March 5, 2016).

39) On March 12, 2016, Employee had his second cervical epidural steroid injection at C7-T1. (Seth report, March 12, 2016).

40) On March 19, 2016, Employee had bilateral L5-S1 epidural steroid injections to address his lumbar radiculopathy. (Seth report, March 19, 2016).

41) On March 23, 2016, Employee reported his pain was about 50 percent better since his two cervical and one lumbar epidural steroid injections. However, his blood sugar had elevated, causing headaches. Employee said he last worked in October 2015. (Seth report, March 23, 2016).

42) On April 2, 2016, Employee had bilateral L2, 3, 4 and 5 lumbar medial branch blocks to address lumbar spondylosis without myelopathy. His "[b]iggest complaint is hips." Employee again mentioned having had a stroke in 2015. (Seth report, April 2, 2016).

43) On April 9, 2016, Employee had his second, bilateral L2, 3, 4 and 5 lumbar medial branch blocks. (Seth report, April 9, 2016).

44) On April 16, 2016, Employee underwent bilateral hip injections to address hip osteoarthritis and pain; he also had lumbar radiofrequency ablation on the left side at L2, 3, 4, and 5 to address lumbar spondylosis and pain. (Seth report, April 16, 2016).

45) Dr. Seth never commented on whether or not the 1985 work injury played any role in Employee's symptoms or need for treatment or in Dr. Seth's findings or diagnoses. (Seth reports).

46) Employee is confident the 1985 plane crash necessitated his 2016 injection therapy because he "had pain in the same spots since the day of that accident" and he wanted relief. His neck had been "stiff 30 years." (Deposition of Jay Jespersen, February 14, 2019, at 22-23, 25).

47) On June 16, 2016, Employee reported "back issues" for over 32 years after an airplane crash, which involved his cervical, thoracic and lumbar spine; Type II diabetes since 2008; and a 2015 stroke after lung surgery. His current problem was worsening left hip pain with left calf spasm, which radiated down to his foot. The pain and weakness had recently been bad enough that Employee had to use crutches to get around. (Anderson report, June 16, 2016).

48) A June 16, 2016 lumbar MRI disclosed mild disc bulges from T12 through L4; there was also mild disc height loss and a "moderate disc bulge," "eccentric to the left" with a mild central disc extrusion and inferior migration of disc material with associated mass effect on the S1 nerve roots "left worse than right," and mild to moderate central canal narrowing all at the L5-S1 level. The radiologist's impression was, "Multiple levels of lumbar spine degenerative change are seen, which are worst at the L5-S1 level." (Jesse Kincaid, M.D., report June 16, 2016).

49) On July 5, 2016, Dr. Jensen performed an L5-S1 laminectomy on Employee for lumbar spinal canal stenosis secondary to a "large disc herniation." He said Employee had progressive symptoms over the winter but beginning in April 2016, he had more difficulty standing, walking and using his left leg given the complete numbness on the sole of his left foot. "His pain levels have made his blood sugars run a little bit high," but these had returned to normal. Dr. Jensen reviewed the June 16, 2016 MRI and found a "large L5-S1 herniated disc" with associated

stenosis and severe recess narrowing on the left. That MRI finding "is directly attributable to the patient's severe left greater than right radicular symptoms." (Operative Report, July 5, 2016).

50) On September 27, 2016, Employee's cervical x-rays showed mild, multilevel degenerative changes more prominent involving the facet joints and best seen at C5-6; straightening of normal lordosis probably positional or related to muscle spasm; and no evidence to demonstrate cervical spine instability. (X-ray reports, September 26, 2016).

51) On September 27, 2016, Employee said his lumbar spine was doing about 80 percent better following his surgery in July. He had intermittent neck pain, spasm and a "locking up" sensation associated with hand tingling. "Jay has had neck issues for a while." When working as a pilot and mechanic, Employee was on his hands and knees and often felt like his neck locked up. Dr. Jensen referenced an MRI "taken this winter" in Fairbanks, which he said showed low-grade spondylosis with some disc space reabsorption at C6-C7; there was severe central narrowing. He noted mild foraminal changes bilaterally at C4 through C6 and a small spur on the right at C6-C7. Dr. Jensen assessed diffuse, cervical spondylosis with some ligament calcification and recommended Flexeril. He offered no causation opinions. (Jensen report, September 27, 2016).

52) On January 13, 2017, Dr. Seth examined Employee for cervical pain. He opined:

> This is a patient with an active job who is with severe pain in the neck, mid back and lower back. I feel that the neck and mid back is due to a combo of cervical spondylosis, thoracic and cervical degeneration. I also feel that he is with lumbar degeneration that is causing LE [lower extremity] paresthesia.

Dr. Seth did not otherwise offer a causation opinion. (Seth report, January 13, 2017).

53) On March 4, 2017, orthopedic surgeon David Bauer, M.D., examined Employee for an EME. He noted a gap in Employee's medical records from 1987 through 2014, and recorded: Employee said he received no medical care during that interval. He told Dr. Bauer, "I got by okay" but his back would "bug him sometimes." Over the prior 10 years "things have gone downhill." He did not recall getting much treatment between 2014 and 2016, but his pain began to increase in 2015, and he saw Dr. Seth who gave him injections; his neck symptoms improved. Lumbar injections and radiofrequency ablations also helped but by summer 2016, "things started to change significantly." When Employee saw Dr. Anderson on June 16, 2016, he was having sudden pain radiating from his left hip down to his foot in an S1 distribution with calf spasms. This was a "sudden onset" one day when "something moved badly." Thereafter, Employee

began having numbness and tingling in his left leg and had to use crutches. Dr. Jensen performed an L5-S1 bilateral discectomy and Employee did well briefly but his back pain began getting worse. Since December 2016, Employee thinks "something has happened again" and his back was as bad as it was before surgery. Dr. Bauer reviewed MRIs from September 7, 2014, February 8, 2016, February 11, 2016 and February 29, 2016. He diagnosed an L5 compression fracture; fractured ribs; and cervical strain, all substantially caused by the work injury. Dr. Bauer opined several other diagnoses were neither caused nor aggravated by the work injury, including: cervical and lumbar degenerative disease; L5-S1 acute disc herniation in 2016; and status-post discectomy. (Bauer report, March 4, 2017).

54) Dr. Bauer addressed two causation questions: Responding to a question prefaced with the "but for" test, he said the November 16, 1985 injury was not "a substantial factor" in Employee's need for surgery in 2016, or in any subsequent care. Dr. Bauer reasoned Employee's L5 top endplate compression fracture did not result in any damage to the L5-S1 disc. He agreed endplate fractures "can be strongly associated with disc degeneration" in the disc adjacent to a fracture but the L5-S1 disc in this case was not affected. Dr. Bauer opined that bone is more brittle than disc and will break, as it did in this case, before the disc is affected. In his view, the 2016 disc herniation was spontaneous and not related to Employee's 1985 work injury. Dr. Bauer opined the surgery would have occurred when it did and to the extent it did notwithstanding that injury. As to alternate causes of the need for medical care in 2016, he further found the injury did not cause a delayed disc herniation; rather, Dr. Bauer attributed aging and normal degeneration as substantial causes for Employee's 2016 surgery and subsequent care. (Bauer report, March 4, 2017).

55) Dr. Bauer's report on page 18 cited in a footnote four studies including, "A Study of the Mechanics of Spinal Injuries," and "The Human Spinal Column and Upward Ejection Acceleration: An Appraisal of Biodynamic Implications." At least three of the four studies involved lumbar discs and tended to show vertebral endplate "burst fractures" may cause disc degeneration in the disc adjacent to the fracture. (Bauer report, March 4, 2017; Employee's April 4, 2019 hearing exhibits; observations).

56) On March 24, 2017, Dr. Seth reevaluated Employee's neck and back. Employee said he was in an airplane accident 32 years earlier and his pain began then. (Seth report, March 24, 2017).

57) On April 3, 2017, a lumbar MRI with and without contrast was compared to Employee's February 29, 2016 lumbar MRI. Radiologist Tyler Gasser, M.D., found postsurgical changes at L5; granulation or scarring; degenerative changes in upper spinal levels; a right disc protrusion at L5-S1 with disc material near the right S1 nerve root; and moderate bilateral foraminal stenosis at L5-S1. (MRI report, April 3, 2017).

58) Possibly in July 2017, (the dates on Dr. Jensen's office reports are not legible) Employee returned to Dr. Jensen and reported he had done well after his lumbar surgery and had even gone to Minnesota and pheasant hunted. However, "in December of last year," Employee "had some episodes" where almost all his symptoms returned. Dr. Jensen recommended either a revision surgery or another lumbar epidural injection. (Jensen report, date illegible).

59) On September 26, 2017, Harren spent 1.2 hours reviewing Dr. Bauer's report and drafting a letter to Dr. Jensen. (Affidavit of Costs Including Paralegal Costs, February 12, 2021).

60) On September 26, 2017, Harren asked Dr. Jensen for his opinion about the relationship between Employee's 1985 work injury and his 2016 surgery. (Harren letter, September 26, 2017).

61) On September 28, 2017, Employee told Dr. Anderson his pre-surgery symptoms had returned; she recommended a lumbar CT. (Anderson report, September 28, 2017).

62) On January 9, 2019, 470 days after Harren's September 26, 2017 questionnaire, Dr. Jensen faxed his answers. He wrote "yes" the injuries Employee sustained in his 1985 plane crash were a substantial factor in causing the need for surgery he performed in 2016. He also wrote "yes" the plane crash was a substantial factor in causing the need for follow-up care since the surgery and additional medical treatment continuing into the foreseeable future. Dr. Jensen elaborated no further on his answers. (Jensen responses, January 9, 2019).

63) On January 11, 2019, Employee requested a hearing on his December 29, 2016 and January 23, 2018 claims and asserted his right to cross-examine Dr. Bauer. (Affidavit of Readiness for Hearing; Request for Cross-Examination, January 11, 2019).

64) On January 11, 2019, Employee also filed and served by mail Dr. Jensen's January 9, 2019 responses to Harren's January 26, 2017 questionnaire. (Medical Summary, January 11, 2019).

65) On January 22, 2019, Employer timely asserted its right to cross-examine Dr. Jensen on his answers to Harren's questionnaire. (Request for Cross-Examination, January 22, 2019).

66) Dr. Jensen's two-word fill-in-the-blank response to Harren's questionnaire was strictly for litigation purposes. (Experience; judgment; and inferences drawn from the above).

67) Employee never presented Dr. Jensen for cross-examination. (Agency file; record).

68) On February 14, 2019, Employee testified that since his accident there were "really hardly any" days that he would call "zero pain, but it was tolerable"; after some prompting from his lawyer, he could "honestly say" that he had "daily pain" related to his injury. (Deposition of Jay Jespersen, February 14, 2019, at 12). He had not seen Dr. Carney as a patient or otherwise since 1987 or 1988. Employee "pretty much had health insurance" all the time even though he thought it was not very good. Nevertheless, he "pretty much stayed away from doctors" until he started having back and leg problems in 2014. (*Id*. at 19). Employee recalled Dr. Helleloid and a physician at a clinic said he would probably have back problems as he got older. (*Id*. at 35). When Employee had leg paralysis and fell in 2014, he recalls the Fairbanks emergency room physician said his L5 vertebra was "crushed" and he fell because "I got pinched nerves that just got pinched on hard enough to lose control of my legs." (*Id*. at 37). Dr. Seth was the only physician Employee saw in Arizona for his back or neck. (*Id*. at 47-48). Employee said the only reason he had injections from Dr. Seth was his work injury because he "had pain in the same spots since the day of that accident" and "after 30 years" it was time to do something. (*Id*. at 22). Employee said his neck has "been stiff" for 30 years. (*Id*. at 25). Between his 1985 work injury and self-employment, he worked for several flying services as a pilot and aircraft mechanic but said he had no injuries while working for them. In 2010, Employee "slipped off a step stool" at his hanger in Arizona, fractured his ankle and required ankle fusion surgery. (*Id*. at 51-52). His first post-injury employment was with Warroad Airways beginning in 1986. (*Id*. at 55; Exhibit 1). Employee began self-employment in 1994, except for a stint with the Interior Department in 1999-2000. (*Id*. at 55-57). Since his injury, Employee has put claims for medical care he attributes to his work injury on his personal health insurance. (*Id*. at 59). In his opinion, the 1985 work injury influences his blood sugar levels. (*Id*. at 61). Employee's Social Security earnings information show no reported earnings for 1986 or 1987 and none from Warroad Airways. (Exhibit 2).

69) No medical record in the agency file supports Employee's account of what the initial clinic physician and Dr. Helleloid allegedly told him about having back problems later in life, or what the Fairbanks physician allegedly told him about why he fell in 2014. (Agency file).

70) On February 14, 2019, Judy Jespersen testified she knew Employee before and after his 1985 accident. (Deposition of Judy Jespersen, February 14, 2019, at 6-7). His 2019 problems included mobility, "pain all the time," restlessness at night, sitting, riding in a car or truck and standing. (*Id*. at 7). She knows his family and is not aware they ever had back problems or surgeries. (*Id*. at 7-8). Once she and Employee purchased their flying service, he piloted planes and did maintenance. (*Id*. at 11). Their flying service has hired help because he can no longer do all the work. (*Id*. at 13). Judy noticed Employee's then-current symptoms had begun four or five years earlier [2014 or 2015] and gradually increased. (*Id*. at 15). They purchased a motorhome in 2015 because Employee could no longer sit still while driving. (*Id*. at 18). Since she and Employee have been together, she has never seen a day when she did not observe some "partial impairment" in Employee's body; he always had some pain or discomfort. (*Id*. at 19). From her perspective, Employee had injection therapy from Dr. Seth because, "He has had the same pain from 30 years ago, so that's what he went for, the low-back pain." (*Id*. at 24).

71) On February 27, 2019, the parties stipulated to file witness lists for an April 4, 2019 procedural hearing and a May 7, 2019 merits hearing in accordance with 8 AAC 45.112. (Prehearing Conference Summary, February 27, 2019).

72) On March 28, 2019, Employee filed a non-conforming witness list for the April 4, 2019 procedural hearing. The list failed to provide a brief description of the subject matter and substance of the witness's expected testimony. Listed witnesses included Employee, his wife Judy Jespersen, and Drs. Bauer and Carney. (Employee's Witness List, March 28, 2019).

73) At hearing on April 4, 2019, Employee filed excerpts from several spine studies Dr. Bauer mentioned in his report. Among these were the two dealing specifically with spine biomechanics: (1) The Human Spinal Column and Upward Ejection Acceleration: An Appraisal of Biodynamic Implications, 1967; and (2) A Study of the Mechanics of Spinal Injuries, 1960. Addressing Employer's petition to quash a subpoena for Dr. Bauer's testimony at that hearing, Employee cited to the treatises referenced in Dr. Bauer's report's footnotes; he wanted to question Dr. Bauer about these biomechanical spine studies. He also conceded that Dr. Bauer's report rebutted the presumption of compensability and shifted the burden to him. Employee, when asked about his pain level since February 14, 2019, Employee testified, "I haven't had a pain-free day for years . . . I haven't had a full night sleep in many years." He did not testify that

he had continuous or chronic, unrelenting pain since his 1985 work injury. (Record, April 4, 2019).

74) On May 15, 2019, Brandon Hirsch, M.D., at The CORE Institute in Arizona recorded a history of cervical and lumbar pain arising from a 1985 airplane accident. Employee's symptoms were much as they had been "for several years" but Employee did not relate continuous or chronic and unrelenting pain since 1985. Dr. Hirsch among other things disc degeneration in the lumbosacral region. He recommended a lumbar spine MRI and physical therapy but offered no causation opinions. (Hirsch report, May 15, 2019).

75) On March 5, 2020, orthopedic surgeon Sidney Levine, M.D., examined Employee for an SIME. Employee said after his 1985 work injury, "his symptoms never fully subsided and he 'just dealt with it.'" Over time, his neck and back symptoms worsened, were irritated more often "and his symptoms would last longer." At some point after the 1985 injury Employee was standing on a five-gallon bucket and fell, twisting his right ankle; this required surgery. He could not recall the year he underwent ankle surgery [earlier records recorded him stating it was 2010]. Dr. Levine diagnosed post-L5-S1 disc herniation with surgery; compression fracture at L5, healed and a right pars interarticularis fracture at L5; Type II diabetes; and peripheral neuropathy. Answering the board's questions, he ruled out the 1985 work injury as a substantial factor in causing disability or need for treatment beginning in 2014. The work injury was the substantial cause for treatment for his back injury including a compression fracture at L5 and at the right pars interarticularis, but these injuries healed and treatment and evaluation in 2014 was unrelated to the 1985 work injury. The alternative cause for treatments beginning in 2014 were normal activities of daily living and work; his diabetes was not related to the work injury. Employee's disability from the work injury ended by June 16, 1987. In Dr. Levine's opinion, Employee needs no further treatment to address the 1985 work injury or its consequences; treatment Employee received in 2016 and thereafter was not related to the compression or pars fracture or the work injury. Answering Employee's question reciting the following from Dr. Person's February 6, 1987 remarks, Dr. Levine said:

> [From Dr. Person's report]. . . The low back is painful, steady, sharp, more on the right side. Bending and lifting is painful. Standing for a long period of time causes discomfort. Lying down at times is uncomfortable. Certain positions will cause them [sic] discomfort in the low back. Twisting is uncomfortable.

> Coughing and sneezing causes pain. Buttock pain is present on the right. He has no leg pain. He has occasional numbness and tingling in his legs.
>
> [By Employee] In your opinion, was the airplane crash of November 1985 a substantial factor in causing the above-reported pain and permanent partial impairment recognized by Dr. Person . . . and, in the 30 years of continuous pain which continued thereafter?
>
> Answer #3:
>
> [By Dr. Levine] Yes, noting that it was less than 2 years following the airplane crash, which resulted in a compression fracture of L5. No, while I believe that a portion of the symptoms would be due to the plane accident, the substantial cause would not relate back to that injury. (Levine report, March 5, 2020, at 64-65).

Employee cited to SIME record 58 to support this question. That Dr. Seth report records Employee stating his pain "began" 32 years earlier after an airplane crash. (Seth report, February 18, 2016). Employer's first SIME question stated an incorrect legal standard for a 1985 injury and asked:

> [By Employer] In your opinion, is the 11/16/1985 work injury the substantial factor in bringing about Mr. Jespersen's current back condition and any need for medical treatment? Please explain the reasons behind your answer.
> Answer #1:
> No. The development of the disc herniation in the degeneration of the disc and degenerative changes within lumbar spine are more likely than not brought about by the normal aging process and the continued work activities over the years as opposed to the specific injury of November 16, 1985. (Levine report, March 5, 2020, at 66).

Dr. Levine agreed with EME Dr. Bauer that any injury that could occur to a disc associated with an L5 compression fracture on the top endplate would occur at the L4-5 level, but in this case Employee's disc problem was at the L5-S1 level. (Levine report, March 5, 2020, at 67).

76) At his April 27, 2020 deposition, Dr. Levine said the work injury was not "a substantial factor" bringing about Employee's current back condition and need for treatment. The alternate cause was normal aging and Employee's continued work over 30 years after the work injury. "That would be any kind of work that would require repetitive bending or pushing or pulling, lifting, those types of activities." Dr. Levine said regarding Employee's 2014 treatment:

> A. [By Dr. Levine] That the plane crash is not the reason for which he sought that treatment.
>
> Q. [By Employee] But was it a substantial factor? Was it one of the reasons?
>
> A. It was not the substantial -- it was not a substantial factor.
>
> Q. What's the difference between a substantial factor, Doctor, and the substantial factor?
>
> A. Well, in my understanding, it has to be that -- substantial under Alaska terminology, I believe, is a major factor or the greatest factor.
>
> Q. The greatest of them all?
>
> A. Yes.
>
> Q. . . . So it's your opinion that in 2014 the plane crash was not the greatest factor that caused him to have pain intervention, correct?
>
> A. Correct.
>
> Q. So what was the major factor that caused him to have intervention 2014?
>
> A. . . . [H]is back pain associated with a disc protrusion and narrowing of the disc space, neuroforamina and lateral recesses at the L5-S1 level.
>
> Q. And what, in your opinion, Doctor, was a substantial factor, just one substantial factor, that caused him to have a disc protrusion and to cause him to have narrowing of . . . the pathology that you described observing?
>
> A. I think that's part of an aging process and in this case not due to a specific injury. (Videoconference Deposition of Sidney H. Levine, M.D., April 27, 2020, at 9-11).

Dr. Levine knew of no other substantial factor than aging in bringing about Employee's need to incur medical expenses to treat his pain in 2014. (*Id*. at 11-12). Employee offered a hypothetical where he had "chronic, unrelenting back pain that depended on his work life for 25 years" and then in 2014 he went for medical care because the pain became unbearable. Dr. Levine said he would need more information about the pain level, area and medical treatment Employee had to assess any connection between the 1985 plane crash and his symptoms 25 years later. (*Id*. at 12). He was "not aware" of the hypothetical facts stated though he had taken a history from Employee. (*Id*.). In that history, Employee said by 1991 his symptoms had "never fully

subsided" and he "just dealt with it" and "over time" his neck and back symptoms worsened, were more frequent and lasted longer. Dr. Levine's deposition continued:

> Q. [By Employer] . . . They fly float planes. So he said you get in the airplane quick and fast because you have got to start on the shoreline, get into the water, pop up onto a float, get in the plane, start up to the taxi. And then once you get that part done, you are just sitting.
>
> But then he talks about once he lands the plane, he's doing the same thing. You're going to pull up to a shoreline or dock, going to shut down, get out pretty fast, and then you're going to back down into the water and try and control the plane. Then usually you get in and out several times with gear. You get anything from duffel bags to coolers to backpacks.
>
> So my question for you, Dr. Levine: Are these the type of work activities that you were referring to in -- in the responses that we just talked about?
>
> A. [By Dr. Levine] Yes.
>
> Q. Okay. And as a physician, an orthopedic surgeon, would you assign responsibility for the medical treatment that Mr. Jespersen needed starting in 2014 to these types of work activities?
>
> A. Yes.
>
> Q. . . . I believe degenerative disc disease has been talked about in Mr. Jespersen's case. When attributable to continued work activities -- and if I understand your responses, that's what you attribute to his degenerative disc disease is his work activities and the normal aging process, is that right?
>
> A. Yes.
>
> Q. Would you expect to see it in other levels of the spine, such as the thoracic and cervical spine?
>
> A. Yes. I -- I would find it throughout the spine, generally speaking.
>
> Q. . . . And in the imaging reports and imaging itself that you reviewed for Mr. Jespersen's evaluation, was degenerative disc disease identified in other levels of his spine?
>
> A. Yes, it was.
> . . . .

> Q. And so would that type of disc degeneration be attributable to a fracture at L5 in 1985?
>
> A. No. (*Id*. at 23-24).

Employee's disc herniation was at L5-S1, the "lowest portion in the low back." Dr. Levine explained why a fracture near the top of vertebral body L5 would not result in a disc herniation below the L5 vertebral body in the L5-S1 disc space:

> A. . . . [I]f there was going to be a disc herniation that occurred, it would be closer in time to that fracture, but the -- the fracture occurs in the bone. The compression occurred in the upper -- comes from the upper level. So that would be higher, closer to the L4-5 disc as opposed to the L5-S1, the lower level.
>
> His problem is at that lower level, and that disc was not involved in the compression fracture, and that fracture did not extend into that disc space. So it did not cause -- in my opinion, cause injury to that disc. (*Id*. at 26-27)

In Dr. Levine's opinion, vertebral fractures usually heal within six months and any remaining symptoms that may continue would be localized low back pain and would not generally be radicular. Employee had some radicular symptoms but on the opposite side from where he had the fractured L5 vertebral body. (*Id*. at 28). In his opinion: The injections Dr. Seth provided "were not for the L5 fracture," but "for the leg pain, the radicular pain." The surgery he had at L5-S1 was "[m]ost definitely for a disc herniation." (*Id*. at 29). A person does not need to have a specific traumatic event have to disc degeneration and a herniation. (*Id*. at 34).

77) On May 13, 2020, the parties agreed to a June 16, 2020 procedural hearing and again stipulated to file witness lists in accordance with 8 AAC 45.112. (Prehearing Conference Summary, May 13, 2020).

78) On June 9, 2020, Employee filed a non-conforming witness list that failed to provide a brief description of the subject matter and substance of the listed witness's expected testimony. This list included Dr. Carney, Employee and his wife Judy. (Employee's Witness List, June 9, 2020).

79) At the June 16, 2020 hearing, Employer objected to Employee's June 9, 2020 witness list because it failed to provide a brief description of the subject matter and substance of the witness's expected testimony under 8 AAC 45.112. Employee withdrew Dr. Carney and requested the board table Employer's request to strike witnesses until such time as he decided to

call Judy. He contended the requirement that the witness list include a brief description of the subject matter and substance of Judy's testimony was non-prejudicial to Employer and was "irrelevant," because she would "obviously" be testifying about things pertinent to the issue pending. Employee ultimately waived his right to call anyone but himself at this hearing. (Record, June 16, 2020).

80) Employer's June 16, 2020 hearing objection put Harren on notice that his witness list format was not in conformance with the regulation and subject to a request at hearing to strike all witnesses except his client. (Experience; judgment; and inferences drawn from the above).

81) On September 3, 2020, endocrinologist Mark Silver, M.D., spoke to Employee by telephone and reviewed his medical records for an SIME. Employee said he had been on Prednisone beginning in 2004 for "arthritis." Dr. Silver found no evidence Employee had diabetes prior to 1985, but found "no link" between his 1985 injury and diabetes. Therefore, the work injury "would not be a substantial factor in causing disability or need for treatment" for diabetes. Alternate causes for Employee's diabetes are his "prior chronic steroid use" and his "family history of diabetes" on his father's side. While chronic pain might aggravate blood sugar control and diabetes, chronic pain was not a substantial factor in Employee developing diabetes. Dr. Silver opined the primary cause of Employee's elevated blood sugars and poor diabetic control was improper medical treatment and inadequate diabetic medications. (Silver report, September 3, 2020).

82) On October 21, 2020, Employee requested a hearing on his amended claims. (Affidavit of Readiness for Hearing, October 21, 2020).

83) On October 28, 2020, Employer timely re-asserted its right to cross-examine Dr. Jensen on his January 9, 2019 report. (Request For Cross-Examination, October 28, 2020).

84) On November 17, 2020, the parties set a February 17-18, 2021 hearing on Employee's claim, and for the third time stipulated to filing witness lists in accord with 8 AAC 45.112 and evidence pursuant to 8 AAC 45.120. Documentary evidence upon which parties wanted to rely at hearing had to be filed and served no later than January 27, 2021. (Prehearing Conference Summary, November 17, 2020; experience; judgment).

85) On December 1, 2020, Employee went to an emergency room for shortness of breath. His history states, "Of note the patient does have chronic abdominal pain due to a number of abdominal surgeries that he has had in the past." (Yining Lu, M.D. report, December 1, 2020).

86) A December 30, 2020 lumbar MRI showed multilevel lumbar spondylosis with postoperative changes at L5 and a small posterior L5 disc herniation on the right. (Michael Caldwell, M.D. report, December 30, 2020).

87) On December 30, 2020, Jacelyn Davidson, M.D., stated, "Please let patient know his MRI does show impingement of the right S-1 nerve. It also shows degenerative disc disease at all the lumbar levels. . . ." (Davidson report, December 30, 2020).

88) On January 26, 2021, Melissa Rose, APRN, CNP, on referral from Dr. Davidson, evaluated Employee for low back and left lower extremity pain; Employee gave the following history:

> [Employee] is a 57-year-old male who presents to the office for evaluation of low back pain and left lower extremity pain with numbness and weakness. Had a work injury in 1985 resulting in L5 compression fracture and had mild low back pain off and on over the years. Current symptoms first started in spring of 2016. . . .

He also listed a family history of diabetes on his father's side. APRN Rose diagnosed lumbar degenerative disc disease but did not offer a causation opinion. (Rose report, January 26, 2021).

89) On January 29, 2021, at 4:59 PM, Employee filed electronically documents upon which he wanted to rely at the February 17, 2021 hearing. (H. Lee email, January 29, 2021).

90) Had the division received Employee's email and all attachments before 5:00 PM on January 29, 2021, Employee's evidentiary filing would still be untimely. (Inferences from the above).

91) The division's computer server received Employee's January 29, 2021 email with all documentary evidence attached at 5:04 PM, which by regulation made the filing effective the next working day, February 1, 2021. (Division server; experience).

92) On February 4, 2021, Dr. Bauer noted Dr. Helleloid's March 5, 1986 report is the only record finding Employee had a fracture at L4; that report referenced the L5 top endplate compression fracture but did not mention any damage to the L5-S1 disc space below. He noted Dr. Carney's May 19, 1986 report said the L5 fracture had completely healed. "Spondylosis" is a synonym for "arthritis." (Videoconference Deposition of R. David Bauer, M.D., February 4, 2021, at 9-11). He found Employee's 1987 records show no L5-S1 disc injury. (*Id*. at 13).

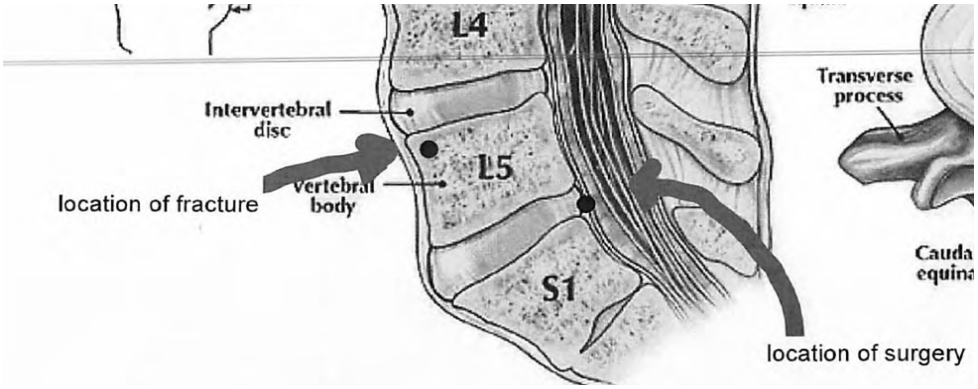
93) Dr. Bauer found no medical record showing Employee continued to complain of back or neck pain after 1987, until sometime in the 2000s, when Employee reported back pain for "a couple of years," not continuously. (*Id*. at 13). Lumbar spine MRIs taken in 2014, after Employee could not walk briefly, did not explain his symptoms. The thoracic and lumbar MRI findings at that time were consistent with degenerative disc disease; there was disc desiccation at multiple levels, degenerative bulging at L4-5 and L5-S1, and facet arthrosis, which is also another word for arthritis. (*Id*. at 14-15). The February 8, 2016 thoracic spine MRI was also consistent with degenerative disc disease, similar to 2014. (*Id*. at 16). Dr. Bauer opined disc degeneration is "a systemic process," which occurs at multiple levels sometimes at varying rates or sometimes at the same time. He noted Employee has degenerative changes in his spine at all spinal levels, which is "very characteristic of a systemic disease rather than a result of trauma." (*Id*. at 16-17). His February 11, 2016 cervical spine MRI also shows degenerative changes. (*Id*. at 17).

94) Dr. Bauer agrees with Dr. Seth's February 2016 opinion that Employee's neck, thoracic and lumbar pain is caused by arthritis and degenerative changes; he saw no causal connection between Employee's L5 compression fracture and Dr. Seth's diagnoses. (*Id*. at 18-19). He noted Dr. Jensen performed his 2016 surgery on the opposite end of the L5 vertebra from where Employee had the L5 compression fracture. (*Id*. at 20). Employee's September 27, 2016 cervical x-rays were also consistent with degenerative disc disease at multiple levels in his opinion. (*Id*. at 21). Dr. Bauer found no muscle atrophy, leading him to conclude Employee had been using them symmetrically. (*Id*. at 27). In his opinion, the 17 percent fracture Employee had at L5 is a "minor compression fracture." (*Id*. at 29). Employee's 2016 acute disc herniation, based on his medical records and the history he gave Dr. Jensen was in Dr. Bauer's view "something new and different at that time causing very severe pain." (*Id*. at 30).

95) Dr. Bauer in a footnote in his report referred to medical journals discussing spine compression physiology and whether it causes injury to discs. A 1967 study showed G-forces 10 times the force of gravity applied to the human spine cracked the bone but not the disc. Dr. Bauer could find no studies refuting this. He reiterated that the 1985 work injury was not a substantial factor in causing Employee's treatment in 2014. Rather, Dr. Bauer opined Employee's fracture healed naturally "and then another disease" started. (*Id*. at 31-34). He explained the distinction between a "burst fracture" and a "compression fracture." A burst

fracture is more serious than a compression fracture and typically will damage the adjacent disc. Even then he opined, in Employee's case, a more serious burst fracture at L5 would have affected the L4-5 disc, the one above the level of the fracture; it would not affect the level below. (*Id*. at 36-37). Figure I, below, attached as an exhibit to Dr. Bauer's deposition, illustrates his explanation:

Figure I



96) Dr. Bauer opined the work injury was not "even an iota" responsible for any delayed disc herniation. (*Id*. at 37-38). He cited a 2006 study, stating trauma caused no acute disc changes and did not aggravate disc degeneration in the lumbar spine. (*Id*. at 39). Dr. Bauer opined that any degenerative disc disease findings in 1987 would be caused by early degenerative disc disease and genetics and did not result from Employee's 1985 work injury. (*Id*. at 41). He opined Drs. Seth's and Jensen's injections and surgery, respectively, were not done as a result of Employee's L5 compression fracture; they were done because degenerative disc disease collapsed the L5-S1 disc space, which caused radicular pain and the need for surgery. (*Id*. at 43). Dr. Bauer opined Employee's continued work as a Bush pilot for at least 15 years caused the symptoms in his cervical and lumbar spine. (*Id*. at 46). He assigns responsibility for medical treatment for pain Employee experienced in 2016 to progression of time, *i.e.*, aging. (*Id*. at 47). He said Employee's Mayo Clinic MRI from December 30, 2020, is not consistent with anything from the 1985 work injury; it is consistent with aging, degenerative disease and post-surgical changes. (*Id*. at 48).

97) On February 9, 2021, Employee filed a non-conforming witness list; this one had less required information than his two prior non-conforming witness lists. His witness list included 15 witnesses; it provided no phone numbers and no description of the subject matter or substance

of any witness's expected testimony. Harren and his associate attorney Lee both signed the witness list. (Employee's Witness List for Hearing, February 9, 2021).

98) On February 10, 2021, Employer asserted its right to cross-examine authors of evidence Employee filed on January 29, 2021. (Request For Cross-Examination, February 10, 2021).

99) On February 12, 2021, Harren's attorney fee affidavit and attached itemization state he spent 1.2 hours reviewing Dr. Bauer's report and drafting a letter to Dr. Jensen on September 26, 2017. (Affidavit of Costs Including Paralegal Costs, February 12, 2021).

100) On the first hearing day February 17, 2021, Employer sought to strike most documents Employee had filed as evidence for hearing as hearsay or irrelevant. It objected to Employee's non-conforming witness list because it did not include phone numbers or descriptions of the subject matter or substance of the witness's expected testimony; Employee subsequently pared his list down from 15 witnesses to four -- Employee, his wife, Dr. Carney and Dr. Ziejewski. Employee sought to reduce the hearing's scope by not having the panel decide his permanent total disability or vocational rehabilitation claims, which were linked to his request to set aside a settlement agreement allegedly waiving those benefits. He wanted Employer's attorney fee billings to its client so Harren could fill in missing items on his own fee affidavit, which he failed to capture for various reasons, and wanted medical bills from the adjuster's office. Employee wanted Employer to stipulate to admissibility of a "schedule" his attorney's office had prepared summarizing his medical expenses and a health-care insurance lien. The parties did not agree on these preliminary issues and oral orders resolved several. (Record).

101) The panel took Employer's petition to strike Employee's evidence under advisement. The parties' positions on these documents to which Employer objected are summarized as follows:

Table I

Document Description	Employer's Position	Employee's Position
#3 Richard Nahin pain prevalence article	Hearsay; needs an expert witness to explain or rely upon	Relevant to show pain prevalence the general population
#6 Medical illustrations	Hearsay; needs an expert witness to explain or rely upon	Relevant to instruct the lay board members on anatomy
#7 Medical illustrations	Hearsay; needs an expert witness to explain or rely upon	Relevant to instruct the lay board members on anatomy
#8 Online Mayo Clinic article about diabetes	Hearsay; needs an expert witness to explain or rely upon	Relevant to Employee's diabetes
#9 Online Mayo Clinic article about arthritis	Hearsay; needs an expert witness to explain or rely upon	Relevant to Employee's claim
#10 All medical bills	Employer's attorney fees and	All medical bills adjuster

adjuster received, and Employer's lawyer's charges to Employer	costs are not relevant to Employee's; Employer already provided information requested; Employee said under oath that he was ready to go to hearing	received, and lawyer bills are relevant to Employee's case to fill in missing information and compare Paddock's fees to Harren's
#11 Bush pilot Hudson obituary	Irrelevant	Relevant to aging and disc degeneration issue
#12 List of 25 worst sport injuries	Not a reputable source; irrelevant	Relevant to traumatic spinal injuries and arthritis
#13 Bush pilot Hall of Fame	Irrelevant	Relevant to aging and disc degeneration issue

102) At hearing the main preliminary issue was Employer's objection to Dr. Ziejewski. In response to its objection, Employee cited Employer's failure to file a petition to strike his witness list and its failure to notify Harren and point out the errors. Harren admitted, "I guess I don't know why I lost sight of that" requirement to file a proper witness list. He said the woman who works the front desk has no legal experience; his associate attorney was relatively new; and the witness list was due the same day as the hearing brief so "it was difficult to do." Harren said, "I guess I didn't see that" witness list requirement but insisted Paddock still should have filed a petition before hearing rather than raise it at hearing. He noted his witness list was in the same format he used before and stated COVID-19 has affected his office and caused "great difficulties." He likened striking Dr. Ziejewski's testimony to a benefit "forfeiture," which "the law abhors." Harren suggested Employer should request a continuance; Employee requested a continuance to allow Employer to depose Dr. Ziejewski or hire its own expert. Dr. Ziejewski provided no report but gave Harren "slides" upon which he intended to rely at hearing, though these were not filed or served prior to the hearing. Treating provider Dr. Carney was a secondary concern; Employee listed him to testify from a chiropractor's perspective to rebut Dr. Bauer. (Record).

103) In response, Employer contended excluding Dr. Ziejewski would not be manifestly unjust to Employee; to the contrary, its due process would be violated if he were allowed to testify, even if Employer cross-examined later, stating once the panel heard his testimony "the bell is rung." Employer contended doing a Google search is inadequate to find out what Dr. Ziejewski knows about this case or to learn his opinions, denying it a reasonable opportunity to cross-examine him. It contended the parties had agreed to a hearing with months to prepare and

Employer was ready for hearing. For these reasons, it also objected to continuing the hearing. (Record).

104) In reply, Employee contended Dr. Bauer in his February 4, 2021 deposition, said some "really outrageous things" of which Employee was not aware and he needed an expert to rebut those statements. He contended Dr. Carney had been Employee's attending physician back in the 1980s and Dr. Ziejewski is a world-renowned biomechanical engineer. Employee contended his right to due process required the panel to allow Dr. Ziejewski's testimony to uncover "junk science" offered by orthopedic surgeons. Harren admitted he gave Paddock no notice prior to filing his witness list that he intended to call Dr. Ziejewski to testify about biomechanical issues; Dr. Ziejewski called Harren the day before witness lists were due and said he was able to testify at hearing. Employee asked the panel hear Dr. Ziejewski's testimony as an offer of proof and then decide what to do about it. Harren said he has 38 years' experience as an attorney and has appeared before the board for 30 years, including representing Employee on his prior settlement in this case in 1988, and has taken at least one case to the Alaska Supreme Court. (Record).

105) The board's witness list requirement is simple and easy to follow. Either Harren, his associate attorney Lee or his office person could have provided the required information on the witness list. (Experience; judgment; observations and inferences drawn from the above).

106) An oral order allowed Employee to limit the hearing issues; the panel would not decide his request to set aside the settlement agreement or related claims. An oral order granted Employer's objection to Employee's witness list; since Dr. Ziejewski provided no written report, absent the required witness information and based on Employer's "trial by ambush" arguments, the order excluded his testimony. The panel held that as a party, Employee could testify; his wife could testify since she had already been deposed; Dr. Carney was allowed to testify because he was Employee's former attending physician and the parties had his medical records. (Record).

107) At hearing, Dr. Carney testified he has been a chiropractor since 1980. He studied anatomy for four years in chiropractic college with focus on the spine. Dr. Carney's father, C. M. Carney, DC, had seen Employee prior to his 1985 work injury. On May 14, 1986, Dr. C. M. Carney diagnosed Employee with a healed, lateral right L5 compression fracture. Dr. Carney opined that vertebra would not have its normal "tin can" shape even though it was healed. When compression-fractured, Employee's L5 vertebra became wedge-shaped on the top front right. In

his opinion, this injury altered the muscles and ligaments around the compression fracture as they compensated for it. Employee had a well-healed L5 pars interarticularis, which was not an issue. (Carney).

108) Dr. Carney, who had treated Employee post-injury, had post-graduate training in orthopedics and "applied spine biomechanics engineering." He said that in May 1986, Dr. C. M. Carney took lumbar x-rays; Dr. Carney said in reference to those x-rays that he, Dr. Carney, found no degenerative disc disease at L5-S1; however, Dr. Carney said he found early degenerative disc disease at L5-S1 on May 1987 x-rays but did not see any disc disease at any other spinal level. During the initial time his clinic treated Employee, Dr. Carney never saw any disc "bulges" because all Employee had in the mid-80s were x-rays, which do not show discs but only show disc spaces. When asked if he had an opinion about whether "the degenerative change that [he] observed in the x-ray in May of 1987 was related in any way" to the 1985 work injury, Dr. Carney said "I believe it was directly responsible for that." In his opinion, any bending or twisting motion would bend, twist and stretch microfibers in the annulus at L5-S1 and cause continuing symptoms. The body can heal itself up to 12 months post-injury. The L5 compression fracture in his view could cause Employee to compensate by leaning to the left, which could account for malalignment of certain vertebrae. (Carney).

109) Dr. Carney read Dr. Person's February 1987 report; Dr. Person did not release Employee to full duty work and limited him to 20 pounds lifting and restricted his postural duties. Dr. Person said Employee might be able to return to Bush piloting in six to eight months and had a chronic cervical and lumbosacral strain, with "chronic" meaning lasting more than three months; a chronic lumbosacral strain lasting for one and one-half years may never resolve on its own. (Carney).

110) Dr. Carney also read Dr. Bauer's report and deposition and disagreed with his conclusions. Dr. Carney opined it is improper to blame all degenerative changes in Employee's spine on normal life. He said normal disc desiccation occurs over time when discs become dehydrated. In Employee's case in his opinion, the fibers in the L5-S1 disc were torn and nucleus material was getting in between fibrous layers in the annulus. This weakened the annulus, which in his opinion is what caused Employee's problem. (Carney).

111) Dr. Carney reviewed Dr. Levine's report and Employee's surgical records. In his opinion, the 1985 plane crash necessitated Employee's lumbar surgery in 2016 as "a direct result."

Employee told Dr. Carney his plane was in a right turn when it crashed; this would mean his spine would be bent forward and twisted to the right causing a torqueing injury to disc fibers, in his view. He opined once fibers are torn leaking nucleus material can eventually cause bulges and over time normal wear and tear, including bending and twisting at the same time, can causes a "protrusion" and the protrusion may touch nerve roots causing radiating symptoms. Eventually, the tears can get worse causing an extruded disc, which occurs when the nucleus "squirts out." In Dr. Carney's opinion, absent the 1985 plane crash Employee's L5-S1 disc fibers would have been normal and would not have developed into a disc herniation or fragment in 2016. Even though the body can heal itself, if damaged L5-S1 disc fibers are constantly reaggravated they will not heal themselves in his opinion. Dr. Carney opined Employee would use intrinsic spinal muscles just to stand up straight because the damaged L5-S1 disc would cause his body to want to go forward and to the right. He would expect to see normal disc dehydration from aging in a relatively similar amount throughout the spine; Employee's MRIs showed disc degeneration was much worse at L5-S1. Annular tears do not show up on an MRI; one can see nucleus material leaking out indicating a tear. Assuming Employee "never overcame the pain in his back" and had symptoms on a "practically daily basis" for 30 years post-injury, Dr. Carney opined Employee's chronic pain was due to altered body mechanics from the compression-fractured L5 vertebra, muscle overuse to maintain posture and continuous micro tears in the L5-S1 disc. (Carney).

112) Dr. Carney disagrees with Dr. Levine's opinion that if Employee had a herniated disc at all from the 1985 plane crash, it would have occurred at the L4-L5 disc, not at L5-S1. In his opinion, the fact that the top end plate of L5 fractured with no damage to the L4-L5 disc shows the disc was stronger than the bone and all the torque occurred on L5-S1 disc. Dr. Carney last examined and treated Employee on December 19, 2019, for residuals from his 1985 accident. He is unaware of any acute injury to Employee's spine since 1985. (Dr. Carney).

113) Dr. Carney had not examined or treated Employee between 1987 and 2019, a period of about 32 years. (Employee; Carney; inferences drawn from the above).

114) Employee does not believe he would be seeking medical benefits for his lumbar spine if he had not had the 1985 airplane crash while working for Employer. Since that accident Employee said he had "never been the same; have never been right." He dealt with "chronic pain" since the crash and it "finally caught up" with him. Employee had pain "for many years" and it prompted

him to see Dr. Seth in 2014. Spinal injections did not work so he turned to Dr. Jensen. The surgery worked for one or two months but then the area "collapsed again." Employee had hoped surgery would end the "hot screw" burning back pain; his low back and neck pain has always been in the same place. He is on a list for back surgery but his hemoglobin A1C levels are too high; he cannot have surgery until he gets the blood sugar numbers down. According to Employee, around the time Dr. Jensen performed low-back surgery he told Employee he was "very positive" the plane crash was a substantial factor in his need for surgery. He does not recall talking about his pain level over the years with Dr. Bauer; in Employee's view, Dr. Bauer's visit was very short. Employee did not think Dr. Levine was well prepared. He saw Dr. Silver by telephone; Employee disagrees with Dr. Silver that his dad died of diabetes and Employee had chronic steroid use. Employee contends his steroid use arose from his work injury. He does not think his back or diabetes came from normal aging because his brothers have no back or diabetes issues. A doctor Employee in the clinic after the 1985 crash allegedly told him he would be all right but someday he would have back problems. He wants his back "fixed up" so he can go back to work flying. Employee thinks Dr. Jensen has not been paid for his services and that is why Dr. Jensen will not speak to him or his lawyer. (Employee).

115) Employee at his expense took Cortisol prescribed by an Arizona physician in 2004 through 2008 for back pain. Employee cannot recall the clinic physician's name who he testified once told him he might have back problems later in life. Employee's father developed diabetes when he was about 83 years old; his mother had surgery to her cervical spine. (Employee).

116) Employee described his pain level between 1985 and 1991: He returned to work in 1987 at his normal job and was "pretty sore." His pain progressively got worse and "never got better." Between 1991 and 2000, Employee felt good enough "to get by"; he was flying, loading and unloading planes, was the first person at work and the last person to leave every day and he bought a new airplane every other year to grow his business. Between 2000 and 2010, he was "good enough to go on" but never "really comfortable." By 2014, Employee could not do the work required and would have to ask clients to help unload planes. During 15 years before Dr. Jensen saw him, Employee did not get much medical care except over-the-counter medications and Cortisol treatments. Following his 2016 surgery, his symptoms suddenly got worse and Employee wondered "what happened?" He could point to no specific event that caused his "what happened" moment but recalls waking up with a "sizzle" in his back and ended up using

crutches again. Eventually in 2018, Employee went to the emergency room in Fairbanks to find out what was going on with his back and learned the surgery had "collapsed." (Employee).

117) Judy Jespersen has been married to Employee for 30 years. His pain descriptions were accurate but he does not like to talk about himself. Over the years, Judy has learned to tell when Employee is feeling pain because it shows on his face; she has never seen Employee "rambunctious or pain-free" since his work injury. Between 1991 and 2000, Employee "worked all the time"; his hobby was working on airplanes. She could tell from his "body mechanics" that he was "hurting." In her opinion, the 1985 plane crash was a substantial factor in Employee's need for back surgery in 2016, because she saw his discomfort progress over time. The only other trauma she knew about was the "stepstool" incident, which resulted in a fused ankle. (Judy Jespersen).

118) During Judy's testimony, Harren took a call from Dr. Jensen's former office manager stating Dr. Jensen was "not willing to help"; so Harren would not be calling him. (Record).

119) On February 18, 2021, at the start of the second hearing day, Employee requested reconsideration of the witness list ruling from the day prior. Employee filed Dr. Ziejewski's "slides" on which he intended to refer during his testimony; he explained what Dr. Ziejewski reviewed and what he would say in response to Dr. Bauer's opinions. Employee requested a two-week continuance so Dr. Ziejewski could give testimony and be subject to cross-examination. He contended if his request for a continuance or to add Dr. Ziejewski as a witness were not granted, Harren may have to contact his errors and omission insurer for advice on how to proceed. Employee further contended, despite winnowing his witness list down to four witnesses, he wanted to add five more, all of whom he contended were "parties." Employee contended he had been trying to get Dr. Jensen's testimony for two years. Harren contended COVID-19 had substantially interfered with his ability to prepare for hearing and noted the Supreme Court issued an order relaxing rules for filing documents in court. Harren said he ethically might have to withdraw from the case because he may have erred, thus causing a conflict-of-interest between him and Employee. (H. Lee email; record, February 18, 2021).

120) In response, Employer contended the panel lacked authority to reconsider an oral decision because reconsideration requires a written decision. It contended Employee was trying to further his "trial by ambush" tactics and the hearing should not be continued so he could cure his failure to prepare properly and file a conforming witness list. Employer noted both parties in November

agreed to a two-day hearing with three months to prepare; all parties knew biomechanical issues had existed in this case since at least 2017, when Dr. Bauer issued his report. Employer contended Employee could have deposed Dr. Jensen long ago but did not. It further noted Dr. Carney had testified with added certifications in biomechanical issues. Employer contended various witnesses on Employee's non-conforming list were not "parties" entitled to testify. (Record).

121) When asked when he first knew Dr. Bauer was raising biomechanical issues, Harren responded "in 2017," when he read Dr. Bauer's report and saw it "in a footnote." After a recess, he wanted "to correct the record" and said he first became aware during Dr. Bauer's February 4, 2021 deposition. Employee also requested "a biomechanical SIME." (Record).

122) The panel denied Employee's request for reconsideration because the Administrative Procedures Act requires a written decision before the power to reconsider it can be invoked, and based on Employer's arguments opposing his request. The panel denied Employee's continuance request because Employee was aware since 2017 that biomechanical issues had been raised and he had years to obtain a biomechanical expert witness and properly notify Employer on his witness list about this expert. The panel did not expressly rule on the SIME request but "froze" the hearing record as of February 18, 2021. (Record).

123) Eventually at hearing the parties agreed the panel could decide if Employee's need for medical treatment was still work-related and the parties could sort out medical issues later if Employee prevailed. Employer objected to all evidence Employee filed untimely, except for Blue Cross Blue Shield documents. (Record).

124) Employee clarified the date on which his claim for medical care begins as the date he first saw Dr. Seth [February 19, 2016]. He clarified the body parts, conditions or functions for which he sought Employer's liability: His low back including L4 through S1 and his neck and mid-back. Employee is not seeking any medical benefits related to diabetes directly. However, Employee said he needs diabetes treatment before his spine can be addressed and such treatment is included in his claim against Employer. (Employee; record).

125) On March 1, 2021, Employee renewed his reconsideration request of the oral order striking his biomechanical engineer expert, contended Drs. Bauer and Levine were biased and should not be relied upon and contended only Dr. Carney had evidence of early degenerative disc degeneration at L5-S1 when he offered his opinions at hearing. Further, he contended Dr.

Levine used the wrong legal standard. He relied extensively on the *Shea* Alaska Supreme Court decision including the referenced "but for" legal analysis, and renewed his request for an order requiring Employer to pay for diabetes treatment sufficient to allow Employee to have surgery for his work-related spine injuries. (Written Closing Argument Part 1 & 2, March 1, 2021).

126) On March 1, 2021, Employer contended the issue was whether the 1985 work injury was still a substantial factor in Employee's multi-level disc degeneration and the need for medical treatment. It agreed the *Shea* "but for" legal analysis applied to Employee's claim. Employer contended little weight should be given to Dr. Carney given his credentials and because he had not treated Employee for 31 years. It contended Dr. Jensen's report was subject to a Smallwood objection and in any event provided no helpful information and was thus entitled to little weight. Employer relies on Employee's medical records and opinions from Drs. Bauer and Levine, who as orthopedic surgeons, it contends are entitled to greater weight. (Employer's Closing Argument for 2/17/21-2/18/21 Hearing, March 1, 2021).

127) It is common for a person to experience muscular aches and pains or joint stiffness at the end of the day after strenuous work. (Experience).

PRINCIPLES OF LAW

AS 23.30.001. Legislative intent. It is the intent of the legislature that

> (1) this chapter be interpreted . . . to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to . . . employers. . . ;
> . . . .
>
> (4) hearings in workers' compensation cases shall be impartial and fair to all parties and that all parties shall be afforded due process and an opportunity to be heard and for their arguments and evidence to be fairly considered.

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

> **AS 23.30.010. Coverage.** Compensation is payable under this chapter in respect of disability or death of an employee.

In *Shea v. State of Alaska*, 267 P.3d 624 (Alaska 2011), the Alaska Supreme Court addressed a Public Employees' Retirement System claim for occupational disability benefits, which involved an alleged work-related aggravation to a non-work-related preexisting condition, chronic pelvic nerve pain. *Shea* defined the "substantial factor" test and said in a case where multiple causes contribute to an injury, the "substantial factor" test requires a claimant to demonstrate: (1) the disability would not have happened "but for" an injury sustained in employment; and (2) reasonable persons would regard the injury as a cause and attach responsibility to it. *Shea* further explained the first element is commonly called "cause-in-fact" and the second "proximate cause." The cause-in-fact or "but for" prong only requires a showing that the employee's damages would not have been incurred "but for" the employment injury. Once the fact-finders determine that the employer's conduct has in fact been one cause of the employee's injury, the question remains whether the employer should be legally responsible for it. To prove this last prong of the substantial factor test, the employee must prove that the work event was so important in bringing about the injury that reasonable persons would regard it as a cause and attach responsibility to it. In other words, was the injury so significant and important cause that the employer should be legally responsible. *Shea* stated:

> Although the ALJ found that Shea's pain worsened during the time she was employed by the State, it does not necessarily follow that her employment was the cause. Shea's pain may have worsened over this period for a variety of reasons, such as new or increased activities outside of her job or as a natural progression of her underlying condition. Shea's conclusion regarding causation does not follow from the mere fact that her condition worsened.
> . . . .
>
> In Alaska, a prolonged work-related factor could contribute to a person's disability in equal proportions to her other daily activities and still be considered "a substantial factor"; even a five to ten percent contribution could suffice if "reasonable persons would regard the injury as a cause of the disability and attach responsibility to it" (citation omitted).

In *Traugott v. Arctec Alaska*, 465 P.3d 499 (Alaska 2020), the Alaska Supreme Court in a "new law" case clarified the causation test applicable to "old law" injuries arising before 2005:

> But-for causation was only one part of the pre-2005 causation analysis. . . . Before the 2005 amendments a worker needed to prove at the third stage of the presumption analysis that work was a substantial factor in his . . . need for medical treatment (footnote omitted). To prove this, the worker needed to show both that work was a but-for (or factual) cause *and* that it was important enough as a cause that reasonable persons would regard it as a cause and attach responsibility to it (footnote omitted; emphasis in original). . . .
> **AS 23.30.095. Medical treatments, services, and examinations.**
> . . . .
>
> (k) In the event of a medical dispute . . . between the employee's attending physician and the employer's independent medical evaluation, the board may require that a second independent medical evaluation be conducted by a physician or physicians selected by the board from a list established and maintained by the board. . . .

If the employer's evidence is sufficient to rebut the statutory presumption of compensability, 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 this 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 23.30.108. Prehearings on discovery matters; objections to requests for release of information; sanctions for noncompliance**. . . .
> . . . .
>
> (c) At a prehearing on discovery matters . . . the board's designee shall direct parties to . . . release documents that are likely to lead to admissible evidence relative to employee's injury. . . .

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

The board's credibility finding "is binding for any review of the Board's factual findings." *Smith v. CSK Auto, Inc.,* 204 P.3d 1001, 1008 (Alaska 2009). When doctors disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.*, AWCAC Decision. No. 087 (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 44.62.330. Application of AS 44.62.330 -- 44.62.630. (a) The procedure of the state boards, commissions, and officers listed in this subsection . . . shall be conducted under AS 44.62.330 -- 44.62.630. . . . Where indicated, the procedure that shall be conducted under AS 44.62.330 -- 44.62.630 is limited to named functions of the agency.

. . . .

(12) Alaska Workers' Compensation Board, where procedures are not otherwise expressly provided by the Alaska Workers' Compensation Act; . . .

AS 44.62.540. Reconsideration. (a) The agency may order a reconsideration of all or part of the case on its own motion or on petition of a party. To be considered by the agency, a petition for reconsideration must be filed with the agency within 15 days after delivery or mailing of the decision. The power to order a reconsideration expires 30 days after the delivery or mailing of a decision to the respondent. If no action is taken on a petition within the time allowed for ordering reconsideration, the petition is considered denied. . . .

8 AAC 45.020. Transaction of business. . . .

. . . .

(c) Papers and documents may be filed . . . by electronic mail.

(d) Papers and documents filed by . . . electronic mail must be in compliance with the following:

. . . .

(4) filing of a document by

. . . .

(B) electronic mail with the division or the board is considered complete upon receipt of the entire document at the division's electronic mail address; . . . .

(5) a document is considered filed upon receipt unless received . . . after 5:00 p.m. Alaska time; if the document is filed . . . after 5:00 p.m. Alaska time, the filing date will be the next working day;

. . . .

(11) permission to deviate from the process under this subsection may only be granted for good cause by order of the designee assigned to the case;

(12) failure to adhere to the process under this subsection may result in rejection of the submitted documents.

8 AAC 45.065. Prehearings. . . .

. . . .

(c) after a prehearing the board or designee will issue a summary of the actions taken at the prehearing. . . . The summary will limit the issues for hearing to those that are in dispute at the end of the prehearing. Unless modified, the summary governs the issues and the course of the hearing.

8 AAC 45.070. Hearings. . . .

. . . .

(g) Except when the board or its designee determines that unusual and extenuating circumstances exist, the prehearing summary . . . governs the issues and the course of the hearing.

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

(A) a material witness is unavailable on the scheduled date and deposing the witness is not feasible;
(B) a party or representative of a party is unavailable because of an unintended and unavoidable court appearance;
(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;
(E) the hearing was set under 8 AAC 45.160(d);
(F) a second independent medical evaluation is required under AS 23.30.095(k);
(G) the hearing was requested for a review of an administrator's decision under AS 23.30.041(d), the party requesting the hearing has not had

adequate time to prepare for the hearing, and all parties waive the right to a hearing within 30 days;
(H) the board is not able to complete the hearing on the scheduled hearing date due to the length of time required to hear the case or other cases scheduled on that same day, the lack of a quorum of the board, or malfunctioning of equipment required for recording the hearing or taking evidence;
(I) the parties have agreed to and scheduled mediation;
(J) the parties agree that the issue set for hearing has been resolved without settlement and the parties file a stipulation agreeing to dismissal of the claim or petition under 8 AAC 45.050(f)(1);
(K) the board determines that despite a party's due diligence in completing discovery before requesting a hearing and despite a party's good faith belief that the party was fully prepared for the hearing, evidence was obtained by the opposing party after the request for hearing was filed which is or will be offered at the hearing, and due process required the party requesting the hearing be given an opportunity to obtain rebuttal evidence;
(L) the board determines at a scheduled hearing that, due to surprise, excusable neglect, or the board's inquiry at the hearing, additional evidence or arguments are necessary to complete the hearing;
(M) an agreed settlement has been reached by the parties less than 14 days before a scheduled hearing, the agreed settlement has not been put into writing, signed by the parties, and filed with the board in accordance with 8 AAC 45.070(d)(1), the proposed settlement resolves all disputed issues set to be heard, and the parties appear at the scheduled hearing to state the terms of the settlement on the record; or
(N) the board determines that despite a party's due diligence, irreparable harm may result from a failure to grant the requested continuance or cancel the hearing; . . .

8 AAC 45.112. Witness list. 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. . . . 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 section, 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 a party, and
(2) deposition testimony completed though not necessarily transcribed, before the time for filing a witness list.

8 AAC 45.120. Evidence. . . .
. . . .

> (e) . . . Irrelevant or unduly repetitious evidence may be excluded on those grounds.
> . . . .
> (f) Any document, including a compensation report, controversion notice, claim, application for adjustment of claim, request for a conference, affidavit of readiness for hearing, petition, answer, or a prehearing summary, that is served upon the parties, accompanied by proof of service, and that is in the board's possession 20 or more days before hearing, will, in the board's discretion, be relied upon by the board in reaching a decision unless a written request for an opportunity to cross-examine the document's author is filed with the board and served upon all parties at least 10 days before the hearing. . . .
> . . . .
> (h) If a request is filed in accordance with (f) of this section, an opportunity for cross-examination will be provided unless the request is withdrawn or the board determines that
>
> > (1) under a hearsay exception of the Alaska Rules of Evidence, the document is admissible;
> > (2) the document is not hearsay under the Alaska Rules of Evidence; or
> > (3) the document is a report of an examination performed by a physician chosen by the board under AS 23.30.095(k) or AS 23.30.110(g). . . .

In *Tolson v. City of Petersburg*, AWCB Decision No. 09-0168 (November 9, 2009), the board said if a party files a timely request for cross-examination of a document's author, and the offering party fails or is unable to produce the author, the document may be admitted only if it is admissible under a hearsay exception of the Alaska Rules of Evidence pursuant to 8 AAC 45.120(h)(1). In *Tolson* the admitted articles were published in reputable scientific or medical journals that maintain websites on the Internet, or were published through a government website, with a purpose to give correct information to the public or the medical community. *Tolson* found these sources have high motivation to correctly reproduce the authors' originally expressed data, methods and conclusions and the authors' interest in their reputations also provides assurances of accuracy.

> **8 AAC 45.900. Definitions.** (a) In this chapter
> . . . .
> (11) "Smallwood objection" means an objection to the introduction into evidence of written medical reports in place of direct testimony by a physician;

> see Commercial Union Insurance Companies v. Smallwood, 550 P.2d 1261 (Alaska 1976). . .

ANALYSIS

1) Should Employer's petition to strike Employee's evidence be granted?

At the November 17, 2020 prehearing conference the parties set a two-day hearing beginning February 17, 2021, and stipulated to file their evidence in accordance with 8 AAC 45.120. Subsection 120(f) requires parties to file their evidence "20 or more days before hearing" if they want it considered at hearing. For their evidence to be deemed timely, the parties had to file evidence for use at the February 17, 2021 hearing by no later than January 27, 2021.

On Friday, January 29, 2021, at 4:59 PM, two days after the deadline, Employee began electronically filing evidence. However, his filing was not completed before close-of-business at 5:00 p.m. that day. The division's server received the documents at 5:04 PM. Pursuant to 8 AAC 45.020(c), parties have a right to file evidence by electronic mail. However, under §020(d)(4)(B), the filing is considered complete upon receipt of the entire document at the division's email address. If, as in this case the server receives it "after 5:00 p.m.," the "filing date will be the next working day" under §020(d)(5). Employee's evidence that should have been filed no later than January 27, 2021, was filed on February 1, 2021. Employee did not request more time to file for good cause under §020(d)(11). Though Employer did not object on this basis untimely filing alone "may result in rejection of the submitted documents" under §020(d)(12).

Since Employer did not object to the documents on tardiness grounds, each will be reviewed on its merits. Technical rules relating to evidence do not apply in these proceedings unless otherwise stated in the law. 8 AAC 45.120(e). Any relevant evidence is admissible if it is the kind of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. Thus, some evidence may be admissible regardless of any common law or statutory rule which might make admission of such evidence improper in civil court. Hearsay evidence is admissible to supplement or explain direct evidence but it is not sufficient by itself to support a finding unless it would be admissible over objection in civil actions pursuant to §120(e).

Table I, above, briefly describes the documents to which Employer objected, its reasons for objecting and Employee's response; it is incorporated here by reference. Item 3, the pain prevalence article, is hearsay and not supported by any direct evidence. Furthermore, the article is simply a survey demonstrating pain prevalence in a population but does not address causation, which is the main issue in this case. It is irrelevant and will be excluded under §120(e). Documents comprising 6 and 7 are medical illustrations which, without expert testimony to explain them, are both hearsay, irrelevant and of little value to fact-finders who do not know whether or not they apply to Employee's situation. They will be excluded under §120(e). Document 8, an online Mayo Clinic article about diabetes, is irrelevant because Employee does not make a claim for diabetes except as precursor treatment may be necessary to allow treatment for his work injury. But the article does not address this precursor issue, which at this point appears to be undisputed in any event. It will be excluded under §120(e). Document 9, an online Mayo Clinic article about arthritis, is hearsay but several physicians have discussed arthritis and how it relates to Employee's claim. This article comes from a reputable online source upon which a reasonable person might rely to reach a conclusion. Though its usefulness in this case is limited, item 9 will be admitted into evidence pursuant to §120(e) and *Tolson*. Employee submitted no documents for item 10; he explained these were medical billings he requested directly from the adjuster, and Employer's attorney fee costs. There is nothing to admit or exclude here, and these two issues have been addressed elsewhere in this decision. Lastly, documents comprising items 11, 12 and 13, a Bush pilot's obituary, stories about the 25 worst sport injuries, and the Bush Pilot Hall of Fame article are irrelevant to any issue in this case because Employee is not mentioned in these articles and none involve a plane crash or its relationship to medical needs 30 years later. They will be excluded under §120(e). Notably, Employee had Dr. Carney testify as a biomechanical and medical expert and could have asked him to comment on these articles but never did.

2) Was the oral order striking one of Employee's four witnesses correct?

There have been three hearings in this case. Before each hearing, the parties attended a prehearing conference at which the hearing dates were set and the parties stipulated to file their witness lists in accordance with 8 AAC 45.112. Of all workers' compensation regulations, §112

is perhaps the simplest and easiest one with which to comply. *Rogers & Babler*. It requires parties to timely file their witness lists and gives specific instructions for the information required: A witness list must indicate whether the witness will testify in person, by deposition, or telephonically and must provide the witness's address, phone number "and a brief description of the subject matter and substance of the witness's expected testimony." The regulation further states if a party fails to file a witness list in accordance with §112 the panel "will exclude the party's witnesses from testifying at the hearing," but it will allow a party's testimony.

Employee's February 9, 2021 witness list was not in accordance with §112. For the most part, it listed the witness's names and addresses but provided no telephone numbers. Most importantly, the list provided no description of the subject matter or substance of any witness's expected testimony. Employer objected and at the panel's suggestion Employee went through the 15 listed witnesses and pared his list down to four people he actually wanted to call: Employee, his wife, Dr. Carney and biomechanical expert Dr. Ziejewski. Employer particularly objected to Employee calling Dr. Ziejewski, who filed no report and with whom Employer was unfamiliar. Employee contended Employer admitted it looked Dr. Ziejewski up on the Internet and he suggested that was adequate. Employer contended though it did search for information about Dr. Ziejewski, it had no idea what evidence this expert had reviewed and what his opinions might be. Therefore, Employer could not have a fair opportunity to prepare to cross-examine him at hearing.

Harren diverted responsibility for filing a non-conforming witness list onto various causes and people including: COVID-19; difficulties associated with the same due date for his hearing brief and witness list; an inexperienced office person; a relatively new associate attorney; and most notably Paddock, whom he blamed for failing to tell him that his witness list was nonconforming prior to hearing. Two licensed Alaska attorneys, Harren and his associate H. Lee, signed the witness list. Ultimately, Harren admitted, "I guess I didn't see that" non-conformance but asserted his prior witness lists used the same format and implied it was not a problem before.

After hearing extensive arguments from the parties, the panel granted Employer's objection in part and disallowed Dr. Ziejewski's testimony but allowed Employee, who as a party has a right

to testify pursuant to §112, his wife who had already been deposed and Dr. Carney who was an attending physician whose records had mostly already been filed. Harren's reference to his prior witness lists is not well taken. Employer had objected to Harren's June 9, 2020 witness list at the June 16, 2020 hearing for the same reasons, putting him on notice that his witness list format was non-conforming and could make his witnesses subject to Employer's successful petition to strike them. That Employer objected again to his February 9, 2021 witness list, which contained even less information than the first two non-conforming witness lists, should not have come as a surprise to him. Employee's two prior witness lists at least included the witness's phone numbers. Nevertheless, to ensure fairness the oral order still allowed Employee to call three out of the four witnesses he ultimately identified as those he wanted to call at hearing. AS 23.30.001(1), (4).

The witness list regulation is intended to prevent "trial by ambush." A basic witness list in conformance with §112 gives parties notice of who they can expect their opponent to call at hearing and in basic terms what they are expected to say. In response to Employer's June 16, 2020 objection to Employee's June 9, 2020 witness list, Harren suggested "obviously" Judy Jespersen would testify about things relevant to Employee's claim. But the same thing could be said of any witness on a witness list. However, a previously undisclosed expert witness like Dr. Ziejewski is different from witnesses who have already been deposed or whose role in a case may be fairly "obvious." An expert witnesses is precisely the person for which the witness list requirement is intended. Had Employee described the subject matter and substance of Dr. Ziejewski's expected testimony on his witness list and filed his "slides" or a written report 20 days prior to the hearing, he would have had at least a colorable argument that Employer was not prejudiced by the non-conforming witness list. But none of that happened. Instead, Employer while busy preparing for the upcoming hearing had to search the Internet to try to find out who this person was. Its research could not have determined much more than that about Dr. Ziejewski. No Internet research could help it reasonably prepare to cross-examine this witness at hearing. AS 23.30.001(1), (4).

Harren suggested Dr. Ziejewski was a last-minute addition to his witness list added only after the biomechanical issues arose during Dr. Bauer's February 4, 2021 deposition; if true, even that

would not have prevented him from filing a conforming witness list since Dr. Ziejewski agreed to testify a day before the witness lists were due. When asked by a panel member when he first knew Dr. Bauer had raised biomechanical issues, Harren said 2017, when he read Dr. Bauer's report and saw articles mentioned in a footnote. After a lengthy break at hearing, Harren corrected the record to say he first learned about the biomechanical issues at Dr. Bauer's February 4, 2021 deposition. It is troubling to note that Harren's February 12, 2021 attorney fee affidavit and attached itemization state he spent 1.2 hours reviewing Dr. Bauer's report and drafting a letter to Dr. Jensen on September 26, 2017, and that Harren offered into evidence at the June 16, 2020 hearing the studies referenced in the footnote in Dr. Bauer's 2017 EME report.

If witness list regulations are to have any purpose they must be followed; otherwise, they are just suggestions the parties can choose to follow or not follow at their option. Both parties have a right to a fair hearing and due process; "trial by ambush" is not due process. AS 23.30.001(1), (4). Harren has 38 years of lawyering. Two attorneys worked on this case, presumably reviewed the witness list, and signed it. This is not an instance where a self-represented litigant needs leeway in filing a witness list because he or she does not understand the rules. Under all the above circumstances, the oral order excluding Dr. Ziejewski's testimony was correct.

On a related matter, on the second hearing day after he was unable to call Dr. Ziejewski, Employee tried to walk back his previous day's statement limiting his witness list to four witnesses, by adding Dr. Jensen. About two years after Harren had sent Dr. Jensen a questionnaire, Dr. Jensen responded by answering "yes," to the two questions asked. He gave no further explanation for his answers. Twice Employer asserted its right to cross-examine Dr. Jensen. Employee never made Dr. Jensen available for cross-examination; he had at least two years to depose or otherwise compel him for examination but failed to do so. Dr. Jensen's questionnaire responses cannot be considered over Employer's Smallwood objection. 8 AAC 45.120(f), (h); 8 AAC 45.900(a)(1).

3) Was the oral order granting Employee's request to narrow the hearing's scope correct?

Employee's amended claim included permanent total disability and vocational rehabilitation benefits. These claims are contingent upon Employee successfully setting aside a settlement agreement. At hearing, he moved to narrow the issues to exclude his permanent total disability and vocational rehabilitation benefit claims, which necessarily included his implicit request to set aside the settlement agreement. Employer objected, contending Employee had no authority to alter the issues previously set for hearing, which included the issues he did not want to address.

The applicable prehearing conference summary "will limit the issues for hearing" and unless modified "governs the issues and the course of the hearing." 8 AAC 45.065(c); 8 AAC 45.070(g). The primary purpose behind these regulations is to avoid a party adding an issue at hearing without notice and for which the other party is not prepared. In other words, these regulations generally "limit" the hearing's scope to prevent a party from increasing the issues but do not necessarily prevent a party from narrowing its scope thereby decreasing issues. Furthermore, the result on the primary issue in this decision may obviate the need to address these other claims. Therefore, the oral order granting Employee's request to narrow the hearing's scope was correct.

4) Was the oral order denying Employee's discovery of Employer's attorney fees correct?

Harren averred at hearing that for various reasons he failed to capture all time for legal work performed on this case; consequently, he requested Paddock's attorney fee itemization. His primary purpose for discovering Employer's attorney fees was so Harren could review Paddock's attorney fee itemizations, compare and contrast her entries recording her interactions with Harren, and fill in any blanks in his own attorney fee affidavit. Employer objected stating Paddock had no duty to assist Harren in completing his itemization or attorney fee affidavit and noted the request was irrelevant and would violate the attorney-client privilege and attorney work product doctrines.

Employee provided no legal authority for his request. Employer has no legal obligation to assist Harren in creating his attorney fee itemization or affidavit. Furthermore, although in theory Paddock's attorney fee itemization could be redacted to exclude attorney-client privilege or work

product doctrine violations, this would create an unreasonable cost on Employer to provide evidence that Harren should have preserved himself. AS 23.30.001(1). If there was a discovery dispute on this issue, Employee should have taken the matter first to a prehearing conference where a designee would have made a discovery ruling from which either party could have appealed the properly framed issue. AS 23.30.108(c). There is no evidence this occurred. Thus, the oral order denying Employee's request to discover Paddock's attorney fee itemization was correct.

5) Should Employer be ordered to provide Employee's medical bills from its adjuster?

At hearing Employee also contended he tried to discover his medical bills Employer's adjuster received from providers, but all he received just before hearing were billings provided from Paddock's office. Employer contended Employee never requested the bills until after he filed his hearing request averring he was fully ready for hearing and had completed all discovery, after the hearing was already scheduled and at a time when less than 20 days remained before the hearing occurred. Nevertheless, Employer contends it provided Employee with all medical billings in its client's possession in less than the 20 days response time provided by law.

As with the previous discovery issue, if there was a dispute on this issue, Employee should have taken the matter first to a prehearing conference where a designee would have entered a discovery order from which either party could have appealed. AS 23.30.108(c). That did not happen. Employee presented no evidence suggesting Employer, its agents or representatives retained any medical billing information not already provided in response to Employee's request. Therefore, Employee's request for an order requiring the adjuster to provide medical bills will be denied.

6) Was the oral order denying Employee's reconsideration request correct?

An oral order granted Employer's request to disallow one of the four witnesses Employee ultimately identified from his 15-person list as those he wanted to call at hearing. He disagreed with this order and on the second hearing day requested reconsideration. Employer objected

noting the panel had no authority to reconsider a decision that had not yet been issued, and contending Employee presented no convincing reason why the order should be changed.

The Alaska Workers' Compensation Act does not address reconsideration. Reconsideration requests arise therefore under the Administrative Procedure Act (APA) AS 44.62.540(a), made applicable to this claim by AS 44.62.330(a)(12). AS 44.62.540(a) allows an agency to reconsider "part of the case" on a party's petition that must be filed with the agency "within 15 days after delivery or mailing of the decision." Thus, the panel at hearing had no statutory authority under the APA to reconsider because this decision had not yet issued. Arguably, AS 23.30.135(a) could give the panel authority to change an oral ruling striking a witness made at a hearing. But the panel had already determined that striking Dr. Ziejewski's testimony was "fair," accorded all parties "due process and an opportunity to be heard" and was the proper manner "by which it may best ascertain the rights of the parties." AS 23.30.001(1), (4); AS 23.30.135(a). Therefore, the oral order denying Employee's reconsideration request was correct. He may file a petition for reconsideration on this issue post-decision.

7) Was the oral order denying Employee's request for a continuance correct?

Employee sought a hearing continuance contending a potential conflict-of-interest between Harren and Employee may result in Harren withdrawing, leaving Employee with no attorney and with a written closing argument looming; this did not materialize. Continuances are not favored and are not routinely granted. 8 AAC 45.074(b). The two-day hearing was nearly completed when Employee requested a continuance; Employer objected. Hearings may be continued for "good cause." There are 14 recognized situations where "good cause exists." 8 AAC 45.074(b)(1)(A)-(N). Employee presented no evidence fitting squarely into any "good cause" category.

The closest he came was under §074(b)(1)(N) when he said excluding Dr. Ziejewski's testimony amounted to a litigation-ending sanction, which could result in "irreparable harm" to his client. But Employee did not exercise "due diligence" in preparing his witness list even after stipulating three times to prepare it under 8 AAC 45.112. Furthermore, he was on notice from Employer's objection to his non-conforming witness list at the June 2020 hearing that his witnesses could be

subject to preclusion. Lastly, Employee did not suffer "irreparable harm" without a continuance because Dr. Carney, who had additional training in spinal biomechanics engineering, testified a day prior and provided his biomechanical perspective. Therefore, the oral order denying Employee's request for a continuance was correct.

8) Should there be another SIME?

Employee's last attempt to continue the hearing so he could cure his witness list defect came with his request for a biomechanical SIME. Dr. Ziejewski is not a medical doctor and Employee presented no legal authority for his request for an SIME pitting a biomechanical engineer against a medical doctor. SIMEs are limited to medical disputes between Employee's attending physician and Employer's independent medical evaluator; no such dispute exists here. AS 23.30.095(k). Employee's request for another SIME will be denied.

9) Has the 1985 work injury remained a substantial cause of Employee's need for medical care and treatment for his spine and diabetes since 2016?

In his briefing Employee agreed Dr. Bauer's EME report rebutted the statutory presumption of compensability. Therefore, the presumption analysis need not be applied and Employee must prove his claim by a preponderance of the evidence. *Saxton*.

Neither party contends Employee had a preexisting spinal condition. Therefore, Employee does not contend his 1985 plane crash aggravated, accelerated or combined with some condition that existed before 1985 to cause his initial need for medical care or the need for medical care that arose when his medical claim began in 2016. He does not contend subsequent employment or self-employment caused his need for medical treatment beginning in 2016. Conversely, Employer has not raised a last-injuries-exposure defense attempting to place blame on a subsequent employer or Employee's self-employment. Both parties agree the *Shea* "but for" analysis applies.

This is an "old law" case; the basic legal standard for causation is "a substantial factor." The initial injury and its past compensability is not disputed and Employer paid Employee benefits until the parties compromised all but medical care and related transportation expenses in 1988;

Employee disputes what the settlement agreement released but at his request that issue is not decided here. The primary issue is whether or not Employee's 1985 work injury remains a substantial factor in his need for medical treatment beginning with his visit to Dr. Seth's office in 2016. He says it does; Employer says it does not. AS 23.30.010. Employee relies on his and his wife's testimony and on Dr. Carney's opinions. His legal theory is that the L5 compression fracture and resultant disc damage at L5-S1 continued to be a substantial factor in Employee's symptoms between 1985 and 2016, when his pain became so unbearable he decided to seek treatment. His diabetes-related claim is based only on his argument that Employer is responsible to treat his diabetes before his work-related conditions can be addressed. Employer relies primarily on medical records and on Drs. Bauer's, Levine's and Silver's reports or testimony. To prevail, Employee must prove his 1985 injury remains a substantial factor in his need for medical treatment for his spine and for precursor diabetes treatment beginning in 2016. *Saxton*; *Shea*; *Rogers & Babler*; *Traugott*.

A) Employee's evidence.

In February 2019 Employee testified that since his accident there were "really hardly any" days that he would call "zero pain, but it was tolerable"; after some prompting from his lawyer, he could "honestly say" that he had daily pain related to his original injury. Daily pain from 1985 until he saw Dr. Seth in 2016 could suggest a continuous symptom stream flowing from his original injury thus implying his work injury remained "a substantial factor" in his need for treatment in 2016. However, at hearing Employee testified, "I haven't had a pain-free day for years" and consequently, "I haven't had a full night sleep in many years." He did not testify that he had "continuous," or as his attorney urged "chronic, unrelenting pain" since his 1985 work injury.

At hearing Employee testified he dealt with "chronic pain" since the crash and it "finally caught up" with him. According to Employee, around the time Dr. Jensen performed low-back surgery Dr. Jensen told him he was "very positive" the plane crash was a substantial factor in his need for surgery. Employee also said a doctor who saw him in the local clinic after the crash told him he would someday have back problems but Employee could not remember his name. Dr. Jensen's and the un-named clinic physician's statements are hearsay and not supported by direct

evidence in contemporaneous medical records. Dr. Jensen's answers to Harren's questionnaire offers this conclusion but cannot be considered as discussed in detail below.

Medical records in Employee's file contradict his deposition and hearing testimony. His last relevant treatment with Dr. Carney occurred on June 16, 1987. Thereafter is a 20-year gap in Employee's medical records from June 16, 1987, until August 29, 2007. Employee testified he had health insurance during relevant times. If he were in continuing, progressing pain one would expect him to seek medical treatment. Not only do these records not reflect "continuous" or "chronic and unrelenting" pain since his 1985 crash, they state or imply exactly the opposite.

For example, after a two-decade hiatus, when he sought medical care for other reasons Employee did not mention his 1985 work injury to his doctors for many years. In August 2007, Dr. Hanley saw him for pneumonia and his report does not mention the 1985 crash or any orthopedic symptoms. While one could argue Employee would not discuss orthopedic issues when a doctor saw him for pneumonia, one would also think that if he had chronic or unrelenting spine pain he might at least mention it. In August 2007, Dr. Lange saw Employee for his lungs and diagnosed diabetes. "He apparently had been taking relatively high-dose steroids off and on since approximately January of this year, which were prescribed by an 'arthritis doctor' in Arizona." The report does not mention the 1985 injury or any spine complaints; the "arthritis doctor" is not otherwise identified. Moreover, Employee testified that Dr. Seth was the only physician he saw in Arizona for his back. This raises the question: Who did Employee see in Arizona for arthritis, what history did he give and where in his body were his arthritic complaints?

There is then a seven-year gap in Employee's medical records from August 2007, until September 2014. If he had continuous, chronic and unrelenting pain, Employee would have sought treatment, especially since he had health insurance. His history for this period provided in subsequent records includes a right ankle fusion in 2010 after he fell while standing on a five-gallon bucket or stepstool. Employee testified in his deposition that this occurred in his Arizona hanger. The fall was bad enough for Employee to break his ankle, which required surgery. There are no contemporaneous records in the agency file describing the fall, the ankle injury or any other possible injuries Employee may have sustained or reported when he fell.

After the seven-year gap, Employee testified that beginning in 2014, he started having bilateral leg issues and was "kind of falling down." There are no contemporaneous medical records showing if he had injuries or received treatment for these falls. On September 7, 2014, Employee reported to emergency room physicians that he had recently fallen on the ground and could not move his legs for 30 minutes. Employee's medical history at this visit did not include his 1985 plane crash. Though Employee testified a physician there told him he fell down because a disc in his low back had pinched a nerve, the medical records do not support this statement. In fact, the medical records for this visit do not include a definitive explanation for Employee's bilateral leg weakness and falling down episodes in late 2014. The differential diagnosis after numerous medical studies was a "mini stroke." Likewise, on September 8, 2014, Employee had MRI safety screening for cervical and thoracic spine MRIs to address his transient paralysis. His history given at that time included metal in his right ankle and coughing up blood but not the 1985 work injury. It is not credible to think an emergency room physician would mention a disc as the reason for Employee's fall but Employee would not even mention his 1985 work injury. AS 23.30.122; *Smith*.

In January 2015, Dr. Loreman saw Employee for a lung problem. His musculoskeletal system review was "normal" and his history did not record the 1985 plane crash or any cervical or lumbar symptoms. Employee continued to see Dr. Loreman off and on for a year for his lung condition. Her reports never mention cervical or lumbar symptoms or his 1985 work injury and Dr. Loreman recorded no musculoskeletal abnormalities. Again, arguably one could argue Employee might not discuss orthopedic issues or pain in his spine to his lung doctor. Nevertheless, on January 21, 2016, he did exactly that: Dr. Loreman recorded for the first time Employee's right arm symptoms and "significant back discomfort hip discomfort." The record still did not mention his 1985 injury.

On February 11, 2016, Employee had a cervical spine MRI for "neck and upper back pain" for "x 2 years." This information came from Employee and again contradicts his testimony.

On February 18, 2016, Employee sought care at Dr. Seth's office. Prior to seeing the doctor, Employee wrote on his New Patient Intake Form "neck-back pain" as the reason for his visit. He described his pain as constant and ranging from six to nine on a pain scale. Though he said he had this pain for "32 yrs.," which approximates his injury date, he still did not mention the 1985 accident by name. Most notably, when Employee completed this form in February 2016, when asked if there was "any injury or accident," Employee checked the "Yes" box and wrote "Fell" but did not also list his 1985 plane crash. In a subsequent record, the person completing it stated in response to a similar question about a precipitating factor for the visit said, "Yes, the patient fell." Employee reported his pain had increased "in the last five years," which correlates roughly with him falling from a bucket or stepstool, fracturing his ankle and having it fused in 2010.

On February 19, 2016, when Dr. Seth saw him, Employee finally mentioned the 1985 work injury; this is the date Employee says his claim for medical benefits begins. Dr. Seth recorded a precipitating injury or event as occurring when "the patient fell." Notwithstanding Employee's expressed precipitating event for this visit, this was the first time any medical record in the agency file recorded him at least mentioning the 1985 work injury since the parties' June 24, 1988 settlement agreement, 28 years earlier. It is inconceivable that if Employee had continuous, chronic and unrelenting symptoms from his work injury since 1985, he would not have sought medical treatment, given he had health insurance, and when he did seek treatment for potential work-related symptoms or other issues, would not even mention the work accident to any medical provider for 28 years or ascribe any responsibility to it. AS 23.30.122; *Smith*.

Moreover, on April 2, 2016, Employee's biggest complaints were his hips, not his spine; he did not include his hips in his claim. On April 16, 2016, Employee had bilateral hip injections to address hip osteoarthritis. On September 27, 2016, Employee told Dr. Jensen he had neck issues "for a while," but did not say he had them continuously since 1985, yet another contradiction.

In his March 2017 EME, Dr. Bauer noted the gap in Employee's medical records from 1987 through 2014, and recorded that Employee said he received "no medical care" during that interval. Employee testified at hearing that Dr. Bauer's evaluation was sub-par and Employee did not recall even discussing continuity of his symptoms from 1985 forward with Dr. Bauer. To

the contrary, Dr. Bauer took a history and Employee told Dr. Bauer he "got by okay" but his back would "bug him sometimes." There is a significant difference between Employee's back bugging him "sometimes" and continuous or chronic, unrelenting back pain.

In May 2019, Dr. Hirsch evaluated Employee and recorded a history of cervical and lumbar pain arising from a 1985 airplane accident. His symptoms were much as they had been "for several years" but Employee's history to Dr. Hirsch did not relate "continuous" or "chronic and unrelenting" pain since 1985. Again, there is a difference between having pain for several years and having it for 34 years. Moreover, knowing he had a hearing on his claim in just a few days, on January 26, 2021, Employee reported to APRN Rose the following history:

> [Employee] is a 57-year-old male who presents to the office for evaluation of low back pain and left lower extremity pain with numbness and weakness. Had a work injury in 1985 resulting in L5 compression fracture and had *mild low back pain off and on over the years*. Current symptoms *first started in spring of 2016*. . . . (emphasis added).

Lastly, in his March 2020 SIME Dr. Levine took a history from Employee and did not understand him to say he had continuing, chronic and unrelenting symptoms since 1985. Employee testified he thought Dr. Levine was not prepared for the evaluation and ascribed his lack of understanding to Dr. Levine's poor preparation. However, consistent with his other recorded histories Employee did not tell Dr. Levine he had continuous, chronic or unrelenting spine symptoms since 1985, which explains why Dr. Levine would not understand that he did. In other words, the problem was not Dr. Levine's misunderstanding, it was the history Employee presented. There are simply too many medical histories recorded by competent medical providers that disagree with Employee's testimony about the continuity of his symptoms since 1985. The medical records repeatedly demonstrate he reported symptoms far short of "continuous," or "chronic and unrelenting." While continuous, chronic and unrelenting spinal pain is not a prerequisite for Employee to prevail in his claim, the lack thereof in his medical records harms his credibility and adversely affects medical opinions relying on his unsupported testimony. Employee's medical records with his contemporary historical reports are given greater weight than Employee's deposition and hearing testimony to the contrary. AS 23.30.122; Smith.

Judy testified she observed daily some "partial impairment" in Employee's body; he always had some pain or discomfort. However, she also said Employee does not like to talk about himself and implied he does not comment on his pain. Consequently, assuming all this were true Judy may be able to recognize pain in Employee's face but would have no medical basis for determining where Employee felt the pain or what caused it. There is no question Employee has a strong work ethic and worked hard in self-employment beginning in 1994. Judy said between 1991 and 2000, Employee "worked all the time" even as a hobby. She could tell from his "body mechanics" that he was "hurting." In her opinion, the 1985 plane crash was a substantial factor in Employee's need for back surgery in 2016, because she saw his discomfort progress over the years.

But Employee described in detail how difficult it is to be an Alaskan Bush pilot pushing the plane around, lifting and twisting while loading and unloading heavy baggage and cargo while hunched over in small, cramped areas and sitting for long periods while piloting the planes. As Dr. Levine noted, these wear and tear activities are exactly what one would expect to cause disc degeneration throughout the spine over time and lead to a herniation. It would also cause Employee to have muscular aches and pains after a long day's work. *Rogers & Babler*. Judy, despite her lay observations and absent any explanation to her from Employee, would have no way of knowing whether the pain she perceived on Employee's face over the years came from 1985 accident residuals, the above-described daily work activities, his chronic abdominal pain or even his hip arthritis. Thus, her observations and testimony will be given little weight. AS 23.30.122; *Smith*.

Dr. Carney, a chiropractor with added training in orthopedics and spine biomechanics engineering, offered articulate and initially persuasive testimony. He said the 1985 plane crash caused a compression fracture near the right top of the L5 vertebra. In his opinion, this may have altered Employee's spine biomechanics and put excessive pressure on the disc below the L5 vertebra at L5-S1 causing microfiber tears in the annulus. In his view, over the years Employee's continued work as a Bush pilot and mechanic involved simultaneous twisting and lifting, which may have caused micro tears and the L5-S1 disc to leak nucleus material through

these tears and may have resulted in a herniation and extrusion. As support, Dr. Carney stated that 1986 x-rays taken at his clinic did not demonstrate degenerative changes in Employee's spine, but on 1987 x-rays he found early degenerative changes only in the L5-S1 disc. Accordingly, he opined there was a direct causal link between the 1985 crash and Employee's need for lumbar surgery in 2016.

There are problems with Dr. Carney's testimony. First, his ultimate opinions were based on the hypothetical assumption that Employee "never overcame the pain in his back" and had symptoms on a "practically daily basis" for 30 years post-injury. As discussed above, Employee's medical records and the histories he gave therein do not support this assumption. This decision gave greater credibility and weight to Employee's medical records than it did to his and his wife's testimony. Consequently, this weakens Dr. Carney's opinions based on an incorrect assumption.

Second, only Dr. Carney in his May 1987 report noticed early degenerative disc disease at L5-S1. Drs. Person and Magnuson, an orthopedic surgeon and radiologist respectively, reviewed x-rays only 78 days before Dr. Carney's May 1987 opinion and did not report any degenerative disc disease at L5-S1 and found Employee's spine x-rays were otherwise negative but for a "slight" L5 compression fracture. Greater credibility and weight will be given to the orthopedic surgeon's and radiologist's x-rays and interpretations than to the chiropractor's. *Moore*; AS 23.30.122; *Smith*.

Next, Dr. Carney's opinions are based largely on presumptions about what could happen or may happened in the spine given Employee's accident. Even though Dr. Carney did not examine Employee for 32 years between 1987 and 2019, he nonetheless assigns the 1985 L5 compression fracture as the inevitable starting point for what he presumes was L5-S1 degenerative disc disease, which progressed over time aggravated merely by Employee trying to stand up straight and by his normal work duties, which eventually resulted in a disc herniation discovered at L5-S1 in 2016. While criticizing Dr. Bauer's opinion, which he incorrectly describes as blaming all degeneration in Employee's spine on "old-age," Dr. Carney does the same thing in reverse and opines that the early degenerative disc disease that only he observed in 1987 at L5-S1 necessarily

remained a substantial factor and progressed over 32 years ultimately resulting in a herniated disc in 2016. This cuts against credibility and weight given to Dr. Carney's testimony. AS 23.30.122; *Smith*.

Lastly, Dr. Carney testified that if Employee's lumbar spine symptoms were caused by ordinary disc desiccation over time, he would expect to see degenerative disc disease throughout his spine and the degeneration should be relatively consistent. As discussed below, Employee's spinal imaging tends to show disc disease at all spinal levels, with L5-S1 being the notable exception. Dr. Levine testified a person need not have a specific injury to have a herniated disc and there need not be similar disc degeneration at all spinal levels for aging and ordinary work activities to be substantial factors in causing a disc herniation -- or to rule out a 32-year-old work injury as still a substantial cause. Greater weight on this issue is given to Dr. Levine's opinion as an orthopedic surgeon. *Moore*; AS 23.30.122; *Smith*.

B) Employer's evidence.

In 2014 Dr. Chen found mild degenerative changes including "disc desiccation" at all levels and three bulging disks in the lower thoracic and upper lumbar spine on MRI. Dr. Hirsch in 2014 diagnosed disc degeneration in the lumbosacral region. In 2014 Dr. Burton found "age-appropriate" spondylosis in the thoracic spine and "small disc protrusions" on Employee's MRI. Employee's 2014 cervical MRI showed "mild annular bulging" in the C4-5 disc. Dr. Dubbs a radiologist found mild mid- and lower-thoracic disc degeneration with shallow disc protrusions on Employee's 2016 thoracic MRI. In 2016 radiologist Dr. Gasser found mild degenerative changes in the cervical spine. In 2016, a lumbar MRI showed mild degenerative changes throughout the lumbar spine. A 2016 lumbar MRI disclosed mild disc bulges from T12 through L4; mild disc height loss and a "moderate disc bulge," at the L5-S1 level. Radiologist Dr. Kincaid's impression was, "Multiple levels of lumbar spine degenerative change . . . which are worst at the L5-S1 level." Employee's 2016 cervical x-rays showed mild, multilevel degenerative changes more prominent involving the facet joints and best seen at C5-6. In 2016 Dr. Jensen noted mild foraminal changes bilaterally at C4 through C6 and a small spur on the right at C6-C7. Lastly, on Employee's 2017 lumbar MRI radiologist Dr. Gasser found degenerative changes in upper spinal levels. These findings, reported mostly by radiologists, are consistent with degenerative disc disease in Employee's spine. They support Drs. Bauer's and

Levine's opinions ruling out the 1985 work injury as a substantial factor in Employee's need for treatment in 2016, and their opinions that normal aging and his physically demanding self-employment over the years caused his symptoms and need for treatment. These imaging reports are given sizable weight. AS 23.30.122; *Smith*.

EME Dr. Bauer also supports Employer's position. He testified Employee's medical records from 1985 through 1987 showed no injury to his L5-S1 disc. No medical records after 1987 until 2016 reported continuous back pain. In his opinion, Employee's diagnostic imaging was consistent with degenerative disc disease because there was disc desiccation at multiple levels; and disc desiccation occurs at varying rates. Dr. Bauer opined the diagnostic imaging was "very characteristic of a systemic disease rather than a result of trauma." He agreed with Dr. Seth's assessment that Employee's pain was caused by arthritis and degenerative changes; Dr. Bauer saw no causal connection between Employee's L5 compression fracture and Dr. Seth's diagnoses. He found no atrophy in any muscles, which showed Employee had been using them symmetrically, countering Dr. Carney's opinion on Employee's intrinsic muscle use to remain standing straight up. Agreeing with radiologist Magnuson, Dr. Bauer found Employee's compression fracture was "minor." He opined "something new and different" occurred in 2016 causing him to have "very severe pain." Dr. Bauer persuasively explained the disc herniation at L5-S1 occurred at the back of that disc, below the L5 vertebra whereas the compression fracture happened at the top front of the L5 vertebra, and the compression fracture had nothing to do with the disc herniation 31 years later. He concluded the 1985 work injury was not a substantial factor in causing treatment Employee began receiving in 2014 based on his opinion that Employee had a natural healing process from the L5 compression fracture and then another disease started. Even Dr. C. M. Carney opined in 1987 that Employee had a "remarkable recovery" from his accident. *Steffey*; *Moore.*

Dr. Bauer referenced studies examining the more serious "burst fracture" situation and found no study showed even a burst fracture would affect the disc in the space below the fractured vertebra. If anything, studies show that with a burst fracture if there is to be any damage to a disc, it would be the disc adjacent to vertebra's burst plate, not in the next disc space beneath the vertebra. Figure I, above, attached to his deposition, visually demonstrated the basis for his opinion. He ruled out the work injury as a substantial factor in Employee's subsequent

symptoms and offered his work as a Bush pilot thereafter as the cause for a "spontaneous" herniation and for his cervical and lumbar spine symptoms. Dr. Bauer assigned responsibility for medical treatment Employee received in 2016 to his subsequent work and aging. *Steffey*; *Moore*; *Shea*. His opinions make sense, are supported by the records and are given considerable weight. AS 23.30.122; *Smith*.

Dr. Levine is an impartial SIME orthopedic surgeon selected randomly from the division's SIME list. He reviewed Employee's symptoms post-injury, reviewed all available records and ruled out the work injury as "a substantial factor" for Employee's treatment beginning in 2014. Dr. Levine offered Employee's subsequent normal activities of daily living and work as the alternate cause for these treatments. His initial responses were confused because Employer's first written SIME question used the wrong legal standard for a 1985 injury and included a "the substantial factor" standard rather than "a substantial factor." Nevertheless, Employer successfully rehabilitated his opinions in his deposition where Dr. Levine clearly opined the work injury was not a substantial factor in bringing about Employee's back symptoms and need for treatment 30 years later. He adequately cleared up any initial confusion between "a substantial factor," which he defined as a major factor and "the substantial factor," which he said would be the greatest factor. Dr. Levine said the 1985 work injury was neither "a" nor "the" substantial factor. The alternative cause was normal aging and Employee's continued work activities over 30 years following the work injury. *Steffey*; *Moore*; *Shea*.

Dr. Levine identified Employee's post-injury work duties as precisely the kind of work that would cause degenerative disc disease in the spine and ultimately lead to a lumbar disc herniation. He corroborated Dr. Bauer's opinion that Employee's diagnostic imaging showed degenerative disc disease throughout his spine, which he expressly stated would not be attributable to an L5 compression fracture in 1985. Dr. Levine also corroborated Dr. Bauer's opinion that a compression fracture near the top of vertebral body L5 would not result in a disc herniation below the L5 vertebral body in the L5-S1 disc space. He opined a disc herniation caused by a compression fracture, if it occurred at all, would occur much closer in time to the fracture; this one did not. At one point Dr. Levine said "a portion of the symptoms would be due to the plane accident," but added any residual pain would be local back pain and not radical pain,

which was consistent with a disc herniation. He also added that portion would not be a substantial factor. Moreover, Dr. Levine's opinions track favorably with the medical records and agree in large measure with Dr. Bauer's. His orthopedic surgeon opinions are given considerable credibility and weight. *Steffey*; *Moore*; *Shea*; AS 23.30.122; *Smith*.

Employee's relevant work injury for his low back was an L5 compression fracture; a cervicothoracic strain was diagnosed for the remainder of his spine. Employee's evidence does not demonstrate the L5 compression fracture or his cervicothoracic strain progressed and remained a substantial factor in his need for treatment beginning in 2016. His 2016 treatment addressed a herniated L5-S1 disc, which caused radicular symptoms into his legs. Only Dr. Carney tried to associate mild degenerative disc disease at L5-S1, which only he saw and attributed to the compression fracture, to a herniated disc in 2016; his opinion was given less weight. In summary, the medical records and Drs. Bauer's and Levine's orthopedic surgeon opinions are given significantly greater weight and are more credible than Dr. Carney's chiropractic opinion and Employee's and his wife Judy's lay opinions. *Steffey*; *Moore*; *Shea*; AS 23.30.122; *Smith*. Based upon the above factual findings, conclusions and analysis, Employee failed to meet his burden of persuasion; the 1985 work injury was neither a factual cause nor a legal cause for his treatment beginning in 2016 for his spine and his claim for medical benefits and related transportation expenses beginning in 2016 will be denied. Since he has not prevailed on his primary claim, his claim for diabetes-related treatment will also be denied. *Traugott*; *Steffey*; *Moore*; *Shea*; *Saxton*.

10) Is Employee entitled to interest and an attorney fee and cost award?

Because Employee has not prevailed in any issue in his claim, he is not entitled to an associated interest, attorney fee or cost award. His claims for these will be denied.

CONCLUSIONS OF LAW

1) Employer's petition to strike Employee's evidence will be granted in part and denied in part.
2) The oral order striking one of Employee's four witnesses was correct.
3) The oral order granting Employee's request to narrow the hearing's scope was correct.

4) The oral order denying Employee's discovery of Employer's attorney fees was correct.
5) Employer will not be ordered to provide Employee's medical bills from its adjuster.
6) The oral order denying Employee's reconsideration request was correct.
7) The oral order denying Employee's request for a continuance was correct.
8) There will not be another SIME.
9) The 1985 work injury has not remained a substantial factor in Employee's need for medical care and treatment for his spine and diabetes since 2016.
10) Employee is not entitled to interest and an attorney fee and cost award.

ORDER

1) Employer's petition to strike Employee's evidence is granted in part and denied in part in accordance with this decision. Item #9, the online Mayo Clinic arthritis article is admitted; all other evidence Employee filed electronically on February 1, 2021 is excluded.
2) Employee's request that Employer provided Employee's medical bills directly from its adjuster is denied in accordance with this decision.
3) Employee's request for another SIME is denied.
4) Employee's claim for medical and related transportation expenses for his cervical, thoracic and lumbar spine, beginning with Dr. Seth's 2016 office visit and any precursor diabetes treatment is denied in accordance with this decision.
5) Employee's claims for interest, attorney fees and costs are denied.

Dated in Anchorage, Alaska on March 19, 2021.

ALASKA WORKERS' COMPENSATION BOARD

/s/
William Soule, Designated Chair

/s/
Robert C. Weel, Member

/s/
Nancy Shaw, 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 Jay Jespersen, employee / claimant v. Tri City Air, employer; Alaska Insurance Guaranty Association, insurer / defendants; Case No. 198528817; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by certified US Mail on March 19, 2021.

/s/
Nenita Farmer, Office Assistant