ALASKA WORKERS' COMPENSATION BOARD

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

GREG WEAVER, Employee, Claimant, v. ARCTEC ALASKA, Self-Insured Employer, Defendant.	FINAL DECISION AND ORDER AWCB Case No. 201320030 AWCB Decision No. 21-0068 Filed with AWCB Fairbanks, Alaska on July 26, 2021

Greg Weaver's July 31, 2018 claim was heard in Fairbanks, Alaska on June 3, 2021, a date selected on March 26, 2021. An August 19, 2020 affidavit of readiness for hearing gave rise to this hearing. Greg Weaver (Employee) appeared telephonically and represented himself. Attorney Nora Barlow appeared telephonically and represented Arctec Alaska (Employer). There were no witnesses. The record closed following deliberations on June 15, 2021.

ISSUES

Employer contends Employee's claim for a 2010 injury is barred by the doctrine of res judicata. It contends Employee's instant claim seeks the same benefits from the same employer, and is based on the same theory, as his claim for the 2013 injury; and his claim for the 2010 injury should have been raised at the same time his claim for the 2013 injury was decided. Employer contends it has incurred incredible expense defending against Employee's claims and it is now being forced to incur even more litigation costs, so the instant claim is exactly the type of claim the doctrine of res judicata is intended to bar.

Employee did not file a hearing brief and neither did he address the application of res judicata at hearing, so his position is unknown. However, it is presumed he opposes the application of any bar to his claim.

1) Is Employee's instant claim barred as res judicata?

Employee contends specific deposition testimony from the second independent medical evaluator (SIME) supports his claim a December 7, 2010 work injury is the substantial cause of his disability and need for medical treatment after January 2014. He seeks an award of benefits set forth in his claim.

Employer contends the reasons that demand the application of res judicata to bar Employee's claim for the 2010 injury also dictate the conclusion Employee cannot prevail on his instant claim. It contends Employee has not submitted any additional evidence that would lead to a result different from that reached in *Weaver III*, which denied Employee benefits arising from a 2013 injury. Employer contends the panel in *Weaver III* considered the SIME physician's deposition testimony on which Employee now relies, but, at the time of hearing, the panel also had more information available to it than the SIME physician did at the time of his deposition, so Employee's claim should be denied here as well.

2) Is Employee's December 7, 2010 injury the substantial cause of his disability or need for medical treatment?

FINDINGS OF FACT

The following facts and factual conclusions are established by a preponderance of the evidence:
1) In 1991, Employee received an "OTHER THAN HONORABLE" discharge from the United States Marine Corps for alcohol abuse rehabilitation failure. In 1993, Employee was convicted of DUI after a motor vehicle accident that left him with a lacerated aorta, upper extremity brachial plexus injury, pancreatitis and a traumatic brain injury. In 2015, Employee was convicted of DUI after an incident that occurred in 2014, where he was riding his ATV in a construction zone and harassing a flagger, who was his wife. Following his 2014 DUI arrest, Employee attended an

inpatient treatment facility in Georgia for substance abuse. Employee's wife filed for divorce in 2014 and sought both short and long-term protective orders, citing alleged alcohol abuse and physical abuse by Employee. Short-term and long-term protective orders were granted. In 2017, Employee was charged with a third DUI. (DD-214; Fu report, April 21, 1993; Weaver, Jr.; Summary of Proceedings, January 15 and January 16, 2015; Vivian Weaver Divorce Complaint, January 22, 2014; Petition for Domestic Violence Protective Orders, December 15, 2014; Short-Term Domestic Violence Protective Order, December 15, 2014; Long-Term Domestic Violence Protective Order, January 16, 2015; CourtView party information, undated).

2) On February 25, 2001, Employee was cleaning a truck while working for a former employer when he injured his lower back. He was taking Flexeril and Aleve but felt these medications did little to resolve his lower back pain. (Northern Chiropractic chart notes, March 8, 2001). Due to Employee presenting with moderate to severe pain, his chiropractor desired to treat Employee in excess of the Alaska frequency standards. (Physician's Report, March 12, 2001).

3) On March 25, 2009, Employee was evaluated and treated for low back pain after performing heavy labor in cold weather. (Eagle River Family Practice chart notes, March 25, 2009).

4) On December 7, 2010, Employee injured his low back tightening tire chains on a dump truck and road grader while he was working as a relief station mechanic at the Tin City Radar Site. (First Report of Occupational injury or Illness, December 9, 2010).

5) On January 12, 2011, Employee sought chiropractic treatment for low back pain that began about one month previous. He reported his pain level was 5 out of 10 and the pain would come and go on a daily basis. (Larson Chiropractic Registration and History, January 12, 2011). He also reported pain levels of 2 to 6 out of 10. Since Employee was leaving for work the following Monday, the plan was to treat Employee for two more days; then, reassess treatment frequency when Employee returned from work. (Larson Chiropractic chart notes, January 12, 2011).

6) On January 13, 2011, Employee reported his pain level was 1 out of 10 and that he "felt good last night" but "tensed up" last night and this morning. (Larson Chiropractic chart notes, January 13, 2011).

7) On January 14, 2011, Employee reported no lower back pain that morning and "felt good last night as well." Employee was going to work for between two to four weeks and he was instructed on lower back exercises. (Larson Chiropractic chart notes, January 14, 2011).

8) Upon his return from work, Employee sought no further treatment from his chiropractor until August 15, 2011. (Observations).

9) On August 15, 2011, Employee next sought medical treatment for upper back pain and stiffness. He reported "doing a lot of activity" and thought that was what caused his discomfort. Cervical and thoracic strain/sprain were assessed. (Larson Chiropractic chart notes, August 15, 2011). Employee did not relate his need for medical treatment to work. (Observations).

10) On October 22, 2011, Employee reported experiencing left hand and forearm numbness at work between October 9, 2011 and October 22, 2011, but he did not know "how it happened." (Report of Occupational Injury or Illness, October 28, 2011).

11) On October 14, 2011, Employee reported minor burns when melted solder dripped on his right hand at work. (Report of Occupational Injury of Illness, October 18, 2011).

12) On October 22, 2011, Employee reported a swollen left knee after it hit the bottom of a heat exchanger at work. (Report of Occupational Injury or Illness, October 28, 2011).

13) On February 16, 2012, Employee reported injuring an unspecified area of his spine while installing garage door panels at work. (Report of Occupational Injury or Illness, February 16, 2012). He did not seek medical treatment for this injury. (Observations).

14) On February 17, 2012, Employee sought treatment from Heather Martin, N.P., for low back pain, which had been intermittent for the last five years. Previous back treatment had included osteopathic adjustments, which significantly improved Employee's low back pain, and chiropractic adjustments, which also improved his low back pain for a period-of-time. Employee's medical history was significant for mild depression, and he reported "drinking more alcohol than he probably should." A urine dip revealed a moderate amount of blood was present. Low back pain and hematuria were assessed, and a renal stone study was ordered. Nurse Practitioner Martin also discussed getting a lumbar magnetic resonance imaging (MRI) study, although she did not think Employee had any disc pathology but, rather, "more of an ongoing chronic issue." She planned to discuss treatment options for Employee's low back pain after renal stone was ruled-out. (Martin chart notes, February 17, 2012).

15) On February 24, 2012, Nurse Practitioner Martin notified Employee his renal stone study was negative but rather consistent with history of trauma from a car accident 14 years previous where Employee was hospitalized for seven weeks and included a ruptured diaphragm and abdominal aorta. Employee reported his urine had returned to a lighter yellow color after drinking

more water and reported his back pain seemed to have resolved. He declined a referral to the Alaska Spine Institute. (Martin chart notes, February 24, 2012; inferences drawn therefrom).

16) On April 12, 2013, Employee's supervisor, Troy Klingfus, emailed Employer expressing his concerns that Employer had not provided rigging for he and Employee to handle 180-pound valves they were moving. Mr. Klingfus was concerned he or Employee might be injured. (Klingfus email, April 12, 2013).

17) On July 23, 2013, Employee reported waking up with back pain after shoveling, erecting scaffolding and pushing a wheelbarrow while working as a station mechanic on Barter Island, Alaska. (First Report of Injury of Illness, July 26, 2013).

18) On July 26, 2013, Employee sought treatment for low back pain from Joyce Restad, D.O., and reported, "He had been shoveling large amounts of sand and gravel in Kaktovik. He slept on an old, soft, bed with a thin mattress and unsupportive 'springs', and woke up in a lot of pain, on 7/23/13." Dr. Restad ordered a lumbar MRI. (Restad reports, July 26, 2013; July 29, 2013).

19) An August 2, 2013, MRI was interpreted to show mild lower lumbar degenerative disc changes with moderate bilateral neural foraminal stenosis at L5-S1. (MRI report, August 2, 2013).

20) On August 9, 2013, Employee's low back pain was now radiating into his buttocks. He reported he had this pain for over a year and thought it was a kidney stone passing. An epidural steroid shot was recommended. (Algone Interventional Pain Clinic chart notes, August 9, 2013).

21) On August 16, 2013, Dr. Restad referred to Employee's injury as an "overuse injury 7/23/2013 at work." Dr. Restad noted Employee was scheduled to receive three epidural steroid injections, but Employer's case manager thought this treatment was "aggressive" and requested a second opinion, to which Dr. Restad agreed. (Restad chart notes, August 16, 2013).

22) On August 20, 2013, Dr. Restad referred Employee to Dr. Shawn Johnston, M.D. (Restad referral, August 20, 2013).

23) On August 21, 2013, Employee saw Dr. Johnston, who opined most of Employee's pain was facet-mediated and he recommended physical therapy, between one to three times per week, for four weeks. (Johnston chart notes, August 21, 2013)

24) On August 30, 2013, Employee underwent a physical therapy evaluation and reported he was experiencing the worst episode of back pain he could recall. (Excel Physical Therapy chart notes, August 30, 2013).

25) On October 4, 2013, Dr. Johnston noted physical therapy had not provided Employee with much relief, so he decided to "try some lumbar traction over the next two weeks." (Johnston chart notes, October 4, 2013).

26) On October 14, 2013, Employee began traction therapy with Thomas DeSalvo, D.C. Employee's back pain was now radiating into both buttocks. After numerous treatments, Employee reported his back pain "come [sic] and goes but lately not getting any better." Dr. DeSalvo reported Employee's prognosis was "guarded," and his impression was Employee has "sustained a cumulative trauma injury to the lumbrosacral spine (chronic)." (DeSalvo reports, October 14, 2013 to November 1, 2013).

27) On October 28, 2013, Dr. DeSalvo updated Dr. Johnston's office on Employee's progress. Employee had asked Dr. DeSalvo to decrease the weight of his traction, but since the weight was already relatively light, Dr. DeSalvo thought doing both physical therapy and traction "are too much." Dr. DeSalvo recommended putting physical therapy on hold. (Alaska Spine Institute chart notes, October 28, 2013).

28) On October 31, 2013, Dr. DeSalvo thought Employee's condition was work related. (Physician's Report, October 31, 2013).

29) On November 3, 2013, Dr. Johnston discontinued lumbar traction since it seemed to aggravate Employee's symptoms and since he was considering prescribing a work hardening program instead. (Johnston chart notes, November 4, 2013).

30) On November 11, 2013, Employee began an eight-week work hardening program. (Initial Evaluation, November 11, 2013).

31) On December 10, 2013, Dr. Johnston discontinued Employee's work hardening program because Employee could not tolerate it. Employee continued with physical therapy, but did not improve. (Alaska Spine Institute chart notes, December 10, 2013; Linn report, December 30, 2013).

32) On January 9, 2014, Stephen Marble, M.D., a physiatrist, conducted an EME, during which Employee initially related his current low back symptoms to performing strenuous labor and sleeping on a bed with little support "sometime during the summer of 2013." Later in the evaluation, Employee commented, for the last three to four years, he had had low back pain so severe that he had to lay down in the fetal position, squeeze his legs, and rock back and forth. Dr. Marble noted Employee to be a "vague/poor historian." Upon reviewing the August 2, 2013, MRI,

Dr. Marble saw significant disc desiccation at L4-5 and L5-S1 with a significant loss of disc height at L5-S1, as well as a broad based disc protrusion at L4-5 and a "very broad based" disc protrusion at L5-S1. Dr. Marble assessed multilevel lumbar degenerative disease, greatest at L5-S1, and thought Employee's recorded history and the imaging findings were evidence of a preexisting, evolving, lumbar degenerative disease. Although Dr. Marble acknowledged there was certainly the potential for the work factors Employee described causing a symptomatic aggravation, because Employee did not describe a specific mechanism of injury, he thought Employee had been experiencing evolving degenerative disc disease symptoms over the course of approximately three years. The substantial cause of Employee's lumbar condition, according to Dr. Marble, was a combination of the combined effects of heredity, aging and possibly the remote 1993 major trauma. (Marble report, January 9, 2014).

33) On January 24, 2014, Employer controverted Employee's benefits based on Dr. Marble's January 9, 2014 report. (Controversion Notice, January 24, 2014).

34) On February 3, 2014, Employer's nurse case manager prepared a letter to Dr. Johnston, which included "check-the-box" answers for Dr. Johnston to indicate whether or not he agreed with the opinions set forth in Marble's January 9, 2014, EME report. On that same date, Dr. Johnston checked each box "yes," indicating he agreed with Dr. Marble's opinions, including Dr. Marble's opinion that no specific medical treatment was reasonable and necessary for Employee's work-related aggravation of his preexisting condition. Dr. Johnston memorialized the meeting with Employer's nurse case manager in a chart note titled "CARE CONFERENCE," where he wrote the following: "Today was a 15-minute care conference with nurse case manager . . . . I did fill out paperwork detailing [Employee's] work-related injury and his treatments." (Davis letter, February 3, 2014; Johnston chart note, February 3, 2014).

35) On February 18, 2014, Dr. Restad authored a letter describing Employee's work activities at the time of the 2013 work injury and urging Employer to "reconsider." On February 21, 2014, Dr. Restad wrote another letter "in support" of Employee, relating an assessment of lumbar strain to his work. She again urged Employer to "re-consider." (Restad letters, February 18, 2014; February 21, 2014).

36) On February 21, 2014, Employee filed a claim for a low back injury sustained on July 23, 2013 while "lifting and twisting while erecting scaffolding; pushing wheelbarrow; shoveling large amounts of sand and gravel while on knees; followed by sleeping in camp on old, thin mattress;

woke the next morning with intense pain radiating into the buttocks." He sought temporary total disability (TTD), temporary partial disability (TPD), permanent total disability (PTD), permanent partial impairment (PPI), medical and transportation costs, a reemployment eligibility evaluation, penalty, interest, a finding of unfair or frivolous controversion, attorney fees and costs and an SIME. (Claim, February 19, 2014).

37) On April 10, 2014, Employee called a veteran's crisis hotline. The call synopsis states:

> SUICIDAL IDEATION WITHOUT PLAN OR INTENT. [EMPLOYEE] TALKED MORE ABOUT FLEETING THOUGHTS AS THE ONLY WAY TO SOLVE THE MULTIPLE ISSUES HE'S EXPERIENCING CURRENTLY. VETERAN HAS A LOT OF PSYCHOSOCIAL ISSUES (WORKER'S COMP APPEAL, BACK PAIN, $65K IN CC DEBT, WIFE LEFT, TBI FROM SKULL FRACTURE AND THE INABILITY TO WORK D/T BACK ISSUES ETC). . . . VETERAN WOULD LIKE ASSISTANCE CONNECTING WITH MENTAL HEALTH TREATMENT AND TO EXPLORE THE OTHER SERVICES AVAILABLE THROUGH THE VA THAT HE MAY BE ELIGIBLE FOR.

[Caps in original]. Employee was assigned a social worker, who followed-up with him:

> Vet contacted the crisis line after feeling overwhelmed with several different stressors. He stated he was on worker's comp for several months and it stopped three months ago. He apparently is in the appeals process due to the chronic back pain. During his time off, he began to realize that his marriage was failing. He has been working in remote areas for several years taking him away from home for extensive amounts of time. His wife had been working as a highway flagger[,] which requires long hours during working months. [Employee] stated that his spouse left with their two children (boys 9 and 11 years old) about three months ago. He has had approximately 4 visits with his sons during this time. He acknowledged that they are more comfortable with his wife. He expressed a desire to work on the relationship with his children. [Employee] reported that approximately 20 years ago he was involved in a MVA that left him hospitalized for 7.5 weeks with the first few weeks being in a coma. He apparently suffered a head injury. The accident was the result of driving under the influence of etoh. He reportedly stopped drinking for quite some time. He now has returned to self-medicating with etoh nightly due to sadness being alone. [Employee] reportedly can drink ½ gal of Vodka within 4-6 days. He stated he does not drink every day. He denied any withdrawal sx during periods of avoidance. [Employee] described the impact of being alone has had on his mood since his family moved out.

After examining Employee's risk and protective factors, the social worker concluded Employee was at a low risk potential for suicide. The plan for Employee included him pursuing information on medication options for depression and anxiety treatment. Employee also agreed to a mental

health intake and medication evaluation appointments. (Call Synopsis and Roush Progress Notes, April 11, 2014).

38) On May 14, 2014, Employee reported severe pain in his lumbar spine that radiated into his buttocks. He also stated he was "having a lot of family issues going through a divorce and issues with a workers comp claim." Tramadol was prescribed for Employee's low back pain. (Inouye report, May 14, 2014).

39) On May 21, 2014, Andrea Trescott, M.D., evaluated Employee for low back pain and recommended a left transforaminal epidural steroid injection at L5-S1. (Trescott chart notes, May 21, 2014).

40) On May 22, 2014, Employee reported Tramadol had not helped with his low back pain. (Inouye chart notes, May 22, 2014).

41) On May 23, 2014, Dr. Trescott administered an epidural steroid injection at L5-S1. She also responded to questions from Employee's attorney concerning the 2013 injury and opined Employee's low back symptoms were substantially caused by his work activities. (Trescott chart notes, May 23, 2014; Trescott responses, May 23, 2014).

42) On June 10, 2014, Dr. Restad responded to questions from Employee's attorney concerning the 2013 injury and opined Employee's low back symptoms were substantially caused by his work activities. (Restad responses, June 10, 2014).

43) On June 17, 2014, Employee amended his claim for the July 23, 2013 low back injury "due to a traumatic incident and / or cumulative trauma sustained in the course and scope of his employment." He sought ongoing TTD from January 15, 2014, PPI, medical and related transportation benefits, reemployment stipend, interest and attorney fees and costs. (Claim, June 17, 2014).

44) On July 10, 2014, a lumbar spine MRI showed a diffuse disc bulge and mild facet arthritis, but no stenosis, at L3-4, a diffuse disc bulge and mild facet arthritis with minimal foraminal stenosis at L4-5, and a diffuse disc bulge and bilateral facet arthritis with moderate bilateral neural foraminal stenosis at L5-S1. These findings were unchanged from the August 2, 2013 MRI. (MRI report, October 8, 2014).

45) On July 24, 2014, Employee filed a request for cross-examination of Dr. Marble's January 9, 2014 EME report, and Dr. Johnston's February 3, 2014 concurrences with Dr. Marble's report. (Request for Cross-Examination, July 22, 2014).

46) On August 26, 2014, Employee testified, after Dr. Trescott administered the epidural steroid injections, he "felt great for a day," and "pretty good" the second day, but over the course of several weeks, "it eventually wore off." (Weaver depo. at 9). Employee has problems with both his short-term and long-term memory resulting from his automobile accident. (*Id*. at 11). Employee served in the U.S. Marine Corps and was discharged in 1991. (*Id*. at 15). Employee initially testified he could not remember why he was discharged from the military, (*id*. at 17), but later testified he was discharged for trouble involving alcohol, (*id*. at 46). At the time of his deposition, Employee was going through a divorce, (*id* at 13-14), and had been arrested in July for a DUI after driving his four-wheeler through a construction zone, (*id*. at 45). Employee also had a DUI 20 years ago. (*Id*. at 46). Employee's wife contends alcohol was an issue leading up to the divorce but Employee does not agree with his wife's contentions. (*Id*. at 46). Employee initially testified he was currently in treatment for alcohol abuse, (*id*. at 45), then later testified he was "thinking about doing that," (*id*. at 46). When asked if he had a pattern of problems involving alcohol, Employee answered, "If you say so." (*Id*.). Employee does not think alcohol is a problem for him, but rather "underlying issues" his problem. (*Id*. at 47). All the pills Employee has "don't really seem to help" his pain, and alcohol is "all that really seems to take [his] pain away." (*id*. at 47-48). Physical therapy and work hardening did not help Employee. (*Id*. at 48). Employee had been working at the Barter Island Radar Site for three or four weeks when he was injured in 2013. (*Id*. at 49). He woke up with pain that had been building up for several months and did not seem to go away. (*Id*.). Before working at Barter Island, Employee had been working at the Indian Mountain Radar Site for several weeks, which was where "the majority of the heavy lifting was." (*Id*.). Employee testified about his interactions with Employer's nurse case manager and Dr. Johnston. (*Id*. at 57-76). He also described the work he performed, including shoveling sand and gravel on his knees, erecting scaffolding, lifting large pipes while twisting and jacking up fuel tanks with a jack that weighed 100 pounds. (*Id*. at 76-77). Employee experienced back pain prior to 2013, after adjusting tire chains on a grader." (*Id*. at 80-81). The first time Employee sought medical treatment for his back was in 2001. (*Id*. at 82). (August 26, 2014).

47) On October 7, 2014, Employee was evaluated by Louis Kralick, M.D., who planned to obtain Employee's pain management records and obtain flexion and extension x-rays. Employee reported Dr. Trescott's epidural steroid injection provided him with excellent relief for two days. Two additional injections were ordered. (Kralick chart notes, October 7, 2014).

48) On October 14, 2014, Employee received another epidural steroid injection. (Operative report, October 14, 2014).

49) On October 16, 2014, Employee filed a "Petition to Join Additional Employer(s) and/or Insurers" from his 2010 injury to his 2013 case. Employer did not oppose the petition. (Employee Petition, October 13, 2014; Employer's Non-Opposition, October 28, 2014).

50) On October 30, 2014, Employee saw Amy Murphy, D.O., for an initial assessment of a traumatic brain injury he suffered during a car accident 21 years earlier. Employee reported stress, alcohol use, anxiety and recently attending an inpatient unit in Georgia for seven and one-half weeks for "dual diagnosis." Employee also reported using alcohol to "deal with" the symptoms of his traumatic brain injury. Employee's stressors included his workers' compensation case and his wife filing for divorce. Employee also reported suffering a heart attack the previous week, which resulted in the placement of two stents. Dr. Murphy prescribed Cymbalta for anxiety, depression and Employee's cognitive defects. (Murphy report, October 30, 2014).

51) On December 2, 2014, *Greg Weaver v. Arctec Alaska*, AWCB Decision No. 14-0154 (December 2, 2014) (*Weaver I*), rejected Employee's contentions that Employer's nurse case manager and Dr. Johnston were EMEs. The decision concluded Employer had not made an excessive change of physician and denied Employee's petition to exclude Dr. Marble's January 9, 2014 EME report on that basis. Although *Weaver I* found Employer's nurse case manager "came dangerously close to directing Employee's medical care," it nevertheless concluded she "made suggestions [concerning Employee's medical care], which Employee and his treating providers sometimes accepted." (*Weaver I*).

52) On December 11, 2014, Employee reported taking one Oxycodone per day, which "was not helping with the pain at all." Employee's prescription for oxycodone was changed from 10 milligrams to 15 milligrams. (Kile chart notes, December 11, 2014).

53) A December 31, 2014 lumbar spine MRI was unchanged from Employee's July 10, 2014 MRI. (MRI report, December 31, 2014).

54) On January 6, 2015, Dr. Kralick interpreted x-rays to show spondylitic changes in Employee's lumbar spine and recommended Employee undergo facet injections at L4-5 and L5-S1. (Kralick chart notes, January 6, 2015).

55) At a January 21, 2015, prehearing conference, Employee's 2010 and 2013 cases were joined. (Prehearing Conference Summary, January 21, 2015).

56) On January 29, 2015, Employee was restricted from driving for three to four months after having been charged with DUI. He was "having a lot of feelings of betrayal" as his wife was one of the persons who testified against him. Employee was also "dealing with a lot of legal issues surrounding his divorce." (Murphy report, January 29, 2015).

57) On January 29, 2015, Employee denied any improvement in his low back pain. His medication was changed from Oxycodone to Hydromorphone. (Walsh chart notes, January 29, 2015).

58) On February 24, 2015, Employee reported an 80 percent relief in his lower back pain for five hours following a medial branch block. (Stonebridge chart notes, February 24, 2015).

59) On March 20, 2015, Patrick Radecki, M.D., conducted an EME, at which Employee recounted the 2010 injury he sustained while putting 200 pound tire chains on a road grader, as well as his 2013 back problems, which "seemed to build up over time" while he was performing strenuous labor. Employee's answers to a number of Dr. Radecki's questions concerning the history of his present illness included, "does not recall" and "cannot recall." Dr. Radecki found Employee's memory of his past medical history "not so good." Employee's biggest complaint, according to Dr. Radecki, was the bunk bed on which he was sleeping, which just had springs and offered little support. Dr. Radecki reviewed and summarized medical records prior to Employee's 2013 back complaints, as well post-injury medical records from July 24, 2013 through November 4, 2013. His reports states, "All additional notes are reviewed but not dictated. Complaints continued despite treatments." Dr. Radecki observed Employee did not sit while Dr. Radecki was taking his history but "stood with much pain behavior, deep breathing, and posturing, leaning at time against the exam table." Dr. Radecki recorded the following findings on physical examination:

> Relative to his head, I put my hand on his head without pressure and he said that was fine. . . . I then pushed down on my hand with a **total pressure of about 5 pounds, and he said that gave him low back pain, and that would be nonphysiologic.** Minimal pressure on the top of your head downward is not going to give you low back pain.
>
> Then, I did a very slight traction on his mastoid process bilaterally with no more than 5 pounds of traction, and he said that caused neck pain. He also had tenderness at each mastoid process, where I was lifting. He said there additional pain with the lifting, which was very gentle.

EXAMINATION OF THE CERVICAL SPINE

Flexion:	10 degrees
Extension:	30 degrees
Right Lateral Bending:	15 degrees
Left Lateral Bending:	20 degrees
Right Rotation:	35 degrees
Left Rotation:	45 degrees

So, there were great restrictions in range of motion. Relative to his neck; in the midline on palpation, he had tenderness at the C5, C6, and C7 spinous processes. The paraspinal muscles were diffusely tender at all areas, C3 to C7, without spasms.

EXAMINATION OF THE THORACIC SPINE

In the thoracic region, he had pain to palpitation over spinous processes T5 through T12, with the pain at T5, T6, T6, T7, and T8 about a 3 to 4, and then the same at T9 and T10. At T11 and T12, he said the pain was a 5 or 6.

EXAMINATION OF THE LUMBAR SPINE

In the lumbar area, L1 through L5, he rated the pain at least a 7; just brushing the skin with a fingertip, he was saying his pain was a 7, which would be grossly nonphysiologic. His paraspinal muscles in the low back were likewise, all said to be pain level 6 to 7, without spasms. **Just pinching his skin, he said there is significant pain; nonphysiologic.**

. . . .

Supine, just a 10 degree straight leg raise on the right was said to give him maximal back pain, which is nonphysiologic since a 10 degree straight leg raise does not possibly stretch the sciatic nerve and on the left, he said is was 20 degrees, again, nonphysiologic. Pain was only in the back with that as well.

Knee flexion, which would cause subsequent hip flexion with hip flexion of 80 degrees on the left **was said to cause pain in the low back** despite the fact that hip and knee flexion simultaneously actually shorten the sciatic nerve. On the right side, at 40 degrees, he complained of back pain with the same maneuver, so grossly nonphysiologic.

[Range of motion findings omitted] With the maneuver of rotation of the pelvis with simultaneous shoulder rotation, he said minimal rotation to the left of 5 degrees gave him low back pain, **which is nonphysiologic and that to the right at 15 degrees did the same.** Approximately 15 pounds of pressure on the shoulders was said to give him low back pain and that is nonphysiologic. Lifting up on the **elbows was said to give him neck pain and that is nonphysiologic.**

[Emphasis in original]. Dr. Radecki opined the 2010 injury resulted in muscle strain that resolved rather quickly. To support his opinion, Dr. Radecki cited range of motion findings from January 12, 2011, which showed a "fairly minimal effect" of the injury on Employee's range of motion, and he noted Employee's pain level the next day was 1 out of 10. Dr. Radecki also added Employee did not miss work because of the 2010 injury. Dr. Radecki did not think "there was any specific injury whatsoever" in 2013; and, referred to Employee's 2013 injury as a "[c]hoice to seek medical attention following sleep." Dr. Radecki thought imaging studies did not show evidence of an acute change and were consistent with preexisting degenerative disc disease in the lumbar spine. Instead, Dr. Radecki opined the cause of Employee's persistent pain was predominantly due to "psychosocial factors." Dr. Radecki also noted Employee's denial of attending an inpatient treatment unit in Georgia for stress, anxiety and alcohol use. (Radecki report, March 20, 2015).

60) On March 23, 2015, Employee reported Hydromorphone has been ineffective for his lower back pain. It was noted Employee tested "greater than 150,000" for ethyl alcohol on his last visit. Employee stated he drinks to help with the pain. Employee's medication was changed from Hydromorphone to Morphine. (Fitzgerald chart notes, March 23, 2015).

61) On April 6, 2015, Employee reported Morphine was ineffective for his lower back pain. He also admitted to taking more of his Hydromorphone than prescribed and to taking Oxycodone from an old prescription. It was decided Employee's facet joints would be treated with radio frequency ablation. Employee was advised radio frequency ablation typically provides relief lasting between six months to two years. (Peterson chart notes, April 6, 2015).

62) On April 22, 2015, Employer deposed Dr. Restad, who testified regarding Employer's nurse case manager and Dr. Johnston's involvement in Employee's treatment, her radiculopathy diagnosis, referrals she had made on Employee's behalf and Employee's need for a travel companion. (Restad depo., April 22, 2015). Dr. Restad referred Employee to Dr. Johnston because Employee wanted a second opinion on conservative treatment options. (*Id*. at 24).

63) On April 30, 2015, *Greg Weaver v. Arctec Alaska*, AWCB Decision No. 15-0050 (April 30, 2015) (*Weaver II*) decided cross-petitions to strike the other parties' questions to the second independent medical evaluator (SIME). The decision concluded both parties' questions were compound and confusing, neither party's questions would be sent to the SIME physician and the board designee's questions would be utilized instead. (*Weaver II*).

64) On May 7, 2015, Employee underwent left-sided radio frequency ablation at L3-4, L4-5 and L5-S1. (Operative Report, May 7, 2015).

65) On May 14, 2015, Employee underwent right-sided radio frequency ablation at L3-4, L4-5 and L5-S1. (Operative Report, May 14, 2015).

66) On May 20, 2015, Employee reported Morphine was not helping with his low back pain. His medication was changed from Morphine to Hydrocodone. (Walsh chart notes, May 20, 2015).

67) On August 5, 2015, Employee reported a decrease in the efficacy of his Hydrocodone. His medication was changed from Hydrocodone to Percocet. He also continued to complain of debilitating back pain. Because Employee had failed to respond to aggressive medical management and physical therapy, as well as minimally invasive pain management procedures, he was referred a neurosurgeon. (Walsh chart notes, August 5, 2015).

68) On September 1, 2015, Employee reported no pain relief following the radio frequency ablation procedures. MS Contin was added to his Percocet prescription due to reports of increased lower back pain. (Walsh chart notes, September 1, 2015).

69) On October 1, 2015, Employee underwent acupuncture treatment for low back pain. (Wedge chart notes, October 1, 2015).

70) On October 27, 2015, Employee related his low back pain to a 2013 work injury. Dr. Kralick opined Employee's symptoms were the result of Employee's job duties. L4-5 and L5-SI discograms were ordered. (McGrath chart notes, October 27, 2015).

71) On November 9, 2015, Employee reported his medications "do not work." One of the medications was changed from MS Contin to Fentanyl. (Walsh chart notes, November 9, 2016).

72) On November 19, 2015, because Employee was having difficulty obtaining Fentanyl patches, his medications were changed from Percocet and Fentanyl to MS Contin and Morphine. (Walsh chart notes, November 19, 2015).

73) On January 15, 2016, Employee reported the Morphine "doesn't take the edge off his pain." He was re-started on Oxycodone and MS Contin. (Harrell chart notes, January 15, 2016).

74) On February 19, 2016, James Scoggin, M.D., an orthopedic surgeon, performed an SIME, during which Employee described being injured sometime prior to July 23, 2013, when he was working at remote radar sites. Employee explained changing valves in a fire pump room and handling 6-inch to 8-inch pipe in confined spaces. Employee also described performing "very physical" work jacking up fuel tanks with a large, heavy jack to build and prepare the ground under

the tanks at the Indian Mountain site, as well as moving tanks using heavy equipment and digging on his knees at another radar site. Meanwhile, according to Employee, he was sleeping on bunk beds that offered no back support. Dr. Scoggin reviewed and summarized medical records between March 13, 1993 and May 7, 2015. He diagnosed preexisting chronic low back pain, preexisting degenerative disc disease, multiple prior episodes of recurrent low back pain and injury, including another work injury in 2001, the tire chain injury in 2010, and an industrial lumbosacral soft tissue injury on July 23, 2013. In Dr. Scoggin's opinion, the July 23, 2013 injury combined with a preexisting condition to cause Employee's disability and need for treatment, but it did not result in a permanent change. Employee was medically stable at the time of Dr. Marble's January 9, 2014 EME, according to Dr. Scoggin. In support of his opinions, Dr. Scoggin cited Employee's reports of back pain predating the July 23, 2013 work injury and imaging studies showing only chronic-appearing degenerative changes in Employee's lumbosacral spine, which were stable on three separate MRI studies. Dr. Scoggin thought Employee's current complaints were subjective and primarily related to his preexisting degenerative disc disease and its expected progression over time. Dr. Scoggin opined no further medical treatment was necessary or appropriate "from the standpoint of the 7/23/13 injury," including surgery. (Scoggin report, February 19, 2016).

75) On April 5, 2016, Dr. Scoggin reviewed Dr. Radecki's March 20, 2015 EME report and Dr. Restad's April 22, 2015 deposition transcript, which did not change his February 19, 2016 opinions. (Scoggin addendum, April 5, 2016).

76) On April 6, 2016, a discogram was positive at L4-5 and L5-S1. (Operative Report, April 6, 2016).

77) A July 12, 2016 lumbar computed tomography (CT) study showed multilevel degenerative disc disease, most severe at L4-5 and L5-S1. At L4-5, a moderate disc protrusion was superimposed on a broad disc bulge resulting in mild central spinal canal stenosis. At L5-S1, a disc osteophyte complex resulted in moderate bilateral neural foraminal stenosis. (CT report, July 12, 2016).

78) A July 12, 2016, lumbar MRI showed moderate bilateral neural foraminal stenosis at L5-S1 and probable mild spinal stenosis at L4-5. (MRI report, July 12, 2016).

79) On July 13, 2016, Dr. Kralick performed an L4-S1 laminectomy with spinal canal and neural foraminal decompression and disc excision at L4-5 with interbody fusion. Dr. Kralick's report

notes, "[s]ignificant canal compromise of the thecal sac by bone and thickened ligamentum flavum was encountered at both the L4-5 and L5-S1 levels." (Operative Report, July 13, 2016).

80) On July 17, 2016, Employee suffered a myocardial infarction, which resulted in the placement of two stents. (Emergency Department report, July 17, 2016; Cardiology Discharge Summary, July 19, 2016).

81) On July 26, 2016, Employee saw Dr. Kralick for a postoperative wound check and reported lower back soreness, bilateral leg weakness, balance changes and left leg numbness and tingling. (Kralick chart notes, July 26, 2016).

82) On August 4, 2016, Dr. Scoggin responded to interrogatories posed by Employee's attorney and cited numerous records documenting Employee experiencing low back pain prior to the July 26, 2013 work injury. Dr. Scoggin added, since both Drs. Marble and Radecki observed Employee to be a poor historian, a review of medical records becomes more important in Employee's case. He wrote, "We know that [Employee] suffered chronic, recurrent low back pain prior to 7/23/13, because his medical records so state this." As a result, Dr. Scoggin ruled out performing "strenuous physical labor" for Employer as the substantial cause of Employee's back pain. Referring to Employee's consistent, subjective, pain-scale reports, and his three MRI studies, where no significant changes were observed, Dr. Scoggin concluded, "Since there is no objective evidence of any significant improvement in his condition and no subjective evidence of any significant change in his complaints, the logical conclusion is that [Employee] was, in fact, medically stable as stated." Dr. Scoggin noted Employee reported the three epidural steroid injections he had received provided him, at most, two days' relief, and the four radio frequency ablations per side Employee had received did not provide him with any short or long-term relief. Therefore, Dr. Scoggin concluded, the additional care Employee received after Dr. Marble's January 9, 2014 EME did not result in any subjective or objective benefit to Employee. Dr. Scoggin again expressed his opinion that the July 23, 2013 injury resulted in a lumbrosacral soft tissue injury, which temporarily exacerbated Employee's subjective complaints, and reiterated his opinion that Employee was medically stable at the time of Dr. Marble's January 9, 2014 EME. (Scoggin interrogatories, August 4, 2016).

83) On August 15, 2016, Dr. Radecki reviewed additional medical records and noted inconsistencies between findings upon physical examinations performed by other medical providers and himself, and concluded differences in these findings mean Employee is "not

reliable." Dr. Radecki also emphasized medical reports that mentioned Employee's alcohol and marijuana use, frustration, anger, difficulties paying bills and legal fees, taking more pain medication than prescribed, taking pain medication from a past prescription, lack of improvement following radio frequency ablation, numerous changes to Employee's narcotic pain management medication with no improvement in his reported symptoms, as well as medical reports where Employee reported the onset of his history of present illness prior to the 2013 work injury. He issued an addendum report that stated the additional medical records reviewed did not change the opinions expressed in his March 20, 2015 EME report. (Radecki addendum, August 15, 2016).

84) On August 23, 2016, lumbar spine x-rays were interpreted to show disc space narrowing at L5-S1 and anterior spurs through the lumbar spine like a previous study. Employee was to begin physical therapy to improve his range of motion and improve his residual pain. (X-ray report, August 23, 2016; Tempel chart notes, August 23, 2016).

85) On August 24, 2016, Employer deposed Dr. Scoggin, who testified he concluded Employee's July 23, 2013 injury did not permanently aggravate Employee's low back condition. (Scoggin depo. at 12). Dr. Scoggin thought "there was some room for discussion in this case" as to what caused the aggravation in Employee's low back because Employee did not point to a single incident, but rather reported more than ten different potential causes for the aggravation, including shoveling, changing valves, jacking up fuel tanks, bending, lifting, moving tanks, digging, "and the most common one is sleeping on a thin mattress." (*Id*.at 12-13). Employee reported to one of his providers that his pain had been occurring for over a year and was aggravated by coughing, bending, twisting, lifting, sitting and standing, "which are all activities of daily living," according to Dr. Scoggin. (*Id*. at 13). Dr. Scoggin did not see any evidence Employee had radiculopathy based on Dr. Restad's July 26, 2013 report, (*id*. at 18), and he did not see evidence of canal stenosis on Employee's August 2, 2013 MRI, (*id*. at 26). Dr. Scoggin disagreed with Dr. Kralick's decision to perform surgery for lumbar stenosis because lumbar stenosis was not documented by Employee's MRIs. (*Id*. at 34). Dr. Scoggin would not have performed surgery on Employee because Employee did not have any of the indications for spinal fusion listed in the *Occupational Disability Guidelines*. (*Id*. at 39). Dr. Scoggin thinks there were multiple factors contributing to Employee's need for medical care and, because Employee had a physical job, Dr. Scoggin thought is was reasonable to conclude Employee experienced increased pain until January 9, 2014. (*Id*. at 44). On cross-examination, Dr. Scoggin testified Dr. Kralick's findings that Employee's spinal

canal was compromised by bone and thickened ligamentum flavum are consistent with degenerative changes. (*Id*. at 53). According to Dr. Scoggin, Employee did not have a herniated disc, a fracture, or anything else that is clearly identifiable as a specific injury. *Id*. at 59. Instead, Employee only experienced an increase in symptoms. (*Id*.). Dr. Scoggin found reports from multiple examiners, who described their findings as degenerative, and Employee's medical records show Employee had prior symptoms. (*Id*. at 60). Dr. Scoggin noted, prior to the 2013 injury, Employee had been having pain, averaging 6 out of 10 for one year. He also noted, "way back" in 2001, Employee was having pain that was 6 out of 10. Therefore, Dr. Scoggin does not think there is any objective evidence that shows Employee's pain is worse after the 2013 work injury than it was before the work injury. (*Id*. at 63). In Dr. Scoggin's opinion, Employee "has multi-factoral pain, which is consistent with degenerative changes." (*Id*. at 64). Dr. Scoggin stated, "I think he's got facet, he's got disc, he's got now the spinal stenosis. He merely has pain. And he doesn't have radiculopathy, and he doesn't have symptoms of spinal stenosis." (*Id*. at 65). There is not a specific injury that would explain Employee's symptoms following the 2013 work injury, in Dr. Scoggin's opinion. "There's no heavy weight he lifted and suddenly had a sharp pain, the types of things we usually see," according to Dr. Scoggin. He thought Employee "got better" after the 2001 injury and was "doing okay" until 2010, which is when Employee described a specific injury of adjusting chains on a road grader, as opposed to 2013, when Employee had "multiple things in his day-to-day life where he noticed pain." (*Id*. at 103-104). Dr. Scoggin thinks Dr. Larson's chart notes from 2011 suggest Employee's back problem "goes back even before 2010, and "there's more history that predates this chiropractic care," because Employee was already on Hydrocodone, a strong narcotic, and muscle relaxers. (*Id*. at 105-106). However, given the "unknowns" prior to 2010, "this is where his current history starts," "[s]o unless there's more information" from before 2010, Dr. Scoggin would say that the 2010 injury is the substantial cause of Employee's disability and need for medical treatment after January 2014. (*Id*. at 107). Dr. Scoggin says this because Employee had a "multiple year history of complaints dating back to [2010]." (*Id*. at 108). However, he also thought "it's obvious that [Employee's] history goes back before this even also, but that's undefined because we don't have records about it." (*Id*.). Dr. Scoggin clarified, it was his opinion, after 2014, Employee's "continuing care" was due to his preexisting condition, "and we know his preexisting condition goes back at least [to 2010]." (*Id*. at 108-109). However, Dr. Scoggin also thinks Employee was medically stable from both the 2010

injury and the 2014 injury after January of 2014, because none of Employee's medical treatment after that time resulted in objectively measurable improvement. (*Id*. at 111, 112).

86) Dr. Scoggin's deposition transcript spans 113 pages. It began at 1:06 pm, *id*. at 2, and concluded at 4:45 pm, *id*. at 113.

87) On August 28, 2016, Employee continued to report lower back soreness and left leg numbness. (Tempel chart notes August 23, 2016).

88) Physical therapy daily progress notes from September of 2016 indicate Employee "admits a sedentary lifestyle," and lists Employee's primary functional limitation as his inability to "resume exercise routine or tolerate functional activities at home due to persistent nature of his [low back pain]." (Daily Progress Notes, September 7, 2015 to September 29, 2016).

89) Following his July 13, 2016 surgery, Employee continued with medical pain management and consistently reported his current pain levels as 3-6 out of 10, and his average pain levels as 2-6 out of 10. On October 26, 2016, Employee's medical pain management provider had the following conversation with Employee: "Discussed with [Employee] what he does to keep busy as he does not currently work. He states that he does not do much of anything. I advised him that it is important for his health to find some kind of hobby to keep him busy. This will improve both his mood and his pain." (Algone Interventional Pain Clinic chart notes, August 10, 2016 to July 10, 2017).

90) On September 22, 2016, Dr. Kralick opined Employee's 2013 injury was the substantial cause of his low back symptoms. (Kralick responses, September 22, 2016).

91) On October 5, 2016, Employee reported "constant" low back aching, "stable" left leg numbness and temporary increases in his low back pain after physical therapy. (Tempel chart notes, October 5, 2016).

92) On January 5, 2017, Dr. Scoggin reviewed additional imaging studies, which did not change any of his previously expressed opinions. (Scoggin addendum, January 5, 2017).

93) On February 17, 2017, Dr. Radecki evaluated Employee a second time. Dr. Radecki asked Employee about returning to work, and Employee informed Dr. Radecki he is already on Social Security Disability for his low back and, if he had a heart problem on the North Slope, he could not be reliably evacuated for medical care. Dr. Radecki concluded, regardless of how Employee's back felt, he would not work remotely because of his heart conditions. Employee was "a little unclear on his medications," and reported he was taking Flexeril three times per day on some days

and, and on some days, he takes less. Employee was taking five Oxycodone tablets, "probably 5 mg tablets," twice per day. In addition, he was taking morphine sulfate, either 15 or 30 mg tablets, twice per day. He also was taking two or three Aleve tablets twice per day and baby aspirin, as well. Dr. Radecki remarked, Employee rated his pain as a 5 or 6, even on all this medication. Upon physical examination, Employee complained of great pain when Dr. Radecki brushed Employee's skin with one fingertip in the lumbar region. Employee's paraspinal muscles were very tender on palpation throughout the thoracic and lumbar regions. Dr. Radecki found hip flexion to be 80 degrees on the right and 70 degrees on the left, where Employee complained of great pain. Dr. Radecki observed, when Employee was sitting on the exam table, he was leaning forward, "so his hip flexion was certainly 100 degrees or greater, so there was an inconsistency between Employee's sitting and supine hip flexion." Employee could not tolerate hip rotation past 5 degrees because it was "very, very painful." Employee complained of non-physiologic low back pain when Dr. Radecki placed his hands on Employee's shoulders. Traction applied upward at Employee's elbows was very painful, which Dr. Radecki thinks should lessen the pain, since it is taking weight off the low back. When Dr. Radecki pulled on Employee's thigh while Employee was laying supine on the exam table, Employee complained of low back pain, which is "grossly non-physiologic since pulling on one thigh does not stretch any nerves or change any joint positions." Dr. Radecki observed, "Pushing on the knees likewise provoked complaints in the hips and low back despite again the fact that no nerves are being stretched, no tissues are actually being moved." He also wrote,

> Hip rotations were the most painful; they are painful at 0 degrees rotations and yet when [Employee] walks and even squats 20 degrees, rotations occurring and he did not complain. Additionally, when [Employee] sat up from a supine position, he put one leg on each side of the exam table, essentially straddling the table, which would require external rotation of each hip and was totally painless.

The findings from Employee's physical examination were "totally unreliable," since he had pain with provocative maneuvers "that cannot possibly cause pain," according to Dr. Radecki. He also diagnosed chronic pain along most of the spine, but predominantly at the lumbar region, longstanding by history, "well before the incident of July 23, 2013." He also concurred with Dr. Marble's opinion that Employee's 2010 injury had "resolved quite quickly." Dr. Radecki observed Employee's condition had changed minimally notwithstanding having undergone spinal surgery,

and opined the pathology documented at surgery was bony encroachment on the spinal canal and a thickened ligamentum flavum, "neither of which is due to a one time incident." Employee's inability to work as a Station Mechanic was twofold, according to Dr. Radecki, and included, 1) psychosocial factors and chronic pain behaviors, and 2) Employee's heart condition. (Radecki report, February 17, 2017).

94) On February 17, 2017, Ronald Teed, M.D., an orthopedic surgeon, also performed an EME, during which Employee reported his surgery helped with some of the sharp pains in his back, but he still had chronic disabling pain. Dr. Teed found Employee very "nonspecific" and "avoidant" during the evaluation. Employee reported his work career has been very sporadic throughout his life due to "personal reasons." Dr. Teed began to measure Employee's range of motion in his cervical, thoracic and lumbar spine, but Employee reported his spine was too painful to perform additional range of motion evaluations. Dr. Teed found this to be inconsistent because he observed Employee moving his head to the left and right without hesitation during questioning and that movement was "well beyond" what was measured with the inclinometer. Similarly, Dr. Teed noted Employee sat on the bed and leaned forward "far beyond" the lumbar range of motion measured with the inclinometer. Employee was exquisitely tender to palpation, even to light touch, over the cervical and lumbar spinous processes and paraspinous musculature, and was tender "just about anywhere" Dr. Teed touched Employee over his thoracic spine. Dr. Teed also found Employee inconsistently tender over the sciatic notch. Other inconsistencies noted by Dr. Teed included inconsistent pain complaints upon hip rotation while seated and supine and reported low back pain when Employee rotated his torso through his legs. Employee reported increased, diffuse, neck tension when Dr. Teed applied "very light" axial pressure on Employee's scalp. Dr. Teed diagnosed functional overlay, which included closed head injury, history of alcohol abuse, history of anxiety/depression, chronic narcotic use/abuse, and chronic non-specific neck pain, chronic non-specific low back pain, including lumbar spondylosis, and cardiovascular disease, none of which were related to Employee's employment. He stated, "[Employee's] presentation is that of overwhelmingly inconsistent, inorganic, non-anatomic findings on exam." As a result, Dr. Teed concluded his findings on exam were unreliable. He found Employee's history of chronic neck, mid and low back pain "well predate" the July 23, 2013 work injury. Additionally, Employee was also unable to describe a specific mechanism of injury. Dr. Teed observed Employee had been treated by many providers since the injury, and those providers' findings were commonly

inconsistent, even between the same providers. In Dr. Teed's opinion, Employee underwent lumbar fusion surgery without a clear presentation of radicular findings or neural defects. The cause of Employee's disability and need for medical treatment, according to Dr. Teed, "are unknown, but unrelated to the July 23, 2013 job injury claim." Because Employee's highly inconsistent presentation, Dr. Teed recommended Employee undergo a multispecialty evaluation, including a psychological evaluation. (Teed report, February 17, 2017).

95) On February 28, 2017, Employee deposed Dr. Trescott, who saw Employee once for an evaluation and once to administer a transforaminal injection. When she evaluated Employee on May 23, 2014, she thought he had "an early degree of lumbar radiculopathy," based on his MRI, which showed a disc bulge. (*Id*. at 31-32). When Dr. Trescott administered the injection, she uses x-ray contrast dye to show her the medicine is going where she wants it to go. (*Id*. at 34-35). In Employee's case, the dye did not go past the dorsal root ganglion, which was consistent with narrowing and impingement at that spot. (*Id*.). Dr. Trescott opined performing heavy labor traumatized an already weakened area of Employee's back. (*Id*. at 39-40). She also thought Employee's lumbar facets contributed to Employee's pain. (*Id*. at 45-46). Dr. Kralick's operative report, which states he found thickening of the ligamentum flavum, is consistent with Dr. Trescott's spinal stenosis findings. (*Id*. at 49-50). She explained the ligament holding Employee's spine together became thickened because it was moving too much, and his body was "laying down extra calcium" in response, which was then encroaching on the spinal column. (*Id*.). On cross-examination, Dr. Trescott acknowledged she obtained Employee's history of the work injury from him, (*id*. at 51-52), she did not record a neurological examination, which is the best information for diagnosing radiculopathy, (*id*. at 61-62), and she cannot opine on whether Employee's disc pathology is acute or chronic, (*id*. at 64). Dr. Trescott was not aware Employee had seen Dr. Inouye on May 14th and May 23rd, was not aware Dr. Inouye had also prescribed Employee medications, and she would be surprised if Employee did not report leg pain to Dr. Inouye on those visits. (*Id*. at 69-70). She thinks it is important to assess the mental health of pain patients but she did not document non-work related stress in Employee's life. (*Id*. at 70-71). Dr. Trescot was critical of another physician for not documenting a patient's substance abuse history, but she did not document Employee's history of substance abuse. (*Id*. at 71). She thinks anxiety can contribute to pain, but she did not consider anxiety in Employee's case. (*Id.*). If a pain patient has tried narcotics, anti-inflammatories, medial branch blocks, radiofrequency ablation and surgery,

and there is no improvement, Dr. Trescott would be concerned there might be an underlying issue that is not being addressed. (*Id*. at 73). There can be reasons, other than something physiological or anatomical reasons, why patients' pain does not improve, such as untreated depression or anxiety, substance abuse and secondary gain, according to Dr. Trescott. (*Id*. at 74). She interpreted Employee's MRI to show a "disruption" of the posterior interspinous ligament, (*id*. at 86), but she acknowledged this is not a commonly accepted finding, (*id*. at 90).

96) On March 3, 2017, Employer filed its hearing brief and attached, as an exhibit, the record documenting Employee's April 10, 2014 telephone call to the veteran's crisis hotline. This record was not available to Dr. Scoggin at the time of his SIME or to Dr. Radecki at the time of his reports. (Employer's Hearing Brief, exhibit A - attachment 2, March 2, 2017; observations).

97) On March 7, 2017, Employer deposed Dr. Teed, who testified Employee had spondylosis, an arthritic condition, and chronic nonspecific low back pain. (*Id*. at 5). According to Dr. Teed, spondylosis involves disc degeneration, facet arthritis and ligamentum hypertrophy, all combined. (*Id*.). Chronic nonspecific back pain means the etiology is unclear - "It's just a subjective complaint." Dr. Teed did not see any evidence in the medical records to support a diagnosis of radiculopathy. (*Id*. at 7). Commenting on Employee's lack of improvement after receiving a variety of treatments, Dr. Teed stated, there is no "Level 1," evidence-based medicine that shows epidural steroid injections, medial and lateral branch blocks or nerve ablations work. (*Id*. at 9; 60). Dr. Teed testified there were inconsistencies between Employee's reports of pain relief to him and Employee's pain relief reports following various treatments documented in his medical records. (*Id*. at 10). According to Employee at the time of Dr. Teed's evaluation, no treatment has helped his low back pain. (*Id*. at 7). Dr. Teed disagrees with Dr. Kralick's decision to perform surgery because Dr. Kralick performed surgery to address Employee's pain and pain is not an indication for surgery. (*Id*. at 11). Dr. Teed thinks an MRI showed Employee had mild stenosis, but Employee did not have symptoms of stenosis, which include increased back pain that radiates into the lower extremities and lower extremity weakness with increased walking or standing. (*Id*. at 12-13). Dr. Teed explained, "functional overlay" means inconsistencies on exam. (*Id*. at 15). Those inconsistencies can be a patient's attendance at appointments, the inconsistency in a patient's history and a patient's physical exam and other findings on exam, such as inorganic or non-anatomic findings that do not make sense from a physiological standpoint. (*Id*.). Dr. Teed recounted the inconsistencies on examination, such as during straight leg raises, torso rotation, hip

rotation, palpation and breakaway strength and cogwheeling. (*Id*. at 17-19). Dr. Teed summarized his examination, stating he made no objective findings, and the subjective findings were Employee would not go through range of motion with his spine because it was too painful. (*Id*. at 20). He also explained the Bradford Hills criteria for causation, which is the human body will generally get better when the causative agent is removed. (*Id*. at 22-23). In other words, if the causative factor is increased, one will have more symptoms, but if the causative factor is decreased, one will have less symptoms. (*Id*.). Patients with spondylosis present with symptoms that wax and wane over time, which has been Employee's presentation back to 2001. (*Id*. at 23-24). Additionally, Employee's symptoms since 2013 have been due to his chronic nonspecific low back pain. (*Id*.). Dr. Teed was unable to identify an acute injury during his evaluation and Employee was unable to describe a specific injury during the evaluation. (*Id*. at 25). Rather, Employee attributed his symptoms to digging and performing manual labor during the months prior to him quitting work. (*Id*.). An x-ray showed Employee had the onset of spondylosis as far back as 2001. (*Id*. at 27). On cross-examination, Dr. Teed testified he does not administer epidural steroid injections, medial branch blocks, facet blocks or radiofrequency ablation, but he has ordered all of them. (*Id*. at 32-33). He also, again, addressed inconsistencies in Employee's medical records where Employee reported one-week relief from an epidural steroid injection to one provider, and two weeks' later Employee reported the injection provided him with no relief to another provider. Dr. Teed commented, "So, I mean, the notes get confusing because they are consistently conflictive. They are conflicting and most consistent with functional overlay. That's what I'm talking about the inconsistencies." (*Id*. at 73-74). When asked if he relied on the Bradford Hills criteria in determining Employee's symptoms were not related to work, Dr. Teed responded, "No. I can't really rely on that criteria because there are episodes that we just described where [Employee] said his pain was gone and then episodes that we just described where [Employee] said the pain never went away." (*Id*. at 75). Additionally, Employee told Dr. Teed his pain never went away, and when Employee was evaluated the same day by Dr. Radecki, Employee reported surgery had reduced his pain one level. (*Id*. at 78). Imaging studies, both before and immediately after the 2013 work injury document Employee's preexisting degenerative conditions, which took many years to develop, according to Dr. Teed. (*Id*. at 99-100). Dr. Teed opines there is no correlation between Employee's spondylosis and the symptoms he describes. (*Id*. at 104-05). He agrees with Dr. Trescott's opinions that it is a "red flag" for functional overlay when a patient fails to improve

after multiple, different treatments, and it is important to have information about a patient's substance abuse history and psychological issues when treating pain. He thinks Employee's chronic pain could be caused by psychosocial issues, but he would defer to a psychological or psychiatric evaluator. (*Id*. at 109-110). Dr. Teed did not think Employee's work activities were a substantial factor in his disability or need for treatment, (*id*. at 107), and based on his evaluation, Dr. Teed was able to rule out Employee's work activities as a cause of his disability or need for treatment, (*id* at 113).

98) At the March 9, 2017, hearing, Dr. Radecki testified, Employee's 2013 injury history differs depending on which chart notes are consulted. Employee explained to Dr. Radecki that his back pain increased over time, but Employee's biggest complaint was the bed on which he was sleeping, which Dr. Radecki thought was odd, because Employee had slept on that bed before. During Dr. Radecki's evaluation, Employee did not connect any specific work activity to his injury. Dr. Restad's chart notes indicate Employee reported going to bed and waking up with pain, and Employee "gave [him] the same story." An August 9, 2013, pain clinic chart note indicates Employee reported he had had pain for over a year, and a February 17, 2012 chart note references back pain in connection to a possible kidney stone. It is "obvious" Employee had back pain pre-dating his injury. Dr. Radecki thinks a patient's early history is most reliable, since it is fresh in the patient's memory and psychosocial factors are not yet prominent. Dr. Restad's August 16, 2013 report, which shows Employee's pain level went down from a 9 to a 3, means Employee was making a good recovery. By October 14, 2013, the records show Employee was "doing pretty darn well," because he had a full range of motion without pain for flexion. When Employee saw Dr. DeSalvo on October 23, 2013, Employee's pain would come and go as usual, and on November 4, 2013, Dr. Johnston opined Employee could go back to work again, so Dr. Johnston must have felt Employee's condition was stable. On November 5, 2013, Employee reported his pain level as a 2 or 3, and by November 11, 2013, Employee's pain level was elevated to 6 or 7 "for no reason at all." Psychosocial factors are one of two statistical factors that can predict the development of low back pain. Substance abuse and secondary gain are psychosocial factors that can effect pain. Employee denied being hospitalized in Georgia. Dr. Radecki found Employee not to be a reliable historian and is not reliable on physical exam either. Dr. Radecki agrees with Dr. Marble and Dr. Scoggin – Employee was medically stable by January 9, 2014. When Dr. Kralick performed surgery on Employee, he was operating based on symptoms, which Dr. Radecki thought was

"wishful thinking surgery." Dr. Radecki repeatedly testified Employee had pain with provocative maneuvers that should not cause pain. Employee is a "perfect picture" of someone who has a somatization disorder. Employee presents with a very complex situation. He has "one psychosocial problem after another." Dr. Radecki thinks Employee's treatment has made him worse, which is what he would expect in a patient with psychosocial phenomenon. Employee is the "last person in the world" who should be treated with narcotics or surgery. Employee was "absolutely destined" not to get better. On cross-examination, Dr. Radecki testified, when Employee saw Dr. Trescott, Employee's pain was a 5 and he was not taking any medication. Now, after years of treatment and invasive surgery, Employee is on both short and long-acting narcotics and his pain level is at 5 or 6, so Employee is worse. According to Dr. Radecki, there is no specific task documented in the medical record to which a specific injury is attributable, and no doctor diagnosed Employee with spinal stenosis the first time the doctors saw him. Employee improved 80 percent with a facet block, which is "a long way from the spinal canal," according to Dr. Radecki. Employee also reported getting a little better with a transforaminal epidural steroid injection, which would not affect the spinal canal, according to Dr. Radecki. Employee did not have any of the classic symptoms of spinal stenosis, such as awaking at night in bed or pain while walking. Dr. Radecki does not believe the majority of Employee's back pain is physical, but rather psychological, due to Employee's substance abuse, his depression, his anxiety and his divorce. Dr. Radecki thinks it was very bad judgment, at best, for Dr. Kralick to perform surgery on Employee. On redirect examination, Dr. Radecki testified, the fact that Employee's pain decreased in November shows he was recovering, and the escalation of Employee's pain beginning on November 20th can only be explained by psychosocial factors, since Employee's MRIs showed no interval change. Employee's complaints of pain just about everywhere is a psychosocial phenomenon. About five percent of the population have widespread, unexplained pain, and Employee is one of those five percent, in Dr. Radecki's opinion. There were eight diagnosis in the first month or two with Employee, which shows how nonspecific Employee's symptoms were. Dr. Radecki stated there was never a consistent symptom complex that would indicate radiculopathy. He also stated there was never a consistent symptom complex that would indicate lumbar stenosis. This is why Employee's providers did a "shotgun" approach, according to Dr. Radecki. "They gave Employee epidurals. They gave Employee facet blocks." Dr. Radecki thinks this approach to Employee's treatment was "nonsensical." (Radecki).

99) At the March 9, 2017 hearing, Employee's father, Greg Weaver, Sr. (Mr. Weaver), testified Employee's pre-injury activities, between 2009 and 2013, included moose hunting, building hunting camps around the state, running four wheelers through the woods, driving riverboats, water skiing, teaching kids to swim and riding jet skis. When Employee returned from work, around July 23, 2013, he was "all gimped up" and his back was definitely hurting. Mr. Weaver instructed Employee he needed to see somebody regarding his back. He never saw Employee with similar symptoms in the four years prior to the work injury. Mr. Weaver is "absolutely" aware of his son's alcohol problem but Employee "never had any problem with that" in the four years prior to the work injury. After Employee was injured, Mr. Weaver noticed an increase in Employee's alcohol consumption. Since Employee's surgery, Mr. Weaver has noticed Employee is doing more. On cross-examination, when asked about Employee's discharge from the military for alcoholism, Mr. Weaver stated he had already testified regarding Employee's alcohol problem. Mr. Weaver acknowledged Employee's 1993 car accident and DUI. Mr. Weaver denied Employee had a serious problem with alcohol prior to 2013. (Weaver, Sr.).

100) At the March 9, 2017 hearing, Employee testified he was in "pretty good" shape when he started working for Employer in 2009. He "absolutely has problems" with memory due to a closed head injury and he carries a notebook to write things down. Employee could not recall having any lasting back problems when he went to work for Employer in 2009. In 2010, Employee was injured tightening chains that had come loose on a road grader and a dump truck. He came home and saw a chiropractor on his own insurance. He did not feel "good at all then," and his pain level was at least a 5. Prior to his 2013 injury, Employee had been installing heat exchangers at power plants. Some weighed over 800 pounds. Employee was also travelling to "dome" sites and repairing and maintaining sprinkler systems, which involved replacing 4, 6, 8 and 10-inch pipes that were between 8 to 20 feet long, as well as "gate valves." His supervisor was Troy Klingfus, who emailed Dave Horn to point out no rigging or lifting devices had been provided to move the 180-pound valves they were moving by hand. Employee and Mr. Klingfus had "very sore body parts" and were icing them in the evenings. After a job hazard analysis, Employer sent some chain hoists and chain that could be used as rigging. After those jobs, Employee was moving large fuel tanks at Indian Mountain for five or six weeks at Barter Island. Employee jacked up the tanks with a railroad jack, which weighed about 120 pounds. The jack handle was a six-foot long bar that weighed 80 pounds or more. Employee also used a chain saw to cut cribbing that came in 18-foot

lengths. After Employee lifted the tanks, he would compact the site and set 14-inch by 14-inch beams, which were 10-feet long. Next, Employee would use a D10 Cat to drag the tanks close to where it needed to be, and then he would dig underneath the tanks to get the tow chain out. For Employee, it was the "worst kind of digging" – down on his knees with his legs spread apart. He also used a wheelbarrow to move rock, which was difficult to push over the rocky surface. Employee noticed himself becoming stiff. The beds Employee slept on did not have steel across them and when someone would lay in them, the bed would sag 8 or 10 inches, like a hammock. Employee tried to reinforce the bed with plywood, but when he woke up in the morning, he could hardly walk. Employee then left the worksite to see a professional. Employee received epidurals, branch blocks and radiofrequency ablations, but none of those treatments helped for more than 24 hours. Employee was also prescribed opioids, which did not help as much as he expected. Employee's pain management provider notified him alcohol showed up in his screenings at least once and he notified his pain management provider he used marijuana for sleep. Employee was drinking more than he should. He was "obviously" self-medicating. His pain was "all over the map" and he would have different symptoms every day. Since the surgery, Employee is able to get out of bed earlier and his pain is 3 ½ to 5 on most days. He is also able to spend more time with his sons. On cross-examination, Employee testified he had been feeling increasingly "odd" in his midsection before the "final straw" in 2013. Employee does not recall telling a provider in 2012 he had been having back pain for the last five years. A March 8, 2001, medical record described Employee as having lower back pain, which he rated 6 out of 10. Employee thinks that record was from when he was working for another employer on the Slope. When questioned on his pain level being a 3 out of 10 on August 16, 2013, and a 3 or 4 out of 10 in November of 2013, Employee thinks he was misunderstanding the pain scale to that point and was underestimating the level of pain he was in. Substance abuse was "one of the reasons" Employee went to Georgia in September of 2014. Regarding his 2014 DUI, Employee explained, "I rode my four-wheeler down to see my wife and try to get her to take our kids to therapy . . . and . . . ended up going to jail for that." Employee was discharged from the military for alcohol problems. Employee was almost killed in a DUI car accident in 1993. Employee's wife had alleged in divorce papers that she left Employee because of physical abuse and his alcohol use, but "nothing could be further from the truth." Employee denied he has a problem with alcohol. Employee denied his DUI two weeks ago had anything to do with alcohol or drugs, but then went on to explain, "Well, there

aren't any troopers at the table, so I . . . will go so far as to tell you . . . that I only took, I believe, two five-milligram oxys that morning and a 10-milligram baclofen around lunchtime." When asked about alcohol abuse delaying his recovery, Employee discussed his brain injury. Employee attributes his lack of sobriety to his brain injury. Employee cannot explain how his pain ended up being at its worst when he woke up on July 23, 2013. On re-direct examination, Employee stated he was not going to deny he has overused and abused alcohol. When asked if he acknowledges he is an alcoholic, Employee answered by discussing symptoms of brain injuries. Employee drinks because of brain injury and he drinks because of his back pain. Employee was repeatedly evasive, and repeatedly used the word "overuse" instead of "abuse" when asked about his alcohol abuse. (Weaver, Jr.; observations).

101) At the March 9, 2017 hearing, Dr. Restad testified Employee's symptoms did get worse from work and the delay in receiving injections contributed to Employee's chronic pain. Dr. Restad has not seen Employee in two years and when she did, she may not have gone into "great detail" in her exam. Dr. Restad diagnosed Employee with radiculopathy, degenerative disk disease with neural foraminal stenosis and back pain. She "absolutely" thinks Employee would not have experienced his low back symptoms had it not been for work. Dr. Restad was "absolutely horrified" at the delays in Employee's treatment. On cross-examination, Dr. Restad testified she did not diagnose Employee with radiculopathy but a specialist did. Dr. Restad knows when to refer to a specialist. She diagnosed Employee with compression of a spinal nerve root. She recalls Employee reporting he was standing on a dock and was having odd sensations in his feet but she did not document Employee's report in her chart notes. Dr. Restad may have made an error in her documentation. When Employee first came to Dr. Restad on July 26, he reported his pain was 9 out of 10. On August 16, Employee's pain was 3 out of 10. Dr. Restad agreed that was an improvement. Regarding her referral to Dr. Johnston, Employee told Dr. Restad he wanted a second opinion on receiving epidural steroid injections so she made the referral. "Everyone is entitled to a second opinion," according to Dr. Restad. On redirect examination, Dr. Restad testified she saw Employee over the course of a year and a half and Employee's symptoms remained constant over that time. In Dr. Restad's opinion, the work Employee performed in July of 2013 was the substantial cause of triggering Employee's pain. (Restad).

102) At a March 28, 2017 prehearing conference, the parties agreed to conclude the March 9, 2017 hearing on July 6, 2017. (Prehearing Conference Summary, March 28, 2017).

103) On July 6, 2017, John Williamson testified he has worked in numerous capacities for Employer for 18 years, and his duties have included performing job hazard analysis to ensure workers' health and safety. Employee's former supervisor, Troy Klingfus, is now employed on a full-time basis as a station mechanic at a radar site. Mr. Klingfus' April 13, 2013 email was not inappropriate or unusual as Mr. Klingfus had been injured a couple of times previously and Employer was concerned he might have been "cutting corners." Employer's expectations under the circumstances would have been for Mr. Klingfus to stop work while Employer arranged for the purchase of the requested materials. Employer did purchase the requested materials as an "O&A" project, which Mr. Williamson clarified meant "over and above" budget, versus "O&M," which stands for "operate and maintain." These terms are contract requirements. Employee continued to work with Mr. Klingfus during the summer of 2013. Mr. Williamson trains new employees on reporting injuries. Because of its remote work locations, Employer "can't afford" for someone to get hurt because medical attention is so far away. Employer requires all employees to report injuries as soon as they happen. The Indian River job involved a tank farm where the ground had heaved and the tanks were no longer level. Therefore, the job involved levelling the tanks. This was an O&A job that involved special equipment to lift and shore the tanks and a procedure to set the tanks back down. There were two to five people on the job. Workers would rotate job duties, so even though Mr. Klingfus was the "lead," he would share in the work. Mr. Williamson worked on the Barter Island job, which involved building pads and access points for two large tanks the Air Force had delivered. Five workers were assigned to this job, including him. He would also lend a hand shoveling and pushing the wheelbarrow. The tanks had to be drug into place on skids; then, scaffolding was erected. The "dirt work" and the scaffolding work was all completed by the time he left the jobsite. Employee knew he was the "safety person" onsite and employees are "well aware" to report injuries. During the period of time Mr. Williamson was at the jobsite, he heard no complaints to the effect, "I'm hurt," or "I can't work," though they were all complaining about sore muscles. He is familiar with the beds at Barter Island, they are Tall Taul brand beds and he does not think they are worse than any other site. It is not accurate to describe the beds as not having any support or being concave. Mr. Willianson is not aware of any other emails from Mr. Klingfus between April and July of 2013. He never had to go back out to the worksite on a safety issue and is confident the employees were provided proper equipment to do the job. Employee never made any specific complaints. On cross-examination, Mr. Williamson

testified he first saw Mr. Klingfus' email when another employee approached him on the O&A. Every site has lifting and rigging equipment, so he presumed that equipment was not available for some reason. Employee was on the worksite one week and 10 days prior to his arrival. Mr. Klingfus' email was sent after he had left the jobsite. Mr. Williamson described having sore muscles as the "nature of the beast" whenever heavy stuff needs to be moved – "it's a very physical job." Employee's photographic exhibits accurately reflected the work site. The Indian Mountain site involved jacking up the tanks. The Barter Island site involved a bulldozer pulling the tanks. He is not familiar with the tanks getting stuck and Employee getting under the tanks. Mr. Williamson confirmed the valves being moved were large and heavy, though he does not know that they weighed 180 pounds. Moving and installing the valves involved working in tight areas and awkward positions. (Williamson).

104) On October 27, 2017, *Weaver v. ASRC Federal Holding Co.*, AWCB Decision No. 17-0124 (October 27, 2017) (*Weaver III*), decided numerous preliminary issues, including whether Dr. Marble's January 9, 2014 EME report should be excluded from consideration; whether Dr. Johnston's February 3, 2014 "check-the-box" concurrences to Dr. Johnston's January 9, 2014 EME report should be excluded from consideration, and whether benefits resulting from a December 7, 2010 injury were a hearing issue, in addition to Employee's claim for benefits arising from a July 23, 2013 injury. It concluded, since Employee had requested opportunities to cross-examine Drs. Marble and Johnston, and since neither testified at hearing, their reports should be excluded from consideration. *Weaver III* also concluded, because Employee had never filed a written claim for benefits for the December 7, 2010, injury, it was not a hearing issue, and it denied Employee's claim for benefits from the 2013 injury. *Id*.

105) On July 31, 2018, Employee filed a claim seeking benefits from his December 7, 2010, tire chain changing, injury, including TTD from January 10, 2014, and continuing, PPI, medical and related transportation costs, reemployment benefits, interests and attorney fees and costs. He included the notation, "Per 8/24/2016 deposition testimony of SIME physician Dr. Scoggin the 12/7/10 injury is the substantial cause of employee's disability since 1/9/14. (see Dr. Scoggin depo p. 107-108 in AWCB case no. 201320030M) . . . ." (Claim, July 31, 2018).

106) On March 15, 2019, in *Weaver v. ASRC Federal Holding Co.*, AWCAC Decision No. 258 (March 15, 2019), the Commission affirmed *Weaver III*, holding the panel had properly protected Employee's cross-examination rights by excluding Drs. Marble's and Johnston's reports from

consideration, but not other reports that may have relied on their reports, and correctly denied benefits arising from Employee's 2010 injury because he had not filed a claim. It also concluded the panel's denial of benefits arising from the 2013 injury was supported by substantial evidence. *Id*.

107) On June 5, 2020, in *Weaver v. ASRC Federal Holding Co.*, 464 P.3d 1242 (Alaska 2020), the Supreme Court decided the Commission had correctly concluded that *Weaver III*'s denial of benefits for the 2013 injury was supported by substantial evidence, that *Weaver III* did not violate Employee's due process rights with respect to its exclusion of Drs. Marble's and Johnston's reports, but not other reports that may have opined on their reports, and correctly concluded that *Weaver III* had properly applied its regulation concerning joinder when it decided benefits arising from Employee's 2010 injury were not a hearing issue. *Id*. The Court concluded its decision by writing, "Because [Employee] has now filed a claim related to the 2010 injury, the parties can litigate that claim before the board." *Id*. at 1257.

108) On August 19, 2020, Employee requested a hearing on his July 31, 2018 claim and included the notation, "To be decided per Dr. Scoggin 8/24/2016 depo. (pgs 107-108), Supreme Court Record, briefs." (Employee's ARH, August 19, 2020). He submitted no additional medical records since *Weaver III*. (Observations).

PRINCIPLES OF LAW

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

> **AS 23.30.001. Legislative Intent.**
> . . . .
>
> (2) workers' compensation cases shall be decided on their merits except where otherwise provided by statute;
> . . . .
>
> **AS 23.30.010. Coverage.** (a) . . . [C]ompensation or benefits are payable under this chapter . . . if the disability . . . or the employee's need for medical treatment

> arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability . . . or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability . . . or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the . . . disability or the need for medical treatment did not arise out of and in the course of the employment. . . .

For injuries occurring on or after November 7, 2005, the relative contribution of all causes of disability and need for medical treatment must be evaluated, and if employment is, in relation to all other causes, "the substantial cause" of the disability or need for medical treatment, benefits are awardable. *City of Seward v. Hanson*, AWCAC Decision No. 146 at 10 (January 21, 2011).

> **AS 23.30.110. Procedure on claims.** (a) . . . [A] claim for compensation may be filed with the board in accordance with its regulations at any time after the first seven days of disability following an injury, or at any time after death, and the board may hear and determine all questions in respect to the claim.

In *Robertson v. American Mechanical, Inc.,* 54 P.3d 777 (Alaska 2002), the Alaska Supreme Court held *res judicata*, or claim preclusion, applies to workers' compensation cases; however, it is not always applied as rigidly in administrative proceedings as in judicial proceedings. *Id.* at 779-780.

> When applicable, *res judicata* precludes a subsequent suit 'between the same parties asserting the same claim for relief when the matter raised was, or could have been, decided in the first suit.' It requires that '(1) the prior judgment was a final judgment on the merits, (2) a court of competent jurisdiction rendered the prior judgment, and (3) the same cause of action and the same parties . . . were involved in both suits.'

Id. at 780 (citations omitted). The question of whether the cause of action is the same does not rest on the legal theory asserted but rather on whether the claims arise out of the same transaction-the same set of underlying facts. *Angleton v. Cox*, 238 P.3d 610, 614 (Alaska, 2010). It is a well-established principle that no decision may constitute res judicata if the party against whom it is asserted has not had a full and fair opportunity to litigate his claims. *Sengupta v. University of Alaska*, 21 P.3d 1240, 1253 (Alaska, 2001).

To determine whether a decision is a "final judgment" that triggers the time limit for an appeal, "the reviewing court should look at the substance and effect, rather than form, of the rendering

court's judgment." *Richard v. Boggs*, 162 P.3d 629, 633 (Alaska 2007). "A 'final judgment' is one that disposes of the entire case and ends the litigation on the merits." *Id*.

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

"The text of AS 23.30.120(a)(1) indicates that the presumption of compensability is applicable to *any* claim for compensation under the workers' compensation statute." *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996) (emphasis in original). Medical benefits, including continuing care, are covered by the AS 23.30.120(a) presumption of compensability. *Municipality of Anchorage v. Carter*, 818 P.2d 661, 664-65 (Alaska 1991). The Alaska Supreme Court in *Sokolowski v. Best Western Golden Lion*, 813 P.2d 286, 292 (Alaska 1991) held a claimant "is entitled to the presumption of compensability as to each evidentiary question."

The presumption's application involves a three-step analysis. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381 (Alaska 1991). First, an employee must establish a "preliminary link" between the "claim" and her employment. In less complex cases, lay evidence may be sufficiently probative to make the link. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Whether or not medical evidence is required depends on the probative value of available lay evidence and the complexity of the medical facts involved. *Id*. An employee need only adduce "some," minimal relevant evidence, *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V*., 742 P.2d 239, 244 (Alaska 1987), establishing a "preliminary link" between the "claim" and the employment, *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). Witness credibility is not examined at this first step. *Excursion Inlet Packing Co. v. Ugale*, 92 P.3d 413, 417 (Alaska 2004).

Second, once an employee attaches the presumption, the employer must rebut it with "substantial" evidence that either, (1) provides an alternative explanation excluding work-related factors as a substantial cause of the disability ("affirmative-evidence"), or (2) directly eliminates any reasonable possibility that employment was a factor in causing the disability ("negative-evidence"). *Huit v. Ashwater Burns, Inc*., 372 P.3d 904; 919 (Alaska 2016). "Substantial evidence"

is the amount of relevant evidence a reasonable mind might accept as adequate to support a conclusion in light of the record as a whole. *Miller v. ITT Arctic Services*, 577 P.2d 1044, 1046 (Alaska 1978). The mere possibility of another injury is not "substantial" evidence sufficient to rebut the presumption. *Huit* at 920, 921. The employer's evidence is viewed in isolation, without regard to an employee's evidence. *Miller* at 1055. Therefore, credibility questions and weight accorded the employer's evidence are deferred until after it is decided if the employer produced a sufficient quantum of evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Compensation Board*, 880 P.2d 1051, 1054 (Alaska 1994); *citing Big K Grocery v. Gibson*, 836 P.2d 941 (Alaska 1992).

For claims arising after November 7, 2005, employment must be the substantial cause of the disability or need for medical treatment. *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 (March 25, 2011) (reversed on other grounds by *Huit*). If an employer produces substantial evidence work is not the substantial cause, the presumption drops out and the employee must prove all elements of the "claim" by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1381 (*citing Miller v. ITT Services,* 577 P 2d. 1044, 1046). The party with the burden of proving asserted facts by a preponderance of the evidence must "induce a belief" in the fact-finders' minds the asserted facts are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

> **AS 23.30.122. Credibility of witnesses**. The board has the sole power to determine the credibility of a witness. A finding by the board concerning the weight to be accorded a witness's testimony, including medical testimony and reports, is conclusive even if the evidence is conflicting or susceptible to contrary conclusions. The findings of the board are subject to the same standard of review as a jury's finding in a civil action.

The board's credibility findings and weight accorded evidence are "binding for any review of the Board's factual finding." *Smith v. CSK Auto, Inc.*, 204 P.3d 1001; 1008 (Alaska 2009).

> **8 AAC 45.050. Pleadings.** (a) A person may start a proceeding before the board by filing a written claim or petition.
>
> (b) **Claims and petitions.**
>
> . . . .

> (5) A separate claim must be filed for each injury for which benefits are claimed, regardless of whether the employer is the same in each case. . . .

ANALYSIS

1) Is Employee's instant claim barred as res judicata?

The application of res judicata, or claim preclusion, requires, (1) the prior judgment was a final judgment on the merits, (2) a court of competent jurisdiction rendered the prior judgment, and (3) the same cause of action and the same parties were involved in both suits. *Robertson*. *Weaver III* was a final judgment on the merits of Employee's February 19, 2014 claim, *Boggs*, and it was rendered by a panel of competent jurisdiction, AS 23.30.110(a). Thus, the first two criteria of the three-part test for the application of res judicata are met. However, as to the third part, the question of whether the cause of action was the same in *Weaver III* as here, turns on whether the claims arose out of the same set of underlying facts. *Angleton*.

Employee's February 19, 2014 claim sought benefits for a cumulative trauma-type injury he sustained in 2013 while engaged in a variety of heavy labor activities at the Barter Island and Indian Mountain Radar Sites. Meanwhile, his instant claim seeks benefits for an injury he suffered while tightening tire chains on a dump truck and road grader at the Tin City Radar Site in 2010. Each claim is based on distinct injuries that occurred at different places and times; thus, they involve different underlying facts. Consequently, Employee's instant claim is not barred by res judicata. *Id*.; *see also* 8 AAC 45.050(b)(5) (requiring a separate claim be filed for each injury, even if the employer is the same in each case). Moreover, it is a well-established principle that no decision may constitute res judicata if the party against whom it is asserted has not had a full and fair opportunity to litigate his claims. *Sengupta*. Here, that opportunity was expressly foreclosed to Employee in *Weaver III* when that decision concluded benefits arising from his 2010 injury were not issues for the 2017 hearing. Finally, the less rigid application of the doctrine in administrative proceedings, *Robertson*, and the legislature's intent for workers' compensation cases to be heard on their merits, AS 23.30.001(2), provide additional bases to not apply res judicata to bar Employee's instant claim.

2) Is Employee's December 7, 2010 injury the substantial cause of his disability or need for medical treatment?

In the absence of evidence to the contrary, Employee is presumed entitled to the benefits he seeks. AS 23.30.120(a)(1). He attaches the presumption with the deposition testimony of the SIME physician, Dr. Scoggin, who opined, Employee's 2010 injury is the substantial cause of his disability and need for medical treatment after January 9, 2014. *Wolfer*. Employer rebuts the presumption with Dr. Radecki's opinion, one of its medical evaluators that opined Employee's 2010 injury resulted in muscle strain that resolved rather quickly. *Miller.* It also rebuts the presumption with Dr. Radecki's opinion that Employee's disability and need for medical treatment after January 9, 2014, were better explained by psychosocial factors. *Huit*. Employee must now prove, by a preponderance of the evidence, that his 2010 work injury was the substantial cause of his disability or need for medical treatment after January 2014. *Koons.*

Employee's July 31, 2018 claim, and his August 19, 2020 affidavit of readiness for hearing, explicitly request that his claim be decided based on pages 107-108 of the SIME physician's testimony. He bases his instant claim on discrete testimony, at the tail-end of Dr. Scoggin's deposition, where he stated the 2010 injury is the substantial cause of Employee's disability and need for medical treatmen*t after* January 2014. Concentrating first on the testimony Employee cites, Dr. Scoggin repeatedly explained he was only stating the 2010 injury was a substantial cause of Employee's disability and need for treatment because Employee's history of back complaints began in 2010. "[T]his is where his current history starts," Dr. Scoggin declared. Dr. Scoggin also repeatedly qualified his opinion because he suspected Employee's history of back complaints predated 2010. He suspected this because, at the time of Employee's 2010 injury, Employee had already been prescribed Hydrocodone, a strong narcotic, and muscle relaxers to treat back pain. Thus, Dr. Scoggin's testimony must be evaluated in light of his oft-repeated explanations and qualifications.

The record shows Employee sustained a low back injury as far back as 2001, when he was cleaning a truck for a former employer, and reporting moderate to severe pain such that his chiropractor desired to treat him in excess of Alaska frequency standards. Employee had already been prescribed a muscle relaxer at this remote point in time. On February 17, 2012, Employee sought

treatment for low back pain that had been intermittent for the last five years, thus dating his lower back complaints to 2007. Employee was also evaluated and treated for low back pain in 2009 after performing heavy labor in cold weather. Therefore, the record simply does not support Dr. Scoggin's notion that Employee's low back complaints originated in 2010.

Dr. Scoggin's opinion on this point is also confusing in light of his other opinions and testimony. He was clearly aware of Employee's 2001 injury because, earlier in his deposition, he noted Employee was reporting pain of 6 out of 10 "way back in 2001," just as he was reporting pain of 6 out of 10 in 2013. Dr. Scoggin also testified he thought that Employee "got better" after the 2001 injury, and was doing "okay" until 2010, which is when Employee described being injured while engaged in a specific activity - adjusting chains on a road grader - as opposed to the 2013 injury, where Employee had "multiple things in his day-to-day life where he noticed pain." However, Employee also described being engaged in a specific activity at the time of his 2001 injury; he was cleaning a truck. Furthermore, in 2012, Employee reported injuring his spine while engaged in a specific activity too; he was installing garage doors. Consequently, it is unclear how adjusting tire chains is any more of a specific activity than cleaning a truck or installing garage doors; or why Dr. Scoggin would not have attributed the origin of Employee's back complaints to 2001, or 2012, instead of 2010. Thus, it is possible, if not likely, that Dr. Scoggin's cited testimony were improvident responses to questions at the tail-end of his nearly four-hour long deposition. *Rogers & Babler.*

Dr. Scoggin's attribution of the 2010 injury as the substantial cause of Employee's need for treatment also appears to contradict his otherwise consistent, previous, opinions that Employee suffered from chronic, progressive, degenerative disc disease. Dr. Scoggins diagnosed chronic low back pain and preexisting degenerative disc disease in his initial SIME report and testified at his deposition that Employee did not have a herniated disc, a fracture, or anything else clearly identifiable as a specific injury. He further testified, Employee "has multi-factorial pain, which is consistent with degenerative changes," and stated, "I think he's got facet, he's got disc, he's got now the spinal stenosis. He merely has pain. And he doesn't have radiculopathy, and he doesn't have symptoms of spinal stenosis." Even Dr. Kralick's findings at surgery, that Employee's spinal

canal was compromised by bone and thickened ligamentum flavum, were consistent with degenerative changes, according to Dr. Scoggin's other deposition testimony.

Additionally, while treating with Dr. Kralick and, when he was evaluated by Dr. Scoggin, Employee related his need for medical treatment to the 2013 injury, not the 2010 injury. Employee's attorney primarily related Employee's disability and need for medical treatment to the 2013 injury since he repeatedly sent written questions to Employee's doctors, soliciting their opinions on the 2013, but not the 2010 injury. Employee's father also related Employee's disability and need for medical treatment to the 2013 injury. At hearing, Mr. Weaver, Sr., specifically testified, when Employee returned from work, around July 23, 2013, he was "all gimped up," and his back was "definitely hurting." He then urged Employee to seek medical treatment because he had never seen Employee with similar symptoms in the *four* years prior to the work injury. Furthermore, Employee's own doctors, including Drs. Restad, Trescott, and Kralick all related Employee's disability and need for medical treatment to the 2013 injury and not the 2010 injury. Thus, because Dr. Scoggin's causation opinion for the 2010 injury stands alone in the record, is unclear, seemingly inconsistent with his other opinions, and not supported by the factual record, it is accorded very little weight and is not credible. AS 23.30.122.

On the other hand, one of Employer's medical evaluators, Dr. Radecki, opined in his March 20, 2015 and February 17, 2017 reports that Employee's 2010 injury resulted in muscle strain that resolved rather quickly. To support his opinion, Dr. Radecki cited range of motion findings from January 12, 2011, which showed a "fairly minimal effect" of the injury on Employee's range of motion, and he noted Employee's pain level the next day was just a 1 out of 10. Dr. Radecki also added Employee did not miss work as a result of the 2010 injury.

The factual record shows, following Employee's injury while changing tire chains in December 2010, Employee first sought chiropractic treatment on January 12, 2011, and he was reporting pain levels of both 5 out of 10, and between 2 to 6 out of 10. Since Employee was leaving for work the following Monday, the plan was to treat Employee for two more days, then reassess treatment frequency when Employee returned from work. On January 13, 2011, Employee reported his pain level was 1 out of 10 and that he "felt good last night" but then "tensed up" last night and that

morning. On January 14, 2011, Employee reported no lower back pain that morning and "felt good last night as well." Employee was going to work for two to four weeks and he was instructed on lower back exercises. Upon his return from work, Employee sought no further treatment from his chiropractor until August 15, 2011, when he sought treatment for *upper* back pain. Employee then went on to report numerous other work injuries throughout the remainder of 2011, none of them related to his low back, or any other part of his spine. This factual record is infinitely more supportive of Dr. Radecki's opinion than Dr. Scoggin's, *Saxton,* and accordingly, Dr. Radecki's opinion is afforded great weight, AS 23.30.122. Therefore, in evaluating whether Employee's 2010 injury resulted in muscle strain that quickly resolved or a "preexisting" condition that became the substantial cause of Employee's disability and need for treatment in January 2014, the factual record, and the weight of the evidence, supports Dr. Radecki's opinion over Dr. Scoggin's. AS 23.30.122.

In opining the 2010 injury resulted in muscle strain that quickly resolved, Dr. Radecki provided "negative-evidence" that eliminated a reasonable possibility that employment was a factor in causing Employee's disability after January 2014. *Huit*. However, Dr. Radecki also offered "affirmative-evidence" of an alternative explanation that excludes work related factors as the substantial cause of disability. *Id*. Specifically, Dr. Radecki pointed towards Employee's alcohol abuse, marijuana use, divorce, frustration, anger, difficulties paying bills and legal fees, taking more pain medication than prescribed, and taking pain medication from a past prescription, as psychosocial factors causing his disability and need for medical treatment. The panel in Weaver *III* accepted Dr. Radecki's opinion as the best explanation for Employee's disability and continuing need for medical treatment, and this panel does, as well.

The analysis in *Weaver III* is persuasive, consistent with the facts and is adopted here. Moreover, this decision sets forth an additional factual finding, not included in *Weaver III*, that further bolsters Dr. Radecki's opinion attributing Employee's disability and need for medical treatment to psychosocial factors. *Saxton*. Nearly a year prior to Dr. Radecki's initial EME, Employee telephoned a veteran's crisis hotline because he was having suicidal ideations. The person answering Employee's call noted he was having "a lot of psychosocial issues" and documented them. Employee was then assigned a social worker who followed up with him and noted Employee

was "feeling overwhelmed with several stressors," which were also documented. Collectively, the "psychosocial" factors and "stressors" documented included: Employee's workers' compensation litigation, back pain, $65,000 in credit card debt, Employee's separation from his wife, Employee's TBI, Employee's inability to work, Employee's separation from his two sons and Employee's alcohol abuse.

This record was not available to either Dr. Scoggin or Dr. Radecki at the time they wrote their respective reports, and it is remarkable that the person answering Employee's call used the same "psychosocial" terminology as Dr. Radecki. This evidence is even more impressive, however, when one considers the significant overlap of the psychosocial factors cited by Dr. Radecki and those Employee himself candidly provided during his call to the crisis hotline and to the social worker during her follow-up. *Rogers & Babler*. Therefore, just as in *Weaver III*, a preponderance of the evidence continues to show psychosocial factors were the substantial cause of Employee's disability and need for treatment after January 2014. *Saxton*. Consequently, Employee's claim will be denied. AS 23.30.010(a).

CONCLUSIONS OF LAW

1) Employee's claim is not barred as res judicata.
2) Employee's December 7, 2010 injury is not the substantial cause of his disability or need for medical treatment after January 2014.

ORDER

Employee's July 31, 2018, claim is denied.

Dated in Fairbanks, Alaska on July 26, 2021.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Robert Vollmer, Designated Chair

/s/
Sarah Lefebvre, 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 GREG WEAVER, employee / claimant v. ARCTEC ALASKA, INC., self-insured employer / defendant; Case No. 201320030; dated and filed in the Alaska Workers' Compensation Board's office in Fairbanks, Alaska, and served on the parties by certified U.S. Mail, postage prepaid, on July 26, 2021.

/s/
Ronald C. Heselton, Office Assistant II