ALASKA WORKERS' COMPENSATION BOARD

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

BRIAN ORTEGA, Employee, Claimant, v. NEESER CONSTRUCTION, INC., Employer, and ALASKA NATIONAL INSURANCE, Insurer, Defendants.	)	FINAL DECISION AND ORDER AWCB Case No. 201507071 AWCB Decision No. 22-0012 Filed with AWCB Anchorage, Alaska on February 14, 2022.

Brian Ortega's May 16, 2018 workers' compensation claim was heard on December 7, 2021 in Anchorage, Alaska, a date selected on August 24, 2021. A June 9, 2021 hearing request gave rise to this hearing. Attorney Joseph Kalamarides appeared and represented Brian Ortega (Employee). Attorney Michelle Meshke appeared and represented Neeser Construction, Inc., and Alaska National Insurance (Employer). Witnesses included Employee, who appeared and testified in his own behalf, and Mr. John Stallone, who also testified for Employee. The record was held open until December 15, 2021 for receipt of Employee's supplemental attorney fee affidavit.

ISSUES

Employee contends his April 30, 2015 work injury is the substantial cause of his need for low back, sacroiliac (SI) joint, neck, bilateral shoulder and left hip medical treatment. He contends he is entitled to medical and transportation benefits.

Employer contends Employee's need for medical treatment after the first six months following his injury are due to pre-existing degenerative conditions rendered symptomatic by his age and degenerative pathology, not his work injury, so he is not entitled to any additional medical or transportation benefits.

1) Is Employee entitled to additional medical and transportation benefits?

Employee contends he is entitled to permanent partial impairment (PPI) benefits when medically stable. He contends, although he was previously medically stable with no PPI, he subsequently became medically unstable and will be entitled to PPI benefits when he again becomes medically stable and is rated.

Employer contends Employee was medically stable six months after his work injury and three physicians have given Employee a zero percent PPI rating. It contends Employee is not entitled to PPI benefits.

2) Is Employee entitled to PPI benefits?

Employee contends he was assisted by his attorney's efforts and is entitled to attorney's fees and costs.

Employer did not put forth any contentions concerning attorney fees, but it is presumed to oppose any attorney fee award.

3) Is Employee entitled to attorney fees and costs?

FINDINGS OF FACT

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

1) Prior to the April 30, 2015 work injury, Employee had a history of lower back and left shoulder pain and injuries:

a. On October 18, 2007, Employee fell in his truck and landed on his back. X-rays showed no fracture, and Employee's primary care provider, family physician Matison White, M.D., assessed blunt trauma to the back with muscle spasm and prescribed the muscle relaxant Flexeril. (White clinic note, October 18, 2007).

b. On July 30, 2010, Employee reported to Dr. White he was having lower back pain. Dr. White diagnosed chronic lumbar osteoarthritic pain. Employee was continuing to use hydrocodone acetaminophen 10/650 for pain, twice a day. (White clinic note, July 30, 2010).

c. On August 8, 2011, Dr. White noted Employee continued to need pain medication for his chronic back and shoulder pains. He wrote a prescription to refill the hydrocodone acetaminophen for pain. (White clinic note, August 8, 2011).

d. On January 12, 2012, Employee reported he was having left shoulder pain after welding in an awkward position. A left shoulder x-ray showed no bony abnormalities or evidence of arthritis or bone spurs. Dr. White diagnosed arthritis or bursitis and performed a shoulder injection of Celestrone and Lidocane. He prescribed hydrocodone acetaminophen. (White clinic note, January 12, 2012).

e. On January 27, 2012, Employee reported his left shoulder was still painful and was bothering him quite a bit. (White clinic note, January 27, 2012).

f. On February 10, 2012, Dr. White opined Employee might need a left shoulder magnetic resonance imaging study (MRI). Employee elected to defer further workup as his work schedule would not permit him to schedule an MRI at that time. (White clinic note, February 10, 2012).

g. On April 11, 2013, Employee treated with Dr. White for "all over" joint pain that had lasted one month. His knees, elbows and lower back were aching badly, and he had been using 2 and ½ hydrocodone daily to help control the pain. Dr. White prescribed a Medrol Dosepak and a vigorous two-week treatment with nonsteroidal anti-inflammatories. He told Employee it was all right to increase his hydrocodone to a maximum of three daily. (White clinic note, April 11, 2013).

h. On April 24, 2014, Dr. White evaluated Employee's complaints of left hip pain and back pain. Employee stated he had fallen off a backhoe and landed on the track the previous week. He reported the pain was intense and he had difficulty walking. Dr. White noted Employee had point tenderness over his left hip, which probably originated from the sacroiliac joint area. Employee complained of a "catch" when he walked, which changed his gait. There was no radiculopathy. An x-ray of the hip was "ok". Lumbar spine x-rays showed mild degenerative lower lumbar disc disease. Dr. White prescribed a Medrol Dosepak. (White clinic note, April 24, 2014).

i. On December 16, 2014, Employee treated with Dr. White for left hip pain. He reported he was crawling and slipped on the ice. His left leg went out from under him and was now hurting. Dr. White noted the left hip was quite painful on internal and external rotation with flexion and abduction. Dr. White opined the pain was a result of his osteoarthritis demonstrated on the April 24, 2014 x-ray. He prescribed a Medrol Dosepak and Norco 10-325, twice a day. (White clinic note, December 16, 2014).

j. On March 10, 2015, on referral from Dr. White, Harold Cable M.D. evaluated Employee's left hip pain. Dr. Cable noted Employee was having severe hip pain and performed a left hip iliotibial band injection under fluoroscopy. (Cable procedure note, March 10, 2015).

k. On April 2, 2015, Employee treated with Dr. White for foot and leg cramping and left hip pain. Dr. White prescribed hydrocodone acetaminophen 10/325 mg, 1-2 tablets twice a day. (White clinic note, April 2, 2015).

2) On May 2, 2015, Scott Peterson, P.A, evaluated Employee for injuries received in the motor vehicle accident on April 30, 2015. Employee reported was at work, driving a company truck, when another vehicle hit the left rear corner of his vehicle. He complained of injury to his left shoulder and left hip, as well as some neck stiffness. The left shoulder x-rays revealed acromioclavicular interval widening, which could represent ligamentous laxity and/or glenohumeral joint effusion. The left hip x-rays did not show fracture, avascular necrosis, osteoarthritis, or dislocation. Cervical spine x-rays showed degenerative disk and joint changes in

the mid and lower cervical spine. PA Peterson recommended over-the-counter medications. (Peterson clinic note, May 2, 2015).

3) On May 6, 2015, Employer filed its report of injury, stating Employee was having pain to the left side of his neck, left shoulder and left hip after he was struck by another vehicle on April 30, 2015, while driving in a company truck. (First report of injury, May 6, 2015).

4) On May 6, 2015, Matison White, M.D. evaluated Employee for his left shoulder, neck, and hip pain. Employee reported he was stopped at a light and was struck by another car. There was a violent acceleration/deceleration motion. Employee reported his worse pain was in his left hip at the anterior superior iliac crest. Dr. White noted Employee had an antalgic gait and limp. Dr. White assessed rapid acceleration deceleration-type injuries from the vehicle accident. He ordered a left hip MRI and prescribed prednisone. (White clinic note, May 6, 2015).

5) On May 7, 2015, a left hip MRI did not show any posttraumatic changes. No arthritic, degenerative or congenital anomalies were defined. (MRI report, May 7, 2015).

6) On May 14, 2015, Dr. White noted Employee was doing much better, and the MRI had shown low risk for long term injury. He prescribed hydrocodone acetaminophen 10/325 mg, 1-2 twice a day for the pain and put Employee on light duty, with no lifting greater than 25 pounds for another week. (White clinic note, May 6, 2015).

7) On May 19, 2015, Employee followed up with Dr. White for left hip pain. Dr. White noted the vehicle accident greatly aggravated Employee's pain, which had not completely gone away. Dr. White administered a left hip intra-articular injection. (White clinic note, May 19, 2015).

8) On June 11, 2015, Harold Cable, M.D., administered a left hip therapeutic injection. (Cable clinic note, June 11, 2015).

9) On July 13, 2015, Employee treated with Dr. White for his ongoing back pain. He reported the left hip injection performed by Dr. Cable a month previously had helped for a couple of weeks. Dr. White planned to refer Employee back to Dr. Cable for a second left hip injection. (White clinic note, July 13, 2015).

10) On August 18, 2015, Dr. White evaluated Employee for his left hip pain, which Employee reported had decreased since his last shot. Employee reported he had jumped off a "rig" and reinjured it. There was no radiculopathy. Dr. White assessed gradual resolution of Employee's hip and low back work injuries and opined they had sufficiently resolved such that Employee could return to work. (White clinic note, August 18, 2015).

11) On September 9, 2015, Dr. Cable performed a left hip therapeutic injection. (Cable clinic note, September 9, 2015).

12) On September 22, 2015, Employee followed up with Dr. White for his left hip pain. He reported his last injection had helped with his pain, but he still had problems when driving his truck. Dr. White prescribed physical therapy. (White clinic note, September 22, 2015).

13) On November 20, 2015, physical therapist Denton Scow noted Employee had slipped and fallen onto his left hip, causing a little increase in soreness and pain. He thought some causative factors for Employee's hip pain might have been radicular symptoms from his low back. (PT Scow physical therapy note, November 20, 2015).

14) On December 8, 2015, Employee followed up with Dr. White for his left hip pain. Employee reported his left hip was much better after physical therapy and he was able to work a full day without pain. Dr. White noted Employee was finished with physical therapy and could be released from workers' compensation at that time, although he also warned Employee he might require further treatment if the pain returned. (White clinic note, December 8, 2015).

15) On January 16, 2016, a lumbar spine MRI was performed for low back pain with right peripheral radiculopathy. The MRI showed a 3mm anterior listhesis of L4 and L5 with associated advanced bilateral facet arthropathy. There was also mild to moderate central stenosis and a diffuse annular bulging at L4-5 with an annular tear to the left. No other abnormalities were noted. (MRI report, January 16, 2016).

16) On March 24, 2016, Dr. White noted Employee's back pain had come back after a trip to Georgia. His right hip was hurting as well. After reviewing Employee's MRI, which showed spondylolisthesis at L5-S1 with severe facet disease at those levels, Dr. White assessed lumbosacral radiculopathy. He referred Employee to Dr. Cable for possible L4-5 facet injections. (White clinic note, March 24, 2016).

17) On April 20, 2016, on referral from Dr. White, a lumbar spine MRI was performed. The impression was degenerative anterolisthesis and marked facet joint disease at L4-L5, with increased fluid compared with the prior exam in January 2016. There was also subligamentous disc protrusion at L4-L5, with a small annular tear protruding into the foramen on the left. All the changes had been present before, but there was now more fluid within the facet joints. (MRI report, April 20, 2016).

18) On April 25, 2016, Employee treated with Dr. White. He complained of a lot of back pain which was significantly interfering with his work as he had to limit himself to jobs that were light in nature. He still had pain radiating down the back of his left leg. Dr. White noted the April 20, 2016 MRI showed significant inflammatory degenerative facet joint disease at L4-L5. (White clinic note, April 25, 2016).

19) On August 22, 2016, on referral from Dr. White, Larry Levine, M.D., evaluated Employee. Dr. Levine diagnosed left lumbar spine pain with presumed facet-mediated pain, but with some relief with prior facet blocks as well as physical therapy, relative deconditioning, and hypertension. Dr. Levine stated he would consider diagnostic and hopefully therapeutic blocks if Employee had any significant flare or increasing pain, but for the present he suggested Employee finish out his physical therapy. He stated he would try a left-hand side facet block, and if this provided some relief but did not last long, he would consider a radiofrequency procedure after that. (Levine letter to Dr. White, August 22, 2016).

20) On September 13, 2016, Dr. Levine performed left L3 and L4 medial branch blocks and a L4-5 facet block due to h Employee's complaints of severe back pain. (Levine clinic note, September 13, 2016).

21) On October 6, 2016, Employee followed up with Dr. Levine. Employee reported he had profound relief after the L3 and L4 medial branch and L4-5 facet blocks, thus Dr. Levine did not think a radiofrequency procedure was indicated at the time. He agreed with the recommendations from Employee's physical therapist to participate in a work-hardening program. Dr. Levine opined Employee's use of low dose hydrocodone was reasonable to allow him to tolerate therapy and work. (Levine letter, October 6, 2016).

22) On March 10, 2017, occupational therapist John DeCarlo completed Employee's functional capacity evaluation (FCE). Mr. DeCarlo determined Employee's FCE placed him in the medium physical demand classification, which allowed him to return to full duty as a heavy equipment mechanic, his job at the time of injury. (FCE report, March 13, 2017).

23) On March 22, 2017, Employee saw Dr. White for follow-up after having completed his work hardening program. Employee was still complaining of back pain and left hip pain. Dr. White reviewed the lumbar spine MRI of the year prior and noted the annular tear at L5 could be related to the work injury. He opined Employee might have further problems with disc herniation due to the annular tear in the future but decided to close the workers' compensation case for now and

reopen it in the future should the disc herniate further. Dr. White noted Employee was aware the facet joint sclerosis could produce continued back pain but doubted the work injury caused the sclerosis. He opined treatment would probably be needed in the future for the facet joint sclerosis, but it would be on Employee's regular insurance program. (White clinic note, March 22, 2017).

24) On March 22, 2017, Dr. White opined Employee was medically stable as of that date. He also opined Employee had incurred no permanent partial impairment and would be able to return to his job at the time of injury as a mechanic foreman. He stated Employee had an annular tear at L5-S1 that would require lifelong lifestyle changes, with including back exercises and physical therapy, and a surgical referral may eventually be needed. (Dr. White's response to Employer's questions, March 22, 2017).

25) On April 5, 2017, Dr. White evaluated Employee for his complaints of neck, shoulder, and arm pain, including right shoulder pain after participating in the work hardening program and lifting weights. He noted the cervical spine x-rays showed disc disease at C4-5, C5-6, and C6-7. The foramina looked "OK." Employee had numbness in the C7 nerve root distribution in his right hand. Dr. White ordered a cervical spine MRI. (April 5, 2017).

26) On April 11, 2017, Employee's cervical spine MRI showed degenerative changes at multiple levels with some central stenosis at C3-4 and C4-5. There was very severe foraminal encroachment at C4-5, right greater than left, and at C5-6 to a slightly lesser degree as well. (MRI report, April 11, 2017).

27) On May 1, 2017, Dr. White followed up with Employee after his cervical spine MRI. Employee was continuing to complain of numbness in his right arm and occasional severe pain in his left shoulder and left arm to the elbow. He also had neck pain posteriorly. He had to use medication to control the pain. Dr. White explained to Employee he had multilevel degenerative disc disease in his neck with the most severe foraminal stenosis at C4-5 on the right and left. Dr. White prescribed Norco 10/325, one every 4-6 hours as needed for pain and planned a neurosurgery referral. (White clinic note, May 1, 2017).

28) On May 15, 2017, on referral from Dr. White, neurosurgeon Louis Kralick, M.D., evaluated Employee for his neck and left shoulder pain. Employee gave a history of having been involved in a motor vehicle accident two years previously. He reported lifting a large amount of weight in a work hardening program when he began to develop neck and left shoulder pain. He reported aching pain in his posterior neck with radiation into his left shoulder. In certain positions, his pain

increased and radiated down his bilateral arms. He also felt weakness on his right side. He continued to work as a heavy equipment mechanic. On examination, he had weakness in his left deltoid and decreased sensation in his left C-6 dermatome, which correlated with the significant multilevel degenerative changes seen at C4-C7 and varying degrees of central canal and neuroforaminal stenosis at those levels due to disc osteophyte complexes. Dr. Kralick recommended conservative treatment such as physical and massage therapy. However, he told Employee he might need surgery, a C4-7 anterior cervical discectomy and fusion in the future, should his degenerative changes progress. Dr. Kralick referred Employee for cervical spine flexion-extension x-rays, which showed moderate multilevel degenerative disc disease, most pronounced at C4-5 and C5-6, with no instability. He referred Employee for C6-7 facet blocks to help target and reduce his neck pain. (Kralick clinic note and cervical spine x-ray report, May 15, 2017).

29) On May 19, 2017, on referral from Dr. Kralick, anesthesiologist and pain medicine specialist Heath McAnally, M.D. evaluated Employee for bilateral C4/C5/6 and C6/7 facet intervention. Dr. McAnally reviewed Employee's medical history, the cervical spine MRI report, and performed a physical examination. Dr. McAnally advised Employee he did have fairly significant spondylosis and they would tentatively plan on facet intervention. He also advised Employee if he concentrated on improving his posture and ergonomics, he would greatly increase his chance of resolution or at least significant improvement in his disc degeneration. Dr. McAnally also advised Employee to wean off opioids. He prescribed the medication Gabapentin. (McAnally clinic note, May 19, 2017).

30) On May 23, 2017, Employee began massage treatment for his neck pain with chiropractor August Manelick, D.C. He continued treatment through July 13, 2018. (Manelick clinic notes, May 23, 2017 through July 13, 2018).

31) On May 30, 2017, Dr. McAnally performed bilateral C4-7 medical branch blocks on Employee. Employee returned seven hours after the procedure and reported he had essentially complete relief of all his symptoms on the right side, but no notable improvement on the left, and his shoulder girdle and upper extremity radicular features had persisted. Dr. McAnally then performed a translaminar cervical epidural steroid injection (ESI) to achieve longer-acting relief. (McAnally clinic note, May 30, 2017).

32) On June 14, 2017, Employee followed up with Dr. White for his left hip and back pain. He had had a lumbar epidural steroid injection a year previously, and the pain was now starting to come back. Dr. White opined this was a workman's compensation related injury. Dr. White repeated the lumbar epidural steroid injection. (White clinic note, June 14, 2017).

33) On July 18, 2017, Employee followed up with Dr. White for his low back pain. Employee reported to Dr. White he was certain his low back pain was related to his work injury, and he would like to reopen the case in order to get the epidural injections again, as those had worked well for him. (White clinic note, July 18, 2017).

34) On August 31, 2017, orthopedic physician R. David Bauer, M.D., evaluated Employee in an employer's medical evaluation (EME). Dr. Bauer reviewed Employee's medical history and reports of imaging studies from May 2, 2015 through March 22, 2017. He also performed a physical examination. Employee's chief complaints at the time of the examination were aching in the posterior aspect of his neck in the interscapular area, predominantly on the left. He also complained of aching in his lower back, also predominantly on the left. He described his injury as occurring when he was the restrained driver of a work truck, and his truck was struck on the left rear corner by a vehicle traveling at a high rate of speed on April 30, 2015. The other vehicle went underneath Employee's work truck, bending the rear steel bumper. He reported being dazed and stunned at the time. The next day he could not move, was very sore and had difficulty turning his head. He reported to Dr. Bauer he had not been symptomatic in any of these areas prior to the injury.

Dr. Bauer diagnosed Employee with cervical spine and lumbar spine strain, both substantially caused by the April 30, 2015 work injury. Dr. Bauer found no evidence of hip disease. He opined the work injury did not create any structural changes in Employee's back or neck. He opined the degenerative changes in the neck and lumbar spine, including the discs and facets, pre-existed the work injury and were not caused or aggravated by the work injury. Employee's ongoing disability and need for medical treatment were not caused by the work injury but were caused by the pre-existing degenerative changes as well as Employee's age, deconditioning and obesity. Dr. Bauer maintained the work injury was the substantial cause of Employee's need for medical treatment for only the first six months following the work injury. Dr. Bauer also opined the work injury did not cause or aggravate the annular tear in Employee's lumbar spine, nor any of the other findings

on the April 20, 2016 MRI. Annular tears are not a sign of injury but occur in the early stages of disk degeneration. Employee was medically stable as of September 13, 2016, or certainly after he completed his work-hardening program and the March 10, 2017 FCE. Employee was able to return to his job at the time of injury once he was medically stable. Employee did not incur a PPI for his lumbar spine or his cervical spine, per the criteria in the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition. Further treatment was neither reasonable nor necessary, other than a home-based exercise program and over-the-counter analgesics and anti-inflammatory medications. Dr. Bauer noted Employee's FCE had demonstrated he was capable of at least medium physical demand level, which was the requirement of his job at the time of injury. (Bauer EME report, August 31, 2017).

35) On September 25, 2017, Employer controverted all future benefits, effective September 18, 2017, based on Dr. Bauer's August 31, 2017 EME report. (Controversion, September 25, 2017).

36) On October 24, 2017, Employee followed up with Dr. Kralick for his neck pain. Employee reported the facet blocks and translaminar epidural steroid injections he had received from Dr. McAnally had provided significant improvement in his pain and had controlled his pain for most of the summer. However, recently he had had a return of his pain with a constant neck ache that radiated to his left side. He also had occasional headaches and numbness in both arms. Dr. Kralick decided to refer him to Dr. McAnally for possible repeat injections. He also ordered a lumbar MRI to assess Employee's low back pain. (Kralick clinic note, October 24, 2017).

37) On November 15, 2017, Employee treated with Dr. White after slipping and falling at work and hurting his back. Dr. White opined he had had a significant setback with reinjury of his back at work. (White clinic note, November 15, 2017).

38) On November 16, 2017, Employee returned to Dr. McAnally for a repeat cervical epidural steroid injection (CESI) after having experienced over four months of complete relief of his typical cervicalgia and shoulder girdle symptoms. (McAnally clinic note, November 16, 2017).

39) On November 22, 2017, Employee treated with Dr. Manelick, who noted Employee was complaining of acute posterior cervical pain and acute central low back pain. Dr. Manelick felt Employee was showing signs of foraminal stenosis and longstanding C6-7 disc disease. He referred Employee to a neurologist in Anchorage as he felt he needed an updated cervical MRI. (Manelick clinic note, November 22, 2017).

40) On December 4, 2017, Dr. McAnally evaluated Employee for new complaints of pain in his right upper trapezius and right shoulder, as well as left lumbar/lumbosacral pain radiating to the posterior lateral thigh. His cervicalgia and headache symptoms were doing well following his CESI, performed a month prior. Dr. McAnally noted Employee reported the motor vehicle accident work injury to Dr. McAnally for the first time about four years previously, according to Dr. McAnally's recollection. Employee described he had suffered a right lateral whiplash-type injury with forced hyperflexion to the right. Dr. McAnally also scheduled a lumbar spine MRI. (McAnally clinic note, December 4, 2017).

41) On December 6, 2017, Employee underwent a lumbar spine MRI. The impression was mild disc desiccation and a small bulge superimposed on moderate facet osteoarthritis resulting in mild to moderate bilateral neural foraminal stenosis and mild central spinal canal stenosis. These changes might affect the exiting L4 nerve root. There was no evidence of S1 nerve root compression. (MRI report, December 6, 2017).

42) On January 9, 2018, Employee treated with Dr. Kralick for his progressive neck and low back pain since a vehicle accident three years previously. Employee reported his neck pain had improved from the facet and ESI injections Dr. McAnally had performed in May 2017. Dr. Kralick opined Employee should follow up with Dr. McAnally, who could use injections to differentiate if the shoulder pain was from the C5 nerve root or within the shoulder. He recommended Employee continue his massage therapy and daily stretching. Employee stated he would like to continue with conservative therapy for his low back pain. (Kralick clinic note, January 9, 2018).

43) On January 17, 2018, Employee followed up with Dr. McAnally for his cervicalgia and left upper extremity symptoms, for which he had received continuing and ongoing relief after his second CESI two months prior. Employee described that during the vehicular accident, to which he attributed most of his symptoms, his right upper extremity was forcibly thrown into a hyperextended internal rotation above and behind his head and absorbed much of the impact of his body colliding into the ceiling of the vehicle. Dr. McAnally advised Employee his mechanism of injury and presentation were concordant with a subscapularis injury and referred him to Kevin Paisley, D.O. (McAnally clinic note, January 17, 2018).

44) On February 5, 2018, Dr. Paisley evaluated Employee for his right shoulder pain. Employee reported the injury could be from a vehicle accident on May 5, 2017. Dr. Paisley stated Employee could not cite a specific traumatic event that led to his right shoulder pain, but he reported he had

a series of significant injuries, most notably a motor vehicle accident two years previously. Dr. Paisley had three-view x-rays taken of Employee's right shoulder, which revealed rotator cuff calcific tendonitis along the greater tuberosity and a partial thickness tearing of the supraspinatus and subscapularis with subacromial impingement and perhaps a superior labrum anterior posterior (SLAP) pathology as well. Dr. Paisley gave Employee an injection into his right shoulder and referred him for formal physical therapy. (Paisley clinic note, February 5, 2018).

45) On February 6, 2018, Employee followed up with Dr. White for his shoulder pain. Employee reported it was difficult to function at work due to working with heavy tools and parts as a heavy equipment mechanic. Dr. White stated he had a long discussion with Employee and told him his orthopedic problems were not stable and he needed further treatment of his neck. He encouraged Employee to return to for a neurosurgery consultation. (White clinic note, February 6, 2018).

46) On February 6, 2018, Employee began physical therapy for his right shoulder. He reported he worked as a heavy equipment mechanic and a month previously he was pulling a transmission out and hurt his shoulder so he couldn't use his shoulder much. He also reported he had been in a vehicular accident three years previously, resulting in three-vertebra degenerative disc disease and right shoulder pain. In addition, he stated a work hardening program he had completed a year earlier had aggravated his pain. (Physical Therapy clinic note, February 6, 2018).

47) On March 6, 2018, Employee followed up with Dr. White and reported his shoulder was his biggest problem, but he also had neck pain. He was participating in physical therapy, which was painful. Dr. White encourage Employee to consider disability retirement and early retirement. (White clinic note, March 6, 2018).

48) On April 25, 2018, Dr. White stated he had reviewed Employee's records and found no evidence for shoulder, neck, or low back issues prior to the work injury. He opined Employee's ongoing shoulder, neck and back issues were a direct result of the injuries he suffered in the May 2015 work injury. (Dr. White's letter, April 25, 2018).

49) On May 14, 2018, Employee filed his claim for permanent partial impairment (PPI), attorney's fees and costs, transportation costs, medical costs and a second independent medical examination (SIME). (Claim, May 14, 2018).

50) On June 19, 2018, Employer controverted all future benefits including, but not limited to medical costs, transportation costs, temporary total disability (TTD), temporary partial disability

(TPD), permanent partial impairment (PPI) and vocational rehabilitation benefits, effective June 14, 2018, based on Dr. Bauer's August 31, 2017 EME report. (Controversion, June 19, 2018).

51) On June 26, 2018, Dr. McAnally evaluated Employee for a CESI as ordered by PA Schafer. However, on Dr. McAnally's evaluation he did not find Employee was suffering from any degree of radiculopathy or central stenosis, as what Employee described was axial left neck pain in the mid to upper section. He had no pain or weakness in the extremities and no myelopathic symptoms. Dr. McAnally performed left C3/4 and C4/5 facet injections. (McAnally clinic note, June 26, 2018).

52) On July 26, 2018, Employee testified by deposition. When asked about prior injuries, he stated he had a work injury when working for Peak Oilfield Service Company in about 1990, when he tore a muscle in his upper back when a big loader tire "tried to come down" on him. He remembered doing some physical therapy and massage therapy and going back to work after a couple of shifts. He also remembered a May 1993 work injury, also when he was working for Peak Oil. He slipped and fell on the ice. He injured his low back and missed two shifts or four weeks. He did not remember very well, but he thinks he just had physical therapy to treat the low back injury. He testified he had been in an auto accident in which he was rear ended in the winter of 2010. Another car slid into his vehicle, but no one was hurt. He had an on-the-job work injury which he did not report to workers' compensation in which he hurt his left hip. He did "the splits" slipping on the ice while repairing a backhoe right before the wreck in 2010. He treated with Dr. White, who referred him to Dr. Cable for an injection when the pain did not go away. Dr. Cable did the injection. He had never had problems with his neck before the work injury. He thought it was whiplash, and the pain did "mellow out." When he went through the work hardening program, the neck pain recurred and kept getting worse and worse, so he had it looked at. He first saw Dr. White, who had been his treating physician since the 1990's. Dr. White ordered a cervical spine MRI. He testified he understands the nerves on the left side of his neck are being crushed. He does have electric shock-type pain that extends into his arms from his neck every so often. He is treating with Dr. Kralick for his neck pain. Employee has back and neck pain every day. He can't sit for long periods without moving. He is restricted from lifting anything over 40 pounds. (Employee Deposition, July 26, 2018).

53) On August 13, 2018, Employee reported to Dr. White he had a sudden onset of pain in his lower back while working on his knees and lifting a heavy brake drum. Dr. White planned to refer

him for L4-5 facet injections and refilled his opioid medication. (White clinic note, August 13, 2018).

54) On December 18, 2018, orthopedic surgeon Floyd Pohlman, M.D., examined Employee in a second independent medical examination (SIME). Dr. Pohlman reviewed Employee's medical history from April 25, 2003, including imaging studies' reports. He also conducted a physical examination. He noted Employee's case was complicated primarily by inconsistencies between the medical records and the history as related by Employee during the SIME. Dr. Pohlman opined, Mr. Ortega presented as a very straightforward individual and he did not detect any attempt to embellish or falsify his history, but where there were inconsistencies, more weight was given to the medical records. Regarding the right shoulder, Dr. Pohlman opined the medical records did not substantiate the history as related by Employee as there were no right shoulder complaints documented for almost two years following the work injury, a specific diagnosis was not offered for more than two years and 6 months, and the right shoulder condition was not posited to be caused by the work injury until two years and 9 months after the work injury. Dr. Pohlman diagnosed cervical strain and degenerative disc disease in the cervical spine, lumbar strain, and degenerative facet disease at L4-L5, left and right shoulder strain as well as degenerative arthritis of the right shoulder with posterior articular supraspinatus tendon avulsion (PASTA) lesion and labral tears. He noted Employee had pre-existing lumbar and cervical conditions which were aggravated by the April 30, 2015 work injury, but opined the aggravations were temporary. Only the cervical and lumbar strains were work related and the work injury was the substantial cause of Employee's need for medical treatment and any disability for approximately six months. After six months, Employee's pre-existing conditions were the cause of his disability and need for medical treatment. Dr. Pohlman further opined Employee's work injuries were medically stable six months after the work injury and he had not incurred a PPI for the work injury, using the criteria in the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition. Employee required continued medical treatment for the cervical and lumbar spines as well as the right shoulder, but that medical treatment was not work-related. Dr. Pohlman noted Employee did not admit to any neck problems prior to the work injury and he had a history of right shoulder problems and lumbar problems that predated the accident. He also noted the findings of the right shoulder MRI were degenerative, not due to a traumatic injury. In addition, he had imagining studies, both x-rays and

MRIs, of the lumbar and cervical areas that showed pre-existing degenerative changes that would not have been caused by the accident. (Pohlman SIME report, December 19, 2018).

55) On December 21, 2018, on referral from Dr. White, Employee had a cervical spine MRI. The impression was multilevel high grade bilateral foraminal stenosis without large protrusions and no extruded disc fragments. The cord was normal. (MRI report, December 21, 2018).

56) On January 14th, March 18th and April 15th, 2019, Employee continued to follow up with Dr. White for neck and back pain. On April 15th, Employee reported he had to do a lot heavier work and going up and down on very large equipment, his back pain flared. There was more radiation of pain into his left buttock. Dr. White referred Employee for L4-5 facet injections, which were performed by Dr. Cable on April 26, 2019. (White clinic notes, January 14, March 18, and April 15, 2019; Cable clinic note, April 26, 2019).

57) On August 5, 2019, Employee treated with Dr. White for sciatic radiation again after heavy lifting. Dr. White referred him to Dr. Cable for injections, which had helped when last done in April. (White clinic note, August 5, 2019).

58) On September 19, 2019, Dr. Cable performed bilateral L4-5 facet joint injections. (Cable clinic note, September 19, 2019).

59) On October 29, 2019, Employee followed up with Dr. White for his back pain, which he described as radiculopathy that started in his buttock and went down his left leg. Dr. White opined Employee's problem was slowly getting worse. (White clinic note, October 29, 2019).

60) On January 17, 2020, Employee underwent a lumbar spine MRI. The MRI showed moderately severe disc disease only at the L4-L5 level, and advanced facet degenerative changes bilaterally. There was slight anterior listhesis of L4 on L5. There was moderate central stenosis at L4-5 and significant central stenosis not defined at other levels. (MRI report, January 17, 2020).

61) On February 7, 2020, on referral from Dr. White, Dr. Cable performed a left L4-L5 facet injection. Employee noted immediate improvement in his left low back pain after the procedure. (Cable procedure note, February 7, 2020).

62) On February 13, 2020, orthopedic surgeon Davis Peterson, M.D., evaluated Employee. He reviewed the January 17, 2020 lumbar spine MRI and the February 13, 2020 x-rays of standing lumbar flexion and extension views. The x-rays showed slight disc height loss at L4-5 and anterolisthesis on flexion. There was also visible facet arthropathy and hypertrophy. Other levels were stable with good retention of disc height and lumbar lordosis. Dr. Peterson assessed chronic

low back pain, left greater than right, on a degenerative basis of both L4-5 disc and facets at L4-5 and L5-S1. There was also degenerative anterolisthesis of grade 1 at L4-5, with some buttock and posterior thigh pain, intermittent radiation into the calf and foot, but no overt radiculopathy on exam. Dr. Peterson noted Employee reported the February 7, 2020 facet block on the left had given him moderate relief during the anesthetic phase and modest relief during the steroid phase. Dr. Peterson noted Employee's number one priority was to continue working until retirement, which was three years away. Dr. Peterson suggested consultation with Heath McAnally, M.D. about radio frequency medical branch blocks at L4-5 and L5-S1 to moderate his pain and allow him to continue working. He also advised Employee degenerative anterolisthesis is usually a slowly progressive process and he might need decompression and stabilization of his L4-5 level in the future. (Peterson clinic note, February 13, 2020).

63) On February 18, 2020, Employee treated with Dr. McAnally for his chronic left low back and pelvis pain that Employee stated began several months previously when he slipped and fell on the ice, landing on the left hemipelvis. Employee reported almost two years of improvement after his left C3-4 and C4-5 facet injections, but he had recently had some recurrence. Employee stated he wanted to prioritize his pelvic issues. Dr. McAnally reviewed the January 17, 2020 lumbar spine MRI, performed a physical examination and opined Employee had a sacroiliac joint strain and trochanteric bursitis following his fall. He recommended injections to the left sacroiliac joint and for the greater trochanteric bursitis into the left hip, which he performed on February 20, 2020. (McAnally clinic notes, February 18 & 20, 2020).

64) On July 2, 2020, Employee followed up with Dr. McAnally for his low back pain. He reported he had been doing very well, experiencing unprecedented complete alleviation of his previous lumbosacral pain following SI joint and hip injections. However, Dr. McAnally noted Employee also reported he had a recurrence of left greater than right low back pain with a focus perceived at the lumbosacral junction. The recurrence of pain began when he was on a remote assignment in Delta Junction and had to stand for hours at a time on a hard concrete floor and climb up and down many ladders, stairs, and cranes. His pain was exacerbated by being on his feet and by prolonged sitting, so he had to get up and move around constantly. It was causing significant disruption to his quality of life and work productivity. Employee reported his multimodal pharmacotherapy regimen, including an opioid component, was not controlling the

pain. Dr. McAnally decided to perform diagnostic blacks, and depending on Employee's response, perform a pro bono sacral lateral branch block as well. (McAnally clinic note, July 2, 2020).

65) On July 15, 2020, Dr. Menelick, D.C., wrote a letter explaining there had been a loss of medical records and documentation, but Employee had been under his chiropractic care for his cervical spine for three years, starting in May 2017. Employee received massage therapy to manage his pain and discomfort to avoid surgical and other interventions. Dr. Menelick opined due to Employee's age, obesity, nicotine use and various other preexisting comorbidities, including extremity injuries and long duration of manual work exposure, he may have been more susceptible to severe injury during the motor vehicle work injury a year prior (sic) to his treatment initiation. Dr. Manelick opined Employee's neck and back injuries sounded like a grade two whiplash injury. (Manelick clinic note, July 15, 2020).

66) On July 21, 2020, Dr. McAnally performed diagnostic lumbar medial branch blocks, dorsal ramus block and pro bono sacral lateral branch block. Employee was released and asked to return that afternoon to report on whether he had relief. When Employee returned, he stated he had ongoing 90% improvement overall that persisted, despite heavy machinery operation at the airport, and despite not using his normal oral analgesics. Dr. McAnally then also performed a pro bono left sacroiliac/greater trochanter bursa injection. (McAnally clinic note, July 21, 2020).

67) On August 11, 2020, Employee followed up on his July 21, 2020 injections with physician assistant Scott Schafer. The appointment was via telemedicine on an audiovisual platform. Employee reported 90 percent improvement in his typical pain at its best, and now had continued 50% improvement, rating his pain on the visual analogue scale (VAS) at 2-3/10. He stated his pain was now only "discomfort" and described it as a dull aching, throbbing stiffness. PA Schafer noted the plan would be to follow Employee and repeat the medial branch blocks and perform radio frequency ablation, should Employee so desire. (Schafer clinic note, August 11, 2020).

68) On September 24, 2020, Employee followed up with Dr. McAnally for the second round of diagnostic blocks involving his severely arthropathic L4/5 and lumbosacral facet joints after a marked recurrence and worsening of his typical left hemi-pelvic and low back pain, following an incident where he accidentally stepped into a hole with his left leg. He experienced increased paresthesias in the left lower extremity extending as far down as the ankle. Dr. McAnally diagnosed lumbar facet arthropathy and sacroiliac joint pain and performed a left L3-4 medial

branch, and L5 dorsal ramus blocks as well as a pro bono S1-2 lateral branch block. (McAnally clinic note, September 24, 2020).

69) On September 30, 2020, Employee followed up with Dr. McAnally and reported he had several hours of at least 80 percent improvement in his left lumbar and lumbosacral pain after the second round of blocks performed on September 24, 2020. However, he experienced a couple of days of intense rebound pain and was provided with oral corticosteroids from his primary care physician. Dr. McAnally advised Employee he met his payer's criteria for denervation of the L4/5 and L5/S1 facet joint if he chose to do so. Employee stated he preferred to seek a surgical solution. (McAnally clinic note, September 30, 2020).

70) On September 30, 2020, on referral from Dr. White, Employee saw anesthesiologist and pain specialist James Price, D.O., for evaluation of Employee's lower back pain with radiation to his left foot. Dr. Price noted Employee appeared to be in moderate distress during the examination and was tearful. He had decreased sensation on the left lateral aspect of the left lower leg. He had an antalgic gait of the left leg. Dr. Price assessed lumbar facet pain and left leg radiculopathy. Employee agreed to weight loss with physical therapy, occupational therapy, and a work-hardening program. Dr. Price prescribed Gabapentin, hydrocodone, and Tylenol for pain control. He ordered a lumbar spine MRI and six-view flexion and extension x-rays of the lumbar spine. (Price clinic note, September 30, 2020).

71) On October 8, 2020, on referral from Dr. Price, an MRI was performed on Employee's lumbar spine because of ongoing low back pain, possibly originating from the left SI joint. At the L4-L5 level, the MRI showed an increased amount of fluid in the left facet joint and moderate chronic changes involving the facets bilaterally. There was also mild central stenosis. No bulges or protrusions at L5-S1were noted. The impression was acute inflammation and mild central stenosis at L4-5, without compromise of foraminal nerves on either side. When x-rays with flexion, extension and neutral lateral views were done, significant instability at the L4-5 level was revealed. A three-view x-ray was also done on the sacrum and coccyx. The impression was normal sacrum and SI joints. (MRI report, October 8, 2020).

72) On October 9, 2020, Dr. Price reviewed the x-rays and MRI with Employee. Employee agreed to have a left SI joint injection with local anesthetic to determine the source of his pain generator. (Price clinic note, October 9, 2020).

73) On October 14, 2020, Employee had a left SI joint injection with anesthetic only. (Price clinic note, October 14, 2020).

74) On October 15, 2020, Employee reported to Dr. Price he was pain free until about 7pm on the day of his injection. Dr. Price planned to refer Employee to orthopedic surgeon Johannes Gruenwald, M.D. (Price clinic note, October 15, 2020).

75) On October 20, 2020, Dr. Gruenwald evaluated Employee for possible SI joint fusion. Dr. Gruenwald noted Employee had had complete elimination of any pain at the SI joint after the anesthetic injection performed by Dr. Price. He opined this gave them a clear diagnostic indication to rule out any other pain generator and Employee would be best served with a fusion of the SI joint. Dr. Gruenwald planned to perform the SI joint fusion surgery. (Gruenwald clinic note, October 20, 2020).

76) On November 2, 2020, Employee presented for a preoperative visit for his left SI joint fusion. Several hours later, he learned the insurance company had put the preauthorization on hold. Employee planned to contact the insurance company and perhaps his attorney to assist him. Dr. Gruenwald planned to see Employee when the insurance questions were resolved. (Gruenwald, November 2, 2020).

77) On November 13, 2020, Employee followed up with Dr. Price. Dr. Price noted Employee was working out and had lost weight. Employee reported his pain level on average was 7/10, with the worst pain over the prior week being 9/10. He reported his current pain relievers, including hydrocodone/acetaminophen 10/325 and Gabapentin gave him enough pain relief to make a real difference in his life. Dr. Price assessed left SI joint pain and gave Employee information on stem wave therapy. Employee's insurance company was being contacted for preapproval of the stem wave therapy. Employee was scheduled for a left SI joint injection on Monday. (Price clinic note, November 13, 2020).

78) On November 18, 2020, Dr. Price performed a left SI joint injection of bupivacaine, an anesthetic and Kenalog, a steroid. Employee's pain decreased from 5/10 to 0/10 after the procedure. The next day, Employee reported a 90% resolution of his low back and SI joint pain, but now complained of neck pain. Dr. Price planned to send a note to workers' compensation, appealing the denial of the SI joint fusion surgery. (Price clinic notes, November 18, and November 19, 2020).

79) On December 2, 2020, Employee treated with Dr. Price and reported he had been feeling a lot better after the SI joint block, although his pain was returning. The SI joint support belt was also helping reduce his pain. Employee declined having a neuro-electrical stimulation for his chronic pain. He preferred to have SI joint fusion. (Price clinic note, December 2, 2020).

80) On February 3, 2021, Employee treated with Dr. Price for increasing left SI joint pain. He stated his pain level on average over the past week was 8/10 and his pain medications reduced the pain by 50 percent. Employee was going to attempt to get some relief with a transcutaneous electrical nerve stimulator (TENS) unit. He was scheduled for a left SI joint injection, which Dr. Price performed on February 12, 2020. Employee reported a reduction in his pain from 5/10 to 0/10 post procedure. (Price clinic notes, February 3, and February 12, 2021).

81) On March 8, 2021, Employee followed up with Dr. Price. His insurance company did not approve the SI joint fusion. He reported his pain level on average over the last week was 6/10, with the worst pain being 8/10. He received 25 percent pain relief with his pain medications. Employee was to continue to use his TENS unit and was given a refill of his pain medication, as well as increasing his Gabapentin dose. Employee was to be given a quote on the cost of an SI joint Stimuplex nerve stimulator. (Price clinic note, March 8, 2021).

82) On April 9, 2021, Employee followed up with Dr. Price for his SI joint pain, which he rated at 8/10 for the past week, on average. He received 75 percent relief with his pain medications. Employee stated he would like to try a trial of Stimwave for his pain and Dr. Price stated he would try to obtain precertification for the Stimuplex for his SI joint. (Price clinic note, April 9, 2021).

83) On May 10, 2021, Employee treated with Dr. Price for an exacerbation of his SI joint pain, which was preventing him from sleeping. He reported he received a 50 percent relief from his pain medications. Dr. Price refilled Employee's pain medications and planned to continue to move forward on precertification with the Stimuplex nerve stimulator, as well as writing a letter to workers' compensation explaining the course of his injury and the treatment which had resolved his symptoms. (Price clinic note, May 10, 2021).

84) On May 17, 2021, Dr. Price wrote a letter stating Employee had experienced lower back pain greater than cervical pain after a motor vehicle accident six years previously. Dr. Price reported Employee had gone through occupational therapy, physical therapy, and massage therapy without relief. Dr. McAnally had suggested radiofrequency ablation of the SI joint. Employee had three left SI joint injections, which provided complete relief of his pain. Dr. Price opined these

injections were diagnostic for left SI joint disease and he proposed a Stimwave temporary peripheral lead placement and if successful, a permanent lead. (Price letter, May 17, 2021).

85) On July 15, 2021, EME physician Dr. Bauer evaluated Employee for a second time. He reviewed Employee's medical history and imaging studies and performed a physical examination. Employee complained of pain in the left buttock cheek, the left side of the buttock and the left side of his neck, with aching and stabbing. The pain was aggravated by working and relieved by the medication Gabapentin and massage therapy every two weeks. Dr. Bauer diagnosed Employee with cervical spine and lumbar spine strains, substantially caused by the work injury, but resolved six months after the work injury. He also diagnosed cervical and lumbar degenerative disease, preexisting, not permanently aggravated by nor accelerated by the work injury. He found no objective evidence of sacroiliac disease. Dr. Bauer stated after reviewing his August 31, 2017 EME report, as well as the contemporaneous medical records, his diagnoses were unchanged. He opined there was no evidence of injury or damage to the SI joint, as multiple MRIs had not shown any damage. He did not consider a response to the sacroiliac block as definitive in SI joint diagnosis. However, even if there was damage to the SI joint, it would not be related to the work injury, as none of examiners from 2015 to 2018 had found evidence of SI disease. Finally, Dr. Bauer, relying on peer reviewed guidelines and peer reviewed medical journals, noted SI fusion was not recommended for mechanical low back pain or "SI joint-mediated pain," except in certain circumstances, none of which applied to Employee. Dr. Bauer opined the ongoing symptomatology in Employee's neck and back was brought about by degenerative disease that preexisted the incident in question. He maintained the work injury was the most important cause for Employee's disability and need for treatment for the first six months after the work injury, but since that time, his symptoms were not related to the work injury. Dr. Bauer also opined Employee had achieved medical stability after the facet blocks on September 13, 2016, and review of the extensive medical records subsequent had not altered his opinion. He stated Employee did not have any PPI as a result of the work injury. Dr. Bauer opined Employee's medical treatment through September 2016 had been reasonable, and work related, but that treatment thereafter had not been medically necessary or reasonable for the process of recovery. He disagreed with the recommendation for sacroiliac joint fusion, finding it neither reasonable or necessary, nor within the realm of acceptable medical options in Employee's case. Dr. Bauer opined Employee's inability to perform at a very heavy physical demand was not due to the work injury, but due to

the progression of his degenerative disease, which had progressed over time regardless of the work injury. (Dr. Bauer EME report, July 15, 2021).

86) On November 16, 2021, Dr. Price testified by deposition. Employee reported to Dr. Price he had back pain after the accident about 5 years previously. The pain started in his lower back and radiated down to his left foot. Dr. Price noted Employee walked with a limp protecting his left side. Dr. Price ordered lumbar spine MRIs as well as lumbar spine six-view flexion, extension x-rays, which revealed disc degeneration and facet joint disease at L4-5 and significant instability at L5. There was also an increased amount of fluid in the left L4-5 facet joint, consistent with acute inflammation, and mild central stenosis at L4-5. The imaging studies were consistent with the physical exam and the radiculopathy Employee was experiencing. Dr. Price explained the SI joint is below the L4-L5 level, and the pain from L4-L5, and the pain from the SI joint imitate each other. Dr. Price performed a left SI joint injection with local anesthetic to determine the source of the pain generator. After the injection, Employee experienced a complete relief of his pain until 7pm that night, which gives a diagnosis of SI joint pain. The options for treatment are therapeutic SI joint injection with local anesthetic and steroids, radiofrequency ablation, Stimwave stimulation and SI joint fusion. Employee was referred to Dr. Gruenwald, who recommended SI joint fusion. However, Employee's insurance company did not preauthorize the SI joint fusion. Therefore, Dr. Price treated the SI joint pain with therapeutic injections and physical, occupational, and massage therapy, as well as with the oral medications hydrocodone, Tylenol, and Gabapentin. Dr. Price testified the type of sheer force Employee experienced in the work injury could cause pain in the SI joint, especially with a seat belt. He stated it was a definite possibility the work injury was a substantial factor in creating the SI joint pain.

Dr. Price was unaware of the following: (1) Employee's medical history prior to the work injury. Specifically, he was not aware Employee had tenderness over his left hip about a year before the work injury and had two left hip injections without relief, one on December 16, 2014 and another on March 10, 2015; (2) Employee had been taking hydrocodone for his left hip pain starting from April 2, 2015 and had had left hip imaging studies done due to his pain symptoms; (3) Employee had gone through a work hardening program in 2017 and after its completion Dr. White had found Employee medically stable with no impairment on March 22, 2017; and (4) Employee was released to full duty to his job at the time of injury on March 10, 2017. Dr. Price acknowledged he

personally had limited experience with SI joint fusion surgery. Dr. Price stated he was unaware Dr. Pohlman, who performed a board-ordered examination at the end of 2018, opined the treatment and symptoms he had during the first six months after the work injury would be related to the work injury, but afterward, Employee's ongoing symptoms would be related to his preexisting genetics and obesity. However, Dr. Price opined one cannot put a magical date of someone resolving their symptoms from a motor vehicle accident at six months. He conceded he had not been privy to all the past medical history that Drs. Bauer and Pohlman had available to them. However, he testified even though Employee had some treatment prior to the work injury, there was a possibility the work injury may have aggravated a preexisting condition. Dr. Price testified he did not agree with Dr. Bauer's statement in his July 15, 2021 EME report that pain physicians have not found even moderate specificity or validity of diagnostic sacroiliac joint injections in making a diagnosis of sacroiliac joint injury. Dr. Price maintained the diagnosis of SI joint disease may be made by a block or maneuvers, and also therapeutic injections. He stated he agreed with the majority of pain physicians who treat SI joint disease and do provocative exams to diagnose it. A response to sacroiliac block is considered definitive. When asked whether Employee's work injury could either cause or aggravate Employee's back pain, he testified a motor vehicle accident could definitely be a contributory factor to Employee's back pain. (Dr. Price's deposition, November 16, 2021).

87) On November 22, 2021, Dr. Bauer testified by deposition concerning his evaluations of Employee on August 31, 2017 and July 15, 2021. Employee's descriptions of the April 30, 2015 vehicle accident were similar during both evaluations. In 2017, Employee's diagnoses were strains of his neck and lower back. He also had the degenerative disease in his neck and back, consistent with his age. There was no evidence of hip disease. Since sacroiliac pathology is part of the standard examination, Dr. Bauer looked for it, and it was not present. The physiology of a muscle strain indicates the body heals itself within 30 to 60 days, so certainly after six months, Employee's symptoms would have been related to his degenerative disease, deconditioning and obesity, not the work injury. There was no aggravation of a preexisting condition, as there were no radicular signs or symptoms, that is, neurological findings within a very short interval after the motor accident. Employee did have subjective complaints of pain, but he did not have objective findings. In the July 2021 examination, Employee continued to have pain in his left buttock and the left side of his neck. Dr. Bauer reviewed all the data once again, including the imaging data, and his

diagnoses regarding the work injury remained unchanged. He did not find any objective evidence of sacroiliac joint disease. The changes he noted in the imaging studies were the facets at L4-5 were very arthritic, and Employee had aged five or six years and he was in his late 50's. The arthritis at the L4-5 level would continue regardless of the incident in question. It is during a person's 50's and 60's when the degenerative conditions in the spine become symptomatic even without trauma. Dr. Bauer testified he did not agree with the diagnosis of SI joint disease. It did not show up on physical examination. He maintained, based on scientific literature, to make a diagnosis of sacroiliac disease, there must be at least three physical findings, no one of them being predictive, plus radiologic evidence of sacroiliac disease. If Employee had injured his sacroiliac joint in 2015, there would be radiologic evidence of change six years later. The October 8, 2020 MRI, dedicated to the sacrum, showed the SI joints were normal, with no inflammatory changes, no arthritis, and no degenerative changes. Dr. Bauer did not agree with Dr. Price's opinion Employee needed a SI joint fusion. His opinion was based on the absence of an objective indication to fuse a normal joint and the very limited literature on the use of sacroiliac fusion. In addition, he opined the buttock, flank, and thigh pain which Employee complained about is a common distribution of lumbar degenerative disease, which is much more common that sacroiliac disease. Further, when the sacroiliac joint is injected, a large amount of fluid is used to cover the whole joint, and it spreads to all the nerves of the lumbosacral plexus, so it is not very specific. Dr. Bauer also testified his examination of Employee's left hip was normal, as was the left hip imaging, so Employee does not have femoral acetabular disease. Finally, Dr. Bauer testified he understood, under Alaska law, an onset of symptoms can be an aggravation of a preexisting condition, which is why he is careful to state whether there is or is not an aggravation of a preexisting condition. In Employee's case, he did not have an aggravation of his preexisting condition. (Dr. Bauer Deposition, November 22, 2021).

88) On December 7, 2021, Employee testified he currently worked for Employer and had been with them for 19 years. His current position is shop foreman. When he first went to work for Employer, he was the only mechanic and was in charge of himself, the shop, the equipment, and the parts. Now he is in charge of an employee, the parts, shop, and the equipment. Neeser Construction, Inc., builds buildings and roads so they have big, heavy gear, including cranes, loaders, dozers, trucks, compacters, and forklifts. He is the one who is called when something breaks down. He does all the maintenance on the equipment, including changing parts. The only

thing he does not do is change tires. Since the equipment is large, so are the parts. He is very careful at work and uses the crane on his truck to move large parts.

Employee testified he had not had problems with his shoulder or neck prior to the work injury. He had had problems with his hip prior to the work injury, but that pain was in the front of his hip. The pain in the front of his hip began when he slipped on the ice and landed on the track of a backhoe and "inflamed" his hip. He treated with Dr. White, who gave him a prescription for prednisone, which did not help. Dr. White then referred him for an injection in his hip, which resolved the pain. However, after his April 30, 2015 work injury, the pain moved from the front of the hip to the tail.

Employee testified the day of the accident he was "chasing parts" and was stopped on International Airport Road waiting to turn right on C Street. When his phone, which was on the console, rang; he took the shoulder part of his seat belt off his shoulder to reach the phone. He answered the phone, then the next thing he knew, he was dazed and confused, hunched over the console, with his face drilled into an alternator which was on the front seat. It knocked a tooth out. His truck was a 550 Ford service truck weighing approximately 46,000 pounds. It has a heavy utility box. The rear bumper has four compartments and there is a quarter inch steel rear work platform. The other driver hit the truck right in the corner, and they estimated he was going 70 to 75 miles per hour. His truck was drilled into the curb and the other car went up under the truck, and the outrigger went right through the passenger side window on the other driver's car. If he had had a passenger, that passenger would have been killed. The car collapsed. His service truck did not collapse, but its big quarter inch steel bumper was bent. He absorbed all the energy inside the truck. After the accident, he was dazed and confused. He slid back into his seat and the driver of the other car came up and asked if he was all right and explained a car pulled out in front of him and he had nowhere to go. Employee responded he was not all right. His ears were ringing, and he hurt from head to toe. When the policemen arrived, they asked if he wanted an ambulance, and he said no. Employee called in to say he wouldn't be at work the next day and was told to file a report of injury with workers' compensation and go to the hospital. He did go to Regional Hospital where they took x-rays of his neck, shoulder, back and hip. He was advised to see an orthopedic doctor. He did go to see Dr. White, whom he has known since he was 25 years old. At the time

he saw Dr. White, Dr. White asked him if it was the same pain he had previously. Employee said it was not the same, as now the pain was in his butt, and he couldn't sit. He also reported he was having neck pain. On driving into Anchorage, he had to stop and stretch because the pain was so bad. Dr. White prescribed physical therapy, which he participated in, but felt it did not help. Dr. White also referred him to Dr. Cable for injections into his hip and those helped a little, but the pain came back. The pain was in his "left butt." Dr. White then ordered a low back MRI, which showed the lumbar spine degenerative disc disease.

Employee testified he requested from physical therapy to participate in a work-hardening program, as there were parts of his job he could not do. He had had to hire another mechanic at work. He went to the work-hardening program in the morning, then at noon he went to work. They worked on strengthening his low back muscles and the muscles in his hip, as well as stretches. He also exercised on treadmills and steps. After a few months, he had to stop the program as he was busier at work. He was given a home exercise program, which he does in the morning before going to work. Employee testified he gets up at around 3 to 3:30 in the morning, does stretching, then walks on the treadmill. He also does stair stepping. He then takes his pain medication and goes to work.

Employee testified he saw Dr. Kralick for his neck pain and Dr. Kralick told him he had a whiplash injury. Dr. Kralick advised him to go as long as possible without neck surgery and suggested massage therapy, which Employee does every few weeks.

Employee testified his primary concern is his lower back pain. His neck bothers him, and he gets headaches, but he has not stopped working as he loves to work. He learned his low back pain was due to his SI joint when Dr. White referred him to Dr. Price. Employee showed Dr. Price pictures of his service truck, the seat belt and described the vehicle accident that resulted in the work injury. Dr. Price stated he would do a test on Employee, and he gave him a nerve block in his SI joint, which eliminated his pain entirely for several hours. Dr. Price then ordered a shot in the SI joint, which reduced his pain considerably for about two weeks. He has had three shots in the SI joint, which reduced his pain considerably, but which did not last for a long time. Employee understood his options for treatment of the SI joint were the SI joint fusion, which would stop the impingement

on his nerve and stop the pain. Another option was to continue with the shots, which did not last very long, and radio frequency ablation, which he would prefer not to have. Employee stated his right shoulder did bother him, but it was not being actively treated. His neck was also bothering him, but he was going to massage therapy for his neck. He sees Dr. Price about once a month. His own health insurance will not pay for the SI joint fusion, and they also will not pay for the shots. (Employee, December 7, 2020).

89) Employee's presentation is sincere and forthright. However, he is a poor historian and does not have a clear recollection of events in his medical history. This is shown by the inconsistencies between his own accounts and recollection of events and the medical records. Therefore, as to the events of his injuries and medical treatment, he is not credible. (Observation, experience).

90) John Stallone testified he is the corporate safety officer for Neeser Construction Co., where he has worked since he retired from the Alaska State Occupational Safety and Health Administration (OSHA) program, where he was in-charge of the program. His work includes checking all the job sites and preparing site specific plans, and anything related to the safety and health of the employees and the subcontractors. He checks the job sites on a regular basis to make sure they are complying with OSHA law and the State of Alaska laws. He does help employees with their workers' compensation claims, but another employee is in-charge of the workers' compensation claims. Mr. Stallone learned of the April 30, 2015 vehicle accident the day after it happened. Because the accident was on a public street, he was not called in to investigate. It was the under the jurisdiction of the police. Mr. Stallone reviewed the police report and talked with Employee about the accident. Mr. Stallone did inspect the truck after the accident. It was a very heavy-duty service truck and there was little damage to it. Mr. Stallone did advise Employee to file a workers' compensation claim. He maintained contact with Employee after the accident as he saw Employee at the shop when he did his inspections at least once a month. Mr. Stallone knew Employee both before and after the work injury, and he felt the main difference in him was the amount of pain he was in. Employer had to hire another mechanic to do some parts of Employee's job, such as lifting, which Employee had been told by his doctors not to do. Mr. Stallone talked to Employee in August 2021, and Employee told him the doctors had determined his pain was coming from the SI joint. (Hearing record, December 7, 2021).

91) Employee claims $24,502.50 in attorney fees and paralegal costs for services rendered through December 14, 2021, as well as other costs totaling $573.72, for a total of $25,076.22. (Amended Affidavit of Attorney Fees and Costs, December 15, 2021).

PRINCIPLES OF LAW

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

> **AS 23.30.010. Coverage**. (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.
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> **AS 23.30.095. Medical treatments, services, and examinations**. (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. However, if the condition requiring the treatment, apparatus, or medicine is a latent one, the two-year period runs from the time the employee has knowledge of the nature of the employee's disability and its relationship to the employment and after disablement. It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require.
> . . . .

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

Under AS 23.30.120, benefits sought by an injured worker are presumed to be compensable, and the burden of producing substantial evidence to the contrary is placed on the employer. *Miller v. ITT Arctic Services*, 577 P2d 1044 (Alaska 1978). The presumption of compensability applies to any claim for compensation under the Act. *Meek v. Unocal Corp.*, 914 P.2d 1276, 1279 (Alaska 1996). An employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski v. Best Western Golden Lion Hotel,* 813 P.2d 286, 292 (Alaska 1991).

A three-step analysis is used to determine the compensability of a worker's claim. At the first step, the claimant need only adduce "some minimal" relevant evidence establishing a "preliminary link" between the injury claimed and employment. *McGahuey v. Whitestone Logging, Inc.*, 262 P.3d 613, 620 (Alaska 2011); *Smith v. Univ. of Alaska, Fairbanks*, 172 P.3d 782, 788 (Alaska 2007); *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987). The evidence necessary to attach the presumption of compensability varies depending on the claim. In claims based on highly technical medical considerations, medical evidence is often necessary to make that connection. *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). In less complex cases, lay evidence may be sufficiently probative to establish causation. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Witness credibility is not weighed at this step in the analysis. *Resler v. Universal Services Inc.*, 778 P.2d 1146, 1148-49 (Alaska 1989).

At the second step, once the preliminary link is established, the employer has the burden to overcome the presumption with substantial evidence. *Smallwood*. To rebut the presumption, an employer must present substantial evidence that either (1) something other than work was the substantial cause of the disability or need for medical treatment or (2) that work could not have caused the disability or need for medical treatment. *Huit v. Ashwater Burns, Inc.*, 372 P.3d 904 (Alaska 2016). "Substantial evidence" is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 611-612 (Alaska

1999). At the second step of the analysis, the employer's evidence is viewed in isolation, without regard to the claimant's evidence. Issues of credibility and evidentiary weight are deferred until after it is determined the employer has produced substantial evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051, 1054 (Alaska 1994); *Wolfer* at 869-870.

If the presumption is raised but not rebutted, the claimant prevails and need not produce further evidence. *Williams v. State*, 938 P.2d 1065, 1075 (Alaska 1997). If the employer successfully rebuts the presumption, it drops out, and the employee must prove all elements of her case by a preponderance of the evidence. *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 at 8 (March 25, 2011) (reversed on other grounds); *Huit v. Ashwater Burns, Inc*., 372 P.3d 904 (Alaska 2016). At this last step of the analysis, evidence is weighed, inferences are drawn, and credibility considered. To prevail, the claimant must "induce a belief" in the fact-finders' minds the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

A fundamental principle in workers' compensation law is the "eggshell skull doctrine," which states an employer must take an employee "as he finds him." *Fox v. Alascom, Inc.*, 718 P.2d 977, 982 (Alaska 1986), citing *S.LW, v. Alaska Workmen's Compensation Board*, 490 P.2d 42, 44 (Alaska 1971); *Wilson v. Erickson, All* P.2d 998, 1000 (Alaska 1970). A pre-existing condition does not disqualify a claim if the employment aggravated, accelerated, or combined with the pre-existing condition to produce the disability or need for medical treatment for which compensation is sought. Under the Act, there is no distinction between the aggravation of symptoms and the aggravation of the underlying condition. *DeYonge v. NANA/Marriott*, 1 P.3d 90, 96 (Alaska 2000); *Peek v. SKW/Clinton*, 855 P.2d 415, 416 (Alaska 1993).

The Alaska Supreme Court has repeatedly held the fact symptoms arose after an event is insufficient to establish causation in workers' compensation cases. *Lindhag v. State*, 123 P.3d 948 (Alaska 2005); *Rivera v. Wal-Mart Stores, Inc*., 247 P.3d 957 (Alaska 2011).

In *City and Borough of Juneau v. Olsen*, AWCAC Decision No. 11-0185 (August 21, 2013), the commission explained the application of "the substantial cause" in cases where a work injury

"aggravates or accelerates" or "combines" with a preexisting condition. When an employee asserts a work injury caused the aggravation or acceleration of a preexisting condition, the board must evaluate the relative contribution of both the preexisting condition and the work injury. To establish causation, the employee must show the work injury played a greater role in the disability or need for medical treatment than did the preexisting condition. *Olsen,* 17-18. When an employee asserts his disability or need for medical treatment arose as a result of a combination of his work injury and a preexisting condition, the employee must establish two additional facts to prevail, first, that the disability or need for treatment would not have happened "but for" the work injury, and second that reasonable persons would regard the work injury as the substantial cause of the disability or need for medical treatment. *Olsen,* 18-19.

DeYonge held a temporary, symptomatic worsening constitutes an injury. Preexisting conditions do not disqualify a claim under the work-connection requirement if the employment injury aggravated, accelerated, or combined with the preexisting infirmity to produce the disability for which compensation is sought. So long as the work injury worsened the injured person's symptoms, the increased symptoms constitute an aggravation, "even when the job does not actually worsen the underlying condition." *Id*. at 96.

In *Morrison v. Alaska Interstate Construction, Inc*., 440 P.3d 224 (Alaska 2019), the Alaska Supreme Court for the first time construed AS 23.30.010(a) and its relationship to the *DeYonge* doctrine and the "last injurious exposure rule." *Morrison* found the legislature did not abrogate the *DeYonge* rule when it amended the coverage statute in 2005. It held the Commission's inquiry improperly focused on what qualifies as an injury, "which is not how the legislature chose to reduce the number of potentially compensable claims." *Id*. at 233. Interpreting AS 23.30.010(a), *Morrison* held the board decides whether "the employment" was "the legal cause," *i.e.*, "a cause important enough to bear legal responsibility for the medical treatment needed for the injury," by looking at the "*causes* of the injury or symptoms" rather than considering the injury type. *Id*. at 233-234; emphasis in original.

Morrison held AS 23.30.010(a) is not complex and requires the board to consider different causes "of the benefit sought" and the extent to which each contributed to the need for the specific benefit.

The board must then identify one cause as "the substantial cause," meaning, the cause which "is the most important or material cause related to that benefit." Based on legislative history, *Morrison* found the legislature did not intend to require that the substantial cause be a "51% or greater cause, or even the primary cause, of the disability or need for medical treatment." The comparison made is "among the causes identified, not in isolation or in comparison to an abstract idea." It is a "flexible" and "fact dependent" determination. *Id*. at 237-238. *Morrison* held the board has the right and responsibility to interpret evidence and draw its own inferences. *Id*. at 239. Finding no error, *Morrison* reversed the Commission and remanded the case with instructions to reinstate the board's award. *Id*. at 240.

Traugott v. ARCTEC Alaska, 468 P.3d 499 (Alaska 2020) held the new causation standard in AS 23.30.010 required the board to identify factors contributing to the disability and need for medical treatment and decide which among them was the most material or important one. *Id*. at 514. *Traugott* held "the statute permits the board to determine which cause among all those identified is the most important or material cause of the current disability and need for medical treatment, even if an expert does not regard it as having more than 50% responsibility for the condition." *Id*. at 511, citing *Morrison*. The board, and not a medical expert, is required to consider the possible cause of an employee's disability and need for medical treatment and determine which of the possible causes is the most important in causing the disability and need for medical care. And the board, not a medical expert, is charged with determining legal responsibility. The board as the fact finder has the authority to interpret an expert's opinion and decide what weight to give it. *Id*. at 514.

> **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 finding "is binding for any review of the Board's factual findings." *Smith v. CSK Auto, Inc.*, 204 P.3d 1001, 1008 (Alaska 2009). When doctors' opinions disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.*, AWCAC Decision No. 087 (August 25, 2008).

> **AS 23.30.145. Attorney Fees**. (a) Fees for legal services rendered in respect to a claim are not valid unless approved by the board, and the fees may not be less than 25 percent on the first $1,000 of compensation or part of the first $1,000 of compensation, and 10 percent of all sums in excess of $1,000 of compensation. When the board advises that a claim has been controverted, in whole or in part, the board may direct that the fees for legal services be paid by the employer or carrier in addition to compensation awarded; the fees may be allowed only on the amount of compensation controverted and awarded . . . . In determining the amount of fees, the board shall take into consideration the nature, length, and complexity of the services performed, transportation charges, and the benefits resulting from the services to the compensation beneficiaries.
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> (a) If an employer fails to file timely notice of controversy or fails to pay compensation or medical and related benefits within 15 days after it becomes due or otherwise resists the payment of compensation or medical and related benefits and if the claimant has employed an attorney in the successful prosecution of the claim, the board shall make an award to reimburse the claimant for the costs in the proceedings, including reasonable attorney fees. The award is in addition to the compensation or medical and related benefits ordered.
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> **AS 23.30.395. Definitions**.
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> (16) "disability" means incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment.
> . . . .
> (28) "medical stability" means the date after which objectively measurable improvement from the effects of the compensable injury is not reasonably expected to result from additional medical care or treatment, notwithstanding the possible need for additional medical care or the possibility of improvement or deterioration resulting from the passage of time; medical stability shall be presumed in the absence of objectively measurable improvement for a period of 45 days; this presumption may be rebutted by clear and convincing evidence.
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> . . . .

ANALYSIS

1) Is Employee entitled to additional medical and transportation benefits?

Employee contends his April 30, 2015 work injury is the substantial cause of the ongoing pain and need for medical treatment for his low back, SI joint, neck, bilateral shoulder, and left hip. To determine compensability, the three-step presumption analysis must be applied to each of Employee's claimed injuries. Relevant to the presumption analysis in this case is the "eggshell

doctrine," under which the employer takes an employee as he finds him. For clarity in the discussion concerning which of Employee's conditions requiring medical care are compensable, each will be discussed separately below.

a) Lumbar spine

The medical records show Dr. White had treated Employee for low back pain and left hip pain prior to the April 30, 2015 work injury in 2007, 2010 and in 2014. On April 24, 2014, a year before the work injury, Employee treated with Dr. White and reported he had fallen off a backhoe the previous week. Dr. White assessed point tenderness over the left hip and opined, anatomically, the pain was probably from the sacroiliac joint area. In any case, Employee's need for lumbar spine medical treatment may be compensable if the work injury aggravated, accelerated, or combined with the pre-existing condition leading to his need for medical treatment. *Fox*; *DeYonge*; *Olsen*; *Morrison*. If, however, the pre-existing pathologies are ultimately found to be the substantial cause of the disability or need for medical treatment, then Employer will prevail. AS 23.30.010(a); *Olsen*; *Morrison*.

At the first step of the analysis, Employee must show a preliminary link between his need for lumbar spine medical care and his employment. *McGahuey*; *Smith*; *Cheeks*. At this stage, neither credibility nor the weight of the evidence is considered. *Resler*. Employee successfully raises the presumption with Dr. White's opinion Employee's need for low back and left hip medical treatment were caused by the work injury. *Smallwood*.

Because Employee raised the presumption, Employer must rebut it and may do so with substantial evidence that either: (1) provides an alternative explanation excluding work-related factors as a substantial cause of the disability; or (2) directly eliminates any reasonable possibility employment was a factor in causing the disability. *Tolbert*; *Huit*. Substantial evidence is the amount of relevant evidence a reasonable mind might accept as adequate to support a conclusion. *Miller*. Again, neither credibility nor the weight of the evidence is considered at the second step. Employer rebutted the presumption with Dr. Bauer's and Dr. Pohlman's opinions Employee's work injury was not the substantial cause of his need for lumbar spine medical treatment beyond the first six months after the April 30, 2015 work injury. Both Dr. Bauer and Dr. Pohlman noted Employee

had preexisting lumbar degenerative disc disease and opined Employee's work injuries were limited to a lumbar strain, which resolved six months after the work injury. After the first six months, both physicians opined the substantial cause of Employee's need for lumbar spine medical treatment were preexisting degenerative changes as well as the Employee's age, deconditioning and obesity.

As Employer rebutted the position, the analysis proceeds to the third step, where Employee must prove by a preponderance of the evidence employment was the substantial cause of his ongoing disability and need for medical treatment. In making this determination, credibility is considered, the evidence weighed, and the relative contribution of other causes is considered. *Norcon*; *Olsen.*

Employee's treating physician, Dr. White, opined Employee's work injury was the cause of his need for low back medical treatment. Dr. White treated Employee's lumbar spine following the work injury until his retirement in 2020. In his April 25, 2018 letter, he opined Employee's ongoing back issues were a direct result of the injuries Employee suffered in the April 2015 work injury. In that letter, Dr. White also stated he had reviewed Employee's records and found no evidence of low back issues prior to the work injury. However, Dr. White himself had previously treated employee for low back pain from 2007 to 2014. His opinion is given less weight as he did not consider Employee's preexisting lumbar spine injuries.

Whether the work injury caused Employee's need for low back medical treatment or only caused symptoms to worsen, it is a compensable injury. *DeYonge*; *Peek*; *Morrison*; *Traugott*. So long as the work injury worsened Employee's symptoms, the increased symptoms constitute an aggravation, even when the work injury does not actually worsen the underlying condition. *Id*.

The relative contribution of different causes of the disability need for medical treatment must be evaluated. Complicating the analysis in Employee's case are the reinjuries to his low back, most of which were reported as having occurred at work, but which were not reported as work injuries. On November 15, 2017, Employee reported to Dr. White he had slipped and fallen at work and re-injured his back. On August 13, 2018, he reported to Dr. White he had a sudden onset of pain while working on his knees while lifting a heavy brake drum. Then, on September 24, 2020,

Employee treated with Dr. McAnally and reported a marked increase in low back pain when he accidentally stepped into a hole with his left leg. These reinjuries, the first two of which occurred at work, but were not reported as work injuries, weaken Employee's contention the substantial cause of his need for low back medical treatment is the April 2015 work injury. The opinions of orthopedic surgeons Dr. Bauer and Dr. Pohlman, both of whom conducted thorough reviews of Employee's medical records and imaging studies, as well as conducting physical examinations, are given the greatest weight. Both opined the work injury was not the substantial cause of Employee's need for low back medical treatment by six months after the work injury. Both doctors pointed to Employee's preexisting lumbar spine degenerative disc and facet disease as the substantial cause of Employee's need for low back medical treatment. Dr. Bauer also pointed to Employee's age, deconditioning and obesity. Employee has not proven by a preponderance of the evidence the substantial cause of his need for low back medical treatment is the April 30, 2015 work injury. *Saxton*; *Wolfer*; *Traugott*. Employee's claim for ongoing lumbar spine medical treatment and disability will be denied.

b) SI joint

Employee is requesting medical benefits for treatment of his SI joint. Employee has raised the presumption the work injury is the cause of his need for SI joint medical treatment with Dr. Price's opinion there was a definite possibility the work injury was a substantial factor in creating the SI joint pain.

Employer rebutts the presumption with Dr. Bauer's opinion Employee did not have SI joint disease. Dr. Bauer examined Employee in July 2021 and found no evidence of SI joint disease. He had also reviewed the imaging studies and found no evidence of injury or damage to the SI joint. He further stated, even if there were damage to the SI joint, it would not be related to the work injury, as none of the examiners from 2015 to 2018 had found evidence of SI disease. *Huit*.

Employee must prove by a preponderance of the evidence the April 2015 work injury is the substantial cause of his need for SI joint medical treatment. Dr. Price's opinion is given less weight for three reasons. The first is he was unaware of Employee's medical history prior to the work injury and was also not privy to much of the medical history Dr. Bauer had available to him. The

second reason is Dr. Price's opinions the work injury caused the SI joint condition are speculative. He opined, even if Employee had been treated prior to the work injury, there was a "possibility" the work injury may have aggravated a preexisting condition. He also stated there was a "definite possibility" the work injury was a substantial factor in creating the SI joint pain. The third reason is Dr. Price admitted he did not have much experience with SI fusions. Greater weight is given to Dr. Bauer's opinion. *Saxton*; *Wolfer*; *Traugott*. Dr. Bauer has a more complete knowledge of Employee's medical history and treatment both before and after the work injury. He examined Employee in person twice and did not discover any evidence of SI joint pain or damage. Dr. Bauer also noted multiple MRIs had not shown SI joint disease, including one devoted to the SI joint, which revealed a normal joint. He explained the buttock, flank and thigh pain Employee complained about is a common distribution of lumbar degenerative disease. Dr. Bauer also explained the procedure is considered unproven by the peer-reviewed guidelines for the diagnoses of mechanical low back pain or "SI joint-mediated pain" and is therefore neither medically reasonable nor necessary nor within the realm of acceptable medical options for Employee. Employee has not proven by a preponderance of the evidence the work injury is the substantial cause of his SI joint disability and need for medical treatment. *Moore*; *Traugott*. Employee's claim for medical and indemnity benefits for his SI joint will be denied.

c) Cervical spine

Employee is requesting medical benefits for past and future cervical spine treatment. The substantial cause of Employee's ongoing need for cervical spine medical treatment is a factual issue subject to the presumption analysis. *Meek*; *Sokolowski*. Employee successfully raises the presumption through his testimony describing the work injury and his reporting of left-sided neck pain to PA Peterson on his initial emergency room on May 2, 2015. *Wolfer*.

Employer successfully rebutted the presumption with the opinions of Drs. Bauer and Pohlman, both of whom maintained Employee's work-related neck pain was a cervical strain that resolved by six months after the April 20, 2015 work injury. Both Dr. Bauer and Dr. Pohlman opined the substantial cause of Employee's need for cervical spine medical treatment after six months following the injury were the preexisting degenerative changes, which were not caused or

aggravated by the work injury. Dr. Bauer also pointed to Employee's age, deconditioning and obesity as causes of Employee's ongoing cervical spine disability and need for medical treatment.

As Employer rebutted the presumption, Employee must prove by a preponderance of the evidence his work injury was the substantial cause of his need for cervical spine medical treatment. Although Employee initially included left-sided neck pain in his report of the work injury, there is no documentation of treatment for the cervical spine, left shoulder or right shoulder for almost two years after the work injury. Employee did not seek treatment for his cervical spine or report neck pain to his medical providers until almost two years after the work injury when he reported to Dr. White on April 5, 2017 that his neck, shoulder, and arm pain were worsened as he participated in his work hardening program, which he had completed on March 10, 2017. He also reported to Dr. Kralick he developed neck and left shoulder pain when lifting a large amount of weight during his work hardening program. However, this new development of neck, shoulder and arm pain was not reported as a work injury. Employee's treating physician, Dr. Manelick, diagnosed Employee's cervical spine pain as a grade two whiplash injury and opined it was work-related. However, Dr. Manelick's opinion is given less weight as he did not have an accurate understanding of Employee's history, including the timing of the work injury, which he apparently understood to be one year prior to beginning treatment with him in 2017, when in fact it was two years prior. The opinions of Drs. Bauer and Pohlman, both of whom had thorough understanding of Employee's medical history, are given more weight. *Saxton*; *Wolfer*; *Traugott*. Employee has failed to prove by a preponderance of the evidence the work injury is the substantial cause of his ongoing cervical spine disability and need for medical treatment. Employee's claim for medical and indemnity benefits for his cervical spine after September 18, 2017 will be denied.

d) Right shoulder

Without regard to credibility and conflicting evidence, Employee raises the presumption his need for right shoulder medical treatment is work-related with the description of the work injury he gave to Dr. McAnally on January 17, 2018, in which his right upper extremity was forcibly thrown into a hyperextended internal rotation above and behind his head and had absorbed much of the impact of his body colliding into the ceiling of the vehicle. Dr. McAnally advised Employee the

mechanism of injury he described was consistent with a subscapularis injury and referred him to shoulder specialist Dr. Paisley.

Employer successfully rebuts the presumption with Dr. Pohlman's opinion eliminating the work injury as the substantial cause of Employee's need for right shoulder medical care due to the extended period between the work injury and Employee's right shoulder complaints, as well as the right shoulder MRI demonstrating degenerative changes that would not have been caused by a traumatic injury.

Employee must prove by a preponderance of the evidence the April 2015 work injury was the substantial cause of his need for right shoulder medical treatment. Less weight is given to Dr. McAnally's opinion as it was based on Employee's description of the work injury almost three years after it took place and Dr. McAnally did not consider nor was he aware that Employee had not complained of right shoulder pain until well over two years after the work injury took place. When Dr. Paisley evaluated Employee's right shoulder pain on February 5, 2018, Employee's explanation for his right shoulder injury was at odds with what Employee had told Dr. McAnally three weeks previously. Employee reported to Dr. Paisley he could not point to a specific traumatic event that led to his right shoulder pain. Rather, he reported he had had a series of significant injuries, most notably a motor vehicle accident, two years previously. Furthermore, when Employee started the physical therapy prescribed by Dr. Paisley on the very next day, February 6, 2018, he reported to the physical therapist he had hurt his shoulder when pulling a transmission out in his work as a mechanic a month earlier so he couldn't use it much. He also stated he had been in a vehicular accident three years previously, which had caused right shoulder pain, and a work hardening program he had completed a year earlier had also aggravated the pain. Employee's inconsistent descriptions of the events he believes caused his right shoulder pain demonstrate he is a poor historian and not credible due to lapses in his memory concerning his injuries and medical history. AS 23.30.122; *Smith*, *Rogers & Babler*. Because the opinions of Drs. McAnally and Paisley are based on Employee's description of the events leading to his right shoulder pain, their opinions on causation are given little weight. *Saxton*. Dr. Pohlman is the only physician who reviewed Employee's entire medical record and compared the contribution of various causes to credibly opine the substantial cause of Employee's need for right shoulder medical treatment was

the preexisting degenerative changes demonstrated on the right shoulder MRI, not traumatic injury. *Moore*; *Lindhag*. Dr. Pohlman also cited the long delay between the work injury in April 2015, and the right shoulder complaints not being documented until almost two years afterwards, as well as no specific diagnosis being made until two years and 6 months after the work injury, or the work-relatedness of that diagnosis being made until three months later. Dr. Pohlman's opinion the work injury is not the substantial cause of Employee's need for right shoulder medical treatment is given the greatest weight. Employee failed to meet his burden of proving the April 2015 work injury is the substantial cause of his need for right shoulder medical treatment. *Saxton*. Employee's claim for right shoulder medical costs and disability after September 18, 2017 will be denied.

e) Left shoulder

Employee raises the presumption his need for left shoulder medical treatment is work-related with his own testimony and his report to PA Peterson on May 2, 2015 that he experienced left shoulder pain after the work injury.

Employer rebuts the presumption with the Dr. Pohlman's opinion Employee had only suffered a left shoulder strain from the work injury, and Dr. White's and Dr. Kralick's opinions the left shoulder symptoms are related to the cervical spine. The record shows Employee did not seek treatment for left shoulder complaints until April 5, 2017, when Dr. White evaluated Employee for his complaints of neck, shoulder, and arm pain, including right shoulder pain, after lifting weights in the work-hardening program, which he had completed on March 10, 2017. Dr. White ordered a cervical spine MRI, which showed degenerative disc disease, and referred Employee to Dr. Kralick. On May 15, 2017, Employee also reported to Dr. Kralick he had developed neck pain, which radiated into his left shoulder after lifting weights in a work-hardening program. Dr. Kralick noted on physical examination Employee's left upper extremity symptoms correlated with the significant multilevel degenerative changes seen at C4-C7. Dr. Kralick recommended conservative treatment directed to the cervical spine. Both doctors' opinions eliminate the work injury as the substantial factor in Employee's need for left shoulder medical treatment directed at the left shoulder itself, as the problem lies in the cervical spine. *Huit.*

Employee must prove by a preponderance of the evidence the April 2015 work injury was the substantial cause of any ongoing left shoulder need for medical treatment. However, Employee has not presented any medical evidence his need for left shoulder medical treatment is work-related. Employee's claim for left shoulder medical benefits after September 18, 2017 will be denied.

f) Left hip

Employee raises the presumption his need for left hip medical treatment is work-related with his report of left hip pain both to PA Peterson on May 2, 2015, when he presented for treatment for his April 2015 work injury, and to Dr. White on May 6, 2015.

Employer successfully rebuts the presumption with Dr. Bauer's deposition testimony the left hip was normal on physical examination in 2017 and 2021, and the left hip imaging was also normal. It also rebuts the presumption with Dr. Pohlman's opinion Employee was treated for left hip pain until March 2016, at which time Dr. White, after reviewing the January 2016 lumbar spine MRI, assessed that the pain Employee experienced in his left hip was actually coming from the low back.

As Employer has rebutted the presumption, Employee must prove by a preponderance of the evidence the work injury is the substantial cause of his need for left hip medical treatment. Employee did not seek medical treatment for work-related left hip pain until March 2016, at which time Dr. White, after reviewing the lumbar spine MRI, determined what Employee experienced as left hip pain was in reality pain from the low back and Dr. White diagnosed lumbosacral radiculopathy. On February 18, 2020, when Employee treated with Dr. McAnally for his chronic left low back and pelvis pain, he reported the pain had started several months previously when he had slipped and fallen on the ice, landing on the left hemipelvis. At that time, Dr. McAnally assessed a sacroiliac joint strain and greater trochanteric bursitis due to the recent fall. Employee did not provide any evidence the work injury is the substantial cause of his need for left hip medical treatment. Employee's claim for left hip medical benefits after September 18, 2017 will be dismissed.

2) Is Employee entitled to PPI benefits?

Employee contends he is entitled to PPI benefits when medically stable and rated. Employer contends Employee was medically stable six months after the work injury and no physician has given him a PPI rating greater than zero. The presumption of compensability applies to this issue. AS 23.30.120; *Meek*; *Sokolowski.* Employee did not provide any medical opinion he was entitled to PPI benefits. Employee failed to raise the presumption. *McGahuey*; *Wolfer*; *Resler*.

Even if Employee established the presumption of compensability, Employer rebutted the presumption with the opinions of Drs. Bauer and Pohlman. Dr. Bauer opined Employee was medically stable as to his work injury six months later, or at the latest when he completed his work hardening program in March 2017. Dr. Bauer rated Employee with a zero percent PPI due to his work-related injuries in both his August 2019 report and his July 2021 report. Dr. Pohlman determined Employee was medically stable from his work injury six months after it occurred and rated his PPI at zero. In addition, Dr. White determined Employee was medically stable as of March 22, 2017 and predicted he would not have a PPI rating greater than zero.

Employee must prove by a preponderance of the evidence the April 2015 work injury is the substantial cause of a PPI. Employee provided no medical opinion he had a PPI rating due to his work injury. Employee's claim for PPI benefits will be denied.

3) Is Employee entitled to attorney fees and costs?

Employee seeks an attorney fee and costs award. Employee did not prevail in his claims for benefits under AS 23.30.95 and AS 23.30.041. Consequently, no attorney fees and costs will be awarded. AS 23.30.145(b).

CONCLUSIONS OF LAW

1) Employee is not entitled to additional medical and transportation benefits.
2) Employee is not entitled to PPI benefits.
3) Employee is not entitled to attorney fees and costs.

ORDERS

1) Employee's May 14, 2018, claim for medical and transportation costs, PPI, and attorney fees and costs is denied.
2) Employee's claim for PPI benefits is denied.
3) Employee's claim for attorney fees and costs is denied.

Dated in Anchorage, Alaska on February 14, 2022.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Judith DeMarsh, Designated Chair

/s/
Nancy Shaw, Member

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

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

APPEAL PROCEDURES

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

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

RECONSIDERATION

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

MODIFICATION

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

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of BRIAN ORTEGA, employee / claimant v. NEESER CONSTRUCTION, INC., employer; ALASKA NATIONAL INSURANCE, insurer / defendants; Case No. 201507071; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by certified US Mail on February 14, 2022.

/s/
Kimberly Weaver, Office Assistant II