# Alaska Workers' Compensation Appeals Commission

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| Gregory Weaver,<br>Appellant,<br><br>vs.<br><br>ASRC Federal Holding Company and Arctic Slope Regional Corporation,<br>Appellees. | Final Decision<br><br>Decision No. 258 March 15, 2019<br><br><br><br>AWCAC Appeal No. 17-025<br>AWCB Decision No. 17-0124<br>AWCB Case No. 201320030 |

Final decision on appeal from Alaska Workers' Compensation Board Final Decision and Order No. 17-0124, issued at Fairbanks, Alaska, on October 27, 2017, by northern panel members Robert Vollmer, Chair, and Jacob Howdeshell, Member for Labor.

Appearances: Michael J. Jensen, Law Office of Michael J. Jensen, for appellant, Gregory Weaver; Nora G. Barlow, Barlow Anderson, LLC, for appellees, ASRC Federal Holding Company and Arctic Slope Regional Corporation.

Commission proceedings: Appeal filed December 22, 2017; briefing completed October 4, 2018; oral argument held December 17, 2018.

Commissioners: James N. Rhodes, Philip E. Ulmer, Deirdre D. Ford, Chair.

By: Deirdre D. Ford, Chair.

*1. Introduction.*

Gregory Weaver asserts he sustained an injury to his low back while working for ARCTEC Alaska, now identified as ASRC Federal Holding Company, and its insurer, Arctic Slope Regional Corporation (ARCTEC), on December 7, 2010, and on July 23, 2013. The Alaska Workers' Compensation Board (Board) heard the merits of the claims on March 9, 2017, and July 6, 2017, in Fairbanks, Alaska, and issued its decision on October 27, 2017, finding Mr. Weaver not entitled to benefits arising out of the July 23, 2013, date of injury. The Board found that Mr. Weaver had not filed a workers' compensation claim (WCC) for benefits for the December 7, 2010, date of injury (although the cases were joined at a prehearing) and, therefore, benefits relating to that injury were not at issue. Mr. Weaver

timely appealed this decision to the Alaska Workers' Compensation Appeals Commission (Commission) which heard oral argument on December 17, 2018. The Commission now finds the Board's decision is supported by substantial evidence in the record as a whole and affirms the Board.

*2. Factual background.*[1]

Mr. Weaver has a history of low back problems. On February 25, 2001, he injured his low back while working for a different employer, but the mechanism of that injury was unclear. Mr. Weaver presented to his chiropractor with moderate to severe pain and his chiropractor sought to treat him in excess of the Alaska frequency standards.[2]

The next medical report is from March 25, 2009, when Mr. Weaver was evaluated and treated for low back pain after performing heavy labor in cold weather.[3] On December 9, 2010, Mr. Weaver reported he injured his low back two days earlier while tightening tire chains on a dump truck and road grader as a relief station mechanic. Mr. Weaver never filed a WCC seeking benefits for his December 7, 2010, work injury, although he did file a report of injury.[4]

Following his December 7, 2010, injury, Mr. Weaver sought chiropractic treatment several times and his low back symptoms resolved in about two months.[5] Then, on January 12, 2011, Mr. Weaver sought chiropractic treatment for low back pain that began

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[1] We make no factual findings. We state the facts as found by the Board, adding context by citation to the record with respect to matters that do not appear to be in dispute.

[2] The Board has issued three decisions in this case. *Weaver v. ARCTEC Alaska*, Alaska Workers' Comp. Bd. Dec. No. 14-0154 (Dec. 2, 2014)(*Weaver I*); *Weaver v. ARCTEC Alaska*, Alaska Workers' Comp. Bd. Dec. No. 15-0050 (Apr. 30, 2015)(*Weaver II*); and, *Weaver v. ASRC Federal Holding Company*, Alaska Workers' Comp. Bd. Dec. No. 17-0124 (Oct. 27, 2017)(*Weaver III*) which is the subject of this appeal. *Weaver III* at 5, No. 2.

[3] *Id.*, No. 3.

[4] *Id.*, No. 4; Exc. 12.

[5] *Id.*, No. 5.

about one month earlier.[6] Mr. Weaver reported on February 16, 2012, he injured his back while installing garage door panels as a station mechanic.[7] On February 17, 2012, Mr. Weaver sought treatment for low back pain, which he indicated had been intermittent over the last five years. Previous back treatment included osteopathic adjustments and chiropractic adjustments, which improved his low back pain for a period of time. Mr. Weaver's medical history is also significant for mild depression, and he reported "drinking more alcohol than he probably should."[8]

On July 23, 2013, Mr. Weaver reported waking up with back pain after shoveling, erecting scaffolding, and pushing a wheelbarrow while working as a station mechanic on Barter Island, Alaska.[9] Mr. Weaver sought treatment on July 26, 2013, for low back pain from Joyce C. Restad, D.O., who reported, "[h]e had been shoveling large amounts of sand and gravel in Kaktovik. He slept on an old, soft, bed with a thin mattress and unsupportive 'springs', and woke up in a lot of pain, on 7/23/13." Dr. Restad ordered a lumbar magnetic resonance imaging study (MRI).[10]

The MRI on August 2, 2013, was interpreted to show mild lower lumbar degenerative disc changes with moderate bilateral neural foraminal stenosis at L5-S1.[11] On August 9, 2013, Mr. Weaver's low back pain was now radiating into his buttocks. He reported he had this pain in his back for over a year and thought it was a kidney stone passing. An epidural steroid shot was recommended.[12]

On August 16, 2013, Dr. Restad referred to Mr. Weaver's injury as an "overuse injury 7/23/2013 at work." She noted Mr. Weaver was scheduled to receive three epidural

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6 *Weaver III* at 5, No. 6.

7 *Id.*, No. 7.

8 *Id.* at 5-6, No. 8.

9 *Id.* at 6, No. 10.

10 *Id.*, No. 11.

11 *Id.*, No. 12.

12 *Id.*, No. 13.

steroid injections.[13] On August 20, 2013, Dr. Restad referred Mr. Weaver to Shawn P. Johnston, M.D., for a second opinion.[14]

Mr. Weaver saw Dr. Johnston on August 21, 2013, who opined most of Mr. Weaver's pain was facet-mediated and he recommended physical therapy, between one to three times per week, for four weeks.[15] On August 30, 2013, Mr. Weaver underwent a physical therapy evaluation and reported he was experiencing the worst episode of back pain he could recall.[16] On October 4, 2013, Dr. Johnston noted physical therapy had not provided Mr. Weaver with much relief, so he decided to "try some lumbar traction over the next two weeks."[17]

On October 14, 2013, Mr. Weaver began traction therapy with Thomas J. DeSalvo, D.C. Mr. Weaver's back pain was now radiating into both buttocks. Over the course of numerous treatments, Mr. Weaver reported his back pain "come [sic] and goes but lately not getting any better." Dr. DeSalvo reported Mr. Weaver's prognosis was "guarded," and his impression was Mr. Weaver has "sustained a cumulative trauma injury to the lumbrosacral spine (chronic)."[18]

On October 28, 2013, Dr. DeSalvo thought doing both physical therapy and traction "are too much," and he recommended putting physical therapy on hold.[19] On October 31, 2013, Dr. DeSalvo stated he thought Mr. Weaver's condition was work related.[20]

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13 *Weaver III* at 6, No. 14.

14 *Id.*, No. 15.

15 *Id.* at 7, No. 16.

16 *Id.*, No. 17.

17 *Id.*, No. 18.

18 *Id.*, No. 19.

19 *Id.*, No. 20.

20 *Id.*, No. 21.

Dr. Johnston, on November 3, 2013, decided to discontinue lumbar traction since it seemed to aggravate Mr. Weaver's symptoms.[21] On November 11, 2013, Mr. Weaver began an eight-week work hardening program that was to consist of two hours per day for two weeks; four hours per day for two weeks; six hours per day for two weeks; and eight hours per day for two weeks.[22] On December 10, 2013, Dr. Johnston discontinued Mr. Weaver's work hardening program because Mr. Weaver could not tolerate it. Mr. Weaver continued with physical therapy, but did not improve.[23]

On January 9, 2014, Stephen Marble, M.D., physiatrist, conducted an Employer's Medical Evaluation (EME), during which Mr. Weaver initially related his current low back symptoms to performing strenuous labor and sleeping on a bed with little support "sometime during the summer of 2013." Later in the evaluation, Mr. Weaver commented, that for the last three to four years he had had low back pain so severe that he had to lay down in the fetal position, squeeze his legs, and rock back and forth. Dr. Marble noted Mr. Weaver to be a "vague/poor historian." Upon reviewing the August 2, 2013, MRI study, Dr. Mable saw significant disc desiccation at L4-5 and L5-S1 with a significant loss of disc height at L5-S1, as well as a broad based disc protrusion at L4-5 and a "very broad based" disc protrusion at L5-S1. Dr. Marble assessed multilevel lumbar degenerative disease, greatest at L5-S1, and thought Mr. Weaver's recorded history and the imaging findings were evidence of a preexisting, evolving, lumbar degenerative disease. Although Dr. Marble acknowledged there was certainly the potential for the work factors Mr. Weaver described causing a symptomatic aggravation, because Mr. Weaver did not describe a specific mechanism of injury, he thought Mr. Weaver had been experiencing evolving degenerative disc disease symptoms over the course of approximately three years. The substantial cause of Mr. Weaver's lumbar "condition,"

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21 *Weaver III* at 7, No. 22.

22 *Id.*, No. 23.

23 *Id.* at 7-8, No. 24.

according to Dr. Marble, was a combination of the effects of heredity, aging, and possibly remote major trauma.[24]

Dr. Restad, on February 18, 2014, authored a letter describing Mr. Weaver's work activities at the time of the 2013 work injury and the relationship between the two. On February 21, 2014, she wrote another letter "in support" of Mr. Weaver, relating an assessment of lumbar strain to his work.[25]

On May 14, 2014, Mr. Weaver reported severe pain in his lumbar spine that radiated into his buttocks, but not below. He also stated he was "having a lot of family issues going through a divorce and issues with a workers comp claim." Tramadol was prescribed for Mr. Weaver's low back pain.[26]

On May 21, 2014, Andrea M. Trescot, M.D., evaluated Mr. Weaver for low back pain and recommended a left transforaminal epidural steroid injection at L5-S1.[27] However, on May 22, 2014, Mr. Weaver reported Tramadol had not helped with his low back pain.[28] On May 23, 2014, Dr. Trescot administered an epidural steroid injection at L5-S1. She also responded to questions from Mr. Weaver's attorney, opining Mr. Weaver's low back symptoms were substantially caused by his work activities.[29] On June 17, 2014, Mr. Weaver amended his WCC for the July 23, 2013, low back injury "due to a traumatic incident and / or cumulative trauma sustained in the course and scope of his employment." He sought ongoing Temporary Total Disability (TTD) from January 15, 2014, Permanent Partial Impairment (PPI), medical and related transportation benefits, reemployment stipend, interest, and attorney fees and costs.[30]

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24 *Weaver III* at 8, No. 25.

25 *Id.* at 9, No. 28.

26 *Id.*, No. 31.

27 *Id.*, No. 32.

28 *Id.*, No. 33.

29 *Id.*, No. 34.

30 *Id.* at 10, No. 36.

On July 10, 2014, a lumbar spine MRI showed a diffuse disc bulge and mild facet arthritis, but no stenosis at L3-4, a diffuse disc bulge and mild facet arthritis with minimal foraminal stenosis at L4-5, and a diffuse disc bulge and bilateral facet arthritis with moderate bilateral neural foraminal stenosis at L5-S1. These findings were unchanged from the previous MRI.[31] On August 26, 2014, Mr. Weaver testified, after Dr. Trescot administered the epidural steroid injections, he "felt great for a day," and "pretty good" the second day, but over the course of several weeks, "it eventually wore off."[32]

Mr. Weaver has problems with both his short-term and long-term memory as a result of an automobile accident.[33] He served in the U.S. Marine Corps and was discharged in 1991.[34] Mr. Weaver initially testified he could not remember why he was discharged from the military,[35] but later testified he was discharged for trouble involving alcohol.[36] At the time of his deposition, Mr. Weaver was going through a divorce,[37] and had been arrested in July 2014 for a DUI after driving his four-wheeler through a construction zone.[38] He also had a DUI 20 years ago.[39] Mr. Weaver's wife contended alcohol was an issue leading up to the divorce, but he did not agree with his wife's contentions.[40] Mr. Weaver initially testified he was currently in treatment for alcohol abuse,[41] then later testified he was "thinking about doing that."[42] When asked if he had

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31 *Weaver III* at 10, No. 37.

32 *Id.* at 10-11, No. 39; Gregory G. Weaver Dep., Aug. 26, 2014, at 9:13-21.

33 *Id.* at 10-11, No. 39; Weaver Dep. at 11:2-7.

34 *Id.* at 10-11, No. 39; Weaver Dep. at 15:5-9.

35 *Id.* at 10-11, No. 39; Weaver Dep. at 17:9-19.

36 *Id.* at 10-11, No. 39; Weaver Dep. at 46:18-20.

37 *Id.* at 10-11, No. 39; Weaver Dep. at 13:25 – 14:2.

38 *Id.* at 10-11, No. 39; Weaver Dep. at 45:10-19.

39 *Id.* at 10-11, No. 39; Weaver Dep. at 46:16-17.

40 *Id.* at 10-11, No. 39; Weaver Dep. at 46:7-12.

41 *Id.* at 10-11, No. 39; Weaver Dep. at 45:24 – 46:3.

42 *Id.* at 10-11, No. 39; Weaver Dep. at 46:4-6.

a pattern of problems involving alcohol, he answered, "If you say so."[43] Mr. Weaver did not think alcohol was a problem for him, but rather "underlying issues" were a problem for him.[44] All the pills he had "don't really seem to help" his pain, and alcohol was "all that really seems to take [his] pain away."[45] Physical therapy and work hardening did not help Mr. Weaver.[46] Mr. Weaver had been working at the Barter Island Radar Site for three or four weeks when he was injured in 2013.[47] He woke up with pain that had been building up for several months and did not seem to go away.[48] Before working at Barter Island, he had been working at the Indian Mountain Radar Site for several weeks, which was where "the majority of the heavy lifting was."[49] He testified about his interactions with ARCTEC's nurse case manager, Tracy M. Davis, R.N., and with Dr. Johnston.[50] He also described the work he performed, including shoveling sand and gravel on his knees, erecting scaffolding, lifting large pipes while twisting, and jacking up fuel tanks with a jack that weighed 100 pounds.[51] Mr. Weaver experienced back pain prior to 2013, after adjusting tire chains on a grader."[52] The first time Mr. Weaver sought medical treatment for his back was in 2001.[53]

Mr. Weaver, on October 7, 2014, was evaluated by Louis L. Kralick, M.D., who planned to obtain Mr. Weaver's pain management records and obtain flexion and

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43 *Weaver III* at 10-11, No. 39; Weaver Dep. at 46:21-23.

44 *Id.* at 10-11, No. 39; Weaver Dep. at 47:1-2.

45 *Id.* at 10-11, No. 39; Weaver Dep. at 47:20 – 48:5.

46 *Id.* at 10-11, No. 39; Weaver Dep. at 48:6-11.

47 *Id.* at 10-11, No. 39; Weaver Dep. at 49:13-19.

48 *Id.* at 10-11, No. 39; Weaver Dep. at 49:8-11.

49 *Id.* at 10-11, No. 39; Weaver Dep. at 49:20-24.

50 *Id.* at 10-11, No. 39; Weaver Dep. at 56 – 74.

51 *Id.* at 10-11, No. 39; Weaver Dep. at 76:12 – 77:12.

52 *Id.* at 10-11, No. 39; Weaver Dep. at 18:11-16.

53 *Id.* at 10-11, No. 39; Weaver Dep. at 82:6-12.

extension x-rays.[54] On October 8, 2014, Mr. Weaver reported Dr. Trescot's epidural steroid injection provided him with excellent relief for two days. Two additional injections were ordered.[55] On October 14, 2014, Mr. Weaver received another epidural steroid injection.[56]

On October 30, 2014, Mr. Weaver saw Amy L. Murphy, D.O., for an initial assessment of a traumatic brain injury he suffered during a car accident 21 years earlier. Mr. Weaver reported stress, alcohol use, anxiety, and recently attending an inpatient unit in Georgia for seven and one-half weeks for dual diagnosis. Mr. Weaver also reported using alcohol to "deal with" the symptoms of his traumatic brain injury. Mr. Weaver's stressors included his workers' compensation case and his wife filing for divorce. Mr. Weaver also reported suffering a heart attack the previous week, which resulted in the placement of two stents. Dr. Murphy prescribed Cymbalta for anxiety, depression, and Mr. Weaver's cognitive defects.[57]

On December 11, 2014, Mr. Weaver reported taking one Oxycodone per day, which "was not helping with the pain at all." Mr. Weaver's prescription for Oxycodone was changed from 10 milligrams to 15 milligrams.[58] The December 31, 2014, lumbar spine MRI was unchanged from Mr. Weaver's July 10, 2014, MRI.[59]

On January 6, 2015, Dr. Kralick interpreted x-rays to show spondylitic changes in Mr. Weaver's lumbar spine and recommended he undergo facet injections at L4-5 and L5- S1.[60] On January 29, 2015, Mr. Weaver was restricted from driving for three to four months after having been charged with DUI. He was "having a lot of feelings of betrayal," as his wife was one of the persons who testified against him. Mr. Weaver was also

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54 *Weaver III* at 11, No. 40.

55 *Id.*, at 41.

56 *Id.*, No. 42.

57 *Id.* at 11-12, No. 44.

58 *Id.* at 12, No. 46.

59 *Id.*, No. 47.

60 *Id.*, No. 48.

"dealing with a lot of legal issues surrounding his divorce."[61] Also, on January 29, 2015, Mr. Weaver denied any improvement in his low back pain. His medication was changed from Oxycodone to Hydromorphone.[62]

On February 24, 2015, Mr. Weaver reported an 80 percent relief in his lower back pain for five hours following a medial branch block.[63]

On March 20, 2015, Patrick L. Radecki, M.D., conducted an EME, at which Mr. Weaver recounted the 2010 injury he sustained while putting 200 pound tire chains on a road grader, as well as his 2013 back problems, which "seemed to build up over time" while he was performing strenuous labor. Mr. Weaver's answers to a number of Dr. Radecki's questions concerning the history of his present illness included, "does not recall" and "cannot recall." Dr. Radecki found Mr. Weaver's memory of his past medical history "not so good." Mr. Weaver's biggest complaint, according to Dr. Radecki, was the bunk bed on which he was sleeping, which just had springs and offered little support. Dr. Radecki reviewed and summarized medical records prior to Mr. Weaver's 2013 back complaints, as well post-injury medical records from July 24, 2013, through November 4, 2013. His reports states, "All additional notes are reviewed but not dictated. Complaints continued despite treatments." Dr. Radecki observed Mr. Weaver did not sit while Dr. Radecki was taking his history, but "stood with much pain behavior, deep breathing, and posturing, leaning at time against the exam table." Dr. Radecki recorded the findings on physical examination, including actions by Mr. Weaver that did not correlate to the physical examination by Dr. Radecki. For example, when Dr. Radecki put a total pressure of 5 pounds on Mr. Weaver's head, he complained of back pain which is nonphysiologic. Another example, per Dr. Radecki, is that Mr. Weaver asserted minimal rotation to the left of 5 degrees gave him low back pain, and that to the right at 15 degrees did the same, which is nonphysiologic.

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61 *Weaver III* at 12, No. 50.

62 *Id.*, No. 51.

63 *Id.* at 13, No. 53.

Dr. Radecki opined the 2010 injury resulted in muscle strain that resolved rather quickly. To support his opinion, Dr. Radecki cited range of motion findings from January 12, 2011, which showed a "fairly minimal effect" of the injury on Mr. Weaver's range of motion, and he noted Mr. Weaver's pain level the next day was just a 1 out of 10. Dr. Radecki also added Mr. Weaver did not miss work as a result of the 2010 injury. Dr. Radecki did not think "there was any specific injury whatsoever" in 2013 and, alternatively, referred to Mr. Weaver's 2013 injury as a "[c]hoice to seek medical attention following sleep." Dr. Radecki said the imaging studies did not show evidence of an acute change and were consistent with preexisting degenerative disc disease in the lumbar spine. Instead, Dr. Radecki opined the cause of Mr. Weaver's persistent pain was predominantly due to "psychosocial factors." Dr. Radecki also noted Mr. Weaver's denial of attending an inpatient treatment unit in Georgia for stress, anxiety, and alcohol use.[64]

On March 23, 2015, Mr. Weaver reported to PA-C Cheryl K. Fitzgerald at Algone Interventional Pain Clinic (Algone) that Hydromorphone had been ineffective for his lower back pain. Mr. Weaver tested "greater than 150,000" for ethyl alcohol on his last visit, and she noted Mr. Weaver stated he drinks to help with the pain. She changed Mr. Weaver's medication from Hydromorphone to Morphine.[65]

On April 6, 2015, Mr. Weaver saw Matthew R. Peterson, M.D., at Algone and he reported that Morphine was ineffective for his lower back pain. He also admitted to taking more of his Hydromorphone than prescribed and to taking Oxycodone from an old prescription. Dr. Peterson decided to treat Mr. Weaver's facet joints with radio frequency ablation (RFA), and advised Mr. Weaver that RFA typically provides relief lasting between six months to two years.[66]

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64 *Weaver III* at 13-15, No. 54.

65 *Id.*, No. 55.

66 *Id.* at 15, No. 56.

On May 7, 2015, Mr. Weaver underwent left-sided RFA at L3-4, L4-5, and L5-S1.[67] On May 14, 2015, Mr. Weaver underwent right-sided RFA at L3-4, L4-5, and L5-S1.[68] On May 20, 2015, Mr. Weaver reported Morphine was not helping with his low back pain. His medication was changed from Morphine to Hydrocodone.[69]

On August 5, 2015, Mr. Weaver reported to Liam Walsh, M.D., a decrease in the efficacy of his Hydrocodone. Dr. Walsh changed his medication from Hydrocodone to Percocet. Mr. Weaver continued to complain of debilitating back pain. Because Mr. Weaver had failed to respond to aggressive medical management and physical therapy, as well as minimally invasive pain management procedures, Dr. Walsh recommended he see a neurosurgeon.[70]

On September 1, 2015, Mr. Weaver reported to Dr. Walsh that he had no pain relief following the RFA procedures. Dr. Walsh added MS Contin to his Percocet prescription due to reports of increased lower back pain.[71] On October 1, 2015, Mr. Weaver underwent acupuncture treatment for low back pain.[72]

Mr. Weaver saw Jennifer A. McGrath, FNP, at Anchorage Neurosurgical Associates, Inc., on October 27, 2015, and he related his low back pain to the 2013 work injury. Dr. Kralick reviewed his lumbar MRI from 2013 and compared it to the December 20, 2014, MRI. He noted significant disc desiccation and bulges at L4-5 and L5-S1. He opined Mr. Weaver's symptoms were the result of Mr. Weaver's job duties, and ordered L4-5 and L5-SI discograms.[73] On November 9, 2015, Mr. Weaver reported to FNP McGrath that his medications "do not work." She changed one of the medications

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67 *Weaver III* at 15, No. 59.

68 *Id.*, No. 60.

69 *Id.*, No. 61.

70 *Id.* at 16, No. 62.

71 *Id.*, No. 63.

72 *Id.*, No. 64.

73 *Id.*, No. 65.

from MS Contin to Fentanyl.[74] On November 19, 2015, Dr. Walsh, because Mr. Weaver was having difficulty obtaining Fentanyl patches, changed his medications from Percocet and Fentanyl to MS Contin and Morphine.[75] On January 15, 2016, Mr. Weaver reported to PA-C Jesika Harrell that Morphine "doesn't take the edge off his pain" and she re-started him on Oxycodone and MS Contin.[76]

On February 19, 2016, James F. Scoggin, III, M.D., an orthopedic surgeon, performed a second independent medical evaluation (SIME), during which Mr. Weaver described being injured sometime prior to July 23, 2013, when he was working at remote radar sites. Mr. Weaver explained changing valves in a fire pump room and handling 6-inch to 8-inch pipe in confined spaces. Mr. Weaver also described performing "very physical" work jacking up fuel tanks with a large, heavy jack to build and prepare the ground under the tanks at the Indian Mountain site, as well as moving tanks using heavy equipment and digging on his knees at another radar site. Meanwhile, according to Mr. Weaver, he was sleeping on bunk beds that offered no back support. Dr. Scoggin reviewed and summarized medical records between March 13, 1993, and May 7, 2015. Dr. Scoggin diagnosed preexisting chronic low back pain, preexisting degenerative disc disease, multiple prior episodes of recurrent low back pain and injury, including another work injury in 2001 and the tire chain injury in 2010, and an industrial lumbosacral soft tissue injury on July 23, 2013. In Dr. Scoggin's opinion, the July 23, 2013, injury combined with a preexisting condition to cause Mr. Weaver's disability and need for treatment, but it did not result in a permanent change. He opined Mr. Weaver was medically stable at the time of Dr. Marble's January 9, 2014, EME. In support of his opinions, Dr. Scoggin cited Mr. Weaver's reports of back pain predating the July 23, 2013, work injury and imaging studies showing only chronic-appearing degenerative changes in Mr. Weaver's lumbosacral spine, which were stable on three separate MRI studies. Dr. Scoggin thought Mr. Weaver's current complaints were subjective and primarily

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74 *Weaver III* at 16, No. 66.

75 *Id.*, No. 67.

76 *Id.*, No. 68.

related to his preexisting degenerative disc disease and its expected progression over time. Dr. Scoggin did not think Mr. Weaver would benefit from surgical intervention.[77]

On April 6, 2016, a discogram was positive at L4-5 and L5-S1.[78] A July 12, 2016, lumbar computed tomography study showed multilevel degenerative disc disease, most severe at L4-5 and L5-S1. At L4-5, a moderate disc protrusion was superimposed on a broad disc bulge resulting in mild central spinal canal stenosis. At L5-S1, a disc osteophyte complex resulted in moderate bilateral neural foraminal stenosis.[79] A July 12, 2016, lumbar MRI showed moderate bilateral neural foraminal stenosis at L5-S1 and probable mild spinal stenosis at L4-5.[80]

On July 13, 2016, Dr. Kralick performed an L4-S1 laminectomy with spinal canal and neural foraminal decompression and disc excision at L4-5 with interbody fusion. Dr. Kralick's report noted, "[s]ignificant canal compromise of the thecal sac by bone and thickened ligamentum flavum was encountered at both the L4-5 and L5-S1 levels."[81]

On July 17, 2016, Mr. Weaver suffered a myocardial infarction, which resulted in the placement of two stents.[82] On July 26, 2016, Mr. Weaver saw Dr. Kralick for a postoperative wound check and reported soreness in his lower back, bilateral leg weakness, balance changes, and left leg numbness and tingling.[83]

On August 4, 2016, Dr. Scoggin responded to interrogatories posed by Mr. Weaver and cited numerous records documenting Mr. Weaver experiencing low back pain prior to the July 23, 2013, work injury. Dr. Scoggin added, since both Drs. Marble and Radecki observed Mr. Weaver to be a poor historian, a review of medical records became more important in Mr. Weaver's case. He wrote, "We know that [Mr. Weaver] suffered chronic,

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77 *Weaver III* at 16-17, No. 69.

78 *Id.* at 17, No. 71.

79 *Id.*, No. 72.

80 *Id.*, No. 73.

81 *Id.*, No. 74.

82 *Id.*, No. 75.

83 *Id.* at 18, No. 76.

recurrent low back pain prior to 7/23/13, because his medical records so state this." As a result, Dr. Scoggin could rule out performing "strenuous physical labor" for ARCTEC as the substantial cause of Mr. Weaver's back pain. Referring to Mr. Weaver's consistent, subjective, pain-scale reports, and his three MRI studies, where no significant changes were observed, Dr. Scoggin concluded, "Since there is no objective evidence of any significant improvement in his condition and no subjective evidence of any significant change in his complaints, the logical conclusion is that [Mr. Weaver] was, in fact, medically stable as stated." Dr. Scoggin noted Mr. Weaver reported the three epidural steroid injections he had received provided him, at most, two days' relief, and the four RFAs per side did not provide him with any short-term or long-term relief. Therefore, Dr. Scoggin concluded, the additional care Mr. Weaver received after Dr. Marble's January 9, 2014, EME did not result in any subjective or objective benefit to Mr. Weaver. Dr. Scoggin again expressed his opinion that the July 23, 2013, injury resulted in a lumbrosacral soft tissue injury, which temporarily exacerbated Mr. Weaver's subjective complaints, and reiterated his opinion that Mr. Weaver was medically stable at the time of Dr. Marble's January 9, 2014, EME.[84]

On August 15, 2016, Dr. Radecki reviewed additional medical records and noted inconsistencies between findings upon physical examinations performed by other medical providers and himself, and concluded differences in these findings meant Mr. Weaver was "not reliable." Dr. Radecki also emphasized medical reports that mentioned Mr. Weaver's alcohol and marijuana use, frustration, anger, difficulties paying bills and legal fees, taking more pain medication than prescribed, taking pain medication from a past prescription, lack of improvement after RFA, numerous changes to Mr. Weaver's narcotic pain management medication with no improvement in his reported symptoms, as well as medical reports where Mr. Weaver reported the onset of his history of present illness prior to the 2013 work injury. He issued an addendum report that stated the additional

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[84] *Weaver III* at 18, No. 77.

medical records reviewed did not change the opinions expressed in his March 20, 2015, EME report.[85]

On August 23, 2016, lumbar spine x-rays were interpreted to show disc space narrowing at L5-S1 and anterior spurs through the lumbar spine similar to a previous study. Mr. Weaver was to begin physical therapy to improve his range of motion and improve his residual pain.[86]

On August 24, 2016, ARCTEC deposed Dr. Scoggin, who testified he concluded Mr. Weaver's July 23, 2013, injury did not permanently aggravate Mr. Weaver's low back condition.[87] Dr. Scoggin thought "there was some room for discussion in this case" as to what caused the aggravation in Mr. Weaver's low back because Mr. Weaver did not point to a single incident, but rather reported more than ten different potential causes for the aggravation, including shoveling, changing valves, jacking up fuel tanks, bending, lifting, moving tanks, digging, "and the most common one is sleeping on a thin mattress."[88] Mr. Weaver reported to one of his providers that his pain had been occurring for over a year and was aggravated by coughing, bending, twisting, lifting, sitting, and standing, "which are all activities of daily living," according to Dr. Scoggin.[89] Dr. Scoggin did not see any evidence Mr. Weaver had radiculopathy based on Dr. Restad's July 26, 2013, report,[90] and he did not see evidence of canal stenosis on Mr. Weaver's August 2, 2013, MRI.[91] Dr. Scoggin disagreed with Dr. Kralick's decision to perform surgery for lumbar stenosis because lumbar stenosis was not documented by Mr. Weaver's MRIs.[92]

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85 *Weaver III* at 18-19, No. 78.

86 *Id.* at 19, No. 79.

87 *Id.* at 19-20, No. 80; James F. Scoggin, III, M.D., Dep., Aug. 24, 2016, at 12:4-12.

88 *Id.* at 19-20, No. 80; Scoggin Dep. at 12:15 – 13:9.

89 *Id.* at 19-20, No. 80; Scoggin Dep. at 13:10-15.

90 *Id.* at 19-20, No. 80; Scoggin Dep. at 18:1-3.

91 *Id.* at 19-20, No. 80; Scoggin Dep. at 26:2-4.

92 *Id.* at 19-20, No. 80; Scoggin Dep. at 35:23 – 36:19.

Dr. Scoggin would not have performed surgery on Mr. Weaver because Mr. Weaver did not have any of the indications for spinal fusion listed in the "Occupational Disability Guidelines.[93] Dr. Scoggin stated there were multiple factors contributing to Mr. Weaver's need for medical care, and because Mr. Weaver had a physical job, Dr. Scoggin thought was reasonable to conclude Mr. Weaver experienced increased pain until January 9, 2014.[94] On cross-examination, Dr. Scoggin testified Dr. Kralick's findings that Mr. Weaver's spinal canal was compromised by bone and thickened ligamentum flavum were consistent with degenerative changes.[95] According to Dr. Scoggin, Mr. Weaver did not have a herniated disc, a fracture, or anything else that is clearly identifiable as a specific injury.[96] Instead, Mr. Weaver only experienced an increase in symptoms.[97] Dr. Scoggin found reports from multiple examiners, who described their findings as degenerative, and Mr. Weaver's medical records show Mr. Weaver had prior symptoms.[98] Dr. Scoggin noted, prior to the 2013 injury, Mr. Weaver had been having pain, averaging 6 out of 10 for one year. He also noted, "way back" in 2001, Mr. Weaver was having pain that was 6 out of 10. Therefore, Dr. Scoggin did not think there was any objective evidence that showed Mr. Weaver's pain was worse after the 2013 work injury than it was before the work injury.[99] In Dr. Scoggin's opinion, Mr. Weaver has multi-factoral pain, which is consistent with degenerative changes.[100] Dr. Scoggin stated, "I think he's got facet, he's got disc, he's got now the spinal stenosis. . . . And he doesn't have radiculopathy, he doesn't have symptoms of spinal stenosis. He merely has pain."[101] In

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93 *Weaver III* at 19-20, No. 80; Scoggin Dep. at 39:8-23.

94 *Id.* at 19-20, No. 80; Scoggin Dep. at 44:10-14.

95 *Id.* at 19-20, No. 80; Scoggin Dep. at 53:5-8.

96 *Id.* at 19-20, No. 80; Scoggin Dep. at 59:23 – 60:1.

97 *Id.* at 19-20, No. 80; Scoggin Dep. at 60:1

98 *Id.* at 19-20, No. 80; Scoggin Dep. at 60:2-16.

99 *Id.* at 19-20, No. 80; Scoggin Dep. at 62:10 – 63:4.

100 *Id.* at 19-20, No. 80; Scoggin Dep. at 64:16-18.

101 *Id.* at 19-20, No. 80; Scoggin Dep. at 64:19-23.

Dr. Scoggin's opinion, Mr. Weaver did not have a specific injury that would explain his symptoms following the 2013 work injury. "There's no heavy weight he lifted and suddenly had a sharp pain, the types of things we usually see," according to Dr. Scoggin. Without additional information, Dr. Scoggin thought Mr. Weaver's 2010 work injury was a substantial factor in Mr. Weaver's need for medical treatment at that time, even though Mr. Weaver's medical records show he had back pain pre-dating the 2013 injury.[102] However, Dr. Scoggin also thought Mr. Weaver was medically stable after January of 2014, because none of Mr. Weaver's medical treatment has resulted in objectively measurable improvement.[103]

On August 28, 2016, Mr. Weaver continued to report lower back soreness and left leg numbness.[104] Physical therapy daily progress notes from September of 2016 indicate Mr. Weaver "admits a sedentary lifestyle," and lists Mr. Weaver's primary functional limitation as his inability to "resume exercise routine or tolerate functional activities at home due to persistent nature of his [low back pain]."[105]

Following his July 13, 2016, surgery, Mr. Weaver continued with medical pain management and consistently reported his current pain levels as 3 to 6 out of 10, and his average pain levels as 2 to 6 out of 10. On October 26, 2016, Mr. Weaver's medical pain management provider "[d]iscussed with [Mr. Weaver] what he does to keep busy as he does not currently work. He states that he does not do much of anything. I advised him that it is important for his health to find some kind of hobby to keep him busy. This will improve both his mood and his pain."[106]

On September 22, 2016, Dr. Kralick opined Mr. Weaver's 2013 injury was the substantial cause of his low back symptoms.[107] On October 5, 2016, Mr. Weaver reported

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102 *Weaver III* at 19-20, No. 80; Scoggin Dep. at 107:11 – 108:21.

103 *Id.* at 19-20, No. 80; Scoggin Dep. at 112:9-21.

104 *Id.* at 20, No. 81.

105 *Id.*, No. 83.

106 *Id.* at 20-21, No. 84.

107 *Id.* at 21, No. 85.

"constant" low back aching, "stable" left leg numbness, and temporary increases in his low back pain after physical therapy.[108]

On January 5, 2017, Dr. Scoggin reviewed additional imaging studies, which did not change any of his previously expressed opinions.[109]

On February 17, 2017, Dr. Radecki evaluated Mr. Weaver a second time. Dr. Radecki asked Mr. Weaver about returning to work, and Mr. Weaver informed Dr. Radecki he was already on Social Security Disability for his low back and, if he had a heart problem on the North Slope, he could not be reliably evacuated for medical care. Dr. Radecki concluded, regardless of how Mr. Weaver's back felt, he would not work remotely because of his heart conditions. Mr. Weaver was "a little unclear on his medications," and reported he was taking Flexeril three times per day on some days and, and on some days, he takes less. Mr. Weaver was taking five Oxycodone tablets, "probably 5 mg tablets," twice per day. In addition, he was taking morphine sulfate, either 15 or 30 mg tablets, twice per day. He also was taking two or three Aleve tablets twice per day and baby aspirin, as well. Dr. Radecki remarked Mr. Weaver rated his pain as 5 or 6, even on all this medication. Upon physical examination, Mr. Weaver complained of great pain when Dr. Radecki brushed Mr. Weaver's skin with one fingertip in the lumbar region. Mr. Weaver's paraspinal muscles were very tender on palpation throughout the thoracic and lumbar regions. Dr. Radecki found hip flexion to be 80 degrees on the right and 70 degrees on the left, where Mr. Weaver complained of great pain. Dr. Radecki observed, when Mr. Weaver was sitting on the exam table, he was leaning forward, "so his hip flexion was certainly 100 degrees or greater, so there was an inconsistency between Mr. Weaver's sitting and supine hip flexion." Mr. Weaver could not tolerate hip rotation past 5 degrees because it was "very, very painful." Mr. Weaver complained of non-physiologic low back pain when Dr. Radecki placed his hands on Mr. Weaver's shoulders. Traction applied upward at Mr. Weaver's elbows was very painful, which Dr. Radecki thought should lessen the pain, since it was taking weight off the low back.

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108 *Weaver III* at 21, No. 86.

109 *Id.*, No. 88.

When Dr. Radecki pulled on Mr. Weaver's thigh while Mr. Weaver was laying supine on the exam table, Mr. Weaver complained of low back pain, which is "grossly non-physiologic since pulling on one thigh does not stretch any nerves or change any joint positions." Dr. Radecki observed, "Pushing on the knees likewise provoked complaints in the hips and low back despite again the fact that no nerves are being stretched, no tissues are actually being moved." He also wrote,

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

The findings from Mr. Weaver's physical examination were "totally unreliable," since he had pain with provocative maneuvers "that cannot possibly cause pain," according to Dr. Radecki. He diagnosed chronic pain along most of the spine, but predominantly at the lumbar region, longstanding by history, "well before the incident of July 23, 2013." He also concurred with Dr. Marble's opinion that Mr. Weaver's 2010 injury had "resolved quite quickly." Dr. Radecki observed Mr. Weaver's condition had changed minimally notwithstanding having undergone spinal surgery, and opined the pathology documented at surgery was bony encroachment on the spinal canal and a thickened ligamentum flavum, "neither of which is due to a one time incident." Mr. Weaver's inability to work as a Station Mechanic was twofold, according to Dr. Radecki, and included, 1) psychosocial factors and chronic pain behaviors, and 2) Mr. Weaver's heart condition.[110]

On February 17, 2017, Ronald L. Teed, M.D., an orthopedic surgeon, also performed an EME, during which Mr. Weaver reported his surgery helped with some of the sharp pains in his back, but he still had chronic disabling pain. Dr. Teed found Mr. Weaver very "nonspecific" and "avoidant" during the evaluation. Mr. Weaver reported his work career has been very sporadic throughout his life due to "personal

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110 *Weaver III* at 21-22, No. 89.

reasons." Dr. Teed began to measure Mr. Weaver's range of motion in his cervical, thoracic, and lumbar spine, but Mr. Weaver reported his spine was too painful to perform additional range of motion evaluations. Dr. Teed found this to be inconsistent because he observed Mr. Weaver moving his head to the left and right without hesitation during questioning and that movement was "well beyond" what was measured with the inclinometer. Similarly, Dr. Teed noted Mr. Weaver sat on the bed and leaned forward "far beyond" the lumbar range of motion measured with the inclinometer. Mr. Weaver was exquisitely tender to palpation, even to light touch, over the cervical and lumbar spinous processes and paraspinous musculature, and was tender "just about anywhere" Dr. Teed touched Mr. Weaver over his thoracic spine. Dr. Teed also found Mr. Weaver inconsistently tender over the sciatic notch. Other inconsistencies noted by Dr. Teed included inconsistent pain complaints upon hip rotation while seated and supine and reported low back pain when Mr. Weaver rotated his torso through his legs. Mr. Weaver reported increased, diffuse, neck tension when Dr. Teed applied "very light" axial pressure on Mr. Weaver's scalp. Dr. Teed diagnosed functional overlay, which included closed head injury, history of alcohol abuse, history of anxiety/depression, chronic narcotic use/abuse, and chronic non-specific neck pain, chronic non-specific low back pain, including lumbar spondylosis, and cardiovascular disease, none of which were related to Mr. Weaver's employment, in Dr. Teed's opinion. Dr. Teed stated, "[Mr. Weaver's] presentation is that of overwhelmingly inconsistent, inorganic, non-anatomic findings on exam." As a result, Dr. Teed concluded his findings on exam were unreliable. Dr. Teed found Mr. Weaver's history of chronic neck, mid and low back pain "well predate" the July 23, 2013, work injury. Dr. Teed observed Mr. Weaver had been treated by many providers since the injury, and those providers' findings were commonly inconsistent, even between the same providers. In Dr. Teed's opinion, Mr. Weaver underwent lumbar fusion surgery without a clear presentation of radicular findings or neural defects. The cause of Mr. Weaver's disability and need for medical treatment, according to Dr. Teed, "are unknown, but unrelated to the July 23, 2013 job injury claim." Because of

Mr. Weaver's highly inconsistent presentation, Dr. Teed recommended Mr. Weaver undergo a multispecialty evaluation, including a psychological evaluation.[111]

On February 28, 2017, ARCTEC deposed Dr. Trescot, who saw Mr. Weaver once for an evaluation and once to administer a transforaminal injection. When she evaluated Mr. Weaver on May 23, 2014, she thought he had "an early degree of lumbar radiculopathy," based on his MRI, which showed a disc bulge.[112] When Dr. Trescot administered the injection, she used x-ray contrast dye to show her the medicine was going where she wanted it to go.[113] In Mr. Weaver's case, the dye did not go past the dorsal root ganglion, which was consistent with narrowing and impingement at that spot.[114] Dr. Trescot opined performing heavy labor traumatized an already weakened area of Mr. Weaver's back.[115] She also thought Mr. Weaver's lumbar facets contributed to Mr. Weaver's pain.[116] Dr. Kralick's operative report, which stated he found thickening of the ligamentum flavum, was consistent with her findings of spinal stenosis.[117] She explained the ligament holding Mr. Weaver's spine together became thickened because it was moving too much, and his body was "laying down" extra calcium in response, which was then encroaching on the spinal column.[118] On cross-examination, Dr. Trescot acknowledged she obtained Mr. Weaver's history of the work injury from him,[119] she did not record a neurological examination, which is the best information for diagnosing radiculopathy,[120] and she could not opine on whether Mr. Weaver's disc pathology was

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111 *Weaver III* at 22-23, No. 90.

112 *Id*. at 23-24, No. 91; Andrea Trescot, M.D., Dep., Feb. 28, 2017, at 31:22 – 33:10.

113 *Id*. at 23-24, No. 91; Trescot Dep. at 34:24 – 35:3.

114 *Id*. at 23-24, No. 91; Trescot Dep. at 35:18-21.

115 *Id*. at 23-24, No. 91; Trescot Dep. at 39:12 – 40:4.

116 *Id*. at 23-24, No. 91; Trescot Dep. at 45:20 – 46:2.

117 *Id*. at 23-24, No. 91; Trescot Dep. at 49:8 – 50:14.

118 *Id*. at 23-24, No. 91; Trescot Dep. at 49:17-21.

119 *Id*. at 23-24, No. 91; Trescot Dep. at 51:19 – 52:5.

120 *Id*. at 23-24, No. 91; Trescot Dep. at 61:18 – 62:5.

acute or chronic[121]. Dr. Trescot was not aware Mr. Weaver had seen Dr. Samuel L. Inouye on May 14th and May 23rd, was not aware Dr. Inouye had also prescribed Mr. Weaver medications, and she would be surprised if Mr. Weaver did not report leg pain to Dr. Inouye on those visits.[122] She thinks it is important to assess the mental health of pain patients, but she did not document non-work related stress in Mr. Weaver's life.[123] Dr. Trescot was critical of another physician for not documenting a patient's history of substance abuse, but she did not document Mr. Weaver's history of substance abuse.[124] She thinks anxiety can contribute to pain, but she did not consider anxiety in Mr. Weaver's case.[125] If a pain patient has tried narcotics, anti-inflammatories, medial branch blocks, RFA, and surgery, and there is no improvement, Dr. Trescot would be concerned there might be an underlying issue that is not being addressed.[126] There can be reasons, other than something physiological or anatomical reasons, why patients' pain do not improve, such as untreated depression or anxiety, substance abuse, and secondary gain, according to Dr. Trescot.[127] Dr. Trescot interpreted Mr. Weaver's MRI to show a "disruption" of the posterior interspinous ligament,[128] but she acknowledged this is not a commonly accepted finding.[129]

On March 7, 2017, ARCTEC deposed Dr. Teed, who testified Mr. Weaver had spondylosis, an arthritic condition, and chronic nonspecific low back pain.[130] According to Dr. Teed, spondylosis "describes the whole," and involves disc degeneration, facet

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121 *Weaver III* at 23-24, No. 91; Trescot Dep. at 64:4-6.

122 *Id*. at 23-24, No. 91; Trescot Dep. at 69:7 – 70:11.

123 *Id*. at 23-24, No. 91; Trescot Dep. at 70:20 – 71:3.

124 *Id*. at 23-24, No. 91; Trescot Dep. at 71:4-17.

125 *Id*. at 23-24, No. 91; Trescot Dep. at 71:18-23.

126 *Id*. at 23-24, No. 91; Trescot Dep. at 73:16-23.

127 *Id*. at 23-24, No. 91; Trescot Dep. at 74:11-24.

128 *Id*. at 23-24, No. 91; Trescot Dep. at 86:2-15.

129 *Id*. at 23-24, No. 91; Trescot Dep. at 90:6-21.

130 *Id.* at 25-27, No. 94; Ronald Teed, M.D., Dep., Mar. 7, 2017, at 5:9-13.

arthritis and ligamentum flavum hypertrophy, all combined.[131] Chronic nonspecific back pain means the etiology is unclear - "It's just a subjective complaint." Dr. Teed did not see any evidence in the medical records to support a diagnosis of radiculopathy.[132] Commenting on Mr. Weaver's lack of improvement after receiving a variety of treatments, Dr. Teed stated, there is no "Level 1" evidence-based medicine that shows epidural steroid injections, medial and lateral branch blocks, or nerve ablations work.[133] Dr. Teed testified there were inconsistencies between Mr. Weaver's reports of pain relief to him and Mr. Weaver's reports of pain relief following various treatments documented in his medical records.[134] According to Mr. Weaver at the time of Dr. Teed's evaluation, no treatment had helped his low back pain.[135] Dr. Teed disagreed with Dr. Kralick's decision to perform surgery because Dr. Kralick performed surgery to address Mr. Weaver's pain and pain is not an indication for surgery.[136] Dr. Teed thought an MRI showed Mr. Weaver had mild stenosis, but Mr. Weaver did not have symptoms of stenosis, which include increased back pain that radiates into the lower extremities and lower extremity weakness with increased walking or standing.[137] Dr. Teed explained, "functional overlay" means inconsistencies on exam.[138] Those inconsistencies can be a patient's attendance at appointments, the inconsistency in a patient's history, and a patient's physical exam and other findings on exam, such as inorganic or non-anatomic findings that do not make sense from a physiological standpoint.[139] Dr. Teed recounted the inconsistencies on examination, such as during straight leg raises, torso rotation, hip rotation, palpation and

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131 *Weaver III* at 25-27, No. 94; Teed Dep. at 5:13-16.

132 *Id.* at 25-27, No. 94; Teed Dep. at 7:16-19.

133 *Id.* at 25-27, No. 94; Teed Dep. at 9:22-24, 60:10-12.

134 *Id.* at 25-27, No. 94; Teed Dep. at 10:2-23.

135 *Id.* at 25-27, No. 94; Teed Dep. at 7:7-12.

136 *Id.* at 25-27, No. 94; Teed Dep. at 11:3-9.

137 *Id.* at 25-27, No. 94; Teed Dep. at 12:7 – 13:10.

138 *Id.* at 25-27, No. 94; Teed Dep. at 15:15-18.

139 *Id.* at 25-27, No. 94; Teed Dep. at 15:19-24.

breakaway strength and cogwheeling.[140] Dr. Teed summarized his examination: he made no objective findings, and the subjective findings were Mr. Weaver would not go through range of motion with his spine because it was too painful.[141] He also explained the Bradford Hills criteria for causation, which is the human body will generally get better when the causative agent is removed.[142] In other words, if the causative factor is increased, one will have more symptoms, but if the causative factor is decreased, one will have less symptoms.[143] Patients with spondylosis present with symptoms that wax and wane over time, which has been Mr. Weaver's presentation back to 2001.[144] Additionally, Mr. Weaver's symptoms since 2013 have been due to his chronic nonspecific low back pain.[145] Dr. Teed was unable to identify an acute injury during his evaluation, and Mr. Weaver was unable to describe a specific injury during the evaluation.[146] Rather, Mr. Weaver attributed his symptoms to digging and performing manual labor during the months prior to him quitting work.[147] An x-ray showed Mr. Weaver had the onset of spondylosis as far back as 2001.[148] On cross-examination, Dr. Teed testified he does not administer epidural steroid injections, medial branch blocks, facet blocks, or RFA, but he has ordered all of them.[149] He also, again, addressed inconsistencies in Mr. Weaver's medical records where Mr. Weaver reported one-week relief from an epidural steroid injection to one provider, and two weeks later Mr. Weaver reported the injection provided him with no relief to another provider. Dr. Teed commented, "So, I mean, the notes get

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140 *Weaver III* at 25-27, No. 94; Teed Dep. at 17:8 – 19:25.

141 *Id.* at 25-27, No. 94; Teed Dep. at 20:12-16.

142 *Id.* at 25-27, No. 94; Teed Dep. at 22:19 – 23:6.

143 *Id.* at 25-27, No. 94; Teed Dep. at 23:3-6.

144 *Id.* at 25-27, No. 94; Teed Dep. at 23:25 – 24:4.

145 *Id.* at 25-27, No. 94; Teed Dep. at 24:11-15.

146 *Id.* at 25-27, No. 94; Teed Dep. at 25:11-19.

147 *Id.* at 25-27, No. 94; Teed Dep. at 25:20-22.

148 *Id.* at 25-27, No. 94; Teed Dep. at 27:17-21.

149 *Id.* at 25-27, No. 94; Teed Dep. at 32:17-25.

confusing because they are consistently conflictive. They are conflicting and most consistent with functional overlay. That's what I'm talking about . . . the inconsistencies."[150] When asked if he relied on the Bradford Hills criteria in determining Mr. Weaver's symptoms were not related to work, Dr. Teed responded, "No. I can't really rely on that criteria because there are episodes that we just described where [Mr. Weaver] said his pain was gone and then episodes that we just described where [Mr. Weaver] said the pain never went away."[151] Additionally, Mr. Weaver told Dr. Teed his pain never went away, and when Mr. Weaver was evaluated the same day by Dr. Radecki, Mr. Weaver reported surgery had reduced his pain one level.[152] Imaging studies, both before and immediately after the 2013 work injury document Mr. Weaver's preexisting degenerative conditions, which took many years to develop, according to Dr. Teed.[153] Dr. Teed opined there was no correlation between Mr. Weaver's spondylosis and the symptoms he described.[154] He agreed with Dr. Trescot's opinions that it is a "red flag" for functional overlay when a patient fails to improve after multiple, different treatments, and it is important to have information about a patient's substance abuse history and psychological issues when treating pain. He opined Mr. Weaver's chronic pain could be caused by psychosocial issues, but he would defer to a psychological or psychiatric evaluator.[155] Dr. Teed did not think Mr. Weaver's work activities were a substantial factor in his disability or need for treatment,[156] and based on his evaluation, Dr. Teed was able to rule out Mr. Weaver's work activities as a cause of his disability or need for treatment.[157]

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150 *Weaver III* at 25-27, No. 94; Teed Dep. at 73:16 – 74:5.

151 *Id.* at 25-27, No. 94; Teed Dep. at 75:1-4.

152 *Id.* at 25-27, No. 94; Teed Dep. at 77:6-15.

153 *Id.* at 25-27, No. 94; Teed Dep. at 99:12 – 100:12.

154 *Id.* at 25-27, No. 94; Teed Dep. at 104:16 – 105:3.

155 *Id.* at 25-27, No. 94; Teed Dep. at 109:1 – 110:3.

156 *Id.* at 25-27, No. 94; Teed Dep. at 107:10-18.

157 *Id.* at 25-27, No. 94; Teed Dep. at 113:8-24.

At hearing, evidence was presented that in 1991, Mr. Weaver received an "OTHER THAN HONORALE" discharge from the United States Marine Corps for alcohol abuse rehabilitation failure. In 1993, Mr. Weaver was convicted of DUI after a motor vehicle accident that left him with a lacerated aorta, upper extremity brachial plexus injury, pancreatitis, and a traumatic brain injury. In 2015, Mr. Weaver was convicted of DUI after an incident that occurred in 2014, where he was riding his ATV in a construction zone and harassing a flagger that later turned out to be his wife. Following his 2014 DUI arrest, Mr. Weaver attended an inpatient treatment facility in Georgia for substance abuse. Mr. Weaver's wife filed for divorce in 2014 and sought both short and long-term protective orders, citing alleged alcohol abuse and physical abuse by Mr. Weaver. Short-term and long-term protective orders were granted. In 2017, Mr. Weaver was charged with a third DUI.[158]

At the March 9, 2017, hearing, Dr. Radecki testified Mr. Weaver's 2013 injury history differed depending on which chart notes were consulted. Mr. Weaver explained to Dr. Radecki that his back pain increased over time, but Mr. Weaver's biggest complaint was the bed on which he was sleeping, which Dr. Radecki thought was odd, because Mr. Weaver had slept on that bed before. During Dr. Radecki's evaluation, Mr. Weaver did not connect any specific work activity to his injury. Dr. Restad's chart notes indicated Mr. Weaver reported going to bed and waking up with pain, and Mr. Weaver "gave [him] the same story." An August 9, 2013, pain clinic chart note indicated Mr. Weaver reported he had had pain for over a year, and a February 17, 2012, chart note referenced back pain in connection to a possible kidney stone. It was "obvious" Mr. Weaver had back pain pre-dating his injury. Dr. Radecki thought a patient's early history is most reliable, since it is fresh in the patient's memory and psychosocial factors are not yet prominent. Dr. Restad's August 16, 2013, report, which showed Mr. Weaver's pain level went down from a 9 to a 3, meant Mr. Weaver was making a good recovery. By October 14, 2013, the records show Mr. Weaver was "doing pretty darn well," because he had a full range of motion without pain for flexion. When Mr. Weaver saw Dr. DeSalvo on October 23,

158 *Weaver III* at 4-5, No. 1.

2013, Mr. Weaver's pain would come and go as usual, and on November 4, 2013, Dr. Johnston opined Mr. Weaver could go back to work again, so Dr. Johnston must have felt Mr. Weaver's condition was stable. On November 5, 2013, Mr. Weaver reported his pain level as a 2 or 3, and by November 11, 2013, Mr. Weaver's pain level was elevated to 6 or 7 "for no reason at all." Psychosocial factors are one of two statistical factors that can predict the development of low back pain. Substance abuse and secondary gain are psychosocial factors that can effect pain. Mr. Weaver denied being hospitalized in Georgia. Dr. Radecki found Mr. Weaver not to be a reliable historian, and was not reliable on physical exam either. Dr. Radecki agreed with Dr. Marble and Dr. Scoggin that Mr. Weaver was medically stable by January 19, 2014.

According to Dr. Radecki, when Dr. Kralick performed surgery on Mr. Weaver, he was operating based on symptoms, which Dr. Radecki thought was "wishful thinking surgery." Dr. Radecki repeatedly testified Mr. Weaver had pain with provocative maneuvers that should not cause pain. Mr. Weaver is a "perfect picture" of someone who has a somatization disorder. Mr. Weaver presents with a very complex situation. He has "one psychosocial problem after another." Dr. Radecki thought Mr. Weaver's treatment has made him worse, which is what he would expect in a patient with psychosocial phenomenon. Mr. Weaver is the "last person in the world" who should be treated with narcotics or surgery. Mr. Weaver was "absolutely destined" not to get better.

On cross-examination, Dr. Radecki testified when Mr. Weaver saw Dr. Trescot, Mr. Weaver's pain was a 5, and he was not taking any medication. Now, after years of treatment and invasive surgery, Mr. Weaver is on both short-acting and long-acting narcotics, and his pain level is at 5 or 6, so Mr. Weaver is worse. According to Dr. Radecki, there is no specific task documented in the medical record to which a specific injury is attributable, and no doctor diagnosed Mr. Weaver with spinal stenosis the first time the doctors saw him. Mr. Weaver improved 80 percent with a facet block, which is "a long way from the spinal canal," according to Dr. Radecki. Mr. Weaver also reported getting a little better with a transforaminal epidural steroid injection, which would not affect the spinal canal, according to Dr. Radecki. Mr. Weaver did not have any of the classic symptoms of spinal stenosis, such as awaking at night in bed, or pain while walking.

Dr. Radecki did not believe the majority of Mr. Weaver's back pain was physical, but rather psychological, due to Mr. Weaver's substance abuse, his depression, his anxiety, and his divorce. Dr. Radecki opined it was very bad judgment, at best, for Dr. Kralick to perform surgery on Mr. Weaver.

On redirect examination, Dr. Radecki testified the fact that Mr. Weaver's pain decreased in November shows he was recovering, and the escalation of Mr. Weaver's pain beginning on November 20th can only be explained by psychosocial factors, since Mr. Weaver's MRIs showed no interval change. Mr. Weaver's complaints of pain just about everywhere is a psychosocial phenomenon. About five percent of the population have widespread, unexplained pain, and Mr. Weaver is one of those five percent, in Dr. Radecki's opinion. There were eight diagnosis in the first month or two with Mr. Weaver, which shows how nonspecific Mr. Weaver's symptoms were. Dr. Radecki stated there was never a consistent symptom complex that would indicate radiculopathy or lumbar stenosis. This is why Mr. Weaver's providers did a "shotgun" approach, according to Dr. Radecki. "They gave [Mr. Weaver] epidurals. They gave [Mr. Weaver] facet blocks." Dr. Radecki thinks this approach to Mr. Weaver's treatment was "nonsensical."[159]

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

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159 *Weaver III* at 27-29, No. 96.

noticed Mr. Weaver is doing more. On cross-examination, when asked about Mr. Weaver's discharge from the military for alcoholism, Mr. Weaver, Sr., stated he had already testified regarding Mr. Weaver's alcohol problem. Mr. Weaver, Sr., acknowledged Mr. Weaver's 1993 car accident and DUI. Mr. Weaver, Sr., denied Mr. Weaver had a serious problem with alcohol prior to 2013.[160]

At the March 9, 2017, hearing, Mr. Weaver testified he was in "pretty good" shape when he started working for ARCTEC in 2009. He "absolutely has problems" with memory due to a closed head injury and he carries a notebook to write things down. Mr. Weaver could not recall having any lasting back problems when he went to work for ARCTEC in 2009. In 2010, Mr. Weaver was injured tightening chains that had come loose on a road grader and a dump truck. He came home and saw a chiropractor on his own insurance. He did not feel "good at all then," and his pain level was at least a 5. Prior to his 2013 injury, Mr. Weaver had been installing heat exchangers at power plants and some weighed over 800 pounds. Mr. Weaver was also travelling to "dome" sites and repairing and maintaining sprinkler systems, which involved replacing 4, 6, 8, and 10-inch pipes that were between 8 to 20 feet long, as well as "gate" valves. His supervisor was Troy Klingfus, who emailed Dave Horn to point out no rigging or lifting devices was provided to move the 180-pound valves they were moving by hand. Mr. Weaver and Mr. Klingfus had "very sore body parts" and were icing them in the evenings. After a job hazard analysis, ARCTEC sent some chain hoists and chain that could be used as rigging. After those jobs, Mr. Weaver was moving large fuel tanks at Indian Mountain for five or six weeks at Barter Island. Mr. Weaver jacked up the tanks with a railroad jack, which weighed about 120 pounds. The jack handle was a six-foot long bar that weighed 80 pounds or more. Mr. Weaver also used a chain saw to cut cribbing that came in 18-foot lengths. After Mr. Weaver lifted the tanks, he would compact the site and set 14-inch by 14-inch beams, which were 10-feet long. Next, Mr. Weaver would use a D10 Cat to drag the tanks close to where it needed to be, and then he would dig underneath the tanks to get the tow chain out. For Mr. Weaver, it was the "worst kind of digging" – down on his

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160 *Weaver III* at 29, No. 97.

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

drugs, but then went on to explain, "Well, there aren't any troopers at the table, so I . . . will go so far as to tell you . . . that I only took, I believe, two five-milligram oxy's that morning and a 10-milligram baclofen around lunchtime." When asked about alcohol abuse delaying his recovery, Mr. Weaver discussed his brain injury. Mr. Weaver attributes his lack of sobriety to his brain injury. Mr. Weaver cannot explain how his pain ended up being at its worst when he woke up on July 23, 2013. On re-direct examination, Mr. Weaver stated he was not going to deny he has overused and abused alcohol. When asked if he acknowledges he is an alcoholic, Mr. Weaver answered by discussing symptoms of brain injuries. Mr. Weaver drinks because of his brain injury and he drinks because of his back pain. Mr. Weaver was repeatedly evasive, and repeatedly used the word "overuse," instead of "abuse," when asked about his alcohol abuse.[161]

At the March 9, 2017, hearing, Dr. Restad testified Mr. Weaver's symptoms did get worse from work and the delay in receiving injections contributed to Mr. Weaver's chronic pain. Dr. Restad has not seen Mr. Weaver in two years and when she did, she might not have gone into "great detail" in her exam. Dr. Restad diagnosed Mr. Weaver with radiculopathy, degenerative disk disease with neural foraminal stenosis, and back pain. She "absolutely" thought Mr. Weaver would not have experienced his low back symptoms had it not been for work. Dr. Restad was "absolutely horrified" at the delays in Mr. Weaver's treatment.

On cross-examination Dr. Restad testified she did not diagnose Mr. Weaver with radiculopathy, but a specialist did, and she knew when to refer to a specialist. She diagnosed Mr. Weaver with compression of a spinal nerve root. She recalled Mr. Weaver reporting he was standing on a dock and was having odd sensations in his feet, but she did not document Mr. Weaver's report in her chart notes. Dr. Restad may have made an error in her documentation. When Mr. Weaver first came to Dr. Restad on July 26, 2013, he reported his pain was 9 out of 10. On August 16, 2013, Mr. Weaver's pain was 3 out of 10. Dr. Restad agreed that was an improvement. Regarding her referral to Dr. Johnston, Mr. Weaver told Dr. Restad he wanted a second opinion on receiving

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161 *Weaver III* at 29-31, No. 98.

epidural steroid injections, so she made the referral. On redirect examination, Dr. Restad testified she saw Mr. Weaver over the course of a year and a half, and Mr. Weaver's symptoms remained constant over that time. In Dr. Restad's opinion, the work Mr. Weaver performed in July of 2013 was the substantial cause of triggering Mr. Weaver's pain.[162]

On July 6, 2017, John Williamson testified he has worked in numerous capacities for ARCTEC for 18 years, and his duties have included performing job hazard analysis to ensure workers' health and safety. Mr. Weaver's former supervisor, Troy Klingfus, is now employed on a full-time basis as a station mechanic at a radar site. Mr. Klingfus' April 13, 2013, email was not inappropriate or unusual, as Mr. Klingfus had been injured a couple of times previously and ARCTEC was concerned he might have been "cutting corners." ARCTEC's expectations under the circumstances would have been for Mr. Klingfus to stop work while ARCTEC arranged for the purchase of the requested materials. ARCTEC did purchase the requested materials as an "O&A" project, which Mr. Williamson clarified meant "over and above" budget, versus "O&M," which stands for "operate and maintain." These terms are contract requirements. Mr. Weaver continued to work with Mr. Klingfus during the summer of 2013. Mr. Williamson trains new employees on reporting injuries. Because of its remote work locations, ARCTEC "can't afford" for someone to get hurt because medical attention is so far away. ARCTEC requires all employees to report injuries as soon as they happen. The Indian River job involved a tank farm where the ground had heaved and the tanks were no longer level. Therefore, the job involved levelling the tanks. This was an O&A job that involved special equipment to lift and shore the tanks and a procedure to set the tanks back down. There were two to five people on the job. Workers would rotate job duties, so even though Mr. Klingfus was the "lead," he would share in the work. Mr. Williamson worked on the Barter Island job, which involved building pads and access points for two large tanks the Air Force had delivered. Five workers were assigned to this job, including him. He would also lend a hand shoveling and pushing the wheelbarrow. The tanks had to be drug into place on skids,

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162 *Weaver III* at 30-31, No. 99.

then, scaffolding was erected. The "dirt work" and the scaffolding work was all completed by the time he left the jobsite. Mr. Weaver knew he was the "safety person" onsite, and employees are "well aware" to report injuries. During the period of time Mr. Williamson was at the jobsite, he heard no complaints to the effect, "I'm hurt," or "I can't work," though they were all complaining about sore muscles. He is familiar with the beds at Barter Island, they are Tall Taul brand beds and he does not think they are worse than any other site. It is not accurate to describe the beds as not having any support or being concave. Mr. Williamson is not aware of any other emails from Mr. Klingfus between April and July of 2013. He never had to go back out to the worksite on a safety issue and is confident the employees were provided proper equipment to do the job. Mr. Weaver never made any specific complaints. On cross-examination, Mr. Williamson testified he first saw Mr. Klingfus' email when another employee approached him on the O&A. Every site has lifting and rigging equipment, so he presumed that equipment was not available for some reason. Mr. Weaver was on the worksite one week and 10 days prior to his arrival. Mr. Klingfus' email was sent after he had left the jobsite. Mr. Williamson described having sore muscles as the "nature of the beast" whenever heavy stuff needs to be moved – "it's a very physical job." Mr. Weaver's photographic exhibits accurately reflected the work site. The Indian Mountain site involved jacking up the tanks. The Barter Island site involved a bulldozer pulling the tanks. He is not familiar with the tanks getting stuck and Mr. Weaver getting under the tanks. Mr. Williamson confirmed the valves being moved were large and heavy, though he does not know that they weighed 180 pounds. Moving and installing the valves involved working in tight areas and awkward positions.[163]

*3. Proceedings*.

In *Weaver I,* the Board addressed the issue of whether the nurse case manager, Tracy M. Davis, R.N., retained by ARCTEC to monitor the injured worker's medical treatment, constituted an EME. The Board noted that a nurse case manager "walks a fine line, balancing the sometimes competing interests of cost containment and patient

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163 *Weaver III* at 32-33, No. 101.

advocacy."[164] The Board then found that Ms. Davis was not an EME physician. The Board likewise found that the referral from the treating physician to Dr. Johnston did not make Dr. Johnston an EME physician. Therefore, the report of Dr. Marble, the EME physician, was not excluded from the record.[165]

In *Weaver II,* the Board addressed whether certain documents should be included in the SIME binders. The first document was a letter from Ms. Davis to Mr. Weaver stating she was closing her file because he was medically stable. This letter was deemed not to be a medical report and was excluded from the SIME medicals.[166] Mr. Weaver also objected to inclusion of the reports of injury and to the job descriptions prepared by the rehabilitation specialist and used to determine Mr. Weaver's eligibility for reemployment benefits. The reports of injury were excluded, but the job descriptions were included in the binders for the SIME.[167] Additionally, the Board determined that only its questions would be asked of the SIME physician and directed the parties to submit interrogatories or schedule depositions after the SIME report had been issued.[168]

Neither party appealed either of these decisions.

On January 24, 2014, ARCTEC controverted Mr. Weaver's benefits based on Dr. Marble's January 9, 2014, report.[169] On July 24, 2014, Mr. Weaver filed a request for cross-examination of Dr. Marble's January 9, 2014, EME report, and Dr. Johnston's February 3, 2014, "check-the-box" concurrences with Dr. Marble's report[170]

Mr. Weaver, on February 21, 2014, filed a WCC for a low back injury sustained on July 23, 2013, while "lifting and twisting while erecting scaffolding; pushing wheelbarrow; shoveling large amounts of sand and gravel while on knees; followed by sleeping in camp

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164 *Weaver I* at 12.

165 *Id*. at 13.

166 *Weaver II* at 9.

167 *Id.* at 9-10.

168 *Id.* at 10.

169 *Weaver III* at 8, No. 26.

170 *Id.* at 10, No. 38.

on old, thin mattress; woke the next morning with intense pain radiating into the buttocks." He sought TTD, temporary partial disability, permanent total disability, PPI, medical and transportation costs, a reemployment eligibility evaluation, penalty, interest, a finding of unfair or frivolous controversion, attorney fees and costs, and an SIME.[171]

On October 16, 2014, Mr. Weaver filed a "Petition to Join Additional Employer(s) and/or Insurers" from his 2010 injury to his 2013 case. ARCTEC did not oppose the petition.[172] On January 29, 2015, Mr. Weaver's vocational rehabilitation specialist advised she was unable to complete his eligibility evaluation due to ARCTEC's controversion.[173] On September 7, 2016, Mr. Weaver filed an Affidavit of Readiness for Hearing on his February 19, 2014, and June 17, 2014, claims.[174]

At an October 10, 2016, prehearing conference, the parties agreed Mr. Weaver's February 19, 2014, and June 7, 2014, claims would be heard on March 9, 2017.[175]

On March 2, 2017, ARCTEC contended the issues for hearing were Mr. Weaver's February 19, 2014, and June 17, 2014, claims, which are both based on Mr. Weaver's 2013 injury. It contended, although Mr. Weaver petitioned to join his 2010 injury to the instant case, he never filed a WCC for that injury, and any claim for Mr. Weaver's 2010 injury would be barred by AS 23.30.105.[176]

On March 6, 2017, Mr. Weaver sought dismissal of ARCTEC's argument his December 7, 2010, injury was not joined as an issue for hearing. He contended ARCTEC clearly knew his 2010 injury was joined because it filed a non-opposition to his petition seeking joinder, it questioned Dr. Scoggin on his 2010 injury at Dr. Scoggin's deposition, and it referenced his 2010 injury in letters to its medical experts.[177] On March 8, 2017,

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171 *Weaver III* at 9, No. 29.

172 *Id.* at 11, No. 43.

173 *Id.* at 12, No. 52.

174 *Id.* at 20, No. 82.

175 *Id.* at 21, No. 87.

176 *Id.* at 24-25, No. 92.

177 *Id.* at 25, No. 93.

Mr. Weaver filed an affidavit that set forth $161,147.46 in attorney fees and costs.[178] At a March 28, 2017, prehearing conference, the parties agreed to conclude the March 9, 2017, hearing on July 6, 2017.[179] Mr. Weaver repeatedly asserted his objections to any consideration of Dr. Marble's report during the hearing on his claims.[180]

On July 13, 2017, Mr. Weaver supplemented his March 8, 2017, affidavit, claiming a revised total of $175,806.50 in attorney fees and costs.[181]

The Board held the hearing on Mr. Weaver's claim for benefits in Fairbanks, Alaska, on March 9, 2017, and July 6, 2017. The Board issued its decision on October 27, 2017. The Board excluded Dr. Marble's EME report from its consideration since Mr. Weaver had filed a request to cross-examine him, and Dr. Marble was not deposed nor did he testify at hearing. The Board also excluded Dr. Johnston's "check-the-box" form from consideration, partially on the basis that Mr. Weaver had requested the right to cross-examine Dr. Johnston and because the "check-the-box" form was not a medical record kept in the usual course of treatment. Furthermore, the opinions on the form seemed in contradiction to his own treatment recommendations for Mr. Weaver. The Board also found Mr. Weaver was not entitled to ongoing benefits related to the 2013 date of injury, finding he had not proved his entitlement to same by a preponderance of the evidence. The Board also held that since no WCC was ever filed for the 2010 injury it was not an issue for hearing. Mr. Weaver timely appealed the Board's decision to the Commission. The Commission heard oral argument on December 17, 2018.

*4. Standard of review.*

The Board's findings of fact shall be upheld by the Commission on review if the Board's findings are supported by substantial evidence in light of the record as a whole.[182] Substantial evidence is relevant evidence that a reasonable mind might accept as

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178 *Weaver III* at 27, No. 95.

179 *Id.* at 32, No. 100.

180 *Id.* at 33, No. 102.

181 *Id.* at 33, No. 103.

182 AS 23.30.128(b).

adequate to support a conclusion.[183] "The question of whether the quantum of evidence is substantial enough to support a conclusion in the contemplation of a reasonable mind is a question of law."[184]

The weight given to witnesses' testimony, including medical testimony and reports, is the Board's decision to make and is, thus, conclusive. This is true even if the evidence is conflicting or susceptible to contrary conclusions.[185] The Board's findings regarding credibility are binding on the Commission as the Board is, by statute, granted the sole power to determine the credibility of a witness.[186]

On questions of law and procedure, the Commission does not defer to the Board's conclusions, but rather exercises its independent judgment. "In reviewing questions of law and procedure, the commission shall exercise its independent judgment."[187]

*5. Discussion.*

*a. Did ARCTEC rebut the presumption of compensability?*

Mr. Weaver contends the opinions of Dr. Radecki and Dr. Scoggin are insufficient to overcome the presumption of compensability because the opinions of Dr. Radecki and Dr. Scoggin differed from the opinions of the treating doctors. He also contends the opinion of Dr. Radecki is not sufficient to overcome the presumption because he has been found not credible by other Board panels.

Under the Alaska Workers' Compensation Act (Act), the presumption of compensability applies to any claim for benefits.[188] AS 23.30.120 states in pertinent part:

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183 *See*, *e.g.*, *Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051, 1054 (Alaska 1994).

184 *McGahuey v. Whitestone Logging*, *Inc.*, Alaska Workers' Comp. App. Comm'n Dec. No. 054 at 6 (Aug. 28, 2007) (citing *Land & Marine Rental Co. v. Rawls*, 686 P. 2d 1187, 1188-1189 (Alaska 1984).

185 AS 23.30.122.

186 AS 23.30.122.

187 AS 23.30.128(b).

188 *Meek v. Unocal Corp.*, 914 P.2d 1276, 1279 (Alaska 1996).

(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;

(2) sufficient notice of the claim has been given;

(3) the injury was not proximately caused by the intoxication of the injured employee or proximately caused by the employee being under the influence of drugs unless the drugs were taken as prescribed by the employee's physician;

The Alaska Supreme Court (Court) has held that an employee establishes the presumption of compensability when the employee presents some evidence of a "preliminary link" between work and the claim for benefits. Medical evidence may be required depending on the probative value of available lay evidence and the complexity of the medical facts.[189] "What a claimant is required to produce is 'some evidence that the claim arose out of, or in the course of, employment before the presumption arises.'"[190] Mr. Weaver established the presumption of compensability through his own testimony and through the medical records and testimony of his treating physicians: Drs. Restad, DeSalvo, Kralick, and Trescot.

"[O]nce the 'preliminary link' has been established, 'it is the employer's burden to overcome the presumption by coming forward with substantial evidence that the injury is not work related.'"[191] In *Huit v. Ashwater Burns, Inc.*, the Court refined what is required to rebut the presumption of compensability.[192] "AS 23.30.010(a) now provides that the 'presumption may be rebutted by a demonstration of substantial evidence that the . . . disability or need for medical treatment did not arise out of and in the course of

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189 *Veco, Inc. v. Wolfer*, 693 P.2d 865, 872 (Alaska 1985)(*Wolfer*).

190 *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381 (Alaska 1991)(citations omitted).

191 *Id.*, citing *Burgess Constr. Co. v. Smallwood*, 698 P.2d 1206, 1211 (Alaska 1985).

192 *Huit v. Ashwater Burns, Inc.*, 372 P.3d 904, 917 (Alaska 2016)(*Huit*).

employment.'"[193] While the Board does not need to consider "the substantial cause" at this stage, it does need "to evaluate the relative contribution of different causes" in deciding whether the need for medical treatment arose out of the employment.[194] "The issue of whether there is substantial evidence to overcome the presumption is a question of law which this court will independently review."[195] "In deciding whether the presumption has been overcome, we will not weigh the testimony or the credibility of the witnesses; instead, the evidence tending to rebut the presumption is examined by itself and is not compared to conflicting evidence in the record."[196]

The employer's doctors at this stage must provide substantial evidence ruling out work as the substantial cause of the need for medical treatment and by providing an alternative explanation for any need for medical treatment.[197] In order to determine whether the need for medical treatment arose out of the employment, the Board must weigh the relative causes for the disability.[198] "An employer may rebut the presumption of compensability 'either by presenting affirmative evidence that the injury is not work-connected or by eliminating all possibilities that the injury was work-connected.'"[199]

Dr. Radecki, ARCTEC's EME physician, testified through his report and at hearing that Mr. Weaver's disability was not the result of his work with ARCTEC and attributed his ongoing complaints to psychosocial factors. Dr. Radecki testified that Mr. Weaver was a poor historian and, thus, the reports of his treating doctors present a better history of his need for medical treatment. Dr. Radecki noted that at the time he saw Mr. Weaver his biggest complaint was the bed he used while working for ARCTEC. Dr. Radecki opined

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193 *Huit*, 372 P.3d at 904, 917.

194 *Id.*

195 *Safeway v. Mackey*, 965 P.2d 22, 27 (Alaska 1998)(*Mackey*).

196 *Id.*

197 *Huit*, 372 P.3d at 919-920.

198 *Id.* at 917.

199 *Childs v. Copper Valley Elec. Ass'n*, 860 P.2d 1184, 1189 (Alaska 1993)(*Childs*).

Mr. Weaver's 2010 injury resolved quickly as demonstrated by his return to work with no time loss. Dr. Radecki found no work injury in 2013, because the three imaging studies did not show any acute change. Rather, Dr. Radecki reported the changes seen on the studies were consistent with ongoing degenerative changes and not a work injury. He attributed Mr. Weaver's pain complaints to psychosocial factors and not to his work.

Dr. Scoggin, the Board's SIME physician, testified through his report and by deposition. He diagnosed preexisting chronic low back pain and preexisting degenerative disc disease. While he opined 2013 work combined with the preexisting conditions and the 2010 report of injury to worsen temporarily Mr. Weaver's condition, the 2013 incident was temporary and did not affect any permanent change. He based his opinion in part on the three separate MRI studies from August 2, 2013, July 10, 2014, and December 31, 2014, which showed Mr. Weaver's chronic appearing degenerative changes were stable. The three MRIs showed degenerative changes and no acute traumatic injury, meaning no recent injury. The MRIs showed no nerve root compression. Mr. Weaver also did not have radiculopathy. Therefore, in his opinion, the 2013 work incident was not the substantial cause of any ongoing disability and opined the preexisting conditions were the cause of any need for future medical treatment.

While Mr. Weaver disagrees with the findings of both Dr. Radecki and Dr. Scoggin, when their reports are viewed in isolation, they each offer substantial evidence that Mr. Weaver did not sustain a work injury.[200] The Court has stated "[a[n employer has always been able to rebut the presumption of compensability by presenting expert opinion evidence that 'the claimant's work was probably not a substantial cause of the disability.'"[201] Mr. Weaver's contentions that their reports were flawed goes to whether he proved his claim by a preponderance of the evidence and not to whether ARCTEC rebutted the presumption of compensability.

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[200] *See, Wolfer*, 693 P.2d 865, 869-70 and 872.

[201] *Stephens v. ITT/Felec Servs.*, 915 P.2d 620, 624 (Alaska 1996)(*Stephens*), citing *Big K Grocery v. Gibson*, 836 P.2d 941, 942 (Alaska 1992).

Both doctors looked at Mr. Weaver's work, reviewed the entire medical record, noted the fluctuations in his pain levels, especially after he stopped working, and reviewed the MRIs for evidence of an acute injury or change in his physical condition. Dr. Radecki reported inconsistent range of motions and exhibitions of pain when there was no trigger for pain. Dr. Radecki thought the 2010 injury was a muscle strain that resolved quickly. He also noted the wide variation in Mr. Weaver's pain complaints to his treating doctors, going from 1 out of 10 on one day to 6 out of 10 on another day. He attributed the pain to Mr. Weaver's preexisting degenerative disc disease. Standing alone, this report is substantial evidence Mr. Weaver did not sustain a work injury in 2013 and provided an alternative explanation that the pain was due to preexisting degenerative disc disease.

Dr. Scoggin, in his SIME report, found Mr. Weaver suffered from recurrent chronic low back pain, preexisting degenerative disc disease, and an industrial lumbosacral soft tissue injury on July 23, 2013, which combined with his preexisting condition to cause his initial disability and need for treatment, but did not result in a permanent change to his condition. He found that Mr. Weaver sustained a temporary aggravation which had resolved by January 2014, looking at both Dr. Marble's and Dr. Johnston's reports. He further opined Mr. Weaver's current complaints were subjective based on the stable appearance of Mr. Weaver's spine on three separate MRI studies.

These two doctors presented affirmative evidence that work was not the cause of any ongoing disability and provided an alternate explanation for Mr. Weaver's complaints. According to both doctors, Mr. Weaver had sustained at most a soft tissue injury that resolved. Dr. Scoggin attributed any disability to his preexisting degenerative disc disease which would continue to progress over time. Dr. Radecki attributed Mr. Weaver's ongoing complaints to psychosocial factors and not the work incident. Their opinions, separately and together, are sufficient to rebut the presumption of compensability.

The medical opinions necessary to rebut the presumption of compensability are viewed in isolation and not in comparison to other opinions. "The Board looks at the

evidence to rebut the presumption in isolation, without weighing it."[202] Here, when viewed in isolation, the reports of either or both Drs. Radecki and Scoggin are sufficient to rebut the presumption of compensability. ARCTEC met its burden of proof and rebutted the presumption.

*b. Did Mr. Weaver meet his burden of proof that his work with ARCTEC was the substantial cause of his need for medical treatment?*

The Board found Mr. Weaver did not prove his claim for medical treatment related to the July 23, 2013, date of injury by a preponderance of the evidence. The Commission does not reweigh the evidence when looking at the substantial evidence test to see if the Board's decision is supported by substantial evidence in the record as a whole. "If medical experts disagree upon the ultimate cause of an employee's injury, then as a general rule. 'it is undeniably the province of the Board and not this court to decide who to believe and who to distrust.'"[203] "When medical experts provide contradictory testimony, the board determines credibility. '[I]f the Board is faced with two or more conflicting medical opinions – and elects to rely upon one opinion rather than the other, we will affirm the Board's decision.'"[204] The Court has further stated "[w]e have never held that the opinion of one type of medical specialist is, as a matter of law, entitled to greater weight than that of another. Rather, '[w]hen medical experts provide contradictory testimony, the [B]oard determines credibility.' Additionally, 'if the Board is faced with two or more conflicting medical opinions – each of which constitutes substantial evidence – and elects to rely upon one opinion rather than the other, we will affirm the Board's decision.'"[205]

The Court, in *Steffey v. Municipality of Anchorage*, stated, "it is not our role to reweigh the evidence. Because the Board determined the evidence presented by Steffey

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[202] *McGahuey v. Whitestone Logging*, 262 P.3d 613, 620 (Alaska 2011); *Stephens*, 915 P.2d 620, 624; *Wolfer*, 693 P.2d at 869.

[203] *Childs*, 860 P.2d at 1189 (citations omitted).

[204] *Cowen v. Wal-Mart*, 93 P.3d 420, 426 (Alaska 2004)(citations omitted).

[205] *Sosa de Rosario v. Chenega Lodging*, 297 P.3d 139, 147 (Alaska 2013)(citations omitted)(*Sosa de Rosario*).

was not credible, we conclude that it was reasonable for the Board to find 'that the employee did not suffer an aggravation or acceleration of his June 6, 1992 injury, nor did his work combine with the 1992 injury to produce the 1994 and 1995 condition.'"[206] "Substantial evidence is 'such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.'"[207]

The Board carefully reviewed all the medical records and testimony and made findings as to which witnesses, including doctors, were the more reliable. Although the Board did not make explicit findings of credibility with regards to the testimony of Mr. Weaver, the Board did indicate that it found his testimony to be "repeatedly evasive" especially about his use of alcohol.[208] Likewise, the Board did not make specific credibility determinations regarding the testimony of Mr. Greg Weaver, Sr., Mr. Weaver's father, but rather found his testimony not reliable. The Board found his testimony that since the surgery with Dr. Kralick his son had been doing more things not quite in keeping with the after surgery medical records. The Board also discounted his testimony when he denied his son had "a serious alcohol problem" prior to 2013, notwithstanding the son's prior DUI conviction and his dishonorable discharge from the military for alcoholism.[209] The Board gave his testimony little reliability.

Dr. Restad testified at hearing that the work with ARCTEC was the substantial cause of Mr. Weaver's problems. She testified Mr. Weaver's condition had improved when he reported pain at 9 out of 10 and then a month and a half later reported it to be 3 out of 10. She then contradicted herself by saying his pain levels remained constant. She initially diagnosed him with radiculopathy, but then changed her testimony to say a specialist made that diagnosis. She also admitted to a documentation error when she recalled Mr. Weaver saying he had odd sensations in his feet, but did not document it in

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206 *Steffey v. Municipality of Anchorage*, 1 P.3d 685, 692 (Alaska 2000).

207 *Mackey*, 965 P.2d 22, 27 (citations omitted).

208 *Weaver III* at 29-30, No. 98.

209 *Id.* at 29, No. 97.

her chart notes. The Board found the testimony of Dr. Restad to be "contradictory and problematic," and the Board afforded her opinions "little weight."[210]

Dr. DeSalvo, Mr. Weaver's chiropractor, stated that Mr. Weaver suffered "cumulative trauma to the lumbosacral spine" and his treatment was for a work related condition.[211] Dr. Kralick also considered Mr. Weaver's condition to be work-related and found when he performed the lumbar fusion that Mr. Weaver also had "[s]ignificant canal compromise of the thecal sac by bone and thickened ligamentum flavum."[212] In deciding that neither opinion merited more than "little weight" the Board found their opinions cursory and afforded them little weight. The Board also noted that neither doctor was deposed nor testified at hearing. The Board found there was no evidence either doctor had reviewed Mr. Weaver's medical records in their entirety.[213]

The Board then considered the opinion of Dr. Trescot who saw Mr. Weaver twice for back pain and administered an epidural steroid injection. In her deposition, she acknowledged she obtained a work history from Mr. Weaver, but she could not determine if his disc pathology was acute or chronic, and she did not record any neurological examination which she agreed is the best way to diagnose radiculopathy. She also stated it is important to assess a patient's mental health, including stressors in her patients' lives but she did not do so in Mr. Weaver's case. The Board, therefore, afforded her testimony little weight.[214]

The Board then considered the EME reports and testimony of Dr. Radecki who opined Mr. Weaver's 2010 injury resulted in muscle strain which resolved quickly, based on Mr. Weaver's range of motion findings in January 2011, his subjective pain level of 1 out of 10, and the fact that Mr. Weaver missed no work after this injury. As to the 2013 date of injury, Dr. Radecki found no specific injury, noting that Mr. Weaver's biggest

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210 *Weaver III* at 50.

211 *Id.* at 50.

212 *Id.* at 17, No. 74.

213 *Id.* at 50-51.

214 *Id.* at 51.

complaint was the bed he slept on at work. He attributed Mr. Weaver's pain complaints to "psychosocial factors."[215] Dr. Radecki evaluated Mr. Weaver again following the surgery with Dr. Kralick and found he had not improved.

Mr. Weaver also attended an SIME with Dr. Scoggin who concluded the 2013 injury combined with a preexisting condition to cause the need for medical treatment. However, Dr. Scoggin found this combination was not permanent, and Mr. Weaver would have been medically stable at the time of the evaluation by Dr. Marble in January 2014. Dr. Scoggin relied on the reports of back pain going back to 2001 and imaging studies showing chronic-appearing degenerative changes on the three separate MRIs. Dr. Scoggin opined Mr. Weaver's complaints were subjective and related primarily to his preexisting condition. The Board noted Dr. Scoggin had responded to interrogatories and been deposed. Dr. Radecki testified at hearing. They both reviewed Mr. Weaver's entire medical file. The Board found the opinions of Dr. Radecki and Dr. Scoggin should be afforded substantial weight.[216]

The Board afforded little weight to the opinion of Dr. Teed, who evaluated Mr. Weaver on referral from Dr. Radecki because he opined "the cause of [Mr. Weaver's] disability and need for medical treatment are 'unknown, but unrelated to the July 23, 2013 job injury.'"[217]

The Board also had medicals from Algone, including one dated March 21, 2017, (several months post-surgery) indicating that Mr. Weaver was taking MS Contin 15MG Tablet ER, 1 Oral BID, along with OxyCODONE HCL 5mg Tablet, 1 Oral every six hours, as needed, and he described his pain averaging 3-4 out of 10. These reports support Dr. Radecki's opinion that Mr. Weaver had not improved his physical condition and complaints following the surgery by Dr. Kralick.[218]

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215 *Weaver III* at 52.

216 *Id.* at 52.

217 *Id.* at 53.

218 R. 4535-39.

The Commission finds the testimony of Dr. Radecki and Dr. Scoggin constitute substantial evidence in the record as a whole to support the Board's decision. The Board gave detailed reasons why it chose their opinions over other opinions in the record. The Court has directed the Commission to accept the Board's determinations of credibility. "The Commission could not permissibly find their testimony 'more probative' and 'more persuasive' than expert testimony the Board found more credible."[219] Therefore, although the medical records are susceptible to alternative interpretations, the Commission gives deference to the Board's findings as to which doctors to believe.

*c. Could the Board accept doctors' opinions that incorporated opinions from an excluded medical report?*

The Board excluded the report of Dr. Marble and the "check-the-box" form filled in by Dr. Johnston from its consideration because ARCTEC had not made either of them available for cross-examination by deposition or at hearing.[220] Mr. Weaver filled a request to cross-examine each doctor, but ARCTEC failed to make them available. In *Commercial Union Companies v. Smallwood*, the Court held that "the statutory right to cross-examination is absolute and applicable to the Board."[221]

Mr. Weaver asserts that upon the Board having excluded the report of Dr. Marble and the "check-the-box" form from Dr. Johnston from its consideration, none of the doctors that examined Mr. Weaver should be allowed to reference either item. However, the Board excluded the reports from its consideration, but did not remove them from the file. The EME and SIME physicians received those reports in the medical records they reviewed when each examined Mr. Weaver. Mr. Weaver did not object to either report being included in the medical records sent to the Board's SIME physician, Dr. Scoggin.

Drs. Radecki, Scoggin, and Teed did list the Dr. Marble EME report in their respective histories of Mr. Weaver's medical records, as Mr. Weaver notes. They would have been remiss not to include these reports since they were part of the medical

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219 *Sosa de Rosario*, 297 P.3d at 146.

220 8 AAC 45.052; *Commercial Union Companies v. Smallwood*, 550 P.2d 1261 (Alaska 1976)(*Smallwood*).

221 *Smallwood*, 550 P.2d at 1265.

documentation sent to each of them. Especially, it would be useful to Dr. Scoggin to review both treating doctors' reports and the EME reports.

Both Drs. Radecki and Scoggin noted Dr. Marble's finding of medical stability, but based their findings of medical stability not only on his date for medical stability, but also on Mr. Weaver's lack of improvement for more than 45 days in 2014. Dr. Teed, in his conclusions, does not reference Dr. Marble's report in his finding of when Mr. Weaver reached medical stability. He thought Mr. Weaver was medically stable on the date of injury since he showed no evidence of improvement. Mr. Weaver presented to him with chronic nonspecific low back pain.

Therefore, none of these doctors based their findings of medical stability solely on Dr. Marble's report or on Dr. Johnston's "check-the-box" form. The references to Dr. Marble's report were incidental factors in these doctors reaching their conclusions which were supported by their other findings and conclusions. While it might have been prudent for ARCTEC to have made Dr. Marble available for cross-examination, since neither Dr. Radecki nor Dr. Scoggin based their respective findings solely on Dr. Marble's date of medical stability, the inclusion of his record for their consideration was proper. Moreover, Mr. Weaver's right to cross-examine Dr. Marble and Dr. Johnston was also properly protected by the Board's exclusion of these two items from the Board's own deliberations and conclusions. The Board did not base any of its conclusions or findings on Dr. Marble's report.

*d. Did the Board make sufficient findings regarding the various doctors' opinions?*

Both the Act and the Court mandate the Commission accept the Board's findings regarding credibility. The Commission is bound by these findings. AS 23.30.122 states:

> 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."

AS 23.30.128(b) is even more restrictive. It simply states, "[t]he board's findings regarding the credibility of testimony of a witness before the board are binding on the

commission." Thus the Board's findings on credibility are binding on the Commission per AS 23.30.122 and AS 23.30.128.

Furthermore, the Court, in *Sosa de Rosario v. Chenega Lodging*, expressly rebuked the Commission where it had not deferred to the Board's findings on credibility. "We construe AS 23.30.128(b) to mean that the Commission must follow the Board's credibility determination. 'Bind' means '[t]o impose one or more legal duties on (a person or institution) . . . . The Commission was thus required to accept the Board's credibility determinations . . . ."[222]

Mr. Weaver contends the Board should not have relied on Dr. Radecki's reports and testimony because other Board panels did not accept his opinions and his reports are mostly prepared for employers. However, this does not go to the weight to be afforded his report in rebutting the presumption of compensability which is reviewed in isolation. It is an argument to be made to the Board as to which doctors the Board should believe and what weight should be given to the opinions of the various doctors.

The Board has the final determination as to which doctors to believe in reaching its conclusions. Even if the record supports an alternate finding, it is the Board's province to decide which doctors to believe and which doctors are less worthy of reliance. The Board detailed why it relied on some opinions and why it rejected others. The Board's decision is supported by substantial evidence in the record as a whole.

*e. Did the Board properly deny benefits related to a 2010 date of injury when no claim for benefits had been filed for the 2010 date of injury?*

Mr. Weaver sought benefits for his 2010 injury with ARCTEC as well as benefits for the 2013 injury. He asserts benefits related to the 2010 injury were at issue because the 2010 injury was joined to the 2013 injury at the prehearing on January 21, 2015.[223] However, the action at the prehearing constituted a joining of cases but not of claims, because no claim for benefits arising from the 2010 date of injury is in the record.

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222 *Sosa de Rosario*, 297 P.3d at 146.

223 R. 6184-88.

Mr. Weaver did file a WCC for the 2010 injury on July 31, 2018, well after the hearing on March 27, 2017.[224] The joinder at the January 21, 2015, prehearing was a joinder of cases, but not of claims.

ARCTEC contends the Board rightly denied any benefits arising out the 2010 date of injury precisely because no WCC was filed for the 2010 date of injury prior to the hearing on March 28, 2017. The record does not reveal any WCC related directly to the 2010 date of injury prior to the March 2017 hearing.

In *Alcan Electrical and Engineering, Inc. v. Redi Electric, Inc. and Hope*, the Commission addressed the issue of the lack of a WCC putting the parties on notice of what benefits are being claimed at hearing.[225]

AS 23.30.105 states in pertinent part:

> (a) The right to compensation for disability under this chapter is barred unless a claim for it is filed within two years after the employee has knowledge of the nature of the employee's disability and its relation to the employment and after disablement. However, the maximum time for filing the claim in any event other than arising out of an occupational disease shall be four years from the date of injury, and the right to compensation for death is barred unless a claim therefor is filed within one year after the death, except that, if payment of compensation has been made without an award on account of the injury or death, a claim may be filed within two years after the date of the last payment of benefits under AS 34.30.041, 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215. It is additionally provided that, in the case of latent defects pertinent to and causing compensable disability, the injured employee has full right to claim as shall be determined by the board, time limitations notwithstanding.
>
> (b) Failure to file a claim within the period prescribed in (a) of this section is not a bar to compensation unless objection to the failure is made at the first hearing of the claim in which all parties in interest are given reasonable notice and opportunity to be heard.

The Board's regulation at 8 AAC 45.050 lays out the requirements for a claim for benefits.

> (a) **Pleadings.** A person may start a proceeding before the board by filing a written claim or petition.

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[224] Exc. 2272-73.

[225] *Alcan Elec. and Eng'g, Inc. v. Redi Elec., Inc. and Hope,* Alaska Workers' Comp. App. Comm'n Dec. No. 112 (July 1, 2009) at 27-33 (*Alcan*).

(b) **Claims and petitions.**

(1) A claim is a written request for benefits, including compensation, attorney's fees, costs, interest, reemployment or rehabilitation benefits, rehabilitation specialist or provider fees, or medical benefits under the Act, that meets the requirements of (4) of this subsection. The board has a form that may be used to file a claim. In this chapter, an application is a written claim.

(2) A request for action by the board other than by a claim must be by a petition that meets the requirements of (8) of this subsection. The board has a form that may be used to file a petition.

(3) Parties must be designated in accordance with 8 AAC 45.170.

(4) Within 10 days after receiving a claim that is complete in accordance with this paragraph, the board or its designee will notify the employer or other person who may be an interested party that a claim has been filed. The board will give notice by serving a copy of the claim by certified mail, return receipt requested, upon the employer or other person. The board or its designee will return to the claimant, and will not serve, an incomplete claim. A claim must

(A) state the names and addresses of all parties, the date of injury, and the general nature of the dispute between the parties; and

(B) be signed by the claimant or a representative.

(5) **A separate claim must be filed for each injury for which benefits are claimed, regardless of whether the employer is the same in each case.** If a single incident injures two or more employees, regardless of whether the employers are the same, two or more cases may be consolidated for the purpose of taking evidence. A party may ask for consolidation by filing a petition for consolidation and asking in writing for a prehearing, or a designee may raise the issue at a prehearing. To consolidate cases, at the prehearing the designee must

(A) determine the injuries or issues in the cases are similar or closely related;

(B) determine that hearing both cases together would provide a speedier remedy; and

(C) state on the prehearing summary that the cases are consolidated, and state which case number is the master case number. (Emphasis added).

The Commission, in *Alcan*, rightly pointed to the above regulation and stated the regulation "clearly [requires] a claim to be filed for every injury for which benefits are

claimed . . . ."[226] The Commission further noted that "in order to join claims, the claims must be in existence."[227] The regulation governing joinder at 8 AAC 45.040 is designed to join additional parties, but the notion that a claim is necessary applies also to situations as here where two distinct injuries are alleged, but no claim for benefits for the earlier injury is filed. ARCTEC is never put on notice that benefits were sought arising out of the 2010 injury, nor what those benefits might be. ARCTEC never had the opportunity to develop any defenses it might have related to the 2010 injury. The vaguely worded request on the June 17, 2014, WCC for benefits for "cumulative trauma" seems grossly insufficient to apprise ARCTEC that Mr. Weaver is also seeking some sort of benefits from the 2010 injury. This is especially significant since the June 17, 2014, WCC does not mention the 2010 injury.

The prehearing conference summaries dated February 27, 2017, and March 28, 2017, listing the issues for hearing, reference the "6/7/2015 and 2/19/2014 Claims."[228] The reference to a "6/7/15" claim seems to be a typographical error because no WCC with that date is found in the record. Rather there is a June 17, 2014, Amended WCC.[229] Both the June 17, 2014, WCC and the February 19, 2014, WCC reference only the July 23, 2013, Date of Injury.[230] The June 17, 2014, WCC does claim benefits arising out of "a traumatic incident and/or cumulative trauma in the course and scope of his employment."[231] However, this WCC does not identify the 2010 date of injury and makes no reference to it in the request for specific benefits.

The Board's decision that an award of benefits is "contingent upon the filling(sic) of a claim" is supported by statute and regulation and by *Alcan.*[232] "A separate claim

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226 *Alcan* at 27.

227 *Alcan* at 29.

228 R. 06245-48, R. 06254-56.

229 R. 00157-58.

230 R. 00019-20, R. 00157-58.

231 R. 00157.

232 *Weaver III* at 48.

must be filed for each injury for which benefits are claimed, regardless of whether the employer is the same in each case."[233] Furthermore, the 2010 injury was not an issue for hearing because the prehearing summaries listed only claims for the 2013 date of injury. Issues for hearing are controlled by the prehearing summaries.[234] The law and substantial evidence in the record of the lack of a claim for the 2010 date of injury support the Board's decision not to decide on benefits arising out of the 2010 date of injury.

*6. Conclusion.*

The Board's decision is AFFIRMED, having substantial evidence in the record as a whole to support it.

Date: *15 March 2019* ALASKA WORKERS' COMPENSATION APPEALS COMMISSION

*Signed*
James N. Rhodes, Appeals Commissioner

*Signed*
Philip E. Ulmer, Appeals Commissioner
*pro tempore*

*Signed*
Deirdre D. Ford, Chair

APPEAL PROCEDURES

This is a final decision. AS 23.30.128(e). It may be appealed to the Alaska Supreme Court. AS 23.30.129(a). If a party seeks review of this decision by the Alaska Supreme Court, a notice of appeal to the Alaska Supreme Court must be filed no later than 30 days after the date shown in the Commission's notice of distribution (the box below).

If you wish to appeal to the Alaska Supreme Court, you should contact the Alaska Appellate Courts *immediately*:

Clerk of the Appellate Courts
303 K Street
Anchorage, AK 99501-2084
Telephone: 907-264-0612

233 8 AAC 45.050(b)(5).

234 8 AAC 45.050(c)(5).

## RECONSIDERATION

A party may ask the Commission to reconsider this decision by filing a motion for reconsideration in accordance with AS 23.30.128(f) and 8 AAC 57.230. The motion for reconsideration must be filed with the Commission no later than 30 days after the date shown in the Commission's notice of distribution (the box below). If a request for reconsideration of this final decision is filed on time with the Commission, any proceedings to appeal must be instituted no later than 30 days after the reconsideration decision is distributed to the parties, or, no later than 60 days after the date this final decision was distributed in the absence of any action on the reconsideration request, whichever date is earlier. AS 23.30.128(f).

I certify that, with the exception of changes made in formatting for publication, this is a full and correct copy of Final Decision No. 258, issued in the matter of *Gregory Weaver vs. ASRC Federal Holding Company and Arctic Slope Regional Corporation*, AWCAC Appeal No. 17-025, and distributed by the office of the Alaska Workers' Compensation Appeals Commission in Anchorage, Alaska, on March 15, 2019.

Date: *March 20, 2019*

*Signed*

K. Morrison, Appeals Commission Clerk