Alaska Workers' Compensation Appeals Commission

Joseph M. Baker, Appellant, vs. ASRC Energy Services, Inc. and Arctic Slope Regional Corporation, Appellees.	Final Decision Decision No. 201 October 2, 2014 AWCAC Appeal No. 14-003 AWCB Decision No. 14-0005 AWCB Case No. 201106861

Final decision on appeal from Alaska Workers' Compensation Board Final Decision and Order No. 14-0005, issued at Fairbanks, Alaska, on January 13, 2014, by northern panel members Robert Vollmer, Chair, Rick Traini, Member for Labor, and Krista Lord, Member for Industry.

Appearances: Joseph A. Kalamarides, Kalamarides & Lambert, for appellant, Joseph M. Baker; Nora G. Barlow, Burr, Pease & Kurtz, P.C., for appellees, ASRC Energy Services, Inc. and Arctic Slope Regional Corporation.

Commission proceedings: Appeal filed February 3, 2014; briefing completed August 14, 2014; oral argument was not requested.

Commissioners: James N. Rhodes, Philip E. Ulmer, Laurence Keyes, Chair.

By: Laurence Keyes, Chair.

1. Introduction.

Appellant, Joseph M. Baker (Baker), had a history of neck, back, and shoulder problems, prior to his employment with appellee, ASRC Energy Services, Inc. (ASRC). On May 15, 2011, while employed by ASRC driving a water truck, Baker injured his neck and right shoulder, leading to him filing a workers' compensation claim (claim). The Alaska Workers' Compensation Board (board) held a hearing on Baker's claim on

September 19, 2013; it issued a Final Decision and Order on January 13, 2014.[1] In denying Baker's claim, the board held: "[B]ased on a preponderance of medical evidence, the substantial cause of [Baker's] continuing disability and need for medical treatment is the natural progression of his degenerative cervical spondylosis[[2]] and not the May 15, 2011[,] work injury."[3] Baker appealed the decision to the Workers' Compensation Appeals Commission (commission). We affirm.

2. Factual background and proceedings.

Baker acknowledged he has a history of neck, back, and shoulder problems. He injured his low back in April 1998, when he fell off a backhoe. Baker injured his chest, back, left arm, and shoulder in 2007, when he fell off the flying bridge of a boat. He suffered back, right shoulder, and neck pain in 2008, as a result of doing manual labor and working as a heavy equipment operator. Baker also experienced head and neck pain in 2009, after hitting his head on a control panel of a water truck.[4]

Following the fall from a backhoe on April 16, 1998, Baker sought treatment for low back pain and also reported some neck pain. Contusion and sprain of the low back were diagnosed. While seeking follow-up care for his back on May 8, 1998, he also reported some right hand paresthesias and numbness and was diagnosed with some radicular complaints with no clear-cut clinical evidence of radiculopathy.[5] On September 24, 1998, Baker was given a five percent whole person permanent partial impairment (PPI) rating for his April 16, 1998, low back injury.[6] From October 1998 to February 1999, he continued to complain of low back pain and underwent physical

---

[1] *See generally Joseph M. Baker v. ASRC Energy Services, Inc., et al.*, Alaska Workers' Comp. Bd. Dec. No. 14-0005 (Jan. 13, 2014) at 1-6.

[2] Cervical spondylosis is defined as "[d]egenerative arthritis, osteoarthritis, of the cervical . . . vertebrae and related tissues. It may cause pressure on nerve roots with subsequent pain or paresthesia in the extremities." Taber's Cyclopedic Medical Dictionary, 21st Ed. (2009).

[3] *Baker,* Bd. Dec. No. 14-0005 at 24.

[4] *See id*. at 3.

[5] R. 2413-15.

[6] R. 2438-39.

therapy.[7] By February 25, 1999, Baker was much improved and had returned to baseline.[8]

There is a significant gap in the medical records until 2006.[9]

On July 26, 2007, Baker sought treatment for chest, back, left shoulder, and arm pain following the incident on the boat in which he fell off the flying bridge. X-rays of his left shoulder and elbow showed mild osteoarthritis, although there were no fractures or dislocations; X-rays of Baker's thoracic spine showed osteoarthritis and anterior wedging at T9, T10, and T11.[10] Until August 25, 2007, he continued to treat his ongoing back and rib pain with medications, including Ultram.[11]

On December 6, 2007, Baker began treating with Margaret Heller, PA-C, after being recently diagnosed with diabetes. He reported unspecified back and joint pain, however, he denied neck pain.[12] Almost a year later, on November 17, 2008, Baker reported to Ms. Heller his right shoulder was starting to bother him from having to position himself while operating heavy equipment and he began reporting neck pain.[13]

On January 29, 2009, ASRC sent Baker to Thomas B. Cross, PA-C, for a return to work evaluation due to his medication usage. He acknowledged taking hydrocodone at bedtime, occasionally with Skelaxin or Ultram, for back and neck pain.[14]

On March 9, 2009, Ms. Heller advised Baker she would not be able to treat his chronic pain indefinitely and referred him to David R. Chisholm, M.D., for chronic pain management.[15] On May 5, 2009, Baker saw Dr. Chisholm and reported chronic low back pain, occasional pain at the base of his neck when his back worsens, and some

---

7 R. 2440-48, 2450-70.

8 R. 2471.

9 *See Baker*, Bd. Dec. No. 14-0005 at 3.

10 R. 2508-11.

11 R. 2513-15, 2520, 2522, 2527, 2529.

12 R. 2540-41.

13 R. 2548-49.

14 R. 2042-43.

15 R. 2550-53.

shoulder discomfort.[16] On June 12, 2009, Dr. Chisholm noted Baker was having some numbness in his shoulders and upper arms bilaterally and burning at the bilateral trapezius and thought he should have a cervical x-ray and possibly a magnetic resonance imaging (MRI) study.[17]

On June 30, 2009, Baker was getting into a water truck when he hit his head on a control panel. He developed neck pain and complained of pain going across the top of his right shoulder. He also developed cervical spasms that were successfully treated with massage therapy. Baker was released back to work on July 7, 2009.[18] On July 30, 2009, Baker began treating with William Erickson, ANP, for neck pain, headache, and pain in the middle of his back and lumbar area. He also reported right upper extremity tingling.[19] The following day, July 31, 2009, Baker saw Dr. Chisholm, who again noted Baker was having some numbness in his shoulders and upper arms bilaterally and burning at the bilateral trapezius. Dr. Chisholm maintained that Baker should have a cervical x-ray and possibly an MRI.[20]

On September 11, 2009, Thomas Williamson-Kirkland, M.D., performed an employer medical evaluation (EME) in connection with Baker's 1998 low back injury. He did not think that the 1998 injury continued to be "a substantial factor" in causing Baker's chronic low back pain; instead, Dr. Williamson-Kirkland thought that injury was "one episode among many that have aged his thoracic and lumbar spine." No further treatment was recommended. He also noted diabetics tend to get more arthritic conditions and spurring in their spine. Dr. Williamson-Kirkland also commented on Baker's use of narcotics and stated it was now counterproductive since Baker was

---

16 R. 2380-82.

17 R. 2388-90.

18 R. 2051, 2054-55.

19 R. 2607.

20 R. 2850-52.

habituated to them, making them less effective. He recommended that Baker use narcotics sparingly.[21]

Between October 22, 2009, and April 7, 2011, Baker periodically treated with ANP Erickson for his chronic back pain. On January 6, 2010, ANP Erickson noted Baker needed an MRI of his neck and lumbar spine. Otherwise, ANP Erickson's treatment of Baker consisted primarily of prescribing medications, including Ultram, hydrocodone, and MS Contin.[22]

On August 12, 2010, MRI's were taken of Baker's lumbar spine and right shoulder. The lumbar MRI showed: 1) high grade L5-S1 spondylosis secondary to broad-based disc/osteophyte bulging with possible right and probable left nerve root impingements; 2) moderate multilevel inferior lumbar neural foraminal stenosis secondary to lateral disc encroachment with possible bilateral L4-5 foraminal nerve root impingements; 3) moderate to severe multilevel and facet lumbar degenerative disease; and 4) chronic T12 and L2 central vertebral body compression injuries. The right shoulder MRI showed: 1) a chronic, low grade, partial thickness supraspinatus tendon tear; and 2) chronic, severe, near circumferential glenoid labral complex tear and intralabral/paralabral cystic degeneration. Complex bicipital tenosynovitis was also noted.[23]

On May 15, 2011, Baker injured his neck and right shoulder in the incident with the water truck that forms the basis of his claim against ASRC.[24] Two days later, on May 17, 2011, he sought treatment from Jose Diaz, PA-C. Baker reported he felt no pain immediately following the accident but had a slightly stiff neck a day later. When he woke up the following day, his neck pain had become severe and he was unable to turn his neck. Baker also reported pain radiating into his right shoulder. PA-C Diaz's

---

21 R. 2095-2108.

22 R. 2608-12, 2617-19; Erickson Dep. 7:2–15:3, Aug. 22, 2013.

23 R. 2613-16.

24 R. 0001.

report states: "[Baker] admits to having chronic neck and back problems."[25] On May 18, 2011, PA-C Cross evaluated Baker. He assessed neck and right shoulder strain, "probably muscular in nature," and referred Baker for MRI studies.[26]

On May 19, 2011, a right shoulder MRI showed a paralabral cyst along the inferior margin of the glenoid tendon and minimal atrophy of the teres minor muscle. No significant rotator cuff pathology was noted. The study also showed a subacromial spur. When the May 19, 2011, right shoulder MRI was compared to the August 12, 2010, MRI, the inferior paralabral cyst had not appreciably changed and the atrophy of the teres minor appeared stable. The supraspinatus tendon was also stable. The cervical MRI showed multilevel degenerative changes, including diffuse disc desiccation, osteophytes, spurring, and mild to moderate foraminal narrowing.[27]

On May 20, 2011, Emile Vandermeer, M.D., evaluated Baker and assessed cervical strain with radiculopathy symptoms. Baker was treated conservatively with physical therapy and his condition reportedly improved, including his neck range of motion.[28] As of June 1, 2011, he reported being 40 to 50 percent better following continued physical therapy.[29] On June 9, 2011, Baker indicated he was 80 percent better overall. The following day, June 10, 2011, he reported being 60 to 65 percent improved.[30]

On June 17, 2011, because of continuing neck pain and paresthesias in Baker's right arm, Dr. Vandermeer referred him to Larry Kropp, M.D., for a nerve root block injection.[31] On June 22, 2011, and June 29, 2011, Dr. Kropp performed C4-5 and C5-6

---

25 R. 2093.

26 R. 2070.

27 R. 2251-59.

28 R. 2073, 2109-13, 2075.

29 R. 2076.

30 R. 2934-35, 2079.

31 R. 2083.

nerve root block injections. Baker reported feeling worse pain following the injections.[32]

On July 27, 2011, a repeat cervical MRI showed marked disc degeneration at multiple levels; marked foraminal stenosis was also noted at C4-5.[33] A day later, nerve conduction and needle electromyography (EMG) studies were normal with no evidence of cervical radiculopathy or nerve entrapment in Baker's right arm.[34]

On August 8, 2011, Baker's condition continued to worsen and he reported severe neck pain that would cause him to pass out at times, migraines with tunnel vision, difficulty swallowing, and tremors in his right arm. ANP Erickson referred Baker to Mark E. Flanum, M.D., for an orthopedic evaluation.[35]

On August 24, 2011, with respect to Baker's cervical spine, Dr. Flanum assessed "clear evidence of cervical radiculopathy" secondary to cervical disc displacement and neural foraminal stenosis. As for Baker's right shoulder, he also assessed a superior labrum anterior and posterior (SLAP) tear, biceps tendon pathology, and perilabral cyst. Dr. Flanum recommended C4-5 and C5-6 anterior cervical discectomy and fusion, as well as future treatment for Baker's right shoulder labral tear.[36]

On September 27, 2011, a repeat cervical MRI showed severe right-sided foraminal stenosis at C3-4 and C4-5 and severe bilateral foraminal stenosis at C5-6.[37] On October 4, 2011, Dr. Flanum performed C4-5 and C5-6 cervical discectomies and fusions.[38] When he saw ANP Erickson on December 5, 2011, Baker reported he was

---

32 R. 2262-63, 2967.

33 R. 2271-72.

34 R. 2273-75.

35 R. 3019-20.

36 R. 2280-83.

37 R. 2307-08.

38 R. 2309-12.

still having a lot of neck pain and could not sleep because of the pain. He also reported burning and numbness in his right arm and hand.[39]

On January 6, 2012, Stephen P. Marble, M.D., performed an EME. Baker reported that surgery had not improved his neck condition and stated, in hindsight, he would not have elected to have the surgery. Baker brought numerous compact discs (CDs) of MRI and x-ray studies to the evaluation, including a June 8, 2009, lumbar spine MRI, which contained whole-spine scout films. Dr. Marble interpreted the scout films to show significant disc protrusions at C4-5 and C5-6. In the records review section of his January 6, 2012, report, Dr. Marble added parenthetical "reviewer's comments" identifying possible early radicular signs in a July 2, 2009, medical report and identifying right shoulder symptomology, "likely radicular from cervical pathology," in a May 19, 2011, medical report. He stated the medical records showed evidence of related preexisting conditions, including cervical MRI findings of advanced multilevel degenerative spondylosis, and thought Baker suffered a temporary cervical spine strain as a result of the May 15, 2011, water truck incident and "may have" returned to pre-injury status in two months. However, to clarify whether the strain was a temporary or permanent aggravation, Dr. Marble suggested numerous other pre-claim medical reports be examined.[40]

On March 28, 2012, Baker filed a claim seeking temporary total disability (TTD) benefits from January 18, 2012, ongoing, PPI, medical and transportation costs, penalty, interest, attorney fees and costs, and a second independent medical evaluation (SIME).[41]

On August 28, 2012, Lowell M. Anderson, M.D., performed an SIME. He noted Baker's history of spine injuries over the course of the last 20-30 years, his use of chronic pain medications for neck, mid-back and low-back discomfort for the past 12-15 years, an increase in pain medication dosages over the past 5-10 years as his

---

39 R. 3096.

40 R. 2316-34.

41 R. 0028-29.

symptoms progressed, and additional records of neck and right shoulder pain for the last 10-15 years. Dr. Anderson also noted the failed nerve root block injections and the normal EMG study. Based on MRI studies, he stated Baker's right shoulder pathology pre-existed the May 15, 2011, work injury and was not affected by it. Instead, he thought Baker's right shoulder symptoms were, more likely than not, related to referred pain from the cervical spine. Regarding causation and Baker's cervical spine condition, Dr. Anderson stated:

> Based on symptoms, without objective findings of cervical radiculopathy, there may have been a permanent aggravation of preexisting cervical spondylosis related complaints resulting in the need for medical treatment to include the subsequent cervical spine surgery and present disability. The upper right extremity complaints were without objective electrodiagnostic study findings for radiculopathy or other pathology to account for the subjective complaints. No evidence of cervical instability. No evidence of acute injury based on multiple cervical MRI studies. Subsequent pain management treatment included selective nerve root blocks without substantive improvement. With normal electrodiagnostic studies there was discussion regarding cervical facet etiology accounting for the ongoing symptoms. In spite of these considerations, the surgical evaluation concluded that cervical disc pathology accounted for ongoing subjective complaints, resulting in the surgical treatment recommendations. . . . Based on objective findings from the cervical x-rays and MRI as well as electrodiagnostic studies, there did not appear to be a permanent change in the preexisting condition. Best considered a temporary aggravation of preexisting cervical spondylosis symptoms.[42]

Evaluating the relative contributions of different causes, Dr. Anderson concluded the "major contribution to the present complaints would be the natural progression of preexisting cervical spondylosis and facet pathology symptoms."[43] He also thought post-surgical changes and scar tissue were also contributing to Baker's present symptoms. Dr. Anderson further explained his rationale as follows:

> The employment injury of 5-15-2011 resulted in claimed increased neck and right upper extremity complaints without objective findings of acute injury or radiculopathy. Subsequent medical evaluations and orthopedic surgical assessment, in spite of these findings, determined that surgical

---

[42] Exc. 681.

[43] Exc. 681.

> treatment was indicated. Nonsurgical care was an appropriate consideration related to the claimed injury and objective findings based on diagnostic studies and physical exam findings. Initial physical therapy estimation of 80% improvement in symptoms. This would indicate resolving cervical strain symptoms and/or resolving symptoms from temporary aggravation of preexisting cervical spondylosis with some nerve root irritation. Because there is identified pathology (from the cervical MRI) does not indicate that that pathology is the primary source of claimed acute symptoms. It is noted that at the time of electrodiagnostic studies that the evaluating physician felt that present exam findings were related to facet pathology and not disc or nerve root pathology. The substantial cause of the need for medical treatment would be acute cervical strain and the natural progression of preexisting cervical spondylosis.[44]

In Dr. Anderson's opinion, Baker was medically stable by September 1, 2011, and was unable to return to work in any capacity because of his preexisting cervical, thoracic, and lumbar spondylosis, functional limitations, deconditioning, narcotic pain medication usage, and disability conviction. Dr. Anderson also cited Baker's diabetes and obesity as conditions that would preclude him from work activity.[45]

On December 17, 2012, Dr. Marble's deposition was taken. He did not think the work injury was the substantial cause of Baker's need for medical treatment because of two factors: 1) imaging studies revealed preexisting degenerative changes to his neck; and 2) medical records indicate Baker had been symptomatic from those changes prior to the work injury.[46] Dr. Marble identified a May 4, 1998, record that indicated Baker was experiencing right hand paresthesias and numbness, which Dr. Marble thought was significant because it indicated Baker was experiencing some radiculitis or radiculopathy at that point in time. He explained it is very common for pain to radiate or be referred into the upper back when there is cervical spine pathology.[47] When asked about a November 17, 2008, medical record, Dr. Marble explained that neck pain extending towards the right shoulder many times means the patient is experiencing referred or

---

[44] Exc. 681.

[45] R. 0666-85.

[46] Marble Dep. 20:4–21:6, Dec. 17, 2012.

[47] Marble Dep. 25:22–26:24.

radiating symptoms from the neck or it could be radicular pain from some of the upper cervical segments. Dr. Marble observed that at that point, Baker was prescribed hydrocodone, Skelaxin, and tramadol.[48] He further explained degenerative spondylosis symptoms usually wax and wane. It is not unusual for the waxing and waning episodes to become more frequent and longer lasting and some patients get to a point where they have chronic pain.[49]

Dr. Marble stated a May 5, 2009, medical record, which indicated Baker had occasional pain at the base of his neck, some shoulder discomfort, and hand-to-arm discomfort, demonstrated that Baker's neck symptoms were expanding out into his shoulders, arms, and hands, which was suggestive of nerve root irritation.[50] Dr. Marble also believed Baker's change of medications on January 6, 2010, from Norco and Ultram to morphine, indicated an escalation of symptoms.[51]

Given the degree of Baker's existing pathology, Dr. Marble thought the work injury caused an aggravation of his symptoms and Baker returned to baseline within a couple of months.[52] Dr. Marble explained the potential significance of Baker's unsuccessful nerve root block injections: it could mean the targeted space was not the pain generator, the injection was not properly placed, or the pathology at the space was so severe an injection would not be effective.[53] Although Dr. Marble stated MRI scout films are not intended for making diagnoses, nevertheless, he believes they are worth reviewing.[54] Discussing Baker's imaging studies, Dr. Marble testified he has "really got a potential for pain generators primarily at C4/5 and C5/6."[55]

---

48 Marble Dep. 28:23–29:22.

49 Marble Dep. 30:15-25.

50 Marble Dep. 33:2-12.

51 Marble Dep. 38:19–39:5.

52 Marble Dep. 40:18–41:7, 56:6-13, 63:20–64:5.

53 Marble Dep. 42:15–43:16.

54 Marble Dep. 51:9-13.

55 Marble Dep. 56:3-4.

Dr. Marble stated the vast majority of soft tissue injuries resolve in one month. Based on the pre- and post-claim pain diagrams, and Baker's reported level of improvement, Dr. Marble thought his work-related condition resolved within a couple of months but was "superimposed" on his preexisting condition.[56] It was important to note, Dr. Marble thought, that a "preexisting condition is not a static condition; it's progressive. So, by the time you return to . . . pre-injury status in six months . . . that pre-injury status had it followed its natural course was going to be a different six months [later] regardless of whether the accident occurred or not."[57]

Dr. Marble stated having additional pre-injury medical records at deposition that were not available to him at the time he wrote his January 6, 2012, report provided him with a clear picture of Baker's condition.[58] According to Dr. Marble, the subsequent availability of previously unavailable medical reports strengthened the opinions he expressed in his January 6, 2012, report.[59]

When asked if the work injury accelerated Baker's preexisting condition, Dr. Marble explained:

> It's possible that you can have -- in general that you can have injuries that accelerate the process. I would certainly agree with that. It's only fair for a doctor like me to consider that. In other words, did I see some acceleration of the process and distinct change in the process or any objective findings that would suggest that there had been an acceleration?
>
> And this is no. In other words, in the end, months down the road were we seeing any signs or symptoms different than what you would expect had this injury not occurred? No. Again, to be fair, that's one of the things I was trying to point out in my report. I said, looks like he had some issues beforehand, and that's why oftentimes I'll recommend a more extensive review of the pre-claim medical records so I can gain a clear picture of what was going on. I don't want to just make assumptions.

---

56 Marble Dep. 61:2-15, 64:2–65:16.

57 Marble Dep. 66:19–67:10.

58 Marble Dep. 68:1-10.

59 Marble Dep. 23:4-9.

> These subsequent records that we've been provided, I think, provide that clear picture.[60]

When questioned about Dr. Anderson's report, Dr. Marble provided a cogent and articulate interpretation of that report. He also related conclusions in Dr. Anderson's report to those in his own.[61]

On August 22, 2013, the parties took ANP Erickson's deposition. During an office visit on May 18, 2011, ANP Erickson noted Baker's complaints included neck pain, in addition to back pain, which was "[d]efin[e]tly different" than the pain Baker exhibited on other visits.[62] On June 30, 2011, ANP Erickson recorded additional symptoms, including migraines and pain and numbness in Baker's right hand.[63] In January and February of 2012, ANP Erickson testified Baker's neck pain was worse. He reportedly was not comfortable in any position, sitting or standing. Baker rated his pain 10 out of 10 on a pain scale of 1 to 10 and complained of dizziness, burning in his neck, and not being able to move his hand. ANP Erickson thought Baker was in severe pain and stated he was tearful at the time.[64] When ANP Erickson was asked to explain why, in his opinion, the work injury was the substantial cause of Baker's need for medical treatment, he stated:

> What I can say is he was worse after his accident. There's just no doubt, he was worse. And, he required more and more medications, more and more shots, more and more treatments. And I thought he got to such a complicated and severe nature that I had to get help. And, so I asked Dr. Flanum to help us out – and get a consultation.[65]

ANP Erickson had not reviewed Baker's medical records that predated their nurse-patient relationship.[66]

---

60 Marble Dep. 67:13–68:10.

61 Marble Dep. 56:14–61:15.

62 Erickson Dep. 15:4–16:4.

63 Erickson Dep. 22:15-16.

64 Erickson Dep. 33:4-24.

65 Erickson Dep. 38:24–39:4.

66 Erickson Dep. 42:21-24.

ANP Erickson was questioned repeatedly about his chart notes. With respect to a December 2, 2010, chart note, he stated: "I can't comment on that. I don't know what that is -- what my scribble means."[67] ANP Erickson did not identify specific conditions he was treating in his chart notes, such as a specific nerve root, stenosis, or spondylosis. He also did not describe MRI results in his chart notes.[68] Regarding his chart notes, ASRC's counsel asked ANP Erickson: "So you don't really describe what you were treating other than pain?" Mr. Erickson answered: "You know, in my notes it's not documented that way. . . . They're just notes. They're not all inclusive of every single thing you do."[69]

On July 29, 2013, the parties took Dr. Flanum's deposition. He testified as follows: Baker's fusion surgery was based on a positive Spurling's test and MRIs. He explained the Spurling's test is when a patient's cervical spine is extended and slightly rotated and compressed. It is indicative of nerve compression in the cervical spine. In Baker's case, the pain radiated into the left trapezius and he had increased weakness and decreased strength in the left biceps and left wrist flexion.[70] Dr. Flanum thought Baker had preexisting degenerative changes, such as neural foraminal stenosis, that were substantially aggravated by the work injury.[71] Even though Dr. Flanum sometimes later learns patients have "exhaustive medical records [with] . . . a very long history of previous similar complaints," he takes the patient "at their word." He explained: "[I]f a person comes in and says, nope, I was doing fine, I was working on the North Slope, I had this accident, and since then I have had neck pain . . . then I say, this is the reason you need surgery, is because you were living with it before. I'm

---

67 Erickson Dep. 14:3-4.

68 Erickson Dep. 52:4-14.

69 Erickson Dep. 52:15-23.

70 Flanum Dep. 7:16–12:19, July 29, 2013.

71 Flanum Dep. 20:7-12.

accepting the patient as they were on that day, and that was the day that things changed."[72]

Dr. Flanum explained that sometimes discs are completely asymptomatic and a jarring-type injury to the nerve "triggers that person into that place where they need surgery."[73] It is common for Dr. Flanum to see patients with large disc herniations and "clear" radiculopathy that cannot be "picked up" on an EMG.[74] Dr. Flanum thought the work injury enlarged a disc herniation, or created a disc herniation, that then pressed on a nerve and generated Baker's symptoms.[75] Dr. Flanum did not review 600 pages of Baker's medical records.[76] Although MRI scout films can raise Dr. Flanum's clinical suspicion of a diagnosis, he does not make diagnoses from them.[77]

At hearing, Baker testified that he is a heavy equipment operator and has worked at the Kuparuk oil field and on the North Slope. He is qualified to operate graders, loaders, "CAT's," all trucks, tankers, and cranes. Baker started work with ASRC in 2008. Baker testified regarding prior injuries, including, a low back injury in 1998, after which he returned to work. He also fell off the flying bridge of a boat. Following this incident, Baker stated it was hard to breathe and he took off work and went to an urgent care facility for treatment. He has also experienced neck pain, which he states was from adjusting his weight on account of low back pain. Specifically, Baker testified he would use his right hand as a support while operating heavy equipment at work. In 2009, Baker hit his head on a control panel at work. He left the North Slope to receive massage therapy. After this incident, his neck was very stiff, but he was approved to return to work.[78]

---

72 Flanum Dep. 22:25–23:13.

73 Flanum Dep. 25:20-21.

74 Flanum Dep. 28:20-21.

75 Flanum Dep. 36:17-20.

76 Flanum Dep. 37:22–38:1.

77 Flanum Dep. 44:12–45:2.

78 Hr'g Tr. 18:16-24, 19:6-8, 19:13-14, 19:24–22:8, 23:21–25:5.

Baker also testified about the May 15, 2011, incident. When the center pin broke, the water wagon dropped in the center and the drive line pulled apart. The hydraulic system broke and drained. The water wagon bounced, hopped and skidded to a stop. His seat in the vehicle only extended about one-half way up his back and the vehicle only had a lap belt. The next day, Baker was stiff and put on light duty. He was then sent off the North Slope, and then to Dr. Kropp for nerve root block injections.[79]

Baker then got a "second opinion" from ANP Erickson, who sent him to Dr. Flanum. When questioned about the June 9, 2011, physical therapy report, which noted him as being 80 percent improved following the injury, Baker explained the goal of his physical therapist was to return him to 80 percent since he did not think Baker could return to 100 percent of his pre-injury status. Baker testified his condition worsened after surgery. He now has constant migraines, sleeping problems, and a "pinch" in his neck. Also, Baker did not think the surgery corrected his problems.[80]

Baker stated ASRC controverted his claim after just six physical therapy sessions following surgery, but he has had no physical therapy since then and has not had any follow-up visits with Dr. Flanum. He described his pain as radiating down his shoulder to "T10-11." Baker has difficulty breathing because, according to him, a bone spur is growing inwards. He experiences numbness in both his hands, which he described as a "pins and needles" sensation. He has migraines two-to-three times per month that last one-to-three days. Baker stated he is sensitive to light and noise and listening to the TV hurts. He has a constant pounding that starts in his neck and the back of his eyes. Baker testified his whole life has changed since the work injury; he cannot play with his grandchildren, fish, or hunt. His goal is to go back to work to support his family like they were used to.[81]

---

79 Hr'g Tr. 27:1–29:24.

80 Hr'g. Tr. 30:25–31:14, 31:22–32:9.

81 Hr'g Tr. 32:10-13, 33:13-20, 34:5–36:7, 36:24–37:3.

On cross-examination, when asked about a physical therapy chart note that stated Baker had a full range of motion, he answered he "never had full range of motion." When asked about Dr. Marble's report, which references "palpation" during the exam, Baker denied Dr. Marble ever touched him.[82]

3. Standard of review.

Only the board has the power to determine the credibility of witnesses; its findings concerning the weight to be accorded witnesses' testimony, including medical testimony and reports, are conclusive.[83] The commission is to uphold the board's findings of fact if they are supported by substantial evidence in light of the whole record. Substantial evidence is such relevant evidence which a reasonable mind might accept as adequate to support a conclusion.[84] The question whether the quantum of evidence is substantial enough to support a conclusion in the contemplation of a reasonable mind is a question of law.[85] We exercise our independent judgment when reviewing questions of law and procedure.[86]

4. Discussion.

a. The commission is bound by the board's credibility and weight findings.

As a preliminary matter, the commission notes that we must defer to the board's credibility and weight findings. AS 23.30.122 states in part: "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." In addition, AS 23.30.128(b) provides in relevant part: "The board's findings regarding

---

82 Hr'g Tr. 48:11-13, 54:22–58:7.

83 *See* AS 23.30.122.

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

85 *See Wasser & Winters Co., Inc. v. Linke*, Alaska Workers' Comp. App. Comm'n Dec. No. 138, 5 (Sept. 7, 2010).

86 *See* AS 23.30.128(b).

the credibility of testimony of a witness before the board are binding on the commission." Given this law, not surprisingly, the Alaska Supreme Court (supreme court) observed:

> The legislative history of this section states that the intent was "to restore to the Board the decision making power granted by the Legislature when it enacted the Alaska Workers' Compensation Act." The "section clarifies and emphasizes the role of the Board in determining the credibility of witnesses and the weight to be accorded medical testimony and reports." The legislature considered rewriting this section in 2005 when it created the Commission but ultimately elected not to do so.[87]

Here, it is the board's weight findings, more so than its credibility findings,[88] which are significant in terms of both the board's and our analyses. The board accorded little weight to ANP Erickson's evidence, in particular his deposition testimony and chart notes, owing primarily to his simplistic opinion regarding causation[89] and his failure to review medical records predating his treatment of Baker.[90] As for Dr. Flanum's evidence, the board assigned less weight to his opinions than those of Drs. Anderson and Marble, for one of the same reasons it accorded ANP Erickson's evidence little weight: Dr. Flanum did not review Baker's complete medical records.[91] We agree with the board that ANP Erickson's and Dr. Flanum's failure to review Baker's medical records is a reasonable basis for assigning less weight to their evidence because such a review would presumably have given them a better perspective in terms of Baker's medical history, their diagnoses, and causation.

---

[87] *Sosa de Rosario v. Chenega Lodging*, 297 P.3d 139, 146 (Alaska 2013)(footnotes omitted).

[88] The board found Baker and his wife credible, for the most part, found Drs. Anderson and Marble credible, and questioned Dr. Flanum's credibility, based on the unsuccessful surgery he performed. *See Baker*, Bd. Dec. No. 14-0005 at 21-23. Perhaps the nexus between the surgery and the finding that Dr. Flanum was not credible was a perception on the board's part that he might tailor his testimony in order to downplay the fact that the surgery was unsuccessful.

[89] ASRC characterized that opinion as follows: "[Baker] was better before the accident and got worse after it." *Baker*, Bd. Dec. No. 14-0005 at 21.

[90] *See Baker*, Bd. Dec. No. 14-0005 at 20.

[91] *See id*. at 21.

On the other hand, the board found the medical opinions of Drs. Anderson and Marble were entitled to more weight. Initially, the board observed: "When the medical record is both examined in detail and viewed in its entirety, a credible and consistent consensus of medical opinion emerges between Drs. Marble and Anderson." The board then addressed Baker's assertion that Dr. Anderson contradicted himself in his report, finding he had not.[92] In particular, Baker argued that the following statement by Dr. Anderson was contradictory: "Based on symptoms, without objective findings of preexisting cervical radiculopathy, there may have been a permanent aggravation of cervical spondylosis related complaints resulting in the need for medical treatment to include the subsequent cervical spine surgery and present disability."[93] Baker's understanding of this statement is that his symptomatology would indicate a permanent aggravation of his cervical spondylosis resulting in his need for medical treatment and disability. However, the board understood Dr. Anderson to be saying that the objective findings contraindicated a finding of permanent aggravation of Baker's cervical spondylosis. This understanding is reinforced by another statement from Dr. Anderson: "Based on objective findings from the cervical x-rays and MRI as well as electrodiagnostic studies, there did not appear to be a permanent change in the preexisting condition. [Baker's cervical condition is b]est considered a temporary aggravation of preexisting cervical spondylosis symptoms."[94] We think the board's understanding of Dr. Anderson's evidence is reasonable and that Baker's understanding of Dr. Anderson's statements is predicated on taking them out of context.

As for Dr. Marble's evidence, the board was more favorably disposed to the opinions he expressed in his later deposition testimony than those in his January 2012 report, concluding that they should be accorded more weight.[95] Specifically, the board noted that Dr. Marble did not have access to Baker's complete medical records for his

---

92 *See Baker*, Bd. Dec. No. 14-0005 at 21-22.

93 Exc. 681.

94 Exc. 681.

95 *See Baker*, Bd. Dec. No. 14-0005 at 22.

report, obtained them prior to his deposition, and maintained his objectivity when evaluating the potential causes of Baker's neck and shoulder complaints.[96] Of special interest to the board was Dr. Marble's identification of pre-injury disc protrusions at C4-5 and C5-6 from the June 8, 2009, lumbar MRI scout films.[97] Those happened to be the same levels of Baker's cervical spine on which Dr. Flanum later performed discectomies and fusions.

The commission finds that the board's credibility and weight findings are well-founded and based on substantial supporting evidence. We cannot disturb them on appeal.

b. There was substantial evidence supporting the board's other factual findings.

"Here, the parties present a classic 'battle of the experts,' making it necessary to choose between competing opinions: ANP Erickson and Dr. Flanum on behalf of [Baker]; and Dr. Marble and Dr. Anderson on behalf of [ASRC]."[98] Elaborating further, the board stated:

> [T]here are two possible causes for [Baker's] disability and need for medical treatment. According to Dr. Flanum, the work injury caused a permanent aggravation to [Baker's] preexisting neural foraminal stenosis. According to Drs. Anderson and Marble, [Baker's] disability and his need for medical treatment are the result of a natural progression of his degenerative cervical spondylosis.[99]

In deciding whether or not the May 15, 2011, work injury was the substantial cause of Baker's need for medical treatment and disability, the board appropriately applied the presumption of compensability analysis. It found that Baker attached the presumption and ASRC rebutted it, findings with which the commission concurs. The

---

96 *See Baker*, Bd. Dec. No. 14-0005 at 22-23.

97 Marble Dep. 50:20–51:1.

98 *Baker*, Bd. Dec. No. 14-0005 at 20.

99 *Id*. at 23.

remaining issue in the presumption analysis is whether Baker proved his claim by a preponderance of the evidence.[100]

The board found the expert medical opinions of Drs. Anderson and Marble to be credible and entitled to more weight, as discussed in the preceding section. Based on the same considerations, the board found that Baker had failed to prove the compensability of his claim by a preponderance of the evidence. The board agreed with ASRC that ANP Erickson's treatment of Baker consisted of "poorly documenting [Baker's] pain complaints and prescribing medication."[101] Moreover, ANP Erickson had not reviewed any of Baker's medical records predating his treatment of him, and the board characterized ANP Erickson's causation explanation, that Baker was worse after the May 15, 2011, work incident, as contrary to law.[102] As for Dr. Flanum's evidence, the board found that he had not reviewed Baker's medical records either, and his practice of taking a patient at his or her word, as he did with Baker, instead of utilizing the patient's voluminous medical records to diagnose and treat the patient, was not reliable.[103]

There was substantial evidence on which the board relied to deny Baker's claim that the May 15, 2011, work injury was the substantial cause of Baker's need for medical treatment and disability. Therefore, Baker failed to prove his claim by a preponderance of the evidence.

---

100 *See Baker*, Bd. Dec. No. 14-0005 at 20.

101 *Id.*

102 *See id*. at 20-21.

103 *See id*. at 21.

5. Conclusion.

The commission AFFIRMS the board's decision. The substantial cause of Baker's neck and shoulder complaints, his need for medical treatment, and his disability, is the natural progression of his degenerative cervical spondylosis, which is not compensable.

Date: *2 October 2014* ALASKA WORKERS' COMPENSATION APPEALS COMMISSION

Signed
James N. Rhodes, Appeals Commissioner

Signed
Philip E. Ulmer, Appeals Commissioner

Signed
Laurence Keyes, Chair

APPEAL PROCEDURES

This is a final decision on the merits of this appeal. The appeals commission affirms the board's decision. The commission's decision becomes effective when distributed (mailed) unless proceedings to reconsider it or to appeal to the Alaska Supreme Court are instituted (started).[104] For the date of distribution, see the box below.

Effective, November 7, 2005, proceedings to appeal this decision must be instituted (started) in the Alaska Supreme Court no later than 30 days after the date this final decision is distributed[105] and be brought by a party-in-interest against all other parties to the proceedings before the commission, as provided by the Alaska Rules of Appellate Procedure. *See* AS 23.30.129(a). The appeals commission is not a party.

---

[104] A party has 30 days after the distribution of a final decision of the commission to file an appeal to the supreme court. If the commission's decision was distributed by mail only to a party, then three days are added to the 30 days, pursuant to Rule of Appellate Procedure 502(c), which states:

> **Additional Time After Service or Distribution by Mail.** Whenever a party has the right or is required to act within a prescribed number of days after the service or distribution of a document, and the document is served or distributed by mail, three calendar days shall be added to the prescribed period. However, no additional time shall be added if a court order specifies a particular calendar date by which an act must occur.

[105] *See id*.

You may wish to consider consulting with legal counsel before filing an appeal. 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

More information is available on the Alaska Court System's website:
http://www.courts.alaska.gov/

RECONSIDERATION

This is a decision issued under AS 23.30.128(e). A party may ask the commission to reconsider this final decision by filing a motion for reconsideration in accordance with 8 AAC 57.230. The motion for reconsideration must be filed with the commission no later than 30 days after the day this decision is distributed to the parties. 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 correction of typographical errors, this is a full and correct copy of Final Decision No. 201, issued in the matter of *Joseph M. Baker vs. ASRC Energy Services, Inc. and Arctic Slope Regional Corporation*, AWCAC Appeal No. 14-003, and distributed by the office of the Alaska Workers' Compensation Appeals Commission in Anchorage, Alaska, on October 2, 2014.

Date: *October 3, 2014*

Signed
K. Morrison, Appeals Commission Clerk