BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS

IN THE MATTER OF:	)	
	)	
M. M.	)	OAH No. 07-0524-PER
	)	Div. R & B No. 2007-023

DECISION

I. Introduction

This is M. M.'s appeal of the Public Employee Retirement System (PERS) administrator's decision to deny his request for occupational disability benefits.[1] Because Mr. M. was vested in the PERS system, the administrator also evaluated Mr. M.'s application to determine whether he was eligible for nonoccupational disability; the administrator concluded he was not.[2] Mr. M. appealed the administrator's decisions.

After several delays caused by the production of over 5,500 pages of additional documentation in the prehearing phase of this matter, a four day hearing took place from September 17 - 20, 2008, with closing arguments held on November 5.[3] The evidentiary record, in addition to the testimony presented at hearing, included the deposition testimony of neurologist John C. Chiu, M.D., psychiatrist Ramzi Nassar, M.D, orthopedic surgeon W. Laurence Wickler, D.O., and Mr. M.[4] It also included over 4,700 pages of medical, employment,

[1] AR at 2. The administrator also had an opportunity to review the additional documents submitted by Mr. M. after the appeal process started. *See fn 5 infra*. His review of the additional documents did not persuade the administrator to change his initial determination.

[2] AR at 3.

[3] *Order Denying In Part Division's Motion For Remand, Dismissal Of Appeal And To Vacate Dates On Calendaring Order And Notice Of Rescheduled Hearing* (March 19, 2008); *Order Denying Division's Second Motion For Remand And Notice Setting New Hearing Date And New Prehearing Deadlines* (April 16, 2008).

[4] SR at 2182- 2206 (Chiu Deposition (June 21, 2007)); SR at 2210 – 2239 (Nassar Deposition (May 30, 2007)); SR at 2240 – 2257 (Wickler Deposition (May 24, 2007)); SR at 2534 – 2591 (Mr. M. Deposition Part 1 (July 26, 2004); SR at 2312 – 2334 (Mr. M. Deposition Part 1 (August 30, 2006)); SR at 2264 – 2287 (Mr. M. Deposition Part 2 April 30, 2007)).

and other records[5] including one accident reconstruction report.[6] Finally, the evidentiary record also included 14 physical evaluations and consultations authored by various medical, osteopathic, and chiropractic professionals;[7] 11 psychological evaluations and consultations authored by various psychiatrics and psychologists;[8] and one functional capacity assessment.[9]

Mr. M. was assisted in this matter by a non-attorney, Barbara. Williams.[10] The division was represented by Assistant Attorney General Joan Wilkerson. Mr. M. testified and presented the testimony of Myron G. Schweigert, D.C., Douglas Savikko, D.O., Jessica Spayd, ANP, and Tim Morgan, business representative Teamsters Local 959. Orthopedic surgeon Ilmar Soot, M.D. and PERS employee Bernadette Blankenship testified for the division.

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[5] AR at 20, 40. The record was submitted in two groups. The first set of documents comprising the agency record consisted of 465 pages and formed the basis of the administrator's initial denial of Mr. M.'s application. The second set of documents group consisting of over 4200 pages was received through the discovery process and provided to the administrator. While the second group may contain some of the documents from the first group, for ease of reference, when referring to a document located in the first group it will be identified by the designation AR and when referring to a document located in the second group it will be identified by the designation SR. There were several reports and other documents entered into the record at hearing by Mr. M. These documents identified as, for example, Mr. M.1. Finally, the division prepared an exhibit book for hearing which contained some documents contained in the record, both AR and SR, and some entered into the record at hearing. The division identified its exhibits by alphabet. Exhibits submitted by the division and not found in either AR or SR documents will be identified as, for example, Div. Ex. A.

[6] SR at 3 – 9 (Hayes and Associates Biomechanical Report for March 24, 2006 WCC (May 9, 2007)).

[7] SR at 4208 – 4231 (Orthopedic Evaluation Ilmar Soot, M.D., July 29, 2008); SR at 350 – 362 (Infectious Disease Evaluation and Interrogatory Responses Phyllis S.B. Ritchie, M.D, Undated (Evaluation related to December 6, 2002 and May 21, 2003 WCCs)); SR at 337 – 350 (Panel Evaluation - Chiropractic Evaluation Richard L. Peterson, D.C., Orthopedic Evaluation John M. Ballard, M.D. (April 20, 2000); SR at 229 – 311 (Orthopedic Evaluation Douglas G. Smith, M.D., November 2, 2000); SR at 272 – 297 (Orthopedic Evaluation John J. Lippon, D.O., June 25, 2001); SR at 233 – 252 (Orthopedic Evaluation James F. Green, M.D., May 21, 2003); SR at 225 – 229 (Infectious Disease Evaluation Dorsett D. Smith, M.D., September 26, 2003); SR at 220 – 223 (Chiropractic Evaluation (Permanent Partial Impairment Rating) David J. Mullholland, D.C. April 6, 2004); SR at 171 – 218 (Orthopedic Evaluation John Ballard, M.D., December 8, 2004.); SR at 153 -169 (Orthopedic Evaluation Alan C. Roth, M.D., March 1, 2005); SR at 128 – 133 (Physiatrist Joella Beard, M.D., August 8, 2006, July 14, 2006, July 11, 2006); SR 11 – 70 (Orthopedic Evaluations, Record Review, Deposition Review by Orthopedic Surgeon Steven J. Schilperoort, M.D., June 25, 2007, March 27, 2007, May 23, 2006); SR at 120 – 127 (Certified DOT Medical Review Officer Leo Morresey, M.D., August 29, 2006).

[8] SR at 4117 – 4125 (Psychiatric Evaluation, Wandal W. Winn, M.D., December 3, 2007); SR at 364 – 366 (Psychological Evaluation Ronald W. Ohlson, Ph.D., Undated (Evaluation Related to May 20, 2002 and May 21, 2003 WCC); SR at 136 – 151 (Psychiatric and Neurologic Evaluation, Record Reviews and Addendums, Ronald G. Early Ph.D., M.D, (March 28, 2005, March 12, 2005, February 15, 2005, January 15, 2005); AR at 76 – 79 (Psychiatric Evaluation Ramzi Nassar, M.D. September 14, 2006); SR at 78 – 118 (Psychiatrist, Eric Goranson, M.D., December 5, 2006); SR at 231 – 232 (Psychiatric Evaluation Addendum Psychiatrist Roy D. Clark, Jr. M.D., October 7, 2003); SR at 233 – 265 (Psychiatric Evaluation Psychiatrist Roy D. Clark, Jr. M.D., September 25, 2003); AR 8 – 12 (Psychiatric Evaluation by Psychiatrist Thomas A. Rodgers, M.D., April 2, 2007); Div. Ex. II (Psychiatric Evaluation by Psychiatrist Thomas A. Rodgers, M.D., September 26, 2008); MM 1 at 7 – 9 (Psychological Evaluation by Clinical Neuropsychologist Richard D. Fuller, Ph.D., June 10, 2008); MM 1 at 1 – 6 (Psychiatric Evaluation by Psychiatrist, William G. Campbell, M.D., August 5, 2008).

[9] SR at 318 – 333 (Jean McCarthy, P.T., October 16, 2000).

[10] 2 AAC 64.160.

Both sides zealously presented their cases. Based on the evidence in the record and the testimony at the hearing, the administrative law judge concludes that Mr. M. did not prove by a preponderance of the evidence that he is eligible for either occupational or nonoccupational disability benefits.

II. Facts

Mr. M. is 53 years old. He was employed by the Municipality of Anchorage (MOA) from 1996 to 2006 as a bus driver. Throughout his employment with the MOA, Mr. M. filed nine reports or workplace injury or illness (ROIs)[11], some of which resulted in the filing of workers' compensation claims (WCCs). The majority of the ROIs complain of neck, shoulder and back pain:[12]

Date of Injury	Causation	Type of Injury Reported
Oct. 16, 1996	MVA[13]	Sprained Neck[14]
Nov. 26, 1999	MVA	Back, Neck, Arms, Face, Leg[15]
Oct. 23, 2000	Repetitive/Over Use of Right Hand	Right Hand and Wrist Pain[16]
March 19, 2002	Washboard Roads	Neck, Back, Loss of Sensation In Hands[17]
May 20, 2002	MVA	Headaches, Arms, Neck, Back[18]
Dec. 6, 2002	Spit Upon by Passenger	Mononucleosis; Ear Infection[19]
May 21, 2003	MVA	Neck, Back, Right Shoulder[20]
March 24, 2006	MVA	Shoulder Strain, Right Arm[21]
April 22, 2006	Assaulted by Passenger with Cane	Face, Neck, Hands, Shoulder[22]

All of Mr. M.'s WCCs' have been disputed by the employer after their doctors concluded Mr. M.'s injuries and complaints attributable to the incident were resolved or not supported by

[11] Report of Occupational Injury or Illness. This is a workers' compensation form which is completed to inform the employer that the employee has suffered an occupational injury or illness.
[12] SR at 2801.
[13] Motor Vehicle Accident (MVA).
[14] Div. Exh. EE.
[15] SR at 2892.
[16] SR at 2805.
[17] Div. Exh. FF.
[18] SR at 2869.
[19] SR at 2853.
[20] Div. Exh GG.
[21] SR at 2821.
[22] SR at 2819.

the objective evidence. At least one, the November 26, 1999, MVA, was resolved through a partial settlement. None of the claims have been to a hearing on the merits before the Alaska Workers' Compensation Board. Mr. M. testified at hearing that he was not claiming all of the incidents in the ROIs were causal factors in his disability. However, they will all be considered for purposes of determining if the cumulative effect resulted in a disability for purposes of PERS.

This case is complex not only in the shear volume of evidence and time period covered, but also in the number of opinions and number of different opinion providers. The bulk of the opinions were requested by the MOA in association with the WCCs and were focused on answering questions unique to workers' compensation proceeding, such as a permanent partial impairment (PPI) rating or date of medical stability or whether the complaints were attributable to a specific injury date. The issues relevant to a PERS disability proceeding, in contrast, are:

1) whether Mr. M. suffers from a mental or physical condition;
2) whether that condition presumably permanently prevents him from performing the duties of a bus driver or other comparable position;
3) whether Mr. M. was terminated from his employment because of the presumably permanent mental or physical condition, and for an occupational disability; and
4) whether a work-related bodily injury sustained or a hazard undergone was the proximate cause of the presumably permanent mental or physical condition.[23]

The WCC opinions were not totally irrelevant but the relevant information had to be gleaned from the hundreds of pages of reports.

Because of the volume of evidence and the length of time over which Mr. M. experienced his complaints, this section will be broken into three parts. The first part is a general overview. The second part is presented chronologically and addresses Mr. M.'s alleged injuries and treatment associated therewith in detail. The third part contains a summary of the reports and evaluations of non-treating professionals.[24]

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[23] For example, several of the opinions address the issue of an appropriate permanent partial impairment (PPI) rating under AS 23.30.190 and/or the date of medical stability as defined at AS 23.30.395(27) which are necessary for determining an employee's workers' compensation benefits. PPI and the date of medical stability are terms of art in workers' compensation and are not relevant to the question of whether a PERS member is eligible for PERS disability benefits.

[24] With the exception of Dr. Gevaert who treated Mr. M. for a short period of time and then subsequently rendered two evaluation reports for the employer. His EME reports are contained in part 2. Conversely, Dr. Beard who saw Mr. M. on referral and did not "treat" Mr. M., her report is included in part 3 because her relationship was similar to that of an expert rendering an evaluation for the employee.

The evaluations and reports of non-treating professionals can be divided into two categories and four classes. The two categories are physical and mental. Within each category there are three classes of evaluations: 1) employer's medical evaluations (EMEs) that were performed at the request of an insurer or the employer, 2) consultants hired by PERS, 3) second independent medical evaluations performed at the request of the workers' compensation board to address disputes between an EME and Mr. M.'s physicians;[25] and 4) evaluations performed at the request of Mr. M. or his attorneys.

A. General Overview

For six of the ten years Mr. M. was employed with the MOA he served on the safety committee. While on the committee he incurred a number of preventable accidents.[26] Nonetheless, until 2005, Mr. M. performance evaluations reflected that he continued to meet his employer's expectations even though he was disciplined for various violations.

In 2005, Mr. M. had three preventable accidents (January 26, 2005, March 10, 2005, and December 3, 2005) which resulted in a suspension.[27] During this time period Mr. M.'s employer received complaints of "Poor customer service is the theme, rudeness, intolerance, lateness and a bad attitude on a daily basis."[28] In 2004 and 2005 he received 23 complaints involving unsafe driving practices, falling asleep at the wheel, poor attitude, and embarrassing and humiliating customers.[29] Mr. M. also received positive comments from passengers, but he was informed that severity of the negative complaints overshadowed any compliments received. This was reflected in his 2005 performance evaluation, when he was evaluated as not meeting the employer's expectations.[30] Despite being counseled, he continued to receive complaints regarding his attitude and customer service until he left the workplace in April 2006.

Mr. M. has had a number of ROIs and WCCs during his tenure with the MOA which are discussed in greater detail in part 2. His last two ROIs involved a May 23, 2006 MVA and an April 22, 2006 assault. Mr. M. did not return to work after the assault. On June 28, 2006 the MOA controverted Mr. M.'s WCCs associated with these incidents based on the opinion of

[25] AS 23.30.095(k); AS 23.30.110(g).
[26] *See e.g.,* SR at 3210 – 3211 (2003 Performance Evaluation); SR at 3505 (December 3, 2001 Accident Report); SR at 3606 (June 19, 2000 Accident Report); SR at 3123 (March 10, 2005 Oral Reprimand); SR 2983 (2005 Performance Evaluation – three preventable accidents); SR at 3284.
[27] SR at 2983 (2005 Performance Evaluation at 1).
[28] SR at 2983 (2005 Performance Evaluation at 1).
[29] SR at 2988.

Orthopedic Surgeon Steven J. Schilperoort, M.D., that there was no reason Mr. M. could not return to work as a bus driver.

On September 11, 2006, in response to an inquiry from a workers' compensation insurer, Dr. Schweigert, Mr. M.'s treating chiropractor, recommended that Mr. M. be medically retired because he was unable to sit for long periods of time due to increasing lumbar and sciatica pain and that Mr. M. could not drive a bus due to shoulder pain and intermittent spasms.[31] Dr. Schweigert considered these restrictions to be permanent and caused by multiple work traumas.[32] Another treating physician Dr. Savikko also provided information to PERS and indicated that surgical intervention was necessary and that Mr. M.'s prognosis was "guarded for [return to work]" because Mr. M. had "too many accumulated traumas."[33] Dr. Savikko believed that Mr. M. could not perform the duties of a bus driver because he could not react to an emergency situation.

Mr. M. was terminated from employment on September 20, 2006, because under the terms of the collective bargaining agreement between the drivers' union and the MOA, if a WCC was controverted the employee was to either return to work or be terminated. Mr. M.'s claim was controverted and his physicians would not release him to return to work; therefore the MOA terminated him. [34]

The memorandum informing Mr. M. of his separation provided in part:

> We received documentation from Dr. Schweigert on 11 September 2006 stating that your restrictions were permanent in nature and you could not return to your duties as a bus driver with the Municipality of Anchorage.
>
> While we had hoped to see you returned to the workplace soon, this just is not in the cards. Since you are unable to return to your job, we must move forward with an administrative separation for medical reasons. The separation will be effective on 20 September 2006.[35]

At the time of his separation, Mr. M. had been preparing his case for disability benefits by gathering supporting information. Mr. M. was contacting his health care providers and asking

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[30] SR at 2983, 2984 (2005 Performance Evaluation – Does Not Meet Expectations).
[31] SR at 451.
[32] SR at 1729 (Written statements contained in a PERS Physician Statement form completed by Dr. Schweigert dated September 25, 2006, corroborate the statements in his September 11 response).
[33] AR at 346. When asked if he expected Mr. M. to improve to the extent that he could work in the future, Dr. Savikko responded "NO – needs surgical repair & post op assessment of function." *Id.*
[34] Testimony of T. M.
[35] AR at 40.

that they complete the PERS physicians' statement or write a letter on his behalf. In his request he asked his treating physicians to emphasize "the fact that the new injuries are in fact a major contributing factor in my inability to perform the basic duties of my job, and that my pain medication is medically necessary for my conditions. My emotional issues PTSD, anxiety disorder and the aggravation from the new injuries will be addressed by Dr. Nassar on 9-14-06."[36]

Mr. M. timely applied for PERS disability benefits, identifying as the nature of his disability "neck, back, shoulders, headaches, PTSD, chronic pain, chronic depression, anxiety" as the result of "multiple traumas." He indicated that his disability was due to a work related injury.[37] The administrator denied the claim because Mr. M. had not proven to the administrator's satisfaction that he was, at the time of separation, presumably permanently disabled as defined by PERS.

Presently, Mr. M. is unemployed and is receiving disability payments from an insurance policy unrelated to PERS.[38] Mr. M. testified that he finds it difficult to perform the daily tasks of living. He does not know from one day to the next how he will be feeling. He once enjoyed hunting, fishing and traveling in his recreational vehicle, activities he no longer pursues. He has made ends meet by taking money from his retirement accounts. He testified that he can not afford the treatments that would help him get better and return him to work.

B. Mr. M.'s Injuries and Medical Treatment

Mr. M. had a history of work injuries and back pain before he started to work for the MOA. The first record of a work-related injury occurred in April 1990.[39] As with the majority of his MOA work-related accidents, this injury was the result of a work-related MVA. Mr. M. complained that he injured his neck, back and shoulder. He was diagnosed with a sprained cervical spine and commenced treatment with a physician identified only as Dr. Christensen. Then, for reasons not reflected in the record, on June 15, 1990, Mr. M. ceased treating with Dr. Christensen and commenced treatment with George B. vWichman, M.D.

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[36] AR at 22-23 (The letter is undated. However the reference to Dr. Nassar indicates that the appointment had yet to occur. Therefore, it is reasonable to conclude that the letter was written before September 14, 2006.
[37] AR at 22, 23. While this letter is undated it is reasonable to conclude that it was written before September 14, 2006 from the indication that the September 14, 2006 meeting with Psychiatrist Ramzi Nassar, M.D., had yet to take place.
[38] SR at 1823; Testimony of Mr. M.
[39] SR at 2906.

When first seen by Dr. vWichman, Mr. M. reported that he was "still having a great deal of pain in the lumbar area and feels that he still cannot work since lifting brings the pain on."[40] Three weeks later, Mr. M. indicated that he was doing better in his neck, but still had problems with his low back and that tension or overworking would bring about muscle spasms. These complaints were noted to be subjective.[41] Over a year later Mr. M. still had not completely recovered and Dr. vWichman wrote "I cannot tell him how long this discomfort would continue and whether he will have permanent after effects of his injury."[42]

The next work-related injury occurred in May 1992 when Mr. M. dropped an item the size of a microwave, injuring his right foot.[43]

This was followed by a non-work related back injury attributed to gardening activities. Mr. M. went to the emergency room on May 9, 1996, complaining of "pain in his back mostly in the medial scapular region…full range of motion of the shoulder."[44]

Mr. M.'s first ROI at the MOA occurred on October 19, 1996, when another driver backed into the front of his bus.[45] Mr. M. was treated at the emergency room where he presented complaining of neck pain.[46] The examination revealed a slightly tender neck. An x-ray of his cervical spine was negative.[47] Mr. M. was prescribed Anexsia, a narcotic, which would impair his job performance. He remained off work until October 30, 1996.[48]

On September 25, 1997, Mr. M. again went to the emergency room for another non-work-related injury. This time he incurred a lumbosacral strain after attempting to lift the front end of a 20 foot boat.[49] When he sought treatment for this injury, Mr. M. informed his physician, Edward Voke, M.D., that he had had previous back problems. An x-ray of his lumbar spine taken at this time was negative.[50] He was prescribed Torodol, Flexeril, Anexsia and

[40] SR at 1663.
[41] SR at 1664.
[42] SR at 1657.
[43] SR at 1694, 2902.
[44] SR at 1651.
[45] SR at 3885, 3894 – 3897.
[46] SR at 1649.
[47] SR at 1648.
[48] SR at 3897.
[49] SR at 1645, 1646.
[50] SR at 1647.

Advil.[51] Dr. Voke noted that the Anexsia would impair his job performance and Mr. M. was taken off of work until October 11, 1997.[52]

From October 22 through December 21, 1998 Mr. M. treated with Kremer Chiropractic.[53] His neck had been bothering him for two years and his shoulder for four or five months. Chart notes from this period reveal that Mr. M. suffered from fatigue and headaches and was taking sleeping pills (Excedrin PM) twice a week. He complained of sensation of pins and needles, a stiff neck and left shoulder pain and the only time he was pain free was upon awakening in the morning. He reported that driving aggravated his symptoms.

On November 26, 1999, Mr. M. was involved in a work-related MVA. He was driving a bus when a vehicle ran a red light and turned left directly in front of him. He was wearing a waist belt and was thrown forward and to the right. Mr. M. maintained control of the bus by holding on to the steering wheel. The driver of the vehicle was seriously injured and remained in the hospital for a period of time. Mr. M. testified that when he exited the bus to check on the driver he found an empty baby seat in the car and thought he had killed a baby.[54]

Mr. M. was treated at the emergency room. His past medical history was significant for a "history of back problems."[55] An MRI of the cervical spine showed a very "minimal extrusion of disk material centrally at C6-7…."[56] He was diagnosed with neck and upper back strain, prescribed muscle relaxants and pain medication, and directed to follow-up with his treating physician.

At the time of the accident Mr. M. was married to a military spouse and had military health privileges. He was seen by a military provider upon his release. He divorced soon afterward; when his divorce became final the first part of December, Mr. M. returned to Dr. Voke's office and was seen by his associate, Cindy Lee, D.O. He treated with Dr. Lee from December 2, 1999 through February 10, 2000.[57] He ceased treating with her when she supported his return to work in a light duty capacity.

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[51] SR at 1443.
[52] SR at 3822, 3824.
[53] SR at 1555 – 1558.
[54] Notably, most of the explanations of this incident contained in providers and consultant's chart notes contain a description of the accident exclude any mention of the other driver being seriously injured or Mr. M. thinking he had killed a baby. It is unknown if they did not think this was information that should be recorded or whether Mr. M. did not inform them of this aspect of the MVA.
[55] SR at 1641.
[56] SR at 1639.
[57] SR at 1437 – 1448.

Dr. Lee's chart notes reveal Mr. M.'s military providers had prescribed Percocet, Flexeril, Soma, Robaxin, and Naprosyn. He presented to Dr. Lee complaining of diffuse low back pain and occasional pain in the buttocks. He described most of his symptoms as persistent spasming that moved through out his entire spine "not really localizing. The worst pain in the back seems to be under the left shoulder blade."[58] Mr. M. denied pain down the leg, numbness in his hands or loss of strength.[59] Dr. Lee's examination contradicted some of Mr. M.'s complaints. She noted a full range of motion at the shoulders and wrists.

Dr. Lee's examination did revealed restricted left side bending and right rotation, a limited range of motion of the cervical spine with tenderness of the left paracervical muscles and left occiput.[60] Dr. Lee found multiple tender points of the thoracic spine as well as tenderness of the paravertebral musculature. Reflexes were equal. Other than showing a straightening of the normal cervical curve, X-rays were unremarkable revealing normal minor degenerative changes in the cervical, thoracic, and lumbar spine.[61]

Dr. Lee diagnosed acute lumbosacral back pain with muscle spasms secondary to MVA and cervicothoracic strain, whiplash type injury, with muscle spasm and exacerbated cervical arthritis, without any evidence of neurological deficit.[62] She prescribed physical therapy as well as Naprosyn and Klonopin. Percocet was recommended only if symptoms got worse. At the time of his first visit, based upon his presentation and history presented, it was believed he would be able to return to work without restrictions in four to six weeks.[63]

By December 16, 1999, Mr. M. was feeling better and Dr. Lee found improved movement and range of motion in his lumbar spine even though Mr. M. still complained of muscle spasms in his back, occasional pain in his left arm, as well as twitching muscles in his left cheek and eye.[64] Dr. Lee ordered an MRI.

When next seen, Mr. M. reported fewer headaches but he was "still having some rather bothersome symptoms into the left arm" and that "simple activities at home cause him quite a bit of discomfort and without the medications he feels completely disabled. He has no idea how he

[58] SR at 1443.
[59] SR at 1443.
[60] Occiput is the back part of the skull. Taber's Cyclopedic Medical Dictionary, 17th ed. at 1344.
[61] SR at 1444.
[62] SR at 1445.
[63] SR at 1447.
[64] SR at 1441.

could possibly work as a bus driver for the People Mover."[65] The MRI revealed a very small central protrusion of disc material, C6-7. The remainder of the cervical disk levels were normal and Dr. Lee did not think the left arm symptoms were related to the protrusion of disc material.[66]

Because Mr. M. was not progressing as anticipated and expected from his objective presentation, Dr. Lee referred Mr. M. to physiatrist M. Gevaert, M.D., for electromyographic (EMG) testing, which revealed normal responses throughout the spine (cervical thoracic and lumbar) with the exception of positive findings at the left C6 distribution.[67]

Mr. M. was last seen by Dr. Lee on February 10, 2000. He claimed little improvement complaining that he was "sore and stiff all the time and the cervical traction worsens his symptoms."[68] He continued to have pain into the left shoulder but not his left arm. Dr. Lee observed that Mr. M. was not acutely uncomfortable and that he suffered from subjective stiffness and discomfort in the cervical and left shoulder. She believed he could return to work in a light duty capacity in a few weeks. Mr. M. ceased treating with Dr. Lee and began treating with Dr. Gevaert on February 21, 2000.

By this time Mr. M. had been off work for more than three months and continued to report exacerbated symptoms including increased low back pain with radicular symptoms. Mr. M. attributed the increase in pain to riding an exercise bike for 15 minutes. An EMG of the lower extremity was normal and did not corroborate Mr. M.'s complaints.

Mr. M. was adamant that he could not return to driving a bus or sit or stand for more than four hours at a time. Dr. Gevaert disagreed and felt that, given Mr. M.'s "negative objective neurologic examination and the negative electrodiagnostic study," Mr. M. should try to return to work in a sedentary capacity not to exceed four hours a day for the first week increasing to 8 hours the following week.[69] Dr. Gevaert did not recommend bus driving and indicated that Mr. M. should be allowed frequent change of position and should not stand or sit for more than 30 minutes at a time. As with Dr. Lee, Mr. M. disagreed, became frustrated with Dr. Gevaert, and requested a referral to Samuel Schurig, D.O.

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[65] SR at 1439.
[66] AR at 407; SR at 1439 ("Normal MRI in regards to the likelihood that his left arm symptoms are from the protrusion of the disc at C6-7. He is not a surgical candidate at present").
[67] SR at 1380.
[68] SR at 1437.
[69] SR at 1375.

Dr. Schurig agreed with Mr. M. that he could not return to work and Mr. M. continued to treat with him until October 24, 2002, when Dr. Schurig's license was suspended.

While treating with Dr. Schurig, Mr. M. would see Chiropractor Myron Schweigert when Dr. Schurig was unavailable.[70] Dr. Schweigert was in the same building as Dr. Schurig.

Dr. Schweigert's chart notes reflect that Mr. M. complained of constant pain, specifically: left lower cervical pain radiating down to his fingers creating occasional numbness and tingling, left upper thoracic rib pain, left shoulder pain and decreased range of motion, lower back pain, left sacroiliac pain and radicular left leg sciatica. Mr. M. also experienced a left facial twitch that he reported would increase with stress and first appeared after the November 1999 MVA. Mr. M. told Dr. Schweigert that he had an EMG and was told that he had left arm damage.[71]

Dr. Schweigert ordered a radiology consultation of the spine which revealed a mild degenerative change at L2 and indicia of a muscle spasm associated with the cervical spine area but was otherwise unremarkable.[72] After treating with Dr. Schweigert almost daily for a week, on March 9, 2000, Mr. M. reported an exacerbation of his left lower extremity pain, lower dorsal pain, headache and left facial tingling after playing with his dog.[73] Mr. M. had not yet returned to work.

From March 9, 2000 to July 25, 2001, there are no chart notes in the record for treatment with Dr. Schweigert. There are extensive indiscernible hand written chart notes and three typed letters regarding Mr. M.'s treatment from Dr. Schurig during this same time frame.[74]

In a letter dated May 16, 2000, Dr. Schurig explained that he authorized Mr. M. to remain off work for an undetermined period of time because of physical restrictions and the prescribed "Percocet and Klonopin which precluded working."[75] He also ordered a lumbar MRI which revealed "mild degenerative disc disease L4-5, with small radial tear in the annulus but without evidence of disc herniation."[76] Dr. Schurig characterized the aggravation experienced by Mr. M. from riding the bicycle in physical therapy as being "so painful he could not walk for three days

[70] Testimony of Schweigert; Testimony of Mr. M.
[71] SR at 735.
[72] SR at 732.
[73] SR 731, 733.
[74] SR at 1188 – 1191 (May 16, 2000 Schurig Letter); SR at 1169 – 1170 (June 14, 2000 Schurig Letter); SR at 1067 – 1069 (September 11, 2001 Schurig Letter).
[75] SR at 1189; SR at 283.
[76] SR at 1638.

afterward."[77] On May 11, 2000, Anexsia was prescribed to replace the Percocet and it was anticipated that Mr. M. could return to work on May 22, 2000 without restrictions because he should have transitioned to non-opiate pain medication.[78] Dr. Schurig diagnosed Mr. M. with

> cervical, thoracic and lumbosacral strain with persistent rib pain and the left mid scapular area due to serratus posterior-inferior muscles sprain and tears at their rib attachments. He also has occipital nerve related headache problems especially on the left along with the myofasciitis of the cervical, thoracic and lumbosacral strain from the sprain injury. In the low back he has one degenerative disc, which represents a radial tear. He has a minimal bulging disc at C6-7.[79]

Mr. M. was not considered a surgical candidate and conservative treatment would be continued. Dr. Schurig anticipated that if Mr. M. continued to do his exercises and did not injure himself there would be continued improvement.[80]

By May 30, 2000, Dr. Schurig restricted Mr. M. to working 4 hours per day and indicated that Mr. M. was taking Percocet at night and it would not impact his ability to drive a bus during the day. By June 14, 2000, Mr. M. had returned to work. Dr. Schurig reported that Mr. M. had pain in his left shoulder and could not elevate his arm. There was "a lot of crunching with movement in his shoulder."[81] Mr. M. continued to experience low back pain and reported that driving the bus aggravated the pain in his neck and back. On June 19, 2000, Mr. M. was involved in a preventable accident at work when he turned too tightly and struck a fire hydrant.[82] At the end of July, Mr. M. was released to work 5 hours a day, increasing to 6 in August.

On January 17, 2001, Dr. Gevaert performed a permanent partial impairment (PPI) rating at the request of the MOA.[83] At the time of this evaluation Mr. M. had returned to work and was driving a bus for 6 hours a day. Mr. M. continued to experience pain in the upper cervical region into the suboccipital area. His pain ranged between a two and four on a scale of one to ten and was always present. "It is worse with lifting, bending, and driving a bus. At present he cannot

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[77] SR at 1188.
[78] SR at 1190; SR at 3635.
[79] SR at 1190.
[80] SR at 1191.
[81] SR at 1169.
[82] SR at 3627, 3628.
[83] PPI is a workers' compensation tool. AS 23.30.190. It is not premised on the concept of a medical impairment as such, but rather, the loss of earning capacity related to that impairment. *Vetter v. Alaska Workers' Comp. Bd.*, 524 P.2d 264 (Alaska 1974).

drive the bus over 6 hours a day."[84] Dr. Gevaert stated his impression was neck and radicular pain in the left C8 distribution, mild spinal stenosis at C5-6 level and EMG showing mild subacute C6 radiculopathy, chronic persistent low back pain, and radicular symptoms not verifiable by EMG.[85] He further opined that Mr. M. would "soon have the physical capacity to return to a regular work schedule of 8 hours a day or 40 hours a week."[86]

In May 2001, Mr. M. was released to work full time provided he worked a rural route, drove a smaller bus, and there was no forced overtime.

Dr. Schurig's final typed assessment of Mr. M. was dated September 11, 2001 and reported no appreciable change in Mr. M.'s condition. Dr. Schurig did opine that he anticipated Mr. M.'s condition would continue to worsen and that in five to ten years Mr. M. would require surgical intervention to resolve his spinal and left shoulder complaints.[87]

On September 18, 2001, Dr. Gevaert performed a follow-up examination for the MOA.[88] Current medications were Percocet and Klonopin at night, Ultram, Zanaflex, Elavil, and Prozac. Dr. Gevaert believed that the medications were "reasonable and necessary for now. Management of chronic pain is always a challenge… [Mr. M.'s] symptoms appear to have stabilized and it is not certain whether one can further wean him from pain medications."[89] When asked if he would recommend a different treatment for Mr. M., Dr. Gevaert responded that Mr. M. appeared despondent and possibly depressed. He noted that Mr. M. was more functional since he started taking Prozac and recommended a psychological evaluation to "assess his present level of depression. [Mr. M.] still maintains a relatively isolated social life, has gained weight since his last visit, although his sleep pattern has improved."[90] Dr. Gevaert advised against chronic use of chiropractic treatments as part of a pain management program. He also noted that Mr. M.'s symptoms had stabilized and expected that Mr. M.'s condition would improve with time.

The next two ROI's filed by Mr. M. were associated with the nature of driving a bus and not associated with a specific event or accident. On October 23, 2000, Mr. M. filed an ROI alleging that he had an overuse injury of his right hand due to the pain he was experiencing on

[84] SR at 1365.
[85] *Id.*
[86] SR at 1367.
[87] SR at 1069.
[88] SR at 1360 – 1363.
[89] SR at 1363.

his left side.[91] He first noted symptoms on or about October 9, 2000. He was taken off work for two days.

On March 19, 2002, Mr. M. filed a report of injury alleging aggravation of pre-existing conditions. He wrote "[w]ashboard roads made old injuries worse and the bump at 4th and Boniface outbound finished me off. Back, neck, both hands numb left knee [indiscernible] up."[92] Mr. M. received several days of workers' compensation benefits associated with this claim.[93]

On February 25, 2002, Dr. Schweigert ordered x-rays which revealed no degenerative changes or other abnormality although there was some evidence of muscle spasm.[94]

On May 20, 2002, Mr. M. was involved in his third work-related MVA. A woman ran a stop sign and hit the side of the bus. She drove away and returned. When she returned, Mr. M. exited the bus and testified that he was standing about 5 -10 feet in front of the car "to keep her from leaving" when it started to come right at him, he put his arms out to brace himself, and the car ran into him. Mr. M. described that the car hit his knees and he was splayed on the hood when it stopped. He recalled hitting his elbow on the hood of the car.[95] This incident resulted in Mr. M. experiencing low back, neck, and right shoulder pain.

Imaging studies of the lumbar and cervical spine were ordered. The lumbar films showed minimal degenerative change at L1-2 with sclerosis at L2 and minimal spurring.[96] The cervical spine was normal.[97] He was diagnosed with strain to neck, back, and shoulders with possible hypertension.[98]

Mr. M. treated with Dr. Schweigert for this work-related accident. After three days of continuous treatment, Dr. Schweigert noted significant improvement. However, considering Mr. M.'s history of "numerous musculoskeletal aches and pains, as well as all the different kinds of medication he is on, [Dr. Schweigert] expect[ed] this patient to respond slower than the average due to pre-existing musculoskeletal symptoms."[99] By May 28, 2002, Mr. M. had returned to

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[90] *Id.*
[91] SR at 3589; Testimony of Mr. M.
[92] SR at 3477.
[93] SR at 2870.
[94] SR at 705.
[95] SR at 1632.
[96] SR at 1635, 1637.
[97] SR at 1636, 1634.
[98] AR at 167.
[99] SR at 702.

work with a restriction that overtime should only be imposed as tolerated.[100] Mr. M. reported no exacerbation of symptoms and there was improvement in his subjective complaints.

Mr. M. continued to miss a few days of work here and there. These absences were attributed to the May 2002 MVA, for which he was paid workers' compensation.[101] Two of the absences, August 29 and 30, 2002, were before his scheduled vacation (September 1 through 6) and were part of the oral counseling discussed above.[102]

During this same time period Mr. M. became concerned by little bumps he saw on the back of his throat and tongue. Dr. Schurig referred Mr. M. to Bret Rosane, M.D., who described Mr. M. as "pleasant and somewhat worried."[103] Dr. Rosane assured Mr. M. that the bumps were not cancer but the normal result of a recent viral infection.

Around this same time period Dr. Schweigert became concerned that Mr. M. may be suffering from rheumatoid arthritis, and ordered a blood test which was negative.[104]

In mid-June 2002, Mr. M. commenced treatment with ANP Jessica Spayd at Eagle River Pain and Wellness for pain management on referral from Dr. Schurig.[105] Mr. M. described his pain as constant and that the intensity of the pain varied with his activities increasing as the day progressed. When asked about the efficacy of Percocet and Prozac on reducing his pain, Mr. M. indicated that they help "a little".[106] Mr. M. reported that the only non pharmaceutical treatment that provided him with pain relief were nerve blocks and cortisone injections. Insomnia was a problem and he required Klonopin to sleep. When asked what pain treatment he desired and what medications he wanted to continue to take, Mr. M. identified only one, Percocet, and noted that he was not interested in any non-drug treatments. ANP Spayd prescribed Percocet in addition to several other medications. She believed that if Mr. M. took the Percocet at night, it would not affect his ability to drive a bus.[107]

On June 14, 2002, Mr. M. complained that after a long day at work he was experiencing "very acute pain" focused on the right cervical and upper occipital region as well as left sided

[100] SR at 694.
[101] SR at 2855; SR at 2867.
[102] SR at 3263, SR at 2855.
[103] SR at 1495.
[104] SR at 695.
[105] SR at 989 to 999 (Eagle River Pain and Wellness Center (ERPWC) Intake Forms and Intractable Pain Program Admission Forms); SR at 991.
[106] SR at 995.
[107] *See e.g.*, SR at 988; Spayd Testimony.

radiating triceps pain, low back and posterior pain.[108] Four days later Mr. M. reported to Dr. Schweigert that he was experiencing "'just awful' pain" even though he had started a pain management protocol.[109] On June 20, 2002, Dr. Schweigert ordered x-rays of the lumbothoracic view which were unremarkable and revealed "no acute and/or bony pathology".[110]

Throughout July 2002, Mr. M. received cortisone injections from Dr. Schurig.[111] The cortisone injections reduced his cervical pain to "moderate".[112] By August 6, 2002, Mr. M. was reporting improvement in his low back and legs although he still experienced moderate headaches, cervical and upper thoracic pain.[113]

Mr. M. continued to work with the understanding that he not be forced into overtime. Mr. M. reported improvement in his low back and a worsening in his cervical spine for which he continued to receive cortisone injections. After the injections, Mr. M. reported that "he felt immensely improved…with increasing cervical ranges in motion with decreasing cervical pain."[114]

In October 2002, Mr. M.'s prescribed medications included Bextra, Percocet, Zanaflex, Klonopin, Ambien, Atenolo, Prozac, Lipitor, and aspirin.[115] Mr. M. was leaving for a trip in early November. Just prior to his vacation, on October 28, 2002, Mr. M. reported an "acute exacerbation of chronic lower back pain with bilateral leg numbness which radiates through the buttocks to the knees" brought about by the general activities of daily living.[116] Dr. Schweigert ordered a series of MRIs that were compared to earlier studies. The cervical MRI was compared to a December 1999 MRI and there was no change. The thoracic MRI was normal. The lumbar MRI showed improvement. It was compared to a March 2000 study. A radial tear previously seen at L4-L5 was no longer visible and there was degenerative lumbar disc disease without evidence of neural impingement.

Even though the MRIs showed improvement or no change in Mr. M.'s condition, by November 20, 2002, Mr. M. complained that his pain had worsened to the point that he could no

[108] SR at 692.
[109] SR at 691.
[110] SR at 690; SR at 1563.
[111] SR at 688.
[112] SR at 687.
[113] SR at 685.
[114] SR at 676; SR at 674.
[115] SR at 669.
[116] SR at 668.

longer work and he remained off work until December 2, 2002, when he returned full-time with no forced overtime. Upon returning to work, Mr. M. continued to improve, reporting an increase in his left arm range of motion and decreased pain.

On December 6, 2002, Mr. M. was driving a passenger bus when he encountered two unruly and combative young men.[117] Mr. M. asked them to leave the bus. One of them spat directly into his face.[118] In spite of this incident, Mr. M. ended the year feeling "quite a bit better than he has in the last several months."[119]

In mid-January Mr. M. reported a new complaint, for the first time that he was now experiencing increasing "right lower back pain with radicular right leg pain."[120]

At the end of January, Mr. M. drove almost 500 miles round trip to Homer and back, which he found "quite comforting…."[121] Before leaving for Homer, in addition to his constant headache, cervical and left arm pain, Mr. M. reported "experiencing generalized, annoying left sacroiliac and lower back pain, as well as he has some mild left leg sciatica at present."[122] When he returned his pain had improved. It was "mild, in his left buttocks and lower back, but there is no radicular left leg sciatica present."[123]

Sometime in January or February 2003, Mr. M. began to develop symptoms of right upper quadrant discomfort, fatigue, and scratchy throat. In March 2003, Mr. M.'s treating physician ordered a blood test and informed Mr. M. that he had infectious mononucleosis.[124] Mr. M. was also informed that he had an enlarged liver.[125] Both conditions he and Dr. Savikko attributed to being spat upon.[126] Mr. M. filed a ROI in March 2003 for the spitting incident.

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[117] SR at 3369.
[118] *Id.*
[119] SR at 646 (Schweigert December 30, 2002 Chart Note); *See* SR at 649 (Schweigert December 19, 2002 Chart Note); SR at 653, 652 (Schweigert December 11, 13, and 17, 2002 Chart Notes).
[120] SR at 641 (Schweigert January 16, 2003 Chart Note).
[121] SR at 638 (Schweigert January 27, 2003 Chart Note).
[122] SR at 640.
[123] SR at 638. Mr. M. also complained of mild upper thoracic pain and cervical stiffness and a constant headache.
[124] Testimony of Mr. M.
[125] Testimony of Mr. M.; SR at 1613.
[126] Testimony of Mr. M.; SR at 1274 – 1275 (December 29, 2003 Savikko Letter) (After being spat upon, "[w]ithin four weeks he had an external otitis media that turned out to be caused by penicillin resistant staphylococcus organism and symptoms of immune system suppression that turned out to be infectious mononucleosis. A viral infection transmitted only through the saliva of infected individuals …on a more likely than not medical probability, the salivary attack….")

In March 2003, Dr. Schweigert referred Mr. M. to Susan Anderson, M.D. for pain control.[127] He was seen on March 17, 2003. Chart notes reveal Mr. M. reported that he had been prescribed Prozac and had a history of depressed mood. He also reported that his pain interfered with his daily activities "most of the time and interferes with his sleep every night."[128] Mr. M. did not provide Dr. Anderson with the November 1, 2002 MRI's that showed improvement in his lumbar spine and stabilization in his cervical spine. Rather, he provided the March 2000 MRI that showed the small radial tear and the December 1999 cervical MRI that showed a disc protrusion at C6-7. Dr. Anderson diagnosed L5 discogenic pain with left L4 radicular pain and C6-7 discogenic pain with left C7 radiculopathy per EMG.[129]

As part of his evaluation with Dr. Anderson, Mr. M. was screened by psychologist Robert Trombly, Ph.D.[130] Contrary to what Mr. M. reported to Dr. Anderson, he denied chronic pain and functional limitations when meeting with Dr. Trombly.[131] The treatment plan involved an epidural steroid injection and further evaluation by Advanced Pain Therapeutics of Alaska. The record does not reveal whether Mr. M. complied with this treatment plan.

Two days later he was seen by Dr. Schweigert. Mr. M.'s primary complaint was left upper thoracic rib pain, generalized cervical pain, decreasing left ranges of motion, left leg sciatica, severe headaches, and constant ongoing lower back pain "which decreases by walking, although to sit for any period of time increases his pain, which unfortunately, his job as a bus driver aggravates."[132] Dr. Schweigert would not release Mr. M. to work.

Because Mr. M. needed medications which Dr. Schweigert could not prescribe, he referred Mr. M. to Dr. Savikko.[133] Dr. Savikko provided "numerous injections of Cortisone" which was reported to reduce Mr. M.'s pain.[134] By the end of April, Mr. M. was feeling "quite good." Dr. Schweigert noted a 50 percent improvement of the left cervical rotation and Mr. M. reported that his "left upper thoracic rib pain is approximately 50% improved at present in the

[127] SR at 1486. Dr. Anderson is a Diplomat American Board of Anesthesiologists, Diplomat Subspecialty Pain Medicine, Diplomat American Board of Pain Medicine, and Fellow of the Interventional Pain Practice. SR at 1486, 1490.
[128] SR at 1488.
[129] The chart note does not mention an EMG study. SR at 1489 - 1450. It is unknown if Dr. Anderson relied upon Mr. M.'s self reporting of Dr. Gevaert's 2000 EMG study or if there was a more recent study provided.
[130] SR at 1487.
[131] *Id.*
[132] SR at 635.
[133] Testimony of Schweigert; Testimony of Savikko, Testimony of Mr. M.
[134] SR at 630.

cervical pain, as well as upper cervical headaches are, at present, about 80% improved. His lower back pain is 80% improved, as is his left leg sciatica."[135]

In early May 2003, Mr. M. returned to Homer for vacation, where he injured his back when he leaned over to pick something up. Mr. M. related that his lower back collapsed and he fell to the ground. Even though Mr. M. reported increased low back pain and sciatica, his cervical ranges of motion were almost normal.[136]

On May 21, 2003, Mr. M. was involved in his fourth work-related MVA.[137] He was driving a relief vehicle when another driver failed to yield and ran into his car. Mr. M. was treated at the emergency room and released. He was assessed with an exacerbation of a prior neck injury.[138] On the report of injury Mr. M. indicated that he had hurt his neck, back, and low back.[139] He also reported numbness to his face, left leg and arm.[140] X-rays of Mr. M.'s lumbar and cervical spine were taken and were unremarkable.[141] ANP Spayd's chart notes reflect that after this MVA, Mr. M. was concerned but doing well. He did not exhibit a painful demeanor and his reported pain level was the same as a month prior, level 4. Regardless, she increased his Percocet prescription to four per day "due to increase in acute pain."[142] Mr. M. remained off work receiving workers' compensation benefits until August 4, 2003.[143]

Mr. M.'s pain and range of motion would improve with adjustments, injections medications and rest; it would worsen with work or sudden movements.[144] ANP Spayd's diagnosis of Mr. M. changed from month to month. One month it would provide a diagnosis of myofascial pain syndrome, the next it would be replaced with a diagnosis of depression, and the following month, the depression would be replaced with insomnia.

After a while, ANP Spayd began to express concerns regarding Mr. M.'s use of Klonopin and its effect on restorative sleep. Mr. M. insisted that ANP Spayd continue to prescribe Klonopin because he believed it was the only medication that would help him sleep. He threatened that if she did not continue to prescribe Klonopin he would have another provider,

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[135] *Id.*
[136] SR at 628.
[137] SR at 3326.
[138] SR at 1614.
[139] SR at 3326.
[140] SR at 3326.
[141] SR at 1608, 1610.
[142] SR at 943 ("Average pain is 4/10 with medications."); *Cf:* SR at 947 ("Average pain is 4/10 with medications.").
[143] SR at 3305 – 3325; SR 2822.
[144] *See* SR at 976; SR at 980; SR at 982 (indicating worst pain at a level 3); SR at 986 (worst pain at a level 4).

PA-C Jan Oxford, write the prescription for him. Mr. M. prevailed and ANP Spayd continued to prescribe Klonopin.

In September 2003, ANP Spayd was unavailable and Mr. M. was seen by Roy Herold, M.D., who works with ANP Spayd. Upon examination Dr. Herold noted that because of Mr. M.'s pre-existing chronic pain and problems it would be hard to isolate the problems, if any, attributable to the May 2003 MVA from Mr. M.'s pre-existing condition. Dr. Herold advised Mr. M. to decrease his use of Klonopin because it was not indicated as a sleep aid and it was not recommended for chronic use for sleep and pain. Dr. Herold noted that Mr. M. was "not receptive to this idea."[145] Nor was he receptive to a prescription of generic opiates.

Dr. Herold explained that the pain clinic had a policy of prescribing generic opiates to reduce the risk of diversion, which Mr. M. resisted. Dr. Herold wrote in Mr. M.'s chart that Mr. M. "has a strong personality, and has been pressuring Jessica related to some of these issues."[146] Dr. Herold refilled Mr. M.'s prescriptions, noting on the Klonopin that it was not recommended for chronic use for sleep, and taper-down was advised.[147]

Dr. Herold saw Mr. M. on his next visit.[148] He noted that Mr. M. was reporting he had not done well since the last visit and was exhibiting a mildly painful demeanor. Dr. Herold modified Mr. M.'s prescriptions noting that he has had "multiple conversations about chronic [use of Klonopin] and all [Mr. M.] does is argue and make threats. He has had the same conversations with other providers. Today I am enforcing what I say, and prescribing less Klonopin. I offered to replace it and he refused."[149]

The following month, Mr. M. was seen by ANP Spayd. She noted that Dr. Savikko was writing all prescriptions except Percocet. Contrary to Dr. Herold's position, ANP Spayd approved brand name prescription for Percocet, justifying the departure from generic due to nausea and vomiting (although neither symptom had been reported in chart notes).

Mr. M. continued to complain to Dr. Savikko about recurrent ear and sinus symptoms and chronic fatigue. On April 5, 2004, on referral from Dr. Savikko, Mr. M. was evaluated by Paul Steer, M.D.[150] Dr. Steer:

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[145] SR at 929.
[146] SR at 929.
[147] SR at 930.
[148] SR at 924, 925.
[149] SR at 925.
[150] SR at 1548 – 1549.

> explained 4 consecutive times to him the fact that I thought it is purely speculative whether the event where he describes somebody as spitting in his face had anything to do with this or not, but my personal opinion was that it did not. The second thing I explained to him on 3 straight occasions, back to back to back, was that there is no evidence for recent mononucleosis and, in fact, the 2 sets of EB virus antibody panels done in May of 2003 and then again last month, support a diagnosis of mononucleosis some time in the distant past, likely years ago.
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> The above comments did not satisfy him, however, since, I think, he is determined to put together his recurrent ear and nose and sinus symptoms with his chronic fatigue and the episode where somebody spit in his face and the mononucleosis, all of which I think are unrelated.[151]

In December 2004, Mr. M. reported a 25 percent reduction in pain, that his neck pain was under control and that he has cut back on his medication usage.[152]

In April 2005, Dr. Savikko referred Mr. M. to Sylvia Condy, Ph.D to be evaluated for possible PTSD.[153] Dr. Savikko testified that he believed Mr. M. suffered from PTSD, not because of any specialized training but based upon his experience with other patients. Dr. Condy treated Mr. M. from April 26, 2005 through June 10, 2005.[154] Her notes reflect that Mr. M. believed that the MOA was trying to get rid of him but that the union would stand behind him. He described his November 1999 accident as causing the driver of the other vehicle to be in a coma and that he thought he had killed her baby. He described the May 20, 2002, accident as the driver running over him. Her chart notes mention Mr. M. complained of flashbacks, dreams, and sweats.

Mr. M. continued to see ANP Spayd throughout 2005.[155] Her chart note from October 27, 2005, reflects that Mr. M. had not been working since April 8, 2005, due to excessive drowsiness, pain being the predominant focus his life, and depression[156] However, under the review of symptoms section ANP Spayd does not indicate Mr. M. is positive for depression or anxiety.[157] When Mr. M. arrived for his scheduled December 8, 2005 appointment, he was

[151] SR at 1548.
[152] SR at 893.
[153] SR at 1236.
[154] SR at 1475 – 1483.
[155] SR at 902.
[156] SR at 900 – 901
[157] *Id.*

informed that Dr. Herold was filling in for ANP Spayd. Mr. M. refused to be seen by Dr. Herold and rescheduled his appointment to a time when he could be seen by ANP Spayd.[158]

On March 23, 2006, the day before his next work-related MVA, Mr. M. was complaining of constant pain in the cervical spine that was shooting in nature and radiating bilaterally to his arms. The pain was identified as an average of 3/10 with medication and limited Mr. M.'s activities of daily living.

On March 24, 2006, Mr. M. was involved in his fifth work-related MVA. He was driving a relief vehicle and was stopped. When he looked in his rear view mirror he could see that the vehicle behind him, although it was attempting to, would not be able to stop in time and would rear end him. He stiffened his arms as he readied for impact.[159] Mr. M. was taken to the emergency room. He complained of injury to his shoulder and right arm with shooting pains down into the right hand.[160] A lumbar x-ray was taken and compared with one from May 21, 2003. There was a slight increase in the mild degenerative disc disease at L1-2 and L2-3.[161] The cervical spine was normal.

Mr. M. believes this incident is the cause of his need for right shoulder surgery.[162] The employer doubted the validity of an injury arising from this incident because there was "zero damage to either vehicle. Contact only rubbed off a little dust."[163]

Mr. M. was seen by Dr. Schweigert on March 28, 2006, and as reported in the chart note of that date, when Mr. M. saw the accident about to happen in his rear view mirror, he started to tense up and feels he jammed his right shoulder and injured his spine. [164] Mr. M.'s subjective complaints were identified as being focused on right sided upper extremity and cervical pain, a headache, upper and midthoracic muscle pain, and generalized lower back pain. The diagnosis was thoracic, cervical and lumbar segmental dysfunction, as well as shoulder sprain/strain, and headache. The prognosis was fair and Mr. M. was to take off work until April 10, 2006. Under "prior diagnosis" Dr. Schweigert identified chronic pain syndrome, PTSD, and chronic

[158] SR at 897.
[159] Testimony of Mr. M.
[160] SR at 1592.
[161] SR at 1586.
[162] Testimony of Mr. M.
[163] SR at 2934.
[164] SR at 614 – 616.

depression.[165] After several visits to Dr. Schweigert there was improvement in Mr. M.'s right shoulder range of motion and a decrease in pain.[166]

A March 30, 2006, MRI of the right shoulder without contrast ordered by Dr. Schweigert showed changes consistent with tendonosis but without a definite rotator cuff tear. No labral tear or subluxation of the long head of the biceps tendon was identified. Mild to moderate degenerative changes were noted, but no impingement was identified.[167]

Regardless of the improvement noted by Dr. Schweigert, Mr. M. was referred to orthopedic surgeon W. Laurence Wickler, M.D. for evaluation of his shoulder complaints. [168] He saw Dr. Wickler on April 18, 2006. Dr. Wickler recommended an arthroscopic evaluation of the shoulder because he felt Mr. M. had a possible SLAP[169] lesion in the right shoulder as well as rotator cuff tendonitis.[170]

On April 22, 2006, Mr. M. was assaulted by a passenger on the bus with a cane.[171] He was taken to the emergency room and treated for multiple contusions or abrasions as well as acute exacerbation of chronic neck and back pain. Mr. M. did not return to work after this incident.

As a result of the assault, Dr. Schweigert ordered an MRI of the right shoulder and x-rays of the cervical, thoracic, and lumbar spine. The right shoulder x-ray revealed no abnormalities and the MRI showed "changes consistent with tendnosis, but without a definite rotator cuff tear currently."[172]

By April 26, 2006, Mr. M. was starting to feel improved with decreasing headache intensity and frequency as well as an improvement in his cervical spine although he still complained of moderate to severe left low back and hip pain and right shoulder pain.[173] In May, Mr. M. reported that his spinal adjustments were providing some relief but that his medication was barely working. [174]

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[165] SR at 616.
[166] SR at 590; SR at 609.
[167] AR at 341.
[168] AR at 324.
[169] Superior Labrum from Anterior to Posterior (SLAP).
[170] SR at 1409.
[171] AR at 421 – 426.
[172] SR at 1468.
[173] SR at 576.
[174] *See, e.g.,* SR at 551, 550.

A May 2, 2006 MRI of the cervical spine revealed a C7-T1 left paracentral disc/osteophyte protrusion coupled with hypertropic change causing mild to moderate left foraminal narrowing. Mild foraminal narrowing was also noted at C4-C5, C5-C6, and C6-C7. The lumbar MRI revealed an L4-L5 moderate post weight-bearing neuroforaminal narrowing secondary to disc protrusion and hypertrophic change as well as a small annular tear.[175] At L3-L4 there was a 3.5 right paracentral post-weight-bearing disc protrusion as well as hypertrophic change in the ligamentum flavum with no significant neuroforaminal or canal stenosis.[176] A May 10, 2006 MRI of the right shoulder showed no change from the March 2006 MRI.[177]

Mr. M. flew to Minneapolis with his girlfriend for her daughter's graduation in mid-May 2006. The day before he left for this ten-day vacation, Mr. M. was seen by Dr. Schweigert.[178] Dr. Schweigert did not note any progress in Mr. M.'s condition. As part of the treatment plan, Mr. M. was to be reevaluated when he returned from vacation and Dr. Schweigert filled out a dismissal slip to take Mr. M. "off work indefinitely."[179] Mr. M. testified that he was only able to travel after getting several injections to help him handle the prolonged sitting and that his activities were restricted.

As planned, upon his return to Alaska, Mr. M. was seen by Dr. Schweigert and reported that while he still experienced bilateral shoulder joint pain, left upper cervical pain and a left upper cervical headache, his bilateral wrist pain was 80% improved and mid thoracic pain was 50% improved. He reported no improvement in his low back and left side lower extremity pain.[180] Mr. M. was not released to work and continued to treat with Dr. Schweigert.

Dr. Schweigert believes that the March 24, 2006 MVA "is the substantial factor for current medical care. [He also feels that it] is a substantial factor in Mr. M.'s inability to work since the date of injury."[181] Dr. Schweigert did not find the lack of evidence of impact compelling because one of the most severe cervical injury cases he had taken care of in his 28 years of practice involved a 42 year old male who injured his spine in a whiplash injury while

[175] SR at 1462 – 1463.
[176] SR at 567; 1462 – 1463.
[177] SR at 1457.
[178] SR at 540-541.
[179] SR at 541.
[180] SR at 535.
[181] SR at 547. This document is signed by Dr. Schweigert and apparently contains his answers to questions from an unidentified source. There are two facsimile stamps at the top: one providing a date of May 10, 2006 and the other May 11, 2006.

riding a roller coaster at the state fair. Dr. Schweigert analogizes the roller coaster injury to Mr. M.'s March 24, 2006 MVA because the roller coaster suffered no damage nor did Mr. M.'s car. He does not believe you can say someone incurred minimal physical bodily injury because there was minimal damage to the car.

On June 12, 2006, Dr. Schweigert referred Mr. M. to John Chiu, M.D., for a surgical consult. The referral letter omitted any reference to suffering from chronic pain or depression.[182]

On June 21, 2006, Dr. Schweigert referred Mr. M. to Physiatrist Joella Beard.[183] Her report is discussed in part 3 *infra.* Again, there was no mention of any suspected psychological involvement.

Mr. M. first met with psychiatrist Ramzi Nassar on September 14, 2006 for 45 minutes.[184] The only other record of Dr. Nassar having met with Mr. M. is October 2, 2006. Dr. Nassar was deposed in connection with Mr. M.'s April 22, 2006 WCC on May 30, 2007. The only records reviewed by Dr. Nassar prior to his deposition were those provided by Mr. M. and had to do with orthopedic conditions. Dr. Nassar's impression that Mr. M. suffered from PTSD was based solely on Mr. M.'s self reporting. No testing was conducted.

Dr. Nassar's report did not mention a prior history of mood problems, prior psychiatric diagnoses, treatment, or having seen any psychiatrist or psychologist. It was Dr. Nassar's understanding that the symptoms described by Mr. M. - decreased mood, night sweats, nightmares, difficulty concentrating, poor sleep, and intrusive memories - only came about after the April 2006 assault and it was on this basis that Dr. Nassar diagnosed Mr. M. as suffering from PTSD. Dr. Nassar explained that PTSD is based on a person's subjective experience of intense fear or helplessness so it makes no difference if a person fights back; it is their subjective impression that counts. It was only after Mr. M. presented Dr. Nassar with a disability form that Dr. Nassar became aware of Mr. M.'s WCC. Dr. Nassar would not sign the form and informed Mr. M. that the goal of treatment was to return him to work if he was physically able to do so.

At his deposition, Dr. Nassar was informed of Mr. M.'s prior history and the letter written by Mr. M. informing his providers that Dr. Nassar would be supporting his psychological claim of disability. Dr. Nassar began to really "wonder whether [Mr. M.'s] statement in the

[182] SR at 538, 539.
[183] SR at 481, 482.
[184] AR at 368- 371; SR at 2210 – 2239 (Nassar Deposition).

beginning" were actually pretty accurate."[185] He was also provided with Dr. Ohlson's report and Dr. Condy's notes.

Based on this more complete history, it was Dr. Nassar's opinion that Mr. M. suffered from PTSD prior to his April 2006 assault and that the April assault was "significant" in his present mental state. Dr. Nassar explained that he had observed what he believed to be an authentic hyper arousal by Mr. M. Had the information provided to Dr. Nassar at his deposition been available at the time of his initial evaluation, he would not have changed his treatment plan or diagnosis. Treatment for PTSD treats both depression and anxiety, so even if Mr. M. did not suffer from PTSD, Dr. Nassar explained that the treatment would be the same. Dr. Nassar concluded that his observations of Mr. M. and Mr. M.'s response to pharmacological treatment were consistent with the diagnosis and treatment of PTSD. Finally, Dr. Nassar did not believe Mr. M. was capable or returning to driving a bus at this time.

On September 21, 2006, ANP Spayd wrote that she was in agreement with "Dr. Savikko and Dr. Nassar's evaluation of [Mr. M. and that she believed he was] unable to perform his job duties due to injuries received on the job."[186] ANP Spayd did not indicate whether she actually reviewed Dr. Nassar's report, nor did she identify what statements of Dr. Savikko's she was referring to. In a progress note of that same day, she wrote that Mr. M. had not been diagnosed with any specific disc problems at that time and that he was going to see a neurosurgeon and that Mr. M. had been told by Dr. Wickler that he needed surgery for the right shoulder and that he would not be able to return to work until he received shoulder surgery.[187] Mr. M. continued to be seen by ANP Spayd monthly.

In the fall of 2006, Mr. M. went hunting. He drove his motor home to Lake Louise where he was able to take two caribou. Mr. M. recruited the help of a friend and two boys he found playing in the area to transport the caribou back to his motor home. Mr. M. testified that he could drive his motor home because the seat and wheel configuration were different from that found on a public transit bus.

On December 11, 2006, Mr. M. underwent a repair of a SLAP lesion and anterior impingement of the right shoulder.[188] Dr. Wickler reported that he was happy with Mr. M.'s

[185] SR at 2217.
[186] SR at 854 (Spayd September 21, 2006 To Whom It May Concern Letter).
[187] SR At 850 - 852.
[188] AR at 354 – 363.

post-surgery progress.[189] On January 12, 2007 Dr. Wickler wrote that Mr. M.'s rear end accident is consistent with creating a SLAP lesion.[190] After his shoulder surgery Mr. M. continued to be in significant pain, noting it was an average of 4/10 with medication.[191] By March 12, 2007, Mr. M. reported that his right shoulder pain had not improved and that the lumbar pain was a constant aching pain that radiated bilaterally to his legs.[192]

On May 24, 2007, Dr. Wickler was deposed in association with Mr. M.'s WCC. Dr. Wickler is a board-certified orthopedic surgeon. He explained that a SLAP lesion occurs when there is a separation of the labrum from the long head of the biceps tendon. Dr. Wickler identified several mechanisms of this type of injury: the natural degenerative process, a "knock off" injury, a "pull off injury", or a rapid contraction of the muscle creating significant force.

A SLAP lesion occurs via a "knockoff" injury where the ball part of the shoulder is driven parallel to the articular surface and literally knocks off the labrum such as falling on an outstretched arm. For a SLAP lesion to occur from a "pull off," a sudden biceps muscle contraction occurs with such force that it literally pulls the cartilage lip off of the bone attachment. An example is when a person is falling down and grabs something to arrest the fall and the arm gets hung up behind them.

During his deposition when asked for literature to support the idea that a rapid muscle contraction could create sufficient force to cause a SLAP lesion, Dr. Wickler responded that his statement was based on his experience. He further explained that there could have been preexisiting degenerative changes or the start of a SLAP lesion from an earlier injury masked by his pain medication and the May 2006 MVA simply completed the process. Dr. Wickler did not find the amount of impact compelling; rather it was the muscle contraction that was the causal factor.

Dr. Wickler was aware of Dr. Beard's report recommending against surgery. Dr. Wickler disregarded her opinion based on his examination of Mr. M. His initial diagnosis of SLAP lesion was confirmed during the surgery.

[189] AR at 95, 96.
[190] AR at 94.
[191] SR at 831.
[192] SR at 823.

Dr. Wickler supported the need for surgery in part because Mr. M. had the "tell tale clunk." Post surgery the clunk remained. Dr. Wickler believed that Mr. M. could return to work after an appropriate post surgery recovery period.

On December 18, 2007, Mr. M. underwent a provocative lumbar discogram L1, L2, L4 and L5 and micro decompressive lumbar disectomy of L1, L4 and L5 under magnification. The postoperative diagnosis was multilevel degenerative herniated lumbar disc with lumbar radiculopathy.[193] On December 20, 2007, Mr. M. under went a cervical discogram C4 and C6 and microdecompresive cervical disectomy of C6-7 under magnification. The postoperative diagnosis was herniated cervical disc with cervical radiculopathy.[194] Dr. Chiu opined that "there is no question [Mr. M.] suffered spinal injuries …as a result of the accidents while working as a city bus driver …the procedures of provocative discogram and microdecompressive cervical and lumbar discectomy are indicated for the relief of his herniated spinal disc symptoms."[195] However, he still complains of lumbar and cervical pain and has not returned to employment in any capacity.

C. Evaluations

1. Physical Evaluations

(a) Employer's Medical Evaluations

(i) RICHARD L. PETERSON, D.C., CHIROPRACTOR AND JOHN M. BALLARD, M.D., ORTHOPEDIC SURGERY (DOE APRIL 20, 2000)[196]

Drs. Peterson and Ballard did not examine Mr. M. They based their conclusions on the records provided by the MOA. It was their opinion, based on the lack of supporting information that Mr. M. could return to his position as a bus driver. "His file does not identify any clear neurological lesion. His reflexes have been reported to be intact and there is no muscular atrophy. He has had sufficient time and therapy, in our opinion for what would be expected as a soft tissue injury. He has no strong objective evidence, particularly in regard to his low back that would keep him from doing a sitting occupation."[197]

They also noted that Mr. M.'s condition appeared to have worsened since he began treating with Dr. Schweigert. Mr. M. was showing a significant decrease in range of motion and

[193] SR at 1420 – 1423.
[194] SR at 1412 – 1415.
[195] SR at 1430 – 1431.
[196] SR at 335 – 350 (including addendums dated June 17, 2000 and July 29, 2000).

reporting pain to many more provocative tests than were previously documented. They also felt that Mr. M.'s doctor shopping to look for a physician who would agree with him indicated that Munchausen's disease[198] could be present. Finally they believed that the lack of objective findings indicated that the continued use of Percocet was unnecessary.

(ii) JOHN J. LIPPON, D.O., ORTHOPEDIC SURGEON (DOE JUNE 25, 2001)[199]

Dr. Lippon's evaluation consisted of an interview with Mr. M., a physical examination and a records review. Dr. Lippon concluded that Mr. M. incurred a temporary aggravation of pre-existing degenerative changes to the cervical, thoracic, and lumbar spine as a result of the November 26, 1999 MVA. The objective testing performed by Dr. Lippon did not support Mr. M.'s complaints of pain and tingling in his left upper and lower extremities. Specifically, the EMG testing conducted by Dr. Gevaert revealed mild C6 involvement but the specific complaints registered by Mr. M. would be associated with C8-T1 involvement. Also, there was no evidence of muscle weakness or atrophy. Dr. Lippon opined that there was no evidence of a permanent aggravation of Mr. M.'s pre-existing underlying degenerative changes and that his ongoing complaints were consistent with his prior complaints and degenerative changes.

(iii) JAMES F. GREEN, M.D., ORTHOPEDIC SURGERY (DOE SEPTEMBER 25, 2003) [200]

Dr. Green's evaluation of Mr. M. was completed without the benefit of emergency room records associated with the May 21, 2003 incident. At the time of evaluation, Mr. M. had returned to work on a full time basis. Throughout his examination Dr. Green observed that Mr. M.'s neurological responses were consistently inconsistent. Based on his observations, Dr. Green believed that Mr. M. was self-limiting his examination with exaggerated reports of pain.

Dr. Green believed Mr. M.'s treatment received to date from providers served to reinforce Mr. M.'s somatic focus thereby prolonging his complaints. He recommended self-directed exercises for flexibility, strengthening, and progressing weight loss would likely be the most beneficial treatment for Mr. M.

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[197] SR at 349.
[198] Munchausen Syndrome is a type of malingering or factitious disorder in which the patient practices deception in order to feign illness. Taber's Cyclopedic Medical Dictionary 17th Ed. at 1249.
[199] SR at 272 – 297. Dr. Lippon's report appears to have been prepared in association with a civil law suit. It is unknown for whom the report was prepared.

Based on his evaluation, Dr. Green opined that Mr. M. has a history of axial strain attributed to the May 21, 2003 MVA that more likely than not this temporarily aggravated Mr. M.'s subjective pre-existing chronic myofascial pain syndrome. Dr. Green could not find objective residuals of the reported MVAs nor could he identify a physical condition that would account for the ongoing symptoms as described by Mr. M. and that Mr. M.'s complaints should have resolved within 6 weeks. Dr. Green concluded that Mr. M. suffered from a pre-existing chronic myofascial pain syndrome that is a learned and patterned behavioral response and not the residual of a physical injury. He also cautioned that Mr. M. should terminate his narcotic use.

(iv) JOHN BALLARD, M.D., ORTHOPEDIC SURGEON (DOE DECEMBER 8, 2004)[201]

Dr. Ballard's evaluation consisted and an interview with Mr. M., a physical examination and a records review. The focus of Dr. Ballard's evaluation was the May 2002 MVA and its role in Mr. M.'s complaints, although he did include the November 1999 and May 2003 accidents as part of his evaluation. Dr. Ballard opined that Mr. M. sustained a temporary aggravation of pre-existing conditions with the May 2002 MVA and that the May 2003 MVA may have contributed tot Mr. M.'s chronic pain picture.

He compared MRI's of the cervical and lumbar spine after the May 2002 accident with those taken before the accident and observed that "there was no objective worsening of his pre-existing conditions, simply, I believe, a temporary exacerbation."[202] Dr. Ballard also believed that any injury sustained in May 2002 was resolved and that the 1999 MVA was, from a subjective point of view, a substantial factor in his multitude of subjective complaints which are not substantiated by the objective findings.

Dr. Ballard observed that at the time of the evaluation Mr. M. had more symptoms "than he has ever had … [Mr. M.] seems to have increasing subjective symptoms of pain, which are not supported by objective findings."[203] It was Dr. Ballard's conclusion that predating the accident of May 2002, Mr. M. was noted to have chronic pain involving his neck, shoulder, left arm, lower back and left leg. He felt that the May 2002 MVA did not cause any new injuries

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[200] SR 233-265 (The evaluation was conducted as part of a "panel" evaluation. The other evaluator was psychiatrist Roy D. Clark, Jr. Dr. Clark's evaluation is discussed below).
[201] SR 171-218. This evaluation was prepared in association with a civil suit associated with the May 20, 2002 incident. The evaluation does not specify if it was prepared for the plaintiff or defense.
[202] SR at 215.
[203] SR at 217.

"but did cause a temporary exacerbation of his chronic pain picture for a six to eight week period."[204]

(v) DAVID J. MULHOLLAND, CHIROPRACTOR, IMPAIRMENT RATING (DOE APRIL 6, 2004)[205]

Dr. Mullholland's evaluation consisted of an interview with Mr. M., a physical examination and a records review. Dr. Mulholland characterized this as "one of the most difficult impairment ratings I have been involved with in some time. Early on in the evaluation of this case it became clear to me that there would be no way to accurately diagnose and assess for impairment the changes that occurred to [Mr. M.'s] cervical and lumbar spine due to the second and third injuries, as no comparative diagnostics were performed to my knowledge. Therefore, since I cannot rate what I do not know, I elected to assess for impairment those things are clearly involved with this last accident."[206] He assigned an 8% whole person rating assigning 4% to the right shoulder and 4% attributable to emotional or behavioral disorders.

(vi) DORSETT. D. SMITH, M.D., OCCUPATIONAL PULMONARY DISEASE (DOE SEPTEMBER 26, 2003)[207]

Dr. Smith rendered his report in association with the December 6, 2002 spitting incident. His evaluation consisted of an interview with Mr. M., a physical examination and a records review. During his evaluation, Dr. Smith noted that Mr. M. appeared to be combative and wondered if he had an anger management problem. Dr. Smith characterized Mr. M.'s history as "a very odd story" and that there "is no evidence that [Mr. M.] was infected with any diseases or that this exposure was the cause of the patient's subsequent complaints."[208]

(vii) HAYES AND ASSOCIATES INJURY BIOMECHANICS REPORT MAY 9, 2007[209]

Hayes and Associates provided a biomechanics report for the March 24, 2006 MVA. The collision resulted in a fore-aft movement which resulted in distributed loading across Mr. M.'s entire back region, which in turn resulted in minimal shoulder loading and eliminated the possibility of relative displacement of his shoulder.

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[204] SR at 219.
[205] SR 220-223. The report does not reveal if the evaluation was conducted at the request of the Board, the employer, or Mr. M.
[206] SR at 223.
[207] SR at 225-229.
[208] SR at 228, 229

The report explained that acute impingement injury can occur if there is a violent force, with respect to the shoulder, such as a fall onto an outstretched arm. According to the reconstruction, the March 24, 2006 MVA did not result in the required upward component and therefore there was no mechanism to produce the alleged shoulder injury. It was characterized as "an extremely benign event with little or no potential for lasting injury…."[210] The report concluded "to a reasonable degree of engineering and biomechanical certainty, that the collision of March 24, 2006, was not a substantial cause of Mr. M.'s alleged shoulder, cervical, thoracic or lumbar injuries."[211]

(viii) STEPHEN J. SCHILPEROORT, M.D., ORTHOPEDIC SURGEON (DOE MAY 23, 2006, AND ADDENDUMS DATED MARCH 7, 2007, AND JUNE 25, 2007)[212]

According to his *curriculum vitae*, Dr. Schilperoort was Board certified by the American Board of Independent Medical Examiners and the American Academy of Orthopedic Surgery. He was an orthopedic surgeon at Kaiser Permanente from 1979 – 1997. In 1997 he became an independent medical consultant specializing in orthopedic surgery. On May 10, 2004, Dr. Schilperoort voluntarily limited his practice to the performance of medical evaluations due to personal health matters. At the time of hearing, Dr. Schilperoort was deceased.

His evaluation consisted of an interview with Mr. M., a physical evaluation and extensive record review, including Dr. Wickler's deposition. The evaluation was conducted in association with the March 24, 2006 MVA and the April 22, 2006 assault WCCs. Dr. Schilperoort believed Mr. M. suffers from a behavioral chronic pain syndrome that had become a learned and patterned behavioral response, not the residual of physical injury.[213]

Dr. Schilperoort acknowledged that pain is generally regarded as having both physical and psychological components as reflected by Mr. M.'s medical records.[214] Consistent with this view, Dr. Schilperoort noted that Mr. M. would report considerable pain and discomfort while impairments on physical examination where basically subjective in nature or subjectively influenced (e.g. palpable tenderness). He noted the absence of disuse muscle atrophy in the right upper extremity. Following this line of thinking, he opined that the SLAP lesion surgery was not

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[209] SR at 3-9.
[210] SR at 8.
[211] SR at 9.
[212] SR at 46 – 70; AR at 200 – 223.
[213] SR at 64.

supported by physical findings, namely that there were only subjective complaints of shoulder pain. The right upper arm was 2.0 cm larger than the left. While the discrepancy could be the result of subcutaneous edema following the December 11, 2006 surgical intervention by Dr. Wickler, it was not noted to be edema. Dr. Schilperoort found this remarkable because despite Mr. M.'s statements of substantial levels of pain and serious amounts of disuse, there was no muscle atrophy verifiable. He concluded therefore, that the amount of residual and persistent pain is not reflected in daily activity use.

Regarding the April 22, 2006 assault, Dr. Schilperoort did not dispute that Mr. M. was injured, but opined that any injury was temporary and is now resolved. Therefore, Mr. M.'s statements of enhanced pain involving the cervical, thoracic, and lumbar spine areas were most likely a case of symptomatic aggravation of Mr. M. chronic pain syndrome.

Based on his examination and review of the records provided, Dr. Schilperoort did not believe that the March 24, 2006 MVA was a causal or contributing factor in Mr. M.'s subsequent surgery by Dr. Wickler. He also believed that Mr. M. could return to work if he were to cease the narcotic medication.

(ix) LEO MORRESEY M.D., CERTIFIED DOT MEDICAL REVIEW OFFICER (DOE AUGUST 9, 2006)[215]

Dr. Morresey based his evaluation on the medical records provided by the MOA. Dr. Morresey agreed with Dr. Schilperoort's conclusion that the medication Mr. M. takes makes him unable to safely drive a bus and that taking Percocet at night would not alleviate any safety concerns. When asked what condition should be placed on Mr. M.'s return to work, should he return to work, Dr. Morresey opined "no chronic daily narcotics nor benzodiazepines, and no unmanaged pain condition capable of causing impairment distraction to the driver such that the public is at any significant increase in risk of accident or injury."[216]

(b) PERS Consultant Employer's Medical Evaluations

(i) WILLIAM COLE, M.D., CONSULTING PHYSICIAN PERS (DOE JANUARY 23, 2007)[217]

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[214] SR at 52.
[215] AR at 110; SR at 120 – 126.
[216] AR at 114.
[217] AR at 16 – 18.

Dr. Cole's evaluation was limited to a record review. He felt he could not render an opinion because Mr. M. was still recovering from his shoulder surgery and "not in a stable state."[218]

(ii) KIM C. SMITH, M.D., CONSULTING PHYSICIAN PERS (DOE JUNE 26, 2007)[219]

Dr. Smith's evaluation was limited to a record review. He reviewed the records of Drs. Savikko, Schweigert, Wickler, and Nassar. Dr. Smith recommended against awarding disability benefits to Mr. M. because:

> In summary, we have a patient who is claiming disability because of his shoulder and for psychiatric reasons. The psychiatric issue has been denied in a previous review. We have no proof from the patient's surgeon that he is disabled by the shoulder, which was operated on in 2006. We do know that he can't drive a bus because of all the pain medication that he takes, but two independent medical evaluators say that he should not be taking this medication to begin with. Therefore, he would not be disabled if he was not taking the medicine. Therefore, if he stops taking the medicine, he can work.
>
> I would therefore recommend not granting this patient disability.[220]

(iii) ILMAR SOOT, M.D., ORTHOPEDIC SURGEON (DOE JULY 24, 2007)[221]

Dr. Soot is board-certified in orthopedic surgery and has an active practice seeing patients.[222] Dr. Soot's evaluation consisted of a record review, interview and a physical examination. He testified consistent with the conclusions contained in his evaluation:

> Of the seven incidents reported by Mr. M. from November 1999, March 2002, May 2002, December 2002, May 2003, March 2006, and April 2006, there is not one of these incidents, nor is there a consequence of the total accumulation of the incidents that would, on a more probable than not, basis explain the symptomatic difficulties and course that he has had.
>
> The findings on previously evaluations are consistently inconsistent. There is not an explainable event from the magnitude of these events to account for his symptoms.
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> * * *

[218] AR at 18.
[219] AR at 6.
[220] *Id.*
[221] SR at 4208 – 4231.
[222] Div. Exh. CC; Soot Testimony.

> Mr. M.'s symptoms to a major degree are of a functional etiology that are not anatomically explainable and his subsequent need for treatment follows that etiology. There is not a predictable orthopedic treatment modality that will help him symptomatically, and certainly this has been bourne *[sic]* out by all of the multiple attempts including the last three major operations that have resulted in no functional benefit to him.
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> * * *
>
> Mr. M. has significant symptomatic subjective limitations. These are not accounted for by the objective findings that are present.
>
> * * *
>
> Mr. M. has some age-appropriate degenerative changes that are occurring in his cervical spine and lumbar spine. These, however, on a predictable correlation basis to age-related limitations, would not account for the magnitude of symptomatic difficulty that [Mr. M.] is experiencing. [223]

Dr. Soot would not comment on the appropriateness of the various antidepressants, anti-anxiety, or sleep inducing medications. He did opine that there were no pre-existing medical conditions that on an objective basis could be identified as contributing to Mr. M.'s conditions and limitations. As to Mr. M.'s separation from work on the basis of his functional limitations, Dr. Soot opined:

> There is no measurement of permanent physical disability that accounts for that separation. This is on a functional basis and related to pain behavior difficulty that is not objectively measurable.
>
> * * *
>
> There is no orthopedically measurable limitation to Mr. M. returning to work in a more modified capacity but, again, to a significant degree, his disability is on a functional basis with nonanatomic explanations for his pain behavior and limitations in work activity.

(c) Second Independent Medical Evaluations

(i) DOUGLAS G. SMITH, ORTHOPEDIC SURGEON (DOE OCTOBER 11, 2000)[224]

Dr. Smith's evaluation consisted of a record review, interview and examination. Dr. Smith provided a probable diagnosis of chronic neck pain from C6-7 disc protrusion, left arm pain from left C6 radiculopathy, and chronic low back pain attributable to lumbar degenerative disc disease. He opined that Mr. M.'s complaints of left leg pain were not supported by the

[223] SR at 4222 – 4223.

electrodiagnostic studies performed on February 21, 2000, and he noted a probable element of psychological involvement with chronic pain syndrome based on the October 16, 2000 "conditionally valid" key functional assessment.[225] Dr. Smith believed that based on his evaluation, Mr. M.'s diagnosis "are probably related in one way or another to the motor vehicle collision of 11/26/99."

(ii) JEAN MCCARTHY, P.T., ASSESSMENT SPECIALIST (DOE OCTOBER 16, 2000)[226]

Ms. McCarthy performed a functional capacity assessment on Mr. M. associated with his November 29, 1999 WCC. The assessment revealed that Mr. M. was providing a submaximal effort which rendered a conditionally valid result. Regardless, it was believed that even though Mr. M. can do more than indicted in his assessment, it was unlikely that he could lift the 50 pounds as identified in the job description for bus driver.

(iii) ALAN C. ROTH, M.D., PHYSICAL MEDICINE AND REHABILITATION (DOE FEBRUARY 4, 2005)[227]

Dr. Roth's evaluation was conducted in connection with the incidents of December 6, 2002 and May 21, 2003 and consisted of an extensive record review, interview and an examination. Dr. Roth is a member of the American Board of Physical Medicine and Rehabilition as well as the American Board of Electrodiagnostic Medicine.

At the time of the SIME, Mr. M. was driving a smaller bus on a remote rural route with fewer passengers than he had been at the time of the incidents. Dr. Roth noted that Mr. M. "has a feeling that his low back cracks and has slight discomfort to both shoulders which he attributes to his May 2002 injury."[228] He also noted that Mr. M. did not believe that he had any "permanent new increase in his discomfort as a result of the May 2003 injury."[229]

Dr. Roth's physical examination revealed some limitation on range of motion of the cervical and lumbar spine with bilateral paraspinal tenderness. No thoracic tenderness was noted. Sensory testing throughout the upper and lower extremities was normal.

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[224] SR at 229 – 316.
[225] SR at 304.
[226] SR at 319 – 333.
[227] SR at 153 – 169.
[228] SR at 154.
[229] *Id.*

Dr. Roth opined that Mr. M. suffered from significant depression and he has likely developed a chronic pain condition. He based his chronic pain diagnosis on the fact that Mr. M. has had ongoing pain since 1999 and his need for constant treatment and chronic prescribed narcotic usage. Dr. Roth further opined that the November 26, 1999 MVA "certainly exacerbated a pre-existing neck and back condition on a permanent basis. Thus, it was a substantial factor in causing his present current condition."[230] Dr. Roth believed that the May 20, 2002 and May 21, 2003 injuries caused Mr. M. to sustain a transient increase in his neck and back discomfort with the eventual resolution back to his pre-existing state prior to either of those incidents. Dr. Roth could not find any objective evidence that Mr. M. developed any of his present complaints as a result of cumulative trauma that occurred as a bus driver.

As a result of his evaluation, Dr. Roth rendered a probable diagnosis of depression, chronic ear infection, cocaine use resulting in perforation of nasal septum (based on records review), chronic neck and low back pain, borderline cervical radiculopothy post 1999 injury, mild degenerative cervical and lumbosacral disc degeneration without herniation or significant stenosis, and probable mild shoulder degenerative joint disease. He felt the May 2002 and May 2003 injuries were temporary flare-ups that should have resolved after a short course (up to two months) of either chiropractic care or physical therapy.

Finally, Dr. Roth wrote "it is my opinion that there is no new additional impairment over and above the agreement reached after his 1999 injury. In other words, all of the impairment arises from his 1999 and prior conditions."[231] Dr. Roth based his opinion "on lack of objective increase in findings and in the absence of further pain complaints associated with increased impairment."[232]

(d) Employee Evaluations

(i) JOELLA BEARD, M.D., PHYSIATRIST (DOE JULY 11, 2006)[233]

On July 11, 2006, Mr. M. was seen by physiatrist Joella Beard, M.D., on referral from Dr. Schweigert. She reviewed Dr. Schilperoort's IME[234] and performed a physical evaluation of Mr. M.

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[230] SR at 168.
[231] SR at 169.
[232] *Id.*
[233] SR at 128 – 133. Dr. Beard's initial evaluation was conducted on July 11, 2006 and two supplemental evaluations, July 14, 2006 and August 8, 2006.

Dr. Beard concurred with Dr. Schilperoort's diagnosis of chronic pain syndrome.[235] She also believed that there were indicators to support a diagnosis of somatoform disorder or other mental health diagnoses. She recommended a psychiatric evaluation and neuropsychological testing.[236] She did not agree with Dr. Schilperoort's opinion that the reporting of an injury is itself a "learned behavior" because the reporting could be required by the employer. She doubted the diagnosis of fibromyalgia and noted that his current medications do not appear to sufficiently treat his pain and mood disorder.[237] Dr. Beard noted that there is literature to support that chronic opioids use does not increase risk with driving. Regardless, she opined that this should be considered on an individual basis especially in light of Mr. M.'s role as a commercial driver.

Mr. M. informed Dr. Beard that he specifically "chose" her to evaluate him based on her reputation.[238] It appeared to her that he expected she would concur with Dr. Wickler's opinion that he needed shoulder surgery.

2. Psychiatric Evaluations

(a) Employer's Medical Evaluations

(i) ROY D. CLARK, JR., M.D. PSYCHIATRIST (DOE SEPTEMBER 23, 2003)[239]

Dr. Clark's evaluation was based on his interview of Mr. M. and his observations of Mr. M. during Dr. Green's examination, the administration of standardized psychiatric tests, and an interview with Mr. M. At the time of his evaluation Mr. M. was taking Wellbutirn, 150 mg twice a day; Klonopin to help with sleep, Percocet one daily at bedtime on workdays and two to three on non workdays, Maxalt for headaches, Bextra, Zanaflex, Texium, Trichlor and Diovan.

The evaluation focused on the May 21, 2003 injury. Interestingly, the recitation of Mr. M.'s history does not mention the November 26, 1999 MVA. Rather, the assessment states that Mr. M. reports "the onset of a mild but clinically significant mood disorder following the October 1996 job-related injury. This condition has periodically required use of antidepressant and anti-anxiety mediations. The treatment provided has been beneficial. The objective mental

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[234] In Dr. Beard's August 8, 2006, report she indicates that she "had the opportunity to review IMEs provided by Mr. M. …." SR at 128. However, other than Dr. Schilperoort, she does not identify a specific IME.
[235] SR at 129.
[236] *Id.*
[237] *Id.*
[238] SR at 128.

status findings do not identify any objective barriers to Mr. M.'s continued full-time employment at any job for which he is otherwise qualified and would choose to pursue."[240]

The pain-related behaviors and inconsistencies noted during Dr. Green's physical evaluation were less noticeable during Dr. Clark's examination. Dr. Clark had Mr. M. complete three diagnostic tools. Mr. M. completed the Zung Self-Rating Depression Scale and his responses were just below the cut-off for the presence of minimal levels of clinical depression. This result was, in Dr. Clark's opinion, consistent with his clinical presentation. Mr. M. also performed the Mini-Mental State Examination and his performance did not suggest gross cognitive impairment. Because Mr. M. presented with evidence of a chronic myofascial syndrome as a behavioral response to his symptoms, Dr. Clark had Mr. M. complete the Millon Behavioral Medical Diagnostic (MBMD) test.

Mr. M.'s responses to the MBMD test produced a valid profile. His responses indicated that Mr. M. would be at increased risk for having an exaggerated negative reaction to serious medical information and that he would have problems adhering to a self-care regime and maintaining a regular exercise program.

Dr. Clark believed Mr. M. suffers from psychological factors affecting his response to job-related injuries, "generating a greater degree of discomfort and disability than would be expected" base on the objective findings presenting clinically as a chronic myofascial syndrome.[241] He also diagnosed a depressive disorder appearing to be a proximate result of the 1996 injury and temporarily aggravated by subsequent injuries. The depressive disorder has responded to antidepressive medication which should be continued to minimize the chance of relapse. Dr. Clark shared Dr. Green's concerns that treating the subjective complaints as having a physical origin would only serve to reinforce Mr. M.'s somatic focus and prolong his recovery.

Regarding Mr. M.'s ability to work, he opined that the "objective mental status findings do not identify any objective barriers to Mr. M.'s continued full-time at any job for which he is otherwise qualified and would choose to pursue."[242] At the time of the evaluation, Mr. M. had returned to work full time.

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[239] SR 233-265 (The evaluation was conducted as part of a "panel" evaluation. The other evaluator was orthopedic surgeon, James F. Green, M.D. Dr. Green's evaluation is discussed above).
[240] SR at 245.
[241] SR at 247.
[242] SR at 245.

(ii) ERIC GORANSON, M.D. PSYCHIATRIST (DOE DECEMBER 5, 2006)[243]

Dr. Goranson attempted to evaluate Mr. M. for the MOA. He was unable to complete the evaluation because Mr. M. became agitated and walked out of the evaluation. Because he was unable to complete the evaluation he was ethically prohibited from providing any specific diagnosis. Regardless, Dr. Goranson did an extensive review of medical records and rendered an opinion noting he had completed 75% of his evaluation. He characterized Mr. M. as exhibiting professional patient behaviors and found him to be insulting, sarcastic, and nonchalant. Dr. Goranson went on to render an opinion that Mr. M. did not seem to be suffering from PTSD, that Mr. M. was malingering and that he had been receiving medical care that "is at best fragmented, poorly documented and influenced adversely by his bullying and manipulativeness towards healthcare professionals. He is receiving entirely too many medications … I do believe that the most reasonable diagnosis in this case is malingering. I would also state unequivocally that he does not have post traumatic stress disorder…."[244] Finally, Dr. Goranson believed that Mr. M. was primarily interested in disability certification.

(iii) RICHARD D. FULLER, PH.D, CLINICAL NEUROPSYCHOLOGIST (DOE JUNE 10, 2008)[245]

On June 10, 2008, Dr. Fuller performed a "blind" evaluation of Mr. M. at the request of an insurer. Dr. Fuller was asked to assess Mr. M.'s chronic pain condition and psychological functioning without the benefit of a records review. Dr. Fuller relied upon his interview with Mr. M. and the results of the MMPI-2[246] test. During the interview process, Mr. M. reported that after his first few accidents he developed a fear of accidents. Mr. M. stated that he had an exaggerated startle response, avoidance of public places, nightmares and flashbacks, depression, irritability, fear of driving, and panic in public places. Dr. Fuller observed that Mr. M.'s affect was "blunted with some agitation and mood depressed. He expressed annoyance with having to do the testing but was cooperative. Pain behaviors were noticeable with him standing, stretching, and wincing frequently… he exhibited a dejected, sad demeanor…He appeared to be responding in a forthright manner."[247]

[243] SR at 78 – 118.
[244] SR at 117, 118.
[245] MM 1 at 7 – 10.
[246] Minnesota Multiphasic Personality Inventory (MMPI-2).
[247] MM 1 at 8.

The testing showed a valid profile. The profile produced by Mr. M. occurred with high frequency in chronic pain patients. "He is preoccupied with his physical maladies to the extent that the worries produce increased awareness of pain. Thus, there is some psychological and behavioral contribution to his experience of chronic pain."[248] Dr. Fuller opined that Mr. M.'s testing supported a diagnosis of chronic pain syndrome, depression, PTSD and panic. Dr. Fuller also noted the presence of an avoidant, dependent personality disorder. He did not render an opinion as to whether Mr. M. could continue to drive a bus but did opine that Mr. M.'s "psychological disturbance is adversely affecting his functioning…resulting in ongoing resentment and disability."[249]

(iv) WILLIAM G. CAMPBELL, M.D. PSYCHIATRIST (DOE AUGUST 5, 2008)[250]

Dr. Campbell, a psychiatrist, met with Mr. M. on August 5, 2008, at the request of an insurer.[251] In addition to interviewing Mr. M., his evaluation included reviewing "about six inches, including treatment notes from Drs. Schurig and Savikko, a report of MMPI-2 testing done by Dr. Richard Fuller on June 10, 2008 and psychiatric evaluations by Drs. Goranson and Nassar."[252] Dr. Campbell noted that Mr. M. had:

> settled into the role of a 'professional patient.' His life is currently centered on taking medications and interacting with doctors and representatives of insurance companies … Not too surprisingly, he finds this lifestyle to be unsatisfying and demoralizing. He feels depressed, …His use of opiates will contribute to symptoms of depression, anxiety, irritability, social withdrawal, fatigue, nightmares and insomnia on a pharmacological basis… He was taking opiates during the time that he was still working as a bus driver. I find this to be surprising. Other examiners have commented that his use of opiates should have disqualified him from a job as a bus driver. I agree with this. I suspect that if he were not taking opiates, he would be able to resume driving a bus.[253]

[248] MM 1 at 9.
[249] *Id.*
[250] MM 1 at 1 – 6.
[251] It appears that Mr. M. is receiving disability benefits from an insurance policy unrelated to his PERS claim. MM 1.
[252] MM 1 at 1.
[253] MM 1 at 5.

Dr. Campbell agreed with Dr. Goranson that the stressors Mr. M. encountered were "not of sufficient criteria for post-traumatic stress disorder."[254] He concluded that Mr. M. suffered from a chronic pain disorder, a depressive disorder and an opiate-induced mood disorder. Finally, Dr. Campbell felt Mr. M. was at "high risk for eventual suicide…. I suspect that it will be difficult to persuade him to reduce or discontinue his use of opiates. Powerful secondary gain and characterologic factors will reinforce illness behavior and promote regression in treatment. His prognosis is poor."[255]

(b) PERS Consultants

(i) THOMAS A. RODGERS, M.D., PSYCHIATRIST (DOE APRIL 2, 2007 AND SEPTEMBER 26, 2008)[256]

According to his *curriculum vitae,* Dr. Rodgers is board-certified in Psychiatry and Neurology. He is a fellow of the American Psychiatric Association and the American College of Psychiatrists. Dr. Rodgers has held several teaching positions and he is presently an Associate Clinical Professor of Psychiatry at the University of Washington. He is presently a staff psychiatrist at Spokane Mental Health.

Dr. Rodgers performed two record review evaluations for the division. The first was incomplete. The records reviewed included seven physical evaluations and only one psychiatric evaluation, Dr. Nassar's. Not surprisingly, Dr. Rodgers' opined that there was not enough information to support a diagnosis of PTSD because Dr. Nassar's conclusion was "based solely on [Mr. M.'s] subjective complaints," not testing, and because "there are no entries in the entire volume of medical data to posit an ongoing psychiatric disorder."[257] Dr. Rodgers recommended against finding Mr. M. eligible for disability benefits because there was "no compelling psychiatric data to document a psychiatric disability."[258]

The second record review occurred in September 2008. The division was able to provide Dr. Rodgers with all psychiatric evaluations obtained through discovery with the exception of Dr. Winn's evaluation (discussed below). Dr. Rodgers acknowledged the findings contained in the reports not previously available to him and opined that:

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[254] MM 1 at 6.
[255] *Id.*
[256] AR at 8 – 12; Div. Exh. II.
[257] AR at 9.
[258] AR at 9.

> [t]here is no question that Mr. M. has been a very difficult man to evaluate and treat successfully. He has filed numerous injury claims, for years has been on very high doses of opiate narcotics, most likely does not totally tell the truth, sees himself as a victim, and bounces from doctor to doctor. It is apparent that he had been treated for depression for many years prior to the purported work related injuries in 2006. What I am impressed with is that his overall psychiatric clinical condition following the 2006 incidents does not appear to be any worse than prior to that date. There is a remarkable consistency in the psychiatric-psychological data prior to the incidents, immediately following the incidents, and now in the 2008 reports.
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> The report from Dr Ohlson very specifically outlined the criteria for malingering. I am not certain that Mr. M. is totally malingering but his underlying personality, bullying and manipulative behavior, and viewing himself as a perpetual victim has significantly colored any ability to document a genuine disorder. No doubt he is frustrated, in pain, and depressed but he was so prior to the 2006 incidents. I do not find compelling evidence that his overall condition changed much following the 2006 incidents even though, in my opinion, he believes it has. He was working in spite of his problems and, in agreeing with Dr. Campbell, he likely could do so again if he could discontinue the opiate pain medications.[259]

Dr. Rodgers did not believe Mr. M. was totally and permanently occupationally disabled at the time he separated from employment due to a mental condition that presumably permanently prevented him from performing duties of a bus driver.

(c) Second Independent Medical Evaluation

(i) RONALD G. EARLY, PH.D., M.D., PSYCHIATRIST AND NEUROLOGIST (DOE JANUARY 15, 2005)[260]

Dr. Early is a member of the American Board of Psychiatry and Neurology, and the American Board of Forensic Medicine. His evaluation was conducted in association with Mr. M.'s December 16, 2002 spitting incident and the May 21, 2003 MVA. The evaluation consisted of a records review, interview and testing. Dr. Early's evaluation took into consideration events going back to the November 26, 1999 MVA.

Testing included the Beck Depression Inventory (which is used to determine whether self reports of symptoms are consistent with depression) and the Millon Clinical Multiaxial Inventory

[259] Div. Exh. II at 3.
[260] SR at 136 – 151 (includes addendum regarding subsequent record reviews).

-III. The result of the Beck Depression Inventory placed Mr. M. in the severe range of depression. The results to the MCMI-III indicated a valid profile that was most consistent with schizo-affective disorder, general anxiety disorder and somatization disorder. The profile was also consistent with "someone who has 'been confronted with an event or events in which he was exposed to a severe threat to his life, traumatic experience that precipitated intense fear or horror on his part'" which would be consistent with a diagnosis of PTSD.[261] However, it was noted that a review of the medical records contemporaneous with the accidents did not reveal any statements by Mr. M. that he felt his life was in danger or that someone else's life was in danger.

Dr. Early's impression was that Mr. M. suffered from depressive and anxiety disorders. However, there was no diagnosis of PTSD other than on a provisional basis because Dr. Early found it difficult to conclude on a more probable than not basis that Mr. M. suffers from the disorder. Dr. Early did not feel it was necessary to determine the validity of a PTSD diagnosis because depression and anxiety are "the fundamental conditions in PTSD and treatment is similar."[262]

Dr. Early opined that the December 6, 2002 and May 21, 2003 work injuries aggravated Mr. M.'s pre-existing depression and "are the proximate cause of the anxiety disorder" which represent a change in his pre-existing condition.[263]

At the time of the evaluation, Mr. M. was driving a bus route that took him into rural areas, allowing him to avoid traffic or other circumstances such as volatile passengers, which might threaten his security or cause increased anxiety. Therefore, Dr. Early concluded that Mr. M. could safely drive a bus under the circumstances of his current job duties and route. Dr. Early reported that Mr. M. "very much wants to continue driving, particularly if he is able to maintain a bus route which allows him to minimize the stress."[264] Dr. Early's final recommendation was that special consideration be given to keeping Mr. M. on a route similar to that which he was currently driving where there is reduced stress, fewer passengers, less traffic and probability of additional incidents.[265]

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[261] SR at 146.
[262] SR at 150.
[263] SR at 151; SR at 419 (Dr. Early opined that the spitting incident has caused an escalation in anxiety because of the differences of opinion regarding the etiology and magnitude of the consequences of that spitting incident.)
[264] SR at 151.
[265] SR at 151.

(ii) WANDAL W. WINN, M.D., PSYCHIATRIST (DOE DECEMBER 3, 2007)[266]

Dr. Winn performed a "blind" evaluation of Mr. M. No records were reviewed and Dr. Winn's conclusions are based solely on his interview with Mr. M. and psychological testing. Dr. Winn is a diplomat of the American Board of Psychiatry and Neurology and of the American Board of Forensic Medicine. Dr. Winn is also a certified medical consultant, National Association of Disability Examiners.[267]

Mr. M.'s results of the Zung Depression Scale were strongly suggestive of clinically significant depression of mood. The Minnesota Multiphasic Personality Inventory (MMPI-2) results were suggestive of depression and somatic complaints. Dr. Winn characterized Mr. M. as having:

> A well developed and moderately severe combination of symptoms, including anxiety, depression, a hyper-startle response, intrusive dreams, and a … preoccupation with multiple past traumas. Cumulative, this is strongly suggestive of [PTSD]. In addition to the anxiety component, his depressive symptoms exceed those typically seen is [PTSD] individuals…I believe the severity and impact on function exceed those typically seen in a simple adjustment disorder, therefore, the Major Depressive Disorder Designation.
>
> …as progress is made in symptom control, he will be a good candidate for referral to the Alaska State Department of Labor's Division of Vocational Rehabilitation, as a return to work is likely to reduce his stressors and his depression through re-establishing his identity as a healthy productive male. The prognosis will be further improved to the extent that his level of pain control can be optimized….[268]

(d) Employee's Evaluation

(i) RONALD W. OHLSON, PH.D. PSYCHOLOGIST (DOE EST. AFTER MAY 2003)[269]

Dr. Ohlson evaluated Mr. M. at the request of Mr. M.'s WCC attorney. The evaluation does not mention whether prior medical records were reviewed. Dr. Ohlson interviewed Mr. M. and reviewed his responses to three psychological tests.

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[266] SR at 4117 – 4125.
[267] Div. Exh. DD.
[268] SR at 4124.
[269] SR at 364 – 366 (While the evaluation is undated, from the work-related accidents mentioned, it is known that the evaluation occurred after May 2003).

The first, the Pain Patient Profile, indicated a valid profile. While Mr. M. did not test more anxious or depressed than the average pain patient, his responses suggested that Mr. M. was experiencing a low level of somatic distress "which may cause problems in his physical treatment program. Thus he has more physical problems, pain and health-related concerns than the average pain patient on this profile. These issues may occupy a disproportionate amount of his attention and he may have difficulty shifting his attention away from pain unless he is distracted by something more interesting."[270]

The second, the Posttraumatic Stress Diagnostic Scale, indicated that Mr. M. met the DSMIV criteria for PTSD and his level impairment was rated as severe. "He experiences having upsetting thoughts or images about a traumatic event, bad dreams about the event, and feeling emotionally upset when reminded of the event. He also demonstrates avoidance …. He feels distant or cut off from others …. He feels emotionally numb and thinks that his future is foreshortened. He has ongoing arousal symptoms, expressed as trouble falling asleep, difficulty concentrating and being easily startled. Especially while driving. His level of impairment is rated as severe on this instrument."[271]

Finally, the Millon Clinical Multiaxial Inventory III yielded a valid profile that suggested a dysthymic disorder, "probably expressed in agitated form" shifting from "periods of anxious futility to self-depreciation and despair. He is preoccupied with health concerns…."[272]

Dr. Ohlson concluded that Mr. M. suffered from an accumulation of traumas arising from workplace accidents resulting in symptoms of PTSD and chronic pain. "He is still able to work and drive his bus, although he is more easily startled and cautious about people in his environment."[273] Notably, Dr. Ohlson did not diagnose Mr. M. as suffering from PTSD. Rather, he diagnosed Mr. M. with dysthymia[274] and passive-aggressive personality features.

III. Discussion

A. Legal Standards

Mr. M. must establish by a preponderance of the evidence that he is entitled to PERS disability benefits.[275] PERS provides its members with two types of disability benefits:

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[270] SR at 365
[271] *Id.*
[272] SR at 365 (Ohlson Evaluation, Undated).
[273] SR at 365 (Ohlson Evaluation, Undated).
[274] A chronic form of mild depression. Taber's Cyclopedic Medical Dictionary 17th ed. at 594.
[275] *State v. Cacciopo*, 813 P.2d 679 (Alaska 1991).

nonoccupational[276] and occupational.[277] Under either, eligibility requires proof by a preponderance of the evidence that the member has a physical or mental condition that presumably permanently prevents the member from satisfactorily performing his or her usual duties.[278] Mr. M. meets his burden of proof by placing evidence in the record or pointing to evidence already in the record that is sufficient to establish that it is more likely than not that he is entitled to PERS disability benefits.

"Presumably permanent" is not defined by statute or regulation. However, a department regulation provides that occupational and nonoccupationl disability benefits cease when a member recovers from an injury or illness and is capable of working.[279] This regulation embodies the idea that a PERS member who has been found eligible for disability benefits may recover. Accordingly, an interpretation of "presumably permanent" that would avoid an inconsistency between the PERS statutory scheme and the regulations which implement that statutory scheme would be that a member could meet the burden by establishing by a preponderance of the evidence that he or she has a condition which precludes performance of work duties and, while the condition may be treatable it is unknown whether recovery will occur.

To be eligible for occupational disability benefits, the member has the additional burden of establishing that "the proximate cause of the [disabling] condition [is] a bodily injury

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[276] AS 39.35.400 provides in part: "(a) An employee is eligible for a nonoccupational disability benefit if the employee's employment is terminated because of a total and apparently permanent nonoccupational disability, as defined in AS 39.35.680…."

[277] AS 39.35.410 provides in part: "(a) An employee is eligible for an occupational disability benefit if employment is terminated because of a total and apparently permanent occupational disability, as defined in AS 39.35.680 , before the employee's normal retirement date."

[278] *Compare* AS 39.35.680(24):

> 'nonoccupational disability' means a physical or mental condition that, in the judgment of the administrator, presumably permanently prevents an employee from satisfactorily performing the employee's usual duties for an employer or the duties of another position or job that an employer makes available and for which the employee is qualified by training or education, not including a condition resulting from a cause that the board, in its regulations has excluded….

and AS 39.35.680(27)

> 'occupational disability' means a physical or mental condition that, in the judgment of the administrator, presumably permanently prevents an employee from satisfactorily performing the employee's usual duties for an employer or the duties of another comparable position or job that an employer makes available and for which the employee is qualified by training or education; however, the proximate cause of the condition must be a bodily injury sustained, or a hazard undergone, while in the performance and within the scope of the employee's duties and not the proximate result of the wilful negligence of the employee;

sustained, or a hazard undergone, while in the performance and within the scope of the employee's duties and not the proximate result of the wilful negligence of the employee…."[280] A member does this by establishing "that the occupational injury is a *substantial factor* in the employee's disability regardless of whether a nonoccupational injury could independently have caused disability."[281] An injury or hazard in the course of employment may be a substantial factor in a disability if it aggravates, accelerates or combines with a pre-existing condition or brings about the symptoms of a pre-existing condition (*e.g.*, pain), even if it does not aggravate the underlying condition. [282] If the member is claiming that an aggravation of a pre-existing condition resulted in the disability, it follows that the work-related aggravation (disability) must be presumably permanent.[283]

Additionally, the

> [f]act that the employee perceives employment as a source of the injury is not enough … there must be some evidence that the employment played an 'active role' in the development of the mental disability and did not 'merely provide a stage for the event.'[284]

Hence, to prevail on an occupational disability claim, it is not enough that Mr. M. was employed while his asserted mental conditions allegedly developed or that there were events at work that coincided with the evolution of his conditions.

Moreover, while the court has stated that PERS occupational disability and workers' compensation claims "draw on common principles and raise similar issues," there are substantial differences between a claim for workers' compensation benefits and PERS occupational disability benefits, namely, the burden of proof and policy considerations.[285] The purpose of the PERS "is to encourage qualified personnel to enter and remain in service with participating employers by establishing plans for the payment of retirement, disability, and death benefits to or

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[279] 2 AAC 35.291(a), (b).
[280] AS 39.35.680(27).
[281] *Lopez v. Administrator, PERS,* 20 P.3d 568, 573 (Alaska 2001) (emphasis in original) *citing State v. Cacioppo*, 813 P.2d 679, 683 (Alaska 1991).
[282] *Hester v. Public Employee's Retirement Board,* 817 P.2d 472, 475 (Alaska 1991) (adopting standard applied in Alaska workers' compensation law).
[283] *In re D.F.*, OAH No. 07-0613-PER
[284] *Fox v. Alascom,* 718 P.2d 977, 984 (Alaska 1986) *citing Albertson's Inc. v. Workers' Compensation Appeals Board. Of state of California,* 131 Cal.App.3d 308, 182 Cal.Rptr. 304, 309. (California 1986).
[285] *State v. Cacioppo*, 813 P.2d 679, 683 (Alaska 1991) (applying the workers' compensation concept of working being a substantial factor if it aggravates, accelerates or combines with a pre-existing condition to bring about the disability in a PERS occupational disability proceeding).

on behalf of the members."[286] PERS is intended to promote continued public employment whereas workers' compensation protects a worker's ability to earn a certain wage.[287] In workers' compensation, an employee who incurs a work-related injury receives a statutory presumption of compensability.[288] There is no similar concept in a PERS disability case.

Mr. M.'s claim is medically complex. He alleges that both mental and physical conditions have rendered him presumably permanently disabled and that this disability is the culmination of his working as a bus driver for ten years. Unlike the Alaska Workers' Compensation statutory scheme, AS 23.30 *et seq.*, PERS has no statute imposing additional eligibility criteria upon an "eggshell" member claiming a disabling mental condition.[289] Therefore, PERS must take the member as it finds him, physically and mentally.[290]

B. Evidentiary Assessment – Objections and Credibility

Adding to the complexity of this matter is the subjective nature of Mr. M.'s self reported pain complaints. Pain, although subjective to the person, can be real even if here are no identifiable physical causes. The subjective nature requires an assessment of Mr. M.'s credibility when dealing with his health care providers. Many providers found Mr. M. to be combative and unwilling to listen to their diagnoses if they were not what Mr. M. wanted to hear.[291] If a provider was unwilling to agree with Mr. M. regarding his course of treatment or ability to return to work, Mr. M. would switch providers. Mr. M. was not forthcoming and failed to provide several providers with a full picture of his medical history. He was observed, throughout the prehearing and hearing in this matter, to be "conveniently confused" when something was not going his way, and then clear and precise when it was not adverse to his outcome. Mr. M. provided testimony that was not corroborated by the extensive medical record. For example, Mr. M. testified that he was able to travel to Minneapolis only after receiving injections and other

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[286] AS 39.35.001.
[287] *State v. Cacioppo*, 813 P.2d 679, 683 (Alaska 1991).
[288] AS 23.30.120.
[289] For injuries sustained after June 1, 1988, to prevail on a workers' compensation mental stress claim, the claimant must establish that (1) the stress was "extraordinary and unusual" and (2) stress was the predominant cause of the mental injury." AS 23.30.010(b). Prior to that date, the claimant was able to rely upon the workers' compensation presumption of compensability for all work related claims, physical or mental. The legislature removed the presumption of compensability for mental stress claims in 1988 in response to the court's decision in *Fox v. Alascom,* 718 P.2d 977 (Alaska 1986). In *Fox* the court rejected the "greater than all employees must experience test" and the "honest perception test" for stress claims and determined that a claim for mental injury caused by gradual mental stress should be analyzed in the same manner as any other WCC.).
[290] *Wade v. Anchorage School Dist.*, 741 P.2d 634, 639 (Alaska 1987) citations omitted.
[291] *See e.g.,* SR at 1548 – 1549.

treatment specifically to ready him for traveling, yet the medical records do not corroborate his testimony. In short, Mr. M. is not a credible witness and the reliability of his subjective complaints is called into question.

Mr. M. raised several objections to the medical evidence relied upon by the division. First, as to Dr. Schilperoort, Mr. M. asked that the report be stricken because Dr. Schilperoort is deceased and cannot be cross-examined. The division replied that many of the experts relied upon Dr. Schilperoort's report and that the report can be independently sustained because Dr. Schilperoort is deceased making his report admissible in civil court as an exception to hearsay under Alaska Rule of Evidence 804. The division's reliance on Evidence Rule 804 is misplaced.

This rule simply provides that certain statements are not excluded as hearsay when the declarant is unavailable. Under Evidence Rule 804(b), a deceased declarant's statement may be admissible if the statement is former testimony, a statement under belief of impending death, a statement against interest, or a statement of personal or family history. Dr. Schilperoort's statement does not fit within in one of the admissible categories and, therefore, would not be admissible as an exception to hearsay.

However, the formal rules of evidence are not applicable to a PERS appeal except as a guide.[292] Therefore, hearsay is admissible in a PERS appeal if it is "evidence of the type on which a reasonable person might rely in the conduct of serious affairs…."[293] An expert opinion is the type of evidence on which a reasonable person might rely and is admissible. The weight to be afforded each opinion will vary based upon a number of criteria including whether all available records were reviewed, whether the evaluator personally examined Mr. M., etc.

The reports generated by the experts generally identified which records were reviewed. Mr. M. argues that any reports should be viewed with suspicion because there are no rules governing what records must be provided and it is unknown if all records were provided. Mr. M. did not identify medical records available at the time of the expert review that were not provided to an expert. Without identifying which records were not provided, Mr. M.'s assertion that the employer's experts should be discounted or disregarded was speculative and unpersuasive.

[292] 2 AAC 64.290(b).
[293] 2 AAC 64.290(a)(1).

The opinion of a non-treating physician who reviews medical records may not automatically be discounted on that ground.[294] However, in the absence of a finding of superior expertise, experience, knowledge, or other valid reasons, the opinion of a physician who has not examined or treated the patient may reasonably be afforded less weight than that of an examining or treating physician.[295]

C. Physical Conditions

The uncontradicted evidence establishes that prior to commencing employment with the MOA, Mr. M. had a history of back injuries, neck injuries and subjective complaints that were noted not to be supported by objective findings.[296] The uncontradicted evidence establishes that prior to commencing employment with the MOA, Mr. M. had been prescribed antidepressants. Mr. M. has a history of work-related injuries and incidents that preceded his separation from employment.

Mr. M. has alleged that he suffers from "neck, back, shoulders, and headaches" as the result of "multiple traumas" and that these conditions presumably permanently preclude him from driving a bus.[297] Mr. M. has not established by a preponderance of the evidence that he suffers from a physical condition that presumably permanently prevents him from performing his duties. The majority of medical opinions agree that he has pre-existing conditions or degenerative changes that were temporarily aggravated by his work related injuries. However, what objective evidence there may be in the record is not persuasive when weighed against the expert medical opinions.

The evidence in the record in support of Mr. M.'s claim that he suffers from a physical condition that presumably permanently precludes him from returning to work as a bus driver are the statements of his treating providers: Drs. Schweigert, Savikko, and ANP Spayd. Drs. Savikko and Schweigert both testified that they believe Mr. M. is disabled as defined by the PERS statute. They wrote that Mr. M. could not perform his duties as a bus driver because he could not react to an emergency situation, he was precluded from sitting due to lumbar and

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[294] *Rhines v. State, Public Employees' Retirement Board*, 30 P.3d 621, 628-629 (Alaska 2001).
[295] *See generally Lopez v. Administrator, Public Employees' Retirement System,* 20 P.3d 568, 571 (Alaska 2001); *Childs v. Copper Valley Electrical Association,* 860 P.2d 1184, 1189-90 (Alaska 1993); *Black v. Universal Services, Inc.,* 627 P.2d 1073, 1075 (Alaska 1981).
[296] *See e.g.,* SR at 1557, 1664.
[297] AR at 22, 23. While this letter is undated it is reasonable to conclude that it was written before September 14, 2006 from the indication that the September 14, 2006 meeting with Psychiatrist Ramzi Nassar, M.D., had yet to take place.

sciatica pain and that he could not drive a bus due to shoulder pain and spasms. However, they were unable to reconcile their conclusions with the objective evidence to the contrary. Specifically, these are negative lower EMG testing, EMG testing that is incompatible with the presumed cervical disc level observed to be slightly bulging, the undeniable failure of all subsequent surgical interventions (Mr. M. continues to complain of shoulder and back pain after surgery), the lack of findings on MRIs and x-rays, and the fact that Mr. M. would, at times, continue to experience an aggravation when he was not working and purportedly resting. Many of their opinions and diagnoses were based upon Mr. M.'s self-reporting of prior diagnosis and failure to provide a complete picture of his health.[298]

Mr. M. has established that it is more probable than not that he suffered a SLAP lesion in his right shoulder. Dr. Wickler performed surgery and found that Mr. M. did have a right should SLAP lesion which was repaired. Dr. Wickler testified that Mr. M. could return to work as a bus driver once the appropriate recovery period had passed. Dr. Wickler has not provided a physician's statement regarding Mr. M.'s claim for disability benefits. There is no medical evidence that a repaired SLAP lesion would prevent Mr. M. from returning to work as a bus driver. Therefore, if it is accepted that Mr. M. had a physical condition, a SLAP lesion, it did not presumably permanently preclude him from returning to work as a bus driver.

Similarly, if one accepts Dr. Chiu's surgical report, Mr. M. had certain physical conditions in his spine which were surgically treated and Mr. M. tolerated the procedure well. If this is so, there is no reason Mr. M. should not be feeling better. There is no opinion from Dr. Chiu that Mr. M. cannot return to work as a bus driver as a result of his operative findings. Mr. M.'s complaints have not changed pre-surgery or post-surgery. Therefore, it is unlikely that the physical spinal conditions were presumably permanently preventing Mr. M. from working as a bus driver.

Consulting physicians who examined Mr. M. observed that he was consistently inconsistent and that his subjective complaints were not supported by the objective findings.[299] Most persuasive is that none of the experts providing physical evaluations and opinions

[298] For example, Mr. M. did not provide Dr. Anderson with the MRIs that showed improvement in his lumbar spine and stabilization of his lumbar condition. Nor did Mr. M. provide Dr. Nassar with a complete and accurate history of his complaints or injuries.
[299] Drs. Ballard, Lippon, Green, Schilperoort, Soot, Roth, and Beard.

recommended against Mr. M. returning to work as a bus driver or in another position.[300] Dr. Roth opined that Mr. M.'s continued working would beneficial. The only factor that several of the physicians expressed concern over was Mr. M.'s use of narcotics. Dr. Morresey opined that Mr. M.'s ability to drive commercially should be conditioned upon "no chronic daily narcotics nor benzodiazepines, and no unmanaged pain condition capable of causing impairment distraction to the driver such that the public is at any significant increase in risk of accident or injury."[301] However, Dr. Morresey's comment was given in response to an inquiry regarding whether the medications taken by Mr. M. make him unable to safely drive a bus. Dr. Morresey did not opine whether Mr. M. suffers from a mental or physical condition that requires he take medication. Therefore, his report is insufficient to establish that Mr. M. suffers from a physical or mental condition that presumably permanently prevents him from driving a bus.

Typically a treating physician's opinion is given greater weight than a consulting physician. This greater weight is justified by the fact that a treating physician has an opportunity to evaluate the patient over a long period of time and is in a better position to assess a patient's medical condition that a consulting physician who may have spent 10 or 15 minutes evaluating the patient and a few hours reviewing the record and dictating a report. However, when, as here, multiple consulting physicians who conducted their own physical examination of Mr. M. are specialists in the area of orthopedic surgery, share the same opinion and their conclusions are supported by the objective evidence, it is appropriate to determine the consulting opinions outweigh the conclusions of the treating physicians. Therefore, when viewed as a whole, Mr. M. has failed to prove by a preponderance of the evidence that he suffers from a disabling physical condition.

D. Mental Condition

When reviewing Mr. M.'s medical history in its entirety there are three constants. First, among these constants are his subjective complaints that are, more often than not, unsupported by objective findings. Second, psychological testing consistently revealed that Mr. M. was at an increased risk for having an exaggerated negative reaction to serious medical information and that he suffered from psychological factors affecting his response to job related injuries resulting

[300] This is so even after the Functional Capacity Assessment revealed Mr. M.'s restrictions. Therefore, it is reasonable to conclude that the restrictions were not considered to be a determinative factor in Mr. M.'s ability to drive a bus.
[301] AR at 114.

in a greater degree of discomfort and disability than would be expected. His predisposition has resulted in diagnosis or suspected diagnosis of chronic pain syndrome, chronic myofascial syndrome, dysthmia (mild chronic depressive) disorder, anxiety disorder, somatic distress, schizoid personality disorder and PTSD. Third, Mr. M. has a history of depression and unresolved pain complaints prior to working at the MOA.

The record and objective testing does establish that it is more likely than not that Mr. M. suffers from some form of a mental condition. Although not definitive, the majority of the expert opinions seem to agree upon some form of chronic pain, depression or anxiety. Simply having one or a combination of these conditions does prevent Mr. M. from driving a bus. It is his subjective complaints that purportedly rendered him unable to drive a bus. His subjective complaints are, without more, insufficient to meet his burden of proof.

The only consultants or providers who have provided a definitive diagnosis of PTSD are Drs. Savikko, Condy, and Nassar. Dr. Savikko's opinion regarding mental condition is given minimal weight. He has had no specialized training and testified that his diagnosis was based on his experience gained in his family medicine practice. He explained that he sees a large number of patients with depression and anxiety diagnosis and a "fair amount" of PTSD, sexual problems and marital problems.[302]

Dr. Nassar, a psychiatrist, has treated Mr. M. twice, has not performed any testing, and has not questioned anything Mr. M. has told him. Dr. Nassar's relationship with Mr. M. is more similar to that of a consulting or expert evaluator than a treating physician and will not be given the same weight of a treating provider. Moreover, his opinion was based on incomplete information received from Mr. M. When, during the course of his deposition, he was made aware of Mr. M.'s history, Dr. Nassar affirmed his decision but suggested that he might have diagnosed depression and anxiety in lieu of PTSD.

Dr. Condy treated Mr. M. for a short period of time and diagnosed him with acute PTSD. However, she never took him off work. Mr. M. began treating with Dr. Condy in 2005, at the same time as he was having disciplinary problems at work. One theory could be that Mr. M. began to have disciplinary problems at work that were caused by his PTSD or other mental condition. However, there is no medical evidence to support such a theory.

[302] Savikko Testimony.

Several consultants opined that it would be beneficial for Mr. M. to return to work while receiving treatment for depression and anxiety. These consultants had a more complete profile of Mr. M. than did Dr. Nassar. Therefore, their opinion regarding Mr. M.'s ability to work is more persuasive than Dr. Nassar's.

Regarding Mr. M.'s possible diagnosis of chronic pain, the belief that Mr. M. cannot work is based on his subjective pain complaints. As discussed above, Mr. M.'s testimony is unpersuasive. His assertion that he is incapable of performing his duties on a presumably permanent basis is not supported by a preponderance of the evidence.

ANP Spayd's testimony and chart notes are also unpersuasive regarding the severity of Mr. M.'s pain. As reflected in her chart notes, she increased Mr. M.'s usage of Percocet when his symptoms were improving.[303]

While the record is voluminous, it does not support a finding that it is more probable than not that Mr. M.'s mental condition(s) presumably permanently precluded him from performing the duties of his job. Because this prerequisite has not been established, the question of whether his condition was proximately cause by his employment with the MOA is not reached.

IV. Conclusion

Mr. M. has not established by a preponderance of the evidence that he is entitled to PERS disability benefits, either occupational or nonoccupational. The decision of the PERS administrator to deny Mr. M.'s application for PERS disability benefits is affirmed.

Dated this 23rd day of April, 2009.

By: *Signed*
Rebecca L. Pauli
Administrative Law Judge

[303] ANP Spayd also justified prescribing the "name brand" narcotic Percocet rather than generic purportedly because of Mr. M.'s nausea and vomiting. However, her chart notes omit any mention of nausea and vomiting.

Adoption

This Order is issued under the authority of AS 39.35.006. The undersigned, in accordance with AS 44.64.060, adopts this Decision and Order as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska Rule of Appellate Procedure 602(a)(2) within 30 days of the date of this decision.

DATED this 26th day of May, 2009.

By: *Signed*
Signature
Rebecca L. Pauli
Name
Administrative Law Judge
Title

[This document has been modified to conform to technical standards for publication.]