Alaska Workers' Compensation Appeals Commission

Ramon Rivero, Appellant, vs. Coldfoot Environmental Services, Inc. and Zurich American Insurance Company, Appellees.	Final Decision Decision No. 200 October 1, 2014 AWCAC Appeal No. 13-022 AWCB Decision No. 13-0108 AWCB Case No. 200906554

Atencion Sr. Rivero: Usted necesita obtener una persona que habla ingles y español para traducir este documento.

Final decision on appeal from Alaska Workers' Compensation Board Final Decision and Order No. 13-0108, issued at Anchorage, Alaska, on September 4, 2013, by southcentral panel members Laura Hutto de Mander, Chair, Rick Traini, Member for Labor, and Linda Hutchings, Member for Industry.

Appearances: Ramon Rivero, self-represented appellant; Jeffrey D. Holloway, Holmes Weddle & Barcott, PC, for appellees, Coldfoot Environmental Services, Inc. and Zurich American Insurance Company.

Commission proceedings: Appeal filed September 23, 2013; briefing completed February 21, 2014; oral argument held on September 25, 2014.

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

By: Laurence Keyes, Chair.

1. Introduction.

Appellant, Ramon Rivero (Rivero), was employed by appellee, Coldfoot Environmental Services, Inc. (Coldfoot), when, on May 7, 2009, he injured his right shoulder while carrying a heavy pipe.[1] Rivero and Coldfoot disputed whether Rivero

[1] Exc. 019, 024.

also injured his lower back in this work incident, when Rivero reached medical stability for his shoulder injury, and whether Rivero was entitled to reemployment benefits.

The matter went to hearing before the Alaska Workers' Compensation Board (board) on February 5, 2013.[2] In due course, the board issued a split decision, with the majority holding: 1) the work incident was not the substantial cause of the need for treatment for Rivero's lower back; 2) Rivero was not entitled to temporary total disability (TTD) benefits from January 23, 2010, to the present; 3) Rivero was not eligible for reemployment benefits, and 4) Rivero was not entitled to interest or transportation costs.[3] The dissent would have awarded benefits based to some extent on witness credibility and testimonial weight findings that differed from those of the majority.[4]

The commission affirms the board majority in part and remands the issue of Rivero's eligibility for reemployment benefits to the board.

2. Factual background and proceedings.

Prior to the work incident on May 7, 2009, Rivero's back was mentioned in four medical records. On April 1, 2005, a doctor at the Anchorage Neighborhood Health Center gave Rivero a slip to excuse him from work for two-to-three days due to back muscle spasms from weight lifting.[5] Rivero testified that he did not go to the clinic that day for his back but was seen for a "tuberculosis problem."[6] On May 25, 2008, Rivero went to the emergency room (ER) with "really bad flu,"[7] testifying that he "complained about my entire body."[8] The ER report documented Rivero's complaints of upper

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2 *See Rivero v. Coldfoot Environmental Services, Inc.*, Alaska Workers' Comp. Bd. Dec. No. 13-0108 at 1 (Sept. 4, 2013).

3 *See Rivero*, Bd. Dec. No. 13-0108 at 51.

4 *See id.* at 53-61 (dissenting opinion).

5 R. 4283.

6 Hr'g Tr. 26:4–27:1, Feb. 5, 2013.

7 Hr'g Tr. 27:17-18.

8 Hr'g Tr. 27:12-13

respiratory problems and back pain.[9] He told the nurse that his level of back pain was an 8 on a scale of 10,[10] but the doctor's notes included no discussion of his back pain other than listing it among the "chief complaints."[11] Rivero was evaluated for a possible urinary tract infection due to left flank pain. He was diagnosed with an upper respiratory infection and sinusitis, and prescribed an antibiotic, cough medication, and pain medication.[12] The last two records were two different medical questionnaires that Rivero completed three months before the work injury, in early February 2009. Rivero indicated that he had never suffered from a backache or any back injury, had never had a disc condition in his back, and was experiencing no current back pain.[13]

The day of the work injury, May 7, 2009, Rivero was injured around 3:30 p.m. and worked until the end of his shift at 4 p.m.[14] He went to the ER the next day, complaining of "severe discomfort" in his right shoulder. Dr. John R. Hanley noted that Rivero reported injuring his shoulder while lifting heavy pipe, and Rivero "denie[d] any direct trauma to the shoulder." After a shoulder X-ray revealed no obvious fracture or dislocations, Rivero was given a sling, a prescription for pain, a work release for four days, and referred to Anchorage Neighborhood Health Center.[15] At hearing, Rivero testified that he complained of back pain that day, but he and the doctor "weren't understanding each other very well" and "[a]t that time I was worried more about my shoulder because I couldn't even move my arm."[16] No mention was made in the ER

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9 R. 2646-47.

10 R. 2642.

11 R. 2646-47.

12 R. 2646-47.

13 R. 0321-23, 0352, 0355-56.

14 Hr'g Tr. 33:25–34:7.

15 Exc. 019-21.

16 Hr'g Tr. 10:1-13.

report of low back pain,[17] however, Rivero is a Cuban immigrant who speaks Spanish and understands little English, and no interpreter was present.[18]

A few days later, on May 12, 2009, Rivero returned to the Providence ER. This time, an interpreter was present. Dr. Michele L. McCall noted that Rivero was suffering from persistent shoulder pain that arose the morning after he "spent all day . . . carrying heavy tubes." He reported that he could not lift his arm. The pain radiated into his neck, but there was no numbness in his fingers. Dr. McCall suspected a rotator cuff injury and referred him to orthopedist Robert J. Hall, M.D.[19]

On May 18, 2009, physician's assistant (PA) John A. Love evaluated Rivero in Dr. Hall's office, with the assistance of an interpreter, and ordered a magnetic resonance imaging (MRI) scan. PA Love noted one of the pipes that Rivero was carrying "fell and landed directly on top of his shoulder."[20] Rivero had a right shoulder MRI a day later that showed "some minor degenerative change of the AC joint"[21] and "some possible articular surface tear of the supraspinatus without retraction."[22]

On May 28, 2009, Rivero complained to Dr. Hall of shoulder pain radiating down to his fingertips and significant neck pain accompanied by headaches. A translator accompanied him at this appointment. In Dr. Hall's notes, Rivero's description of how the injury occurred was that a heavy pipe he was carrying on the top of his shoulder fell and landed on his shoulder. Concerned about the decreased sensation in Rivero's right arm and hand, as well as weakness in his wrist, Dr. Hall ordered a cervical MRI.[23]

Dr. Hall referred Rivero to Dr. James M. Eule, who evaluated him on June 9, 2009, for "significant cervical spondylolysis with significant right shoulder and arm pain

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17 Hr'g Tr. 10:1-13.

18 Exc. 019-21; Hr'g Tr. 20:11-21.

19 Exc. 022-23.

20 Exc. 026-27.

21 "AC joint" refers to the acromioclavicular joint. Taber's Cyclopedic Medical Dictionary (2009).

22 Exc. 028-29.

23 Exc. 029-30.

and numbness."[24] An interpreter was present at this appointment. In Dr. Eule's notes, Rivero's injury occurred when he tried to remove a heavy pipe and fell, landing on his shoulder. Based on the cervical MRI done on May 29, 2009,[25] Dr. Eule diagnosed severe cervical spondylolysis with some neck pain. He also diagnosed questionable brachial plexus injury and possible soft tissue shoulder injury. Dr. Eule could not explain the numbness in Rivero's hand, and prescribed four weeks of physical therapy along with anti-inflammatories.[26]

The first mention of back pain in Rivero's medical records occurred five weeks after the work incident, on June 12, 2009, at his first physical therapy appointment for evaluation of his right shoulder. Physical therapist (PT) Jeff Evans noted that in addition to the shoulder pain, Rivero "has been starting to have lower back pain as well recently, not sure why this is." An interpreter was present at this appointment.[27]

On June 30, 2009, Rivero filled out a questionnaire for the adjuster in which he specified that his injured body part was his "right shoulder," and "pain now also in neck and spine." He stated that his symptoms began on May 7, 2009.[28] He also wrote that he was currently experiencing severe pain, unable to move his arm properly, had numbness in his arm and neck, and pain in his arm, neck, and back.[29] When asked if he lifted weights or had a regular exercise program, he responded, "I did have but stopped two years ago."[30]

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[24] Exc. 032.

[25] Exc. 031.

[26] Exc. 032-33.

[27] Exc. 035-36.

[28] R. 0181.

[29] R. 0182.

[30] R. 0183.

On July 6, 2009, Dr. Erik M. Kussro performed electrodiagnostic testing on Rivero's right shoulder to evaluate for brachial plexopathy.[31] Dr. Kussro noted that a friend accompanied Rivero and interpreted for him. Dr. Kussro summarized Rivero's medical history since the May injury, writing that Rivero noted "some significant low back pain, which he states has been present since early on after the injury." Rivero also described in detail his shoulder pain as well as "electric shock type impulses" in his legs.[32] Dr. Kussro's impressions were electrodiagnostic evidence of mild right carpal tunnel syndrome, but no findings of a right brachial plexopathy, a right cervical radiculopathy, or an ulnar neuropathy.[33]

On July 7, 2009, Rivero returned to Dr. Eule for follow up after his electromyography[34] (EMG) studies and physical therapy. Dr. Eule noted that Rivero was "here with his interpreter today, who is excellent, and is interpreting for us." He noted that physical therapy was ended due to Rivero's pain. Rivero was "basically incapacitated" due to the neck pain, arm pain that radiated into his hands, and back pain. Upon examination Dr. Eule found Rivero's pain "out of proportion for what it should be with the findings." Dr. Eule speculated that Rivero might be developing complex regional pain syndrome or reflex sympathetic dystrophy[35] and referred him to the Alaska Spine Institute for further evaluation and to determine if sympathetic nerve blocks were warranted. Dr. Eule also referred Rivero back to Dr. Hall for shoulder treatment.[36]

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[31] Exc. 037. "Brachial" refers to the arm; "plexopathy" refers to any disease of a peripheral nerve plexus. Taber's Cyclopedic Medical Dictionary (2009).

[32] Exc. 037-38.

[33] Exc. 039.

[34] "Electromyography" is the preparation, study, and interpretation of electromyograms that record the electrical activity of selected skeletal muscle groups while at rest and during voluntary contraction. Taber's Cyclopedic Medical Dictionary (2009).

[35] "Dystrophy" is a disorder caused by defective nutrition or metabolism. Taber's Cyclopedic Medical Dictionary (2009).

[36] Exc. 042-43.

In terms of his low back pain, Rivero was treated again in the Providence ER on July 17, 2009. A fluent Spanish-speaking admitting clerk acted as an interpreter during this evaluation. Rivero reported a "several week long history of diffuse lumbar pain," as well as chronic shoulder problems since his May work injury. Dr. Vincent L. Imbriani ordered a lumbar MRI, which was "reasonably normal." The MRI showed a slight disc protrusion at the L4 level, but no evidence of disk herniation or nerve entrapment. Dr. Imbriani thought Rivero's back pain may be from spasm, either compensating for his right shoulder injury or as a result of his prolonged inactivity since the work injury. Dr. Imbriani changed Rivero's pain medication and directed him to follow up with Dr. Eule.[37]

Less than a week later, on July 22, 2009, Dr. Michel L. Gevaert evaluated Rivero at the Alaska Spine Institute. Rivero described diffuse aching pain in his right shoulder, pain, numbness, and tingling in the right arm, and numbness in the fingers of his right hand. He also reported diffuse pain from the cervical region into his back and both buttocks, and a burning sensation in both legs. He reported that his present pain level was 10 on a scale of 10 but ranged from between 5 and 10. Dr. Gevaert noted that Rivero's history was inconsistent in the medical records that he reviewed. He observed, "This may or may not be a language issue." He also concluded that the lumbar spine MRI, the cervical spine MRI, the right shoulder x-ray, and the EMG study were "not congruent with the patient's present clinical presentation." Dr. Gevaert's impressions were: 1) right shoulder injury, x-rays reveal calcification, 2) nonphysiologic signs and symptoms combined with significant symptom magnification, 3) cervical spine reveals diffuse spondylolysis, 4) normal EMG of right upper extremity, and 5) lumbar spine MRI, benign. Dr. Gevaert ordered a right shoulder MRI because he could not locate the records on the May shoulder MRI. He prescribed pain medication and five days of physical therapy.[38]

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[37] Exc. 046-48.

[38] Exc. 051-53.

On July 30, 2009, Rivero returned to Dr. Gevaert for reevaluation. Rivero reported that his pain was not responding to physical therapy or pain medication. After reviewing the right shoulder MRI, which showed impingement syndrome, and evidence of bursitis and fluid in the shoulder, Dr. Gevaert referred Rivero back to Dr. Hall to consider surgery.[39]

On August 11, 2009, Dr. Hall performed surgery on Rivero's right shoulder. An arthroscopic subacromial decompression, mini-open rotator cuff repair, and open Mumford procedure were performed. The post-operative diagnoses were right shoulder rotator cuff tear and acromioclavicular joint degenerative disease.[40]

On August 15, 2009, Dr. John M. Ballard conducted an employer medical evaluation (EME) with the assistance of a translator.[41] He diagnosed right shoulder acromioclavicular joint arthritis, partial rotator cuff tear of the right shoulder, and cervical degenerative disc disease.[42] Dr. Ballard opined the cervical disc disease was related to age and the mechanism of injury did not support relating any type of cervical spine injury to the May 7, 2009, work incident.[43] Dr. Ballard stated that the work incident permanently aggravated degenerative changes present in Rivero's right rotator cuff, leading to the partial tear. Dr. Ballard concluded that the work injury was the substantial cause of Rivero's disability and need for shoulder surgery.[44] Dr. Ballard noted that Rivero's "back has been bothering him since about one month after the injury,"[45] but concluded that the low back pain had "no relation to the injury in question of May 7, 2009."[46] He testified, "[Y]ou can occasionally get patients that have a low-

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39 R. 0693.

40 Exc. 055.

41 Exc. 058-9.

42 Exc. 065.

43 Exc. 066.

44 Exc. 067-68.

45 Exc. 059.

46 Exc. 065.

back injury and maybe the symptoms start two or three days later. You know, they're sore, they're stiff, but five weeks is not possible."[47] Dr. Eule agreed with Dr. Ballard's report.[48] Dr. Hall agreed with the report as well, except that he expressed no opinion on Rivero's low back pain because he had not evaluated or treated Rivero's low back.[49]

On August 24, 2009, Rivero began his post-surgery physical therapy. PT Evans noted that Rivero's post-surgery pain was much different than his pain prior to surgery, and overall he was doing much better.[50]

On September 3, 2009, Dr. Hall noted Rivero's pain was different than before surgery, and Rivero had pain on the medial border of his scapula and in his low back. He observed that Rivero was progressing in physical therapy and had good passive range of motion. Dr. Hall cleared Rivero for active assist range of motion, kept him off work for an additional six weeks, and refilled his pain medication.[51]

On September 20, 2009, Rivero was seen in the Providence ER for left lower back, and right knee and calf pain. No mention was made of any interpretation assistance.[52] Rivero reported to the triage nurse he had an injury "years ago" and has had ongoing problems since that time.[53] Dr. McCall reviewed the previous lumbar MRI, and ordered a Doppler study of Rivero's right leg, given his recent surgery and decreased activity. There was no evidence of deep vein thrombosis. A right knee x-ray was also normal. Dr. McCall's diagnoses were viral syndrome, internal knee injury, and low back pain.[54]

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47 Ballard Dep. 25:9-12, Jan. 23, 2013.

48 Exc. 076.

49 Exc. 072.

50 R. 0733.

51 R. 0742.

52 R. 0757-58.

53 R. 0755.

54 R. 0757-58.

On September 21, 2009, Rivero returned to physical therapy after missing two appointments because of his low back pain, and resulting lack of sleep. PT Evans noted the low back was the major area of pain and interfered with Rivero's ability to do active range of motion shoulder exercises. Evans consulted with Dr. Hall who referred Rivero to Dr. Gevaert to follow up on the lumbar pain, and to restart shoulder physical therapy after Rivero's consultation with Dr. Gevaert.[55]

On October 2, 2009, Rivero returned to Dr. Hall who noted that Rivero had increased pain in the shoulder and in the low back that radiated into both legs and prevented him from sleeping. Dr. Hall stated the back pain was causing the shoulder pain through increased stress and lack of sleep, and attempted to move up Rivero's appointment with Dr. Gevaert. An interpreter was present at this appointment.[56]

On October 14, 2009, Coldfoot's adjuster notified the Alaska Spine Institute that Rivero's lower back was not covered by workers' compensation.[57]

On October 23, 2009, Rivero was seen in the Providence ER two days after a motor vehicle accident. Dr. A. Kathleen McCue listed Rivero's primary complaints as low back, upper back, right shoulder, and neck pain. Although Rivero reported that the pain in his upper and lower back and right shoulder had been chronic, the pain in all these areas became significantly worse since the car accident. No interpreter was present for this appointment; however, Dr. McCue noted, "[h]e speaks Spanish primarily but is able to express himself very adequately in English." Dr. McCue wrote that Rivero told her he had had rotator cuff surgery "several years ago" and that he was seeing Dr. "Debar" (apparently a reference to Dr. Gevaert), and Dr. Hall. On examination, she noted that he had classic symptoms of frozen shoulder, had increased pain in his lower back, and positive bilateral straight leg raises. Dr. McCue assessed acute exacerbation of chronic neck, back, and right shoulder pain, prescribed a muscle

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55 R. 0762.

56 R. 0766.

57 R. 0768.

relaxant and pain medication, and directed Rivero to keep his already scheduled medical appointments.[58]

On November 5, 2009, Dr. Gevaert evaluated Rivero's low back pain. Rivero reported to him that the pain began in June 2009 and "has been building up progressively. It has gotten worse since the [shoulder] surgery."[59] Dr. Gevaert observed that Rivero "barely complained" of low back pain when he evaluated him in July. Dr. Gevaert concluded that the origin of Rivero's diffuse thoracic and lumbar pain was unclear but he did not believe it was work-related. "[T]he patient presents with significant symptom magnification and/or altered pain perception." Dr. Gevaert recommended continuing palliative care for Rivero's "self-reported" back pain.[60] The notes do not mention whether an interpreter was present.[61]

Throughout November and December 2009, Rivero continued to experience unexplained low back pain.[62] He resumed physical therapy for his shoulder but PT Evans noted that the back pain limited his progress.[63]

On January 5, 2010, Rivero returned to Dr. Hall accompanied by Coldfoot's case manager and an interpreter.[64] Rivero reported that he received temporary relief from an injection in his shoulder joint that he received in December 2009[65] that lasted only as long as the temporary anesthetic. Dr. Hall notified Rivero that there was no further treatment he could offer and referred him to AA Pain Clinic.[66]

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58 R. 0776-77.

59 Exc. 073.

60 Exc. 075.

61 Exc. 073-75.

62 R. 0806 (November 19, 2009, appointment), R. 0809 (November 23, 2009, appointment), R. 0810 (November 25, 2009, appointment), Exc. 077-78 (December 28, 2009, appointment).

63 R. 0802, 0814.

64 R. 0823.

65 R. 0818.

66 R. 0823-24.

On January 23, 2010, Dr. Ballard conducted a second EME. A translator accompanied Rivero.[67] Dr. Ballard's report describes Rivero's current symptoms:

> He cannot lift anything or do anything, and he states that he does not use his shoulder at all. It is painful when he uses his shoulder. It is painful if he tries to do his passive motion exercises. He gets strong cramps, posterior shoulder, anterior shoulder, penetrating. If he presses up on his arm, they will go away. The cold makes it worse. The surgery did not help, expect it decreased the pain a little. He always holds his arm across his body, which makes his symptoms feel better.
>
> He describes low back pain, constant, cramping, and penetrating.
>
> He has loss of strength in his legs. He can walk or sit for five minutes before he will need to change positions. He cannot lie down in bed. He has to be turning over constantly. He uses a cane, if not, he loses his balance.
>
> The pain in his back will go up and down his spine. He describes it as a stabbing, aching pain, along with stabbing, aching pain up the entire arm and shoulder on the right side.[68]

Dr. Ballard stated that Rivero's "physical examination was filled with significant signs of symptom magnification, pain behavior, and facial grimacing. . . . With any type of testing on physical examination, he was wincing and grimacing in pain." Dr. Ballard concluded that Rivero had significant symptom magnification, pain behavior, and psychological overlay.[69] Dr. Ballard maintained the same opinions he expressed during his first EME, that Rivero's shoulder injury was work-related and that his low back pain was not. Dr. Ballard observed that Rivero reported to him that the low back pain began immediately after the work injury in contrast to the medical records that did not mention back pain until a month later.[70] Dr. Ballard thought that Rivero needed no further treatment for the work-related right shoulder condition and was medically stable as of the date of his examination.[71]

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67 Exc. 079.

68 Exc. 084-85.

69 Exc. 085-87.

70 Exc. 088.

71 Exc. 090-91.

A few weeks later, on February 5, 2010, Dr. Ballard reviewed surveillance video that was taken on August 10, 2009, the day before Rivero's shoulder surgery, on December 28, 2009, and on January 22, 2010.[72] Dr. Ballard described the following:

> 08/10/09: He is seen getting into an SUV type of car. He is turned to the right apparently talking to someone in the backseat. He is wearing a sling on the right shoulder. He is then seen, after apparently having gone back to his house, walking with his sling on, slow gait. No significant limp is noted.
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> 12/28/09: He is seen getting out of a car. He is walking, using his cane with his arm across his chest. He apparently was going to a medical appointment. It then shows him driving the car. He is approaching his residence. He is then seen exiting his residence walking without his cane. He is noticed to be walking normally with both arms apparently at his side. This occurred at approximately 12:27. He is then noticed to be walking around his residence without a limp, without a cane. The arm is not held across his chest, but it is not used a lot on the right side. He then is noticed to be going to a doctor's appointment. He is noticed to be walking using his cane with his arm held across his chest. He then is noted to be at his residence walking without his cane. He seems to be using his right arm, and certainly, the right arm is not being held across his chest. No significant limp is noted. He is then noticed going to Costco using a cane, holding his right arm across his chest. He is then noticed walking out of Costco, his arm dangling from the side, normal walk, holding his cane but not using it. He is actually lifting his arm somewhat. At 5:38, he is then noticed to be out of the car. This time, there is good visualization that he is using his right arm, able to button his jacket, no activities above, but certainly he is using it to do certain items with what appears to be some type of a machine or device outside of his car. He is then noted to be getting out of the car wash walking around on the ice without his cane. He then is arriving at his residence. He is then at his house outside without using his cane. He seems to be using both of his arms. He is also noted to be carrying things into his house without use of his cane.
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> 01/22/10: He is carrying groceries with his left arm. No limp is noted.[73]

Dr. Ballard stated that the video surveillance confirmed his impressions in his EME report: "[T]his gentleman had significant psychological factors that are interfering with his ability to recover from his injury. I certainly believe that he can function at a much

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[72] Exc. 093-94.

[73] Exc. 093-94.

higher level than he demonstrated when being seen at that Independent Medical Evaluation."[74]

Meanwhile, Rivero followed up on Dr. Hall's referral to AA Pain Clinic and had his first appointment with Dr. Alfred Lonser on April 5, 2010. No interpreter was available for this appointment; however, Dr. Lonser noted, "[B]etween the patient's limited English and my limited Spanish, we will be able to come to an understanding regarding his issues."[75] Dr. Lonser assessed lumbar degenerative disc disease and right shoulder pain, and scheduled Rivero for an L5-S1 lumbar epidural steroid injection.[76]

More than a month later, on May 13, 2010, Rivero received the epidural steroid injection.[77] Twelve days later, Rivero reported to Dr. Lonser that the injection made his pain worse. Dr. Lonser referred Rivero for a surgical consult.[78] In late July, Rivero received a second midline L5-S1 interlaminar epidural steroid injection.[79]

On July 15, 2010, Coldfoot controverted benefits, including all benefits sought for Rivero's lumbar spine and for TTD after January 23, 2010, based on Dr. Ballard's January EME report.[80] Coldfoot renewed this controversion on May 26, 2011.[81]

On August 3, 2010, Dr. Eule examined Rivero for the surgical consult. Dr. Eule noted Rivero's low back pain had progressively worsened over the last year, and he now suffered from bilateral leg pain and numbness from the knees down. Dr. Eule ordered a lumbar MRI and EMG. There was no indication that an interpreter was present for this appointment.[82] The lumbar MRI showed degenerative disc disease at

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74 Exc. 094. He noted that the video showed Rivero walking without a limp; however, his January EME report also noted that Rivero had no limp. Exc. 085.

75 R. 0863.

76 R. 0864.

77 R. 0871-72.

78 R. 0874.

79 R. 0891-92.

80 R. 0038.

81 R. 0042.

82 Exc. 106-08.

L4-5 and L5-S1 with a focal protrusion of disc material in the foramen on the right at L4-5, moderate sized, and a small right-sided protrusion of disc material at L5-S1 not encroaching the foramen.[83] The EMG of the lower extremities was normal.[84]

On August 17, 2010, Rivero returned to Dr. Eule to follow up on his EMG and MRI. Dr. Eule concluded that if Rivero's pain was incapacitating the only option left was disc replacement. Dr. Eule scheduled a discogram for levels L3-4 for control, and at L4-5 and L5-S1. After the discogram, Dr. Eule would decide whether to recommend surgery. There was no mention of an interpreter at this appointment.[85]

On August 20, 2010, Rivero saw Dr. Lonser, who reviewed the procedure for a discogram with an interpreter present to make sure Rivero understood the procedure and consented to it.[86] On September 2, 2010, Dr. Lonser performed a discogram on levels L3-4, L4-5, and L5-S1. Rivero's pain was concordant at L4-5 and L5-S1.[87]

On September 8, 2010, Dr. Eule responded to a letter from Michael J. Patterson, who was Rivero's attorney at the time. Dr. Eule stated that Rivero would not be able to return to any of the "heavy lifting" jobs that he held in the ten years prior to his injury, recommended retraining, stated that it "does not appear to be the case" that the pain medication prescribed for the shoulder masked the low back problem identified five weeks after the original date of injury. He answered "no" when asked if Rivero's low back condition was related to his work injury.[88]

That same day, Rivero returned to Dr. Eule to follow up on his discogram. With the help of an interpreter, Dr. Eule explained his concerns regarding Rivero's history of symptom magnification, positive Waddell signs, poor recovery from shoulder surgery, and two levels of concordant pain on his discogram. Dr. Eule explained he would

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83 Exc. 109.

84 Exc. 111.

85 Exc. 113.

86 R. 0903-04.

87 R. 0905-06.

88 Exc. 114-15.

require a psychological evaluation that must say Rivero is a good surgical candidate before Dr. Eule would consider seeking approval for a two-level disc replacement.[89] More than eight months later, on May 19, 2011, Dr. Eule noted a psychiatric evaluation provided no contraindication for lumbar surgery. Dr. Eule stated:

> My thought would be, based on our ability to get him authorized for surgery, not based on what we think is best for the patient; what I think is best for the patient is probably a two-level lumbar arthroplasty, and if he can get his Workers' Compensation reinstated since this originally dates back to a work injury, then maybe we can do a two-level lumbar arthroplasty, otherwise we will try to get him approved for an L4-L5 lumbar arthroplasty with an L5-S1 anterior lumbar interbody fusion.[90]

In the eight months between Rivero's last two consultations with Dr. Eule, Rivero had his deposition taken and continued to see Dr. Lonser for pain management.[91] Dr. Lonser performed an L4-5 interlaminar epidural steroid injection on February 23, 2011.[92] Rivero reported some, although not long lasting, pain relief from the injection.[93] Dr. Lonser prescribed a TENS[94] unit and physical therapy on April 11, 2011.[95]

At his deposition on October 13, 2010, Rivero described how his injury occurred on May 7, 2009: "There were some pipes, iron pipes. . . . I was carrying one. So you had to go through two frames. In that moment, I was passing but one of the pipes had like an elbow. . . . And so I hit the frame of the door. I didn't realize that I was going to hit the frame. I ran into the frame and fell. The pipe fell on my right shoulder and so I fell on the floor."[96] Rivero described feeling a "very sharp pain" in his shoulder

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89 R. 0911-12.

90 R. 0986.

91 R. 0915-16, 0922-25.

92 R. 0926-28.

93 R 0929-30.

94 TENS is an acronym which stands for transcutaneous electrical nerve stimulation. Taber's Cyclopedic Medical Dictionary (2009).

95 R. 0931-32.

96 Rivero Dep. 20:22–21:11, Oct. 13, 2010.

right after the incident but did not recall feeling pain anywhere else.[97] He believed that he also injured his low back in the May 2009 incident.[98] He testified, "I started complaining about my back from the end of May, beginning of June."[99] In terms of his current abilities, Rivero testified that he was able to drive a car but had difficulty holding the steering wheel with his right hand.[100] He also stated that he started using a cane sometimes in the winter after slipping and falling getting out of the car.[101]

Around this same time, Dr. Lonser also responded to letters from Rivero's attorney. On September 17, 2010, Dr. Lonser stated Rivero would be unable to work in any "heavy lifting" jobs due to his severe degenerative disc disease at L4-5 and L5-S1, which causes severe pain, and his significant shoulder pain. Dr. Lonser recommended retraining and thought Rivero would benefit from a functional analysis. Dr. Lonser marked "yes," to inquiries whether the May 7, 2009, work injury was the substantial cause of Rivero's need for the treatment being provided and the treatment was reasonable and necessary. Dr. Lonser commented that it "seems more likely than not, that his injury has at the very least complicated and/or worsened his pain."[102] On May 9, 2011, Dr. Lonser answered "yes" to a question of whether Rivero's shoulder pain could have masked his low back pain for the first month after his injury. However, Dr. Lonser elaborated that this was "unlikely, as the narcotic pain medications currently do not mask the pain."[103] Dr. Lonser and PA Jane Sonnenburg, who worked with Dr. Lonser, also agreed that Rivero's May 7, 2009, work injury was the substantial cause of his need for the injections to treat his low back condition.[104]

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97 Rivero Dep. 22:9-13.

98 Rivero Dep. 35:14-17.

99 Rivero Dep. 35:18-23.

100 Rivero Dep. 41:3-6.

101 Rivero Dep. 37:17-21.

102 R. 0913-14.

103 R. 0982.

104 R. 0983.

Coldfoot made two requests to cross-examine Dr. Lonser based on these two letters.[105] Dr. Lonser's deposition appears to have been scheduled for a date in early December 2011.[106] However, the board record contains no deposition transcript and no indication as to why the deposition was not conducted.

Meanwhile, Rivero continued to treat with Dr. Lonser for his chronic pain for the rest of 2011 and 2012.[107] On July 12, 2011, Rivero requested a repeat lumbar epidural steroid injection as it provided the most relief for his pain, and declined refills on his pain medications, explaining that he was hoping to reduce or eliminate the oral medications.[108] Dr. Lonser administered the L4-5 interlaminar epidural steroid injection two days later.[109] A month later, Rivero reported some improvement from the injection but asked for refills on his pain medications as he continued to suffer from constant, severe pain.[110] On September 15, 2011, and February 8, 2012, Rivero received L4-5 interlaminar epidural steroid injections.[111] Rivero also received monthly refills of his pain medications from Dr. Lonser's clinic from October 2011 through August 2012, other than in July 2012.[112]

On April 26, and May 23, 2012, Rivero's urine was tested for compliance with his medication regimen. Both times, his urine was negative for the opiates he was prescribed.[113] At a June 20, 2012, appointment, PA-C Sarah E. Bigelow tried to discuss Rivero's negative drug screens with him but their communication was limited due to the

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105 Exc. 117-18, 166-67.

106 R. 2512.

107 R. 0987-88, 1001-03, 1016-17, 1202-05, 1206-08, 1289-92.

108 R. 0987-88.

109 R. 0992-94.

110 R. 0995-96.

111 R. 1013-15, 2523-25.

112 R. 1330-34.

113 R. 1303, 1308-09.

lack of an interpreter.[114] At his next appointment in August 2012, he also did not bring an interpreter and was instructed to bring one next time.[115] Rivero testified that he took his medication correctly and he did not know why the drug screens were negative.[116]

There are no medical reports from Rivero's providers in the board record dated after August 2012. At the hearing on February 5, 2013, Rivero sought to introduce into evidence Dr. Lonser's chart notes from September 2012 through January 3, 2013. Rivero stated he was unaware of the deadline for filing evidence before a hearing.[117] Patterson had withdrawn as Rivero's attorney on August 31, 2012,[118] and no prehearing conferences were held after his withdrawal and before the hearing.[119] The board nevertheless excluded Dr. Lonser's chart notes from September 2012 to January 2013 because they were not timely filed before the hearing.[120]

Two Second Independent Medical Evaluations (SIMEs) were performed addressing Rivero's right shoulder and lower back conditions. Dr. John J. Lipon conducted an SIME on April 23, 2011, limited to Rivero's right shoulder condition.[121] Dr. Lipon wrote that Rivero "went to carry a pipe on his right shoulder . . . Rivero says he was carrying the heaviest pipe which had an elbow on it. As he was going through a doorframe, the elbow struck the doorframe. This caused him to fall down and the pipe

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114 R. 1320-21.

115 R. 1323-25.

116 Hr'g Tr. 60:18–61:13.

117 Hr'g Tr. 17:23-25. In response to Coldfoot's attorney's arguments that the records should be excluded as untimely, Rivero responded, "Nobody ever told me about all these things that you're talking about. If you had let me know, and . . . I don't speak English. Everything was sent to me in English." *See* 8 AAC 45.120, 8 AAC 45.052.

118 R. 0151.

119 The last prehearing conference before the February 2013 hearing was held on June 13, 2012. Patterson was in attendance. R. 4024.

120 *See Rivero*, Bd. Dec. No. 13-0108 at 42-45.

121 Exc. 119, 146.

fell on top of him, striking his right shoulder and the side of his neck." Rivero also mentioned a back condition but Dr. Lipon reminded him the examination was focused on his right shoulder condition.[122] Dr. Lipon concluded that the May 2009 work injury was the substantial cause of Rivero's shoulder condition.[123] He noted:

> There is some discrepancy as to the mechanism of injury. Initially in the emergency room[ ]reports of May 8 and May 12, 2009, he had been lifting heavy pipes and carrying heavy tubes. On May 18, 2009, he reported that one of the pipes fell and landed directly on top of his shoulder. Subsequent records support that the pipe did fall onto that right shoulder causing this industrial injury.[124]

Dr. Lipon concluded that Rivero needed no further formal medical treatment for his right shoulder and should continue in his self-directed home exercise program to maximize his range of motion and function.[125] Dr. Lipon also stated that Rivero was medically stable.[126] At his deposition, he testified that medical stability would have been reached at the latest as of November 2010, based on Dr. Hall indicating on January 21, 2010, that Rivero would not be able to work in some capacity full time for eight to ten months.[127] Dr. Lipon stated that Rivero could work "five days a week on a sustained basis as relates to his right shoulder condition. He would have restrictions for above shoulder level work and repetitive work with his right upper extremity. He most likely would fit best in a light work duty setting for his right shoulder condition."[128]

A second SIME was conducted on March 21, 2012,[129] because the earlier SIME did not address Rivero's low back pain. Dr. James F. Scoggin, III, obtained Rivero's

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122 Exc. 147.

123 Exc. 157.

124 Exc. 158.

125 Exc. 159.

126 Exc. 163. He did not specify a date at which Rivero reached medical stability.

127 Lipon Dep. 27:15–29:6, Oct. 20, 2011.

128 Exc. 162.

129 Exc. 245. The SIME report was dated April 4, 2012.

history of injury and treatment through an interpreter.[130] Rivero described to Dr. Scoggin that he was hurt when a heavy metal pipe that he was carrying on his right shoulder hit the frame of a door, causing him to fall against the frame of the door, twisting his back and feeling a "big pain" in his right shoulder. Rivero stated that when he went to the ER the next day, he had shoulder and back pain but that the shoulder pain was worse.[131] As of the SIME date, Dr. Scoggin noted that Rivero continued to experience pain in his right shoulder at a level of five out of ten, his neck at a level of five out of ten, and his back at a level of six out of ten. Rivero denied any injury to his right shoulder or neck prior to the May 2009 work injury. He also denied any back pain or injury and stated that he never saw a doctor for his back for any reason before the May 2009 injury.[132] Dr. Scoggin observed, "Rivero did not exhibit excessive pain behavior at the time of this examination and, in fact, was very cooperative."[133] Dr. Scoggin's diagnoses included right shoulder pain with rotator cuff tear attributed to the May 7, 2009, work injury; complaints of right-sided neck pain attributed to the May 7, 2009, work injury; and low back pain without radiculopathy not related to the May 7, 2009, work injury.[134] For the right shoulder and neck, Dr. Scoggin concluded that a home exercise program, including strengthening for his rotator cuff and stretching, was the only remaining treatment necessary.[135]

In deciding that the low back pain was not work-related, Dr. Scoggin relied on inconsistencies in the descriptions of how Rivero was injured, specifically in the ER the day after the injury, at the appointment with PA Love in Dr. Hall's office on May 18, 2009, and at the appointment with Dr. Eule on June 9, 2009.[136] These varied

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130 Exc. 246.

131 Exc. 246.

132 Exc. 247.

133 Exc. 313.

134 Exc. 313.

135 Exc. 321.

136 Exc. 315-16.

explanations were that lifting of a pipe caused the shoulder pain, a pipe falling on the shoulder caused the pain, and Rivero landed on his shoulder when he fell while carrying a pipe.[137]

Dr. Scoggin also inferred that Rivero had a history of low back pain because of three medical records.[138] The first record documented muscle spasms from weightlifting in 2005.[139] In the second record, Rivero complained of low back pain, along with a sore throat, fever, and upper respiratory symptoms, in the ER in May 2008.[140] In the third record, Rivero referred to an injury "years ago," rather than months ago, when he went to the emergency room for back pain and other complaints in September 2009.[141] Dr. Scoggin concluded that the back pain was "probably related to underlying degenerative conditions, and clearly unrelated to the 5/7/09 incident":

> He clearly had a prior history of low back pain, he is not documented to have injured his back as a result of the 5/7/09 injury, and the onset of the low back pain complaints does not correspond chronologically with his care for the 5/7/09 injury.
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> Mr. Rivero saw multiple practitioners following the 5/7/09 injury. . . . Certainly, if Mr. Rivero had back pain as a result of the 5/7/09 injury, it is medically improbable that these complaints would have been missed by four physicians, and a physician's assistant, all independently of one another.[142]

Moreover, Dr. Scoggin did not believe the shoulder pain would have masked the back pain for the first few weeks after the injury.[143] Dr. Scoggin also concluded there was no evidence the May 7, 2009, injury led to Rivero's lumbar degenerative disc disease becoming symptomatic. He cited the three medical records from which he inferred a

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137 Exc. 019, 026, 032.

138 Exc. 316.

139 R. 4283.

140 R. 2642, 2646-47.

141 R. 0755.

142 Exc. 316-17. The physicians he saw were Dr. Hanley on May 8, 2009, Dr. McCall on May 12, 2009, Dr. Hall on May 28, 2009, and Dr. Eule on June 9, 2009. Rivero saw PA Love on May 18, 2009.

143 Scoggin Dep. 28:3-5, Jan. 21, 2013.

history of low back pain, as well as "multiple practitioners hav[ing] indicated that what Mr. Rivero was demonstrating was related to symptom magnification."[144]

Dr. Scoggin testified that Rivero's shoulder injury would have been medically stable in approximately April 2010. "Following a rotator cuff repair in a laborer or someone who does heavy physical work, every individual is a little different, but I would generally say that medical stability is usually reached about eight months after that.[145] However, Dr. Scoggin agreed with Dr. Ballard that Rivero could be released to full time work as of January 23, 2010, as long as the work was light duty.[146]

In addition to medical and disability benefits, Rivero also sought reemployment benefits by amending his claim and sending a letter to the Reemployment Benefits Administrator (RBA) on May 4, 2011.[147] Later that month, the RBA notified the parties that reemployment benefits specialist Steve Coley (Coley) would conduct Rivero's reemployment benefits eligibility evaluation.[148]

Despite the use of an interpreter, Coley was unable to determine the name of Rivero's physician at AA Pain Clinic, referring to him as "Lance."[149] Coley determined that Dr. Eule was the current primary physician,[150] and addressed a letter to him on June 9, 2011, requesting his opinion on Rivero's impairment and his physical ability to perform specified jobs.[151]

Dr. Eule predicted that Rivero would have a permanent impairment.[152] Dr. Eule indicated that Rivero could not perform the jobs that he had held in the past 10 years, which were described as Construction Worker II, Truck Driver, Commercial or

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144 Exc. 319.

145 Scoggin Dep. 18:12-21.

146 Scoggin Dep. 19:13–20:4.

147 R. 0105-06, 4029.

148 Exc. 168-69.

149 R. 4667-68.

150 R. 4668.

151 Exc. 170-71.

152 Exc. 170.

Institutional Cleaner, Machine Washer, and Cook Helper.[153] Because Rivero had experience as a barber, Dr. Eule checked both "yes" and "no" to the question of whether Rivero would be able to perform the physical demands of the job. He explained: "He may have trouble standing for extended time."[154]

On August 28, 2011, Coley recommended that Rivero be found eligible for reemployment benefits.[155] Coley relied on Dr. Eule's opinion about Rivero's capabilities as well as a prediction by Dr. Lipon that Rivero could not return to any of the jobs that he held in the 10 years before his work injury.[156] Dr. Lipon, who conducted the SIME limited to Rivero's right shoulder condition, disapproved seven jobs in Rivero's 10-year work history (Asbestos Removal Technician, Washer, Machinist, Driver, Sales Route Worker, Janitor, and Kitchen Helper) because the jobs were in the light-medium to heavy classification and required above shoulder-level or repetitive work with the right arm.[157] Dr. Lipon also disapproved the barber job. He testified that Rivero would not be able to perform the job because "there's constant movement of the arms and often having to get in awkward positions to use scissors or the shaver or washing hair. I don't – it's my opinion he would not be able to do this because of that repetitive activity required."[158]

On October 13, 2011, RBA designee Deborah Torgerson (Torgerson) found Rivero eligible for reemployment benefits based on Coley's evaluation. In a footnote, she explained that although Dr. Eule checked both the "yes" and "no" boxes on the job description for barber, his notation about Rivero's difficulty standing for long periods was a prediction that Rivero would not have the permanent physical capacities to work as a barber. Torgerson also noted that because Rivero worked as a barber in another

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153 Exc. 172-79.

154 Exc. 180.

155 R. 4667-73.

156 R. 4668, 4672-73.

157 Exc. 161.

158 Lipon Dep. 37:6-14.

country, he had not received the training required to get a license to perform the job in the U.S.[159]

Coldfoot sought review of the designee's eligibility determination on October 17, 2011.[160] Coldfoot's expert, Dr. Ballard, had concluded in his second EME report on January 23, 2010, that, on an objective basis, Rivero could return to his regular job at the time of injury without restrictions but that because of psychological factors he would probably never return to that type of work.[161] Dr. Ballard testified that Rivero should be able to return to heavy-duty work with no restrictions because, in terms of both his shoulder and lower back, there were no objective findings to suggest otherwise.[162] Dr. Ballard also testified that he was capable of working any medium-duty or light-duty job, including as a barber.[163] Coley's eligibility evaluation mentioned the conclusions in Dr. Ballard's report.[164]

Five months after the eligibility determination, Dr. Scoggin agreed that Rivero was unable to return to his heavy-duty job at the time of injury due to the May 7, 2009, shoulder injury.[165] Dr. Scoggin concluded that Rivero was capable of performing only light-duty work. He stated that Rivero's low back condition, which was not work-related in Dr. Scoggin's opinion, was the "main limiting factor" in his ability to work but that "he may still have some limitations due to his shoulder."[166] Dr. Scoggin also reviewed the job description for barber and approved it on a full-time basis.[167]

Coldfoot paid Rivero TTD benefits from May 18, 2009, to January 22, 2010, a lump sum representing 2% permanent partial impairment (PPI) in the amount of

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159 Exc. 182-83.

160 Exc. 184-85.

161 Exc. 091.

162 Ballard Dep. 21:20–22:5 (shoulder), 35:3-5 (low back).

163 Ballard Dep. 21:6-11, 35:11-17.

164 R. 4668.

165 Exc. 323.

166 Exc. 323.

167 Scoggin Dep. 21:5-9.

$3,540.00 on January 28, 2010, biweekly PPI for the remaining $8,850.00 of his 7% PPI, and AS 23.30.041(k) stipend benefits from October 19, 2011, to January 31, 2012.[168]

At the hearing, Rivero requested a different interpreter because the first one was "not translating good the words."[169] Coldfoot agreed to the change because the interpreter Rivero wanted was also present.[170] Rivero testified providers did not understand his reports to them because the interpreters did not always properly interpret his Spanish dialect.[171] The interpreter testified, however, that Cuban was "not a dialect. . . . It's just an accent."[172] Rivero also argued that communications problems occurred as a result of poorly qualified interpreters. "Anybody thinks that if they can speak English and Spanish, they can interpret, and that's not like that," he said.[173]

The board majority observed that "[c]ultural differences between a medical provider and patient can increase the risk of the medical provider misinterpreting a patient's responses and physical cues. . . . The AMA *Guides* also require evaluators to . . . be aware of the quality of interpreters used in medical appointments, including those used when recording a patient's medical history."[174] Nevertheless, the board majority concluded that Rivero was not credible, "particularly in his symptoms and exertional limit reports to medical providers."[175] The majority stated, "In most instances, an interpreter was present when [Rivero] provided his history. Accounts are markedly different. Language issues could not have accounted for these

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168 R. 0032, 0045, 0048.

169 Hr'g Tr. 4:16-17.

170 Hr'g Tr. 4:24–25:2.

171 Hr'g Tr. 120:25–121:10.

172 Hr'g Tr. 120:9-11.

173 Hr'g Tr. 115:2-4.

174 *Rivero*, Bd. Dec. No.13-0108 at 33.

175 *Id.* at 34.

differences."[176] The board majority also inferred that Rivero was not credible based on his unexplained negative drug screens.[177] From the negative screens, the majority inferred that Rivero was not taking his medication and that if he had, his symptoms might have been controlled sufficiently so that he could return to work.[178]

The majority concluded that Rivero's low back condition was not work-related, relying on Rivero's lack of credibility and the medical opinions of Drs. Scoggin, Gevaert, Hall, Eule, and Ballard. The majority noted Rivero's inconsistent injury descriptions, his late reporting of back pain five weeks after the injury, and his subjective pain complaints not matching objective findings.[179] The majority also concluded that Rivero was not entitled to further TTD benefits because it agreed with Dr. Ballard's opinion that his shoulder was medically stable as of January 22, 2010.[180]

The board majority reversed and remanded the RBA designee's decision that Rivero was eligible for reemployment benefits. The majority decided that its credibility determination and Dr. Scoggin's opinion that Rivero could work as a barber were newly discovered evidence not available to the specialist and RBA designee when they rendered their eligibility decisions.[181] The board stated: "Employee is not credible and physicians who support his position have unwittingly relied upon his statements concerning his symptoms and his exertional limitations. Thus, their opinions are tainted and unreliable."[182] The majority also observed that the reemployment specialist and RBA designee could not rely on opinions from medical providers who were evaluating

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176 *Rivero*, Bd. Dec. No.13-0108 at 49.

177 *See id.* at 49-50.

178 *See id.* at 50.

179 *See id.* at 45.

180 *See id.* at 46-47. However, Dr. Ballard found that Rivero was medically stable as of "January 23, 20010 [*sic*]." Exc. 091.

181 *See id.* at 50.

182 *Id.* at 48-49. Although the board did not explicitly say so in its decision, this was apparently a reference to Dr. Lipon's opinion. He disapproved the barber position due to Rivero's shoulder injury. Lipon Dep. 37:6-14.

Rivero's ability to work based on his low back condition that was not work-related.[183] Furthermore, the board majority noted that nothing in the statute or the regulation required considering whether Rivero was licensed as a barber in the United States.[184] The majority denied an award of interest because Rivero was not entitled to any additional benefits.[185]

After the hearing, Rivero filed a transportation log claiming 2,360 miles in medical-related transportation costs. He claimed 20 miles each for the Providence ER visits on May 8, and 12, 2009; 500 miles for orthopedic visits from May 18, 2009, to 2010; 400 miles for 10 physical therapy appointments; and 1,440 miles for visits to AA Pain Clinic between February 2010 and February 2013. There is no certificate of service on the log showing it was served on Coldfoot.[186] The board denied Rivero's claim for transportation costs because the log was not specific enough and Rivero had been given opportunities to submit an accurate log, including during the period when he was represented by an attorney and another chance when the chair left the record open following the hearing.[187]

The board chair dissented from the majority decision. She would have found Rivero's low back condition compensable, relying on Dr. Lonser's, Dr. Imbriani's, and PA Sonnenburg's opinions; the absence of records documenting back pain before Rivero's May 2009 work injury; and her contrary conclusion that Rivero was credible.[188] She rejected Dr. Scoggin's piecing together of three medical records to assert a history of low back pain: "[I]f Employee had a history of lumbar back pain working as he did

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183 *See Rivero*, Bd. Dec. No.13-0108 at 48-49. Although the board did not explicitly say so, this was apparently a reference to Dr. Eule's opinion that Rivero would have difficulty working as a barber because he might not be able to stand for long periods due to his back condition. Exc. 180.

184 *See id.* at 49.

185 *Id.* at 50.

186 R. 4028.

187 *Rivero*, Bd. Dec. No. 13-0108 at 50-51.

188 *See id.* at 53 (dissenting opinion).

in heavy to very heavy jobs, there would have been many more records of unambiguous treatment for his lumbar spine complaints to support the assertion."[189] She also observed that it was "not unusual for the character and intensity of work injuries to change over time" and that Rivero was initially most concerned about his shoulder.[190] Furthermore, she believed Rivero was credible, noting that using certain interpreters, such as untrained family members and office staff, might lead to interpretation errors,[191] and that cultural differences could account for Rivero's subjective reporting of his pain levels.[192] She also concluded that the majority's inferences that Rivero was faking his pain and diverting his pain medication were not supported by substantial evidence because urinalysis can produce false negatives based on the "timing of the test, metabolism of the patient, or the amount of fluid intake of the patient."[193] In addition, she observed that Rivero was taking his medication "as needed for pain, not at prescribed intervals," so it was possible he did not take any medication before the drug screens.[194] The dissent also concluded that Rivero's right shoulder was medically stable as of April 23, 2011, the date of Dr. Lipon's examination, and Rivero was therefore entitled to TTD from January 23, 2010, through that date.[195]

Lastly, she concluded that substantial evidence supported the RBA designee's decision and that decision should be affirmed. She thought that Dr. Scoggin's opinion that Rivero could return to work as a barber was limited to his lower back and thus, did not contradict Dr. Lipon's opinion that Rivero's shoulder injury would preclude him working as a barber.[196] She further observed that both Dr. Scoggin and Dr. Lipon

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189 *See Rivero*, Bd. Dec. No. 13-0108 at 54 (dissenting opinion).

190 *See id.* (dissenting opinion).

191 *See id.* at 53-54 (dissenting opinion).

192 *See id.* at 55-56 (dissenting opinion).

193 *Id.* at 60 (dissenting opinion).

194 *See id.* at 61 (dissenting opinion).

195 *Id.* at 57 (dissenting opinion).

196 *Id.* at 61 (dissenting opinion).

reviewed Dr. Ballard's report, and she disputed the validity of Dr. Ballard's opinion because his role was not to determine credibility and he mischaracterized the surveillance video.[197]

Rivero appeals.

3. Standard of review.

The commission must accept the board's credibility determinations and the board's assignment of weight to the evidence.[198] Our role is to evaluate whether substantial evidence in light of the whole record supports the board's findings of fact.[199] We exercise our independent judgment when reviewing questions of law and procedure.[200] A decision of the RBA designee is subject to review under the abuse of discretion standard.[201]

4. Applicable law.

a. Statutes and regulations.

> **AS 23.30.041. Rehabilitation and reemployment of injured workers.**
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> (a) The director shall select and employ a reemployment benefits administrator. . . .
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> . . .
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> (c) An employee and an employer may stipulate to the employee's eligibility for reemployment benefits at any time. If an employee suffers a compensable injury and, as a result of the injury, the employee is totally unable, for 45 consecutive days, to return to the employee's employment at the time of injury, the administrator shall notify the employee of the employee's rights under this section within 14 days after the 45th day. If the employee is totally unable to return to the employee's employment for 60 consecutive days as a result of the injury, the employee or employer may request an eligibility evaluation. The administrator may approve the request if the employee's injury may permanently preclude the employee's

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197 *See Rivero*, Bd. Dec. No. 13-0108 at 59-60 (dissenting opinion).

198 *See* AS 23.30.122; AS 23.30.128(b).

199 AS 23.30.128(b).

200 *See id*.

201 *See, e.g., Irvine v. Glacier General Const.*, 984 P.2d 1103, 1107 (Alaska 1999).

return to the employee's occupation at the time of the injury. If the employee is totally unable to return to the employee's employment at the time of the injury for 90 consecutive days as a result of the injury, the administrator shall, without a request, order an eligibility evaluation unless a stipulation of eligibility was submitted. If the administrator approves a request or orders an evaluation, the administrator shall, on a rotating and geographic basis, select a rehabilitation specialist from the list maintained under (b)(6) of this section to perform the eligibility evaluation. If the person that employs a rehabilitation specialist selected by the administrator to perform an eligibility evaluation under this subsection is performing any other work on the same workers' compensation claim involving the injured employee, the administrator shall select a different rehabilitation specialist.

(d) Within 30 days after the referral by the administrator, the rehabilitation specialist shall perform the eligibility evaluation and issue a report of findings. The administrator may grant up to an additional 30 days for performance of the eligibility evaluation upon notification of unusual and extenuating circumstances and the rehabilitation specialist's request. Within 14 days after receipt of the report from the rehabilitation specialist, the administrator shall notify the parties of the employee's eligibility for reemployment preparation benefits. Within 10 days after the decision, either party may seek review of the decision by requesting a hearing under AS 23.30.110. The hearing shall be held within 30 days after it is requested. The board shall uphold the decision of the administrator except for abuse of discretion on the administrator's part.

(e) An employee shall be eligible for benefits under this section upon the employee's written request and by having a physician predict that the employee will have permanent physical capacities that are less than the physical demands of the employee's job as described in the 1993 edition of the United States Department of Labor's "Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles" for

(1) the employee's job at the time of injury; or

(2) other jobs that exist in the labor market that the employee has held or received training for within 10 years before the injury or that the employee has held following the injury for a period long enough to obtain the skills to compete in the labor market, according to specific vocational preparation codes as described in the 1993 edition of the United States Department of Labor's "Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles."

. . .

(h) Within 90 days after the rehabilitation specialist's selection under (g) of this section, the reemployment plan must be formulated and approved.

The reemployment plan must require continuous participation by the employee and must maximize the usage of the employee's transferrable skills. The reemployment plan must include at least the following:

(1) a determination of the occupational goal in the labor market;

(2) an inventory of the employee's technical skills, transferrable skills, physical and intellectual capacities, academic achievement, emotional condition, and family support;

(3) a plan to acquire the occupational skills to be employable;

(4) the cost estimate of the reemployment plan, including provider fees; and the cost of tuition, books, tools, and supplies, transportation, temporary lodging, or job modification devices;

(5) the estimated length of time that the plan will take;

(6) the date that the plan will commence;

(7) the estimated time of medical stability as predicted by a treating physician or by a physician who has examined the employee at the request of the employer or the board, or by referral of the treating physician;

(8) a detailed description and plan schedule;

(9) a finding by the rehabilitation specialist that the inventory under (2) of this subsection indicates that the employee can be reasonably expected to satisfactorily complete the plan and perform in a new occupation within the time and cost limitations of the plan; and

(10) a provision requiring that, after a person has been assigned to perform medical management services for an injured employee, the person shall send written notice to the employee, the employer, and the employee's physician explaining in what capacity the person is employed, whom the person represents, and the scope of the services to be provided.

AS 23.30.122. Credibility of witnesses.

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

AS 23.30.128. Commission proceedings.

. . .

(b) The commission may review discretionary actions, findings of fact, and conclusions of law by the board in hearing, determining, or otherwise acting on a compensation claim or petition. The board's findings regarding the credibility of testimony of a witness before the board are binding on the commission. The board's findings of fact shall be upheld by the commission if supported by substantial evidence in light of the whole record. In reviewing questions of law and procedure, the commission shall exercise its independent judgment.

. . .

AS 23.30.185. Compensation for temporary total disability.

In case of disability total in character but temporary in quality, 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the disability. Temporary total disability benefits may not be paid for any period of disability occurring after the date of medical stability.

AS 23.30.395. Definitions. In this chapter,

. . .

(27) "medical stability" means the date after which further objectively measurable improvement from the effects of the compensable injury is not reasonably expected to result from additional medical care or treatment, notwithstanding the possible need for additional medical care or the possibility of improvement or deterioration resulting from the passage of time; medical stability shall be presumed in the absence of objectively measurable improvement for a period of 45 days; this presumption may be rebutted by clear and convincing evidence[.]

. . .

8 AAC 45.070. Hearings.

. . .

(b) Except as provided in this section and 8 AAC 45.074(c), a hearing will not be scheduled unless a claim or petition has been filed, and an affidavit of readiness for hearing has been filed and that affidavit is not returned by the board or designee nor is the affidavit the basis for scheduling a hearing that is cancelled or continued under 8 AAC 45.074(b). The board has available an Affidavit of Readiness for Hearing form that a party may complete and file. The board or its designee will return an affidavit of readiness for hearing, and a hearing will not be set if the affidavit lacks proof of service upon all other parties, or if the affiant fails to state that

the party has completed all necessary discovery, has all the necessary evidence, and is fully prepared for the hearing.

(1) A hearing is requested by using the following procedures:

(A) For review of an administrator's decision issued under AS 23.30.041(d), a party shall file a claim or petition asking for review of the administrator's decision and an affidavit of readiness for hearing. The affidavit of readiness for hearing may be filed at the same time as the claim or petition. In reviewing the administrator's decision, the board may not consider evidence that was not available to the administrator at the time of the administrator's decision unless the board determines the evidence is newly discovered and could not with due diligence have been produced for the administrator's consideration.

b. The presumption of compensability.

In *Runstrom v. Alaska Native Medical Center*,[202] the commission had the opportunity to discuss the presumption of compensability, as it was formulated both before and after the 2005 amendments to the Alaska Workers' Compensation Act.

> As the commission has observed, prior to the 2005 amendments to the Act, case law required that employment be "a substantial factor" in causing the employee's disability, need for medical treatment, etc. . . . Under AS 23.30.010(a), as has always been required of the employee under the presumption of compensability analysis, to attach the presumption, the employee must first establish "a causal link" between employment and his or her disability, need for medical treatment, etc. . . .
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> . . .
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> As for the second step of the analysis, to rebut the presumption under former law, the employer's substantial evidence had to either (1) provide an alternative explanation which, if accepted, would exclude work-related factors as a substantial cause of the injury, etc.; or (2) directly eliminate any reasonable possibility that employment was a factor in causing the injury, etc. . .
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> . . .
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> If the employer successfully rebuts the presumption, under former law, the supreme court consistently held that in the third step of the analysis, 1) the presumption dropped out, and 2) the employee was required to

[202] Alaska Workers' Comp. App. Comm'n Dec. No. 150 (Mar. 25, 2011); the Alaska Supreme Court (supreme court) affirmed, 280 P.3d 567 (Alaska 2012).

prove all elements of his or her claim by a preponderance of the evidence.[203]

5. Discussion.

a. The commission is required by law to defer to the board's witness credibility and weight findings.

While the dissent may have the latitude to disagree with the board majority's witness credibility and testimonial weight findings,[204] the commission's hands are tied. Under AS 23.30.128(b), the board's, or in this case the board majority's, "*findings regarding the credibility of testimony* of a witness before the board *are binding on the commission*."[205] Furthermore, "*[a] finding by the board concerning the weight to be accorded a witness's testimony*, including medical testimony and reports, *is conclusive* even if the evidence is conflicting or susceptible to contrary conclusions."[206] The commission is not aware of any source of law which carves out an exception to these statutory directives. As we said in another matter, "had the Alaska legislature intended there to be exceptions, we assume they would have been stated in the statute or elsewhere."[207] Moreover, no judicially-created exception to them has been brought to our attention. Consequently, we must accept the board majority's witness credibility and testimonial weight findings.

Probably the most critical credibility finding by the board majority was that it found Rivero not credible.[208] As support for this finding, the majority noted that Rivero was not credible in terms of accurately reporting to his medical providers or evaluators 1) his medical history relative to his low back, and 2) his symptoms, both in terms of

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203 *Runstrom*, App. Comm'n Dec. No. 150 at 5-7 (footnotes omitted).

204 *See Rivero*, Bd. Dec. No. 13-0108 at 53-61 (dissenting opinion).

205 AS 23.30.128(b) (italics added).

206 AS 23.30.122.

207 *Dillard v. Dick Pacific/Ghemm Co.*, Alaska Workers' Comp. App. Comm'n Dec. No. 198 at 21 (July 16, 2014).

208 *See Rivero*, Bd. Dec. No. 13-0108 at 45.

their timing and severity.[209] Furthermore, unlike the dissent, the majority was not troubled by the quality, or lack thereof, of the translations of communications between Rivero and his medical providers/evaluators. It found that an interpreter was present on most occasions when Rivero was providing his medical history, and that even though their translations resulted in differing versions of that history, the translation issues could not have accounted for the discrepancies in his history.[210]

As further support for its credibility finding with respect to Rivero, the board majority inferred that Rivero was not credible based on his lack of a plausible explanation for his negative drug screens.[211] The majority concluded that Rivero was not taking his medication and that if he had, his symptoms might have been controlled sufficiently so that he could return to work.[212] The dissent countered:

> [T]he majority's assertion [Rivero] was faking his pain or diverting his pain medication was not supported by substantial evidence. The majority reaches this conclusion because no scientific reason was offered to explain the two negative urinalysis tests for opioids [Rivero] was prescribed for his pain; however the majority conclusion fails to consider the basic science behind common false negatives in urinalysis. As one example, urinalysis for semisynthetic opioids, such as hydrocodone like [Rivero] was taking, often produce false negatives based on the timing of the test, metabolism of the patient, or the amount of fluid intake of the patient. The majority also fails to consider that the two urinalyses which showed no hydrocodone were conducted after [Rivero] was diagnosed with diabetes, his blood sugar was under control, which was when he was reporting better pain control. At that time, he was taking the hydrocodone as needed for pain, not at prescribed intervals. He was also required to drive to the doctor's office, so it is possible he did not take any prior to his appointment for the safety of himself, his family, and others on the roadway. Indeed, the fact Dr. Lonser and his colleagues continued to treat [Rivero] and provide pain medications after the two negative urinalyses, instead of dismissing him from care, is further indication the

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209 *See Rivero*, Bd. Dec. No.13-0108 at 34.

210 *See id*. at 49.

211 *See id.* at 49-50.

212 *See id.* at 50.

urinalyses were explained and not substantial evidence of drug diversion.[213]

The commission rejects the dissent's explanation for Rivero's failed drug screens, for the following reasons. First, the principle is well-established that "[t]he [b]oard may base its decision not only on direct testimony, medical findings, and other tangible evidence, but also on the [b]oard's experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above."[214] Nevertheless, the commission believes the board's, or a board member's, experience and judgment are no substitute for evidence *in the record*. Here, there was no record evidence regarding the accuracy of the drug screens. That so-called "evidence" was introduced in the dissenting opinion. Second, contrary to Rivero's testimony that he was taking his medication, the dissent speculates that he was not taking his medication before driving to doctors' appointments out of a concern for everyone's safety. Third, the dissent again speculated as to the reasons why Dr. Lonser did not dismiss Rivero from treatment following the two failed drug screens. Because the board majority's finding with respect to Rivero's credibility is binding on the commission, and given the substantial evidentiary support in the record for its finding that he was not credible, we concur in the majority's finding.

The board majority also found that the medical opinions of Drs. Scoggin, Gevaert, Hall, Eule, and Ballard, were credible and entitled to the most weight.[215] Again, these credibility findings are binding on the commission and the weight finding is conclusive. Moreover, when the board is faced with conflicting medical opinions that are supported by substantial evidence, it may rely on one opinion rather than the other.[216] Here, the board majority chose to assign more weight to and rely more heavily on evidence from the aforementioned providers/evaluators rather than the

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213 *Rivero*, Bd. Dec. No.13-0108 at 60-61 (dissenting opinion).

214 *Fairbanks North Star Borough v. Rogers and Babler*, 747 P.2d 528, 533-34 (Alaska 1987) (citations omitted).

215 *See Rivero*, Bd. Dec. No. 13-0108 at 45.

216 *See Yahara v. Construction & Rigging, Inc.*, 851 P.2d 69 (Alaska 1993).

opinions of Dr. Lonser, Dr. Imbriani, and PA Sonnenburg, especially in terms of the compensability of Rivero's lower back. The commission is obligated by law to do likewise.

b. Was Rivero's low back claim compensable?

The board majority applied the presumption of compensability analysis to the factual dispute whether the May 7, 2009, incident was the substantial cause of Rivero's need for treatment for his low back.[217] It ruled that Rivero attached the presumption and Coldfoot rebutted it.[218] We concur. The majority held that Rivero had to, but did not, prove the compensability of his low back claim by a preponderance of the evidence.[219] The commission agrees with this finding as well, as it is supported by substantial evidence.

According to the board majority, the evidence supporting noncompensability consisted of the opinions of Drs. Scoggin, Gevaert, Hall, Eule, and Ballard, to which the majority attached greater weight, Rivero's lack of credibility, his pain behavior, which was out of proportion to the objective findings, his inconsistency in describing the injury and how it occurred, and the delay in his reporting that he injured his low back.[220] The dissent would have ruled that the low back was compensable, based on 1) the paucity of records for prior treatment of the low back, 2) Rivero's credible, consistent testimony regarding the mechanism of injury and the lack of preexisting lumbar pathology, and 3) the opinions of Drs. Lonser and Imbriani and PA Sonnenburg.[221]

Again, the commission must accept that, consistent with the majority's findings, Rivero was not credible, Drs. Scoggin, Gevaert, Hall, Eule, and Ballard, were credible, and their evidence was entitled to more weight than the evidence provided by Drs. Lonser and Imbriani and PA Sonnenburg. These findings, standing alone, compel

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217 *See Rivero*, Bd. Dec. No. 13-0108 at 45.

218 *See id*.

219 *See id.* at 45.

220 *See id*.

221 *See id*. at 53-54 (dissenting opinion).

the conclusion that Rivero's low back condition is not compensable. Also, unlike the dissent, we are not willing to downgrade the persuasive value of Drs. Scoggin's and Gevaert's opinions based on supposed discrepancies in the translation of Rivero's statements to them and vice-versa.

The commission affirms the board majority's holding that Rivero's low back condition is not compensable.

c. When was Rivero medically stable, after which he was ineligible for TTD benefits?

First, the board majority cited AS 23.30.185 for the proposition that "TTD benefits are payable during periods of work-related total disability through the date of medical stability."[222] Second, having found Rivero's low back claim was not compensable, the majority noted that only his shoulder injury would entitle him to TTD benefits.[223] Third, the majority applied the presumption of compensability analysis to the factual dispute concerning the date Rivero was medically stable in terms of his shoulder.[224] Fourth, the majority found that Rivero attached the presumption that he is entitled to additional TTD benefits through the opinions of Drs. Lipon, Scoggin, and Hall, that Coldfoot rebutted the presumption through the opinion of Dr. Ballard, and that Rivero would have to prove his TTD claim by a preponderance of the evidence.[225] The commission concurs with these statements from and findings by the board majority.

Pivotal to the board majority's analysis is its observation that the "definition of medical stability . . . requires a determination of 'the date' after which further objectively measurable improvement from the effects of [Rivero]'s work related shoulder injury were not reasonably expected to result from additional medical care or

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222 *Rivero*, Bd. Dec. No. 13-0108 at 46.

223 *See id*.

224 *See id*.

225 *See id*.

treatment[.]"[226] It pointed out that neither Dr. Lipon nor Dr. Scoggin provided a date when Rivero's shoulder injury was medically stable, whereas Dr. Ballard said he was medically stable as of January 22, 2010,[227] approximately six months after Dr. Hall performed shoulder surgery on August 11, 2009. This evidence of medical stability was found credible and given greater weight by the majority.[228] The dissent maintains that the opinions of Drs. Lipon and Scoggin are the most credible on this issue,[229] a finding with which the commission cannot agree, given the restrictions that AS 23.30.122 and .128(b) place on our review of the board's credibility and weight findings.

We affirm the board majority's holding that Rivero was medically stable as of January 22, 2010. Therefore, Rivero is not entitled to additional TTD benefits.

d. Was Rivero entitled to reemployment benefits?

The RBA designee decided Rivero was eligible for reemployment benefits. A decision of the RBA designee is reviewed under the abuse of discretion standard.[230] An abuse of discretion occurs when the decision 1) is arbitrary, capricious, manifestly unreasonable, or stems from an improper motive, or 2) fails to apply controlling law, or fails to exercise sound legal discretion.[231] The board majority found that the RBA designee did not abuse her discretion in either of these respects. Rather, the majority decided that its finding that Rivero was not credible and Dr. Scoggin's opinion that Rivero could work as a barber were newly discovered evidence which, under 8 AAC 45.070(b)(1)(A), the board could consider in rendering its reemployment benefits

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226 *Rivero*, Bd. Dec. No.13-0108 at 46.

227 *See id*.

228 *See id.* at 47.

229 Specifically, Dr. Lipon's opinion was based on Rivero reporting to him on April 23, 2011, that in spite of treatment, there had been no change in his condition since the date of injury. Dr. Scoggin concurred. *See id*. at 57 (dissenting opinion).

230 *See, e.g., Irvine v. Glacier General Const.*, 984 P.2d 1103, 1107 (Alaska 1999).

231 *See Manthey v. Collier*, 367 P.2d 884 (Alaska 1962).

eligibility determination.[232] On these bases, the majority reversed the decision and remanded the matter to the RBA designee with instructions to determine Rivero's "eligibility for reemployment benefits in accord with [its] decision."[233]

The commission concludes that the board majority's reversal and remand of the RBA designee's finding that Rivero was eligible for reemployment benefits ought to be vacated and the issue remanded to the board so that Rivero's eligibility for reemployment benefits can be revisited, for the following reasons. First, we question whether the board majority's finding that Rivero was not credible is newly discovered "evidence," within the meaning of 8 AAC 45.070(b)(1)(A), such that it opens the door to the majority deciding Rivero's reemployment benefits eligibility utilizing credibility as a criterion. Because "the board has the *sole* power to determine the credibility of a witness[,]"[234] arguably neither the reemployment benefits specialist nor the RBA designee should pass judgment on the credibility of an employee when determining eligibility for reemployment benefits. And as the dissent pointed out, it is the board's responsibility to make credibility decisions; others should not usurp that function.[235] Consequently, in the commission's view, Rivero's credibility was not an appropriate consideration on which the board majority should have expanded its inquiry and reversed the RBA designee's reemployment benefits eligibility determination.

Second, the board majority also found Dr. Scoggin's opinion that Rivero could work as a barber, stated in his deposition, to be newly discovered evidence which influenced its decision to reverse the RBA designee's eligibility determination. However, even though it may be deemed newly discovered evidence, was it substantial evidence that Rivero could work as a barber, thus making him ineligible for reemployment benefits? We think not. In the first place, Dr. Lipon, not Dr. Scoggin, was tasked with performing an SIME of Rivero's shoulder. Dr. Scoggin's role was to evaluate Rivero's

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232 *See Rivero*, Bd. Dec. No. 13-0108 at 50.

233 *Rivero,* Bd. Dec. No. 13-0108 at 50.

234 AS 23.30.122.

235 *See Rivero*, Bd. Dec. No. 13-0108 at 59-60 (dissenting opinion).

back. Second, Dr. Eule, who, together with Dr. Hall, was involved in the treatment of Rivero's shoulder, thought that Rivero's ability to stand would affect his work as a barber. Thus, he responded both "yes" and "no" to the rehabilitation specialist's inquiry in that respect. It would be reasonable to infer that Rivero's ability to stand was a product of his low back condition, which was not compensable, not his shoulder, which was. Therefore, Dr. Eule's equivocal answer to the question whether Rivero could work as a barber is understandable. Dr. Lipon's opinion, on the other hand, was unequivocal. In disapproving the barber job, he testified that Rivero would not be able to perform the job because "there's constant movement of the arms and often having to get in awkward positions to use scissors or the shaver or washing hair. I don't – it's my opinion, he would not be able to do this because of that repetitive activity required."[236]

The board majority's reversal of the RBA designee's determination that Rivero is eligible for reemployment benefits is vacated. We remand the issue of Rivero's reemployment benefits eligibility to the board.

e. Was Rivero entitled to interest or transportation costs?

The board majority disallowed awards of interest or transportation costs.[237] The denial of interest was premised on the majority's holding that Rivero was not entitled to additional benefits. Since there were no benefits that were not paid when due, there is no principal amount against which interest could be calculated. The commission concurs. As for transportation costs, they were denied by the majority owing to Rivero's initial failure to provide a transportation log at the hearing and subsequent failure to produce a log that was specific enough to support an award of transportation costs. We agree with the majority in this respect as well.

6. Conclusion.

The commission AFFIRMS the board majority's decision in all respects except its reversal of the reemployment benefits eligibility determination. We VACATE the

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236 Lipon Dep. 37:6-14.

237 *See Rivero*, Bd. Dec. No. 13-0108 at 50.

majority's decision and REMAND the issue of Rivero's reemployment benefits eligibility to the board for further proceedings consistent with this opinion.

Date: ___*1 October 2014*_____ ALASKA WORKERS' COMPENSATION APPEALS COMMISSION

Signed
James N. Rhodes, Appeals Commissioner

Signed
Philip E. Ulmer, Appeals Commissioner

Signed
Laurence Keyes, Chair

This is a final decision on the merits of this appeal as to the appeals commission's affirmation of the board's decision in part. This is a non-final decision as to the appeals commission's remand of the matter in part to the board. The final decision portion of this decision becomes effective when distributed (mailed) unless proceedings to 1) reconsider the final decision portion are instituted (started), pursuant to AS 23.30.128(f) and 8 AAC 57.230, or 2) unless proceedings to appeal the final decision portion to the Alaska Supreme Court, pursuant to AS 23.30.129(a) are instituted. See Reconsideration and Appeal Procedures sections below.

The non-final portion of this decision becomes effective when distributed (mailed) unless proceedings to petition for review to the Alaska Supreme Court, pursuant to AS 23.30.129(a) and Rules of Appellate Procedure 401-403 are instituted. See Petition for Review section below.

To see the date of distribution look at the box below.

RECONSIDERATION

A party may request the commission to reconsider this decision as to the final decision portion by filing a motion for reconsideration. AS 23.30.128(e) and 8 AAC 57.230. The motion for reconsideration must be filed with the commission no later than 30 days after the day this decision is distributed (mailed) to the parties. If a request for reconsideration of a final decision is filed on time with the commission, any proceedings to appeal must be instituted within 30 days after the reconsideration decision is mailed to the parties, or, if the commission does not issue an order for reconsideration, within 60 days after the date this decision is mailed to the parties, whichever is earlier. AS 23.30.128(f).

APPEAL PROCEDURES

The commission's final decision portion becomes effective when distributed unless proceedings to appeal to the Alaska Supreme Court are instituted (started). Proceedings to appeal this decision must be instituted (started) in the Alaska Supreme Court no later than 30 days after the date this final decision is distributed[238] and be brought by a party-in-interest against all other parties to the proceedings before the commission, as provided by the Alaska Rules of Appellate Procedure. *See* AS 23.30.129(a). The appeals commission and the workers' compensation board are not parties.

You may wish to consider consulting with legal counsel before filing an appeal. If you wish to appeal to the Alaska Supreme Court, you should contact the Alaska Appellate Courts *immediately*:

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

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

PETITION FOR REVIEW PROCEDURES

A party may petition the Alaska Supreme Court for review of that portion of the commission's decision that is non-final. AS 23.30.129(a) and Rules of Appellate Procedure 401-403. The petition for review must be filed with the Alaska Supreme Court no later than 10 days after the date this decision is distributed.[239]

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

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

[239] A party has 10 days after the distribution of a non-final decision of the commission to file a petition for review with the Alaska Supreme Court. If the commission's decision was distributed by mail only to a party, then three days are added to the 10 days, pursuant to Rule of Appellate Procedure 502(c). *See* n.238 for Rule of Appellate Procedure 502(c).

You may wish to consider consulting with legal counsel before filing a petition for review. If you wish to petition the Alaska Supreme Court for review, you should contact the Alaska Appellate Courts *immediately*:

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

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

I certify that, with the exception of the correction of typographical errors, this is a full and correct copy of Final Decision No. 200, issued in the matter of *Ramon Rivero vs. Coldfoot Environmental Services, Inc. and Zurich American Insurance Company*, AWCAC Appeal No. 13-022, and distributed by the office of the Alaska Workers' Compensation Appeals Commission in Anchorage, Alaska, on October 1, 2014.

Date: *October 2, 2014*

Signed

K. Morrison, Appeals Commission Clerk