ALASKA WORKERS' COMPENSATION BOARD

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

EDUARDO CAMPOAMOR, Employee, Claimant, v. HOPE COMMUNITY RESOURCES, INC., Employer, and BERKSHIRE HATHAWAY HOMESTATE INSURANCE COMPANY, Insurer, Defendants.	)	FINAL DECISION AND ORDER AWCB Case No. 201700005 AWCB Decision No. 19-0114 Filed with AWCB Anchorage, Alaska on November 8, 2019

Eduardo Campoamor's (Employee) September 27, 2018 claim was heard on August 28, 2019, in Anchorage, Alaska, a date selected on June 18, 2019. The parties' June 18, 2019 stipulation gave rise to this hearing. Attorney Keenan Powell appeared and represented Employee who appeared and testified. Attorney Adam Sadoski appeared and represented Hope Community Resources, Inc. and its insurer (Employer). Other witnesses included Jeffrey Anderson, Teri Fuller, Bonnie Dorman, Bernard Vannoy, Chris Kolerok, Linda Hoffman and Lacie Windsor, DPT, all of whom appeared in person or by telephone and testified for Employee. Post-hearing, Scot Youngblood, M.D., testified by deposition on Employer's behalf. The record closed on November 2, 2019, to accommodate Dr. Youngblood's deposition, the parties' written closing arguments, Employee's supplemental attorney fee and cost affidavit and Employer's objection to it.

ISSUES

Employee contends he is entitled to additional temporary total disability (TTD) benefits from September 20, 2018, through January 2, 2019, and again from May 1, 2019, and continuing until he is medically stable or no longer disabled.

Employer contends Employee is medically stable. Accordingly, it contends no TTD benefits can be paid after the date he became medically stable. It also contends it made an overpayment.

1) Is Employee entitled to additional TTD benefits?

Employee contends he is entitled to temporary partial disability (TPD) benefits from January 3, 2019, through April 30, 2019, during the period he was working part-time.

Employer contends since Employee is medically stable, he is not entitled to TPD benefits after the date he became medically stable.

2) Is Employee entitled to TPD benefits?

Employee contends he may be entitled to additional permanent partial impairment (PPI) benefits after his condition becomes medically stable and is rated.

Employer contends Employee is already medically stable, it paid him PPI benefits resulting from a past rating and he is entitled to no additional PPI benefits.

3) Is Employee's PPI claim ripe?

Employee contends his work injury requires additional medical care and treatment. He seeks medical benefits and a related transportation cost award.

Employer contends it paid all medical benefits to which Employee is entitled.

4) Is Employee entitled to additional medical benefits?

Employee contends Employer made a frivolous or unfair controversion because it lacked a responsible medical opinion supporting its controversion. He seeks an appropriate finding and a referral to the Division of Insurance.

Employer contends its controversions were not frivolously or unfairly made because a responsible medical opinion supported them. It seeks an order denying Employee's request.

5) Did Employer make a frivolous or unfair controversion?

Because he contends Employer made a frivolous or unfair controversion, Employee contends he is entitled to an appropriate penalty under AS 23.30.155(e).

Because it contends its controversions were supported by responsible medical opinions, it contends Employee is not entitled to a penalty.

6) Is Employee entitled to a penalty?

Because he contends he is entitled to additional benefits, Employee contends he is also entitled to interest and an attorney fee and cost award.

Because it contends Employee is not entitled to additional benefits, Employer contends he is not entitled to interest or an attorney fee or cost award.

7) Is Employee entitled to interest, or an attorney fee or cost award?

FINDINGS OF FACT

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

1) On January 20, 1981, Employee, while working as a police officer, had a near head-on motor-vehicle collision with a suspect. His symptoms included mostly right-sided neck pain. An x-ray showed cervical lordotic curve reversal, resulting from muscle spasms. A doctor diagnosed a sprain and prescribed a soft collar. (Emergency Room report; x-ray report, January 20, 1981).

2) On September 6, 2005, Employee said in August he was moving boxes and "had severe pain in his neck and right arm. . . . He said it was terrible pain." Employee said he was "a very stoic guy,"

but this was incapacitating. Two weeks later, he was moving boxes and his leg hurt. At this visit, Employee's arm and neck pain had "gotten substantially better." James Eule, M.D., diagnosed right C7 radiculopathy and lumbar issues. Dr. Eule was concerned about possible cervical disc impingement on the spinal cord causing Employee's occasional "tipsy" feeling and right arm weakness, which was getting better. He ordered a cervical magnetic resonance imaging (MRI) to assess cord compression, and prescribed physical therapy (PT). (Eule report, September 6, 2005).

3) On September 9, 2005, a cervical MRI showed a disc extrusion at C6-7 centrally with major thecal sac narrowing and mild-to-moderate cord compression. There was diffuse spondylosis changes with multilevel abnormalities and disc protrusions and osteophyte formation worse on the left at C4-5, on the right at C5-6 and central at C6-7. (MRI report, September 9, 2005).

4) On September 15, 2005, Employee reported pain in his right arm and neck after moving boxes and referenced the C6-7 herniated disc found on the recent MRI. He displayed normal cervical motion with some hypermobility noted at C7-T1. There was a positive Neer's impingement test on the right shoulder but no tenderness at the supraspinatus or biceps tendons. The report mentions no assessment for cervical issues. (PT report, September 15, 2005).

5) On October 25, 2005, Employee said his neck and arm pain and weakness was much improved. Dr. Eule prescribed cervical PT, diagnosed cervical degenerative disc disease with C7 radiculopathy and discharged him from treatment. (Eule report, October 25, 2005).

6) On October 31, 2007, Employee called PT asking for discharge stating he was "pain free." (PT report, October 31, 2007).

7) On June 17, 2009, Employee was lifting his garage door, heard a pop and had pain in his right elbow and biceps. X-rays were normal and Cindy Lee, D.O., diagnosed partial versus full biceps tendon rupture and prescribed painkillers and a shoulder immobilizer. (Lee report, June 17, 2009).

8) On July 13, 2009, Employee had increasing right forearm numbness and generalized weakness in his right arm. Dr. Lee ordered a right elbow and forearm MRI. (Lee report, July 13, 2009).

9) On July 16, 2009, the right elbow MRI showed a ruptured and retracted biceps tendon with swelling and effusion. (MRI report, July 16, 2009).

10) On July 28, 2009, Michael McNamara, M.D., recommended PT and revisiting surgery to reattach the tendon later if necessary. (McNamara report, July 28, 2009).

11) On September 12, 2014, Employee reported left shoulder, neck and hip pain with no inciting event. Providers directed imaging only to his low back and hip. (Alaska Back Care report, September 12, 2014; MRI report, September 25, 2014).

12) Between September 25, 2014, and December 6, 2016, Employee had symptoms related to 1987 and 2014 lumbar surgeries, evaluations for his low back and a second lumbar fusion in 2015. Marius Maxwell, M.D., recommended a revision. Employee was taking over-the-counter pain medication and Tylenol with codeine during this period. (Maxwell report, December 6, 2016).

13) Between December 2, 2016, and February 13, 2017, Employee was taking oxycodone-acetaminophen and acetaminophen-codeine for lumbar and hip pain. (Alaska Prescription Drug Monitoring Program report, August 25, 2017).

14) Employee's medical records disclose minimal neck and no right shoulder symptoms prior to his work injury with Employer. (Inferences drawn from above).

15) On December 29, 2016, Employee slipped on exterior stairs and fell at work, injuring his right shoulder. (First Report of Injury, December 30, 2016; Employee).

16) On January 6, 2017, Employee reported he was walking up metal stairs on December 29, 2016, when he lost his balance and fell approximately four steps while holding onto the hand rail with his right hand; his arm progressively outstretched as he fell. He had acute-onset right shoulder pain and had already been taking Tylenol with Codeine for his low back for which he was scheduled for surgery. Employee reported no prior right shoulder complaints and did not mention neck pain. Benjamin Kennah, PA-C, diagnosed right shoulder osteoarthritis, pain and a likely superior labrum anterior and posterior (SLAP) lesion with a possible rotator cuff tear. An intra-articular injection provided nearly complete relief. (Kennah report, January 6, 2017).

17) On January 9, 2017, a right shoulder arthrogram and MRI revealed a full-thickness supraspinatus tear, partial thickness tears of the distal infraspinatus and subscapularis tendons, biceps tendinopathy and moderate osteoarthritis. (MRI, January 9, 2017).

18) On January 16, 2017, Doug Vermillion, M.D., recommended arthroscopy, debridement, an open rotator cuff repair and a biceps tenodesis. Employee was to have back surgery and wanted to have it done before addressing the shoulder. (Vermillion report, January 16, 2017).

19) On February 17, 2017, he had lumbar surgery. (Maxwell report, February 15, 2017).

20) On March 7, 2017, Employee had a physical for his pending shoulder surgery. His neck was supple and non-tender with normal motion. (John Cates, D.O., report March 7, 2017).

21) On March 23, 2017, Dr. Vermillion repaired a rotator cuff tear, and addressed the SLAP lesion, biceps tendinosis and labral tear. (Operative Report, March 23, 2017).

22) On March 29, 2017, PA-C Kennah recommended upper extremity exercises and "rotating [Employee's] neck and shoulder blade." (Kennah report, March 29, 2017).

23) By April 6, 2017, Employee had surgical site symptoms consistent with an infection. Tracie Rieker, PA-C, referred him for immediate evaluation. (Rieker report, April 6, 2017).

24) On April 12, 2017, he began right shoulder PT. (Kristen Obert, DPT report, April 12, 2017).

25) On April 17, 2017, PA-C Kennah diagnosed an infected abscess in Employee's shoulder and sent him to surgery for irrigation and drainage. (Kennah report, April 17, 2017).

26) On April 17, 2017, Dr. Vermillion irrigated, drained and debrided Employee's right shoulder incision. (Operative Report, April 17, 2017).

27) On April 24, 2017, Employee's cervical motion was normal without tenderness and his neck was supple. (Emily Church, M.D., report, April 24, 2017).

28) On April 26, 2017, he reported normal neck motion with no tenderness; it was supple. (Michael Mraz. M.D.; Kennah reports, April 26, 2017).

29) On April 26, 2017, Dr. Vermillion repeated irrigation and drainage in Employee's right shoulder. (Operative Report, April 26, 2017).

30) On April 27, 28, and 29, 2017, Dr. Mraz examined Employee's neck and found it supple, non-tender and with normal motion. (Mraz reports, April 27, 28, and 29, 2017).

31) During April and May 2017, before and after his second right shoulder irrigation and drainage, Employee took Nucynta, a long acting narcotic, for pain. (Kennah report, May 17, 2017).

32) On May 19, 2017, Employee completed an intake form for right shoulder PT. On a pain drawing, he marked his right shoulder but not his neck. He reported no tingling in his right upper extremity and no neck symptoms. (PT pain drawing; PT report, May 19, 2017).

33) On June 14, 2017, an MRI showed a full-thickness supraspinatus tear, retraction, cyst, marked labrum degeneration and joint space narrowing, and effusion. (MRI, June 14, 2017).

34) By June 23, 2017, Employee was no longer taking narcotics but was using Tylenol and Aleve only, as needed. (Vermillion report, June 23, 2017).

35) Employee wore a right shoulder sling off and on for months after his right shoulder surgeries. (Employee; inferences drawn from the medical records).

36) On June 28, 2017, Employee had numbness and tingling in all fingertips at rest but if he made his shoulder ache he did not notice the tingling. Kevin Paisley, M.D., diagnosed a large, retracted rotator cuff tear and multiple debridements for postoperative infections. He recommended another debridement as a primary treatment, tissue sampling to determine if infection was still present and possibly a total shoulder arthroplasty as a secondary procedure assuming there was no infection. Employee wanted to proceed. Dr. Paisley ordered "General" anesthesia and an interscalene injection for the next surgery. (Paisley reports, June 28, 2017).

37) On June 30, 2017, Employee's treatment plan included the recommended debridement and tissue biopsy followed by a reverse shoulder arthroplasty. (Vermillion report, June 30, 2017).

38) On September 1, 2017, Windsor discharged Employee, who was to stop PT until after his shoulder surgery. This is Windsor's first report. (PT Discharge Summary, September 1, 2017).

39) On September 9, 2017, Dr. Paisley found Employee's fingers were well-perfused and had "no motor or sensory deficits." (Paisley report, September 9, 2017).

40) On September 12, 2017, prior to surgery, Jeff Worrell, CRNA, gave Employee a peripheral, interscalene, brachial plexus nerve block under fluoroscopic guidance in the right shoulder to assist with post-op pain management. (Procedure Report, September 12, 2017).

41) On September 12, 2017, Dr. Paisley debrided Employee's right shoulder, removed retained sutures, took a tissue sample for evaluation for infections and performed an open deltoid repair but did not repair the rotator cuff. (Operative Report; Procedure Summary, September 12, 2017).

42) On September 13, 2017, Employee told Windsor he had surgery a day prior, which was a precursor to a "future rotator cuff repair or replacement surgery." Contrary to the records, Employee said he did not have a right shoulder nerve block. He said his decision not to have one was important to him as he had already regained feeling in and use of his right hand. On examination, his "Light touch sensation" was intact and symmetrical in both arms. Employee did not report numbness or tingling in his right hand. His current pain level was "9/10." He completed another pain drawing and marked symptoms on his right shoulder extending toward the base of his neck. (PT report, September 13, 2017).

43) Between September 13, 2017, and October 9, 2017, Employee had approximately 15 PT visits. He did not report numbness or tingling in his right upper extremity at any visit. (PT reports, September 13, 2017, through October 9, 2017).

44) On September 22, 2017, Dr. Paisley reported the shoulder tissue showed no continuing infection. Employee wanted to move forward with the next surgery including arthroscopic rotator cuff repair and a superior capsular reconstruction. (Paisley report, September 22, 2017).

45) On September 22, 2017, PA-C Bethany Myers limited Employee to light-duty and no lifting, pushing, or pulling over five pounds with his right shoulder. (Work Status, September 22, 2017).

46) On September 25, 2017, Dr. Paisley prepared his post-surgical orders for the next right shoulder surgery. He directed Employee to call after surgery if his fingers had "new numbness* or tingling." The "*" referred to a note stating Dr. Paisley routinely used numbing medicine around the surgical site, "which may cause numbness for 12-16 hours." (Post-Operative Instructions: Upper Extremity (Hand/Elbow/Shoulder), September 25, 2017).

47) On September 26, 2017, PA-C Myers ordered anesthesia for Employee's next right shoulder surgery, including "General" and a "Regional Block." (Preoperative Orders, September 26, 2017).

48) On October 10, 2017, prior to surgery, an anesthesiologist administered a "right single shot interscalene brachial plexus block" into Employee's right lower neck under fluoroscopic guidance. (Robert Clark, M.D., report; Operative Report, October 10, 2017).

49) On October 10, 2017, Dr. Paisley diagnosed an irreparable supraspinatus rotator cuff tear, a partial infraspinatus and subscapularis tear, loose bodies and subacromial impingement. He surgically addressed these and said ". . . there is the very significant increase [sic] complexity of the case, this required repair of 2 tendons with a third tendon being irreparable, which prompted the staff to proceed with the graft augmentation." (Operative Report, October 10, 2017).

50) On October 11, 2017, PA-C-Myers called Employee to check on him post-surgery; he reported facial redness where a foam pad had been, and a painful bump on his head. He did not mention tingling or numbness in the right upper extremity. (Patient Visit Note, October 11, 2017).

51) On October 20, 2017, at his first post-surgery visit Employee said "hes [sic] been experiencing" an "electrical shock" sensation and constant soreness as well as occasional numbness and tingling on his right hand in the middle, ring and small finger. PA-C Myers prescribed Gabapentin for "nerve pain" and numbness and tingling in his right hand, which she hoped would improve sans the sling at eight weeks post-op. (Myers report, October 20, 2017).

52) The typographical error in the October 20, 2017 chart note, "hes," was supposed to be either "he's" or "has." It was most likely "he's," the contraction for "he has." Either way, the note

indicates Employee reported on this date having had these symptoms for an unspecified period. (Experience, judgment and inferences drawn from the above).

53) On October 30, 2017, Employee returned to Windsor for a PT evaluation. Subjectively, he was, "Negative for cervical red flags," with no explanation for what this means. On his pain drawing, Employee for the first time indicated symptoms on several fingers on his right hand, but did not mark any neck symptoms. He reported his arm hurt and it felt like there are "a bunch of fire ants all over the top of the shoulder." (Windsor report; pain drawing, October 30, 2017).

54) On November 6, 2017, he reported "jerking" at night. (PT report, November 6, 2017).

55) On December 11, 2017, Employee still had numbness and tingling in three fingers on his right hand. Dr. Paisley refilled his Neurontin. (Paisley report, December 11, 2017).

56) By January 12, 2018, Employee still had numbness and tingling in his right hand. (Paisley report, January 12, 2018).

57) Employee reported falling on the ice "a few times" since surgery but never onto his shoulder. His records do not suggest Employee injured his neck or right shoulder in any slip or fall. (PT report, January 22, 2018; observations).

58) On February 12, 2018, Employee reported continuing right shoulder pain and said his shoulder "locked up." He had "nerve-like" pain like "something is crawling under [his] skin." (Paisley report, February 12, 2018).

59) On February 26, 2018, an MRI showed a "new" supraspinatus tendon tear, tendinosis in the subscapularis tendon, marked glenohumeral joint space narrowing and a degenerated labrum. (MRI report, February 26, 2018).

60) On March 2, 2018, Employee still had tingling fingers in his right hand. He denied any new injuries. On reviewing the most recent MRI, Dr. Paisley said he did not repair the supraspinatus tendon, suggesting there was no "new" tear, and said the MRI was "textbook" for superior capsular reconstruction. Given Employee's continued trigger-point-like pain, Dr. Paisley referred him to Heath McAnally, M.D., for pain management. The "worst-case scenario" would include a reverse total shoulder arthroplasty if Employee did not experience pain relief or overall functional improvement. (Paisley report, March 2, 2018).

61) On March 12, 2018, Employee's main complaints included pain in his right shoulder, upper extremity and chest wall. His worst pain migrated from the "cervical/upper trapezius/lateral shoulder region," to the periscapular zone, with radiation into his anterior chest and neck, along

with decreased motion. He was advised to discontinue the sling. Employee's cervical motion was limited by pain and he had a positive right Spurling's maneuver. Relevant diagnoses included chronic pain, right scapulocostal syndrome and "brachial radiculitis." Dr. McAnally opined:

> While I think that his main issue from a subacute exacerbation standpoint is a scapulocostal syndrome, the differential diagnosis for his unusual broad palette of symptoms and signs includes at least the T4 syndrome, thoracic outlet syndrome (especially given the unilateral supraclavicular vascular congestion and hand paresthesias) and possibly superimposed cervical segment referral and/or radiculopathy. From a local shoulder standpoint, there is probably certainly some capsulitis and other sequela of multiple operations and chronic infection.

Dr. McAnally recommended switching and tapering opioids to Nucynta and prescribed diagnostic and therapeutic scapulocostal and costovertebral injections. To address the brachial radiculitis, he suggested plain cervical x-rays and an MRI to rule out comorbid cervical root injury, disc injury or plexopathy. (McAnally report, March 12, 2018).

54) On March 19, 2018, Dr. Paisley predicted Employee would have a right shoulder PPI rating but could not predict his physical capacities. (Paisley report, March 19, 2018).

55) On March 20, 2018, Dr. McAnally gave Employee a right scapulocostal injection, which improved his shoulder pain. (McAnally report, March 20, 2018).

56) On March 23, 2018, for the first time Employee's chief complaint to his massage therapist included neck pain. (Morgan Johnson, LMT report, March 23, 2018).

57) On March 28, 2018, Employee's cervical x-rays showed degenerative discs and endplate changes from C3 through T1, severe degenerative endplate spurring and disc height loss at C4 through C7, severe uncovertebral osteoarthritis from C4 through C7 and severe right neural foraminal stenosis at C6-7. (X-ray reports, March 28, 2018).

58) On March 29, 2018, Employee had neck and shoulder pain. (PT report, March 29, 2018).

59) On April 9, 2018, a cervical MRI showed severe degenerative changes at multiple levels, a large central herniation at C6-7 resulting in marked cord effacement and significant central stenosis, and severe right neural foraminal stenosis, which "may well correlate with current symptoms." There was also lesser central stenosis at C3-4 and C4-5 and moderate foraminal encroachment on the right at C4-5. (MRI, April 29, 2018).

60) The radiologists interpreting the September 9, 2005 and April 29, 2018 cervical MRIs report similar findings. (Experience, judgment and inferences drawn from the above).

61) On April 10, 2018, Dr. McAnally reviewed Employee's 2018 cervical x-rays and MRI and diagnosed spinal stenosis, intervertebral disc herniation with radiculopathy and right scapulocostal syndrome. He suggested Employee's shoulder symptoms could result from severe right C6-7 foraminal stenosis. Dr. McAnally concluded, "I think it is entirely plausible that his fall and self-arrest exacerbated preexisting cervical spine disease." (McAnally report, April 10, 2018).

62) On April 12, 2018, Employee still had right shoulder and neck pain. (Jennifer DeGraffenried LMT report, April 12, 2018).

63) On April 18, 2018, Dr. Paisley restricted Employee from work until his next appointment at which time his work status would be reassessed. (Work Status, April 18, 2018).

64) On May 7, 2018, Employee's shoulder still hurt but his overall symptoms improved with cervical traction. Windsor opined, "It is likely that the prolonged and severe pain in his shoulder is directly related to his cervical pathology recently discovered by MRI." She reasoned his right shoulder surgery successfully reattached the supraspinatus but his pain plateaued nonetheless. He opposed a shoulder operation but wanted cervical spine surgery. (Windsor Report, May 7, 2018).

65) On May 9, 2018, Dr. Paisley reviewed the 2018 cervical MRI and said, "Eddie has a relatively complex history of multiple shoulder surgeries as well as having the cervical pathology, all which seem to stem from his work-related injury." (Paisley report, May 9, 2018).

66) On May 14, 2018, Dr. McAnally diagnosed spinal stenosis and a disc herniation with radiculopathy and said, "I think that his disc degeneration there [C6-7] is a relatively recent issue. . . ." If radiculopathy persisted, Dr. McAnally would refer him to a surgeon. He recommended continued medical care and "income subsidization" from workers' compensation "for the next several months while we are getting this issue resolved." (McAnally report, May 14 2018).

67) On May 15, 2018, Dr. Paisley said physicians were trying to exhaust conservative care but Employee may need shoulder replacement surgery, he was not medically stable and would have a PPI rating upon medical stability. He "possibly" on this date had physical capacities to return to his job as Administrator of Professional Development & Training. (Paisley report, May 15, 2018).

68) On June 19, 2018, Employee reported continuing right shoulder pain and was beginning to drop items with his numb and tingling right hand. He wanted to avoid cervical surgery if possible and agreed to try an epidural steroid injection. (McAnally report, June 19, 2018).

69) By July 10, 2018, Employee had progressing right arm weakness and was dropping things frequently. He had an epidural steroid injection at C7-T1. (McAnally report, July 10, 2018).

70) From the injury date to this point, no physician had found Employee medically stable or released him to return to work full- or part-time. (Inferences drawn from the above).

71) On July 20, 2018, EME Scot Youngblood, M.D., reviewed records, including those documenting ongoing pain management and Dr. Paisley's March 2, 2018 "worst-case scenario" plan for a reverse total shoulder arthroplasty if Employee did not have pain relief or overall functional improvement. The records provided did not include Dr. Paisley's June 28, 2017 report recommending debridement and a total shoulder arthroplasty if there was no infection, procedures with which Employee wanted to proceed, or Dr. Vermillion's June 30, 2017 report reiterating Employee's treatment plan including the debridement and tissue biopsy followed by a reverse shoulder arthroplasty. (Youngblood report, July 20, 2018; observations).

72) Dr. Youngblood examined Employee and diagnosed a right shoulder sprain with rotator cuff tear and biceps tenodesis. He attributed these, and infections and related repairs, to the work injury as "the substantial cause," and said all would be medically stable by June 30, 2018, eight months after the last surgery. Dr. Youngblood diagnosed multilevel cervical degenerative disc disease, which preexisted the work injury and was not substantially caused "or aggravated" by it. His examination "was not consistent with any findings of a cervical radiculopathy" and there was no complex regional pain syndrome (CRPS) present. However, during this examination Employee reported "significant" pain with any right shoulder movement. Questions and answers included:

> **7. Do you recommend any further diagnostic studies or tests at this time?**
>
> No.
>
> **8. What kind of further treatment, including physical therapy, exercise, medication, chiropractic treatment, injections, or surgery, if any, is recommended as a result of [Employee's] injury of December 29, 2016? Please detail the duration and frequency of treatment recommended, if any.**
>
> No additional treatment is deemed indicated, recommended or necessary for any after effect of the December 29, 2016, injury. As noted above, the cervical spine conditions are not related in any way to the industrial injury under study. There is no complex regional pain syndrome. There is no identifiable indication for pain management treatment.
>
> **9. For any condition that you think is related to [Employee's] injury of December 29, 2016, does the work injury remain the substantial cause of his**

> **need for the treatment you have recommended? Please explain your response in detail.**
>
> Not applicable. None is recommended.
>
> **10. If you do not believe [Employee's] injury of December 29, 2016 remains the substantial cause of his current need for treatment, please detail the alternative causes for any recommended treatment.**
>
> Please see above Discussion. Subjective complaints significantly outweigh the claimant's objective findings. Symptom magnification is present on physical examination. This excess presentation and his excessive subjective complaints would not be deemed related to the industrial injury (emphasis in original).

The next question provided the Act's "medical stability" definition and asked if the diagnosed conditions were medically stable. Dr. Youngblood said both the right shoulder and preexisting neck conditions were medically stable. He opined the neck had always been stable and the right shoulder was stable effective June 30, 2018. In his opinion, since medical records showed no neck or cervical spine injury occurring on December 29, 2016, no cervical spine "condition" is related to the work injury. He said "age and genetics" were the substantial cause of Employee's cervical disc disease. In his opinion, the "excessive presentation and his excessive subjective complaints would not be related to the industrial injury." Dr. Youngblood's Jamar grip strength testing showed dramatically diminished right- versus left-hand strength. His report does not suggest the test was invalid. He thought it "unclear" why a shoulder lesion would "cause such profound weakness of the right grip strength versus the left," but did not offer an explanation for his Jamar findings. Dr. Youngblood gave a four percent whole-person PPI rating for the right shoulder injury and opined Employee could return to his job as Administrator of Professional Development & Training effective June 30, 2018, and could also return to work as Academic Dean; Faculty Member, College or University; Inspector, Healthcare Facilities; Manager, Regulated Program; and Administrator, Healthcare Facility pursuant to job descriptions he reviewed. Employee was restricted from lifting or carrying more than 25 pounds and could do no above-shoulder work, placing him in the "Light" work category. He did not say Employee had no weakness, pain, numbness, tingling or was faking or malingering. (*Id*.).

73) Dr. Youngblood's report ruled out cervical radiculopathy and CRPS as pain generators but did not provide an alternative cause for Employee's right shoulder pain, right upper extremity weakness and right hand numbness and tingling. (Judgment and inferences drawn from the above).

74) Employer paid Employee TTD benefits through September 20, 2018. (ICERS).

75) On August 22, 2018, Dr. McAnally charted significant worsening in Employee's right upper extremity pain, weakness and paresthesias. Employee reported very good response to his second scapulocostal injection, and reduced his Nucynta. Dr. McAnally diagnosed a C6-7 disc with radiculopathy, cervical spinal canal stenosis, chronic pain following surgery, and right scapulocostal syndrome. He refilled Employee's Nucynta, started Lyrica and referred him to a neurosurgeon for his neck. (McAnally report, August 22, 2018).

76) On August 29, 2018, Employee reported increased right shoulder pain and decreased strength. Dr. Paisley agreed he needed a cervical spine evaluation. The "next step with regards to his right shoulder would be considering a reverse total shoulder arthroplasty." However, before proceeding with it, Dr. Paisley wanted the cervical spine evaluation done first, and said Employee "is most certainly not considered to be medically stable as we are considering potential further surgery." He restricted Employee's right shoulder to no lifting, pushing or pulling and no over-shoulder activities. (Paisley report, August 29, 2018).

77) On September 11, 2018, Upshur Spencer, M.D., evaluated Employee for his neck concerns including weakness and altered gait. He diagnosed severe spinal stenosis at C6-7 with myelopathy and severe right upper extremity radicular symptoms and an early gait disturbance. Dr. Spencer found lesser degenerative changes at other cervical levels and noted the right shoulder condition. He recommended a C6-7 anterior discectomy and fusion. He expected this to help Employee's hand symptoms and weakness though it probably would not affect his right shoulder complaints. Dr. Spencer opined that even though Employee had some preexisting cervical spine issues, "that does not by any means mean that the disc herniation seen at C6-7 did not occur at the time of his injury." He noted Employee's high functional level prior to the work injury and did not think a physician could state "absolutely" that the disc herniation preceded the work injury. Dr. Spencer posited it was possible Employee could have suffered a rotator cuff tear and a central disc herniation at the same time. He disagreed with Dr. Youngblood's opinion on the 2018 MRI and found an abnormal signal in the spinal cord at the C6-7 level, noting the MRI was done in an "open magnet," which typically does not have high sensitivity. (Spencer report, September 11, 2018).

78) On September 19, 2018, Dr. McAnally reacted to EME Dr. Youngblood's report and stated:

> I disagree completely with Dr. Youngblood's notion of "age and genetics" causing this man's cervical disc degeneration, and presumably acute right C3/4 effusion as

> well. To my knowledge and review of the literature, there are no allelic variation/polymorphisms that have shown any consistent association with degenerative disc disease, and furthermore this gentleman has never undergone DNA sequencing. Thus, the claim of genetic involvement is beyond untenable at this point. As far as attributing his issues to his age, without longitudinal imaging available, this is also an impossible claim. I agree with Dr. Spencer who notes that the patient was doing fine without any trouble in this regard until his workplace injury of December 29, 2016[,] and who subsequently has evidenced symptoms, signs and advanced imaging that all correlate and point to cervical radiculopathy and possibly even cord involvement as a major issue here. (McAnally letter, September 19, 2018).

79) On September 21, 2018, Employer denied Employee's right to all benefits related to his cervical spine; TTD and TPD benefits and PPI benefits greater than four percent; all reemployment benefits and all medical care for the right shoulder as of September 21, 2018. Employer based its denial on Dr. Youngblood's EME report. (Controversion Notice, September 20, 2018).

80) On September 21, 2018, Employer paid $7,080 in PPI benefits based on Dr. Youngblood's four percent whole-person right-shoulder rating. (ICERS, September 25, 2018).

81) Employee's TTD compensation rate for this injury is $1,113.24 per week. (ICERS).

82) On September 24, 2018, Dr. McAnally said MRI effusion at the C3-4 level correlates with Employee's shoulder girdle dermatome and the "very large" C6-7 posterior disc herniation, not flanked by osteophytes that would otherwise indicate a chronic situation, and which was dynamic on flexion and extension views, suggested an acute or subacute injury. The latter, he said, correlates with Employee's distal upper extremity symptoms including right hand weakness. He also agreed with Dr. Paisley's assessment that the shoulder is not medically stable and needs further surgery. (McAnally letter, September 24, 2018).

83) On September 27, 2018, Employee claimed TTD and PPI benefits; attorney fees and costs; medical and travel costs; a late-payment penalty; interest; and an unfair or frivolous controversion finding. (Claim for Workers' Compensation Benefits, September 27, 2018).

84) On October 3, 2018, in response to a vocational rehabilitation specialist's request for predictions about Employee's future ability to return to jobs he held in the 10 years prior to his injury, and at the time of his injury, Jen Fayette, PA-C, at Dr. Paisley's office predicted he would have a PPI rating greater than zero and would continue to have pain and decreased motion and strength in his right upper extremity. She predicted Employee "will have the permanent physical capacities to perform the physical demands" of the job descriptions presented for Manager,

Regulated Program; Inspector, Healthcare Facilities; and Administrator, Healthcare Facility. The rehabilitation specialist said one of these descriptions represented Employee's job at the time of his work injury with Employer. PA-C Fayette did not release Employee to return to any job on this date. (Fayette reports, October 3, 2018).

85) On October 19, 2018, Employer controverted Employee's claim for all benefits related to the cervical spine; TTD, and PPI benefits greater than four percent for the right shoulder; medical benefits for the right shoulder effective September 21, 2018; all reemployment benefits; interest, penalty, attorney fees and costs. (Controversion Notice, October 18, 2018).

86) On November 21, 2018, Employee was found not eligible for reemployment benefits based on opinions reports from PA-C Fayette and Dr. Youngblood. (Letter, November 21, 2018).

87) In December 2018, Employee was leaving his house when he "tripped on [his] feet," fell and cut his forehead, which required stitches. He attributes this fall to his cervical issues. (Videotaped Deposition of Eduardo Campoamor, April 5, 2019, at 29-30).

88) On January 29, 2019, Dr. McAnally said Employee had significant modifiable neurologic insult from severe cervical spine disease. In his opinion, Employee's recovery would depend on whether he got timely neck surgery. (McAnally letter, January 29, 2019).

89) On February 12, 2019, Employer filed the September 9, 2005 cervical MRI report. This is the first time this MRI report appears in the agency file. There is no evidence Drs. McAnally, Paisley, Spencer, Youngblood or DPT Windsor reviewed this report before offering their opinions about Employee's cervical spine. (Medical Summary, February 12, 2019; observations).

90) On April 23, 2019, Employee filed and served various check stubs and timesheets related to his work with Bering Straits. (Certificate of Service, April 23, 2019).

91) On March 11, 2019, Employee filed and served a receipt for $1,350 he paid Dwight Ellerbe, M.D., for December 14, and 26, 2018 service dates, for "layer closure intermediate" and a post-operative visit. Dr. Ellerbe appears to be an ears, nose and throat specialist (ENT). This bill correlates with Employee's trip and fall on his steps at home and the related forehead laceration. (Certificate of Service, March 11, 2019; inferences drawn from the above).

92) On April 9, 2019, SIME Paul Puziss, M.D., reviewed all the medical records, examined him and reported Employee told him that after Dr. Paisley's first surgery, he was having tingling in his arm and was told it was because he had been wearing a sling. Employee's chief complaint was pain throughout the entire right shoulder blade, anterior shoulder, into the pectoral area and down

to near the elbow. He had numbness and tingling on the entire right hand but mostly in the middle, ring and little finger, and weakness in the shoulder, arm and hand. In his record review section, Dr. Puziss did not mention the interscalene block for Employee's September 12, 2017 right shoulder surgery; he did mention the interscalene block given on October 10, 2017, when reviewing the right shoulder operation on that day. Employee had severe pain on palpation in the precise area where he had a scalene block. He did not exhibit any pain behavior during this examination. Dr. Puziss diagnosed: an acute right rotator cuff tear; various right shoulder surgeries and complications; a right brachial plexus injury secondary to a scalene block on September 12, 2017; a preexisting and likely non-aggravated, moderately large C6-7 disc protrusion and spinal stenosis with milder stenosis at C4-5 and C5-6; post scapula thoracic trigger point injections, which were temporarily helpful; preexisting, multi-level cervical degenerative disc disease without radiculopathy or myelopathy, not substantially caused or aggravated by the work injury; lumbar surgery not related to the work injury; mild right glenohumeral joint degeneration and post-infection arthritis; and evidence for a right C6-7 facet syndrome. He listed all causes for Employee's disability and need for treatment:

> The patient has several causes of disability, at this time, as well as need for medical treatment. The primary cause is that of the failed original right rotator cuff repair due to infection, deep abscess. He has developed some arthritis in the shoulder which probably has some relationship to the deep abscess, although the abscess was ultimately treated successfully, and he had eventual rotator cuff repair with a capsular reconstruction. He still has quite limited shoulder motion in all planes due to the scar tissue formation. However, most importantly, in terms of his pain, he has what is most likely a brachial plexopathy due to the right scalene block on 09/17/2017, which appeared to cause problems somewhat later, but which persist now. This type of problem is not unknown to me as I have treated a number of patients in the past with similar problems and causes. These are very difficult to treat.

Dr. Puziss did not believe the work injury aggravated, accelerated or combined with any preexisting neck or shoulder condition. He opined radiculopathy from several nerve roots around the brachial plexus is the primary pain generator keeping Employee from returning to work. This causes him more pain than his shoulder. In Dr. Puziss' view, there is little if any pain contribution from the C6-7 chronic herniated disc. As for the substantial cause of Employee's disability or need for medical treatment, Dr. Puziss said:

> The substantial cause of the patient's disability relating to his shoulder is the original injury of 12/29/2016[,] which tore his rotator cuff which, unfortunately, became infected after his first repair and needed several surgeries after that. There is no doubt about this. Regarding his radiculopathic symptomatology, he is very tender over the scalenes where he had the scalene block and he has not been fully evaluated for this condition. However, the substantial cause of the pain after the scalene block with the original surgery of 09/12/2017[,] which was necessitated by his original injuries.

Dr. Puziss opined Employee's work-related disability continues and he is not medically stable regarding the scalene block but is medically stable for his right shoulder. The right shoulder became medically stable on July 20, 2018, when Dr. Youngblood saw him, in Dr. Puziss' view. He recommends electromyography and nerve conduction studies to determine how much damage was done to Employee's brachial plexus nerves, and an ultrasound-guided steroid injection; Employee may require a spinal cord or nerve root stimulator. Because Dr. Youngblood questioned Employee's subjective symptoms, Dr. Puziss suggested a psychological evaluation to rule out a somatoform disorder or malingering. He recommended medial branch blocks to the right C6-7 facet to see if he has facetogenic pain, and if he does, Dr. Puziss recommends radiofrequency ablation. He opined facet issues are related to abnormal shoulder biomechanics resulting from his shoulder injury and treatment. In Dr. Puziss' opinion, Employee's medical treatment was necessary and reasonable, but he needs more. Additional treatment, if successful, would enable him to return to work and participate in reemployment. Dr. Puziss agrees with the four percent right shoulder PPI rating Dr. Youngblood gave. He cannot predict when Employee would be medically stable following appropriate brachial plexus treatment. Delaying cervical surgery did not prolong Employee's disability, in his opinion. He agreed it would be reasonable for Employee to have a reverse total shoulder arthroplasty and said the work injury is the substantial cause for this treatment; however, Dr. Puziss said the plexopathy treatment should occur prior to shoulder replacement surgery. (Puziss report, April 9, 2019).

93) The medical records support Employee's testimony that he has not been pain free in his right shoulder since his work injury. (Inferences drawn from the medical records).

94) On June 18, 2019, Employee orally amended his claim to include TPD benefits. (Prehearing Conference Summary, June 18, 2019).

95) On July 31, 2019, and August 1, 2019, Employee filed and served additional check stubs for his work with Bering Straits. (Certificates of Service, July 31, 2019; August 1, 2019).

96) Post-hearing on September 4, 2019, Dr. Youngblood said 10 times that he could not explain Employee's pain and suggested there could be psychiatric diagnoses to explain his subjective complaints. When asked if he considered a brachial plexus injury, Dr. Youngblood thought he would always consider it to "some degree" but it is in his view so "far afield and so rare" that he did not think it was even worth mentioning in his report. He explained:

> A. And so with a brachial plexus injury -- and I believe Dr. Puziss thinks that it happened in his September 2017 surgery with the interscalene block, so when you -- when you see a brachial plexus injury due to such a block, they are exceedingly rare, but when you see them, the patient will have significant pain in the distribution of the nerves that are affected. It will be immediate and obvious after the surgery, or at least in the early recovery period.
>
> Patients who get brachial plexus injuries after the -- after a surgery or procedure will come in at their one-week or two-week appointment and say "my arm is still completely numb," or "This is the problem. I have searing pain down here," going all the way down the distribution of the nerve that was affected.

Dr. Youngblood does not believe Employee had a brachial plexus injury because he does not think the medical records show Employee voiced appropriate complaints until months after surgery. For support, he points to a September 13, 2017 PT note documenting a completely normal right upper extremity sensory examination. He recommends no additional treatment for the work injury. In the event Employee needs a reverse total shoulder arthroplasty, "it would probably be related to the injury and its aftereffect." Dr. Youngblood said there is really no good treatment for a brachial plexus injury though there are centers that operate on it. Electromyography and nerve conduction studies would clarify if Employee has a brachial plexus injury and, if so, an ultrasound-guided steroid injection in the area would be helpful. However, he questions why an injection is appropriate since an ultrasound-guided injection allegedly caused the problem to begin with; he considers the injection idea "insane." Dr. Youngblood is not sure if spinal cord or nerve root stimulators have been well-studied in brachial plexus injuries. He agrees a medial branch block near the right C6-7 facet is appropriate to diagnose a facetogenic pain generator. Dr. Youngblood recalled Employee had no neck pain on examination so he would not recommend a medial branch block. If he had facet-mediated pain, radiofrequency ablation would be helpful. Dr. Youngblood could not explain Employee's weak grip on his right hand, while not doubting he had it. He did not check or document Employee's dermatomes but they did discussed them. Dr. Youngblood

does not believe Employee has radiculopathy or myelopathy from his neck. Consequently, he does not think electromyography or nerve conduction studies are indicated. Though Employee said he did not have neck pain on the date he examined him, Dr. Youngblood charted that Employee had, referring to a March 12, 2018 injection, a cervical epidural steroid injection with 35 to 40 percent pain relief. In his opinion, this pain relief would have nothing to do with a brachial plexus lesion. Nevertheless, he conceded it is possible Employee has more than one condition causing his pain. Though he did not do sensory testing on Employee's hand or arm, Dr. Youngblood disagreed with other providers' opinions and findings on their sensory examinations. He conceded he is the only physician examining Employee who cannot offer a cause for why he still has pain, though the other physicians disagree on the pain's source. Dr. Youngblood said body positioning during shoulder surgery can injure a brachial plexus. While a herniated disc does not always cause neck pain, one would expect functional symptoms from the disc such as numbness, tingling or altered gait. He did not say he had ever diagnosed or treated a brachial plexus injury, but said, "I've seen nerve injuries after shoulder surgery. . . ." He is not a spinal surgeon. Dr. Youngblood "completely supports" what Employee claims for his right shoulder but cannot explain "the rest of it." He spends one to two days a month doing EMEs and is paid $600 per hour; $650 for depositions; he typically does 15 per month and said this a complex case and he spent at least five hours on his report. (Videotaped Deposition of Expert Witness Scot Youngblood, M.D., September 4, 2019).

97) Employee seeks TTD benefits from September 20, 2018, through January 2, 2019, and again from May 1, 2019, and continuing until he becomes medically stable. He also seeks TPD benefits from January 3, 2019, through April 30, 2019, when he worked part-time. (Record).

98) Employee conceded he had not filed or served a medical transportation log. (*Id*.).

99) Employee contends Dr. Youngblood refuses to consider injuries may include an aggravation to a preexisting condition. He contends Dr. Youngblood ignored the cervical epidural steroid injection on July 10, 2018, just 10 days before his EME, which ameliorated his symptoms temporarily, which is why Employee did not mention cervical symptoms. Accordingly, he contends Dr. Youngblood's "malingering" diagnosis is false. Employee contends he is not medically stable because his cervical and brachial plexus issues, which he contends are all work-related, need additional medical treatment. He seeks benefits related to disability and impairment associated with the medical care he needs. (*Id*.).

100) Employer contends this case is not about Employee's credibility and denies Dr. Youngblood said he was malingering. It contends most medical care Employee has had in the past two years was to his neck, not his shoulder. Employer contends Dr. Youngblood's EME report is substantial evidence to rebut the presumption. It relies on the *Harp* Supreme Court decision for support, and contends he opined the cervical conditions are not related to the work injury. It contends Employee had significant pre-injury accidents and symptoms, implying these could be responsible for his cervical problems. Employer contends Dr. Youngblood's EME report is entitled to greater weight than the SIME report. It contends the only compensable medical condition is medically stable and Employee is not entitled to additional disability benefits. Employer contends separating the neck and shoulder symptoms is important because it accepts only the shoulder as compensable. It contends Dr. Pusziss' brachial plexus opinion is not supported by any other physician. Employer contends Employee is not entitled to a penalty on late-paid PPI benefits, which it concedes were paid late, because Employee continued to receive TTD benefits resulting in a TTD benefit overpayment that would exceed any penalty on the late-paid PPI benefits. (*Id*.).

101) Anderson worked with Employee from 1999 through 2007 and observed him on a daily basis. He noticed no physical impairment or neck, back or shoulder symptoms. Employee worked hard and set up chairs and folding tables in auditoriums with no apparent difficulty. In Anderson's view, Employee is honest in every way. (Anderson).

102) Fuller is Employee's wife since May 2018. They met in December 2011 at work. Prior to the work injury, Employee never complained to her about neck or shoulder pain. She never saw him appear to have difficulty with his neck or shoulder. Fuller observed Employee participate in two, 12 hour cardiopulmonary resuscitation (CPR) trainings without physical limitations. Employee is right-handed and used his right hand while performing CPR on a dummy. Prior to his work injury, he walked and fished, along with his other daily activities. Since his work injury, Employee is in constant pain; he does not sleep well and has problems using his right arm. For example, Employee drops things with his right hand. He is hard-working, honest and has a strong moral compass. She does not believe he is faking his pain level. Fuller observed Employee in a sling for "months." (Fuller).

103) Dorman met Employee in 2006. She played racquetball, lifted weights, fished on the Kenai River, hiked, walked and camped with him prior to his work injury. She observed no neck or shoulder issues. Since Employee's work injury, Dorman has not done similar activities with him.

He now appears uncomfortable at most times. Employee is one of the most ethical people she knows and she does not think he is faking his pain. (Dorman).

104) Vannoy has known Employee since December 2018. He knew Employee had a one-year contract for human resource services and worked with him. Employee's work with Bering Straits Regional Housing Authority (Bering Straits) is over. He assumes Employee's invoices in May and June 2019 would represent services performed during those periods. Employee grimaces in pain often and cannot continue working for long periods without resting. In his view, Employee is "aggressively honest." (Vannoy).

105) Sharick has known Employee since 2011, when he was her supervisor. She found him hard-working. Sharick never saw Employee having any neck issues and he appeared physically active and healthy. He had a cheerful demeanor and showed no signs of physical disability. Sharick would describe Employee as physically "robust." She has not seen him since 2016. Sharick has never known Employee to lie. (Sharick).

106) Kolerok worked with Employee at Bering Straits and has known him since 2012, professionally and socially. Before his work injury, Employee did not demonstrate any physical limitations. He was active, fished often and walked regularly. Since Employee's work injury, Kolerok noticed Employee had difficulty with overhead baggage compartments on airplanes and could not use his right shoulder. He "walked funny," had a wider stance than normal and took shorter steps because his leg would occasionally go numb and he would fall. Employee is ethical and honest. (Kolerok).

107) Hoffman worked with Employee in 2004, and he exhibited no neck or shoulder problems before December 2016. (Hoffman).

108) Windsor is a physical therapist who treated Employee in 2017 and 2018. She has training and experience in orthopedic physical therapy. Employee presented initially with shoulder pain but eventually his pain radiated down into his arm and up to his cervical spine. He had been in a sling for a long time. She does not believe wearing a sling caused cervical issues. Windsor opined there was cervical pathology along with his shoulder issue. In her view, often there is "regional interdependence" because the shoulder and neck are so closely related. Windsor has heard of brachial plexus issues resulting from scalene injections and opined it was within the realm of possibilities. She saw no evidence Employee exaggerated his symptoms; it was often difficult for him to express symptoms and he was "more stoic." Windsor's objective findings supported her

opinion. She was surprised Employee handled his symptoms so well given his significant muscle and joint issues. Windsor is capable and authorized to make musculoskeletal diagnoses. Employee's primary diagnosis was his shoulder but she also directed attention to his cervical spine. (Windsor).

109) Employee stopped seeing doctors when Employer controverted his case. He had two injections into his shoulder blade area and only one into his neck. All the injections worked to some extent, but not for long. He is in constant pain beginning on the right rear side of his neck down to his right elbow and from his right breast into his shoulder. "It never goes away." He takes significant over-the-counter pain medication and spends time in a hot tub to relieve pain. Employee's pain interferes with his concentration, sleep and confidence leaving his home. He is right-handed and is afraid he may fall. Any right arm movement causes pain. Employee has little sensation in his hand and will drop things so his wife will not let him carry valuable things at home in his right hand. He never had this problem before his work injury. Prior to the work injury, Employee was active, loved fishing, biking and ping-pong and reduced his weight from 283 down to 205 pounds. In his various jobs, he set up tables and chairs, did janitorial work, lifted up to 50 pounds regularly, taught Mandt and CPR procedures and climbed around basements and attics inspecting homes. He wrote regularly on a whiteboard when teaching. Since his work injury, Employee cannot do these things. He can type on a keyboard if he takes numerous breaks. He cannot lay in bed for more than four to four and one-half hours each night but not all at one time, due to pain. Pain affects his whole life. In his view, he has not been able to work full-time at a permanent position since his injury because he cannot trust himself and does not want to besmirch his name by doing a bad job. He took the job at Bering Straits because for the first time in his life, in his view, he could not work at a real job. He worked for Bering Straits as a negotiator and consultant and worked from home except when he met with negotiators. He last performed services for Bering Straits and got paid for this work in July 2019. (Employee).

110) Employee thought Dr. Youngblood was racist because he sounded surprised when Employee told him he had a Master's Degree. In Employee's opinion, his examination was not extensive and Dr. Youngblood left the room for seven minutes to take a phone call. At most, the exam lasted less than 40 minutes including the telephone call. (*Id*.).

111) If Employee prevails on his medical claim, he will get whatever medical care the board allows him to have. He thought he had a delayed whiplash injury when he fell because he was

holding up his 205 pound body weight with one arm. Employee will pursue shoulder replacement surgery if the board awards his medical benefits; he knows several people who have had the surgical procedure and have had good results. Employee feels he cannot live with his pain and he is in "survival mode." He needs some relief to get back to work. (*Id*.).

112) The record remained open until October 2, 2019, for Dr. Youngblood's deposition and transcript, 10 page closing arguments and an updated attorney fee and cost itemization from Employee and any opposition from Employer. (Record).

113) On September 25, 2019, the parties timely filed their written closing arguments addressing Dr. Youngblood's post-hearing deposition. Each party highlighted the findings referenced above that support their positions and argued accordingly. (Observations).

114) On October 2, 2019, Employer filed a supplemental brief objecting to Employee's supplemental attorney fee and cost affidavit. It objects to attorney fees in general but specifically to Powell's $400 per hour rate, citing her relative inexperience compared to other attorneys receiving this rate. Employer made specific objections set forth in table below; the amounts this decision finds reasonable and fully compensable are included in the right-hand column as follows:

Table I

Line Item	Claimed	Objection	Awarded
19122	1.0	Excessive to review and transmit five standard medical releases	.5
19211	.3	Excessive for a one-sentence letter	.3
20577	.3	Does not correlate with received docs	.3
19295	3.6	Does not correlate with received docs	3.6
19554	.2	Time not justified for a single medical record	.2
19708	.3	Powell's error should not be paid	Not billed
19862	.5	Does not correlate with sent docs	.5
19930	.2	Does not correlate; unjustifiable time	.2
20693, 20698, 20699, 20700, 20701, 20735, 20736, 20739	10.4	Time spent on post-hearing brief excessive and not justified	10.4

(Employer's Supplemental Hearing Brief in Objection to Employee's Supplemental Affidavit of Counsel Regarding Fees and Costs, October 2, 2019).

115) Employee has not been, and is not, covered by Medicare or Medicaid. (Videotaped Deposition of Eduardo Campoamor, April 5, 2019, at 70).

116) Powell bills her contingent fees at $400 per hour for attorney work and provides her own paralegal services, which she bills at $185 per hour. The board and appeals commission have

awarded her these rates in numerous cases. For this case, she requests $34,897.50 in attorney fees and paralegal costs as well as $3,056.03 in other costs, not including the cost for Dr. Youngblood's deposition transcript, which is a reasonable and necessary litigation expense. (Supplemental Affidavit of Counsel regarding Fees and Costs, September 25, 2019).

117) This is a medically complex case with numerous medical conditions, any one of which could cause Employee's symptoms. Employer litigated the case vigorously with experienced counsel. Employee prevails on most substantive issues that result in benefits paid to him. The benefits awarded below are significant. Powell represented Employee for a moderate period. (Experience, judgment and inferences drawn from all the above).

PRINCIPLES OF LAW

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

> **AS 23.30.010. Coverage.** (a) . . . compensation or benefits are payable under this chapter for disability . . . or the need for medical treatment of an employee if the disability . . . or the employee's need for medical treatment arose out of and in the course of the employment. . . . When determining whether or not the . . . disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability . . . or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability . . . or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability . . . or need for medical treatment.

In construing AS 23.30.010(a), *Morrison v. Alaska Interstate Construction, Inc*., 440 P.3d 224, 237 (Alaska 2019), said the board must consider different causes of the "benefits sought" and the extent to which each cause contributed to the need for the specific benefit at issue. The board must then identify one cause as "the substantial cause." *Morrison* held the statute does not require the substantial cause to be a "51% or greater cause, or even the primary cause, of the disability or need for medical treatment." The board need only find which of all causes, "in its judgment is the most important or material cause related to that benefit." (*Id*.). *Morrison* further held that preexisting

conditions, which a work injury aggravates, accelerates or combines with to cause disability or the need for medical treatment, can still constitute a compensable injury. (*Id*. at 234, 238-39).

> **AS 23.30.095. Medical treatments, services, and examinations.** (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. . . . It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require. . . .

When the board reviews a claim for medical treatment made within two years of an injury that is indisputably work-related, "its review is limited to whether the treatment sought is reasonable and necessary." *Philip Weidner & Associates v. Hibdon*, 989 P.2d 727, 730-32 (Alaska 1999).

> The question of reasonableness is 'a complex fact judgment involving a multitude of variables.' However, where the claimant presents credible, competent evidence from his or her treating physician that the treatment undergone or sought is reasonably effective and necessary for the process of recovery, and the evidence is corroborated by other medical experts, and the treatment falls within the realm of medically accepted options, it is generally considered reasonable. (Citations omitted) (*Id*.).

Complications from work-related treatment are still compensable and the employer is liable for continuing medical benefits. *Ribar v. H&S Earthmovers*, 618 P.2d 582 (Alaska 1980).

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

The presumption applies to any claim for compensation. *Meek v. Unocal Corp*., 914 P.2d 1276 (Alaska 1996). In the first step, the claimant need only adduce "minimal" relevant evidence establishing a "preliminary link" between the injury and employment. *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987). In claims based on highly technical medical considerations, medical evidence is often necessary to make a connection. *Burgess Construction Co. v. Smallwood*, 623 P.2d 312 (Alaska 1981). In less complex cases, lay evidence

may be sufficient to establish causation. *VECO, Inc. v. Wolfer*, 693 P.2d 865 (Alaska 1985). Credibility is not weighed here. *Resler v. Universal Services Inc.*, 778 P.2d 1146 (Alaska 1989).

In the second step, if the employee's evidence raises the presumption, it attaches to the claim and the production burden shifts to the employer. The employer has the burden to overcome the presumption with substantial evidence to the contrary. "Substantial evidence" is such "relevant evidence" as a "reasonable mind might accept as adequate to support a conclusion." *Tolbert*, 973 P.2d at 611-12. Credibility is not examined at the second step either. *Resler*. Whether the amount of evidence is substantial is a legal question. When evidence offered to rebut the presumption is uncertain or inconclusive, the presumption is not overcome. *Bouse v. Fireman's Fund Insurance Co.*, 932 P.2d 222 (Alaska 1997).

The Alaska Supreme Court fourth in detail what constitutes substantial evidence to rebut the presumption in the second step. *Kessick v. Alyeska Pipeline Service Co.*, 617 P.2d 755 (Alaska 1980), discussed objective medical evidence, and substantial evidence to support a board decision. Reversing the denial of benefits based on an opinion citing no objective evidence, *Kessick* said:

> Nor does the lack of objective signs of an injury in and of itself preclude the existence of such an injury. (Citation omitted). There are many types of injuries which are not readily disclosed by objective tests. (*Id*. at 758).

Further addressing substantial evidence to rebut the presumption, *Huit v. Ashwater Burns, Inc.*, 372 P.3d 904 (Alaska 2016), said an employer can rebut the presumption by showing the worker's injury did not arise out of his employment. To do so, it needs to show the work injury could not have caused the condition requiring treatment or causing disability (the negative-evidence test) or that another, non-work-related event or condition caused it (the affirmative-evidence test). In *Huit*, the employer's experts opined work was probably not the substantial cause of disability. Rejecting this argument, *Huit* said "merely reciting the proper words as an opinion is not necessarily enough to rebut the presumption of compensability, because the employer must provide *substantial evidence* that the disability was not work-related" (emphasis in original). *Huit* concluded the employer did not meet the "negative-evidence test" because its doctors did not show that the work-related injury (a scratch) could not have been the entry point for bacteria that caused infection and also failed to meet the "affirmative-evidence test" because no expert provided substantial evidence

of another entry point for the bacteria. *Huit* also held the mere possibility of another injury source is not substantial evidence sufficient to overcome the presumption. An "unknown cause" is not substantial evidence to rebut it. Identifying other possible causes, without identifying the injured worker has those causes, is also not substantial evidence rebutting the presumption.

In the third step, if the employer's evidence rebuts the presumption, it drops out and the employee must prove his claim by a preponderance of the evidence. *Huit* held in determining whether the disability or need for treatment arose out of and in the course of employment, the factfinders in the third step must evaluate the relative contribution of different causes of the disability or need for treatment. The employee must "induce a belief" in the fact-finders' minds that the asserted facts are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). However, *Huit* found if "no other cause was identified" as contributing to the employee's injury, the board need not evaluate the relative contribution of different causes in the third step. The evidence is weighed, inferences drawn and credibility determined. *Steffey v. Municipality of Anchorage*, 1 P.3d 685 (Alaska 2000).

Carter v. B&B Construction, Inc., 199 P.3d 1150, 1158 (Alaska 2008), held that where the employer does not rebut the raised presumption of compensability by substantial evidence to the contrary, the claimant is entitled to benefits as "a matter of law."

> **AS 23.30.122. Credibility of witnesses.** The board has the sole power to determine the credibility of a witness. . . .

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

> **AS 23.30.135. Procedure before the board.** (a) . . . The board may make its investigation or inquiry or conduct its hearing in the manner by which it may best ascertain the rights of the parties. . . .

Egemo v. Egemo Construction Co., 998 P.2d 434 (Alaska 2000) held filing a claim prematurely "does not justify [claim] dismissal," and stated:

> In our view, when a claim for benefits is premature, it should be held in abeyance until it is timely. . . . (*Id*. at 441).

> **AS 23.30.145. Attorney fees.** (a) Fees for legal services rendered in respect to a claim are not valid unless approved by the board, and the fees may not be less than 25 percent on the first $1,000 of compensation or part of the first $1,000 of compensation, and 10 percent of all sums in excess of $1,000 of compensation. When the board advises that a claim has been controverted . . . the board may direct that the fees for legal services be paid by the employer or carrier in addition to compensation awarded; the fees may be allowed only on the amount of compensation controverted and awarded. . . . In determining the amount of fees the board shall take into consideration the nature, length, and complexity of the services performed, transportation charges, and the benefits resulting from the services to the compensation beneficiaries. . . .

Attorney fees in workers' compensation cases should be fully compensatory and reasonable so injured workers can retain competent counsel. *Cortay v. Silver Bay Logging*, 787 P.2d 103 (Alaska 1990). In *State v. Cowgill*, 115 P.3d 522 (Alaska 2005), the board ruled in Cowgill's favor on her controverted claim. The state appealed, and the superior court reversed. On remand, the board reviewed its past decisions and came to a similar result. The state appealed again. *Cowgill* explained what constitutes adequate board findings to support an attorney fee award:

> The board explained that the
>
> > claim was vigorously litigated by very competent counsel. The range of litigated benefits to the employees was significant (between $0.00 and $24,300.00 in PPI benefits). . . . [W]e find the medical evidence was fairly complex. Last, we find the employer raised unique arguments regarding attorney's fees, not previously decided. (*Cowgill*, 115 P.3d 522 at 526).

Fees incurred on lost, minor issues will not be reduced if the employee prevails on primary issues. *Uresco Construction Materials, Inc. v. Porteleki*, AWCAC Decision No. 152 (May 11, 2011).

> **AS 23.30.155. Payment of compensation**. (a) Compensation under this chapter shall be paid periodically, promptly, and directly to the person entitled to it, without an award, except where liability to pay compensation is controverted by the employer. . . .
> . . . .
>
> (e) If any installment of compensation payable without an award is not paid within seven days after becomes due, as provided in (b) of this section, there shall be added to the unpaid installment an amount equal to 25 percent of the installment. . . . The

> additional amount shall be paid directly to the recipient to whom the unpaid installment was to be paid.
> . . . .
>
> (o) The director shall promptly notify the division of insurance if the board determines that the employer's insurer has frivolously or unfairly controverted compensation due under this chapter. After receiving notice from the director, the division of insurance shall determine if the insurer has committed an unfair claim settlement practice under AS 21.36.125.
>
> (p) An employer shall pay interest on compensation that is not paid when due. . . .

Childs v. Copper Valley Electric Association, 866 P.2d 1184, 1192 (Alaska 1993), held medical benefits are subject to a penalty under AS 23.30.155(e) because they are "compensation," and to incentivize insurance companies to pay promptly. *Sumner v. Eagle Nest Hotel*, 894 P.2d 628 (Alaska 1995), however, held a penalty was not appropriate even if a controversion was made in bad faith if the controversion does not delay payment.

Harp v. ARCO Alaska, Inc., 831 P.2d 352, 358 (Alaska 1992), said, "For a controversion notice to be filed in good faith, the employer must possess sufficient evidence in support of the controversion that, if the claimant does not introduce evidence in opposition to the controversion, the Board would find that the claimant is not entitled to benefits." The employer in *Harp* cited two reasons for controverting: (1) the employee failed to prove she continued to be disabled, and (2) the employee's disability was not work-related. Addressing the first issue, *Harp* said the employee had no legal duty to prove continuing disability and the employer failed to send the employee to an EME before controverting and consequently had no evidence stating she was not still disabled. As to the second argument:

> The evidence which the employer possessed at the time of controversion was, at best, neutral evidence that Harp was not entitled to benefits. . . . The employer points out that when Dr. Berkeley examined Harp in December 1987, he was 'at a loss to understand what [was] going on and why she had recurrent symptoms.' This statement alone would not constitute substantial evidence that Harp is not entitled to benefits. . . .

Harp also said the opposite of "good faith" is "bad faith":

> Because neither reason given for the controversion was supported by sufficient evidence to warrant a Board decision that Harp is not entitled to benefits, the

> controversion was made in bad faith and was therefore invalid. A penalty is therefore required by former AS 23.30.155(e). (*Id*. at 358-59).

The employee in *Harp* was injured in 1987, prior to AS 23.30.185 amendments, which end TTD benefits on the date of "medical stability." This amendment, and the "medical stability" definition to which it refers, became effective July 1, 1988.

In *Harris v. M-K Rivers*, 325 P.3d 510, 517 (Alaska, 2014), the Alaska Supreme Court said, "*Harp* does not require an inquiry into the motives of the controversion's author. We have never overruled *Harp*, and it is still the law." *Harris* further stated:

> When the Board finds that an employer has unfairly or frivolously controverted 'compensation due,' AS 23.30.155(o) says that the Director of the Division of Workers' Compensation must notify the Division of Insurance. In its regulations, the Board has interpreted 'compensation due' in AS 23.30.155(o) to mean 'the *benefits sought* by the employee, including . . . medical . . . benefits . . . *whether paid or unpaid at the time the controversion was filed*.' (Citation omitted). Although we do not decide here whether a controversion that is not made in good faith under *Harp* is always frivolous or unfair under AS 23.30.155(o), both the Board and the Commission linked the penalty provisions of AS 23.30.155(e)-(f) to the unfair or frivolous controversion provision of AS 23.30.155(o).

Irby v. Fairbanks Gold Mine, Inc., 203 P.2d 1138 (Alaska 2009), said the board's determination in an unfair or frivolous controversion case may be based on fact-based or legal-based findings. Fact-based findings focus on whether the controversion is based on adequate facts to justify it. Legal-based findings focus on whether the employer was legally justified in controverting benefits.

> **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.

Lowe's v. Anderson, AWCAC Decision No. 130 (March 17, 2010), explained to obtain TTD benefits, assuming the presumption has been rebutted, an injured worker must establish: (1) she is disabled as defined by the Act; (2) her disability is total; (3) her disability is temporary; and (4) she has not reached the date of medical stability as defined in the Act. (*Id*. at 13-14).

> **AS 23.30.190. Compensation for permanent partial impairment; rating guides**. (a) In case of impairment partial in character but permanent in quality, and not resulting in permanent total disability, the compensation is $177,000 multiplied by the employee's percentage of permanent impairment of the whole person. . . .
>
> **AS 23.30.200. Temporary partial disability**. (a) In case of temporary partial disability resulting in decrease the of earning capacity the compensation shall be 80 percent of the difference between the injured employee's spendable weekly wages before the injury and the wage-earning capacity of the employee after the injury in the same or another employment, to be paid during the continuance of the disability. . . . Temporary partial disability benefits may not be paid for a period of disability occurring after the date of medical stability. . . .

A disability award must be supported by a finding the employee suffered a compensable disability. The injured worker must have a decrease in earning capacity due to a work-connected injury, not because of non-work-related situations or conditions. *Vetter v. Alaska Workmen's Compensation Board*, 524 P.2d 264 (Alaska 1974).

> **AS 23.30.395. Definitions**. In this chapter,
> . . . .
>
> (16) 'disability' means incapacity because of injury to earn the wages which the employee was receiving at the time of injury. . . .
> . . . .
>
> (24) 'injury' means accidental injury . . . arising out of and in the course of employment, and . . . infection that arises naturally out of the employment or that naturally or unavoidably results from an accidental injury. . . .
> . . . .
>
> (28) '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. . . .

An employer may rebut the continuing disability presumption and gain a "counter-presumption" by producing substantial evidence proving medical stability. *Anderson*. If the employer raises the counter-presumption, "the claimant must first produce clear and convincing evidence" he has not

reached medical stability. (*Id*. at 9). The 45 day provision signals when "proof is necessary." *Municipality of Anchorage v. Leigh*, 823 P.2d 1241, 1246 (Alaska 1992).

Thoeni v. Consumer Electronic Services, 151 P.3d 1249, 1255 (Alaska 2007), said it is the employer's burden to prove "noncompensability." The board in *Thoeni* found the worker was medically stable based on two physicians' reports, one which predicted no "major changes in the next 45 days" and the other that said her knee would improve with a diligent exercise regime. But ultimately, the doctors' predictions "proved incorrect." *Thoeni* noted:

> By the time the board determined medical stability, it knew [the two predictions] . . . were incorrect. It also knew that another knee surgery to improve the knee was recommended on January 25, 2001. . . . Indeed, another surgery to improve the knee was . . . performed in April 2001. Thus, the board knew [the two doctors'] . . . predictions proved incorrect.

Thoeni held the two incorrect predictions were not substantial evidence upon which the board could reasonably conclude the worker had achieved medical stability and reversed. (*Id*.).

> **8 AAC 45.084. Medical travel expenses**. . . .
>
> (b) Transportation expenses. . . .
> . . . .
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> (d) Transportation expenses, in the form of reimbursement for mileage, which are incurred in the course of treatment or examination are payable when 100 miles or more have accumulated, or upon completion of medical care, whichever occurs first. . . .
>
> **8 AAC 45.182. Controversion**. . . .
> . . . .
>
> (d) After hearing a party's claim alleging an insurer or self-insured employer frivolously or unfairly controverted compensation due, the board will file a decision and order determining whether an insurer or self-insured employer frivolously or unfairly controverted compensation due. Under this subsection,
>
> > (1) if the board determines an insurer frivolously or unfairly controverted compensation due, the board will provide a copy of the decision and order at the time of filing to the director for action under AS 23.30.155(o); . . .
> . . . .

> (e) For purposes of this section, the term 'compensation due,' and for purposes of AS 23.30.155(o), the term compensation due under this chapter,' are terms that mean the benefits sought by the employee, including but not limited to disability, medical, and reemployment benefits, and whether paid or unpaid at the time the controversion was filed.

ANALYSIS

1) Is Employee entitled to additional TTD benefits?

To obtain additional TTD benefits, Employee must be temporarily, totally disabled by his work injury, and not medically stable, during the claim period. AS 23.30.185; *Anderson*. He claims TTD benefits from September 21, 2018, through January 2, 2019, and from May 1, 2019, and continuing until he is no longer disabled or is medically stable. Employer claims a TTD benefit overpayment beginning July 1, 2018, through September 20, 2018, based on Dr. Youngblood's June 30, 2018 medical stability date. "Disability" means incapacity to earn wages Employee was receiving at the time of his injury, due to the injury. AS 23.30.395(16). "Medical stability" is the date after which further objectively measurable improvement from the injury is not reasonably expected to result from additional medical care or treatment. Forty-five days passing without objectively measurable improvement creates a presumption of medical stability, which can be rebutted by clear and convincing evidence. AS 23.30.395(28); *Anderson*. Employee seeks TTD benefits for three body parts: (A) neck; (B) right shoulder; and (C) brachial plexus. To succeed on his claim for additional TTD benefits, if the presumption is rebutted, he must show each part had a compensable "injury" or the work injury was the substantial cause to aggravate, accelerate or combine with a preexisting condition, to cause him disability. AS 23.30.395(16), (24); *Morrison*.

(A) The "neck."

The parties disagree on whether Employee injured or aggravated his neck when he slipped and fell at work. This causation issue creates a factual dispute to which the presumption analysis applies. AS 23.30.120; *Meek*. Employer agrees Employee raises the presumption. Dr. Youngblood's report stating the injury did not cause or aggravate a herniated cervical disc and Dr. Puziss' opinion stating the injury did not aggravate, accelerate or combine with any preexisting neck condition rebut it. *Tolbert*; *Resler*. This shifts the burden back to Employee who must prove causation as it relates to his cervical discs and stenosis by a preponderance of the evidence. *Saxton*.

Employee had neck symptoms beginning in 1981, when he had right-sided neck pain following a motor vehicle accident. In 2005, he had incapacitating neck and right arm pain after moving boxes. Dr. Eule diagnosed right C7 radiculopathy and ordered an MRI. A 2005 MRI showed a disc extrusion at C6-7 centrally with mild-to-moderate cord compression. There were multilevel abnormalities and disc protrusions from C4 through C6, but predominantly centrally at C6-7. Employee's 2005 MRI is similar to his 2018 post-injury MRI. *Rogers & Babler*. The presence of a herniated disc and stenosis in 2005 does not preclude the possibility the 2016 injury aggravated, accelerated or combined with preexisting conditions as the substantial cause of disability arising from Employee's neck. *Morrison*. Dr. Puziss reviewed the 2005 and 2018 MRI reports and determined Employee had "chronic" herniated discs especially at C6-7 and opined the work injury neither caused nor aggravated, accelerated nor combined with this preexisting condition to contribute to his symptoms. He derived a different reason for Employee's symptoms, discussed below. This is convincing evidence Employee's work injury did not injure his neck, and he did not aggravate or accelerate, or combine with, preexisting cervical conditions when he slipped and fell at work. Dr. Puziss' opinion is credible and given great weight. AS 23.30.122; *Smith*; *Steffey*.

Because Employer first filed the 2005 MRI report on February 12, 2019, Drs. McAnally, Paisley, Spencer and DPT Windsor had not seen it prior to stating the work injury caused or aggravated Employee's neck conditions. It is unknown if their opinions would change were they to see the 2005 MRI. Dr. McAnally said it was "impossible" to relate Employee's symptoms to his "age" without "longitudinal imaging studies." He was unaware there was a 2005 cervical MRI, which demonstrates chronic cervical conditions. Dr. Youngblood saw no causal connection between the work injury and Employee's cervical disc issues, but he is not a spinal surgeon. Consequently, these providers' opinions linking C6-7 disc causation or aggravation to the work injury, or disavowing any connection, respectively, are given less weight. AS 23.30.122; *Smith*; *Steffey*.

There is no evidence suggesting the work injury accelerated or combined with the preexisting cervical conditions to cause disability or need for treatment. Employee's medical records show no significant neck pain or symptoms attributable to a cervical disc injury until October 20, 2017, when he reported having "electrical shock" feelings in his right hand and numbness and tingling in several fingers since shoulder surgery. Prior to October 2017, neck examinations in January,

March, April and May 2017, showed normal neck motion with no tenderness or other symptoms one would associate with a herniated disc, such as numbness or tingling in his right upper extremity. One isolated report on June 28, 2017, mentioned numbness and tingling in his fingers, which was likely related to wearing a sling. *Rogers & Babler.*

As Dr. Youngblood said, while a person with a symptomatic herniated cervical disc may not have actual "neck" pain, they should have functional issues related to nerve or spinal cord impingement resulting from the disc. This might include a shocking sensation, weakness, numbness, or tingling in the proper dermatomal pattern, or altered gait. Pain medication would not necessarily affect neurological symptoms. At hearing, Employee for the first time said he thought he might have had a delayed cervical "whiplash" injury when he slipped on the stairs at work. There is no similar report from him in any record and this testimony is given less weight. AS 23.30.122; *Smith*.

The above analysis rules out the work injury as the substantial cause of Employee's stenosis or herniated cervical discs or any aggravation, acceleration or combining with Employee's preexisting cervical conditions shown on MRI. *Huit*; *Morrison*. Because the cervical disc injuries shown on MRI did not arise out of Employee's work, it is irrelevant whether they are medically stable or disabling. AS 23.30.010(a).

There is an exception to causation for Employee's "neck." Dr. Puziss opined Employee has right neck pain due to abnormal shoulder biomechanics resulting from surgeries. The medical records corroborate that Employee eventually developed neck pain. Medical complications related to his right shoulder injury or surgeries are compensable. AS 23.30.010(a); *Ribar*. Dr. Puziss recommends medial branch blocks near the right C6-7 facet to verify facetogenic pain. If the pain's source is verified, he recommends radiofrequency ablation. Dr. Puziss' opinion on this point is credible and given considerable weight. AS 23.30.122; *Smith*; *Steffey*. However, while investigating facetogenic pain, and the pain itself, are compensable results arising from Employee's surgeries for his work injury, there is no evidence that past facetogenic pain, or a future medial branch block or radiofrequency ablation, has caused or will cause disability.

In summary, Employee's preexisting cervical conditions found on MRI are not compensable and therefore could not cause awardable TTD benefits. His claim for TTD benefits from September 21, 2018, through January 2, 2019, and from May 1, 2019, and continuing based on preexisting cervical conditions shown on MRI will be denied. However, right neck pain arising from abnormal shoulder biomechanics and related injections and treatment are compensable but there is no evidence it has caused any disability. Employer never paid TTD benefits based on the neck, so there is no TTD benefit overpayment for the neck. Future TTD benefits claims based on facetogenic pain are held in abeyance because they are not ripe. AS 23.30.010(a); *Egemo*.

(B) The right shoulder.

The right shoulder injury is undisputed. AS 23.30.010(a). Employer claims an overpayment beginning July 1, 2018; Employee disagrees. The parties further disagree on medically stable, disability and entitlement to additional TTD benefits beginning September 21, 2018, for the right shoulder. This creates a factual dispute to which the presumption analysis applies. *Meek*.

(1) <u>Medical stability.</u>

Employee raises the presumption he was not medically stable for his shoulder with opinions from Drs. Paisley, McAnally and Puziss. On March 2, 2018, Dr. Paisley referred Employee for pain management and said he would need a reverse total shoulder arthroplasty if he did not experience pain relief or functional improvement. On August 29, 2018, he said Employee's "next step" was a reverse total shoulder arthroplasty and he was "most certainly not considered to be medically stable as we are considering potential further surgery." On September 24, 2018, Dr. McAnally agreed the shoulder was not medically stable and Employee needed shoulder surgery. On April 9, 2019, Dr. Puziss said Employee's right shoulder was medically stable on July 20, 2018. *Cheeks*; *Resler*. Employer rebuts the presumption with Dr. Youngblood's September 4, 2019 opinion stating Employee's right shoulder is medically stable, functional and he would not recommend a reverse shoulder arthroplasty at this time. *Tolbert*; *Resler*. Since Employer claims an overpayment beginning July 1, 2018, and he claims TTD benefits from September 21, 2018, and continuing until medical stability, Employee must show his right shoulder was not medically stable on July 1, 2018, through September 21, 2018, and continuing, by clear and convincing evidence. *Anderson*; *Leigh.*

On June 28, 2017, Dr. Paisley first recommended an arthroplasty as secondary treatment following debridement, assuming Employee's shoulder infection cleared. Employee wanted to proceed with the plan. On June 30, 2017, Dr. Vermillion said the treatment plan included debridement and tissue biopsy followed by a reverse shoulder arthroplasty. Repeated infections delayed the arthroplasty as physicians struggled to clear chronic infection and identify a pain source and resolve it with the least invasive treatments. On March 2, 2018, Dr. Paisley again recommended an arthroplasty if Employee did not respond to Dr. McAnally's treatments. Unfortunately, around the same time efforts turned toward Employee's neck, further delaying shoulder treatment. On May 15, 2018, Dr. Paisley said Employee was not medically stable because he may need an arthroplasty. In context, the "may need" phrase refers to expected arthroplasty in the event lesser treatments did not help. *Rogers & Babler*. In August 2018, after unsuccessful treatment for other pain sources, Dr. Paisley said the "next step" would be arthroplasty assuming he did not respond to neck treatment. However, Dr. Paisley recommended the cervical spine evaluations occur first and opined Employee was "most certainly not considered to be medically stable" because he was considering potential shoulder surgery. Soon thereafter, Employer controverted Employee's case in September 2018. *Thoeni*.

However, as discussed more fully below, since Drs. Paisley and Vermillion recommended a right shoulder arthroplasty within two years of Employee's injury date, all physicians agree the surgery is reasonable and causation for the right shoulder injury is not disputed, he is entitled to it. *Hibdon*. Because he is entitled to the surgery, which is expected to improve his symptoms, it will render him not medically stable until he recovers from it. AS 23.30.395(28); *Thoeni*.

Dr. Youngblood testified Employee's attending physicians were merely considering additional shoulder surgery and not actually recommending it. To the contrary, the records show Employee was reluctant to have additional shoulder surgery given his past surgical issues, and his physicians disagreed on how to treat him and in what order. Having failed all else though, he needed a reverse total shoulder arthroplasty according to four physicians, three of which, Drs. Paisley, Vermillion and McAnally, recommended it before Employer controverted medical care for the right shoulder on September 21, 2018. Dr. Youngblood selected June 30, 2018, eight months after the last surgery, as the date Employee became medically stable. He gave no explanation for selecting this

date other than it was eight months post-surgery; the medical records show no treatment occurred on June 30, 2018, and he failed to explain this date's significance. Therefore, Dr. Youngblood's right shoulder medical stability opinion is given less weight. AS 23.30.122; *Smith*; *Steffey*.

Dr. Puziss opined Employee's right shoulder became medically stable on July 20, 2018, the date Dr. Youngblood saw him. As was the case with Dr. Youngblood, Dr. Puziss' right shoulder medical stability opinion is conclusory and he does not explain how he derived the July 20, 2018 date for right shoulder medical stability. Moreover, Dr. Puziss agreed it is reasonable for Employee to have the right shoulder arthroplasty, an opinion inconsistent with his conclusory finding of right shoulder medical stability effective July 20, 2018. Therefore, Dr. Puziss' opinion on the right shoulder medical stability date is also given less weight. AS 23.30.122; *Smith*; *Steffey*.

In summary, additional right shoulder surgery is intended to result in objectively measurable improvement, or physicians would not recommend it. *Rogers & Babler*. Recommendations for right shoulder surgery would render Employee not medically stable from the date the recommendation was made. AS 23.30.395(28); *Thoeni*. Drs. Paisley's, Vermillion's and McAnally's arthroplasty recommendations and opinions on medical stability are credible and given significant weight. AS 23.30.122; *Smith*. Since Employer's TTD benefit overpayment defense begins on July 1, 2018, and Employee's claim for TTD benefits begins September 21, 2018, his right shoulder's medical stability status on those dates is critical. Given the above analysis, the overwhelming medical evidence demonstrates Employee's right shoulder was not medically stable effective July 1, 2018, or September 21, 2018. AS 23.30.395(28); *Thoeni*.

(2) <u>Disability</u>.

In addition to his right shoulder not being medically stable, to obtain TTD benefits if the presumption is rebutted Employee must also show it disabled him beginning July 1, 2018, through September 21, 2018, and continuing. The parties disagree on disability, which means the presumption analysis applies. *Meek.* He raises the disability presumption with Dr. Paisley's opinions and his own testimony. On March 2, 2018, Dr. Paisley referred him to Dr. McAnally for pain management and concluded he would need a shoulder arthroplasty if he did not have pain relief or functional improvement. On August 29, 2018, he said Employee had increasing right

shoulder pain and decreasing strength and restricted him to no lifting, pushing or pulling or over-shoulder activities with his right arm. Employee testified he is never pain free, sleeps poorly, drops things with his right hand, is afraid of falling and cannot work. *Cheeks*; *Resler*. Employer rebuts the presumption with Dr. Youngblood's report stating, after reviewing the description for Employee's job, he could return to his job at the time of injury effective June 30, 2018. *Tolbert*; *Resler*. Employee must prove disability from his right shoulder beginning July 1, 2018, and continuing, by a preponderance of the evidence. *Saxton*.

In addition to Dr. Paisley's reports, discussed above, on February 26, 2018, a right shoulder MRI showed a supraspinatus tear, tendinosis, joint space narrowing and a degenerated labrum. On March 12, 2018, Dr. McAnally said Employee had capsulitis and other issues from multiple right shoulder operations and chronic infections. On March 20, 2018, he gave Employee a scapulocostal injection into the right shoulder. Employee's right shoulder pain continued. On April 18, 2018, Dr. Paisley restricted him from work until his next appointment. On May 14 2018, Dr. McAnally recommended additional disability benefits for "several months." Through June and July 2018, Employee's right shoulder pain persisted and after interscalene blocks he developed progressive numbness, tingling and weakness in his right hand and arm. On October 3, 2018, PA-C Fayette said Employee would continue to have pain and decreased motion and strength in his right upper extremity. In response to a vocational reemployment specialist's questionnaire, she "predicted" he would have permanent physical capacities sufficient to enable him to return to work in three positions he held in the 10 years prior to his work injury with Employer, and his job at the time of injury. However, she did not release him to return to work; no attending physician released him to return to work after his last right shoulder surgery. On April 9, 2019, Dr. Puziss said Employee's continued disability results in part from a failed original rotator cuff repair with related infections and scar tissue. These medical opinions are consistent with the treating medical record, are credible and are given considerable weight on the disability issue. AS 23.30.122; *Smith*; *Steffey*.

For years before his work injury, Employee was physically active, hiked, fished, played handball and had no disability from his right shoulder. He has been in constant pain since his work injury, takes significant over-the-counter pain medication and spends time in a hot tub to relieve pain. Pain interferes with his concentration, sleep and confidence. He is afraid he will fall. Moving his

right arm even slightly causes pain; pain interferes with his sleep. Anderson worked with Employee for years pre-injury and never noticed him having any difficulty using his shoulder. Employee worked hard physically and was honest in every way. Fuller corroborates Employee's testimony. She never observed him having shoulder pain and saw him participate in two, 12 hour CPR trainings using his right upper extremity on the CPR dummy without difficulty. Dorman played racquetball, lifted weights, fished, hiked, walked and camped with Employee prior to his work injury. She never noticed him having any shoulder issues. Since Employee's work injury, Dorman says he appears uncomfortable at most times. He is one of the most ethical people she knows. Post-injury, Vannoy noted Employee grimaced often and could not work for long periods without resting; he is "aggressively honest." Sharick said he was physically "robust" pre-injury. She has never known him to lie. Kolerok worked with Employee at Bering Straits and noticed he had difficulty lifting baggage overhead and had difficulty using his right shoulder. Employee is ethical and honest. Hoffman worked with him in 2004, and did not notice any shoulder problems before his work injury. DPT Windsor believes he is stoic given his objective findings. Employee, DPT Windsor and Employee's lay witnesses are all credible. AS 23.30.122; *Smith*.

Employee convincingly testified he would have had difficulty working full-time earning the wages he earned at the time of his injury. Inferences from lay witnesses that observed him from early 2018 forward support his testimony. His wife, Fuller, had the best opportunity to observe him on a daily basis and said he was in constant pain, did not sleep well at night and had problems using his right arm and hand. Employee is right-handed and corroborated his wife's testimony that his right hand is weak and he drops things. He cannot lay in bed for more than four to four and one-half hours due to pain, which affects his whole life. Employee and his wife are credible and their testimony is given considerable weight. AS 23.30.122; *Smith*. It would have been difficult for Employee to work full-time with chronic right shoulder weakness and pain, and sleep deprivation, resulting from shoulder symptoms caused by his work injury. There is no evidence Employer offered him an easier job with less physical requirements. *Rogers & Babler*.

The sole contrary evidence is Dr. Youngblood's opinions. He reviewed job descriptions and found Employee physically able to work. There was no physical capacity evaluation. Dr. Youngblood testified he did not think Employee was malingering, lying or magnifying his symptoms. He said

10 times that he simply had no orthopedic explanation for Employee's continuing pain. Yet, he concluded that whatever the cause, the pain was not related to his work injury with Employer. It is not credible for Dr. Youngblood to say he cannot explain Employee's continued pain while also stating the undisputed right shoulder work injury is not the substantial cause of the unknown reason for his pain; the concepts are mutually exclusive. He tries to minimize Employee's symptoms without actually saying he does not have them. His symptom minimization necessarily forms the basis for his belief Employee could return to work. His view is not shared by any other attending physician. Therefore, his opinion on disability is given less weight. AS 23.30.122; *Smith*; *Steffey*.

Given the above analysis, Employee met his burden and demonstrated his right shoulder was not medically stable and was temporarily totally disabling beginning July 1, 2018, and continuing through September 21, 2018, through January 2, 2019, and from May 1, 2019, and continuing. There was no TTD benefit overpayment. He is entitled to additional TTD benefits from September 21, 2018, through January 2, 2019, and from May 1, 2019, and continuing based on his need for a right shoulder arthroplasty, until his right shoulder is medically stable or is no longer disabling. AS 23.30.395(16); AS 23.30.395(28).

A complicating factor in this analysis is the undisputed fact that on September 21, 2018, Employer paid Employee $7,080 in lump-sum PPI benefits based on Dr. Youngblood's four percent right shoulder PPI rating. This decision found Employee's right shoulder was not medically stable as of July 1, 2018, and continuing. Therefore, Employer made an advanced PPI benefit payment. Employee's weekly TTD rate is $1,113.24. This decision will direct Employer to re-characterize the previously paid PPI benefits as TTD benefits paid at that weekly rate. AS 23.30.135. This calculation will reduce Employer's TTD benefit liability to Employee by a little over six weeks. Thus, the TTD benefits awarded in this decision will be offset beginning September 21, 2018, by the prorated PPI benefits paid in advance, in accordance with this decision.

(C) The brachial plexus.

Since he cannot receive TTD benefits more than once for the same period, Employee alternately seeks TTD benefits based on Dr. Puziss' brachial plexus diagnosis. Assuming the presumption is rebutted, before he could be entitled to TTD benefits for this condition, he must prove it is

compensable. Drs. Youngblood and Puziss are the only physicians giving opinions on this diagnosis. The parties disagree on whether he has this condition and, if so, what caused it. These factual disputes require the presumption analysis. *Meek.*

Employee raises the presumption with his testimony and medical records showing his symptoms appeared shortly after his interscalene injections, and with Dr. Puziss' report. Employee and his records either relate the right hand and arm numbness and tingling to his shoulder surgery or show a contemporaneous relationship between the two. Dr. Puziss directly connects an interscalene block given for a right shoulder surgery to a brachial plexus injury. *Cheeks*; *Resler*. Employer rebuts it with Dr. Youngblood's testimony stating Employee does not have a brachial plexus injury arising from an interscalene injection. *Tolbert*; *Resler*. Employee must prove his injury was the substantial cause of a brachial plexus injury by a preponderance of the evidence. *Saxton*.

Employee had interscalene blocks for his September 12, 2017 and October 20, 2017 right shoulder surgeries. By September 13, 2017, Employee had regained feeling in his hand with intact sensation and no reported tingling or numbness. He had 15 PT visits between September 13 and October 9, 2017, with no numbness or tingling reported. However, on September 25, 2017, a provider warned him that numbness and tingling could result from numbing medication injected at the surgical site for his upcoming October 10, 2017 shoulder surgery. A reasonable inference from this warning is that a known risk from an interscalene injection is neurological symptoms. *Rogers & Babler*. On October 10, 2017, prior to right shoulder surgery he had another interscalene block. The next day when the physician assistant called him, Employee reported minor issues from his surgery but did not mention numbness or tingling. However, within 10 days, on October 20, 2017, at his first office visit following his last right shoulder surgery, Employee reported for the first time having "electrical shock" sensations in his right hand and numbness and tingling in several fingers. The surgeon's assistant prescribed Gabapentin for "nerve pain," which Employee said began at some point "after surgery." On October 30, 2017, Employee for the first time marked finger symptoms on a pain drawing. Thereafter, his medical records from October 2017, through February 2018, show continuing nerve-related symptoms including "fire ants," "jerking," "crawling under the skin," and "nerve-like pain," many of which worsened over time. Employee also began experiencing right hand weakness and started dropping things. This generally fits the one- to two-

week reporting pattern Dr. Youngblood described in his testimony. These contemporaneous medical record reports are given considerable weight. AS 23.30.122; *Smith*; *Steffey*.

On Dr. Puziss' examination, Employee had severe pain in the precise area where he had scalene blocks. Dr. Puziss diagnosed a right brachial plexus injury secondary to the September 12, 2017 block. It is worth noting that in his report's record review section, Dr. Puziss did not mention the September 12, 2017 interscalene block but did mention the one Employee had on October 10, 2017. Dr. Puziss opined the plexopathy arose from the September 12, 2017 block. However, the correlating symptoms appear to have arisen immediately following the October 10, 2017 block. Dr. Puziss did not agree symptoms arising from a brachial plexus injury from a scalene injection had to occur immediately, *i.e.*, the next day, following the injection. He has experience with plexopathy from nerve blocks because he has treated numerous patients with it. Dr. Puziss' diagnosis not only correlates with Employee's symptoms, it also explains why Dr. Youngblood could not understand how a torn rotator cuff could cause Employee's symptoms. Given Dr. Puziss' experience diagnosing and treating brachial plexus injuries from interscalene injections, and correlation in the records between the interscalene injections and the permanent onset of Employee's hand symptoms, Dr. Puziss' causation opinions are given great weight. AS 23.30.122; *Smith*; *Steffey*. Dr. Youngblood said this was an "exceedingly rare" condition, implying he is not as familiar with it as is Dr. Puziss. *Rogers & Babler*. Dr. Youngblood never said he has ever diagnosed or treated a patient with this condition, though he has "seen nerve injuries after shoulder surgery." It is unclear if he meant he had "seen" it through his own surgical experiences or in reviewing medical literature. When asked if he considered the brachial plexopathy in his exam, Dr. Youngblood did not answer the question directly. Instead, he said:

> A. Well, I think you always consider it to some degree, but it is so far afield and so rare that, you know, it wasn't even worth mentioning.

His report does not mention a brachial plexus diagnosis. A reasonable inference from his answer is that he did not consciously consider it. *Rogers & Babler*. Most importantly, Dr. Youngblood's testimony does not offer an alternative explanation for Employee's right shoulder pain, the weakness he experiences in his upper right extremity or the numbness and tingling sensations in his hand. While ruling out cervical radiculopathy, myelopathy and CRPS as possible symptom

sources, Dr. Youngblood fails to offer any alternative explanation for the symptoms. At the same time, he never disputes Employee has these symptoms. He testified if Employee had a brachial plexus injury arising from an interscalene block, his symptoms would have arisen "immediately." As an example for immediacy, Dr. Youngblood said Employee would have come in at his "one-week or two-week appointment" after surgery and said something like, "This is the problem. I have searing pain down here," in the distribution of the nerve that was affected. In his review, Employee's medical records do not reflect this. But, Dr. Youngblood's opinion is not supported fully by the records. Within 10 days of his last shoulder surgery on October 10, 2017, which included a brachial plexus interscalene injection, Employee mentioned his new nerve symptoms at his first post-surgery visit and said he noticed the symptoms post-surgery. Dr. Youngblood's opinion will be given less weight. AS 23.30.122; *Smith*; *Steffey*. The preponderance, weight and credibility of the medical evidence supports a finding that Employee's work injury, through surgical complications, was the substantial cause of his right brachial plexus injury and that condition is compensable. AS 23.30.010(a).

The next question is whether Employee is entitled to TTD benefits from July 1, 2018, based on Employer's TTD overpayment defense and September 21, 2018, as requested in his claim, based on his brachial plexus injury. Assuming the presumption is rebutted, to succeed on this claim, Employee's brachial plexus injury must not be medically stable and he must be disabled by it.

(1) <u>Medical stability.</u>

Dr. Puziss said Employee was not medically stable because his brachial plexus injury needs treatment. Dr. Youngblood testified Dr. Puziss' report did not change any conclusions from his report; he still opined Employee was medically stable effective June 30, 2018. This raises a factual dispute to which the presumption analysis applies. *Meek*. Employee raises the presumption with Dr. Puziss' opinion. *Cheeks*. Employer rebuts with Dr. Youngblood's testimony. *Tolbert*; *Resler*. Employer claims a TTD benefit overpayment beginning July 1, 2018; his claim is for TTD benefits from September 21, 2018, and continuing. Thus, Employee must demonstrate his brachial plexus injury was not medically stable on both dates, by clear and convincing evidence. *Anderson*; *Leigh.*

Dr. Puziss has experience diagnosing and treating patients with this condition and expressly stated, while it is difficult to treat, brachial plexus injuries can be treated with expected improvement. This is clear and convincing evidence the condition is not medically stable. Dr. Youngblood did not expressly consider the brachial plexus diagnosis in his examination, did not mention it in his report, and in his testimony did not demonstrate experience diagnosing and treating such injuries, even though he "has seen" them. The fact he recited symptom timing and possible treatments for the condition available from a textbook does not indicate he has experience diagnosing and treating it. His opinion that the condition is "extraordinarily rare" supports this reasonable inference. *Rogers & Babler*. Greater weight is given to Dr. Puziss' opinion based on his expressed experience and less weight is given to Dr. Youngblood's opinion as discussed above. AS 23.30.122; *Smith*; *Steffey*. Employee's brachial plexus injury has not been treated, and needs treatment with expected improvement; therefore it is not medically stable. AS 23.30.395(28).

(2) <u>Disability</u>.

Dr. Puziss said Employee is disabled and his brachial plexus injury is his primary pain generator. Dr. Youngblood testified Dr. Puziss' report did not change any conclusions from his report; he still opined Employee was able to return to his job at the time of injury. This raises a factual dispute to which the presumption analysis applies. *Meek*. Employee raises the presumption with his medical records, testimony and Dr. Puziss' report. His medical records show he was not released to return to work by any treating physician given his pain complaints. Employee said he could not work because pain from his right shoulder prevents him from sleeping well and from effectively using his right hand and arm. Dr. Puziss said Employee has been, and remains, disabled by his brachial plexus injury. *Cheeks*; *Resler*. Employer rebuts it with Dr. Youngblood's report stating Employee could return to work effective June 30, 2018. *Tolbert*; *Resler*. Employee must show his plexopathy disabled him effective June 30, 2018, and September 21, 2018. *Saxton*.

On September 22, 2017, following Employee's interscalene injection for his September 12, 2017 right shoulder surgery, PA-C Myers restricted him to light-duty with a five pound lifting limit. On April 18, 2018, Dr. Paisley restricting him from work until his next appointment. On May 14, 2018, Dr. McAnally recommended additional disability benefits for "several months." Through June and July 2018, Employee's right shoulder pain continued and following his interscalene

injections he developed progressive numbness and tingling in his hand and weakness in his right arm. On October 3, 2018, PA-C Fayette said Employee would continue to have pain and decreased motion and strength in his right upper extremity. For a vocational reemployment questionnaire, she "predicted" he would have permanent physical capacities to enable him to return to work in prior jobs, and his job at the time of injury. However, she did not release him to return to work. No attending physician released Employee to return to work after his last right shoulder surgery.

The lay witnesses' testimony discussed in detail, above, is incorporated here by reference. This testimony also supports Employee's disability claim for the brachial plexus, which is a medical consequence of surgery for his work injury. AS 23.30.122; *Smith*. The lay evidence supports Employee's claim he has been unable to work full-time since July 1, 2018, and September 21, 2018, and has been temporarily totally disabled for the dates for which he requests TTD benefits. It also shows there was no TTD benefit overpayment beginning July 1, 2018. *Wolfer*.

Dr. Puziss found Employee had severe pain on palpation in the precise place he had a scalene block. He did not believe Employee was exaggerating and opined the most important pain generator is a plexopathy resulting from the September 17, 2017 right scalene block. Dr. Puziss said the substantial cause of Employee's disability related to his shoulder is the original injury and its sequela, including the scalene block. He opined Employee's work-related disability continues until the brachial plexus injury receives additional diagnosis and treatment. For the reasons stated above, Dr. Puziss' opinion is given greater weight. AS 23.30.122; *Smith*; *Steffey*.

The only other relevant opinion on this issue is Dr. Youngblood's. His disability opinion is given less weight for the reasons discussed above. AS 23.30.122; *Smith*; *Steffey*. The most credible evidence shows Employee was not medically stable and was disabled by his brachial plexus injury for the periods in question. Therefore, Employee alternately prevails on his claim for TTD benefits based on his work-related brachial plexus injury from July 1, 2018 through September 20, 2018, through January 2, 2019, and from May 1, 2019 and continuing until his brachial plexus injury becomes medically stable or this condition ceases to be disabling. AS 23.30.185.

2) Is Employee entitled to TPD benefits?

Employee also requests TPD benefits from January 3, 2019, through April 30, 2019, when he worked part-time for Bering Straits. AS 23.30.200(a). Employee contends for the period in question he could only work part-time, and lost earnings because of pain-related disability resulting from his work injury. Dr. Youngblood opined Employee could return to light-duty work full-time. This creates a factual dispute to which the presumption analysis applies. *Meek*. Disability is not necessarily a complex medical issue. *Wolfer*. Employee raises the presumption with his testimony and his medical records. He said his pain restricted his sleep and his ability to work full-time because he was in constant pain and had to take numerous rest breaks throughout the day. His providers' medical records show he was never released to full- or part-time work. *Cheeks*; *Resler*. Employer rebuts the presumption with Dr. Youngblood's report and testimony stating there was no reason he could not return to work full-time. *Tolbert*; *Resler*. Employee must demonstrate his work injury partially disabled him from January 3, 2019, through April 30, 2019, by a preponderance of the evidence. *Saxton*.

No physician suggests Employee is lying, faking, exaggerating his symptoms or malingering. There is no other medical explanation offered for his inability to work full- or part-time other than pain and other symptoms arising from his December 29, 2016 work injury with Employer. *Vetter*. Dr. Youngblood testified Employee may have psychiatric issues to explain his pain, but he did not offer a diagnosis and is not a psychiatrist. A mere possibility Employee may have another cause for his disability is not substantial evidence to rebut the presumption or support a conclusion. *Huit*.

The lay witnesses' testimony discussed in detail, above, is incorporated here. It supports the TPD benefit claim for Employee's shoulder and plexopathy injuries and shows he has been unable to work full-time since September 21, 2018, could only work part-time from January 3, 2019, through April 30, 2019, and has been temporarily partially disabled for the dates for which he requests TPD benefits. *Wolfer*. The TTD analysis from above is incorporated here by reference and Employee's claim for TPD benefits from January 3, 2019, through April 30, 2019, will be granted for the same reasons. The hearing evidence was unclear on precise dates his work for Bering Straits began and ended. Employer will be directed to review the payroll information Employee provided and to calculate TPD benefits pursuant to the Act. In the event the payroll information

does not show employment matching the periods for which Employee requests TPD benefits, he is otherwise deemed temporarily totally disabled and entitled to TTD benefits for those periods.

3) Is Employee's PPI claim ripe?

Employee claims additional PPI benefits. AS 23.30.190(a). This decision found his right shoulder, brachial plexus and C6-7 facet issues are not medically stable. Given the above analyses, he may receive a right shoulder arthroplasty, brachial plexus treatment that may include a spinal cord or nerve roots stimulator and medial branch blocks to the right C6-7 facet, and radiofrequency ablation. It is unclear what, if any, effect these procedures may have on Employee's PPI rating. Therefore, these work-related medical conditions are not ready for rating. Nevertheless, Employer has already paid him a four percent PPI rating. As discussed in the TTD section, above, there is no TTD benefit overpayment. Employer made an advanced PPI benefit payment and will re-characterize and prorate PPI benefits beginning September 21, 2018, as TTD benefits. This will result in Employer having paid Employee no PPI benefits for his injury to date. Therefore, Employee's PPI claim will be held in abeyance because it is not ripe. *Egemo*.

4) Is Employee entitled to additional medical benefits?

Employee requests additional medical care and transportation expenses for (A) his neck; (B) his right shoulder; and (C) his brachial plexus. AS 23.30.095(a).

(A) The "neck."

For the reasons stated above, Employee's work injury is not the substantial cause of his preexisting cervical conditions found on MRI and did not aggravate, accelerate or combine with those conditions to cause the need for treatment. Therefore, his claim for medical benefits related to conditions found on MRI will be denied. Additionally, even had Employee filed an itemized mileage log for medical care related to MRI findings, his claim for transportation costs for that treatment will also be denied.

However, based on Dr. Puziss' opinion, Employee is entitled to medical care for his work-related facetogenic pain, including but not limited to electrodiagnostic testing, medial branch blocks at

C6-7 to confirm facetogenic pain and, if confirmed, radiofrequency ablation. The basis for this finding, discussed above, is incorporated here. There are no travel expenses yet for this condition.

(B) The shoulder.

Employee contends he is entitled to additional treatment for his right shoulder. Employer contends he is not. This creates a factual dispute to which the presumption analysis applies. *Meek*. Employee raises the presumption with his testimony, a February 26, 2018 right shoulder MRI, and opinions from Drs. Paisley, McAnally and Puziss. Employee testified he has significant right shoulder pain, which causes sleep disturbance and an inability for him to work full-time and he has increasing tingling, numbness and strength loss in his right upper extremity. He says he needs more treatment to address these issues. A February 26, 2018 MRI disclosed a supraspinatus tendon tear, tendinosis, joint space narrowing and a degenerated labrum. On March 2, 2018, Dr. Paisley referred him to Dr. McAnally for pain management and recommended a reverse total shoulder arthroplasty if he did not respond. On March 12, 2018, Dr. McAnally recommended additional treatment for Employee's shoulder and prescribed medication and injections. On August 29, 2018, Dr. Paisley renewed his call for a total shoulder arthroplasty. On April 9, 2019, Dr. Puziss recommended additional diagnostic testing for Employee's right brachial plexus injury and agreed a total shoulder arthroplasty is reasonable. *Cheeks*; *Resler*. The burden shifts to Employer to rebut the raised presumption with substantial evidence to the contrary. *Tolbert*; *Resler*.

Employer cannot rebut the presumption regarding medical treatment with Dr. Youngblood's report or testimony. He had no objective explanation for Employee's continued right shoulder pain, weakness and numbness and tingling in his hand. *Kessick.* He did not dispute Employee had these symptoms, though he thought they were excessive. Since he had no explanation for Employee's symptoms, his opinion was at best uncertain or inconclusive, and though evidence, it is not "substantial evidence" to rebut the presumption that Employee's symptoms arose from his undisputed, work-related shoulder injury. *Bouse*. By failing to rule out the work injury as a cause for Employee's symptoms and need additional treatment, his report and testimony failed to meet the "negative-evidence" test. He also failed to provide an alternative cause for the symptoms. Therefore, his report and testimony failed to meet the "affirmative-evidence" test. *Huit*. Because

Employer failed to rebut the raised presumption on medical care for Employee's right shoulder, he would prevail on the raised but unrebutted presumption. *Carter*.

Alternatively, assuming Dr. Youngblood's report or testimony rebuts the presumption in respect to right shoulder medical care, Employee must show his work injury causes a need for additional right shoulder treatment, either as a matter of law or by a preponderance of evidence. *Saxton*.

The records show Drs. Paisley and Vermillion, within two years of Employee's December 29, 2016 work injury, recommended a total right shoulder arthroplasty on June 28, 2017, and June 30, 2017, respectively. If physicians recommend treatment within two years following a work injury, and it is within the realm of normally acceptable treatment, the injured worker is entitled to the treatment as a matter of law. *Hibdon*. Dr. Paisley recommended total right shoulder arthroplasty surgery on several more occasions within the first two years post-injury including March 2, 2018, May 15, 2018, and August 29, 2018. Drs. Puziss and Vermillion agreed a right shoulder arthroplasty was reasonable. These consistent and credible opinions are given significant weight. AS 23.30.122; *Smith*; *Steffey*. Though he disagreed with causation and surgery, Dr. Youngblood said a total shoulder arthroplasty is an appropriate treatment, given Employee's arthritis, although in his view it is premature. Nevertheless, Dr. Youngblood has no explanation for Employee's continued right shoulder pain. His opinion is given less weight. AS 23.30.122; *Smith*; *Steffey*. On this alternative analysis, Employee is entitled to the recommended right shoulder arthroplasty both as a matter of law and based on a preponderance of the evidence. *Hibdon*; *Saxton*.

(C) The brachial plexus.

Employee contends he is entitled to additional treatment for his brachial plexus injury. Employer contends he is not. This creates a factual dispute to which the presumption of compensability analysis applies. *Meek*. Employee raises the presumption with Dr. Puziss' opinion. On April 9, 2019, he opined Employee's work injury was the substantial cause of a brachial plexus injury, which resulted from an interscalene injection, which was necessitated by Employee's right shoulder surgeries. He said Employee needs additional treatment for this condition. *Smallwood*; *Cheeks*; *Resler*. Employer rebuts it for plexopathy treatment with Dr. Youngblood's testimony

stating Employee needs no further medical treatment for his work injury. *Tolbert*; *Resler*. Employee must demonstrate his brachial plexus injury needs additional treatment. *Saxton*.

For the reasons stated in the above analysis, which are incorporated here by reference, Dr. Puziss' opinion on the brachial plexus injury is given the greatest weight and Dr. Youngblood's the least. AS 23.30.122; *Smith*; *Steffey*; *Moore*. Therefore, Employee is entitled to the medical treatment Dr. Puziss recommended for the brachial plexus injury. This includes but is not limited to electrodiagnostic studies, ultrasound-guided steroid injections and a spinal cord or nerve root stimulator. Dr. Puziss suggested a psychological evaluation to rule out a somatoform disorder or malingering, based solely on Dr. Youngblood's comments about Employee's subjective symptoms. If Employee's attending physician believe this is necessary, his attending physician may refer him to an appropriate mental health evaluator for testing at Employer's expense.

In summary, Employee is not entitled to medical care for preexisting conditions shown on MRI but is entitled to evaluation and medical care for his C6-7 facet to address facetogenic pain, and treatment including but not limited to medial branch blocks and radiofrequency ablation. He is entitled to additional medical care for his right shoulder including but not limited to a reverse total shoulder arthroplasty. Employee is also entitled to treatment for his right brachial plexus injury including but not limited to electromyography and nerve conduction studies, ultrasound-guided steroid injections and a spinal cord or nerve root stimulator. He is entitled to a psychological evaluation by an appropriate provider if his attending physician believes this is necessary. Employee did not file a mileage log; his travel claim will be denied. 8 AAC 45.084(b), (d).

To be clear, this decision does not require Employee to obtain any or all of these treatments. It is up to him in consultation with his attending physicians to decide what treatment he should have and the order in which it should be provided. *Hibdon*. This decision simply finds these treatments compensable, which means Employer must authorize them. AS 23.30.095(a).

5) Did Employer make a frivolous or unfair controversion?

Benefits under the Act must be either paid promptly or controverted. AS 23.30.155(a). Employee contends Employer frivolously or unfairly controverted benefits due under the Act. He seeks a

finding and referral to the director for referral to the division of insurance. AS 23.30.155(o). On September 21, 2018, Employer controverted Employee's right to all benefits. On October 19, 2018, it controverted Employee's claim. In both instances, as to the undisputed right shoulder injury it controverted TTD and TPD benefits and PPI benefits greater than four percent, all reemployment benefits and all care for the right shoulder after September 21, 2018. Employer relied solely on Dr. Youngblood's EME report to controvert. Therefore, this analysis focuses solely on Dr. Youngblood's report; his deposition testimony is irrelevant because Employer did not rely upon it to controvert.

The Alaska Supreme Court adopted the *Harp* penalty analysis to resolve frivolous and unfair controversion issues. AS 23.30.155(o); *Harp*; *Harris*. *Harp* and *Huit* are used to find if the denials were "good faith" controversions. Under *Harp* and *Huit*, a good faith controversion notice is one that demonstrates with "substantial evidence that the disability . . . or need for medical treatment did not arise out of and in the course of the employment." Dr. Youngblood's report needed to show that the work injury could not have caused his disability and need for treatment (the negative-evidence test) or that another non-work-related cause is what caused his disability and required the continuing care (the affirmative-evidence test). His report had to be "substantial," not uncertain or inconclusive, and not just "merely reciting the proper words." *Bouse*; *Huit*.

(A) All benefits related to the cervical spine.

Dr. Youngblood reviewed Employee's records, examined his cervical spine and concluded there was no medical evidence suggesting he injured his neck when he slipped and fell at work. Employee's physical examination was not consistent with cervical radiculopathy. Dr. Youngblood found the work injury did not substantially cause or aggravate Employee's herniated cervical discs. Accordingly, his report provided substantial evidence and an adequate basis such that if the fact-finders had only Dr. Youngblood's report upon which to rely, Employee would not have been entitled to medical benefits for his cervical spine issues shown on MRI. *Harp*; AS 23.30.010(a). Therefore, the controversions related to the cervical spine were not frivolous or unfair.

(B) TTD and TPD benefits.

Dr. Youngblood's report said Employee's work injury was medically stable and he could return to his prior employment including his job at the time of injury. Based on these opinions, Employer controverted Employee's right to benefits and his claim. Dr. Youngblood's report selects June 30, 2018, eight months post-surgery, as the medical stability date without further explanation. The records show nothing occurred on that date. However, while this is a very close call, the adjuster gave him the "medical stability" definition, and a reasonable inference is that Dr. Youngblood found medical stability based on no objectively measurable improvement within 45 days. *Rogers & Babler*. Furthermore, he reviewed job descriptions for Employee's work in the 10 years prior to his injury and at the time of injury. Based on his review, Dr. Youngblood said Employee could return to all these jobs. Since TTD and TPD benefits are premised on both medical instability and disability, and Dr. Youngblood's report barely satisfied the first, but satisfied the second prong, substantial evidence justified Employer's TTD and TPD controversions. Therefore, the TTD and TPD benefits denials were not frivolous or unfair.

(C) PPI benefits.

When Dr. Youngblood issued his EME report, his PPI rating was the only rating offered for Employee's work injury. Therefore, Employer was justified in denying additional benefits absent a higher rating. Its controversion related to PPI benefits was not frivolous or unfair.

(D) All reemployment benefits.

Dr. Youngblood reviewed the applicable job descriptions and found Employee could return to all the listed jobs. His opinion was substantial evidence supporting Employer's denial reemployment benefit denial. The denials related to reemployment benefits were not frivolous or unfair.

(E) Medical benefits for the right shoulder.

Dr. Youngblood's report said the work injury was the substantial cause of the need to treat Employee's right shoulder. He also said Employee needed no further treatment for his work injury notwithstanding his continuing pain, weakness, numbness and tingling. His non-responsive answers to questions posed in his report make this analysis more difficult. For example, when asked to identify all causes contributing to Employee's "need for medical treatment" following the

work injury, Dr. Youngblood instead listed potential causes for Employee's "right shoulder conditions." When asked when the work injury, compared to other causes, no longer played the greatest role in Employee's "need for treatment," he merely stated the right shoulder "condition" achieved "medical stability" on June 30, 2018. He did not identify any alternative cause for Employee's continuing right shoulder symptoms.

Dr. Youngblood addressed the cervical disc issues and CRPS and ruled those out as pain generators but did not specifically address an alternative cause for Employee's right shoulder pain or the weakness, numbness and tingling in his right upper extremity. Instead, he said there was "no identifiable indication for pain management treatment." When asked to provide "the alternative causes for any recommended treatment," Dr. Youngblood said Employee's subjective complaints significantly outweighed his objective findings, and symptom magnification was present on physical examination. He also said Employee's "excess presentation and his excessive subjective complaints would not be deemed related to the industrial injury." However, Dr. Youngblood never stated Employee did not have pain, weakness, numbness or tingling. Further, he never identified the source of Employee's pain and never provided an alternative cause for his "excess presentation and excessive subjective complaints." An unknown cause is not a substantial cause. *Huit*. His opinions are not substantial evidence explaining why Employee continues to have pain.

Dr. Youngblood's EME report had to either rule out the work injury as a cause for Employee's right shoulder pain, right hand weakness, numbness and tingling and his requested treatment (the negative-evidence test) or show that something else caused his right shoulder pain, right hand weakness, numbness and tingling and his need for care (the affirmative-evidence test). *Huit*. It failed on both accounts. His report does not say the work injury could not be causing his symptoms and any needed treatment. Instead, he found "no identifiable indication for pain management treatment" and said it was "unclear" how Employee's right shoulder lesion could cause such profound weakness in the right hand. *Bouse*. His opinion that Employee needed no further treatment for his work injury must have been based on the fact he could find no symptom generator. He simply could not identify Employee's pain source or why he had weakness, numbness and tingling, while not disputing he has these symptoms. Dr. Youngblood then concluded Employee's excessive subjective complaints, for which he could identify no cause, would not be work-related.

These opinions fail the *Huit* test. Dr. Youngblood's report ruled out cervical radiculopathy and CRPS. Thus, by his own admission, these conditions could not have been an alternate source of Employee's pain and other symptoms to satisfy *Huit*.

An "unclear" causation opinion for right hand weakness is by definition uncertain and inconclusive. *Bouse*. "Reciting the proper words" in conclusory fashion, as Dr. Youngblood did in this report, is not substantial evidence to support denying continuing medical care. *Huit*. Had Dr. Youngblood's July 20, 2018 report been the only evidence the fact-finders reviewed, his rationale for stating Employee needed no further medical treatment for his work injury would not be deemed substantial evidence and Employee would be found entitled to medical benefits for his right shoulder and hand symptoms including pain, weakness, numbness and tingling. *Harp*. Thus, the controversions denying further medical benefits for the work injury based on Dr. Youngblood's EME report were not "good faith" controversions. Plus, since within two years of the injury date Drs. Paisley and Vermillion recommended a right shoulder arthroplasty, Employee was entitled to that treatment as a matter of law. *Hibdon*. Based on the above analysis, the controversion notices lacked a plausible legal defense (legal-based) and evidence (fact-based) to support controverting right shoulder medical care because Dr. Youngblood's report, upon which the controversions were based, did not meet the affirmative- or negative-evidence tests. *Irby*.

In summary, Employer's controversions based on Dr. Youngblood's cervical spine, TTD, TPD and reemployment benefits opinions were appropriate and neither "frivolous" nor "unfair." The controversions denying medical benefits for Employee's work injury were "frivolous" or "unfair." Accordingly, this decision will ask the division director to refer this case to the division of insurance for further investigation. AS 23.30.155(o); 8 AAC 45.182(d)(1), (e).

6) Is Employee entitled to a penalty?

Employee seeks a penalty under AS 23.30.155(e). A controversion notice must be filed in "good faith" to protect Employer from a penalty. *Harp*. Dr. Youngblood's July 20, 2018 report opined Employee's work injury needed no further medical treatment. For the reasons set forth immediately above, incorporated here by reference, Employee would have been found entitled to continuing medical treatment for his work injury based solely on Dr. Youngblood's report, which

did not rebut the raised presumption. *Huit*. He would have been found not entitled to cervical spine benefits or TTD, TPD, PPI greater than four percent or reemployment benefits.

Employee could be entitled to a penalty under AS 23.30.155(e) for medical care prescribed but not yet obtained. *Childs*; *Harris*. However, a penalty will not be assessed if a controversion, even one made in bad faith, did not interfere with obtaining the benefit at issue. *Sumner*. In 2017 and early 2018, Employee wanted to proceed with shoulder arthroplasty. His cervical issues confused the matter and by May 7, 2018, Employee opposed additional shoulder surgery but wanted neck surgery. Employee cannot be faulted for following his physicians' advice. However, it cannot be easily determined from the record what medical care was unpaid or delayed on the dates Employer issued its controversion notices. *Id*.

Furthermore, Employee presented no evidence concerning the value of medical benefits not obtained due to Employer's controversions. The only medical bills Employee submitted for reimbursement were Dr. Ellerbe's related to sewing up Employee's forehead when he tripped and fell at home. Employee contends he fell due to his neck issues. Since this decision denies benefits related to Employee's cervical spine, with one limited exception, Dr. Ellerbe's bills would not be compensable. Further, Employee's physicians were suggesting his cervical conditions be addressed prior to his right shoulder surgery. At one point in 2018, Employee wanted cervical surgery and resisted having shoulder surgery. At hearing, he said he would get any medical treatment this decision awarded. Given this record, it remains unclear if Employer's controversion notices actually delayed his right shoulder arthroplasty, which at various times he was reluctant to obtain. Since there was no brachial plexus diagnosis until 2019, the 2018 controversion notices could not have delayed treatment for that condition because it was not yet identified or included in the denials. Therefore, since it is unclear what, if any, medical care was delayed by Employer's bad faith controversion, identified above, and Employee provided no evidence showing the cost of medical benefits upon which a penalty could be awarded, no penalty will be awarded on the unknown value of such medical treatment. *Harris*.

7) Is Employee entitled to interest, or an attorney fee or cost award?

Employer controverted Employee's claim, and he has prevailed on most issues so attorney fees are awardable under AS 23.30.145(a); *Porteleki*. He seeks $34,897.50 in actual attorney fees and paralegal costs, and $3,056.03 in other costs, not including Dr. Youngblood's deposition transcript, which he has not yet received. Employer's competent counsel vigorously litigated Employee's claim. The medical evidence is extremely complex, involving several medical conditions, any of which could have caused Employee's symptoms. *Rogers & Babler*. The litigated benefits ranged between $0 and TTD benefits paid at $1,113.24 per week. *Cowgill*. Employee claimed additional TTD and TPD benefits, and Employer claimed a TTD benefit overpayment. Employee prevailed fully on those issues. Given his high weekly disability rate, the resultant award is a significant benefit to him. Because he prevailed, Employee won his interest claim and is entitled to interest on the awarded past TTD and TPD benefits, which is another benefit to him. AS 23.30.155(p).

His claim for additional PPI benefits is not ripe; but this decision did not deny his right to additional PPI benefits either, as Employer requested. Employee prevailed on that issue as well because he is certain to be entitled to at least some PPI benefits once he becomes medically stable because his previously paid PPI benefits were re-characterized as TTD benefits. This is also a great benefit.

Employee claimed additional medical benefits for his neck conditions identified on MRI. He lost on this part of his claim but succeeded on his claim for medical benefits for the C6-7 facet syndrome, his right shoulder and his brachial plexus condition. This too is a significant benefit. Employee did not prevail on his penalty claim for lack of evidence and prevailed on one part of his request for an unfair or frivolous finding under AS 23.30.155(o).

Employer objected to Powell's $400 hourly attorney fee rate. She has previously been awarded her current rate in numerous decisions and on appeal. Her attorney fee and paralegal rates are reasonable. *Rogers & Babler*. Employer also objected to specific itemized attorney fee entries reflected in Table I. Its objection to item 19122 has merit, as it does not appear it would take Powell an hour to review five releases and advise her client. Her overall attorney fee request for this item will be reduced by $200 as set forth in Table I. Employer's other objections are without merit as they are merely arguments. Specifically, though it might not take .3 hours to prepare a

one-sentence letter, it may take time to decide what to put in the letter. The fact a few attorney fee entries do not correlate with documents Employer received, does not mean Powell did not work on these documents on more than one occasion. Powell's charge for .2 hours to review a medical record is not on its face unreasonable. She did not bill for her error on SIME records. Lastly, spending 10.4 hours on post-hearing briefing is not excessive especially when the file review and briefing is not accomplished in one sitting. *Rogers & Babler*.

Overall, Employee prevailed with Powell's assistance on most issues that provide a benefit to him. Powell represented him on this case for a moderate period. Attorney fees in these cases must be fully compensatory and reasonable so injured workers canned retain competent lawyers. *Cortay*. Employer did not object to the requested costs. Therefore, Employee will be awarded $34,697.50 ($34,897.50 - $200 = $34,697.50) in attorney fees and $3,056.03 in other costs. He will also be directed to submit the bill for Dr. Youngblood's deposition transcript to Employer, who will be ordered to pay this additional cost. AS 23.30.145(a); AS 23.30.135(a).

CONCLUSIONS OF LAW

1) Employee is entitled to additional TTD benefits.
2) Employee is entitled to TPD benefits.
3) Employee's PPI claim is not ripe.
4) Employee is entitled to additional medical benefits.
5) Employer made a frivolous or unfair controversion.
6) Employee is not entitled to a penalty.
7) Employee is entitled to interest and an attorney fee and cost award.

ORDER

1) Employee's claim for additional TTD benefits for Employee's right shoulder and brachial plexus injuries is granted. He is entitled to TTD benefits from September 21, 2018, through January 2, 2019, and from May 1, 2019, and continuing until he is medically stable from all work-related conditions or is no longer disabled. There is no TTD benefit overpayment. Employer is directed to re-characterize PPI benefits previously paid to TTD benefits pursuant to this decision.

2) His claim for TTD benefits for preexisting conditions identified on cervical MRI is denied.

3) Employee's claim for TPD benefits for Employee's right shoulder and brachial plexus injuries is granted. He is entitled to TPD benefits from January 3, 2019, through April 30, 2019.

4) His claim for TPD benefits for preexisting conditions identified on cervical MRI is denied.

5) Employee's claim for PPI benefits is not ripe and is held in abeyance until his work-related conditions become medically stable.

6) Employee's claim for additional medical benefits for his right shoulder, brachial plexus and C6-7 facetogenic pain is granted in accordance with this decision.

7) Employee's claim for additional medical benefits for conditions identified on cervical MRI is denied, as is his claim for all past medical travel because he failed to file an itemized log.

8) Employee's request for a finding and referral under AS 23.30.155(o) is granted in part and denied in part. His request is denied as to Employer's controversion of his cervical spine, TTD and TPD benefits, PPI benefits greater than four percent and all reemployment benefits. His request is granted as to Employer's controversion of all medical care for the right shoulder as of September 21, 2018, in accordance with this decision. Staff will provide a copy of this decision to the director for him to forward to the Division of Insurance for investigation.

9) Employee's request for a penalty under AS 23.30.155(e) and *Harp* is denied in accordance with this decision.

10) Employee's request for interest, attorney fees and costs is granted. He is entitled to $34,697.50 in reduced, actual attorney fees and $3,056.03 in costs. Employer is directed to pay the cost for Employee obtaining Dr. Youngblood's deposition transcript, upon receipt of the bill.

Dated in Anchorage, Alaska on November 8, 2019.

ALASKA WORKERS' COMPENSATION BOARD

/s/
William Soule, Designated Chair

/s/
Robert C. Weel, Member

/s/
Justin Mack, Member

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

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

APPEAL PROCEDURES

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

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

RECONSIDERATION

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

MODIFICATION

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

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of Eduardo Campoamor, employee / claimant v. Hope Community Resources, Inc., employer; Berkshire Hathaway Homestate Insurance Company, insurer / defendants; Case No. 201700005; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on November 8, 2019.

_____/s/_____
Nenita Farmer, Office Assistant