ALASKA WORKERS' COMPENSATION BOARD

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

BRAD J. HANSON,	)	
	)	
Employee,	)	FINAL DECISION AND ORDER
Applicant,	)	
	)	AWCB Case No. 200808717
v.	)	
	)	AWCB Decision No. 13-0165
MUNICIPALITY OF ANCHORAGE,	)	
(self-insured),	)	Filed with AWCB Anchorage, Alaska
	)	on December 20, 2013
Employer,	)	
Defendant.	)	
	)	

Brad Hanson's (Employee) July 23, 2009 claim for permanent partial impairment (PPI) and attorney's fees and costs was heard on October 9, 2013, in Anchorage, Alaska, a date selected on August 13, 2013. Employee's claim is on remand from the Alaska Workers' Compensation Appeals Commission. Attorney Michael Jensen appeared and represented Employee. Attorney Trena Heikes appeared and represented the self-insured Municipality of Anchorage (Employer). There were no witnesses. The record initially closed at the hearing's conclusion but was reopened on October 10, 2013, for 10 days so the parties could obtain and provide a correct, current version of Table 17-4, American Medical Association, *Guides the Evaluation of Permanent Impairment*, 6th Edition (*Guides*). The record closed on December 17, 2013, when the panel met to deliberate after receiving and reviewing the clarified Table 17-4.

ISSUES

Employee contends the *Guides* 6th Edition must be used to rate Employee's 1992 and 2008 injuries. He contends the 1992 injury cannot be rating under the *Guides* 6th Edition for lack of information. Alternately, Employee contends the 6th edition *Guides* rating for the 1992 injury would be rated at

"Class 0," which results in a zero PPI rating for the 1992 injury. Either way, as there is no *Guides* 6th Edition PPI rating reduction for the 1992 injury, Employee contends he is entitled to the five percent PPI rating provided by Marilyn Yodlowski, M.D., for the 2008 injury.

Employer also contends the *Guides* 6th Edition must be used to rate both the 1992 and 2008 injuries. However, it contends because Dr. Yodlowski provided a valid *Guides* 6th Edition rating for the 1992 injury, it must be subtracted from the 2008 PPI rating she provided. Employer contends if Dr. Yodlowski's 1992 PPI rating is subtracted from 2008 PPI rating, the net PPI rating is zero percent.

1) Is Employee entitled to an additional PPI award?

Employee contends he is entitled to full, actual attorney's fees. He contends the commission did not disturb his paralegal or other costs and the only other issue on remand is attorney's fees. Employee contends *Hanson II* correctly awarded attorney's fees and he is now entitled to additional attorney's fees and costs pursuing these issues on remand.

Employer contends Employee is entitled to only statutory minimum attorney's fees because Employer controverted his case. It further contends Employee's attorney is not entitled to reasonable, actual attorney's fees because these would far exceed the benefits awarded Employee.

2) Is Employee entitled to an award of attorney's fees and costs?

SUMMARY OF DECISIONS

Hanson v. Municipality of Anchorage, AWCB Decision No. 10-0175 (October 29, 2010) (*Hanson I*), concluded Employee's need for medical treatment at the L4-5 spinal level arose out of and in the course of his employment with Employer; his employment was the substantial cause of the need for medical treatment to the L4-5 spinal level; Employee's PPI claim was held in abeyance; Employee's transportation request was denied; Employee and his medical providers were entitled to interest; Employee was entitled to a penalty; and Employee was entitled to attorney's fees and costs. *Hanson I* awarded Employee $39,252.50 in attorney's and paralegal fees and $2,389.14 in other costs.

Hanson v. Municipality of Anchorage, AWCB Decision No. 12-0031 (February 21, 2012) (*Hanson II*) concluded the oral decision to accept Employer's late brief and witness list as filed was correct; Edward Barrington's deposition was admissible for any purpose; Employee was entitled to a PPI award; Employee was entitled to two days' TTD for time spent attending medical evaluations before he was medically stable; Employee was entitled to interest; and Employee was entitled to $26,911.50 in attorney's and paralegal fees and $8,872.90 in other costs.

Hanson v. Municipality of Anchorage, AWCB Decision No. 12-0058 (March 22, 2012) (*Hanson III*) concluded *Hanson II* correctly awarded Employee full, reasonable attorney's fees and costs; clarified that Employee's hypogastric nerve plexus injury and resultant retrograde ejaculation were compensable, ratable injuries; the conclusion Employee had an eight percent preexisting PPI rating for his lumbar spine and no signs of radiculopathy at the time of his PPI ratings was not reconsidered; and *Hansen II* had no authority to reconsider its PPI decision based on Employee's Constitutional challenges.

Employer appealed and Employee cross-appealed. On June 12, 2013, the appeals commission reversed *Hanson II*'s two days' TTD award, and reversed and remanded *Hanson II*'s lumbar PPI decision and attorney's fee award. *Municipality of Anchorage v. Hanson*, AWCAC Decision No. 182 (June 12, 2013). On July 17, 2013, the commission awarded Employee full, reasonable attorney's fees and costs as the successful claimant on appeal, over Employer's objection (Order on Motion for Attorney Fees and Costs on Appeal, July 17, 2013). The instant decision addresses the commission's remanded PPI and attorney's fees issues on their merits.

FINDINGS OF FACT

A review of the relevant record, including factual findings and conclusions incorporated from *Hansen I, II* and *III* establishes the following facts by a preponderance of the evidence:

1) There is no evidence Employee had any low back injury or ratable, low back permanent impairment prior to 1991 (record).

2) Employee has a history of a low-back injury to the L5-S1 area in 1991 or 1992 (hereinafter 1992, for simplicity), which included surgical correction around 1992 (Physician's Report, November 6, 2000; Hanson deposition, February 9, 2010, at 8-9).

3) The only information and data in the record concerning Employee's 1992 low back injury and surgery is Employee's self-report, which is first recorded in a medical record eight years later as a "laminectomy," presumably in 1992. Subsequent medical record references specifying a type of surgical procedure in 1992 are necessarily based on either Employee's self-report or the authors' inferences (record, observations, and inferences drawn from all the above).

4) There is no evidence of a PPI rating having ever been performed for Employee's 1992 injury and surgery, until those provided in respect to his pending claim in the instant case (record).

5) Following surgery for the 1992 low back injury, Employee had an excellent result and went several years without any related symptoms (Hanson deposition, February 9, 2010, at 9).

6) The record contains no relevant medical records earlier than those referencing an October 19, 2000 work-related injury (*id.*).

7) On October 19, 2000, Employee strained his low back while moving a gurney across the lawn while at work for Employer. He mentioned "a previous injury to L5-S1 and surgery to that area." There was "no radiation," and "lumbosacral strain" was the diagnosis. An x-ray report states:

> **Lumbosacral spine**: Anterior and posterior vertebral alignment is maintained. There is no loss of vertebral height to suggest a vertebral fracture. The intervertebral disc spaces are appropriate. No calcific opacities are seen overlying the kidneys or expected course of the ureters. The remaining soft tissues and bony elements are unremarkable.
>
> Impression: unremarkable lumbar sacral spine (chart note, October 19, 2000; X-ray report, October 19, 2000).

8) On September 21, 2003, Employee felt something pop in his back while carrying a patient on a stretcher for Employer. The low back pain did "not radiate down his legs or into his buttocks." He had no numbness or tingling in his legs. According to Employee's 2003 record: "He has had a herniated disc at L5-S1 and had a laminectomy in 1992 at that same level." The diagnosis was "lumbar disc disease" and the examiner prescribed medication. An otherwise unidentified radiogram of the same date was read as "degenerative disc disease L5 only" (Progress Notes, October 8, 2003; L-spine exam, October 8, 2003).

9) On December 3, 2003, Employee had a magnetic resonance imaging (MRI) scan of his lumbar spine, which showed a right-sided L5-S1 "disc protrusion" with lateral recess narrowing and

posterior right S1 root displacement. "Surgical changes" were noted, though not otherwise specified, at the L5-S1 level (MRI report, December 3, 2003).

10) On January 14, 2004, Employee saw Upshur Spencer, M.D., and described his September 2003 injury. The examiner reviewed the above-referenced MRI scan and alternately used the terms "disc protrusion" and "disc herniation" to describe the findings. Employee complained of buttock and posterior thigh pain, which Dr. Spencer thought was secondary to his degenerative disc disease and not his L5-S1 disc (Physician's Report, January 14, 2004).

11) Effective March 31, 2008, the *Guides* 6th Edition is used to rate PPI for injuries occurring on or after that date, unless and until a newer *Guides* version is adopted (Bulletin 08-02, January 15, 2008).

12) Through May 29, 2008, there is no medical record documenting Employee had any resolved radiculopathy or non-verifiable radicular complaints present at the time of any medical examination (record; judgment and inferences from all the above).

13) On May 30, 2008, Employee injured his lower back while removing hoses from the battalion chief's truck. Employee felt a pull in his lower back and the resultant pain "persisted and increased" (Report of Occupational Injury or Illness, June 1, 2008).

14) On May 31, 2008, Employee sought care at Wasilla Medical Clinic for the May 30, 2008 injury. He reported a low back injury approximately five years earlier with Employer and lumbar surgery in 1992 arising from a work-related injury in Utah (Physician's Report, May 31, 2008, with attachments).

15) On June 3, 2008, an MRI scan showed a "normal" L4-5 disc, but a right-sided L5-S1disc "extrusion" measuring "5 mm by 15 mm," which affected a right-sided nerve root, which was also noted to be "edematous," *i.e.*, swollen (MRI, June 3, 2008).

16) On June 20, 2008, Employee saw Estrada Bernard, M.D., who recommended disc surgery at L5-S1 (report, June 20, 2008).

17) On August 23, 2008, Douglas Bald, M.D., evaluated Employee at Employer's request for an employer's medical evaluation (EME). He opined Employee suffered an acute disc extrusion or herniation at L5-S1 with his May 30, 2008 work injury and developed right lower extremity radiculopathy as a result (Bald deposition, August 13, 2010, at 6-9).

18) On October 20, 2008, Marshall Tolbert, M.D., recorded Employee had a several month history following his May 30, 2008 injury of "pain radiating down the posterior aspect of his

right leg, mostly to the knee, occasionally extending down to his heel" (Tolbert letter, October 20, 2008).

19) On October 23, 2008, Dr. Tolbert performed a right, L5-S1 laminotomy, discectomy and foraminotomy on Employee to address a right-sided L5-S1 herniated disc with radiculopathy (Operative Report, October 23, 2008).

20) Prior to his 2008 surgery, Employee had a documented history of right leg radiculopathy arising from his May 30, 2008 work-related injury (Tolbert report, November 19, 2008).

21) On November 19, 2008, Employee reported doing well for about seven days following his surgery when he felt a pop in his low back and significant low back pain (Tolbert report, November 19, 2008).

22) Employee bent over to grab his toothbrush a few days after his surgery, felt a "pop," felt something "give" in his low back, and had returned symptoms which persisted and caused him to seek more diagnostics and medical care (Employee).

23) As a result of the toothbrush incident, Dr. Bald opined Employee needed further surgical treatment and was a candidate for either disc replacement surgery or possibly a fusion at the L5-S1 level (Bald deposition, August 13, 2010, at 14).

24) On November 19, 2008, a repeat MRI showed "new," mild disc bulging and degenerative changes at L4-5 with mild, bilateral neuroforaminal narrowing, when compared to the December 2003 MRI report (MRI, November 19, 2008).

25) On February 25 and March 24, 2009, Dr. Tolbert referred Employee to Timothy Cohen, M.D., within the same clinic to discuss options for treating his lumbar pain (Employee; letters, February 25, 2009 and March 24, 2009).

26) On August 18, 2009, Employer controverted among other things, PPI, fees, costs and interest (Controversion Notice, August 17, 2009).

27) On April 18, 2009, Dr. Bald opined Employee had suffered a complete collapse of the L5-S1 disc space following his 2008 lumbar surgery, and the May 30, 2008 work-related injury was the substantial cause of this disc space collapse and need for further treatment (Bald report, April 18, 2009, at 8).

28) On April 29, 2009, Employee's physician Grant Roderer, M.D., referred Employee to Rick Delamarter, M.D., in California at Employee's request for disc replacement surgery (Employee; Roderer report, April 29, 2009; Consultation Request, May 4, 2009).

29) On May 27, 2009, Dr. Delamarter performed a preoperative evaluation on Employee and noted "some decreased sensation in the L5-S1 distribution on the right side, perhaps a half grade of weakness of the gastrocsoleus" (Delamarter report, May 27, 2009, at 3).

30) On May 28, 2009, Dr. Delamarter and Brandon Strenge, M.D., performed anterior disc resections and bilateral neural foraminotomies at L4-5 and L5-S1, a ProDisc prosthetic disc replacement at L4-5, a partial corpectomy at L5-S1 in preparation for fusion, and an anterior interbody fusion at L5-S1 with instrumentation on Employee (Operation Report, May 28, 2009).

31) On June 17, 2009, Employee returned to Dr. Roderer who had been asked by Dr. Delamarter to perform postoperative incision checks, a neurological evaluation and lumbar spine AP and lateral projection X-ray studies. Upon examination, Dr. Roderer found slight weakness on the right at the extensor hallucis longus and mild pain into Employee's groin radiating into his lower extremities on the right greater than the left. Employee reported some of his leg symptoms had already begun to resolve (Progress Note, June 17, 2009; Progress Note, July 8, 2009).

32) On August 19, 2009, Employee reported to Dr. Roderer he had good muscle strength in his lower extremities and no radicular symptoms (Progress Note, August 19, 2009).

33) On February 5, 2010, Employee saw Edward Tapper, M.D., for a second independent medical evaluation (SIME). Using the 6th Edition, Dr. Tapper diagnosed intervertebral disc herniations at multiple levels with surgery and residual radiculopathy, which placed Employee in "Class 3" impairment. Dr. Tapper placed Employee in Class 3 based specifically upon radiculopathy documented as weakness in Employee's legs. Dr. Tapper suspected the leg weakness was related to Employee's 2008 work injury given he had led a physically active lifestyle for 15 years without significant issues (Tapper deposition at 21-22).

34) While placing Employee in Class 3 impairment, Dr. Tapper did not go through the "grade modifiers" in the AMA *Guides* to reach his rating. Grade modifiers are used to grade radiculopathy and Dr. Tapper did not consider these when he rated Employee. When reviewing the grade modifiers, based upon the February 2010 evaluation, Dr. Tapper thought Employee's grade modifier was probably zero, except motor strength was Grade 1. He was uncertain if the leg weakness he detected was from the 1992 or 2008 injuries (*id.* at 23).

35) Dr. Tapper conceded he had never used grade modifiers and, before he rated Employee, had never used the *Guides* 6th Edition. Dr. Tapper had no training on the *Guides* 6th Edition (*id.*).

36) On March 5, 2010, Employer controverted PPI (Controversion Notice, March 4, 2010).

37) On April 15, 2010, Employer again controverted PPI (Controversion Notice, April 14, 2010).

38) On June 8, 2010, Employee saw Marilyn Yodlowski, M.D., for an EME (Yodlowski deposition at 10-11). Dr. Yodlowski opined the 1992 surgery probably did not have a direct effect on any subsequent low back condition because the prior surgery and "discectomy" were "healed up" (*id.* at 27-28).

39) Dr. Yodlowski opined the *Guides* 6th Edition is a "little murky" because in one place it says impairment is not rated based on "degenerative changes," but on the other hand it provides ratings for surgeries for intervertebral disc "herniations," which in her understanding are predominantly caused by degenerative changes, which are age and genetically caused (*id.* at 26, 33-34). On cross-examination, Dr. Yodlowski acknowledged an earlier attending physician in June 2009, noted right extensor hallucis longus weakness as evidence of radiculopathy (*id.*). Dr. Yodlowski also agreed Dr. Bald on his examination noted evidence of radiculopathy and she did not necessarily disagree with Dr. Bald's conclusion (*id.* at 44). She was unaware of any evidence Employee had radiculopathy symptoms prior to the May 30, 2008 injury (*id.* at 47-48).

40) On August 13, 2010, Dr. Bald agreed he did not offer a PPI rating in his report, though his report states "[c]learly, Mr. Hanson will have additional permanent partial impairment related to either surgical procedure." When asked during his deposition for an estimate, Dr. Bald initially opined an estimated PPI rating for Employee's lumbar spine would be Class 3, 19 percent. However, he immediately retracted his estimate after further reviewing the *Guides*, and stated Employee fit into Class 1 with seven percent PPI because he had no residual radiculopathy. In Dr. Bald's opinion, Employee's retrograde ejaculation issue is not a "radiculopathy" but is a complication of his lumbar surgery subject of this injury. Dr. Bald had no way of knowing whether Employee had any impairment from his 1992 low back surgery, did not offer an opinion on any preexisting PPI and did not make a PPI reduction (Bald deposition at 23-28).

41) Dr. Bald agreed Employee "completely recovered" from the effects of his 1992 injury and surgery (*id.* at 28).

42) Dr. Bald did not refer to any required *Guides* "modifiers" to derive Employee's PPI rating (observations).

43) Employee recovered completely from his 1992 work-related injury suffered in Utah. In respect to the 2008 work injury, Employee returned to work in January 2010 to full duty following his disc replacement surgery and had no problems affecting his ability to perform his job. Though

he has no pain, his physicians advised him he has muscle atrophy, muscle weakness, "nerve issues," and he is aware of damage to nerves causing him to suffer retrograde ejaculation (Employee; judgment and inferences drawn from all the above).

44) Employee had a truly remarkable result from his 1992 and 2008 injuries and surgeries (judgment and inferences drawn from all the above).

45) On October 29, 2010, *Hanson I* among other things found Employee's L4-5 disc issue was compensable but held Employee's PPI claim in abeyance pending further medical evaluations. *Hanson I* awarded Employee $39,250.50 in attorney's and paralegal fees and $2,389.14 in other costs (*Hanson I* at 38).

46) On April 27, 2011, Thomas Gritzka, M.D., performed an SIME and opined Employee had a Class 3, 19 percent PPI rating attributable to the 2008 injury, with no reduction for any preexisting impairment (Gritzka report, April 27, 2011, at 19).

47) On May 27, 2011, Dr. Yodlowski reviewed and responded to the SIME report from Dr. Gritzka. She noted Dr. Gritzka did not state whether he used the *Guides* 6th Edition second printing, or the first printing with uncorrected errors. Dr. Yodlowski opined using the corrected *Guides* 6th Edition is important in providing a correct rating. She agreed with Dr. Gritzka that Employee falls under the diagnostic category of "motion segment lesions," in Table 17-4 on page 570. "Alteration of motion segment integrity" (AOMSI) discussed on pages 577-78, encompasses Employee's surgical fusion performed at L5-S1. Dr. Yodlowski opined AOMSI also includes Employee's disc replacement surgery at L4-5, as specified on page 563, placing Employee into the "motion segment lesions" category at two spinal levels. However, she disagreed with Dr. Gritzka placing Employee in a Class 3 motion segment lesion simply because he has AOMSI at two spinal levels. She and Dr. Gritzka agreed Employee presented with a normal physical examination and functional history and has a "grade modifier" of zero in each category because he had essentially a normal physical examination, as he did when Dr. Yodlowski examined him on June 8, 2010, for an EME. As Employee's physical findings were normal, according to Dr. Yodlowski this by definition excludes objective findings of residual radiculopathy. Though she agreed the AOMSI at multiple levels with medically documented findings with or without surgery correctly placed Employee in Class 3, Dr. Yodlowski noted the essential second part of the Class 3 description in the corrected *Guides* 6th Edition requires "documented residual radiculopathy at a single clinically appropriate level present at the time of the examination." She further noted the uncorrected *Guides* 6th Edition included the

words "with or without" documented radiculopathy. Dr. Yodlowski stated if Dr. Gritzka used the uncorrected *Guides* in his rating, placing Employee and Class 3 would be correct. However, she further noted the corrected version precludes placing Employee into Class 3. In Dr. Yodlowski's opinion, Employee fits into Class 1 on page 570 for his 2008 injury because he has:

> Intervertebral disk herniations or documented AOMSI at single levels or multiple levels with medically documented findings with or without surgery and with documented resolved radiculopathy at clinically appropriate levels or non-verifiable radicular complaints at clinically appropriate levels present at the time of the examination.

Dr. Yodlowski opined these findings put Employee in default grade C within Class 1, with default seven percent whole person impairment for his lumbar spine. Using the grade modifiers, as required, resulted in Employee's default rating having a -2 adjustment in her opinion. This resulted in Dr. Yodlowski's opinion, in Employee having a five percent PPI rating for his lumbosacral spine for his 2008 work injury. However, in Dr. Yodlowski's opinion, Employee had the same five percent PPI rating before his 2008 injury, resulting from the 1992 injury and surgery, which results in Employee having a net zero percent PPI rating (Yodlowski EME report, May 27, 2011, at 5).

48) On June 1, 2011, Employer again controverted PPI (Controversion Notice, May 31, 2011).

49) On October 26, 2011, Dr. Gritzka testified he performed a PPI rating on Employee. During his examination, Dr. Gritzka found no appreciable weakness on muscle testing and no radiculopathy. Employee's functional review was normal. Dr. Gritzka gave "0" grade modifiers because Employee reported no functional limits and was asymptomatic at the time of Dr. Gritzka's examination. He did "not really pursue" the grade modification protocol because he "thought it was silly, frankly," because Employee had a good outcome from his lumbar surgeries and Dr. Gritzka found a normal physical examination of Employee's lumbar spine. As these resulted in zero modifiers, and in Dr. Gritzka's opinion the two zeros "cancelled out," this left Employee with the default, 19 percent impairment rating. Dr. Gritzka conceded for Employee's 2008 injury and subsequent surgeries, his disk herniation at a single level with resolved radiculopathy put him in Class 1 with a seven percent default PPI rating. However, Dr. Gritzka did not believe Class 1 adequately rated Employee given his fusion and lumbar disc replacement. "So this is a clinical judgment on my part more than being -- strictly following the guides." Dr. Gritzka disagrees with the *Guides*. He was asked:

> Q. And under these guides there is nothing that would indicate this higher rating of 19 percent supported in the guides; am I right? So if you read the guides and follow them, it would be 7 percent. If you add in additional factors you believe are relevant, you would put him at another percentage?
>
> A. Yes (Gritzka deposition at 12-13).

50) Dr. Gritzka stated without records or a prior examination concurrent with Employee's 1992 injury, the *Guides* prohibited giving a preexisting impairment rating and Employee's impairment for his 1992 injury and resulted surgery would be zero percent (*id*. at 16).

51) On December 6, 2011, Dr. Barrington in deposition, based solely on a record review, opined it would be "next to impossible" to derive a valid PPI assessment for Employee's 1992 low back surgery without medical records related to that procedure (Barrington deposition, December 6, 2011, at 19).

52) Dr. Barrington also reviewed the Lumbar Spine Regional Grid, Table 17-4 from the *Guides*, and opined Employee fit under "Motion Segment Lesion" because he had alteration of motion segments in his spine at multiple levels. Dr. Barrington stated Employee's permanent nerve damage resulting in sexual dysfunction met the first part of the *Guides*' definition of radiculopathy. He also stated Employee's lingering symptoms radiating from his low back into his hip were radiculopathy from a spinal nerve root, which did not go into his leg, but rather went to his sexual organs. Dr. Barrington placed Employee in Class 3 impairment for the lumbar spine based upon his document review. Based upon the disc replacement, Dr. Barrington put Employee in a "Grade 2 modifier," which resulted in a 15 percent PPI rating for the lumbar spine (*id*. at 24-41).

53) Dr. Barrington agreed if Employee had no radiculopathy, he would fall into Class 1 on Table 17-4 (*id*. at 53).

54) On December 20, 2011, Employer filed an objection to Employee's December 14, 2011 fee affidavit. Employer argued Employee's fees where excessive "if not outrageous." Employer objected to the hourly rates charged for Employee's counsel and his paralegal. It argued no more than a statutory minimum fee could be awarded under AS 23.30.145(a), because Employee's claim was controverted. Employer maintained the hearing involved only one, simple PPI issue, which it argued Employee's lawyer should have easily been able to perfect. Employer compared the hourly fee for Employee's counsel's paralegal with pay for legal interns with two years of law school.

Employer also objected to Employee's counsel's fee affidavit, because it contended the affidavit did not include enough detail to tell what time was spent an unsuccessful issues, clerical matters, or "frivolous endeavors." Employer objected to eight specific entries for Employee's attorney, and 13 specific entries for his attorney's paralegal (Opposition to December 14, 2011 Affidavit of Attorney Fees, December 20, 2011).

55) Employee agreed with Dr. Tapper's February 5, 2010 report at page 3, where he states Employee is asymptomatic and performs all activities of daily living without problem; though Employee does not disagree with Dr. Tapper's finding of reduced strength in his bilateral legs, Employee could not and cannot discern any loss of strength in either leg (Employee).

56) Employee still had residual right buttock pain when Dr. Gritzka evaluated him in April 2011. Employee still experiences minimal back pain and right buttock pain, which is almost always present and made worse through various activities. If Employee's pain becomes particularly bad, he will take over-the-counter medication (*id*.).

57) Employee's pain complaints have reduced since his disc replacement surgery; however, Employee still frequently complains of back pain and pain radiating into his buttock (*id*.).

58) At hearing on December 20, 2011, Dr. Yodlowski testified she has special training in the *Guides* 6th Edition, and has taught its use to other physicians. She testified generally consistent with her previous reports critiquing Dr. Gritzka's PPI rating (Yodlowski).

59) Since the commission rejected *Hanson II*'s reliance on the *Guides* 3rd Edition to rate the 1992 injury, Dr. Yodlowski's PPI rating reduction must be more closely scrutinized (judgment and inferences drawn from all the above).

60) When asked by Employer's attorney how "a preexisting impairment" is calculated under the *Guides*, Dr. Yodlowski stated:

> A. Well, the way that it's done properly, it's explained on page 26 of the AMA guides, and it's very important that the preexisting apportionment be determined based on the sixth edition, and the reason for that is the current ratings for the same condition may come out with different numbers if you're using the third, fourth, fifth or sixth edition. So to properly do impairment -- I'm sorry, to properly do apportionment, you have to take the information that you know was available and translate it using the sixth edition.
>
> Q. I'm -- Doctor, I have -- and I'm going to pass out to the board members pages 25 and 26, section 2.5(c) on apportionment. Is that the section you were speaking of?

A. Yes.
. . .

Q. What -- Mr. Jensen argues that there's insufficient information about the 1992 treatment and condition that -- to estimate or determine what the preexisting impairment was under section 2.5(c) of the guides. Do you agree?

A. I disagree. I think you can determine the previous impairment.

Q. Okay. The guides state: If no rating was previously assigned, the examiner must use available information to estimate what the rating was before the new injury and subtract this from the new rating, as noted earlier. What information is available here?

A. There is information about the phy -- his physical condition prior to the injury, and there's also information about the [telephone connection cut out and then reestablished]
. . .

[Dr. Yodlowski continued on with her prior answer] Yes. And the history of his prior surgery. He had a surgery in 1992 which included disc surgery.

Q. So what category would that put him in for that previous injury?

A. That would -- that would put him back into class I again because that's for single or multiple levels with or without surgery, and no radiculopathy.

Q. Okay. Now, Mr. Jensen argued in his brief that you stated in your report you were unable to do a preexisting impairment rating because of lack of information. Is that true?

A. It's strictly true in terms of can I do the impairment rating, but that doesn't mean that I can't do the apportionment, that's why the apportionment is very specifically described in the guides, because he didn't have the information, no, you -- nobody could do apportionment. . . .

Q. Oh.

A. . . . because you have to do it. . . .

Q. Oh.

A. . . . from the new -- newest level of the guides, from the sixth level.
. . .

> Q. Okay, just because you don't have a medical report from 1992 in this case and a surgical report, under the guides that doesn't prohibit you from doing an apportionment.
>
> A. That's correct (Hearing Transcript, December 20, 2011, at 242-46).

61) However, on cross-examination when queried about whether her previous written opinion at page 29 stating medical records were necessary to determine the appropriate PPI rating for the 1992 injury and resultant surgery had changed, Dr. Yodlowski testified:

> A. In terms of rating him how he was in 1992, my opinion is unchanged, but I do have records from 2004, so he can be rated as he was in 2004.
>
> Q. Okay. So -- but you cannot do any rating as to how he was 1992? So you're adjustment was strictly based on how he was 2004?
>
> A. Well, I have -- that's correct. . . .
>
> Q. Okay, so -- I need to get this clear in my mind. Prior -- your preexisting impairment rating for Mr. Hanson is seven percent?
>
> A. It is based on the information that I have, and I'm just going to look at the . . . some of his notes mention some areas of numbness, so it would be at -- at seven percent, possibly six percent, depending on his level of function. If he was functioning without any difficulty, it would have been six percent.
>
> Q. Okay, and you base that on the medical records you had for 2004?
>
> A. [Mostly indiscernible].
>
> Q. [From the chair] Whose report was it in 2004?
>
> A. It was a report from Dr. Spencer, and dated January 14th 2004.
>
> Q. And so your rating -- your [sic] deducting for seven percent was based on a one-time eval in 2004?
>
> A. No, the seven percent is based on the diagnosis of him having had that prior surgery, so he falls into -- he had surgery in 1992, correct?
>
> Q. Yes. Do have any . . . records relating to that surgery?
>
> A. I do not have that operative report, no.

> Q. So what kind of -- how do you know what the surgery -- what -- the basis for that surgery?
>
> A. The -- the basis for the surgery. Well . . . let's see, he had a disc herniation, which is read as a recurrent disc herniation.
>
> Q. How do you know that?
>
> A. I'm reading the radiologist report from 2003.
>
> Q. It says that there was a disc herniation -- in 2003 it refers to a disc herniation from 1992?
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> A. I don't know what it was from. It was recurrent right L5-S1 disc protrusion with lateral recess narrowing. He says recurrent here, so he may have had something to compare it to. I don't know . . . there are surgical changes at the L5-S1 level, so that imaging study confirmed that there was surgery at that motion segment.
>
> Q. But we don't know if the surgery was for a herniation or a bulge or simply symptoms of pain, do we?
>
> A. No, but he did have surgery at that motion segment, so he had alteration in his motion segment integrity of some sort.
> . . .
>
> Q. Is there any evidence of a disc herniation in the medical records?
>
> A. No, but that doesn't matter. If he had disc surgery, he would still fall under the category of AOMSI.
> . . .
>
> Q. Yes. Is the rating based on a person having a disc herniation?
>
> A. Not -- as I read it here it says or if you have surgery at that disc, you've had alteration in that disc.
>
> Q. Okay, so you're saying because he had the surgery it doesn't make a difference if it was a herniation?
>
> A. That's correct (*id*. at 272-78).

62) On February 21, 2012, *Hanson II* was issued, and among other things not relevant to the remanded issues, awarded Employee three percent PPI for sexual dysfunction; two days' TTD

for medical evaluations; interest; and $26,911.50 in attorney's fees, $6,220.50 in paralegal fees, and $2,652.40 in other costs (*id*. at 61).

63) On March 22, 2012, *Hanson III* was issued. It denied Employer's request for reconsideration of Employee's attorney fee award. *Hanson III* granted Employee's request for clarification of *Hanson II* to expressly find his hypogastric nerve plexus injury and resultant retrograde ejaculation were compensable, ratable injuries, but denied Employee's request for reconsideration of the lumbar PPI rating (*id*. at 32).

64) Employer appealed these decisions to the Alaska Workers' Compensation Appeals Commission primarily on the TTD and attorney's fees issues, and Employee cross-appealed on the PPI rating decision. On June 12, 2013, the commission issued a decision reversing the two days' TTD award to Employee for medical evaluations, and reversed and remanded the board's lumbar PPI decision and attorney's fee award (*Municipality of Anchorage v. Hanson*, AWCAC Decision No. 182 (June 12, 2013)).

65) The commission gave specific instructions to the board on remand: The same *Guides* edition must be used to rate both the 1992 and 2008 injuries (*id*. at 27). The commission instructed the board on remand to determine: 1) whether the 1992 injury can be rated under either the 3rd or 6th *Guides* edition; 2) whether both injuries can be rated using the same *Guides* edition; and 3) apportion impairment between the injuries, if in the board's estimation, apportionment is possible (*id*. at 28).

66) Specifically, the commission stated:

- "Hanson has argued that the 1992 injury cannot be rated, but if it is possible to rate the 1992 injury, the board should have used the *Guides* 6th Edition to rate both the 1992 injury and surgery and the 2008 injury and surgeries (footnote omitted). Applying the reasonable basis standard of review, (footnote omitted) for a number of reasons discussed below, we agree, reverse, and remand this matter to the board to revisit the PPI rating issue and, if appropriate, apportion Hanson's impairment between them, as recommended by the *Guides* 6th Edition" (*id*. at 11).
- *Hanson II*'s approach using the *Guides* 3rd Edition to rate the 1992 injury was flawed in several respects (*id*. at 12-14).
- "However, one conclusion is inescapable: Under the circumstances, different editions of the *Guides* should not be used, notwithstanding board precedent for doing so" (*id*. at 14).

- "In summary, applying the reasonable basis standard of review, there are a number of reasons for concluding that the board erred when it used the *Guides* 3rd Edition for rating Hanson's 1992 injury. Among them are the lack of evidence relative to the 1992 injury, (footnote omitted) the markedly different methodologies between the 3rd and 6th editions for rating lumbar spine impairment, and the admonition to use the same edition of the *Guides* when apportioning PPI between injuries" (*id*.).
- "On remand, the board should determine whether the 1992 injury can be rated under either the 3rd or 6th edition of the *Guides*, whether both injuries can be rated using the same edition of the *Guides*, (footnote omitted) and apportion impairment between the injuries, if, in the board's estimation, that is possible. In the process, the board should state its findings in each of these respects" (*id*.).
- The two footnotes omitted from the two quotes above state: "This consideration [the lack of evidence relative to the 1992 injury] would apply to rating the 1992 injury using the *Guides* 6th Edition as well." "Ordinarily, the 2008 injury would have to be rated under the *Guides* 6th Edition. *See* AS 23.30.190(d) and 8 AAC 45.122(a). However, the 6th Edition instructs that the edition that best describes the individual's impairment should be used for apportionment. *See* n. 139, *supra*. Thus, all other considerations aside, the 3rd Edition might arguably be used to rate the 2008 injury" (*id*. at 14 n. 140, 141).
- As for the attorney's fee issue, the commission stated: "However, here, the issue is not so much whether the board abused its discretion. Instead, the issue is whether the board made adequate findings to support its award of attorney fees" (*id*. at 15).
- "As mentioned at the outset of this decision, the commission has concluded that the board's attorney fee award must be reversed and remanded (footnote omitted). We do so for three reasons: 1) the board's findings that MOA otherwise resisted payment of compensation, in support of its decision to award fees under AS 23.30.145(b), are not adequate for that purpose; 2) the board's findings do not satisfy the requirement set forth in *Lewis-Walunga v. Municipality of Anchorage* (footnote omitted) that the board explain its reasons for awarding fees under AS 23.30.145(b) when a claim is controverted; and 3) given our disposition of the PPI rating issue, the board may wish to revisit and revise its award" (*id*.).
- "On remand, the board may or may not decide that 1) the 1992 injury can be rated under either the 3rd or 6th Edition of the *Guides*; 2) both injuries can be rated using the same edition

of the *Guides*; or 3) impairment can be apportioned between the 1992 and 2008 injuries. All these factors may cause the board to reconsider its original PPI rating, in which case it may find it desirable to adjust its attorney fee award upward or downward" (*id*. at 16).

67) On July 17, 2013, the appeals commission issued its order on Employee's motion for attorney's fees and costs on appeal. Employer argued Employee was not the successful party on his cross-appeal. It also argued Employee's attorney's fees and costs on appeal were unreasonable. The commission noted Employer's primary objection to Employee's attorney fees on appeal was that they were "excessive." The commission found contrary to Employer's argument, "the PPI rating issue in particular to have been complex." The commission awarded the full attorney's fees Employee requested on appeal (Order on Motion for Attorney Fees and Costs on Appeal, July 17, 2013, at 7).

68) At hearing on remand on October 9, 2013, there was disagreement between the hearing panel and the parties concerning the commission's intent. As to: 1) whether the 1992 injury can be rated under either the 3rd or 6th *Guides* edition, the panel took this to mean whether or not it is physically possible to rate the injuries under the 3rd and 6th editions. Both parties interpreted the commission's question to be whether or not the two injuries were ratable under either edition as a matter of law. Addressing the panel's interpretation, Employee argued the 1992 injury could not be rated under either the 3rd or 6th edition; because there was inadequate evidence upon which to base a rating under either *Guides* addition. Employer conceded it was physically possible to rate the 1992 injury under the 3rd edition, but legally impossible. Employer contended both injuries had to be rated under the *Guides* 6th Edition (hearing record).

69) At hearing on October 9, 2013, the parties eventually agreed the *Guides* 6th Edition should be used to rate both the 1992 and 2008 injuries as a matter of law, thus mooting the commission's first issue on remand (record).

70) As to: 2) whether both injuries can be rated using the same *Guides* edition, this question on remand is also moot as the parties have agreed the *Guides* 6th Edition should be used to rate both injuries (*id*.).

71) As to: 3) whether there can be an apportionment, the record contains adequate information from which to derive a *Guides* 6th Edition PPI rating for the 2008 injury. *Hanson II* found Dr. Yodlowski provided such a rating and she alone did so strictly and solely in conformance with the

Guides 6th Edition. Therefore, there is no other acceptable, 6th Edition *Guides* PPI rating for the 2008 injury (*Hanson II* at 26).

72) The appropriate Table 17-4, Lumbar Spine Regional Grid from the corrected *Guides* 6th Edition says in relevant part:

Lumbar Spine Regional Grid					
Class	Class 0	Class 1	Class 2	Class 3	Class 4
IMPAIRMENT RATING (WPI %)	0	1%-9%	10%-14%	15%-24%	25%-33%
. . .	. . .	. . .			
MOTION SEGMENT LESIONS					
Intervertebral disk herniation and/or AOMSI Note: AOMSI includes instability (specifically as defined in the *Guides*), arthrodesis, failed arthrodesis, dynamic stabilization or arthroplasty, or combinations of those in multiple-level conditions	0 Imaging findings of intervertebral disk herniation without a history of clinically correlating radicular symptoms	5 6 7 8 9 Intervertebral disk herniation(s) or documented AOMSI, at a single level or multiple levels with medically documented findings; with or without surgery *and* for disc herniation(s) with documented resolved radiculopathy or non-verifiable radicular complaints at clinically appropriate level(s), present at the time of examination	10 11 12 13 14 Intervertebral disk herniation or any AOMSI at a single level with medically documented findings; with or without surgery *and* with documented residual radiculopathy at the clinically appropriate level present at the time of examination (*see Physical Examination adjustment grid in Table 17-7 to grade radiculopathy*)	15 17 19 21 23 Intervertebral disk herniations and/or AOMSI at multiple levels, with medically documented findings; with or without surgery *and* with documented residual radiculopathy at a single clinically appropriate level present at the time of examination (*see Table 17-7 to grade radiculopathy*)	25 27 29 31 33 Intervertebral disk herniations and/or AOMSI, at multiple levels, with medically documented findings; with or without surgery *and* with documented signs of residual bilateral or multiple-level radiculopathy at the clinically appropriate levels present at the time of examination (*see Table 17-7 to grade radiculopathy*)
. . .	. . .	. . .	. . .	. . .	. . .
* Or AOMSI in the absence of radiculopathy, or with documented resolved radiculopathy or non-verifiable radicular complaints at the clinically appropriate levels present at the time of examination.					
. . .					
* Note: The following applies to the cervical, thoracic, and lumbar spine grids: 1) Intervertebral disk herniation excludes annular bulge, annular tears and disk herniation on imaging without consistent objective findings of radiculopathy at the appropriate level(s) when most symptomatic. 2) When AOMSI is the diagnosis being rated, imaging is not included in the Net Adjustment Calculation, because imaging is used to confirm the diagnosis.					
. . .					
Note: Alteration of motion segment integrity indicates AOMSI. It is defined using flexion/extension X-rays (figure 17-5 and 17-6). In the lumbar spine (L1-5), a diagnosis of AOMSI by translation measurements requires greater than 8% anterior or greater than 9% posterior relative translation of one vertebra on another, on flexion or extension radiographs, respectively. In the lumbosacral spine (L5-S1), it requires greater than 6% anterior or greater than 9% posterior relative translation of L5 on S1, on flexion or extension radiographs, respectively. A diagnosis of AOMSI by angular motion measurements requires greater than 15° at L1-2, L2-3, L3-4; greater than 20° at L4-5, or greater than 25° at L5-S1 (compared to adjacent level angular motion). Alternatively, may have complete or near-complete loss of motion of a motion segment due to developmental fusion or due to successful or unsuccessful attempt at surgical arthrodesis.					

73) Further as to the board's duty on remand to: 3) apportion impairment between the injuries, if in the board's estimation, apportionment is possible, *Hanson II* found the following PPI ratings relevant to the remand were supported in the record, as indicated:

Physician	Date offered in report or deposition	Anatomy or function	Rating	Reduction?	Modifiers used?	Strictly & solely under Guides 6th Edition?
SIME Tapper	6/4/10	Lumbar spine	23%	Up to 13%	No	No
EME Bald	8/13/10	Lumbar spine	7%	0%	No	No
SIME Gritzka	10/26/11	Lumbar spine	19%	0%	No	No
Barrington	12/6/11	Lumbar spine	15%	0%	No	No
Yodlowski	12/20/11	Lumbar spine	5%	5%	Yes	Yes

74) The commission cast doubt on whether or not Dr. Yodlowski performed the 6th Edition PPI rating for the 1992 injury strictly and solely in conformance with the *Guides* when it questioned whether the injury could be rated under either *Guides* edition (AWCAC Decision 182 at 27-28).

75) Specifically, the commission stated:

> Because the respective methodologies are dissimilar, we question whether the 1992 injury, assuming it could be rated at all, and the 2008 injury, can be rated using the same edition of the *Guides*, whatever edition that might be. . . . Finally, where, as here, no rating was previously assigned, the board, as distinguished from the evaluators, would need to use available information to estimate what the rating was before the new injury, and subtract this from the 'new' rating. As noted earlier, there is a scant amount of information available to rate the 1992 injury, making an estimated rating for that injury problematic (*id.*).

76) Dr. Yodlowski's 6th Edition "rating" and resultant "apportionment" for the 1992 injury was not done strictly and solely in conformance with the *Guides* for several reasons: First, she ultimately admitted she could not perform a rating for the 1992 injury. Thus, she never actually performed a 1992 rating to deduct from the 2008 rating. Dr. Yodlowski based her "apportionment" not on an impairment "rating" for the 1992 injury, but rather, on medical records demonstrating a herniated disc from 2004. She first reported she could not perform an impairment rating for the 1992 injury, and then testified she could, then testified she really could not but could still do "the apportionment," contrary to what the *Guides* says must occur. Second, her 1992 pseudo-rating violates the *Guides'* Fundamental Principles, principle seven, from Table 2-1 because it does not follow the "3-step" approach. Though she reviewed available medical records, Dr. Yodlowski admittedly did not review medical records pertaining to the 1992 injury and surgery and any

sequelae before performing her PPI pseudo-rating for the 1992 injury because there were no medical records directly related to that injury to review. Third, she admitted she cannot accurately determine the diagnosis for which Employee had surgery in 1992, absent medical records, and the *Guides* state an accurate diagnosis is the starting point for any rating. Fourth, Dr. Yodlowski did not perform an evaluation on Employee in or anywhere near 1992. Therefore, she cannot properly analyze non-existent findings and accurately discuss or report how her PPI pseudo-rating for the 1992 injury was derived. Fifth, there is no documented medical evidence Employee had an intervertebral disc herniation in 1992. Similarly, there is no documented medical evidence Employee had resolved radiculopathy or non-verifiable radicular complaints at clinically appropriate levels present at the "time of the examination" because there was no contemporaneous examination in the record. As stated above, at least three examiners long after the 1992 injury found no evidence of radicular complaints at any examination, and Dr. Yodlowski used this lack of a resolved radiculopathy or non-verifiable radicular complaints to adjust the default rating for the 2008 injury rating from seven to five percent. There is no medical evidence documenting radiculopathy or non-verifiable radicular complaints at clinically appropriate levels at any time between 1992 and 2008, because there are no medical records to document anything from the 1992 injury. Similarly, there is no medical evidence showing Employee had resolved radiculopathy or non-verifiable radicular complaints at clinically appropriate levels at the time of any examination related to his 2000 or 2003 work injuries either. Sixth, Dr. Yodlowski did not strictly and solely follow the *Guides* because she placed Employee's 1992 injury into Class I from the 6th Edition solely because she found his 1992 lumbar surgery qualified as "alteration of motion segment integrity" (AOMSI), which is contrary to the *Guides* definition of AOMSI. Even if it was proven Employee had a herniated disc in 1992, and this lead to surgery, a herniated disc and surgery to correct it do not qualify as AOMSI as defined in the *Guides* (*Guides* 6th Edition, at 563; Table 17-4, 570-74; judgment, and inferences drawn from all the above).

77) Given the above factual findings and factual conclusions, the record on remand supports the following PPI ratings:

Physician	Date offered in report or deposition	Anatomy or function	Rating	Reduction?	Modifiers used?	Strictly & solely under Guides 6th Edition?
SIME Tapper	6/4/10	Lumbar spine	23%	Up to 13%	No	No
EME Bald	8/13/10	Lumbar spine	7%	0%	No	No
SIME Gritzka	10/26/11	Lumbar spine	19%	0%	No	No
Barrington	12/6/11	Lumbar spine	15%	0%	No	No
Yodlowski	12/20/11	Lumbar spine	5%	0%	No	No - 1992 Yes - 2008

78) There is no valid *Guides* 6th Edition PPI rating for the 1992 injury from which to reduce or apportion Dr. Yodlowski's five percent PPI rating for the 2008 injury (judgment, and inferences drawn from all the above).

79) Employee's 2000 and 2003 work injuries similarly would not result in a *Guides* 6th Edition rating deductible from the five percent PPI rating Dr. Yodlowski attributed to the 2008 injury for the same reason set forth above (*id.*).

80) Employee has a five percent, *Guides* 6th Edition PPI rating for the 2008 injury based upon Dr. Yodlowski's un-reduced rating (*id.*).

81) As of the *Hanson I* hearing on August 19, 2010, Employee's counsel billed at $350.00 per hour for himself, and $150.00 per hour for his paralegal (*Hanson I* at 14).

82) Since September 1, 2010, Employee's counsel bills at $385.00 per hour for himself, and $165.00 per hour for his paralegal (Supplemental Affidavit of Attorney's Fees and Costs for Services Since September 18, 2010, September 20, 2010; Final Supplemental Affidavit of Attorney's Fees, January 3, 2010).

83) Prior to this increase, Employee's attorney had not billed at an increased hourly rate since July 1, 2008 (Supplemental Affidavit of Attorney's Fees and Costs for Services Since September 18, 2010, September 20, 2010).

84) In total, Employee itemized and requested actual fees totaling $26,911.50, paralegal costs of $6,220.50, and revised costs of $2,652.40 (*id.*; Final Supplemental Affidavit of Attorney's Fees, January 3, 2010; letter, January 3, 2012).

85) On January 3, 2012, Employee's counsel responded to Employer's opposition to his December 14, 2011 fee affidavit. He adequately explained the time split for his December 6, 2011 entry concerning Dr. Barrington's deposition and his hearing brief preparation. Employee's counsel adequately explained the participation of his paralegal in assisting with preparing his witness list, an

opposition to the petition to quash Dr. Barrington's testimony, reviewing SIME binders, preparing his hearing brief and reviewing *Hanson I* (Response to Employer's December 20, 2011 Opposition to December 14, 2011 Affidavit of Attorney Fees, January 3, 2012).

86) It is not uncommon or unusual for an attorney and paralegal to work on the same legal research for a pleading or a hearing, to save time. Use of a paralegal to concurrently supplement an attorney's efforts simply reduces the overall cost of concurrent research or preparation, and saves time, while the paralegal is billed at a significantly lower rate than the attorney (experience, judgment, observations and inferences drawn from all of the above).

87) On January 3, 2012, Employer objected to Employee's December 20, 2011 supplemental affidavit of fees. This objection mirrored in many respects Employer's prior opposition to Employee's December 14, 2011 affidavit of attorney's fees. Again, Employer argued Employee's fees were "excessive and outrageous." Employer objected to costs associated with long-distance phone charges, facsimile transmissions, mileage for attorney travel, and courier charges arguing these are not recoverable under regulations. Employer also objected to charges related to Dr. Barrington's deposition. Lastly, Employer objected because it contends Employee's counsel rarely loses before the board, is paid when cases end by settlement, and suggested income tax schedules between Employer's counsel and Employee's counsel should be compared and would reveal Employee's counsel is essentially not paid on a contingency basis (Opposition to December 20, 2011 Supplemental Affidavit of Attorney Fees, January 3, 2012).

88) On January 5, 2012, Employee's counsel responded to Employer's objection to his supplemental affidavit of attorney's fees. He explained the costs were adjusted down to reflect Employer's objections, from $2,885.12 to $2,652.40. He adequately explained long distance telephone charges were appropriate as his client lives outside the local Anchorage telephone area. His copy charges were reduced to reflect the regulatory maximum. Employee's counsel adequately explained he sent medical records to Dr. Barrington both in hardcopy and electronic mail. Similarly, he explained hourly charges for Dr. Barrington's deposition were not duplicative of attorney's fees charged in relation to Dr. Barrington's testimony, as Dr. Barrington charged $600 for his services at the deposition and $300 for services prior to deposition reviewing medical records and meeting with Employee and his attorney. Lastly, Employee's counsel reiterated his affidavits properly reflected costs for Dr. Gritzka's and Dr. Barrington's deposition transcripts (Limited

Response to Employer's Opposition to the 12/20/2011 Supplemental Affidavit of Attorney's Fees, January 4, 2012).

89) At hearing on October 9, 2013, Employee submitted additional affidavits for attorney's fees and costs. From August 13, 2013 through October 9, 2013, Employee documented $5,005.00 in additional attorney's fees for work done before the board since the commission's June 12, 2013 decision. He further documented $528.00 in paralegal costs from one paralegal and $49.50 in paralegal costs from another paralegal, both since the June 12, 2013 commission decision (Supplemental Affidavit of Attorney's Fees and Costs for Services since the AWCAC's 6/12/13 Decision, October 9, 2013; Supplemental Affidavit of Paralegal Costs for Services Since the AWCAC'S 6/12/13 Decision [Gedicks], October 9, 2013; Supplemental Affidavit of Paralegal Costs for Services Since the AWCAC's 6/12/13 Decision [Haugstad], October 9, 2013).

90) A fire alarm interrupted the October 9, 2013 hearing. Employee incurred approximately two more hours in attorney's fees given the oral argument and the fire alarm delay (observations).

91) Employee's attorney is an experienced litigator, with over 31 years' experience as an attorney. He is well-versed in workers' compensation law and his briefing and presentations at hearing in this case were helpful (Response to Employer's December 20, 2011 Opposition to December 14, 2011 Affidavit of Attorney Fees; judgment, experience, observations).

92) Employee's counsel's current $385.00 per hour and his paralegal's $165.00 per hour rates for legal services are reasonable and consistent with rates charged by other claimant attorneys and their paralegals with similar experience in these cases (experience, judgment, observations and inferences drawn from all of the above).

93) Employee's counsel's itemized fee and cost affidavits provide sufficient detail and clarity to determine whether the fees and costs were reasonably incurred, in accordance with the law (*id*.).

94) Employer was also represented by very experienced counsel who zealously and ably represented her client (experience, observations).

95) Employer vigorously resisted Employee's claim by repeatedly denying and controverting his PPI and related attorney's fees and costs (record).

96) Some of Employer's arguments concerning settlement offers and attorney's fees were identical to arguments already rejected by the Alaska Supreme Court, which nonetheless required Employee's attorney to respond appropriately (judgment, experience).

97) The range of PPI benefits at stake in this case was broad, from zero percent up to at about 27 percent (*id.*).

98) Employee prevailed on his primary PPI claim and obtained five percent additional PPI, worth $8,850.00 (*id.*).

99) Employee lost on a *de minimis* TTD issue worth less than $900.00 (*id.*).

100) The medical evidence in this case was very complex, with widely varying opinions about PPI and application of a relatively new *Guides* protocol in an unusual case where Employee had two, very substantial surgical procedures as a result of his work-related injury, complications from one surgery affecting a different body function and a generally excellent result otherwise, with few residual symptoms, requiring equally complex legal services (*id.*).

101) It is highly unusual for an injured worker who has had three lumbar surgeries, including a disc replacement and a fusion, to have essential normal function and virtually no symptoms (*id.*).

102) The length of legal services provided in this case since *Hanson I* was long, but about average for a case of this high complexity (record; experience, judgment, observations and inferences drawn from all of the above).

103) Employee did not specify under which AS 23.30.145 subsection his fee request fell. However, implicit from his briefing and oral arguments, Employee seeks the higher of statutory minimum or actual attorney fees. It does not appear Employee is concerned with which subsection his fees are awarded, so long as he is awarded the most fees he is legally entitled to obtain (*id.*).

104) The PPI rating issue was particularly complex given the two *Guides* editions, which could be applicable to this case, and their dramatic differences (*id.*).

105) Employee's likelihood of prevailing on his PPI claim without the able assistance of experienced, competent counsel would have been slim (*id.*).

106) Attorneys representing injured workers, including Employee's lawyer in this case, are paid on a contingent basis, do not always prevail at hearing, and frequently reduce their actual fees significantly even when the parties reach settlements (*id.*).

107) Attorneys representing injured workers sometimes withdraw from representing an injured worker after expending considerable time preparing the workers' cases. In such instances, the attorneys often receive no fee (*id.*).

108) The workers' compensation claimant's bar in general is aging and at least two current claimant attorneys are in their mid-70s and early 80s and are nearing retirement (*id.*).

109) There are few younger attorneys entering the workers' compensation bar on the claimant's side. It is difficult for injured workers to find competent counsel. Approximately half of all injured workers who appear before the board have no attorney to advise them (*id.*).
110) It is unlikely Employee's lawyer would have represented him if he knew beforehand he was limited to receiving only statutory minimum attorney's fees upon prevailing (*id.*).

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). Less weight may be given to a physician who appears to be advocating for a party. *Geister v. Kid's Corps*, AWCB Decision No. 08-0258 at 30 (December 29, 2008).

> **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; . . . .

An employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski v. Best Western Golden Lion*, 813 P.2d 286, 292 (Alaska 1991). The presumption's application involves a three-step analysis. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381 (Alaska 1991). First, the employee must establish a "preliminary link" between the claim and his employment. In less complex cases, lay evidence may be sufficiently probative to establish the link. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). The employee need only adduce "minimal" relevant evidence establishing a "preliminary link" between the claim and the employment. *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987). The witnesses' credibility is of no concern in this first step. *Excursion Inlet Packing Co. v. Ugale*, 92 P.3d 413, 417 (Alaska 2004).

Second, in claims arising after November 5, 2005, employment must be the substantial cause of the disability or need for medical treatment. AS 23.30.010(a). In *Runstrom v. Alaska Native*

Medical Center, AWCAC Decision No. 150 (March 25, 2011), the commission stated "if the employer rebuts the presumption, it drops out, and the employee must prove, by a preponderance of the evidence, that in relation to other causes, employment was the substantial cause of the disability, need for medical treatment, etc. Should the employee meet this burden, compensation or benefits are payable" (*id*.). The commission further stated an employer need only demonstrate work is not the substantial cause and does not need to rule out employment as the substantial cause (*id*.). This test would also apply to claims for benefits other than "disability or need for medical treatment," based on the commission's use of "etc." in *Runstrom*. The party with the burden of proving asserted facts by a preponderance of evidence must "induce a belief" that the asserted facts are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

> **AS 23.30.122**. **Credibility of witnesses**. The board has the sole power to determine the credibility of a witness. A finding by the board concerning the weight to be accorded a witness's testimony, including medical testimony and reports, is conclusive even if the evidence is conflicting or susceptible to contrary conclusions. The findings of the board are subject to the same standard of review as a jury's finding in a civil action.

> **AS 23.30.145. 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, in whole or in part, 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. When the board advises that a claim has not been controverted, but further advises that bona fide legal services have been rendered in respect to the claim, then the board shall direct the payment of the fees out of the compensation 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.
>
> (b) If an employer fails to file timely notice of controversy or fails to pay compensation or medical and related benefits within 15 days after it becomes due or otherwise resists the payment of compensation or medical and related benefits and if the claimant has employed an attorney in the successful prosecution of the claim, the board shall make an award to reimburse the claimant for the costs in the proceedings, including reasonable attorney fees. The award is in addition to the compensation or medical and related benefits ordered. . . .

Rose v. Alaskan Village, Inc., 412 P.2d 503 (Alaska 1966) explained:

> AS 23.30.145(a) of the Alaska Workmen's Compensation Act enjoins the Board, in determining the amount of legal fees that are to be awarded, to
>
> > take into consideration the nature, length and complexity of the services performed. . . .
>
> In the instance where an employer fails to pay compensation or otherwise resists the payment of compensation, AS 23.30.145(b) provides:
>
> (I)f the claimant has employed an attorney in the successful prosecution of his claim, the board shall make an award to reimburse the claimant for his costs in the proceedings, including a reasonable attorney fee. The award is in addition to the compensation ordered. . . .
>
> We construe AS 23.30.145 in its entirety as reflecting the legislature's intent that attorneys in compensation proceedings should be reasonably compensated for services rendered to a compensation claimant. . . .

Johns v. State, Dept. of Highways, 431 P.2d 148 (Alaska 1967) dealt with fees for an injured worker's lawyer on appeal. But the court said in referring to AS 23.30.145 the court reiterated: "We construe AS 23.30.145 in its entirety as reflecting the legislature's intent that attorney's [sic] in compensation proceedings should be reasonably compensated for services rendered to a compensation claimant" (footnote omitted; *id*. at 154).

In a four justice plurality opinion, *Haile v. Pam American World Airways, Inc*., 505 P.2d 838 (Alaska 1973), the issue was whether attorneys in three workers' compensation death cases were entitled to a statutory minimum attorney's fee percentage under AS 23.30.145(a) or, in the alternative, whether the board could award a "reasonable" attorney's fee without regard to the minimum provisions, under AS 23.30.145(b). The board had awarded a lower fee under §145(b), and the employees appealed. *Haile* noted in multiple death cases, "the minimum attorney's fees could well exceed $15,000, whereas reasonable fees for the services involved would be a much smaller sum" (*id*. at 839). The employer in *Haile* never controverted the death claims but "failed to respond to the claim or to pay compensation," so the claimants filed claims, which were set for hearing (*id*.). Prior to hearing, the employer notified the board it did not contest any of the claims (*id*. at 839-40). After citing AS 23.39.145, *Haile* concluded: "Thus, the

award of the minimum statutory fees applies only in cases where a claim has been controverted" (*id*. at 840). *Haile* further said:

> It is to be noted that subsection (b) makes no reference to the award of a minimum fee, but refers only to the allowance of a 'reasonable attorney fee.' Had the legislature intended the minimum fee provision to apply to subsection (b), it would have been a simple matter to have so specified. The failure to do so, coupled with the illogic of awarding a fee which may be out of all proportion to the services performed, dictates a construction of subsection (b) as being separate and distinct from the minimum fee provision of subsection (a) (*id*.).

As to whether the employer's delay in payment without having filed a formal controversion notice equated to a controversion in fact, bringing the fee request under §145(a), *Haile* declined to find doing nothing is not a "controversion" and reasoned:

> The attorneys who represented the claimants are certainly entitled to an award of reasonable feeds. That is provided for by the act. But there is no reason why they should receive a sum out of all proportion to the services performed. Alaska's provision allowing attorney's fees is unique in its generosity to the claimants and their counsel (footnote omitted). It, however, does not provide that a delay in payment, by itself, constitutes a controversion of the claim justifying the award of the minimum fees. There is no justification for adding such provision to the comprehensive terms of the act (*id*. at 841).

In *Bradley v. Mercer*, 563 P.2d 880 (Alaska 1977), the Alaska Supreme Court addressed attorney's fees where the employer "did not contest workman's right to compensation, but did contest the computation of average weekly wages for the purpose of fixing the amount of such compensation" (*id*. at 880). Bradley was injured and the insurer began voluntarily paying benefits, though at the minimum weekly rate. Bradley filed a claim and prevailed on his rate adjustment claim. The board awarded attorney's fees but ordered these paid from Bradley's award. He appealed; the superior court affirmed and he appealed again. The opinion does not say whether or not the carrier filed a controversion notice. On appeal, the employee argued he was entitled to fees under §145(b) in addition to his benefits. The employer argued §145(a) applied because it did not oppose paying compensation, but only objected to the amount requested (*id*. at 881). *Bradly* rejected the employer's argument and said: "We hold that when a carrier contests the amount of compensation owed to an injured workman, it 'resists the payment of compensation' within the meaning of AS 23.30.145(b). In such cases, if the claimant has

hired an attorney in the successful prosecution of his claim, AS 23.30.145(b) entitles him to reasonable attorney's fees in addition to any added compensation that is awarded to him" (*id*.).

In *Alaska Interstate v. Houston*, 586 P.2d 618 (Alaska 1978), the board awarded reasonable fees under §145(b) and the employee appealed, apparently because statutory minimum fees under §145(a) would have been considerably higher. The superior court reversed. The Alaska Supreme Court affirmed the higher award. The court's opinion does not state whether or not the employee's claim was controverted or "controverted in fact." *Houston* stated:

> Houston claimed that he was entitled to [PTD] and [TTD]. The carrier resisted both of these claims. . . . The Board found in favor of Houston on each claim. However, it refused to award him percentage attorney fees based on AS 23.30.145(a); instead it granted $1,000 in attorney fees under AS 23.30.145(b), to be paid by the carrier. In justifying this award the Board stated:
>
> The defendant did resist payment of compensation, and the applicant retained an attorney in the successful prosecution of his case. We find that the applicant's attorney was only required to do a minimal amount of work, and the claim was not complex, but the benefits resulting to the applicant were considerable (*id*. at 619).

On appeal, the employer argued *Haile* resolved the necessity of a controversion and apparently because there was no controversion filed in *Houston*, argued the superior court was wrong to apply §145(a). It objected to statutory fees that were "glaringly absurd." *Houston* said:

> Section 145(a) requires only that the Board 'advises that a claim has been controverted,' not that a formal notice of controversy be filed under §155(d). That latter provision serves the independent concern, not relevant here, of §155, and does not purport to define when a claim is in fact controverted. To require that a formal notice of controversion be filed as a prerequisite to an award of the statutory minimum attorney fees would serve no purpose that we are able to perceive. It would be a pure and simple elevation of form over substance because the nature of the hearing, the pre-hearing discovery proceedings, and the work required of the claimant's attorney are all unaffected by the existence or not of a formal notice of controversion when there is controversion in fact (*id*. at 619).
> . . .
>
> It is not part of our function to question the wisdom of legislation, and if the minimum fees are in general too high that is true independent of whether there exists in the file of any given case a formal notice of controversion. Thus, any

> absurdity that might be said to exist is inherent in the statute and not dependent on any interpretation which might be given it (*id*. at 621).

Notably, *Houston*, referencing *Bradley*, above, said: "As the carrier admits in the present case, controversion of a claim may at the same time also include 'an attempt to resist payment of compensation,' and therefore arguably be subject to the provisions of §145(a) and §145(b) (*id*. at 620).

Wien Air Alaska v. Arant, 592 P.2d 352 (Alaska 1979) (*reversed on other grounds*), in adopting the "controversion-in-fact" doctrine, stated:

> In *Haile* . . . we held that the section 145(a) formula only applies to 'controverted' claims and the section 145(b) grant of reasonable attorney fees applies to an employer who otherwise fails to make payment of compensation (footnote omitted). The Arants maintain that Wien controverted the claim. Wien maintains that while it 'resisted' payment of the increased amount, it did not 'controvert' the claim (*id*. at 364).

The board in *Arant* had not discussed the controversion issue but merely concluded the employer had resisted the claim in excess of a certain amount, the employee retained an attorney in the successful claim prosecution and the board awarded fees under §145(b). *Arant* held the employer had controverted the claim by denying it owed the employee more benefits without filing a formal controversion notice, distinguished *Haile* on that basis, and remanded for fee computation under §145(a). The fact the employer agreed to pay some benefits but "only disputed the amount" did not preclude a controversion finding (*id*. at 365). *Arant* concluded: "We hold that a notice of controversion by the employer is not required for an award of attorney's fees under AS 23.30.145(a)" (*id*.). In remanding to the board for fee redetermination, *Arant* further stated:

> AS 23.30.145 seeks to insure that attorney's fee awards in compensation cases are sufficient to compensate counsel for work performed. Otherwise, workers will have difficulty finding counsel willing to argue their claims (footnote omitted). Also, high awards for successful claims may be necessary for an adequate overall rate of compensation, when counsel's work on unsuccessful claims is considered (*id*. at 365-66).

The Alaska Supreme Court in *Whaley v. Alaska Workers' Compensation Board*, 648 P.2d 955 (Alaska 1982) stated the Act is "designed to provide the most efficient, dignified, and certain

means of determining benefits for workers sustaining work-connected injuries." *Whaley* further noted: "In particular, AS 23.30.145 is unique in its generosity to claimants and their counsel" (*id*. at 959).

Wise Mechanical Contractors v. Bignell, 718 P.2d 971 n. 7 (Alaska 1986), a controverted case addressed fees under §145(c) and applied factors from the Alaska Code of Professional Responsibility, DR-106(B) in determining a "reasonable fee" as follows:

> The factors are:
>
> (1) The time and labor required, the novelty and difficulty of the questions involved, and the skills requisite to perform the legal service properly.
> (2) The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer.
> (3) The fee customarily charged in the locality for similar legal services.
> (4) The amount involved and the results obtained.
> (5) The time limitations imposed by the client or by the circumstances.
> (6) The nature and length of the professional relationship with the client.
> (7) The experience, reputation, and ability of the lawyer or lawyers performing the services.
> (8) Whether the fee is fixed or contingent.

In expanding this holding to all workers' compensation fees, *Bignell* said: "We see no reason to exclude that factor [contingent fee] from the reasonableness determination to be made in worker's compensation cases" (*id*. at 974-75). *Bignell* further noted:

> In this case, as in many worker's compensation cases, the only fee arrangement between the claimant and counsel is that counsel will be paid whatever fee is approved by the board or the court, and payment of any fee is contingent upon success (footnote omitted). A contingency arrangement is ordinarily necessary because most injured claimants lack the financial resources to pay an attorney an hourly fee. If an attorney who represents claimants makes nothing on his unsuccessful cases and no more than a normal hourly fee in his successful cases, he is in a poor business. He would be better off moving to the defense side of the compensation hearing room where attorneys receive an hourly fee, win or lose, or pursuing any of the other various law practice areas where a steady hourly fee is available (*id*. at 975).

In *Bailey v. Litwin Corp*., 713 P.2d 249 (Alaska 1986), the court remanded the case and "instructed the Board to award Bailey attorney's fees and costs pursuant to AS 23.30.145(a), (b)"

(*id*. at 259). On remand the employee requested $21,700.00 in fees, which were double his "normal hourly rate," but the board awarded him only $5,156.25. In *Bailey v. Litwin Corp*., 780 P.2d 1007 (Alaska 1989), the Alaska Supreme Court reviewed the latter ruling, addressed some of its prior cases discussing attorney's fees and stated:

> In this case, the Board determined that Bailey was not limited to the minimum fee calculated under AS 23.30.145(a), but that he was entitled to additional compensation because of the nature, length and complexity of the services performed. Bailey's actual attorney's fees were $10,850, representing 62 hours at $175 per hour. He requested $21,700. The Board adjusted the hourly rate from $175 to $125 (footnote omitted). The Board also reduced the number of compensable hours from 62 to 55, because the Board found that Bailey had already been paid for seven hours of work. This finding is supported by the record (*id*. at 1011).

The board had declined to apply a contingency factor in this case and found the employee did not prevail on all issues in his claim. *Bailey's* footnote omitted from the above quotation says: "The Board has consistently held that $125 an hour is a reasonable fee" (*id*. at 1011 n. 11). On this record, *Bailey* affirmed the board's attorney's fee award (*id*. at 1012).

In *Cortay v. Silver Bay Logging*, 787 P.2d 103 (Alaska 1990), an injured worker lost on a controverted disability claim before the board but prevailed on his medical claim. The board awarded only statutory minimum fees under §145(a) (*Cortay v. Silver Bay Logging*, AWCB Decision No. 87-0239 (October 8, 1987) at 7). On the employee's appeal, the superior court reversed the fee award stating it was "inadequate as a matter of law," and directed the board to award higher, actual fees apparently at one-half the lawyer's hourly rate for the employee's success on the medical care issue (*Cortay v. Silver Bay Logging*, Memorandum of Decision (September 13, 1988) at 8). The employee again appealed the fee issue arguing the superior court's fee award, though higher than the board's was still "inadequate as a matter of law" (*id*. at 108). *Cortay* reviewed prior Alaska Supreme Court cases interpreting and applying AS 23.30.145, including §145(c), which applies only to attorney's fees on appeal, and reiterated "a 'full fee' is not necessarily limited to an hourly fee if a fee calculated at an hourly rate would not reflect the amount of work expended" (*id*.; citations omitted). In reversing the superior court's attorney's fee award and without discussing why §145(b) applied in this "controverted" case rather than §145(a), *Cortay* concluded:

> Applying this analysis to the present case, the superior court erred in not awarding attorney's fees with respect to Cortay's attorney's work on the prevailing medical issues at his actual rate of $110 per hour. Awarding fees at half a lawyer's actual rate is inconsistent with the purpose of awarding full attorney's fees in the workers' compensation scheme. If lawyers could only expect 50% compensation on issues on which they prevail, they will be less likely to take injured workers' claims in the first place (*id*. at 109).

Olson v. AIC/Martin, J.V., 818 P.2d 669 (Alaska 1991) held fees were properly awarded under §145(b) where an employer unsuccessfully tried to obtain a compensation rate reduction, which would have resulted in a $44,000.00 overpayment had the employer been successful. The board found the employer had "otherwise resisted" paying benefits and there was no "award" to the employee upon which to base a fee order under §145(a), which "requires that compensation be 'awarded.'" Neither the Alaska Supreme Court's opinion nor the board's decision state whether or not the employer controverted the claim or the employee's right to benefits (*id*.; *Olson v. AIC/Martin, J.V.*, AWCB Decision No. 88-0254 (September 29, 1988)).

In *Childs v. Copper Valley Electric Ass'n*, 860 P.2d 1184, 1187 (Alaska 1993), the employer controverted the employee's claim. The employer voluntarily paid some benefits after a claim was filed and before hearing, the employee lost on most issues at hearing, but the board failed to award any attorney's fees on the amounts controverted but later paid voluntarily. On appeal, the Alaska Supreme Court cited AS 23.30.145 and distinguished it from Civil Rule 82, noting §145 provides "attorney's fees in workers' compensation cases should be *fully* compensatory and reasonable, in order that injured workers have competent counsel available to them" (*id*. at 1190-91; citations omitted; emphasis in original). *Childs* held the employer's voluntary payment was the "equivalent of a Board award, because the efforts of Childs's counsel were instrumental to inducing it" (*id*. at 1191). Consequently, the board should have awarded Childs' lawyer fees on the voluntary payment "pursuant to AS 23.30.145(a)." The opinion does not say if these fees were limited to statutory minimum. Lastly, *Childs* said:

> In addition, CVEA delayed payment of TTD benefits that were due until August 1990. Where an employer fails to pay compensation due or resists paying compensation, AS 23.30.145(b) directs an award of reasonable attorney's fees and costs to successful claimants. Thus Childs should receive an award of reasonable fees and costs, because the efforts of his attorney were necessary to inducing CVEA to finally pay the benefits. Though CVEA asserts that it already paid the

> attorney's fees applicable to the delayed payment of TTD benefits, the Board should ascertain if they are reasonable pursuant to the statute (*id*.).

Childs concluded: "Childs is entitled to a Board award of full reasonable attorney's fees for those matters on which he has prevailed: CVEA's payment of TTD benefits, interest payments, and the 20 percent penalty" (*id*. at 1193).

Underwater Construction, Inc. v. Shirley, 884 P.2d 156 (Alaska 1994) held: "Nonetheless, section 145(a) limits the Board's authority to award attorney's fees to 'the amount of compensation controverted and awarded'" (*id*. at 159). *Shirley* reviewed the "policies underlying the attorney's fees statute" and said these included "to ensure that injured workers are able to obtain effective representation" and the fact the "employer is required to pay the attorneys' fees relating to the unsuccessfully controverted portion of the claim because he created the employee's need for legal assistance" (*id*.).

In *Bouse v. Fireman's Fund Ins. Co*., 932 P.2d 222 (Alaska 1997), both parties appealed the board's award of 50 percent of the requested, actual attorney's fees in a controverted case. The employee contended he should have been awarded 100 percent and the employer said Bouse should have been awarded no attorney's fees because it had controverted his claim merely as a precaution. The Alaska Supreme Court affirmed the board's award noting the employee did not prevail on his main issue; it also rejected the employer's argument noting the insurer had "filed a controversion and exposed itself to an attorney's fees award" (*id*. at 242).

Thompson v. United Parcel Service, 975 P.2d 684 (Alaska 1999), in a controverted claim reversed the board's denial of a compensation rate adjustment (*id*. at 686, 691). The Alaska Supreme Court said: "Because we reverse, Thompson is entitled to receive reasonable attorney's fees and legal costs pursuant to AS 23.30.145" (*id*. at 691).

In *Seville v. Holland America Line Westours, Inc*., 977 P.2d 103 (Alaska 1999), a controverted claim, the Alaska Supreme Court reversed the board's benefits denial. The court further stated, without analysis: "Seville has separately argued that the Board erred in failing to award attorney's fees. We need not address the issue. Having now prevailed on her claim for

compensation, Seville will be entitled as a matter of course to an award of fees under AS 23.30.145(b)" (*id*. at 113 n. 56).

In *Bustamante v. Alaska Workers' Compensation Board*, 59 P.3d 270 (Alaska 2002), the Alaska Supreme Court recognized, referring to the injured worker: "Without counsel, a litigant's chance of success on a workers' compensation claim may be decreased" (*id*. at 274).

In *State v. Cowgill*, 115 P.3d 522 (Alaska 2005), the board ruled in Cowgill's favor on her controverted claim (*Cowgill v. State*, AWCB Decision No. 00-0147 (July 18, 2000) at 8). In a subsequent decision the board said:

> The employer argues that because it filed a timely controversion notice that the employee is limited to an award of attorney fees under subsection .145(a). We disagree. We read subsection .145(b) literally, finding that there are three separate scenarios under which we may award attorney's fees under this subsection. First, an employer fails to timely controvert. Second, an employer may fail to pay compensation or other benefits. Third, the employer may otherwise resist payment of compensation. We find that a timely controversion does not preclude an award of attorney's fees under AS 23.30.145(b). We find the employer did not pay and resisted paying the employee's PPI benefits (by filing a timely controversion), and conclude we will award attorney's fees under subsection .145(b).
>
> Subsection .145(b) requires that the attorney's fees awarded be reasonable. Our regulation 8 AAC 45.180(d) requires that a fee awarded under subsection 145(b) be reasonably commensurate with the work performed. It also requires that we consider the nature, length and complexity of the services performed, as well as the amount of benefits involved.
>
> We find practice in the Workers' Compensation forum to be contingent upon prevailing upon issues presented to the Board. We find the employee's counsel has practiced in the specialized area of workers' compensation law for many years. We find the employee's counsel to have considerably more experience than the other well qualified counsel who were recently awarded $200.00 and $215.00 per hour respectively (citations omitted). In light of Mr. Kalamarides' expertise and extensive experience, and the contingent nature of workers' compensation practice, we find $240.00 per hour to be a reasonable hourly rate for Mr. Kalamarides (*Cowgill v. State*, AWCB Decision No. 01-0099 (May 10, 2001) at 17-18).

The state appealed, and the superior court reversed and said:

> In conclusion, the legislature has provided a framework under which the Board awards attorney's fees for representing claimants. How those fees are calculated, and whether the employer is directed to pay the fees in addition to other benefits awarded, depends on the employer's actions or inactions regarding the payment of the benefits ultimately 'awarded' by the Board. The Board decided that an employer by simply filing a timely controversion notice is also 'failing' to timely pay benefits and 'otherwise' resisting payment of benefits. Contrary to the Board's construction, the legislature and the courts have recognized that separate and distinct actions or inactions trigger separate and distinct fee awards under AS 23.30.145(a) and (b). Because the State filed a timely controversion notice, the Board should have awarded attorney's fees under AS 23.30.145(a). Therefore, the award is reversed and this matter is remanded to the Board for a fee calculation based upon the relevant factors, under AS 23.30.145(a). In reaching this decision, the court is not suggesting that the amount awarded in this case would not be appropriate under AS 23.30.145(a). The amount of attorney's fees is left to the Board's discretion under the applicable part of the statute (*State of Alaska v. Cowgill,* 3AN 01-7469 Civil (April 17, 2002).

On remand the *Cowgill* board reviewed its past decisions and found:

> In *Wooley v. City of Fairbanks,* AWCB Decision No. 86-0283 (October 28, 1986), we implied that an award of actual fees may be awarded under AS 23.30.145(a). Because we find that Employer controverted Employee's claim, section 145(a) applies to the award of attorney's fees. Under section 145(a), fees may not be less than the specified statutory minimums, *i.e.*, 25 percent of the first $1000 of compensation, and 10 percent of all sums exceeding $1000 of compensation. However, this section gives the Board discretion to award additional attorney's fees when justified by the nature, length and complexity of the case.
>
> The Board has, in fact, more recently, awarded actual fees under AS 23.30.145(a). In *Koerber v. Lynden Transport,* AWCB Decision No. 95-0193 (July 27, 1995), after reviewing the nature, length, and complexity of the services performed, and the benefits resulting to the employee, we awarded the reasonable hourly fees requested by the employee under subsection .145(a). Accordingly, we conclude we have the authority to award an hourly fee in the present case (*Cowgill v. State,* AWCB Decision No. 02-0252 (December 5, 2002, at 5).

Using the same analysis it used for the first attorney's fee award under §145(b), the board concluded the same hourly rate applied under §145(a) and awarded the same actual fees. The board in explaining its reasonableness determination relied on among other things, the contingent nature of representing workers' compensation claimants (*id*. at 523-24). The state appealed again and the superior court affirmed, finding the $240.00 hourly rate was not unreasonable; the state appealed to the Alaska Supreme Court (*Cowgill,* 115 P.3d 522 at 524).

Apparently, on appeal the state abandoned its argument made at hearing that only statutory minimum fees could be awarded in this case under §145(a). Instead, on appeal the state argued defense fees were the benchmark for evaluating claimants' fees, and the "enhanced" so-called "normal" rate is not justifiable because claimants' lawyers seldom receive nothing for their work when awards and settlement are considered (*id*.). Though the court did not have occasion to address the abandoned §145(a) issue, *Cowgill* explained what constitutes adequate Board findings to support an attorney's 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 (*id*. at 526).

In *Circle De Lumber Co. v. Humphrey,* 130 P.3d 941 (Alaska 2006), the employer argued the board erred by awarding the injured worker's lawyer attorney's fees in excess of statutory minimums because the lawyer failed to file a fee affidavit. The board had awarded 35 percent of the overall award, to the attorney. *Humphrey* stated:

> Although we have previously noted that subsections (a) and (b) are construed separately (*see Haile v. Pan American,* 505 P.2d 838, 840 (Alaska 1973)), they are not mutually exclusive. Rather, in a controverted case, the claimant is entitled to a percentage fee under subsection (a) but may seek reasonable fees under subsection (b). In prior cases we have looked to hourly measures of reasonable compensation, even though the cases qualified for treatment under subsection (a). *See, e.g., Bailey v. Litwin Corp.*, 780 P.2d 1007, 1011 (Alaska 1989) (affirming board's conclusion that claimant was not limited to statutory minimum fee calculated under subsection (a), but rather claimant was entitled to additional reasonable compensation) (*Humphrey,* 130 P.3d 941, 953 n. 76).

Humphrey noted the superior court had remanded and directed the board to make findings to support its award, absent the required fee affidavit. The board on remand exercised its discretion under 8 AAC 45.195 and "set aside" the procedural requirement for the employee to file a fee affidavit finding the requirement worked a "manifest injustice" on a party. On review, the Alaska Supreme Court applied a deferential standard to the board's relaxation of the fee affidavit requirement and found the lack of the fee affidavit did not impede the employer's ability to

challenge the fee award. *Humphrey* therefore found the board did not abuse its discretion in awarding the fee, and affirmed (*id*. at 954). Neither the board's decisions nor *Humphrey* discussed whether or not the claim was controverted or controverted-in-fact.

Harnish Group, Inc. v. Moore, 160 P.3d 146, 150 (Alaska 2007) said §145(a) authorizes attorney's fees as a percentage of the amount of benefits awarded to an employee when an employer controverts a claim. An award under §145(a) may include continuing attorney's fees on future benefits. By contrast, §145(b) requires an employer to pay reasonable attorney's fees when the employer delays or "otherwise resists" payment of compensation and the employee's attorney successfully prosecutes his claim. In *Harnish*, an injured worker received benefits and participated in a reemployment plan. When the plan did not work out, another was developed. His employer changed his benefits to permanent total disability benefits but five days later signed a second reemployment plan. An attorney filed a workers' compensation claim on the employee's behalf. In response to the claim, the employer admitted it was liable for permanent total disability benefits but denied it should have to pay attorney's fees, asserting that it had not controverted the claim. The board awarded statutory minimum attorney's fees under §145(a) after finding the employer had controverted the claim in fact. The employer appealed to the superior court, which affirmed; the employer again appealed the determination it had controverted the claim. The Alaska Supreme Court found because the employer had not controverted the claim, attorney's fees were not awardable under §145(a). *Harnish* further said:

> But we remand for an award of reasonable attorney's fees under AS 23.30.145(b) because the Board's findings that NC Machinery resisted payment of benefits and that Moore's attorney played a significant role in his receipt of benefits are supported by substantial evidence (*id*. at 147).

The board had awarded Harnish's lawyer statutory minimum fees under §145(a) finding in its decision on reconsideration, that the employer had "controverted in fact" (*id*. at 151). On appeal, noting a "claim" is a written application for benefits filed with the board, *Harnish* concluded: "In order for an employer to be liable for attorney's fees under AS 23.30.145(a), it must take some action in opposition to the employee's claim after the claim is filed" (*id*. at 152). Since the employer reclassified the employee's benefits to PTD before the employee's lawyer filed a claim, and the employer admitted liability for PTD in its answer to the claim, there was no

controversion-in-fact and the board erred by awarding attorney's fees under §145(a). *Harnish* also explained how attorney's fees are awarded under §145(b). There must be a finding the employer "otherwise resisted" payment of benefits and the claimant "employed an attorney in the successful prosecution of the claim" (*id*. at 153). Notably, the Alaska Supreme Court has never cited *Harnish* for any purpose.

In *Lewis-Walunga v. Municipality of Anchorage*, 249 P.3d 1063, 1065 (Alaska 2011), "the Municipality controverted Lewis-Walunga's workers' compensation claim." The employer argued at the board hearing that the employee's fees should be awarded under §145(a) rather than (b). The board ultimately rejected this argument and awarded attorney's fees under §145(b), but reduced them by 30 percent. The employee appealed and the commission reversed and ordered the board to not reduce the attorney's fees "under AS 23.30.145(b) based on the size of the benefits awarded to his client," but rather to award attorney's fees "the Board finds were reasonably incurred in the representation of the employee in this case" (*id*. at 1065). The commission further raised the question why the attorney's fees should be calculated under §145(b), rather than §145(a), and decided the board plainly erred in failing to explain why it awarded fees under subsection §145(b) rather than subsection §145(a). Noting AS 23.30.145(a) established "a minimum fee, but not a maximum fee," the commission held "the record could support" the board's decision to award "a reasonable fee in excess of the statutory minimum" but determined the board "had not made adequate findings" (*id*.). The Alaska Supreme Court stated: "We note that neither the workers' compensation statutes nor the Board's regulations authorize the Board to consider settlement offers when awarding attorney's fees. *See* AS 23.30.145(a)-(b); 8 AAC 45.180 (2004)" (*id*. at 1070 n. 20).

In *Uresco Construction Materials, Inc. v. Porteleki*, AWCAC Decision No. 152 (May 11, 2011) the appeals commission addressed the employer's claim the board erred by awarding attorney's fees under both §§145(a) and (b). Though the commission vacated the board's decision on other grounds, it discussed attorney's fee awards anticipating the issue would arise again, and stated:

> Uresco makes two arguments regarding the attorney fees award (footnote omitted). Uresco argues that the board cannot award 'duplicative' fees based on both AS 23.30.145(a) and (b) (footnote omitted)[] and that the board should have

reduced the award because Porteleki did not prevail on the issue of frivolous or unfair controversion. We address these arguments because they are likely to arise again on remand if the board decides that Porteleki prevailed on his claim for medical benefits.

The board awarded reasonable fees under AS 23.30.145(b), but concluded 'the employee is entitled to mandatory statutory minimum attorney fees under AS 23.30.145(a) when, and if, the statutory minimum amount based on the payment of past and future medical, indemnity, and all other benefits exceeds the attorney fee awarded under AS 23.30.145(b)' (footnote omitted). Although the Supreme Court has held that fees under subsections (a) and (b) are distinct, the court has noted that the subsections are not mutually exclusive (footnote omitted). Subsection (a) fees may be awarded only when claims are controverted in actuality or fact (footnote omitted). Subsection (b) may apply to fee awards in controverted claims, (footnote omitted) in cases in which the employer does not controvert but otherwise resists, (footnote omitted) and in other circumstances (footnote omitted). It is undisputed that Uresco controverted Porteleki's claim. Thus, we see no reason his attorney could not seek fees under either AS 23.30.145(a) or (b) and find no error in the board's decision to award fees under the higher of (a) or (b).

We review the board's decision to not deduct for the time spent on the unsuccessful unfair or frivolous controversion claim for an abuse of discretion. 'The board is in a far better position than the commission to evaluate . . . whether a party successfully prosecuted a claim, and any other consideration bearing on the attorney fee issue (footnote omitted). Here, the board acted within its discretion in evaluating the fee award and adequately explained its reasoning for deciding the time spent on the unsuccessful controversion claim was *de minimis*, and substantial evidence supports the *de minimis* finding. Thus, on remand, if the board decides in favor of Porteleki on the medical benefits claim, the board need not reduce the fee award for the time spent litigating the unsuccessful unfair controversion claim (*id*. at 7-8).

AS 23.30.155. Payment of compensation. . . .

. . .

(p) An employer shall pay interest on compensation that is not paid when due. . . .

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. The percentage of permanent impairment of the whole person is the percentage of impairment to the particular body part, system, or function converted to the percentage of impairment to the whole person as provided under (b) of this

section. The compensation is payable in a single lump sum, except as otherwise provided in AS 23.30.041, but the compensation may not be discounted for any present value considerations.

(b) All determinations of the existence and degree of permanent impairment shall be made strictly and solely under the whole person determination as set out in the American Medical Association Guides to the Evaluation of Permanent Impairment, except that an impairment rating may not be rounded to the next five percent. The board shall adopt a supplementary recognized schedule for injuries that cannot be rated by use of the American Medical Association Guides.

(c) The impairment rating determined under (a) of this section shall be reduced by a permanent impairment that existed before the compensable injury. If the combination of a prior impairment rating and a rating under (a) of this section would result in the employee being considered permanently totally disabled, the prior rating does not negate a finding of permanent total disability. . . .

8 AAC 45.180. Costs and attorney's fees.

. . .

(b) A fee under AS 23.30.145(a) will only be awarded to an attorney licensed to practice law in this or another state. An attorney seeking a fee from an employer for services performed on behalf of an applicant must apply to the board for approval of the fee; the attorney may submit an application for adjustment of claim or a petition. An attorney requesting a fee in excess of the statutory minimum in AS 23.30.145(a) must (1) file an affidavit itemizing the hours expended, as well as the extent and character of the work performed, and (2) if a hearing is scheduled, file the affidavit at least three working days before the hearing on the claim for which the services were rendered; at the hearing, the attorney may supplement the affidavit by testifying about the hours expended and the extent and character of the work performed after the affidavit was filed. If the request and affidavit are not in accordance with this subsection, the board will deny the request for a fee in excess of the statutory minimum fee, and will award the minimum statutory fee.

. . .

(d) The board will award a fee under AS 23.30.145(b) only to an attorney licensed to practice law under the laws of this or another state.

(1) A request for a fee under AS 23.30.145(b) must be verified by an affidavit itemizing the hours expended as well as the extent and character of the work performed, and, if a hearing is scheduled, must be filed at least three working days before the hearing on the claim for which the services were rendered; at hearing the attorney may supplement the affidavit by testifying about the hours expended and the extent and character of the work performed after the filing of the affidavit. Failure by the attorney to file the request and affidavit in

> accordance with this paragraph is considered a waiver of the attorney's right to recover a reasonable fee in excess of the statutory minimum fee under AS 23.30.145(a), if AS 23.30.145(a) is applicable to the claim, unless the board determines that good cause exists to excuse the failure to comply with this section.
>
> (2) In awarding a reasonable fee under AS 23.30.145(b) the board will award a fee reasonably commensurate with the actual work performed and will consider the attorney's affidavit filed under (1) of this subsection, the nature, length, and complexity of the services performed, the benefits resulting to the compensation beneficiaries from the services, and the amount of benefits involved. . . .

> **Rule 408. Compromise and Offers to Compromise.** Evidence of (1) furnishing or offering or promising to furnish or (2) accepting or offering or promising to accept, a valuable consideration in compromising or attempting to compromise a claim which was disputed as to either validity or amount, is not admissible to prove liability for or invalidity of the claim or its amount. Evidence of conduct or statements made in compromise negotiations is likewise not admissible. This rule does not require the exclusion of any evidence otherwise discoverable merely because it is presented in the course of compromise negotiations. This rule also does not require exclusion when the evidence is offered for another purpose, such as proving bias or prejudice of a witness, negativing a contention of undue delay, or proving an effort to obstruct a criminal investigation or prosecution, but exclusion is required where the sole purpose for offering the evidence is to impeach a party by showing a prior inconsistent statement.

In *Lopez v. Administrator, Public Employees' Retirement System*, 20 P.3d 568 (Alaska 2001), the Public Employees' Retirement Board refused to admit into evidence a compromise and release agreement from the injured worker's workers' compensation claim. In the agreement, the employer, against whom Lopez had also filed an occupational disability claim, admitted her injury was work related. Lopez sought to admit this evidence as an admission by a party opponent against its interest. The Alaska Supreme Court in affirming the board's decision referenced Evidence Rule 408, which bars admission of compromises between parties. The court further noted compromised settlements are ordinarily of little probative value as they reflect the litigants' "desire for peace rather than any concession of a weak position" (*id*. at 575). The public employees' retirement board had a regulation, 2 AAC 35.160(c), similar to 8 AAC 45.120(e), which stated:

> The hearing will not be conducted according to technical rules relating to evidence and witnesses. Relevant evidence, including hearsay evidence, will be admitted if it is evidence on which responsible persons are accustomed to rely in

> the conduct of serious affairs. Irrelevant and unduly repetitious evidence will be excluded or curtailed.

The Alaska Supreme Court held the board did not abuse its discretion by excluding the compromise release agreement from evidence (*id.* at 575-76).

The *Guides* 6th Edition, contains numerous, "fundamental principles." Among these are:

> 7) A valid impairment evaluation report based on the *Guides* must contain the 3-step approach described in Section 2.7 (*Guides* 6th Edition, Table 2-1 at 20).

The three-step process referenced above includes:

> **2.7 Preparing Reports**.
>
> A clear, accurate, and complete report must be provided to support a rating of permanent impairment. The following 3-step process is required by the examiner to estimate impairment according to the *Guides*: clinical evaluation, analysis of the findings, and discussion of how the impairment rating was calculated.
>
> **2.7a Clinical Evaluation**
>
> The relevant history is obtained by a review of medical records reflecting past medical history and the patient's presentation of the current history. It is important to review medical records *before* performing an impairment rating, as this will enable the examiner, among other things, to:
>
> - Clarify or at least document inconsistencies, if any, between the history provided by the patient and the history contained in the medical records.
> - Reconcile inconsistencies, if any, between the patient's history during the examination and other previous medical records. It is necessary to clarify historical inconsistencies because several issues, including causation, are primarily determined by the history.
> - Focus on the portions of the history pertinent to the permanent impairment rating. . . .
>
> **2.7b Analysis of the Findings**
>
> Discuss how specific findings relate to the conclusion of diagnoses and MMI status. Refer to the current abilities of ADLs and any validated deficiencies. Explain the absence of any pertinent data and how the physician determined the impairment rating with limited data.
>
> **2.7c Discussion of How the Impairment Rating was Calculated**

> Discussion of how the *Guides*' criteria were applied to medical information that generated the specific rating is required for an impairment evaluation be consistent with the *Guides*. Compare the appropriate information obtained on history and objective findings with the criteria described in the applicable chapter of the *Guides*. Include an explanation of each impairment value with reference, including pages and table number, to the applicable criteria of the *Guides*. Combine multiple impairments for a final composite whole person impairment number, unless otherwise directed by jurisdictional application. Discuss how individual ratings were combined or added to create a final number; explain why certain ratings were disregarded in the final analysis due to invalid measurements and test results; and perform apportionment, where applicable. Include a summary list of impairments and impairment ratings by percentage, including calculation of the whole person impairment, as appropriate.
>
> . . .
>
> The 3-step process described in this section applies to rating all organ systems. Although the underlying impairment evaluation criteria may differ, the process is essentially the same for rating all organ systems. The first 2 steps must be performed by a licensed physician, and if the clinical findings are fully described, any knowledgeable observer may check the findings against the *Guides*' criteria (*Guides* at 28; emphasis in original).
>
> . . .
>
> Impairment ratings in the spine and pelvis are based on identification of a specific diagnosis or diagnoses. In the current method, this results in assignment to an impairment class (IC), using grids designed for this purpose. . . . The impairment value within the class is further refined by considering information related to functional status, physical examination findings, and the results of clinical testing. Range of motion is no longer used as a basis for defining impairment, since current evidence does not support this as a reliable indicator of specific pathology or permanent functional status. . . . (*Guides* at 558).
>
> . . .
>
> The impairment evaluation and report should include a comprehensive, accurate medical history; a review and summary of all pertinent records; and a comprehensive description of the individual's current symptoms and their relationship to daily activities. The examiner should perform a careful, thorough physical examination and review findings of all relevant laboratory, radiographic (imaging), and ancillary tests (*Guides* at 559).
>
> Anatomic, diagnostic, and functional bases for determining impairment are part of the ICF Model. Diagnosis-Based Impairment (DBI) regional grids are provided for each of the four regions of the spine and pelvis (cervical, thoracic, lumbar, and pelvis). These regional grids include five columns containing impairment classes, numbered from 0 to 4 as summarized in Table 17-1, Definition of Impairment Classes and Impairment Ranges. These classes are designed to reflect the degree of

impairment related to a condition, and numerical ranges of impairment have been assigned to each class.

Impairment values for the spine and pelvis are calculated using the DBI method. Impairment class is determined by the diagnosis and specific criteria that are considered the 'key factor' and then adjusted by grade modifiers, or 'non-key factors,' that may include Functional History (FH), Physical Findings (PE), and relevant Clinical Studies (CS). The grade modifiers (non-key factors) are considered only if they are determined by the examiner to be reliable and associated with the diagnosis. The process for calculating impairment values is described in detail in section 17.3f, Impairment Calculation Methodology.

Diagnoses for the spine and pelvis are defined in several major categories, based on the selected region. Categories include:

- Non-specific chronic, or chronic recurrent spine pain
- Intervertebral disk and motion segment pathology (single and multiple levels)
- Cervical and lumbar stenosis
- Spine fractures and/or dislocations
- Pelvic fractures and/or dislocations

In the event that a specific diagnosis is not included in the diagnosis-based regional grid, the examiner should use a similar listed condition as a guide for determining an impairment value. In the report, the examiner must fully explain the rationale for the analogy (*id.*).
. . .

Case history is based on information presented by the patient and ascertained from medical records. Evaluating physician(s) should obtain objective data from physical examination and review of appropriate clinical studies. If information provided by the patient or noted on previous medical records or findings on physical examination are inconsistent, the evaluators report should reference the inconsistencies. The diagnosis used for placement in an impairment class must be based on reliable findings reflective of the impairment that is being assessed, and supported by the clinical history, current examination, and clinical studies. Objective findings are always given the greater weight of evidence over subjective complaints. . . . (*id.* at 559-60).

Functional History

A proper functional history enables the physician to determine the impact of a given spine- or pelvis-related condition on basic function and activities as they pertain to ADLs. . . . (*id.* at 560).
. . .

Physical Examination

Guided by the history, a physical examination is performed, documenting spine- . . . related physical findings. . . . Neurologic findings, including root tension signs and sensory and motor deficits in upper and/or lower limbs, should be described. . . . The examiner should consider the patient's diagnosis, the reliability of findings on examination, and the results of previous examinations and observations as recorded in the medical records documenting previous treatment. . . . (*id.*).
. . .

Clinical Studies

The physician needs to review and document actual studies and findings from relevant diagnostic studies, including laboratory tests, roentgenographic (X-ray) studies, computed tomographic (CT) scans, magnetic resonance images (MRI), nuclear medicine scans, ultrasound exams, and electrodiagnostic testing (EMG/NCS). In some cases, only reports may be available, and that should be noted in the record. Although imaging and other studies may assist physicians in making a diagnosis, they are not the sole determinants of a diagnosis. The examiner should comment on clinical test results that do not correlate with the patient's symptoms or support the patient's diagnosis (*id.*).

The *Guides* explain in detail how spinal impairment ratings are derived in the 6th Edition:

17.2 Diagnosis-Based Impairment

Impairment ratings are calculated using the DBI method, in which impairment class (IC) is determined by the diagnosis and specific criteria and then adjusted by considering non-key factors or grade modifiers. . . .
. . .

Diagnosis-based impairments are the method of impairment evaluation used for the spine. . . . Four regional grids, listing relevant diagnoses, are provided: one for each region of the spine (cervical, thoracic, and lumbar) and one for the pelvis.

There are five classes in the DBI grid:

- Class 0: no objective problem
- Class 1: mild problem
- Class 2: moderate problem
- Class 3: severe problem
- Class 4: very severe problem approaching total functional loss

Subjective complaints without objective physical findings or significant clinical abnormalities are generally assigned class 0 and have no ratable impairment.

> After the impairment class has been determined based on the diagnosis, the final impairment rating within the class is determined using the grade modifiers, or non-key factors, described in the adjustment grids for the spine. . . . The final impairment grade is determined by adjusting the grade up or down from the default value 'C,' by the calculated net adjustment. . . . Grade modifiers allow movement within a class but do not allow movement into a different class (*id.* at 560-61).
> . . .
>
> The regional grid is used for 2 purposes: (1) to determine the most appropriate class for a specific regional diagnosis and (2) to determine the final numerical impairment rating after appropriate adjustments are made using the grade modifiers. . . .
>
> If an examiner is routinely using multiple diagnoses without objective supporting data or rating multiple regions, the validity and reliability of the evaluation may be questioned (*id.* at 561-62).
> . . .
>
> In the event that a specific diagnosis is not listed the DBI grid, the examiner should identify a similar listed condition to be used as a guide to the impairment calculation. The rationale for this decision should be described in the report (*id.* at 562).
> . . .
>
> The term *alteration of motion segment integrity* was first used in earlier editions of the *Guides* to describe loss of motion segment integrity, identified on flexion/extension X-rays (following specific protocols) and related to either instability or fusion, regardless of the cause. In this edition, the term has been expanded to include surgical motion-preserving technologies such as disc arthroplasty and dynamic stabilization techniques. The current parameters for a AOMSI are explained at the bottom of each regional grid for the cervical, thoracic, and lumbar spine.
>
> If a diagnosis of AOMSI, pseudoarthrosis, fracture or spondylolisthesis is made, imaging studies should be excluded as a grade modifier.
>
> Many of the terms used in the grids are described in greater detail in the text following them (*id.* at 563).

The *Guides* 5th Edition described "alteration of motion segment integrity" as either:

> [L]oss of motion segment integrity (increased translational or angular motion) or decreased motion resulting mainly from developmental changes, fusion, fracture healing, healed infection, or surgical arthrodesis. An attempt at arthrodesis may not necessarily result in a solid fusion, but it may significantly limit motion at a motion segment and qualify for alteration of motion segment integrity.

> Motion of the individual spine segments cannot be determined by a physical examination but is evaluated with flexion and extension roentgenograms. . . . Loss of motion segment integrity is defined as an anteroposterior motion of one vertebrae over another that is greater than . . . 4.5 mm in the lumbar spine. . . . Loss of motion segment integrity is also defined as a difference in the angular motion of two adjacent motion segments greater than 15° at L1-2, L2-3, and L3-4 and greater than 20° at L4 to L5. Loss of integrity of the lumbosacral joint is defined as angular motion between L5 and S1 that is greater than 25°. . .
>
> When routine x-rays are normal and severe trauma is absent, motion segment alteration is rare; thus flexion and extension x-rays are indicated *only* when the physician suspects motion segment alteration from history or findings on routine x-rays (American Medical Association *Guides to the Evaluation of Permanent Impairment*, 5th Edition, at 378-79; emphasis in original; citations omitted).

ANALYSIS

1) Is Employee entitled to an additional PPI award?

The commission reversed and remanded *Hanson II*'s PPI award. This decision is directed to determine: 1) whether the 1992 injury can be rated under either the *Guides* 3rd or 6th Editions; 2) whether both the 1992 and 2008 injuries can be rated using the same *Guides* edition; and 3) apportion impairment between the injuries, if in the panel's estimation, apportionment is possible. The commission's first two directives on remand are moot, since the parties at hearing both agreed the *Guides* 6th Edition must be used to rate the 1992 and 2008 injuries. As to directive three, this issue involves factual determinations to which the presumption of compensability applies. AS 23.30.120; *Sokolowski*.

A *Guides* 6th Edition PPI rating for the lumbar spine and any appropriate apportionment requires a three-step process: First, there must be a current, "all-inclusive," total PPI rating irrespective of any impairments related to any preexisting conditions. *Guides* §2.5c. Employee raises the presumption on this prong through Drs. Tapper's, Bald's, Gritzka's and Barrington's 23, seven, 19 and 15 percent PPI ratings, respectively. *Cheeks*; *Koons*; *Ugale*. Employer rebuts the raised presumption with Dr. Yodlowski's five percent PPI rating. *Runstrom*; *Ugale*. As was the case in *Hanson II*, the burden of production and persuasion shifts back to Employee who must prove his PPI claim by a preponderance of the evidence. *Runstrom*; *Saxton*. The only valid *Guides* 6th Edition PPI rating for Employee's 2008 lumbar injury remains Dr. Yodlowski's five percent

rating because she is the only rating physician to perform the 2008 PPI rating strictly and solely in conformance with the *Guides*. All other examiners disregarded the *Guides*, used the wrong diagnosis and placed Employee in the wrong class or failed to properly apply the grade modifiers. Therefore, as was found in *Hanson II*, Employee has a five percent lumbar PPI rating for his 2008 injury. *Saxton*.

As to the second step in the PPI rating three-step process, a "baseline rating" accounting solely for preexisting conditions, Employee raises the presumption with Drs. Gritzka's and Barrington's opinions it is not possible to rate the 1992 injury accurately given the lack of historical, medical information related to his 1992 injury and surgery. *Guides* §2.5c; *Cheeks*; *Koons*; *Ugale*. If accepted, this would result in a zero percent PPI rating for preexisting conditions. As will be discussed below, Employer cannot rebut the raised presumption because Dr. Yodlowski's 1992 PPI apportionment is not done strictly and solely in conformance with the *Guides* 6th Edition. *Runstrom*. Even assuming, for argument's sake, Dr. Yodlowski's five percent PPI reduction for Employee's preexisting injuries is adequate to rebut the raised presumption, (*Cheeks*; *Ugale*), Employee still proves his claim for additional PPI by a preponderance of the evidence. *Saxton*.

The law requires *all* PPI ratings be done strictly and solely in conformance with the *Guides*. AS 23.30.190(b). This includes any preexisting impairments used in the *Guides* three-step apportionment process. AS 23.30.190(c). The "all inclusive" PPI rating determined under §190(a) "shall be reduced by a permanent impairment that existed before the compensable injury." AS 23.30.190(c). If clinical findings supporting a PPI rating are fully described, "any knowledgeable observer may check the findings against the *Guides*' criteria." Conversely, if the findings supporting a PPI rating are not fully described, or do not follow the *Guides* protocol, this decision can check this against the *Guides* criteria and determine the rating is not done in accordance with the *Guides*. The commission specifically directed this decision to determine if the applicable ratings were done pursuant to the *Guides*, and determine any appropriate apportionment.

The commission cast doubt on whether or not Dr. Yodlowski performed the 6th Edition PPI rating for the 1992 injury strictly and solely in conformance with the *Guides* when it questioned whether

the 1992 injury could be rated under either *Guides* edition. As *Hanson II* used the 3rd Edition to rate the 1992 injury, little scrutiny was given to Dr. Yodlowski's reduction performed under the 6th Edition because the 3rd Edition rating *Hanson II* used already exceeded the accepted 6th Edition rating. Employer relies on Dr. Yodlowski's PPI rating reduction, while Employee contends the 1992 injury is not ratable under the *Guides* and thus there is no reduction.

Dr. Yodlowski opined the 1992 surgery probably did not have a direct effect on any subsequent low back condition because the prior surgery and presumed "discectomy" were "healed up." She was unaware of any evidence Employee had radiculopathy symptoms prior to the May 30, 2008 injury. Dr. Bald had no way of knowing whether Employee had any impairment from his 1992 low back surgery, did not offer an opinion on any preexisting PPI and did not make a PPI reduction. Dr. Bald agreed with Dr. Yodlowski and Employee that Employee "completely recovered" from the effects of his 1992 injury and surgery. Employee credibly testified he recovered completely from his 1992 work-related injury suffered in Utah. AS 23.30.122. Furthermore, notwithstanding his extensive surgery following his 2008 injury, Employee has recovered spectacularly from that as well. Employee had a truly remarkable result from his 1992, 2000, 2003 and 2008 injuries and his surgeries related to the first and last injuries. His results are highly unusual and not typically seen. *Rogers & Babler*.

Dr. Yodlowski, upon whom Employer relies, explained her PPI rating and reduction:

> A. Well, the way that it's done properly, it's explained on page 26 of the AMA guides, and it's very important that the preexisting apportionment be determined based on the sixth edition, and the reason for that is the current ratings for the same condition may come out with different numbers if you're using the third, fourth, fifth or sixth edition. *So to properly do impairment -- I'm sorry, to properly do apportionment*, you have to take the information that you know was available and translate it using the sixth edition (emphasis added).

Dr. Yodlowski appears to make a subtle distinction between a preexisting PPI "rating" and an "apportionment" absent an actual "baseline" rating. She stretches to make her reduction plausible. This is not consistent with the *Guides*. *Guides* §2.5(c) is the section to which she referred to support the proper way to do a PPI rating and reduction strictly and solely in accord with the *Guides*. Initially, when asked if she agreed with Employee that "there's insufficient information

about the 1992 treatment and condition that -- to estimate or determine what the preexisting impairment was under section 2.5(c) of the guides," Dr. Yodlowski said: "A. *I disagree*. I think you *can determine* the previous impairment" (emphasis added). Later in her hearing testimony, Dr. Yodlowski veered from this opinion. When specifically asked: "Mr. Jensen argued in his brief that you stated in your report *you were unable to do a preexisting impairment rating* because of lack of information. Is that true?" Dr. Yodlowski testified: "It's *strictly true in terms of can I do the impairment rating*, but that doesn't mean that I can't do the apportionment, that's why the apportionment is very specifically described in the guides, because he didn't have the information, no, you -- nobody could do apportionment. . . ." (emphasis added). In other words, Dr. Yodlowski first said she disagreed with Employee's position and said she *could* do a baseline PPI rating for the 1992 injury, then did an about-face and stated she agreed with Employee's position that she *could not* do an actual PPI rating for the 1992 injury, but that would not stop her from doing an apportionment. Dr. Yodlowski fails to adequately explain how she can apportion or reduce an existing PPI rating by a preexisting PPI without actually performing a "baseline" rating. She leaves out step two of the three-step process set forth in the very *Guides* section upon which she relies. *Guides* §2.5c. Her opinion in this regard, which strained to find a reason to reduce Employee's five percent PPI by a preexisting impairment of at least equal value, is not credible, and is given no weight. AS 23.30.122. If credibility were removed from the analysis, Dr. Yodlowski's reduction opinion would not overcome the raised presumption as a matter of law, because it is not done in strict conformance with the *Guides*. *Saxton*; *Ugale*.

The only reason Dr. Yodlowski put Employee into Class 1 for the 1992 injury was "the history of his 1992 surgery." She treated the presumed herniated disc surgery as an "AOMSI." On cross-examination when asked whether her previous written opinion stating medical records were necessary to determine the appropriate PPI rating for the 1992 injury and resultant surgery had changed, Dr. Yodlowski testified it had not, but she could rate Employee's preexisting PPI based on records showing how Employee was in 2004. But Dr. Yodlowski conceded she had no records from the 1992 injury or surgery, did not know why the surgery occurred, assumed the radiologist's MRI report of a disc protrusion was a "herniated disc," and most importantly placed Employee into Class 1 for the 1992 injury because: "He did have surgery at that motion segment,

so he had alteration in his motion segment integrity of some sort" and concluded: "If he had disc surgery, he would still fall under the category of AOMSI."

Dr. Yodlowski's view of what constitutes AOMSI is not consistent with the *Guides*. To fit into Class 1, if Employee did not have an AOMSI in 1992, he would have to have had a herniated disc *and* "resolved radiculopathy or nonverifiable radicular complaints at clinically appropriate level(s), present at the time of examination." None of these were ever documented. Since Dr. Yodlowski tried, but struggled, to place Employee in Class I without knowing for sure whether or not he had a herniated disc in 1992, but knowing he lacked the *conjunctive* requirements regarding radiculopathy, she simply decided to improperly expand the definition of AOMSI to include any kind of disc surgery so she could fit him into Class I for the 1992 injury and reduce his PPI to zero. The *Guides* applicable Table 17-4 expressly defines AOMSI in the first column:

> Intervertebral disk herniation and/or AOMSI. Note: AOMSI includes instability (specifically as defined in the *Guides*), arthrodesis, failed arthrodesis, dynamic stabilization or arthroplasty, or combinations of those in multiple-level conditions.

It further states at the bottom of Table 17-4:

> Note: Alteration of motion segment integrity indicates AOMSI. It is defined using flexion/extension X-rays (figure 17-5 and 17-6). In the lumbar spine (L1-5), a diagnosis of AOMSI by translation measurements requires greater than 8% anterior or greater than 9% posterior relative translation of one vertebra on another, on flexion or extension radiographs, respectively. In the lumbosacral spine (L5-S1), it requires greater than 6% anterior or greater than 9% posterior relative translation of L5 on S1, on flexion or extension radiographs, respectively. A diagnosis of AOMSI by angular motion measurements requires greater than 15° at L1-2, L2-3, L3-4; greater than 20° at L4-5, or greater than 25° at L5-S1 (compared to adjacent level angular motion). Alternatively, may have complete or near-complete loss of motion of a motion segment due to developmental fusion or due to successful or unsuccessful attempt at surgical arthrodesis.

The *Guides* text further defines AOMSI:

> The term *alteration of motion segment integrity* was first used in earlier editions of the *Guides* to describe loss of motion segment integrity, identified on flexion/extension X-rays (following specific protocols) and related to either instability or fusion, regardless of the cause. In this edition, the term has been expanded to include surgical motion-preserving technologies such as disc

> arthroplasty and dynamic stabilization techniques. The current parameters for a AOMSI are explained at the bottom of each regional grid for the cervical, thoracic, and lumbar spine.

The *Guides* 5th Edition specifically referred to AOMSI as translation of one vertebra over another, angular motion or decreased motion resulting from developmental changes, fusion, fracture healing, healed infection, or surgical arthrodesis or attempts at arthrodesis. The 5th Edition said nothing about a herniated disc or general lumbar surgery to treat one being "AOMSI." Similarly, the 6th Edition specifically defines what constitutes AOMSI, and a herniated disc or herniated-disc-surgery, or otherwise unspecified general lumbar surgeries are not included among the definitions. There is no evidence Employee's 1992 surgery was a "motion-preserving" technology. There is no evidence surgery to treat a herniated disc, if that is the surgery Employee had in 1992, is "motion-preserving technology." The record is clear whatever the 1992 surgery was, it was not a fusion, disc arthroplasty or dynamic stabilization technique. It does not fit into Class 1. Therefore, Dr. Yodlowski's PPI rating reduction is not done strictly and solely in accordance with the *Guides*, notwithstanding her testimony, which is advocacy, not credible and given no weight. AS 23.30.122; *Geister*.

Upon further review on remand, Dr. Yodlowski's 6th Edition rating for the 1992 injury was not done strictly and solely in conformance with the *Guides* for several additional reasons: Specifically, first, her 1992 pseudo-rating violates the *Guides'* principle seven, from Table 2-1 because it does not follow the "3-step" approach as discussed above. Though she reviewed available medical records, Dr. Yodlowski admittedly did not review medical records pertaining to the 1992 injury and surgery and any sequelae before performing her PPI rating for the 1992 injury because there were no medical records directly related to that injury to review.

Second, she admitted she cannot accurately determine the diagnosis for which Employee had surgery in 1992, absent medical records. The *Guides* say this is the first, critical step in determining a PPI rating.

Third, Dr. Yodlowski did not perform an evaluation on Employee in or anywhere near 1992. Therefore, she cannot properly analyze non-existent examination findings and accurately discuss or report how her pseudo-rating for the 1992 injury was derived.

Fourth, there is no documented medical evidence Employee had an intervertebral disc herniation in 1992. Similarly, there is no documented medical evidence Employee had resolved radiculopathy or non-verifiable radicular complaints at clinically appropriate levels present at the "time of the examination" because there was no contemporaneous examination in the record. At least three recent examiners found no evidence of radicular complaints at any examination, and Dr. Yodlowski used this lack of a resolved radiculopathy or non-verifiable radicular complaints to adjust the default rating for the 2008 injury rating from seven to five percent. There is no medical evidence documenting radiculopathy or non-verifiable radicular complaints at clinically appropriate levels at any time between 1992 and 2008, because there are no medical records to document anything from the 1992 injury. Similarly, no medical evidence shows Employee had resolved radiculopathy or non-verifiable radicular complaints at clinically appropriate levels at the time of any examination, with exception of records post-2008 which showed Employee's radiculopathy from the 2008 injury had resolved following his two surgical procedures.

Lastly, Dr. Yodlowski did not strictly and solely follow the *Guides* because she placed Employee's 1992 injury into Class I from the 6th Edition solely because she found his 1992 lumbar surgery qualified as AOMSI, which is contrary to the *Guides*' definition of AOMSI. Even if it was proven Employee had a herniated disc in 1992, and this lead to surgery, a herniated disc does not qualify as AOMSI as defined in the *Guides*. Consequently, because Employee's 1992 surgery, whatever it might have been, does not qualify under the *Guides* as an AOMSI, and he lacks the second part of a Class I PPI rating, the documented resolved radiculopathy or non-verifiable radicular complaints at clinically appropriate levels present at the time of examination, he cannot fit into Class I for the 1992 injury. He clearly fits into Class I for the 2008 injury, and Dr. Yodlowski's five percent PPI rating for the 2008 injury is credited as being done solely in strictly in conformance with the *Guides*. But her equal reduction to zero for the 1992 and subsequent injuries while working for Employer is not. The 2000 and 2003 injuries while Employee worked for Employer moving people on gurneys similarly do not fit into Class I for the same reasons the 1992 injury does not fit. AS 23.30.122.

Independent from the issues with Dr. Yodlowski's testimony, the *Guides* makes a distinction between "[i]ntervertebral disc *and* motion segment pathology" (emphasis added) on page 559. This distinction is paramount in the all-important diagnosis step, which determines the class into which a condition falls in the Table 17-4 grids. If an intervertebral disc herniation and motion segment pathology describing AOMSI were the same things, the *Guides* would not have listed them separately. Nothing in the *Guides* allows a party or a physician to redefine expressly defined terms such as AOMSI. This is precisely with Dr. Yodlowski has done in this case. Since *Hanson II* and this decision give credence to Dr. Yodlowski's five percent PPI rating for the 2008 lumbar injury, and there is no valid *Guides* PPI rating reduction for any preexisting impairment, Employee is entitled to an additional five percent PPI for his lumbar spine and Employer will be directed to pay it, plus mandatory interest as awarded in *Hanson II*.

2) Is Employee entitled to an award of fees and costs?

The commission reversed and remanded *Hanson II's* attorney's fee award. Employee seeks an award of reasonable, actual attorney's fees pursuant to AS 23.30.145 although he did not specify under which subsection he applied. *Johns*. Employer objects and argues the fee request should be analyzed under AS 23.30.145(a), which it says limits Employee to statutory minimum fees only.

The attorney's fees statute, AS 23.30.145 is somewhat difficult to understand on its face and rather confusing. It has a long and tortured history, as demonstrated by the cases cited in the principles of law section, above. Early cases from the Alaska Supreme Court are rather fact specific. The early trend was to award only statutory minimum attorney's fees in cases which were controverted. *Rose*; *Haile*. Later cases determined a controversion in fact was adequate to award the claimant statutory minimum fees. Still later cases decided an injured worker's lawyer was entitled to attorney's fees even if there were no claim filed but the injured worker's lawyer successfully defended against an employer's offensive. *Bradley*. Unfortunately, many of the court's decisions lack analysis. *Houston*. Eventually, the Alaska Supreme Court determined the goal in awarding attorney's fees in workers' compensation cases was to ensure competent counsel was available to represent injured workers. *Arant*. *Whaley*; *Bignell*; *Bailey*. This has been a constant theme ever since. *Cortay*; *Olson*; *Childs*; *Shirley*; *Bouse*. At some point, again without much analysis, the Alaska Supreme Court began affirming fees awarded in controverted cases under either §145(a) or (b), and started

holding such fees were awardable on the court's own motion. *Thompson*; *Seville*; *Cowgill*. The court also explained these two fee sections are "not mutually exclusive." *Humphrey*. Some cases have provided analysis on the fee statute but have never again been cited by the court for any purpose. *Harnish.* Notably on this attorney's fee issue, Employer raised similar arguments it raises in Employee's case, in another case and the Alaska Supreme Court rejected those arguments. *Lewis-Walunga.* Yet, Employer still makes the same arguments, which requires Employee to address them, increasing time and expense for both parties. Lastly, the commission has weighed in on attorney's fees and concluded in a controverted case "we see no reason why [the employee's] attorney could not seek fees under either AS 23.30.145(a) or (b) and find no error in the board's decision to award fees under the higher of (a) or (b)." *Porteleki* at 7-8.

Understandably, Employee wants the highest attorney's fees award to which he is legally entitled. In this case, statutory minimum fees under §145(a) would be relatively minimal and would not fairly compensate Employee's attorney for the work he did on this case to obtain PPI for his client. It is unlikely Employee's counsel would have accepted the case if he knew he would be limited to statutory minimum fees. The commission did not say *Hanson II* abused its discretion in awarding Employee full attorney's fees. The commission simply said on remand this decision should make more specific findings explaining why *Hanson II* awarded actual, reasonable attorney's fees in a "controverted" claim. More recent Alaska Supreme Court cases and the commission's *Porteleki* decision recognize actual attorney fees may be awarded under either §145(a) or §145(b). Similarly, the attorney's fee regulation has like provisions for awarding actual attorney fees under either section. 8 AAC 45.180(b), (d). Thus, it is not clear why the "controversion" factor is of any import.

Nevertheless, since Employee's claim was repeatedly controverted, Employee's fee request is evaluated under §145(a) and 8 AAC 45.180(b). Alternately, even if Employee's attorney fee request were reviewed under §145(b) and 8 AAC 45.180(d), the result would be identical. The Alaska Supreme Court in *Cowgill* affirmed what it thought constituted adequate findings to support an attorney's fee award:

> [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* at 526).

It is not clear what additional findings the commission feels are necessary in this case, given *Cowgill*'s example affirming a minimalist approach. It is likely the commission wanted findings supporting the subsection used to award the fees, rather than additional findings supporting the award itself. Nonetheless, this decision endeavors to make specific, adequate findings to support its attorney's fee award.

First, the nature length and complexity of the services provided: Employee's medical and legal issues were extremely complex and varied in nature, requiring similar legal services. Employee's lawyer pursued this difficult case for years. The issues involved complicated interplay of preexisting conditions, prior lumbar surgery at one of the same levels involved in the instant claim, gaps in the medical evidence involving PPI, and two post-injury surgeries.

Employer is represented by competent counsel who vigorously defended against Employee's claim. In fact, Employer made some of the same arguments concerning settlement offers already rejected by the Alaska Supreme Court. *Lewis-Walunga.* Settlement offers are simply not admissible as evidence. Rule 408; *Lopez.* To admit settlement discussions for any reason would have a chilling effect on parties' willingness to negotiate settlement. Settlement in workers' compensation cases is a good thing and is to be encouraged. As the Alaska Supreme Court stated, nothing in the law authorizes the fact finders in a workers' compensation case to consider settlement offers. *Lewis-Walunga.* Even ethical requirements for attorney's fees do not consider settlement offers as a factor. *Bignell.* This decision rejects Employer's arguments and Employee's fees will not be reduced because Employer made arguments already rejected, to which he was obligated to respond. These arguments all contributed to the difficult, complex, lengthy nature of this claim. Similarly, Employer made arguments concerning statutory minimum fees which have also been rejected by the commission and the Alaska Supreme Court. *Cortay*; *Porteleki.*

Transportation costs: To the extent Employee's counsel has included travel time to and from claim-related activities he is compensated for his transportation costs.

Benefits resulting from the services: Employee lost on a *de minimis* TTD issue, worth less than $900.00. He prevailed on his primary claim, which was for PPI. He obtained an additional five percent PPI, worth $8,850.00 plus interest. This is a significant benefit to Employee. Attorney's fees his counsel obtained on appeal are completely irrelevant in this analysis. AS 23.30.145(a). A relevant comparison between the benefits Employee obtained and his lawyer's fees is also irrelevant and not included in the law's required findings. *Id.* Employee cannot be required to predict the future and know which, if any, of numerous hotly disputed PPI ratings is likely to be relied upon, and adjust his efforts and his lawyer's legal services accordingly. In this instance, prior bulletin directives and decisional law requiring the *Guides* 3rd Edition be used for the 1992 rating have been reversed by the commission. As the commission said in this case, referring to Employee's request for attorney's fees on appeal, Employee's attorney's fees are not excessive simply because Employer says they are.

Similarly, the law does not require this decision to compare income tax returns from Employer's counsel with Employee's lawyer to determine an appropriate attorney's fee for Employee. Though Employer argues Employee's attorney's fees are excessive, it has not demonstrated Employee's lawyer performed any legal services in this case that were unreasonable or unnecessary in presenting Employee's claim or responding to Employer's arguments. Employer has a duty to weigh the benefits at issue and determine how much resistance it wants to mount knowing full well if it loses, Employee's lawyer is likely to receive actual attorney fees, possibly far in excess of the benefits Employee receives. Employer's controversions created the need for Employee to obtain and retain counsel. *Shirley.* Employee's likelihood of prevailing in this PPI claim without the able assistance of his attorney, or one like him, would have been slim. *Bustamante.*

In reviewing Employee's attorney's fee affidavits, experience, judgment, observations and inferences drawn from all of the above show his services appear reasonably commensurate with the actual work performed given the nature, length, and complexity of the services performed, and the actual benefits resulting to Employee from the services. *Rogers & Babler*. The attorney's hourly rate is not unlike or inconsistent with those seen in other cases with similarly experienced legal representatives. It is the same hourly rate Employee's attorney received in this case. *Hanson I.*

The claimant's bar is aging rapidly. It is a limited bar to begin with, with only a handful of competent attorneys willing to represent injured workers. Two claimant lawyers are in their 70s and 80s and are nearing retirement. There are few, if any young attorneys entering the worker's compensation bar representing injured workers or other claimants. It is difficult for injured workers to find a competent attorney, and approximately 50 percent of all injured workers who appear at hearings are not represented by an attorney. Awarding Employee's counsel statutory minimum fees in light of these facts, in a case like this, will not encourage young attorneys to enter the workers' compensation bar on the claimant's side and soon there will be even fewer competent counsels willing to represent injured workers and other claimants.

Because Employee prevailed on the primary PPI issue, he is entitled to additional PPI and related interest. This is a significant present benefit for Employee and is the result of his attorney's conscientious efforts. Given all the above considerations, and including time spent at hearing, Employee's attorney will be awarded $32,686.50, in actual, reasonable attorney's fees ($26,911.50 + $5,005.00 + $770.00 = $32,686.50) and $9,489.86 in costs ($6,798.00 paralegal fees + $528.00 paralegal fees + $49.50 paralegal fees + $2,691.98 in other costs = $9,489.86).

CONCLUSIONS OF LAW

1) Employee is entitled to an additional PPI award.
2) Employee is entitled to an award of attorney's fees and costs.

ORDER

1) Employee's claim for additional PPI is granted.
2) Employer is ordered to pay Employee $8,850.00 in additional PPI benefits plus statutory interest calculated from the date of Dr. Yodlowski's five percent PPI rating for the lumbar spine.
3) Employee is awarded actual, reasonable fees of $32,686.50, and costs of $9,489.86.

Dated in Anchorage, Alaska on December 20, 2013.

ALASKA WORKERS' COMPENSATION BOARD

_____
William Soule, Designated Chair

_____
Patricia Vollendorf, Member

_____
Ron Nalikak, 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 Worker's Compensation Appeals Commission.

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 Board 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 grounds 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 accordance 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 accordance 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 BRAD J. HANSON Employee / applicant v. MUNICIPALITY OF ANCHORAGE, self-insured Employer / defendant; Case No. 200808717; dated and filed in the office of the Alaska Workers' Compensation Board in Anchorage, Alaska, on December 20, 2013.

_____

Kimberly Weaver, Office Assistant