ALASKA WORKERS' COMPENSATION BOARD

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

THOMAS J. FRUICHANTIE, Employee, Claimant, v. BRIAN BUTLER, Employer, and AMERICAN INTERSTATE INSURANCE CO., Insurer, Defendants.	FINAL DECISION AND ORDER AWCB Case No. 201106485 AWCB Decision No. 14-0077 Filed with AWCB Anchorage, Alaska, on June 6, 2014

Thomas Fruichantie's (Employee) January 17, 2012 workers' compensation claim was heard on April 1, 2014, in Anchorage, Alaska, a date selected on January 15, 2014. Attorney Burt Mason appeared and represented Employee, who appeared and testified. Attorney Aaron Sandone appeared and represented Brian Butler and American Interstate Insurance Co. (Employer). Other witnesses included Jaylee Harris who appeared for Employee and Colin O'Riordan, M.D., who appeared by telephone for Employer. The record remained open to receive depositions and closed on May 7, 2014, when depositions were received, read and the panel deliberated.

ISSUES

Employee contends he has been disabled continuously since August 22, 2011, the date Employer contends medical stability ended his disability. Because Employer paid him TTD through

October 5, 2011, Employee seeks an order stating TTD paid from August 22, 2011 through October 5, 2011, was not an overpayment, and stating he is entitled to continuing TTD beginning October 6, 2011, until he is medically stable. Employee further contends he is entitled to TTD during a brief incarceration because his work injury also disabled him during that time.

Employer does not dispute Employee had a low back injury on April 26, 2011. However, it contends the work injury was only a low back sprain or strain, which resolved by August 22, 2011, when Employee became medically stable. Employer contends the work injury was not the substantial cause of any disability Employee claims after August 22, 2011. Employer further contends as a matter of law Employee cannot receive TTD while he is in jail.

1) Is Employee's April 26, 2011 work injury the substantial cause of disability after August 22, 2011?

Employee contends he has been disabled at all times since his April 26, 2011 injury. He further contends TTD benefits paid since August 22, 2011, were not an overpayment and he is entitled to continuing TTD benefits until he again reaches medical stability or returns to work.

Employer contends Employee has been medically stable since August 22, 2011 and is therefore not entitled to TTD benefits after that date. It seeks an order denying Employee's TTD claim.

2) Is Employee entitled to TTD?

Employee contends he is ultimately entitled to a permanent partial impairment (PPI) rating and PPI benefits after he recovers from recent low back surgery. He concedes his PPI claim is premature as Employee has not yet recovered from low back surgery and when medically stable will need a PPI rating.

Employer contends as the work injury was only a low back sprain or strain, it did not result in any ratable PPI. Because it also contends the work injury was not the substantial cause of Employee's need for low back surgery, Employer further contends any PPI resulting from the low back surgery is not its responsibility.

3) Is Employee's PPI claim ripe for adjudication?

Employee contends he has unpaid and out-of-pocket medical expenses and his health insurer has a lien for work-related medical bills it paid, all of which Employer should have paid. He seeks an order requiring Employer to pay his unpaid work-related medical bills, reimburse his out-of-pocket medical expenses, pay his medical-related mileage and resolve his health insurer's lien.

Employer contends the work injury was only a low back strain or sprain, and Employee's work injury was not the substantial cause of Employee's need for medical treatment after August 22, 2011, including low back surgery. Accordingly, Employer contends it is not responsible for any medical benefits Employee claims for this injury after August 22, 2011.

4) Is Employee entitled to additional medical benefits for his work injury?

Employee contends his right to vocational reemployment benefits needs to be reviewed based on Dr. Humphreys' opinions and Employee's recent low back surgery. He seeks an order directing the Rehabilitation Benefits Administrator (RBA) to consider Employee's physical capacities in his eligibility assessment after Employee recovers fully from low back surgery.

Employer contends the RBA has not yet made an eligibility determination in Employee's case. Therefore, it contends this decision has no jurisdiction to direct the RBA to do anything.

5) Is Employee's reemployment benefits eligibility status ripe for decision?

Employee contends he and his medical providers are entitled to statutory interest on benefits they are owed from Employer. He seeks an order awarding interest to all entitled parties.

Employer contends Employee and his medical providers are not entitled to any additional benefits. Therefore, it contends they are not entitled to an interest award.

6) Are Employee and his medical providers entitled to interest?

Employee contends Employer controverted and resisted his claim for benefits. Consequently, Employee contends he is entitled to an attorney's fee and cost award.

Employer contends Employee and his medical providers are not entitled to any additional benefits. Therefore, it contends Employee is not entitled to an attorney's fee or cost award.

7) Is Employee entitled to attorney's fees and costs?

FINDINGS OF FACT

The following facts and factual conclusions are established by a preponderance of the evidence:

1) On April 11, 2011, Employee saw Jared Wallace, PA-C, for a toe injury. He was subjectively "negative" for "back pain." Employee listed neck surgery in his history. This is the earliest medical record in Employee's file (Wallace Progress Note, April 11, 2011; observations).

2) The record contains no evidence Employee had low back pain or any spine-related lower extremity symptoms before April 26, 2011 (observations).

3) On April 26, 2011, Employee injured his low back when, while lifting a rock weighing about 300 pounds with another worker, the other person dropped the rock. Employee held the rock's weight momentarily to avoid having the rock fall onto his feet (Report of Occupational Injury or Illness, May 30, 2011; Employee deposition, July 13, 2012, at 29; Employee).

4) On May 5, 2011, Employee saw PA-C Wallace for this injury and gave a consistent injury history. He complained of lower back pain primarily on the right side with muscle spasms, soreness, throbbing and swelling on the right side. On examination, Employee demonstrated mild to moderate tenderness in the right and left SI joints with associated muscle spasms on the right. PA-C Wallace diagnosed sacroiliitis and prescribed Flexeril and Percocet tablets and Flector patches (Wallace Progress Note, May 5, 2011).

5) By May 10, 2011, Employee had difficulty sleeping and pain down his right leg. The diagnosis included sacroiliitis and low back pain (Wallace Progress Note, May 10, 2011).

6) On May 11, 2011, Employee had a lumbar spine x-ray which showed mild, age-appropriate degenerative changes (Diagnostic Imaging Radiology x-ray, May 11, 2011).

7) On May 25, 2011, Employee had a magnetic resonance imaging (MRI) scan which showed lower lumbar spine degenerative changes, which were more prominent at the L3-L4 level. At this level, the radiologist saw a disc protrusion into the left neural foramen resulting in moderate left-sided neural foraminal narrowing (Diagnostic Imaging Radiology MRI, May 25, 2011).

8) Employee consistently complained of pain in his right SI joint radiating down his right leg and up into his upper back (Laverne Davidhizar, D.O., Progress Note, June 7, 2011).

9) On May 31, 2011, Employee had right leg numbness and tingling. PA-C Wallace refilled Employee's Percocet, started Valium and stopped Flexeril (Wallace Progress Note, May 31, 2011).

10) On June 7, 2011, Employee said all his Percocet, Valium, clothes and papers had been stolen over the weekend in Anchorage. Dr. Davidhizar added "limb pain" to Employee's diagnosis, and injected steroids into Employee's right sacroiliac (SI) joint. Dr. Davidhizar gave Employee one-week's supply of 10 mg Toradol tablets, and started Employee on Soma but did not renew his Percocet or Valium prescriptions (Davidhizar Progress Note, June 7, 2011).

11) On June 7, 2011, Dr. Davidhizar stated Employee could return to "light duty work without heavy lifting" (Davidhizar letter, June 7, 2011).

12) Employer never offered Employee light duty within his physical restrictions (Employee).

13) Employer did not rebut Employee's testimony on this point (record).

14) On June 16, 2011, Employee reported to PA-C Wallace he felt worse since his SI injection, his Toradol and Soma made him sick so he stopped taking them and his pain level was at "4/10" without his medicine. PA-C Wallace's note mentioned Employee received Percocet and Valium prescriptions on May 31, 2011, but did not reference Employee's June 7, 2011 report that his medicines had been stolen. Employee requested a note stating he was either on "normal or light duty" because he had been treating for his injury since April 26, 2011. PA-C Wallace noted improved muscle spasms, stopped Toradol and Soma, and renewed Employee's Percocet and Valium and started him on Piroxicam (Wallace Progress Note, June 16, 2011).

15) On June 16, 2011, PA-C Wallace wrote a letter stating Employee had been treating at PA-C Wallace's clinic since May 5, 2011, and '[d]uring this time he has been available to work but under light duty restrictions. . . ." (Wallace letter, June 16, 2011).

16) On June 30, 2011, Employee again reported his right SI joint pain was worse than before his steroid injection and was "8/10" on a pain scale. On examination, PA-C Wallace noted worsening muscle spasms (Wallace Progress Note, June 30, 2011).

17) On July 12, 2011, Employee's back examination was unchanged. Dr. Davidhizar applied electric stimulation therapy (E-Stim) to Employee's low back. E-Stim treatments "definitely" provided relief (Davidhizar Progress Note, July 12, 2011; Employee).

18) On July 18, 2011, Employee reported he had "been doing a lot of lifting getting ready for a garage sale and his back [was] in a lot of pain/stiffness." His back pain was "5/10" without

medication and Employee was out of his medicines and had been for a few days. E-Stim treatments continued daily (Davidhizar Progress Note, July 18, 2011).

19) On July 27, 2011, Employee reported E-Stim treatments were helping, but if he tried to be active he still had increased pain. He admitted the pain was less when he came for his daily E-Stim treatments. Pain caused Employee difficulty sleeping through the night, so he requested medication to last through the night, and possibly a TENS Unit to relieve his muscle spasms. Employee's medications continued to be Piroxicam 20 mg, Valium 5 mg tablets and Percocet 10 mg tablets and he continued to have occasional osteopathic manipulative therapy (OMT) (Wallace Progress Note, July 27, 2011).

20) On August 2, 2011, Employee's SI and left hip x-rays were normal (Diagnostic Imaging Radiology x-ray, August 2, 2011).

21) By August 2, 2011, Employee's lower back pain was better but still present at "2/10" and Employee stated he had a "lump" in his lower back. Physical examination did not disclose a palpable lump (Wallace Progress Note, August 2, 2011).

22) E-Stim treatments continued (Davidhizar Progress Notes, August 2, 2011; August 4, 2011; August 8, 2011).

23) On August 5, 2011, Employee faxed PA-C Wallace's June 16, 2011 work-limitation letter to adjuster Jennifer Lorentz at Employer's insurer's office (Fax Transmittal, August 5, 2011).

24) On August 9, 2011, Employer began paying Employee TTD benefits retroactive to May 5, 2011 (Compensation Report, August 17, 2011).

25) On August 9, 2011, Employee reported his E-Stim treatments provided only temporary relief. He said if he did not perform any physical work, he might be "doing better faster." Employee also stated his pain medications were not really working anymore and his previous injection did not help at all (Wallace Progress Note, August 9, 2011).

26) On August 16, 2011, Employee reported his back was stiff and painful when he did any physical work, and even when he sat down. He awoke at night 10 to 15 times because he could not find a comfortable sleeping position (Wallace Progress Note, August 16, 2011).

27) On August 22, 2011, Employee saw Colm O'Riordan, M.D., for an employer's medical evaluation (EME). Employee had right-sided low back pain, which was constant and radiated at times down his right thigh area and was worse with activities. His pain level was "6/10 to 7/10" with or without medications. Employee reportedly could walk, sit, stand and drive for one-half

hour. Employee could perform his daily living activities but was in constant pain and had to guard what he was doing. Sleeping presented great difficulty. Employee stated he was unable to work though he had been released to light duty, which he reported was not available. On examination, Employee's axial compression and rotation tests were negative. Dr. O'Riordan found no muscle spasms and, though Employee complained of a lump in his lumbar spine area, Dr. O'Riordan could not find it. Dr. O'Riordan diagnosed an acute lumbosacral strain or sprain related to Employee's April 26, 2011 event by history, resolved, and opiate dependency. The medical cause and the substantial cause for these "conditions" was Employee's April 26, 2011 work injury with Employer. In Dr. O'Riordan's opinion, Employee reached medical stability effective August 22, 2011, and needed no further medical treatment. Dr. O'Riordan opined Employee was physically capable of returning to his job at the time of injury without restrictions, and had no ratable PPI (O'Riordan EME report, August 22, 2011).

28) Employee continued to receive medical care for his work injury from Dr. Davidhizar (Davidhizar Progress Notes, August 23, 2011; August 24, 2011 and August 29, 2011).

29) On August 29, 2011, PA-C Wallace reported Employee's back examination was "unchanged" (Wallace Progress Note, August 29, 2011).

30) Employee continued to receive E-Stim treatment for his low back (Davidhizar and Wallace Progress Notes, August 29, 2011; August 31, 2011; September 6, 2011; September 7, 2011; September 8, 2011 and September 9, 2011).

31) On September 12, 2011, Employee reported "Pt. Is continuing to work and lift heavy stuff, his pain is the same -- [e]specially after the weekends when Pt. went to garage sales and lift[ed] the stuff." Employee's physical examination remained unchanged (Wallace Progress Note, September 12, 2011).

32) Employee received more E-Stim treatment for his low back (Davidhizar Progress Notes, September 12, 2011; September 13, 2011; September 14, 2011; September 15, 2011; September 19, 2011; September 20, 2011; September 21, 2011 and September 22, 2011).

33) By September 26, 2011, Employee still complained of lower back pain at a "3/10" pain level, but this was improving with E-Stim. Employee's back examination remained "unchanged" (Wallace Progress Note, September 26, 2011).

34) Beginning September 26, 2011, Employee received six more E-Stim treatments (Davidhizar Progress Notes, September 26, 2011; September 27, 2011; September 28, 2011; September 29, 2011; October 5, 2011 and October 6, 2011).

35) On October 5, 2011, Employer ceased paying Employee TTD benefits based upon its October 6, 2011 controversion, which Employer filed on October 7, 2011 (Compensation Report, October 14, 2011).

36) On October 7, 2011, Employer controverted Employee's right to TTD or temporary partial disability (TPD) benefits after August 22, 2011; PPI benefits; reemployment benefits and benefits under AS 23.30.041(k). Employer based its denial on Dr. O'Riordan's EME report (Controversion Notice, October 6, 2011).

37) The record does not reflect why Employer continued to pay Employee TTD after Dr. O'Riordan's August 22, 2011 EME report said he was medically stable (observations).

38) On October 8, 2011, Employee reported his lower back pain had been worse the previous week, more so on his right side. He further stated the E-Stim treatments had been painful in the prior week instead of feeling good, though he was using his TENS unit at home. On physical examination, Employee's paravertebral muscles in the lumbar area were very tender to palpation and "extremely tight." Otherwise, his back examination was unchanged. Employee was started on MS Contin tablets, extended release, 30 mg, along with his Percocet and Valium tablets and Flector patches, previously prescribed (Davidhizar Progress Note, October 8, 2011).

39) Beginning October 10, 2011, Employee had six more E-Stim treatments to his lower back (Davidhizar Progress Notes, October 10, 2011; October 11, 2011; October 12, 2011; October 19, 2011 and October 20, 2011).

40) By October 24, 2011, Employee reported his E-Stim treatments helped his low back pain, but only temporarily. Overall, his back was better but he still had ongoing pain primarily on his right side in the lower back, which radiated upward and downward. Employee also had right SI joint pain. Physical therapy helped and his pain level averaged "2-3/10" on a daily basis with medication. His paravertebral muscles in the lumbar area were still tender and extremely tight. Otherwise, his physical examination was again unchanged (Wallace Progress Note, October 24, 2011).

41) Beginning October 24, 2011, Employee had a series of E-Stim treatments (Davidhizar Progress Notes, October 24, 2011; October 25, 2011; October 26, 2011 and October 27, 2011).

42) On October 31, 2011, Employee reported his low back pain averaged "3/10" on a pain scale while he was taking medications, but muscle stiffness and pain occasionally brought his pain level up to "5/10." Consequently, Employee asked for an MS Contin refill stating it helped him sleep better. PA-C Wallace provided Employee a therapeutic Toradol injection into his right gluteus muscle. PA-C Wallace refused to provide MS Contin until the normal refill schedule for this prescription drug had expired (Wallace Progress Note, October 31, 2011).

43) Beginning October 31, 2011, Employee had three more E-Stim treatments for his low back (Davidhizar Progress Notes, October 31, 2011; November 1, 2011 and November 2, 2011).

44) By November 8, 2011, Employee reported he still had lower back pain "almost without changes," he still had pain-related sleeping problems, his pain level was "4-5/10" and E-Stim did not help as much as it had in the past. Otherwise, with exception of tender and extremely tight paravertebral muscles in the lumbar area, Employee's physical examination remained unchanged. Dr. Davidhizar provided another E-Stim treatment and assessed sacroiliitis, low back pain and, for the first time, "degeneration of intervertebral disc" (Davidhizar Progress Note, November 8, 2011).

45) Beginning November 9, 2011, Employee had seven more E-Stim treatments for his low back (Davidhizar Progress Notes, November 9, 2011; November 14 2011; November 16, 2011; November 18, 2011; November 28, 2011; November 29, 2011 and November 30, 2011).

46) On December 1, 2011, Employee complained of low back pain at "6/10" before E-Stim treatment and at "4/5" after treatment. He also reported having tingling in his bilateral feet and toes "that is new," and numbness in his hands. Employee mentioned he had neck surgery done and had a bone removed from his right hip and he thought this was causing most of his pain. Employee thought the bone graft may have worn down. Employee demonstrated paravertebral muscle spasm and pain, thoracic muscle spasm and pain, and normal straight leg raising tests. Dr. Davidhizar diagnosed sacroiliitis, low back pain, and somatic thoracic dysfunction. For the first time, Dr. Davidhizar discussed the importance of decreasing Employee's pain medication, getting a "good consistent treatment program" and weaning Employee from his medications. For his sacroiliitis, Dr. Davidhizar recommended Employee have E-Stim treatments daily and cold laser treatments every other day and cautioned him to not miss any appointments. For Employee's low back pain, Dr. Davidhizar continued to prescribe MS Contin, Valium and Percocet tablets (Davidhizar Progress Note, December 1, 2011).

47) Beginning December 1, 2011, Employee had E-Stim treatments daily, on regular business days, followed by laser treatments roughly every other day through December 19, 2011 (Wallace and Davidhizar Progress Notes, December 1, 2011 through December 19, 2011).

48) On December 21, 2011, Dr. Davidhizar wrote a "to whom it may concern" letter to Employee's attorney. Dr. Davidhizar explained:

> [Employee] is a patient of mine, whom I have been seeing since April 2011. He currently suffers from somatic dysfunction of his thoracic back, muscle spasms and pain in his back, and sacroiliitis. These problems are secondary to a workman's [sic] compensation injury that occurred on 04/26/2011. . . . (Davidhizar letter, December 21, 2011).

49) On January 16, 2012, Employee complained of neck pain and requested a medication refill because he was leaving the state. On physical examination, Employee demonstrated palpable swelling over his right SI joint with associated muscle spasm. His right-sided SI joint pain radiated into his right leg and interior pelvis. Overall, Employee reported his pain had improved slightly as there was less tenderness to palpation over his SI area (Davidhizar Progress Note, January 16, 2012).

50) On January 16, 2012, Employee underwent a right hip MRI without contrast, which demonstrated mild, inflammatory, right sacroiliitis and an unremarkable right hip (MRI report, January 16, 2012).

51) On January 17, 2012, Employee through counsel filed a claim for TTD, PPI when rated, medical care -- past and future, transportation costs, a vocational rehabilitation eligibility evaluation, attorney's fees, costs and interest (Workers' Compensation Claim, January 17, 2012).

52) Around this time Employee left town to attend a funeral, and was, therefore, temporarily "inconsistent with his treatment regimen" (Davidhizar Progress Note, February 1, 2012).

53) On February 1, 2012, Dr. Davidhizar stated Employee suffered from lumbar disc syndrome, and was expected to recover, but Dr. Davidhizar expected it would take 10 months for him to recover (Preliminary Examination for Interim Assistance, February 1, 2012).

54) On February 1, 2012, Dr. Davidhizar examined Employee and found his right SI joint mildly to moderately tender and found palpable swelling over the SI joint on the right side, which radiated into his right leg and occasionally into his interior pelvis. Dr. Davidhizar also

appreciated associated muscle spasm. Radicular numbness and tingling into Employee's right leg and foot all remained unchanged (Davidhizar Progress Note, February 1, 2012).

55) On February 1, 2012, Dr. Davidhizar referred Employee to Craig Humphreys, M.D., orthopedic surgeon to review Employee's sacroiliitis, thoracic spine somatic dysfunction, degenerated intervertebral disc and low back pain (Davidhizar Referral, February 1, 2012).

56) On February 13, 2012, Employer controverted Employee's claim for TTD and TPD after August 22, 2011; PPI benefits; reemployment benefits or benefits under AS 23.30.041(k) and medical benefits after August 22, 2011. Employer based its denial on Dr. O'Riordan's EME report (Controversion Notice, February 10, 2011 (sic)).

57) On February 17, 2012, Employee was back in town, back on his consistent treatment schedule and noticed minimal improvement of approximately 10 percent. He reported no new injuries or aggravations to his back. On examination, Employee again demonstrated palpable swelling and muscle spasms (Davidhizar Progress Note, February 17, 2012).

58) On March 6, 2012, Employee reported he was scheduled for a surgical consult in two days. He still complained of chronic pain in his low back and right-sided SI joint at a level averaging "6/10," which got worse with activity. He did not feel E-Stim or physical therapy treatments were still improving his symptoms. Since his Valium was decreased, Employee noticed increased muscle spasms. His physical examination findings were unchanged from the previous visit (Davidhizar Progress Note, March 6, 2012).

59) On March 8, 2012, Employee saw a different physician's assistant at Dr. Humphreys' office who noted positive pain generation with SI joint manipulation. Despite the herniated disc and disc bulges, Kurt Pulver, PA, opined Employee's sacroiliitis caused his continual pain. He prescribed physical therapy for SI joint stabilization and a right SI joint injection from Dr. Humphreys (Pulver Progress Note, March 8, 2012).

60) On March 16, 2012, Employee saw another physician assistant, Jolynn Montgomery, PA-C. PA-C Montgomery observed paravertebral muscle spasms and pain worse on the right side. There were no other abnormal findings (Montgomery Progress Note, March 16, 2012).

61) On March 17, 2012, at Dr. Humphrey's request, Employee had another lumbar spine MRI, without contrast. When compared to the May 25, 2011 MRI, this MRI showed no significant changes and no change in the left, lateral protrusion at L3-L4, which was causing moderate, left-sided foraminal stenosis (Diagnostic Imaging MRI, March 17, 2012).

62) Employee continued to receive E-Stim to his low back (Davidhizar Progress Notes, March 19, 2012; March 21, 2012; March 23, 2012; March 30, 2012; April 2, 2012; April 4, 2012 and April 6, 2012).

63) On April 17, 2012, Dr. Davidhizar wrote Employee's attorney stating:

> On his most recent exam, he has pain to palpation over his lumbar muscles bilaterally and right sacroiliac joint with appreciated swelling of the joint. He also has decreased range of motion and reported radicular pain into his anterior groin and down his legs bilaterally into both feet on occasion. These problems are secondary to the Workmen's [sic] Compensation injury that occurred on 04/26/2011. . . . (Davidhizar letter, April 17, 2012).

64) On April 30, 2012, Dr. Humphreys prescribed physical therapy for Employee's lumbar spine (Humphreys Physical Therapy Prescription, April 30, 2012).

65) On May 22, 2012, Employee told his physician he had lost his medication. He filed a police report, which the doctor scanned into Employee's chart, stating he lost his oxycodone pills while in Anchorage and believes the bottle fell from his pocket while he was working on his vehicle (Davidhizar Progress Note, May 22, 2012).

66) On June 12, 2012, Employee underwent a right SI joint injection from Dr. Humphreys (Humphreys chart note, June 12, 2012).

67) On June 26, 2012, Employee saw PA Pulver in follow up for his right SI joint injection. Employee reported some relief but increasing pain as he became more active. PA Pulver suggested Employee may have "reached maximum medical improvement" but he wanted to perform another epidural steroid injection at the L5-S1 level rather than in the SI joint (Pulver chart note, June26, 2012).

68) On August 29, 2012, Michael Merrick, M.D., signed a physician's statement allowing Employee to have a medical marijuana card (Merrick Physician Statement, August 29, 2012).

69) Employee's marijuana use was for residuals from his neck surgery (Employee).

70) On August 30, 2012, Employee saw Cynthia Kahn, M.D., on Dr. Humphreys' referral. Employee provided a consistent history of his symptoms and his work injury. Dr. Kahn assessed lumbar disc degeneration, lumbosacral spondylosis with myelopathy and sacroiliitis (Kahn Progress Note, August 30, 2012).

71) On September 5, 2012, Employee saw Neil Pitzer, M.D., for a second independent medical evaluation (SIME). Dr. Pitzer noted the July 19, 2011 urinalysis drug screen was positive for

THC but negative for opioids. Dr. Pitzer thought there was a second urinalysis drug screen with a similar result on July 27, 2011, but this proved to be incorrect according to PA-C Wallace. Employee told Dr. Pitzer his pain was "3/10" on his best day and "8-9/10" on his worst day. He complained of aching in the low back, and right buttock burning. Employee also had pins, needles and numbness throughout his entire right lower extremity. Dr. Pitzer diagnosed a lumbar strain with probable ligamentous dysfunction, possible right-sided sacroiliitis, and a non-physiologic neurologic exam in the right lower extremity with diffuse sensory loss but normal reflexes and strength. Dr. Pitzer reviewed radiology reports and noted no evidence of a disc herniation or nerve root compression. He did not believe the ligamentous strain injury over the right SI area would improve since Employee had been off work for over a year without any significant change in his symptoms. He had extensive passive care with Dr. Davidhizar and was likely medically stable, with one additional injection reasonable as a "maintenance treatment." Dr. Pitzer opined Employee did not require any lumbar spine surgery, epidural injections, facet injections or additional therapy. Dr. Pitzer was very concerned about Employee's opioid use because there was no significant functional improvement. Employee was a poor candidate for chronic opioid use, given his lack of improvement, substance abuse history and negative toxicology screen. He opined Employee should be weaned from prescription medications and Dr. Davidhizar should perform a urinalysis drug screen immediately to determine if Employee is taking his medications. If he was, since he has not shown improvement, he should be tapered from them. Dr. Pitzer could not identify any preexisting lumbar spine condition. Therefore, he opined no preexisting condition was aggravated or accelerated by Employee's work injury. Dr. Pitzer suspected the work injury "did accelerate some preexisting arthritis in his back but this had resolved and now he is left with right-sided sacroiliac ligament dysfunction." In Dr. Pitzer's opinion, the only other cause for Employee's "injury" was possible drug-seeking behavior and preexisting degenerative changes. Dr. Pitzer first said Employee reached medical stability as of June 12, 2012, when his right SI joint injection confirmed his diagnosis. Dr. Pitzer also stated "I think likely" the patient was at medical stability on August 22, 2011, when he had his EME. Under the "AMA guidelines, fifth edition," for ongoing lumbar pain with a normal neurological examination without radicular components or fractures, Employee would have category II lumbar spine impairment, resulting in a five percent whole-person PPI rating. The work injury was the substantial cause of the lumbar strain. In Dr. Pitzer's opinion, further narcotics were not

reasonable or necessary and should be reduced promptly. He opined Employee's physical capacities were at the "medium" level with 25 pounds frequent and 50 pounds occasional lifting. The need for ongoing medical treatment was his opiate dependency, not his work injury, in Dr. Pitzer's view. Further explaining his medical stability opinion, Dr. Pitzer again stated Employee's diagnosis was not adequately determined until June 12, 2012. Treatment thereafter was passive and included opioid medication, neither of which improved his "condition." In responding to Employer's SIME question, Dr. Pitzer said Employee had a two percent whole-person PPI rating for nonspecific SI joint symptoms without objective findings (Pitzer SIME report, September 5, 2012).

72) False negative and false positive urinalysis test results are not uncommon (experience).

73) On October 2, 2012, PA-C Wallace responded to a questionnaire from Employee's attorney and stated PA-C Wallace's clinic had performed only one urinalysis drug screen on Employee (Wallace response to Mason letter, October 2, 2012).

74) On October 2, 2012, Dr. Kahn found a palpable mass "(likely muscle)" in the right lumbosacral junction (Kahn Progress Note, October 2, 2012).

75) On October 10, 2012, Dr. Kahn gave Employee an epidural steroid injection at the right L5-S1 level (Kahn Operative Report, October 10, 2012).

76) On October 25, 2012, Dr. Pitzer responded to questions from Employer's attorney. Dr. Pitzer opined Employee was medically stable on August 22, 2011, and at that time the primary cause of his likely, ongoing disability was drug dependency or drug-seeking behavior. Dr. Pitzer opined the June 12, 2012 SI joint injection did not improve his condition and demonstrated his pain was not coming from the SI joint. Dr. Pitzer further stated the work injury was the cause for a two percent whole-person PPI rating under the AMA *Guides* Sixth Edition. Dr. Pitzer opined it was difficult to say the work injury caused Employee's controlled substance dependency as his urine toxicology screens showed he was not taking the medication regularly. Dr. Pitzer suggested Dr. Davidhizar repeat the toxicology screen and if it was negative for Oxycodone, this would mean Employee was not taking the medication and, therefore, did not need any treatment. Conversely, if the test showed Employee was taking Oxycodone, it should be tapered rapidly since it is not effective, given his ongoing symptoms. Dr. Pitzer's opinions could not be more specific because the lack of routine urinalysis throughout his treatment, and lack of documented improvement, made this difficult. However, Dr. Pitzer opined the work injury triggered the

initial Oxycodone prescription but felt it was likely Employee's substance dependency issues are not related to his work injury. He did not believe a third SI joint injection was reasonable as Employee had adequate treatment trials and further injections were likely related to his degenerative condition, not his work injury (Pitzer letter, October 25, 2012).

77) On November 9, 2012, Employee appeared at his physician's office and looked lethargic and groggy. Employee stated he could not pay his outstanding bill as he had no job. Employee and his significant other were observed removing pictures in the doctor's offices' atrium. Employee stated he was trying to find out where the pictures were made so he could order some. Employee was brought into the minor emergency room and was "obviously overmedicated." Employee explained he had inadvertently taken an extra medication dose because his significant other thought he had forgotten to take his first dose, which turned out to be incorrect. Employee was given Narcan intravenously and responded quickly. He became much more alert, able to talk coherently about his situation and denied he was trying to steal the artwork. Dr. Davidhizar discontinued Employee's Valium (Davidhizar Progress Note, November 9, 2012).

78) On November 20, 2012, Employee apologized to Dr. Davidhizar for his behavior during the last visit and behaved normally. He was feeling better, his back pain level was at "5/10" and he was to have an injection in Dr. Khan's office (Davidhizar Progress Note, November 20, 2012).

79) On January 21, 2013, Employee's urinalysis drug screen was positive for THC, Morphine and Oxazepam (Family Medical Clinic in House Drug Screen, January 21, 2013).

80) On February 5, 2013, Employee's pain was unchanged and he had received no benefit from the October 2012 epidural steroid injection (Kahn Progress Note, February 5, 2013).

81) On March 20, 2013, Employee saw James Price, D.O., at Employee's normal clinic. Employee reported only Dr. Humphreys' injection had relieved his pain. He reported spasms accompanying his lower back pain, which radiated from his right SI joint down his posterior thigh into his toes. On examination, Employee's general appearance included pressured speech, inability to sit still, dilated eyes and he was "derailing." Dr. Price diagnosed facet arthropathy and substance abuse versus bipolar disorder, and a possible manic episode. He had a long discussion with Employee regarding opioid medications and his concern for over-sedation. Dr. Price recommended Employee go to Providence Breakthrough in Anchorage for "Suboxone" therapy (Price Progress Note, March 20, 2013).

82) On April 18, 2013, Employee reported to PA-C Wallace ongoing low back pain, and stated his medications helped him function. Injections with Drs. Davidhizar, Humphreys and Kahn provided no improvement. PA-C Wallace discussed with Employee his previous referral to Providence Breakthrough, which Employee did not keep it because he did not think he needed to go. Employee stated he had a driving under the influence (DUI) case pending concerning his medications. PA-C Wallace told Employee he needed a urinalysis drug screen (Wallace Progress Note, April 18, 2013).

83) On April 18, 2013, Employee's urinalysis drug screen was positive for THC, Morphine and Oxycodone (Family Medical Clinic in House Drug Screen, April 18, 2013).

84) On May 6, 2013, Employee reported he was no longer seeing Dr. Kahn, whose injections had made his back pain worse. He did not want any more injections. Employee said when he moved furniture he had help but was "still doing a lot of lifting himself." Dr. Davidhizar cautioned him against doing this, but Employee said he had no income otherwise (Davidhizar Progress Note, March 8, 2013).

85) On May 22, 2013, Employee's attorney met with Dr. Davidhizar, who opined alternatives for Employee's work injury included surgery, which he would not recommend, and adjusting Employee to his present pain level. He would discuss these matters with Employee at his next appointment (Davidhizar Progress Note, May 22, 2013).

86) As of July 13, 2012, Employee estimated he had made at least $10,000 in the prior year holding garage sales, including selling his personal belongings to pay bills. He did not run a "business" selling things at garage sales and there are no sales records. Employee also rented out part of his residence for income (Employee deposition, July 13, 2012, at 20-22).

87) On August 2, 2013, Employee saw Dr. Humphreys, reported low back pain and discussed a possible injection. Dr. Humphreys diagnosed sacroiliitis and suggested another SI joint injection under fluoroscopic guidance and sedation (Humphreys Progress Note, August 2, 2013).

88) On August 9, 2013, Dr. Davidhizar reported reviewing job descriptions including: Landscape Gardener; Landscape Labor Work; Highway Maintenance Worker; Material Handler; Industrial Cleaner; Peddler; Small-Engine Mechanic; Assembled Wood Products Preparer; Fishing Vessel Deckhand; Front-End Loader Operator and Fishing Vessel Captain. He opined none of them were suitable for Employee except the boat captain position and said Employee

would not be able to do any manual labor but could run the boat (Davidhizar Progress Note, August 29, 2013).

89) On August 9, 2013, Dr. Davidhizar predicted Employee would have a permanent partial impairment resulting from his April 26, 2011 work injury (Physician's Prediction of Physical Capacities, August 9, 2013).

90) On August 13, 2013, SI joint x-rays showed degenerative changes in Employee's lumbosacral spine, right greater than left, and questionable degenerative enthesophyte versus a soft tissue calcification of the right hip joint (Diagnostic Imaging report, August 13, 2013).

91) On August 13, 2013, Employee underwent a lumbar spine and SI MRI without contrast, which was compared to prior radiographic studies. The MRI revealed mild to moderate bone marrow edema present on the right L5-S1 pedicles with surrounding soft tissue edema. The radiologist opined this finding may be on the basis of a stress reaction related to a developing right L5 pars defect. The radiologist determined, among other things, Employee had central canal stenosis at L3-L4 and L4-L5, which was mild, and neural foraminal stenosis at L3-L4 moderate on the left, L4-L5 moderate on the right, and L5-S1 moderate to severe on the right (Diagnostic Imaging report, August 13, 2013).

92) On August 29, 2013, in response to Employer's letter, Dr. Pitzer opined Employee would not have permanent physical capacities to perform duties of a Landscape Laborer or Material Handler, but would have capacities to be a Peddler; Fishing Vessel Captain; Roofer and Front-End Loader Operator (Pitzer job descriptions, August 29, 2013).

93) On August 29, 2013, again in response to Employer's letter, Dr. O'Riordan initially checked "no" on the same job descriptions Dr. Pitzer had completed, and then changed all his "no" answers to an opinion stating Employee would have permanent physical capacities to perform the duties of a Landscape Laborer; Material Handler; Peddler; Fishing Vessel Captain; Roofer and Front-End Loader Operator (O'Riordan job descriptions, August 29, 2013).

94) On September 12, 2013, Employee underwent a lumbar spine CT scan without contrast. This was compared with previous radiographic studies. The scan showed lumbar spine degenerative changes most prominent at the L5-S1 level, and, upon further review, revealed a "prominent (not moderate)" facet hypertrophy involving the right L5-S1 facet. The radiologist also noted advanced spur formation seen with a degree of subchondral sclerosis most likely degenerative (Diagnostic Imaging CT Scan, September 12, 2013).

95) On October 2, 2012, Dr. Humphreys recommended a foraminotomy along with a partial facetectomy and possibly a fusion at L5-S1 depending upon what he saw during surgery (Humphreys Progress Note, October 2, 2012).

96) On October 30, 2013, Employee underwent a complete facetectomy with discectomy and interbody cage fusion on the right at L5-S1. During surgery, Dr. Humphreys identified the facet joint "which is extremely abnormal; cystic and soft." There appeared to be a crack or pars defect through the joint. Because it was so severe, "the joint was taken off." Dr. Humphreys decided against doing a foraminotomy because he determined this would not alleviate Employee's pain. As Dr. Humphreys proceeded with surgery, it became obvious the inferior foramen was hitting the ganglion and the exiting L5 nerve root. Therefore, Dr. Humphreys removed the facet. He elected at that point to fuse Employee's lumbar spine because of the foraminal collapse and hypertrophy on this side (Humphreys Operative Note, October 30, 2013).

97) On October 30, 2013, lumbar x-rays showed evidence of an L5-S1 spinal fusion and right foraminotomy and an otherwise unremarkable intraoperative study (Diagnostic Imaging report, October 30, 2013).

98) By November 2, 2013, Employee was doing "quite well." He reported no leg pain and had good strength (Humphreys Progress Note, November 2, 2013).

99) On November 3, 2013, Employee was discharged from the hospital in good condition on the same prescriptions he was on when he was admitted. Dr. Humphreys' plan was to wean him from these medications over the following 12 to 16 weeks and coordinate with Dr. Davidhizar (Humphreys Discharge Summary, November 3, 2013).

100) The SI joint is what connects the end of one's spine to one's pelvis. Employee had a working diagnosis of sacroiliitis and a "disc" at L3-L4 on the left (Humphreys deposition, March 14, 2014, at 7-8). Dr. Humphreys injected Employee at the right SI joint and though his symptoms improved initially, when he got active Employee's pain returned. Pain going all the way down Employee's leg is not consistent with sacroiliitis (*id*. at 8-9). Following the first injection, the physician's assistant in Dr. Humphrey's office was uncertain sacroiliitis was the correct diagnosis (*id*. at 9-10). When injections did not resolve Employee's pain, Dr. Humphreys suggested a repeat MRI. The MRI showed "increased uptake" in the pars on the right side at L-5, which "would mean where basically the bone took stress and there is a fracture at that level" (*id*. at 11). The moderate to severe right foraminal stenosis shown on the MRI is not "age-

appropriate" and is not normal for Employee's age group, so "something had changed there basically, or that's what it looked like" (*id*. at 13). Dr. Humphreys suggested surgery because the MRI and CT scan showed some impaction, the facet was enlarged, which means it was reacting, and "actually it's collapsed down on that side." In Dr. Humphreys' view, the "whole story starts to make more sense at that point." Dr. Humphrey explained:

> He kind of came in with one diagnosis and a MRI, and Kurt saw him initially. And then when we got the repeat MRI, then we saw where the pars had been injured, which in my opinion explains why that facet degenerated so quickly. Like if you tore the cartilage real bad in your knee and then kept moving around on it for two years, it could booger it up.
>
> And then actually in hindsight, it wasn't until Aaron and I went, and it kind of dawned on me when we were talking, I went back and looked at the prior MRI. It's actually on the prior MRI, the one that was taken before we saw him right after the injury.
>
> And I think -- and his history is a lift and an extension maneuver, which is the maneuver that would do that. And unfortunately the SI joint and the L5/S1 facet are a centimeter or two apart, and it's very similar. And once that first MRI had been negative, I think the diagnosis got channeled to SI joint, which is little unusual for single lift.
>
> So I think everyone was scratching their head until we repeated, then all of sudden the story started to make a lot more sense (*id*. at 14-15).

101) When asked if Employee had originally been "misdiagnosed," Dr. Humphrey stated:

> It's a hard call, yeah, I do too [hate to use the word misdiagnosed]. Because the original one -- and we typically look at the films, but that's a hard call for Kurt and the original radiologist. And he was seen by other people before he came.
> . . .
>
> And he's a nice guy, but he's a little emotional, too. So we were just meeting him trying to put it -- and he's coming in with tests, and none of it is working, and he's on high doses of medication, so you're trying to sort through all of this.
>
> And again, not making excuses, I think everybody did the best they could. But, I think, yeah, initially if that MRI had been seen, it probably would have changed what everyone was thinking (*id*. at 14-15).

102) Dr. Humphreys initially planned to do a foraminotomy before he saw the CT scan. The point was to release the nerve which was trapped where it exits right under the joint that had

gotten enlarged. Once Dr. Humphreys began the surgery, and saw the extent of damage to the facet joint, he thought for a moment the joint had become infected from a facet joint injection one of the other pain doctors had provided. However, laboratory tests showed there was no infection (*id*. at 16-17).

103) The "sacroiliitis" misdiagnosis was, in Dr. Humphreys' opinion an "excusable misdiagnosis." In respect to how prior radiologists could have missed the stress fracture in the right L5-S1 facet, Dr. Humphreys noted radiologists "don't have the advantage of having the clinical history and exactly what happened." He further stated Employee's situation was "an uncommon thing" and he had seen it rarely in 20 years (*id*. at 16).

104) Had Employee's condition found at surgery been present before his April 2011 work injury, Employee probably would have had symptoms in his back and legs (*id*. at 17). In Dr. Humphreys' opinion, the work injury was the trigger that caused the symptoms by injuring Employee's back. Dr. Humphrey stated: "if he had not had the injury, I don't think he would have had the problem that required surgery" (*id*. at 18). When asked to list all possible causes of Employee's "condition," Dr. Humphrey stated: "I don't know of any others without having a history of this. . . . And the fact that he reports not having any history other than perhaps minor, and I don't even know about any minor conditions, and it starting on a heavy lift, that's the most likely diagnosis, unless there's something he's not telling us, that I'm aware of." The only known cause of Employee's operable condition is the work injury (*id*. at 18-19).

105) Not only were the surgical findings beyond age-appropriate for Employee, they were unilateral, on only one facet. Dr. Humphreys explained if facets wear out, even at an accelerated rate not caused by an injury, they will both were out similarly. When one is much worse than the other, "it's often indicative of an injury" (*id*. at 19).

106) Employee had minimal degenerative changes in the operated facet joint, to the extent Dr. Humphreys believes the injury "pretty much caused" the stress fracture (*id*. at 19).

107) Employee probably could have answered a telephone but he was otherwise totally disabled when Dr. Humphreys first saw him in August 2013, because he would not have been able to do much functionally and was on pretty high narcotics doses (*id*. at 20).

108) Dr. Humphreys saw no evidence Employee's yard sales accelerated or made his condition worse (*id*. at 21).

109) When Dr. Humphreys started considering surgery, he reasonably expected there would be improvement in Employee's condition as a result of surgery. Following surgery, Employee reported his leg pain was virtually gone. He expects Employee to be fully recovered around nine to 12 months following surgery (*id*. at 22-23).

110) Given his time off from work, Employee will probably need post-surgery therapy. Dr. Humphreys plans to reduce Employee's narcotic medications. If Employee has difficulty weaning, he may have to go to pain management (*id*. at 23-24).

111) Employee may need a functional capacity evaluation following physical therapy. He expects Employee will need a PPI rating after therapy and recovery from surgery (*id*. at 24-25).

112) Dr. Humphreys does not believe Employee improved at any time after his injury to the date of surgery. His impression was Employee kept getting worse with occasional times when he "thought he was better." So far as Dr. Humphreys knows, there was never a surgical recommendation prior to August or September 2013. Dr. Humphreys was "kind of almost resigned to the fact that [Employee] was going to need surgery" (*id*. at 28-30).

113) On January 10, 2014, the RBA designee directed Employee's reemployment specialist to seek Dr. Humphreys' opinion on questions related to reemployment benefits eligibility (Torgerson letter, January 10, 2014).

114) On January 15, 2014, the parties' attorneys appeared at a prehearing conference. The parties agreed to a hearing on Employee's claim on April 1, 2014, and identified the following issues for hearing: TTD; PPI; medical and related transportation costs; rehabilitation benefits; attorney fees, costs and interest (Prehearing Conference Summary, January 15, 2014).

115) On March 25, 2014, Employee's attorney filed and served his attorney's fee and cost affidavit. Through March 22, 2014, Employee's attorney had incurred 128.9 hours at $375 per hour for a total attorney fee request of $48,337.50. Employee's costs through the same date totaled $3,217.05 (Statement of Legal Services Rendered on Behalf of: Thomas J. Fruichantie (March 24, 2014).

116) On March 25, 2014, Employee's hearing brief argued he had no prior low-back injury or low-back medical care before April 26, 2011. He argued Dr. Davidhizar's clinic provided reasonable, conservative medical care to treat an initial sacroiliitis diagnosis complicated by a herniated disc. Employee acknowledged SIME physician Dr. Pitzer stated Employee was medically stable effective August 22, 2011, and opined drug dependency was the cause of any

subsequent disability. Employee further argued EME Dr. O'Riordan's report stated Employee's work injury was the medical cause of his symptoms and conditions. Employee stated it was very significant that Dr. O'Riordan's opinions were rendered after an MRI was performed on Employee, but the MRI is not referenced in the Diagnostic Study Interpretation section of Dr. O'Riordan's report. He also argued it is important that neither SIME Dr. Pitzer nor EME Dr. O'Riordan had the benefit of reviewing Employee's 2013 MRI or CT scans, and neither had performed surgery on Employee and visualized the aberrant facet joint. Employee relies upon Dr. Humphreys' reports and deposition, the relevant details of which are cited above. He further argues Employee's symptoms have dissipated significantly since Dr. Humphreys performed surgery (Employee's Hearing Brief, March 24, 2014, at 1-8).

117) Employee seeks TTD from August 22, 2011, to the date of medical stability after recovering from surgery, "although TTD was paid into October 2011." He also seeks PPI based on a rating after recovery from his recent surgery; a complete eligibility evaluation for reemployment benefits after recovering from surgery; an order requiring Employer to pay medical bills of past and future including Employee's out-of-pocket expenses and liens held by his health insurer; mileage for which he would submit a mileage log; attorney fees; costs and interest. Employee further argued yard sales in which Employee engaged from time to time do not constitute employment. As Dr. Davidhizar released Employee to light duty work and none was offered to him, Employee argued he is entitled to TTD beginning October 6, 2011, and continuing through his recovery period following surgery until he is medically stable. As for PPI, Employee argued it was premature to rate him because he was not medically stable following his recent surgery. Employee asked for an order requiring the rehabilitation benefits administrator (RBA) to evaluate him for eligibility following his recovery from surgery. Lastly, he requested an order requiring Employer to pay medical bills, transportation expenses, interest, attorney's fees and costs (*id*. at 9-10).

118) On March 24, 2014, Employer in its hearing brief argued Employee is not entitled any benefits after August 22, 2011. It argues both SIME Dr. Pitzer and EME Dr. O'Riordan opined as a result of the work injury, Employee suffered only a lumbar strain, which resolved over a few months. It argued Employee had a non-physiological examination with right lower extremity symptoms, which belied his complaints. Employer argued it was not until over two years after Employee's injury that a radiologist reviewing an August 2013 MRI noted objective evidence of

any issues on the right side at L5-S1. Furthermore, Employer argued Employee's garage sale efforts and other personal activities aggravated, increased and continued his back pain. It argued even Employee admitted he would have recovered faster but for his physical work performing personal interests. In summary, Employer argued Employee cannot meet his burden of persuasion and consequently all his requested benefits and claims should be denied (Employer's Hearing Brief, March 24, 2014, 11-15).

119) At hearing on April 1, 2014, Employee testified he had worked mostly as a landscaper, fishermen and roofer. He had never injured his low back or sought medical care for it before this work injury with Employer. He had never lost work because of a low back injury before working for Employer. Employee worked in the winter for Employer doing snow removal and in the summer performing landscaping. Snow removal was generally paid by Employer "under the table." Employer had a contract with Homer Electrical Association to remove snow from all its facilities. Employee had a very good working relationship with Employer, which paid him $20 per hour even though the original agreement was for $18 per hour. On the injury date, Employee was at the KeyBank location with a coworker doing spring clean-up in the parking lot. Employer asked Employee and his coworker go next door to The Moose is Loose property to pick up large rocks and put them in a pickup truck. Employee and Paul were lifting rocks when a particularly large one slipped and Paul let go, leaving Employee holding the rock which took him "to the ground." Employee felt pain in his low back immediately and he told Paul he "felt different" and had a lot of pain. Employee never returned to work for Employer thereafter. He called and left messages with Employer's phone advising he could not return to work and needed to see a doctor. Employee first sought medical care in early May 2011. Dr. Davidhizar thought Employee's SI joint was causing his difficulties. He and other physicians tried E-Stim therapy, spinal injections into the SI joint and traction to treat the SI joint, but were unaware Employee had a broken bone in his joint. Dr. Davidhizar referred Employee eventually to Dr. Humphreys, who we saw for the first time around July 2012. The SI joint injections provided short-lived but no long-term relief (Employee).

120) Every day Employee's pain seemed to get worse. He had to climb stairs at home and using the stairs caused increased pain. "Doing anything" caused more pain. Even sitting around or lying in bed caused pain. Employee reported this to Dr. Davidhizar who prescribed pain medication (*id.*).

121) When Dr. Kahn performed an SI joint injection, something went wrong, and medical staff told Employee he "launched off the operating table" and ended up on the floor, though he has no personal recollection of this event as he was semi-conscious. Following this event, Employee was not interested in any further SI joint injections (*id*.).

122) Employee returned to Dr. Davidhizar and eventually was referred back to Dr. Humphreys in July 2013. Dr. Humphreys sent Employee for a new MRI and CT scan, which revealed findings for which Dr. Humphreys recommended surgery. Once surgery began, Dr. Humphreys had Employee's permission to do whatever he felt necessary to resolve Employee's problems. The surgery has been more successful than any injections. It decreased his leg pain, given him ability to move and do "a lot more" things he could do previously and he was "was on the right track" to have the right diagnosed injury corrected. Walking was difficult before his surgery, but now he can walk much better. Employee's life is "a lot less painful" than it was. Dr. Humphreys wants to keep Employee on his current prescriptions and wean him down after two months (*id*.).

123) Employee has not had a job since his April 26, 2011 work injury. He has held several garage sales trying to generate money to support himself along with money from his rental unit since Employer stopped paying him. He held garage sales before his injury and typically would come to Anchorage with a trailer, buy materials locally, take them down to the Peninsula and then sell them for a profit. He previously did this, for 20 years, when his seasonal labor did not otherwise keep him busy. Following his work injury with Employer, however, Employee could not handle large furniture and heavy items because he had difficulty loading them. He paid people to load these items for him and felt he had been "handicapped" from doing many of the garage sale activities he previously performed. Employee has hired four to five people to move things around his yard sales while he simply negotiated and made sales. Employee sold many personal items he would not otherwise have sold at garage sales, but for the fact he needed money and was about to lose his home because he could not pay the mortgage (*id*.).

124) Employee drove from his home on the Peninsula to Anchorage the evening before the hearing. Employee's home is about 150 miles from Anchorage. His hotel room cost approximately $67 per day (*id*.).

125) Employee's hearing participation was necessary so his demeanor could be observed (experience, judgment).

126) As of the hearing, Employee was still taking Oxycodone, Morphine and occasionally Valium. Since April 2011 until his surgery, his medication intake had remained about the same. Since surgery, his medication level has dropped. He takes approximately one pill less per day of each medication than he was prior to surgery. Since surgery, Employee's pain level has ranged from "3/4 to 4/5" with medication. Sitting is somewhat problematic. Prior to surgery, Employee's pain was "intolerable," and was typically from "6/7 to 7/8." Prior to surgery, the pain ran up and down his back and down his leg. The pain Employee felt after surgery has "definitely decreased" though he still has some pain in the same areas. For the first four months post-injury, Employee had severe pain in the low back area (Employee).

127) Employee conceded the more he did on his garage sales, the more he hurt. He had to hire people to do what he normally would do because he learned he could not do it. Employee's garage sale activities very much aggravated things and caused pain. Everything he did, including walking stairs and bending over hurt and generated more pain (*id*.).

128) At post-injury garage sales, Employee would pull out and put away tables weighing about 20 pounds. He would also carry and sell small, lightweight items. Prior to his injury, Employee never hired anyone to help him and always did the work himself, including working long hours. At times since his injury, Employee has lifted more than 20 pounds, but when he did so, it increased his pain level and "put him down" for a day or so and made his life "absolutely miserable" (*id*.).

129) At hearing, Employee stated he did not believe any of his garage sales "made his injury worse." He conceded, however, he "dealt with a lot of pain" so he could save his house from foreclosure and that is why he did what he could at his garage sales (*id*.).

130) When confronted with PA-C Wallace's July 12, 2011 medical record, wherein Employee reported pain levels at "2/10" with medication and "4/10" without, Employee assumed he correctly reported this information. Employee conceded the July 18, 2011 medical record, in which he reported he had been doing a lot of lifting getting ready for a garage sale and his back was in a lot of pain and stiffness and at a "5/10" pain level, was probably accurate (*id*.).

131) Employee stated the lump in his lower right back was present after the injury on the same day, grew bigger the next day and to his knowledge is still present. Employee maintained he always reported the lump from the first time he saw a doctor (*id*.).

132) At times, Employee had pain going down both legs. He also had numbness and tingling going down mostly his right leg. The mostly right-legged pain has certainly decreased "a lot" since surgery, is much better, more tolerable, and he his been able to do much more than he could before (*id*.).

133) Employee did not agree a December 1, 2011 medical record stating he was having "new" symptoms of bilateral tingling in his feet and toes was correct. Employee maintained he complained of tingling and numbness down his legs from the first time he saw a doctor. Employee saw different providers on many occasions, and his symptoms gradually got worse over time (*id*.).

134) As for the urinalysis drug screen showing no narcotics in his urine, but positive for THC in June 2011, Employee explained he was regularly taking his medication as prescribed, and on that occasion he probably was not taking it because he was out of it, which would explain its absence. His prescriptions only remained in his urine for 48 to 72 hours. As for the THC, Employee has a medical marijuana card and a marijuana prescription to address gastric problems and residual symptoms from his old neck operation. However, Employee conceded if he had been seen within two weeks of when he renewed his prescriptions, he should not have run out within 15 days. If he was scheduled for a procedure such as an epidural steroid injection, the doctors told him not to take his medication before the injection so he would not have an adverse reaction. Other than these reasons, Employee had no explanation for the negative drug screen urinalysis in June 2011 (*id*.).

135) Since his work injury, Employee spent approximately 25 days in jail for DUI and a related theft charge. Employee agreed to a plea bargain on the theft charge. Employee maintained his innocence on the theft charge and testified he only agreed to it as a plea bargain. Employee maintained to this day, he still does not know what he was accused of stealing. Employee was a passenger in another person's vehicle and the other person allegedly "took a box of clothes" or something and put it in the truck. He has not completed his 40 hours community service (*id*.).

136) Employee noted a May 10, 2011 Progress Note stated he was getting pain and tingling down his right leg. Similarly, Employee reviewed his May 17, 2011 pain diagram in which he diagrammed pain going down his right leg less than a month following his work injury. He further reviewed a May 19, 2011 Progress Note stating he had shooting pain going up and down his back and down his right leg (*id*.).

137) Following his work injury, Employee's pain level typically was at "3/4" or perhaps "4/5" and was always present. When he had activities such as a garage sale, his pain level would temporarily increase to "5/6 or 6/7" and then would go back down to "3/4 or 4/5" after he reduced activity (*id*.).

138) Employee does not recall anyone ever discussing a negative drug urinalysis result with him and does not know what some medical providers mean when their records say this was discussed and "reconciled" with him (*id*.).

139) Employee held garage sales at his personal residence, hired people to move things and paid them in cash through Job Service. He did not have a business license and did not provide workers' compensation insurance for these people (*id*.).

140) Employee applied for unemployment insurance and received approximately $118 total. He gets letters from unemployment requesting reimbursement (*id*.).

141) At hearing on April 1, 2014, Jaylee Harris stated she has had a relationship with Employee for over five years. She resided at his home during this time, including since his work injury with Employer. She described Employee's ability to function pre-and post-injury like going "from 100 to 30 miles per hour." One day of activity typically would mean three days sitting on the couch doing nothing. After each rest period, Employee's symptoms did not really go back to a baseline, but seemed to Harris to get worse, especially at night. During sleep, Employee's whole body "would jump and spasm." Surgery has helped resolve Employee's pain complaints, with the possible exception of sleeping at night, with which Employee still has trouble (Harris).

142) At hearing on April 1, 2014, EME Dr. O'Riordan explained his EME report. Dr. O'Riordan opined Employee suffered an acute lumbosacral sprain or strain and had a history of opioid dependency. Subsequent to his EME evaluation, Dr. O'Riordan reviewed subsequent records from Dr. Humphreys, Dr. Pitzer's evaluation, new MRI and CT scans, and operative reports from Employee's surgery. Dr. O'Riordan agrees with Dr. Pitzer's report. In Dr. O'Riordan's opinion, the lumbar surgery Dr. Humphreys performed was not directly related to the reported injury. In his opinion, edema, infection or pars defect, are normal changes over time and progressive, and are not work-related. Dr. O'Riordan does not believe these findings were present on MRIs done in May 2011 or March 2012. He reviewed the reports and actual films himself. In his opinion, if the fracture Dr. Humphreys found at surgery was present since the April 2011 injury, it would have shown up on the May 2011 or March 2012 MRI. Similarly, x-

rays did not reveal the fracture found two and half years later either. Dr. O'Riordan believes these 2013 findings would have shown up on these diagnostic tests. He does not believe three competent radiologists would miss these findings. In Dr. O'Riordan's opinion, the 2011 work injury was not the substantial cause of Employee's need for treatment following his EME (O'Riordan).

143) Dr. O'Riordan did not give an opinion about what necessitated the October 2013 surgery, but simply opined the work injury did not cause the need for it. All he could say was, based upon Dr. Humphreys' opinion, changes found on the MRI were the substantial cause of the need for surgery. In Dr. O'Riordan's opinion, the 2013 MRI findings were the result of natural degeneration of the lumbosacral spine. Dr. O'Riordan read Dr. Humphreys' operative report, but did not read his deposition. He was unaware lab reports demonstrated no infection in Employee's lumbosacral spine subject of the surgery. But this fact has no effect on his opinions. He also reviewed the 2013 CT scan, and opined the degenerative changes on the right facet joint area were age-appropriate. The right facet joint is a couple of centimeters away from the left facet joint. In Dr. O'Riordan's view, there was "slightly less" degeneration on the left facet joint than on the right. He stated there is no set, medical standard for describing facet degeneration. "Mild, moderate and severe" degeneration have no quantitative definition, in his opinion. In Dr. O'Riordan's opinion, the difference between "mild" versus "moderate" or "severe degeneration" in a facet joint "not significant." In his opinion, the work injury did nothing to effect the right facet joint degeneration. When Dr. O'Riordan saw Employee, he probably could have lifted 100 pounds, worked on his feet for eight hours, walked, crawled and climbed stairs at will. He does not believe the MRI and CT scan findings in 2013 were causing his symptoms (*id*.).

144) In Dr. O'Riordan's opinion, the injury did cause the symptoms Employee felt after the accident up to August 22, 2011 (*id*.).

145) Dr. O'Riordan agreed Dr. Humphreys' surgical procedure was the correct way to fix the abnormality seen on the 2013 MRI, but he does not think the symptoms were being caused by the abnormality seen on the radiographic studies. Employee's improvement since the surgery could be a result of the "placebo effect," but to further answer this question Dr. O'Riordan would have to re-examine Employee (*id*.).

146) Dr. O'Riordan agrees sacroiliitis was never Employee's correct diagnosis (*id*.).

147) When asked about Dr. Pitzer's 20 to 50 pound lifting restriction, compared to his opinion Employee could lift up to 100 pounds without any other restrictions, Dr. O'Riordan explained perhaps the degenerative osteoarthritis had progressed to the point where Dr. Pitzer believed these limits were more appropriate. It is difficult to predict how long it might take for degenerative osteoarthritis of a facet joint to require surgical correction. A lifting injury with the 200 to 300 pound rock would not have accelerated the degenerative facet condition (*id*.).

148) The only factors Dr. O'Riordan could identify since the date of injury to account for any alleged disability was: 1) Employee's complaint of subjective pain, which Dr. O'Riordan did not believe was justified by the medical records, 2) his opioid dependency and 3) his voluntary decision not to work. Dr. O'Riordan could not identify a physical reason why Employee could not work, and not working was simply a voluntary decision Employee made. Employee had an acute lumbosacral strain or sprain, which generated a chronic pain syndrome in Dr. O'Riordan's opinion (*id*.).

149) At hearing on April 1, 2014, Employee's counsel provided a supplemental statement for legal services rendered from March 26, 2014 through March 31, 2014, totaling 9.2 hours at $375 per hour for total supplemental request of $3,450 (Supplemental Statement of Legal Services Rendered on Behalf of Thomas J. Fruichantie, March 31, 2014).

150) Employee seeks 5.8 additional attorney's fees hours for preparing for and attending the hearing (Employee's hearing statements).

151) As of the April 1, 2014 hearing, the RBA designee had not come to a decision on Employee's eligibility for reemployment benefits (Torgerson letter, January 10, 2014).

PRINCIPLES OF LAW

AS 23.30.001. Intent of the legislature and construction of chapter. It is the intent of the legislature that

> (1) This chapter be interpreted . . . to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to . . . employers. . . .

The board may base its decision not only on direct testimony 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). A finding reasonable persons would find employment was a cause of the employee's disability and impose liability is, "as are all subjective determinations, the most difficult to support." However, there is also no reason to suppose panel members who so find "are either irrational or arbitrary." That "some reasonable persons may disagree with a subjective conclusion does not necessarily make that conclusion unreasonable" (*id.* at 534).

> **AS 23.30.010. Coverage.** (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. . . . When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.
>
> **AS 23.30.095. Medical treatments, services, and examinations.** (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires. . . .
>
> **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. . . .

Under AS 23.30.120(a)(1), benefits sought by an injured worker are presumed to be compensable. *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996). The presumption of compensability is applicable to any claim for compensation under the workers' compensation statute (*id.*; emphasis omitted). The presumption application involves a three-step analysis. To attach the presumption of compensability, an employee must first establish a "preliminary link" between his injury and the employment. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 610 (Alaska 1999). For injuries occurring after the 2005 amendments to the Act, if an employee establishes the link, the presumption may be overcome at the second stage when the employer presents substantial evidence, which demonstrates a cause other than employment played a greater role in causing the

disability or need for medical treatment. *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 (March 25, 2011) at 7.

If the board finds the employer's evidence is sufficient to rebut the presumption, it drops out and the employee must prove his case by a preponderance of the evidence. He must prove that in relation to other causes, employment was "the substantial cause" of the disability or need for medical treatment. *Runstrom*, AWCAC Decision No. 150 at 8. This means the employee must "induce a belief" in the minds of the fact finders the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). In the third step, the evidence is weighed, inferences are drawn from the evidence, and credibility is considered.

> **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.

The board's finding of credibility "is binding for any review of the Board's factual findings." *Smith v. CSK Auto, Inc.*, 204 P.3d 1001, 1008 (Alaska 2009). The board has the sole power to determine witness credibility, and its findings about weight are conclusive even if evidence is conflicting. *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249, 1253 (Alaska 2007). The board has sole discretion to determine weight accorded to medical testimony and reports. When doctors' opinions disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.*, AWCAC Decision. No. 087 at 11 (August 25, 2008).

> **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. . . .

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:

> 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).
>
> **AS 23.30.155. Payment of compensation**. (a) Compensation under this chapter shall be paid periodically, promptly, and directly to the person entitled to it, without an award, except where liability to pay compensation is controverted by the employer. . . .
> . . .
>
> (p) An employer shall pay interest on compensation that is not paid when due. . . .
>
> **AS 23.30.185. Compensation for temporary total disability**. In case of disability total in character but temporary in quality, 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the

> continuance of the disability. Temporary total disability benefits may not be paid for any period of disability occurring after the date of medical stability.

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

The Alaska Supreme Court in *Ranney v. Whitewater Engineering*, 172 P.3d 214 (Alaska 2005) said where a statute expressly enumerates "the things or persons to which it applies," the court invokes the principle of statutory construction called *expressio unius est exclusio alterius.* This principle establishes an inference that, where certain things are designated in a statute, "all omissions should be understood as exclusions" (footnote omitted). *Ranney* further noted this doctrine is "particularly compelling," where the scheme in question "is purely statutory and without a basis in the common law" (footnote omitted). *Ranney* said the Alaska Workers' Compensation Act creates a "detailed and complicated scheme" for requiring employers to provide benefits to injured workers and their families. In this context, the court denied Ranney's request for death benefits because she was not married to the decedent at the time of his death, reasoning had the legislature wanted to compensate unmarried cohabitants it would have done so (*id*. at 219).

In *London v. Fairbanks Municipal Utilities*, 473 P.2d 639, the Alaska Supreme Court said where the statutory mandate is clear and would allow compensation, "it is improper for the Workmen's Compensation Board to inject its own views on the policies underlying the Workmen's Compensation Act by imposing additional restrictions of the statutory language. It was similarly error on the part of the court below to affirm the decision of the Board" (*id*. at 642-43). *London* found the act's language was "clear and unambiguous with regard to compensation for temporary partial disability." London's employer argued the board had to interpret the Act as his "was a case of first impression." The Alaska Supreme Court disagreed. *London* found there was no indication in the statute that any limit on disability benefits, as the board applied, was intended. The board added a limitation to the statute based on the board's belief the policies underlying temporary partial and temporary total disability benefits were closely interrelated.

London said the board simply and inappropriately "decided to insert an additional restriction into the statutes covering temporary partial disability" (*id*. at 641-42).

In *Burke v. Houston NANA, LLC*, 222 P.3d 851 (Alaska 2010) the Alaska Supreme Court reversed a board decision implementing an internal process, which the board in its rulemaking authority had not chosen to adopt. Burke asserted the board could not by adjudication "add requirements to the law that neither the legislature nor the executive branch in its rule-making power chose to add to the Act or regulations, respectively." The court said: "We agree: If the board wished to add to the deadlines it explicitly set in the regulations -- via adoption of a discovery rule -- it was required to do so by regulation." *Id*. at 867. The court further stated:

> We have previously held that an administrative agency can set and interpret policy using adjudication instead of rulemaking, absent statutory restrictions and due process limitations, (footnote omitted) and noted that the board has broad powers to administer the Alaska Workers' Compensation Act, including the authority to interpret statutes (footnote omitted). But the board's power is not unlimited. Alaska law requires an agency to follow certain procedures, including public notice and an opportunity for public comment, before it can supplement or amend a regulation (footnote omitted). Alaska Statute 44.62.640(a)(3) defines 'regulation' to include 'every rule, regulation, order, or standard of general application *or the amendment, supplement, or revision* of a rule, regulation, order, or standard adopted by a state agency to implement, interpret, or make specific the law enforced or administered by [the agency]' (emphasis in original).
> . . .
>
> The dissent argues that it was reasonable for the board to interpret its regulation. . . . (footnote omitted). As to the first point, it is true that the board could have adopted a regulation to provide for a new ninety-day period, but it did not do so. This is critical, because there is no doubt that the interpretation given by the board here -- enforcement of a discovery rule -- 'interprets and makes more specific' the former statute *and it does so in a way that alters the rights of the parties*. In these circumstances, an agency must act through rule-making, not adjudication (footnote omitted; emphasis added) (*id*. at 868).

In *Johns v. State, Department of Highways*, 431 P.2d 148 (Alaska 1967), the Alaska Supreme Court addressed a dispute over stays in workers' compensation appeals and said:

> In light of the broad public policy considerations which shaped and are embodied in workmen's compensation legislation, we believe cross-appellees' authorities are inapposite. Ideally, *final resolution of this issue lies within the province of our*

> *legislature*. The legislature is well equipped to study the question of balancing the need on the part of injured claimants for compensation payments against possible instances of employer's inability to recover unwarranted payments (emphasis added).

Vetter v. Alaska Workmen's Compensation Board, 524 P.2d 264 (Alaska 1974) reversed the board's decision denying TTD. On April 24, 1970, Vetter was assaulted on the job by a customer while working for her uninsured employer. At hearing, Vetter won medical care but lost her disability claim. In denying Vetter's disability claim, the board found:

> The Board believes that applicant does not want to work and that her husband, who did not want her to work before the injury, probably keeps her from working now (*id*. at 265).

Given these facts, in its analysis the Alaska Supreme Court in *Vetter* concluded, as a general proposition:

> If a claimant, through voluntary conduct unconnected with his injury, takes himself out of the labor market, there is no compensable disability (*id*. at 266-67).

Vetter's majority found a lack of substantial evidence to support the board's finding Vetter "was unwilling to work." On remand the board again found Vetter voluntarily removed herself from the labor market and again denied her disability claim. In Vetter's second appeal, the Alaska Supreme Court found the board reconsidered an issue already decided on appeal, without authority. The court reversed and remanded with more forceful instructions. *Vetter v. Wagner*, 576 P.2d 979 (Alaska 1978).

Estate of Ensley v. Anglo Alaska Construction, Inc., 773 P.2d 955 (Alaska 1989), addressed the question of successive, independently and temporarily disabling conditions, one work-related and one not. In *Estate of Ensley*, the board terminated Ensley's TTD benefits finding he could no longer work as a result of medical treatments for non-work-related cancer. The court reversed the board's decision and remanded the case for determination as to the date Ensley's back condition no longer constituted a disability. *Estate of Ensley* held: "We believe the Board erred by failing to consider whether Ensley's back condition constituted a disability regardless of his treatment for cancer. Liability for workers' compensation benefits will be imposed when employment is established as a causal factor in the disability" (citation omitted) (*id*. at 958).

In *Cortay v. Silver Bay Logging*, 787 P.2d 103 (Alaska 1990) the court reviewing a TTD decision was again urged to apply *Vetter*. The court concluded "*Vetter* does not control this case." The court noted: "There is no evidence that Cortay intended to remove himself from the labor market" (*id*. at 107). *Cortay* cited *Estate of Ensley* and stated:

> Today we clarify our holding in *Estate of Ensley* that TTD benefits cannot be denied to a disabled employee because he or she may be unavailable for work for other reasons. Though *Estate of Ensley* concerns unavailability for medical reasons, the rationale for not denying TTD benefits applies to any reason that might render the employee unavailable for work (*id*. at 108).

Hinkle v. Cornerstone Remodel & Design, AWCB Decision No. 14-0023 (February 28, 2014), reviewed the law in respect to an injured worker's right to receive TTD while disabled but incarcerated or in non-work-injury treatment. Decisions were split with six holding the claimant is not entitled to TTD because imprisonment or non-work-related treatment rendered them unavailable for work, while four came to the opposite result. These decisions include: *Mallott v. Fluor Alaska, Inc*., AWCB Case No. 76-01-0149 (June 7, 1978) (unpublished) (denied TTD while incarcerated); *Norris v. City & Borough of Juneau*, AWCB Decision No. 86-0324 (December 17, 1986) (denied TTD while incarcerated); *Lajiness v. H.C. Price Construction Co*., AWCB Decision No. 89-0046 (February 24, 1989) (TTD paid during incarceration not offset as overpayment); *Collins v. Trident Seafoods*, AWCB Decision No. 91-0109 (April 18, 1991) (granted TTD while in alcohol treatment); *Yinger v. Arctic Slope/Wright Schuchart*, AWCB Decision No. 91-0141 (May 10, 1991) (granted TTD while in cancer treatment); *Ayson v. D&A Mechanical*, AWCB Decision No. 92-0196 (August 14, 1992) (granted TTD while incarcerated); *Leblanc v. Rowan Companies, Inc*., AWCB Decision No. 94-0061 (March 21, 1994) (denied TTD while incarcerated); *Largent v. Alaska Concrete Sawing, Inc*., AWCB Decision No. 95-0154 (June 8, 1995) (denied TTD while incarcerated); *Sheets v. Capitol Disposal*, AWCB Decision No. 02-0021 (January 24, 2002) (denied TTD while incarcerated); *Randolph v. Fullford Electric, Inc*., AWCB Decision No. 07-0339 (November 9, 2007) (denied TTD while incarcerated). One of each persuasion was written by the same hearing officer. Only one case was appealed, a decision holding against the injured worker, and the superior court reversed. *Mallott v. Fluor Alaska, Inc*., Superior Court Case No. 3AN-78-5089 Civil (May 28, 1980).

Hinkle reasoned disabled injured workers are sometimes denied TTD by statute, as in cases where they receive unemployment benefits and do not repay them. Noting the legislature had provided numerous other situations when a disabled person is not entitled to TTD, *Hinkle* refused to exceed its authority, legislate a result where the Act was silent, and take an injured worker's property interest in TTD benefits without a statute or regulation as legal support.

Injured workers have an economic interest in their disability benefits. *Gilmore v. Alaska Workers' Compensation Board*, 882 P.2d 922 (Alaska 1994).

> **AS 23.30.187. Effect of unemployment benefits**. Compensation is not payable to an employee under AS 23.30.180 or AS 23.30.185 for a week in which the employee receives unemployment benefits.

In *Alyeska Pipeline Service Co. v. DeShong*, 77 P.2d 1227 (Alaska 2003), the Alaska Supreme Court, in addressing the board's interpretation of a statute, affirmed the board's order allowing and requiring an injured worker to repay unemployment benefits before she could receive TTD. AS 23.30.187 states an injured worker cannot receive TTD in any week in which she also received unemployment. Yet the board found this did not preclude the worker from paying the unemployment back so she could receive board-ordered TTD (*id*. at 1237).

> **AS 23.30.395. Definitions**. In this chapter
> . . .
>
> (16) "disability" means incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment;
> . . .
>
> (27) "medical stability" means the date after which further objectively measurable improvement from the effects of the compensable injury is not reasonably expected to result from additional medical care or treatment, notwithstanding the possible need for additional medical care or the possibility of improvement or deterioration resulting from the passage of time; medical stability shall be presumed in the absence of objectively measurable improvement for a period of 45 days; this presumption may be rebutted by clear and convincing evidence. . . .

An employer may rebut the continuing presumption of compensability and disability, and gain a "counter-presumption," by producing substantial evidence that the date of medical stability has

been reached. *Lowe's v. Anderson*, AWCAC Decision No. 130 (March 17, 2010), at 8. Once an employer produces substantial evidence to overcome the presumption in favor of TTD, the employee must prove all elements of the TTD claim by a preponderance of the evidence. However, if the employer raised the medical stability counter-presumption, "the claimant must first produce clear and convincing evidence" that he has not reached medical stability (*id*. at 9). One way an Employee rebuts the counter-presumption with clear and convincing evidence is by asking his treating physician to offer an opinion on "whether or not further objectively measurable improvement is expected." *Municipality of Anchorage v. Leigh*, 823 P.2d 1241, 1246 (Alaska 1992). The 45 day provision in AS 23.30.395(27) merely signals "when that proof is necessary" (*id*.).

In *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249 (Alaska 2007), the Alaska Supreme Court further explained this concept. Thoeni had a knee injury and her insurer discontinued TTD benefits based on its claim she was medically stable. The TTD period in dispute was from November 2, 2002 January 25, 2001. At hearing in September 2002, the board found she was medically stable based upon one physician who predicted no expected "major changes in the next 45 days" and on another who predicted the employee's knee was "capable of improvement with a diligent exercise program" (*id*. at 1255-56). By the time the board heard Thoeni's claim in 2002, it knew the first two physicians' predictions "proved incorrect," because the employee's knee got worse and did not improve with exercise. The board also knew a third physician had recommended additional knee surgery, which Thoeni had in April 2001 (*id*. at 1256). *Thoeni* held the first two physicians' predictions, which proved to be incorrect, "were not substantial evidence upon which the board could reasonably conclude that Thoeni had achieved medical stability." Accordingly, *Thoeni* reversed the board's medical stability determination (*id*.).

Egemo v. Egemo Construction Co., 998 P.2d 434 (Alaska 2000) held filing a claim prematurely "does not justify dismissal" of the claim, as the employer was not prejudiced or inconvenienced (*id*.). In summary, *Egemo* stated:

> In our view, when a claim for benefits is premature, it should be held in abeyance until it is timely, or it should be dismissed with notice that it may be refiled when it becomes timely (footnote omitted). In the present case, it would have been appropriate for the Board either to hold Egemo's claim in abeyance until the

surgery took place or to notify him that his claim was premature so that he would know to refile it after the surgery (*id*. at 441).

8 AAC 45.142. Interest. (a) If compensation is not paid when due, interest must be paid at the rate established . . . AS 09.30.070(a) for an injury that occurred on or after July 1, 2000. If more than one installment of compensation is past due, interest must be paid from the date each installment of compensation was due, until paid. If compensation for a past period is paid under an order issued by the board, interest on the compensation awarded must be paid from the due date of each unpaid installment of compensation.

(b) The employer shall pay the interest

(1) on late-paid time-loss compensation to the employee . . . .
. . .

(3) on late-paid medical benefits to

(A) the employee . . . if employee has paid the provider or the medical benefits;
(B) to an insurer, trust, organization, or government agency, if the insurer, trust, organization, or government agency has paid the provider of the medical benefits; or
(C) to the provider if the medical benefits have not been paid.

ANALYSIS

1) Is Employee's April 26, 2011 work injury the substantial cause of disability after August 22, 2011?

This issue raises factual disputes to which the statutory presumption of compensability applies. AS 23.30120; *Meek*. Employee raises the presumption with his testimony and with Dr. Davidhizar's medical opinions. *Tolbert*. Employer rebuts the raised presumption with Dr. O'Riordan's opinions. *Runstrom*. Therefore, Employee must prove his work was the substantial cause of his disability after August 22, 2011, by a preponderance of the evidence. *Saxton*.

Employee credibly testified he had no, lumbar spine symptoms before his April 26, 2011 work injury with Employer. His significant other credibly testified his functionality decreased post-injury like going "from 100 to 30 miles per hour." AS 23.30.122. His medical records support his assertion. On April 26, 2011, Employee suffered an injury, which conceivably could have

caused pain and symptoms in his back and lower extremities. Lifting an extremely heavy object, then extending one's arms to avoid dropping it on one's feet while letting the object go, is not a medically complex way to injure oneself. Medical opinions disagree about whether Employee simply suffered a short-lived strain/sprain in his lumbar spine, sacroiliitis, or a fractured facet joint. *Moore*. Dr. Davidhizar thought Employee suffered sacroiliitis and treated this condition for a lengthy time. EME Dr. O'Riordan opined Employee simply had a strain/sprain in the lumbar spine that resolved quickly. Thus, in his view a strain/sprain would not account for ongoing disability after August 22, 2011. SIME Dr. Pitzer mostly agreed with Dr. O'Riordan's opinions. Dr. Humphreys, on the other hand, reviewed early radiographic reports, performed additional radiographic imaging, reviewed Employee's entire clinical history, and concluded the April 26, 2011 work injury with Employer was not only the substantial cause in his need for medical treatment and disability, but was the substantial cause of the actual medical condition, a fractured facet joint, and the resulting disability from treating this condition. Furthermore, Dr. Humphreys opined Employee did not have a strain/sprain because his symptoms never abated.

The law only requires Employee to prove his April 26, 2011 work injury was "the substantial cause" of his disability to succeed on his TTD claim. Employee does not have to prove the work injury was the substantial cause of any underlying "condition." Physicians and Employer identified several possible causes of Employee's alleged inability to work, only one of which can legally be "the substantial cause" of his disability. AS 23.30.010(a); *Runstrom*. These include: 1) Employee's subjective pain, 2) opioid dependency, 3) a voluntary decision not to work, 4) sacroiliitis, 5) natural degeneration in his lumbar spine 6) garage sale activities, and 7) his April 26, 2011 work injury with Employer.

Dr. O'Riordan supported the following possible causes for Employee's continuing disability: 1) Employee's subjective pain, 2) opioid dependency, 3) a voluntary decision not to work, and 4) natural degeneration in his lumbar spine. Employee's subjective pain complaints were not questioned as being unreliable or insincere by his attending physician, his attending surgeon, or by several physician's assistants who treated him extensively since his work injury. His subjective pain complaints were explained by Dr. Humphreys' subsequent investigation. They have an objective basis in his facet joint. They have been relieved by Dr. Humphreys' medical

treatment. Subjective pain complaints are not the substantial cause of Employee's disability. *Rogers & Babler*.

Employee's opioid dependency, if he has it, began when Dr. Davidhizar prescribed narcotics to relieve Employee's pain from his work injury. Dr. O'Riordan admitted as much. Thus, only the April 26, 2011 work injury could be responsible for Employee's initial prescriptive medication. *Rogers & Babler*.

A voluntary decision not to work is unlikely the substantial cause of Employee's inability to work. No physician other than Dr. O'Riordan endorses this theory. Employee credibly testified he held garage sales and even sold his personal belongings to make ends meet and to avoid losing his personal residence to foreclosure. This theory is not supported by the evidence. AS 23.30.122; *Vetter*.

Natural spinal degeneration is also unlikely as the substantial cause for Employee's disability, as Dr. Humphreys convincingly opined the operated facet joint degeneration was not "age-appropriate," and was significantly different than the opposing facet joint at the same level. Dr. Humphreys' opinion on this point is credible, expresses sound, medical logic and is given significant weight. AS 23.30.122; *Moore*. By contrast, Dr. O'Riordan said the left and right facet joints were not that different and disputed Dr. Humphreys' view. But Dr. O'Riordan also stated in medicine, there is no significant, identifiable, quantitative difference between a "mild" and a "severely" degenerated facet joint. This opinion defies medical logic and experience. Dr. O'Riordan's opinion is not credible. AS 23.30.122. Therefore, Dr. O'Riordan's opinion one of these possible causes is "the substantial cause" of Employee's inability to work or his alleged "disability" since August 22, 2011, is given little weight. AS 23.30.122; *Moore*; *Rogers & Babler*; *Saxton*.

SIME Dr. Pitzer also endorsed the opioid dependency causal factor as the substantial cause for Employee's inability to continue working. As already discussed, if Employee has opioid dependency, his work injury with Employer caused it because the work injury is the only reason Employee began taking narcotics. AS 23.30.010(a). Furthermore, Dr. Pitzer's causation opinion

is tainted by his apparent belief Employee had two negative urinalysis tests while taking narcotics. The record discloses he is mistaken, as the physician's assistant clarified there was only one urinalysis administered at Employee's attending physician's office by the time Employee saw Dr. Pitzer. Dr. Pitzer appears fixated on this incorrect belief and was probably, understandably, suspicious of Employee's motives. However, as Dr. Pitzer's presumption proved incorrect, his causation opinion is given a lesser weight. AS 23.30.122; *Moore*. One negative urinalysis test is not dispositive, and does not support Dr. Pitzer's concerns, because experience shows false negatives and false positive urinalysis tests are not uncommon.

Furthermore, Dr. Pitzer's opinions are given less weight because he initially, in the same report, said Employee was medically stable on June 12, 2012, then revised his opinion to place medical stability on August 22, 2011, and said Employee had a five percent PPI rating then changed this to two percent. In a subsequent report, Dr. Pitzer opined August 22, 2011 was the correct medical stability date and two percent the correct PPI rating. Dr. Pitzer's uncertainty and equivocation undermines his credibility and reduces the weight accorded his opinions. Furthermore, Dr. Pitzer's causation opinion is confusing since he also provided a PPI rating. If, as Dr. O'Riordan and Dr. Pitzer suggested, Employee had only a resolved strain/sprain injury, why would Dr. Pitzer give him a work-related PPI rating? AS 23.30.122; *Moore*.

No physician seriously suggested Employee's disability was caused by his garage sale activities. Employee credibly testified any significant physical activity after his April 26, 2011 work injury caused back pain. Harris supported this testimony. Both are credible. AS 23.30.122. It is not surprising lifting items at a garage sale would also contribute to his symptoms. There is no lay or medical evidence supporting the idea Employee damaged his facet joint while lifting items during garage sales. Employee was already disabled by the time he held garage sales to generate income to avoid losing his home. While Employee once told his doctor garage sales made his condition worse, there is no medical opinion suggesting garage sales made the underlying "condition" worse. What Employee was really saying is lifting items at garage sales, like any other physical activity he performed after his work injury, made his symptoms worse. Therefore, garage sale activities cannot be the substantial cause of Employee's continuing disability. AS 23.30.010(a); *Rogers & Babler*.

Employee's sacroiliitis and his April 26, 2011 work injury with Employer are the remaining, possible causative factors in Employee's inability to work from August 22, 2011, and continuing. The medical evidence taken as a whole, and in retrospect, demonstrates Employee probably did not have sacroiliitis; if he did, it did not cause his disability. AS 23.30.122; *Moore*. However, absent Dr. Humphreys' subsequent discovery of the real culprit in the facet joint, it is understandable how Dr. Davidhizar could misdiagnose this medical condition. Sacroiliitis is why Dr. Davidhizar originally removed Employee from work. Though Employee had a light duty work release, Employer provided Employee no light duty work to perform. The fact the sacroiliitis was misdiagnosed does not mean the correct medical condition Dr. Humphreys diagnosed did not disable Employee during the relevant time.

In short, the weight of the medical evidence and lay testimony shows: 1) Employee's subjective pain, 2) opioid dependency, 3) voluntary decision not to work, 4) sacroiliitis and 5) natural degeneration in his lumbar spine and 6) garage sale activities are not substantial factors in Employee's inability to work beginning August 22, 2011, and thereafter and are not the substantial cause in his disability. *Rogers & Babler*. As Dr. Humphreys' opinions on the causation issue are given the greatest weight and are most credible, Employee's work injury with Employer is the substantial cause of Employee's inability to work, and thus his disability beginning August 22, 2011 and continuing, which is the period at issue in this decision. AS 23.30.122; *Saxton.*

2) Is Employee entitled to TTD?

There are four elements to a successful TTD claim: (1) Employee is disabled as defined by the Act; (2) his disability is total; (3) his disability is temporary; and (4) he has not reached the date of medical stability as defined in the Act. *Anderson* at 13-14. The TTD issue here focuses on Employee's TTD entitlement from August 22, 2011, and continuing. This issue raises factual disputes to which the statutory presumption of compensability applies. AS 23.30.120; *Meek*. Employee raises the statutory presumption with his own testimony and with opinions from Drs. Davidhizar and Humphreys. *Tolbert*. Employer rebuts the presumption with Dr. O'Riordan's EME opinions. *Runstrom*. Employee must prove his TTD claim from August 22, 2011 forward by a preponderance of the evidence. *Saxton*. However, because Dr. O'Riordan rebutted the

presumption of continuing TTD by raising the counter-presumption of medical stability, Employee must first rebut the counter-presumption of medical stability with "clear and convincing evidence" that he was not medically stable. If successful, Employee must then prove his TTD claim by a preponderance of the evidence. *Anderson*; *Leigh*.

A) Rebutting the counter-presumption.

Rebutting the counter-presumption is simple. *Leigh*; *Anderson.* Dr. Humphreys stated when he decided to perform lumbar surgery he reasonably expected there would be improvement in Employee's condition as a result of the surgery. This medical opinion is adequate to rebut the counter-presumption of medical stability and is clear and convincing evidence that objectively measurable improvement from the effects of Employee's compensable injury was reasonably expected to result from additional medical care and treatment. *Leigh*.

B) Proving TTD by a preponderance of the evidence.

Moving to the next step, Employee must now prove his TTD claim by a preponderance of the evidence.

i) Is Employee disabled?

Disability is defined as "incapacity because of injury to earn the wages" which Employee was receiving at the time of injury in the same or any other employment. AS 23.30.395(16). Employee credibly testified he was not able to work at full capacity after his injury. Harris confirmed this. AS 23.30.122. Employer offered Employee no lighter duty work at any time following his injury. Drs. Davidhizar and Humphreys both opined Employee was disabled. Dr. Davidhizar disapproved various job descriptions for work Employee had done in the past. Only Dr. O'Riordan opined Employee could do some of his previous work and could return to his job at the time of injury. Drs. Davidhizar and Humphreys are given greater weight as they were more familiar with employee's situation having treated him for a lengthy time. AS 23.30.122. Furthermore, as discussed above, Dr. O'Riordan's opinions are given less weight because they defy the panel's experience in other cases. Employer has not demonstrated there was work available within Employee's physical limitations since August 22, 2011, and he prevails on this prong of his TTD claim by a preponderance of the evidence. *Saxton*.

ii) Is his disability total?

Other than an occasional garage sale, there is no evidence Employee was gainfully employed. He said he was not and Employer offered no contrary evidence. AS 23.30.122. Employer cited no legal authority for the concept that occasional garage sales are considered "employment." In this instance, Employee held garage sales and sold many personal belongings to make ends meet so he would not lose his home to foreclosure. Absent evidence Employee was employed, he has proven his disability was total. *Saxton*.

iii) Is his disability temporary?

Employee was improving following surgery. Dr. Humphreys opined he expected objectively measurable improvement following surgery. Currently, there is no evidence suggesting Employee's disability will be anything other than temporary. Therefore, Employee has met his burden of proving his disability is temporary. *Saxton*.

iv) When was he medically stable?

Anderson does not specifically state what happens when an employer raises the counter-presumption and the employee rebuts it with clear and convincing evidence showing he was not medically stable. Presumably, as is the case with other presumptions, the counter-presumption Employer enjoys drops out and Employee must prove this element of his TTD claim by a preponderance of the evidence. As he has already demonstrated by clear and convincing evidence, which is a higher standard than a preponderance of the evidence, that he was not medically stable, this prong seems a given. Nevertheless, this case is similar to *Thoeni*. In *Thoeni*, two physicians made "predictions" upon which the injured worker's TTD claim was denied based upon a medical stability finding. A third physician's opinion stating the injured worker needed additional surgery combined with evidence the first two physicians' opinions proved to be incorrect, resulted in the Alaska Supreme Court holding reliance upon the first two physicians' opinions was not substantial evidence upon which to base a medical stability finding.

The only distinction between *Thoeni* and Employee's case is that Drs. O'Riordan and Pitzer gave opinions, rather than "predictions," stating Employee was medically stable as defined in the Act. As in *Thoeni*, these physicians' opinions turned out to be incorrect as Employee's physicians

were treating the wrong condition, sacroiliitis, and he was not medically stable. Once Dr. Humphreys correctly diagnosed the facet problem, and recommended surgery, Dr. Humphreys had an expectation that objectively measurable improvement from the effects of the compensable injury was reasonably expected to result from surgery. AS 23.30.395(27); *Thoeni*. Therefore, Employee has proven this prong of the TTD test by a preponderance of the evidence. *Saxton.*

Thoeni held the injured worker was not medically stable during the entire period in question. Likewise, as this decision gives great weight and credibility to Dr. Humphreys' opinions, his opinions demonstrated Drs. O'Riordan's and Pitzer's medical stability opinions were also incorrect -- albeit for a slightly different reason, their reliance upon incorrect diagnoses. AS 23.30.122; *Moore*. Consequently, in this case as in *Thoeni* by the time Employee's hearing took place, the correct diagnosis had been made, surgery had been recommended and surgery had been obtained. Employee's symptoms were improving, further demonstrating Dr. Humphreys was correct. Therefore, as was the case with the first two physicians in *Thoeni*, Drs. O'Riordan and Pitzer's medical stability opinions are not substantial evidence upon which to find Employee was medically stable since August 22, 2011. Accordingly, he was not medically stable and, given he satisfied all four prongs of the TTD test by a preponderance of the evidence, Employee is entitled to TTD from August 22, 2011 and continuing until such time as he becomes medically stable following recovery from his surgery, or returns to work. Since Employer already paid Employee TTD benefits through October 5, 2011, it need not pay these benefits again, but these TTD payments are not considered an overpayment. However, Employee's claim for TTD benefits from October 6, 2011 and continuing will be granted and TTD payments will continue until such time as Employee is medically stable or returns to work. AS 23.30.185.

Employee cannot receive TTD benefits in any week in which he also received unemployment benefits, unless he pays them back. AS 23.30.187; *DeShong*. The record is not clear as to the week in which Employee received under $200 in unemployment benefits. If the parties can determine the precise week in which these benefits were paid, and if the benefits fall within the period for which TTD benefits are awarded in this decision, Employee will be entitled to TTD benefits for the appropriate week only after he demonstrates he has repaid the unemployment division for these previously received unemployment benefits. AS 23.30.187; *DeShong.*

Employer contended Employee cannot receive TTD benefits while he was incarcerated. As was the case in *Hinkle*, and cases cited therein, this decision will not exceed its authority by interjecting the fact-finders' own beliefs concerning whether or not an otherwise disabled injured worker should or should not receive TTD benefits while incarcerated. *Ranney*; *Burke*; *London; Cortay; Ensley*. Had the legislature wanted to deprive an injured worker of his property interest in TTD benefits while incarcerated, it could have done so, just as it did with unemployment, periods when an employee failed or refuses to cooperate in discovery, and in other instances. *Gilmore*. As the law is silent on this issue, it is inappropriate for this decision to "interpret" the Act and add additional circumstances to the Act in which Employee cannot receive TTD benefits. *London*. This lies within the legislature's purview. *Johns*. Employee's TTD request is granted as stated above.

3) Is Employee's PPI claim ripe for adjudication?

Employee has recently undergone significant, lumbar surgery. As discussed above and below, not only was the April 26, 2011 work injury the substantial cause of the need for treatment and disability, this decision found it was the substantial cause of the underlying condition requiring surgical intervention. As such, it will be the substantial cause of any eventual PPI rating. As Dr. Humphrey convincingly said, and as Employee conceded, it will take months for Employee to recover from his surgery, and an additional PPI rating will be required thereafter. Therefore, it is premature to award PPI as there is no current, valid rating which takes into account Employee's surgery and possible recovery. Therefore, Employee's PPI claim is not yet ripe for adjudication and will be held in abeyance until such time as it is. *Egemo*.

4) Is Employee entitled to additional medical benefits for his work injury?

Though Employer contends it is not liable for any medical care after Dr. O'Riordan's EME report, there does not appear to be a serious dispute over any outstanding medical bills, out-of-pocket medical costs Employee paid, and any health insurance liens for work-related medical care. The issue is over Employer's liability to pay or reimburse these medical amounts. This issue raises factual disputes to which the statutory presumption of compensability applies. AS 23.30.120; *Meek*. Employee raises the presumption with his testimony and Drs. Davidhizar's and Humphreys' opinions. *Tolbert*. Employer rebuts it with Dr. O'Riordan's opinions.

Runstrom. For the reasons set forth above, incorporated herein for brevity, Employee's April 26, 2011 work injury with Employer is the substantial cause of his ongoing need for medical care. His request for medical benefits will be granted. *Moore*; *Saxton*.

However, as also discussed above, by June 26, 2012, it was apparent Dr. Davidhizar's treatments were not effective. Even Dr. Davidhizar's physician's assistant stated he thought Employee had reached maximum medical improvement by June 26, 2012. Though Employee cannot be faulted for following his doctor's advice, at some point the onus fell on Employee to try something different when ongoing treatment proved ineffective, and Dr. Davidhizar should have ceased his ineffective treatments. Therefore, the medical evidence as a whole demonstrates the care and treatment Employee received for his work injury from April 26, 2011, through June 26, 2012, was reasonable and necessary. AS 23.30.095(a). However, treatment Employee received from Dr. Davidhizar thereafter was not reasonable or necessary as the records demonstrate Employee's symptoms essentially remained unchanged as a result of his care. Dr. Davidhizar's referrals to other physicians, however, were reasonable and necessary as these at least gave Employee an opportunity for a proper diagnosis. *Moore*. Employee's request for an order requiring Employer to pay for these referrals will be granted. To the extent Employee seeks payment or insurance reimbursement for Dr. Davidhizar's medical treatments from April 26, 2011 through June 26, 2012, his request will be granted. To the extent he seeks payment or insurance reimbursement from Employer for Dr. Davidhizar's treatments after June 26, 2012, his request will be denied. The only exception to this is pre-surgical prescription painkillers, which were necessary to address Employee's ongoing symptoms while his physicians labored under a misdiagnosis, and post-surgical prescriptions for work-related medications or physical therapy Dr. Davidhizar's clinic may have prescribed on referral from Dr. Humphreys.

By contrast, it was reasonable and necessary for Employee to see Dr. Humphreys' clinic for further evaluation and treatment. *Moore*. Dr. Humphreys accurately diagnosed the injury and provided the proper treatment. Therefore, Employee's request for an order requiring Employer to pay for Dr. Humphreys' medical care and treatment including the lumbar surgery will be granted, with exception of any epidural injections Dr. Humphreys' office performed after June

26, 2012. Any such injections were not reasonable and necessary for the same reasons discussed above, which are incorporated herein for brevity.

5) Is Employee's reemployment benefits eligibility status ripe for decision?

As of the April 1, 2014 hearing, the rehabilitation benefits administrator had not made a decision on Employee's request for an eligibility evaluation. Therefore, as the RBA has the right to determine whether or not Employee is eligible for vocational reemployment benefits, and no decision has yet been made, there is nothing for this decision to review. Employee's rehabilitation benefits eligibility status is not ripe for decision and will be denied without prejudice. *Egemo*.

6) Are Employee and his medical providers entitled to interest?

Interest on unpaid benefits is statutory and mandatory. AS 23.30.155(p); 8 AAC 45.142. Therefore, Employee is entitled to pre-judgment interest on TTD benefits awarded in this decision. He is also entitled to pre-judgment interest on any out-of-pocket medical expenses awarded as a result of this decision. His medical providers and his healthcare insurer are entitled to statutory interest on their paid or reimbursed medical bills, as ordered in this decision, if the proper documentation was filed in accordance with the Act and the regulations. As noted above, these amounts do not appear to be disputed. Jurisdiction over this issue will be reserved to resolve any continuing disputes.

7) Is Employee entitled to attorney's fees and costs?

Employer controverted Employee's claim for benefits. Therefore, fees will be awarded under AS 23.30145(a). Employee's request for actual attorney's fees may be granted under either AS 23.30.145(a) or (b). Given *Porteleki*, it is unclear what difference it makes under which section attorney's fees are awarded, as actual attorney's fees are awardable under either subsection. Employer did not object to Employee's hourly attorney's fee rate, total hours expended, or his litigation costs. Employee sought an order holding there was no TTD overpayment from August 22, 2011, through October 5, 2011. He succeeded on this request. Employee also sought an additional TTD award from October 6, 2011 and continuing until medical stability. He also prevailed on this claim. Employee also succeeded on his medical

benefit claim with exception of Dr. Davidhizar's bills to a limited extent. This results in a significant benefit to Employee whose medical care for his lumbar spine for the most part must now be paid by Employer. He benefits directly by being reimbursed for his out-of-pocket expenses, and his health insurer benefits by being reimbursed, as Employee requested. Employee's PPI claim and his request for an order determining his reemployment eligibility status were both not ripe. Employee spent *de minimis* time on these issues. Lastly, Employee prevailed on his request for interest.

Employer did not argue for a reduction in Employee's attorney fees or costs. Consequently, given the above findings, there is no reason to reduce Employee's attorney fees or costs. He documented $53,962.50 in actual, reasonable attorney's fees including his two attorney's fee affidavits and the time spent preparing for and attending the hearing, and $3,217.05 in litigation costs. Therefore, Employee will be awarded $53,962.50 in attorney's fees and $3,217.05 in costs for successfully prosecuting the main issues in his claim.

CONCLUSIONS OF LAW

1) Employee's April 26, 2011 work injury is the substantial cause of disability after August 22, 2011.
2) Employee is entitled to TTD.
3) Employee's PPI claim is not ripe for adjudication.
4) Employee is entitled to additional medical benefits for his work injury.
5) Employee's reemployment benefits eligibility status is not ripe for decision.
6) Employee and his medical providers are entitled to interest.
7) Employee is entitled to attorney's fees and costs.

ORDER

1) Employer's TTD payments from August 22, 2011 through October 5, 2011 are not an overpayment.
2) Employer is ordered to pay Employee TTD from October 6, 2011, and continuing, until Employee is medically stable under the Act, or returns to employment.

3) If Employee received unemployment benefits during any period for which this decision awards TTD benefits, Employee is entitled to TTD benefits for the week in which he received unemployment benefits only if he demonstrates he has reimbursed the Unemployment Insurance Division for the benefits received.

4) Employee's TTD benefits will not be reduced or abated for any period in which he was incarcerated.

5) Employee's PPI claim is held in abeyance until he is rated following medical stability and there arises a continuing PPI rating dispute.

6) Employer is ordered to reimburse Employee's out-of-pocket work-related related medical expenses, pay any remaining, outstanding work-related medical bills and reimburse Employee's health insurer to satisfy its lien for work-related medical expenses in accordance with the Act and administrative regulations. Jurisdiction is reserved to resolve any disputes on this issue.

7) Employee's request for an order determining his reemployment benefits eligibility status is denied without prejudice.

8) Employer is ordered to pay Employee interest on TTD benefits awarded in this decision and pay him and his medical providers and healthcare insurer statutory interest on work-related medical expenses and reimbursements as ordered in this decision.

9) Employer is ordered to pay Employee attorney $53,962.50 in attorney's fees and $3,217.05 in costs.

Dated in Anchorage, Alaska, on June 6, 2014.

ALASKA WORKERS' COMPENSATION BOARD

_____
William Soule, Designated Chair

_____
Rick Traini, Member

DISSENT BY MEMBER HUTCHINGS

The industry member respectfully dissents from the majority's decision. The dissent finds Employee not credible. AS 23.30.122. Because he is not credible, the dissent discounts opinions from all doctors who relied upon Employee's statements. *Saxton*. For example, the medical records show Employee tried to steal artwork from the atrium in his attending physician's clinic. Similarly, Employee, in respect to a criminal conviction, claimed he did not know what he was accused of stealing, which crime led to a plea bargain, jail time and community service. It is inconceivable, in the dissent's view, Employee would not know the crime with which he was charged, and for which he pled guilty. AS 23.30.122.

The dissent further questions Employee's narcotics use and abuse and the comment he uses "medical marijuana" as well. On one occasion, Employee had his medications filled and they should have appeared in his drug screen just seven days later. Yet, his drug test was negative for all prescribed medications. The dissent infers from this finding that Employee was diverting his narcotics to uses other than those for which the narcotics were prescribed. Furthermore, he denied, or did not recall, being referred to Providence Breakthrough to address his drug addiction, which further diminishes his credibility. By contrast, Employee was able to remember the precise time the April 26, 2011 injury occurred and could recall it was a 200 to 300 pound rock he was moving when injured. This demonstrates Employee's selective memory and further diminishes his credibility. The dissent questions whether two individuals could even lift a rock weighing 300 pounds, especially given the shape of most landscaping rocks. His story simply does not make sense. AS 23.30.122.

Furthermore, the dissent questions how several radiologists could miss or misdiagnose the facet condition Dr. Humphreys discovered in September 2013. This is unlikely. Though the dissent agrees Employee needed the lumbar surgery to address what ailed him, the April 26, 2011 work injury was not "the substantial cause" of the need for that treatment or any resultant disability.

The dissent finds Employee injured himself while self-employed at his "garage sales," which included moving stoves, refrigerators, furniture and other items he picked up in Anchorage and around the Kenai Peninsula to sell at his home. Employee made this his business but did not have a business license or pay sales tax to the Kenai Peninsula Borough according to his testimony. Employee injuring his lumbar spine performing garage sale activities explains why earlier radiologists and physicians did not see an issue with Employee's facet joint, but Dr. Humphreys noticed it after Employee had been involved in numerous garage sales and admittedly lifted heavy objects while so doing. The facet defect did not exist earlier. *Saxton*. Furthermore, Employee admitted he hired workers through Job Service to perform garage sale work and conceded he provided no Workers' Compensation insurance for these employees as required by law.

Given all this evidence, and the dissent's serious reservations as to Employee's credibility, the dissent accepts EME Dr. O'Riordan's well-reasoned opinions and finds Employee was medically stable and needed no further work-related medical care for his April 26, 2011 injury after August 22, 2011. Accordingly, the dissent would deny Employee's claims and would award him and his attorney nothing. His claims should be denied.

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Linda Hutchings, Member

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

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

APPEAL PROCEDURES

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

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

RECONSIDERATION

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

MODIFICATION

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

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of THOMAS J. FRUICHANTIE, employee / claimant v. BRIAN BUTLER, employer; AMERICAN INTERSTATE INSURANCE CO, insurer / defendants; Case No. 201106485; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on June 6, 2014.

_____

Kimberly Weaver, Office Assistant