ALASKA WORKERS' COMPENSATION BOARD

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

DANIEL T. VAIDHYAN, Employee, Claimant, v. FIRST STUDENT, INC., Employer, and NEW HAMPSHIRE INSURANCE COMPANY, Insurer, Defendants.	)	FINAL DECISION AND ORDER AWCB Case No. 201007080 AWCB Decision No. 14-0118 Filed with AWCB Juneau, Alaska on August 26, 2014

Daniel Vaidhyan's (Employee) December 20, 2012 and July 25, 2013 claims for additional temporary total disability (TTD) benefits and attorney fees and costs were heard on July 15, 2014 in Juneau, Alaska, a date selected on January 30, 2014. Attorney John Franich appeared and represented Employee. Attorney Krista Schwarting appeared and represented First Student, Inc. and its insurer (Employer). There were no witnesses. Employer objected to Employee's filed hearing brief. The panel issued an oral order accepting Employee's brief. The record was left open until July 25, 2014, to receive Employee's supplemental affidavit of attorney's fees and costs and Employer's objection to the supplemental affidavit. The record closed on August 26, 2014, after further deliberation. This decision examines the oral order accepting Employee's filed hearing brief, and addresses Employee's claim on its merits.

ISSUES

As a preliminary matter, Employer objected to Employee's hearing brief, contending it was filed late.

Employee contended his brief should be accepted as filed.

1) **Was the oral order accepting Employee's hearing brief correct?**

Employee contends he has been unable because of his injury to earn the wages he was receiving at the time of injury in the same or any other employment. Employee contends his condition worsened despite treatment and he could not have reached medical stability while his condition was worsening. He seeks an order awarding additional TTD benefits.

Employer contends Employee's treating physicians at the Rehabilitation Institute of Washington's pain management program (RIW) opined Employee became medically stable in February 2012 and released Employee to return to work with restrictions. Employer also contends Employee's condition has not improved with treatment, and under AS 23.30.395(27), Employee is presumed to have reached medical stability when he failed to improve for a 45 day period.

2) **Is Employee entitled to additional TTD benefits?**

Employee contends his attorney provided valuable legal services in a complex case. Employee contends he is entitled to actual attorney's fees under AS 23.30.145(b).

Employer contends Employee is not entitled to any benefit, and is thus not entitled to attorney's fees. Employer also objected to Employee's attorneys' hourly rate, fees billed for duplicative services, and paralegal rate.

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

FINDINGS OF FACT

The record establishes the following relevant facts and factual conclusions by a preponderance of the evidence:

1) On May 10, 2010, Employee was injured while working for Employer when the school bus he was riding on came to a sudden stop, causing Employee to fall to the floor. (Report of Occupational Injury or Illness, June 3, 2010; Claim, December 20, 2012; Claim, July 25, 2013).

2) On May 20, 2010, a left knee magnetic resonance imaging (MRI) scan showed a tear of the posterior horn of the medial meniscus as well as arthrosis with mild cartilage loss in the medial femoral condyle and moderate cartilage loss in the superior medial aspect of the patella. (Radiologist Report, Russell Fritz, M.D., May 20, 2010).

3) On June 21, 2010, orthopedic surgeon Daniel Harrah, M.D., at Juneau Bone & Joint Center, performed a left knee arthroscopy with partial medial meniscectomy to repair Employee's tear. (Operative Report, Dr. Harrah, June 21, 2010).

4) On July 15, 2010, Dr. Harrah treated Employee for pain and swelling in both knees. (Chart Note, Dr. Harrah, July 15, 2010).

5) On September 21, 2010, Dr. Harrah treated Employee for continued left leg edema and opined, "I am not sure why he is having edema in the L leg." (Chart Note, Dr. Harrah, September 21, 2010).

6) On November 18, 2010, Employee's family practitioner Eric Olsen, M.D., treated Employee for left leg symptoms and opined, "I fear the patient may be headed for a reflex dystrophy problem. I suggested to Dr. Harrah that Dr. Bursell be involved." (Chart Note, Dr. Olsen, November 18, 2010).

7) On January 3, 2011, orthopedic surgeon Matthew Provencher, M.D., examined Employee for an employer's medical evaluation (EME). Dr. Provencher diagnosed: (1) left knee posterior horn medial meniscus tear, work-related, (2) postoperative pain syndrome, work-related, 3) long history of diabetes, non-work related, and 4) right olecranon fracture, resolved. He opined Employee's conditions were not yet medically stable and recommended Employee be evaluated by an anesthesia pain physician and neurologist for further diagnosis and treatment, including possible complex regional pain syndrome. Dr. Provencher further opined Employee was unable to return to his regular work. (EME Report, Dr. Provencher, January 3, 2011).

8) On February 7, 2011, physiatrist John Bursell, M.D., at Juneau Bone & Joint Center, treated Employee for left leg swelling and diagnosed lower limb reflex sympathetic dystrophy (RSD). Dr. Bursell recommended physical therapy for strengthening and pain relief, a custom compressive stocking, pool exercise, and a sympathetic nerve block. (Chart Note, Dr. Bursell, February 7, 2011).

9) On February 8, 2011, Dr. Harrah saw Employee for left leg follow up, and diagnosed left leg complex regional pain syndrome (CRPS). Dr. Harrah stated, "His knee is actually doing fairly well from the perspective of the meniscectomy and his arthritis. It started out with swelling, but now has developed into full blow obvious complex regional pain syndrome with the typical features of this disorder." (Chart Note, Dr. Harrah, February 8, 2011).

10) On February 15, 2011, Dr. Bursell saw Employee for left leg CRPS and referred Employee for a sympathetic nerve block. (Chart Note, Dr. Bursell, February 15, 2011).

11) On March 14, 2011, Dr. Bursell stated, "He was to have lumbar sympathetic block done last week, but decided not to have this done. He notes that he had a fever the night before, and was concerned about having the injection done so it was canceled." Employee reported his left foot swelling had decreased but his foot and leg pain and sensitivity had still increased. Dr. Bursell again referred Employee for a lumbar sympathetic block. (Chart Note, Dr. Bursell, March 14, 2011).

12) On April 1, 2011, Marco Wen, M.D., performed a left lumbar sympathetic nerve block. (Chart Note, Dr. Wen, April 1, 2011).

13) On April 11, 2011, Dr. Bursell saw Employee in follow up to his left sympathetic nerve block. Employee reported he had at least two days of pain relief following the procedure but the day after the procedure, Employee started vomiting and had chest pain. Dr. Bursell recommended a second, left sympathetic nerve block and continued physical therapy. (Chart Note, Dr. Bursell, April 11, 2011; Deposition of Daniel Vaidhyan, April 9, 2013).

14) On May 10, 2011, Dr. Harrah saw Employee who reported he was not able to wear any type of support stocking and attempts at the swimming pool or bathtub had not proved successful. Dr. Harrah opined, "At this point in time, I really do not have anything to offer him. . . . His complex regional pain syndrome is the underlying problem currently. . . . It is impossible to tell how much this will improve over time. From my observation, his symptoms appear to be stable

under the Alaska state law definition of medical stability." (Chart Note, Dr. Harrah, May 10, 2011).

15) On May 10, 2011, Dr. Bursell recommended a second, left sympathetic nerve block, which Employee declined. Dr. Bursell stated, "At this point I think that the appropriate next step would be a referral to a chronic pain management program such as the Rehabilitation Institute of Washington." (Telephone Note, Dr. Bursell, May 10, 2011).

16) On May 27, 2011, neurologist and psychiatrist Alan Goldman, M.D., and physical medicine and rehabilitation specialist Maria Armstrong, M.D., examined Employee for an EME. Drs. Goldman and Armstrong diagnosed: 1) status post industrially related injury with left knee "medical (sic) meniscal tear" and arthroscopic surgical repair, 2) complex regional pain syndrome of the left lower extremity, in association with diagnosis #1, 3) status post right avulsion fracture of the right olecranon in association with diagnosis #1, healed and resolved, 4) status post right knee contusion in association with diagnosis #1, resolved, and 5) diabetes mellitus, hypertension, and hyperlipidemia, deferred to primary treating physician. They opined Employee's work-related CRPS is incapacitating him and stated:

> It is the Panel's strong opinion that Mr. Vaidhyan is in need of further and more aggressive treatment for his Chronic Regional Pain Syndrome and such treatment should be done at a university center that is well experienced in this very difficult disorder. . . . If Mr. Vaidhyan's pain cycle can be broken, then further active physical rehabilitation can more easily be undertaken. . . . It is our further comment that treatment for Chronic Regional Pain Syndrome and the resolution of discomfort, thereafter, may take months to years and, as above, should be undertaken in a multi-disciplinary program with, as stated, physicians well experienced in this most difficult disorder.

Drs. Goldman and Armstrong also documented on physical examination multiple physical abnormalities and stated they had never seen CRPS presented as dramatically as Employee's. They opined Employee was unable to perform any work activities and, "has not reached a point of medical stability" and "may not reach such a point until six to 12 months after he has been evaluated and treated by an appropriate University center with experience in Chronic Regional Pain Syndrome / Reflex Sympathetic Dystrophy." (EME Report, Drs. Goldman and Armstrong, May 27, 2011).

17) On June 3, 2011, Employee's physical therapy concluded. Physical therapist Lucrecia Mervine reported no consistent or significant progress was made after several treatment sessions.

Employee was able to obtain one to three hours of mild to moderate pain relief after independent treatment with a TENS unit at home, and a TENS unit was approved and dispensed for home use. (Physical Therapy Chart Note, PT Mervine, June 3, 2011).

18) On August 9, 2011, Dr. Bursell reviewed Drs. Goldman and Armstrong EME report, agreed with their impressions and recommendations, and initiated referral to a CRPS specialist in Seattle, Washington. (Chart Note, Dr. Bursell, August 9, 2011).

19) On September 6, 2011, Dr. Bursell referred Employee to the Rehabilitation Institute of Washington (RIW) for further evaluation and treatment of Employee's left lower extremity CRPS and associated pain symptoms. (Chart Note, Dr. Bursell, September 6, 2011).

20) On October 27, 2011, Dr. Bursell stated, "He has been evaluated at RIW, and further treatment in their program was offered along with the option of an epidural catheter placement. He is concerned about that as he had problems with prior sympathetic block. I recommended that he pursue the treatment recommended through RIW including the catheter placement if they think that is (sic) would likely be beneficial and would not be too much of a risk." (Chart Note, Dr. Bursell, October 27, 2011).

21) On November 29, 2011, Dr. Bursell reported, "I have spoken with RIW, and am in agreement with their plan. Mr. Vaidhyan doesn't wish to have the epidural catheter placed." (Chart Note, Dr. Bursell, November 29, 2011).

22) On January 3, 2012, Employee began his structured pain program at RIW, with the goal to get more physically fit and reduce his lower extremity swelling. (Progress Note, RIW Pain Management Program, January 3, 2012).

23) On January 13, 2012, RIW stated Employee was participating fully in his occupational and physical therapy, with fair to good effort level. Employee's anticipated discharge date was January 31, 2012. (Treatment Plan Rounds Note, RIW Pain Management Program, January 13, 2012).

24) On January 16, 2012, Lee Robertson, D.O., with RIW, treated Employee for continued left lower extremity swelling. Employee reported "burning pain." (Chart Note, Dr. Robertson, January 16, 2012).

25) On January 24, 2012, Dr. Robertson treated Employee for continued left lower extremity swelling and increased pain. Employee reported he was unable to participate in that day's therapies secondary to increased pain. Dr. Robertson stated, "I told him we have nothing more

to offer him at this point and he agreed that it was reasonable that he be discharged from the program today." (Chart Note, Dr. Robertson, January 24, 2012).

26) On January 25, 2012, Jacob Heller, M.D., at Virginia Mason Emergency Department, treated Employee for left leg pain, diagnosed left lower extremity cellulitis and left lower extremity CRPS, prescribed Clindamycin, and referred him to Virginia Mason's vascular surgery clinic for further evaluation. (Emergency Department Note, Dr. Heller, January 25, 2012).

27) On January 26, 2012, Edmond Raker, M.D., at Virginia Mason, evaluated Employee for left leg difficulties, diagnosed reflex sympathetic dystrophy with chronic pain, hyperesthesias and edema, and recommended Employee revisit his pain management clinic and consider a sympathetic block. He also recommended use of a lymphedema compression pump. (Chart Note, Dr. Raker, January 26, 2012).

28) On February 2, 2012, RIW opined Employee had achieved maximum medical improvement following early discharge from the program, released Employee to light duty work as of February 6, 2012, and assessed 14 percent permanent partial impairment. RIW opined Employee participated fully in the program, put forth good effort and made gains functionally. Specifically, Employee progressed to normal gait, full range of motion, good stability, and good strength and cardiovascular fitness. His carrying capacity improved from zero to 20 pounds at discharge, and kneeling on the floor was four inches at discharge. RIW opined Employee ended up meeting a "light" functional level and moved very well without a cane. However, Employee's swelling remained generally constant throughout treatment. RIW stated its physicians, "met with the patient on the 24th of January and after a long discussion and per the patient's request, he was discharged from the program. He states he wanted to pursue other treatment options rather than what we had to offer here at RIW including possible ketamine infusion." RIW also stated, "The patient has achieved maximum medical improvement at this time. He is released from this program at a light level and from our perspective may return to work within his current physical capacities." Regarding Employee's cooperation in the program, RIW stated Employee participated but, "never believed that a rehabilitation approach would benefit him. From the first day of treatment he was convinced that exercise would only aggravate his leg swelling and pain. He was not interested in continuing in the remainder of the program despite our encouragement. He was also not interested in regional anesthesia interventions that might have made treatment

easier for him. Whether he would have seen improvements in his symptoms with continued participation is unknown." (RIW Discharge Summary, February 2, 2012).

29) On February 10, 2012, the first appointment following Employee's discharge from RIW, Dr. Bursell saw Employee for CRPS follow up and stated Employee, "was discharged early from RIW as he was unable to tolerate the program. It looks like he didn't buy into the idea that increasing activity would improve his situation. He reports that the more time he spent up the more his left leg swelled. It reached a point where he went in to the ER for evaluation." Dr. Bursell recommended again trying a compression stocking for the swelling and referred Employee to physical therapy for another compressive stocking fitting. Dr. Bursell also recommended Employee perform ankle pumps multiple times per day, use hydrostatic pressure for the swelling by filling up his bathtub and keeping his left leg on the bottom of the bathtub for 30 minutes per day, and follow up with Dr. Olsen regarding possible cellulitis. (Chart Note, Dr. Bursell, February 10, 2012).

30) On March 2, 2012, physical therapist Denice Blefgen McPherson treated Employee and assessed left leg swelling but no lymphedema, stating, "the patient seems to think the swelling is worse, although measurements do not support this." McPherson discussed treatment options with Employee including sequential pump (i.e. Flexitouch) in conjunction with a custom compression stocking, with the treatment goal of reducing Employee's pain and swelling. (PT Evaluation, McPherson, March 2, 2012).

31) On March 5, 2012, Dr. Olsen saw Employee, diagnosed CRPS with cellulitis secondary to chronic swelling, diabetes, hypertension, hyperlipidemia, and asthma, and recommended Nortriptyline. Dr. Olsen described Employee's CRPS as a, "[v]ery resistant case," and stated with regard to Employee's CRPS and leg issues, "I have little to offer" and "I have nothing else to offer." (Chart Note, Dr. Olsen, March 5, 2012).

32) On March 14, 2012, Dr. Bursell saw Employee who reported hypersensitive skin and continued left lower extremity pain and swelling, but with less swelling in his foot and ankle and more in the calf. Employee had been prescribed Nortriptyline 10 mg by Dr. Olsen but Employee reported no improvement. Dr. Bursell prescribed use of a sequential pump in conjunction with a custom compression stocking for Employee's left lower extremity edema. Dr. Bursell also increased Employee's Nortriptyline prescription to 20 mg per day and recommended continued water therapy for external compression. (Chart Note, Dr. Bursell, March 14, 2012).

33) On April 11, 2012, Dr. Bursell saw Employee who reported continued left lower leg swelling and pain as well as development of two new areas of increased sensitivity and pain over the past three weeks, with an associated rash. Dr. Bursell recommended treating the rash with hydrocortisone cream and opined Employee's left lower extremity swelling appeared to be decreased when compared with prior examinations. (Chart Note, Dr. Bursell, April 11, 2012).

34) On April 11, 2012, Dr. Bursell opined Employee was unable to return to any work. (Patient Duty Status Report, Dr. Bursell, April 11, 2012).

35) On May 24, 2012, physical therapist Sandra Gelber treated Employee and noted he had been wearing his left thigh-high compression garment but had developed left hip pain. Employee asked to begin using the Flexitouch pump but PT Gelber recommended it not be used until Employee's left hip pain was evaluated. (PT Note, Gelber, May 24, 2012).

36) On May 31, 2012, Employee reported he was able to wear his custom compression stocking throughout the day, but stated it did not reduce his left leg swelling or pain. Dr. Bursell stated, "The fact that he can now wear the compressing stocking is a good sign." Employee also reported development of left low back pain and Dr. Bursell opined, "He likely has a lumbar disc injury resulting in low back pain. This will be treated with a course of oral steroids." (Chart Note, Dr. Bursell, May 31, 2012).

37) On June 21, 2012, Employee said his compression stocking helped with swelling, but the swelling returned when he took the stocking off. Employee also reported the oral steroids did not help his low back and posterior hip pain. Dr. Bursell referred Employee to physical therapy for his low back pain. (Chart Note, Dr. Bursell, June 21, 2012).

38) On June 29, 2012, Dr. Bursell opined Employee's low back pain was related to Employee's May 2010 work injury, stating it was a result of gait changes related to left lower extremity pain from CRPS that developed after left knee surgery. (Dr. Bursell response to Letter from Kanndy Omana, June 29, 2012).

39) On August 9, 2012, physical therapist Timi Johnson, at Juneau Bone & Joint Center, treated Employee for low back pain and opined Employee's low back pain was, "the result of prolonged dysfunctional gait/postural pattern due to LLE CRPS." (Chart Note, Johnson, August 9, 2012).

40) On September 6, 2012, Johnson treated Employee for low back pain and stated, "When asked directly whether his low back pain has improved, he says no. When observed he transitions through all functional transfers without guarding or evidence of pain, and is ambulating well

without significant trunk lean without single point cane and with B LE in neutral posture." (Chart Note, Johnson, September 6, 2012).

41) On October 5, 2012, Dr. Armstrong and orthopedic surgeon Donald Schroeder, M.D., examined Employee for an EME. Drs. Armstrong and Schroeder diagnosed: 1) right olecranon fracture status post healing, 2) right knee sprain status post hearing, 3) left knee meniscal tear status post meniscectomy, 4) left lower extremity CRPS type I without an identifiable lesion of a peripheral nerve, and 5) acute on chronic lymphedema of the left lower extremity. They opined all these diagnoses were related to Employee's May 2010 work injury, and stated:

> Given the overall gestalt of Mr. Vaidhyan's report of symptomology, exam findings, and medical history, his treatment to date has not been appropriate or medically reasonable. He was taken to Seattle at great expense and underwent multidisciplinary pain management course including multiple therapists for hopes to improve his functional status. This seems reasonable, however he was not treated with a pain intervention that could serve as a permanent treatment of his RSD to improve his functional status, improve his stance phase, and pain and weightbearing tolerance in his left involved lower extremity. Rather, when the specialist saw him in Seattle they only opined as regards to an immediate pain medication and pain management epidural catheter which would help him participate in an interdisciplinary pain program. He was not evaluated for a permanent device such as a spinal cord stimulator. Thus, it seems as though the type of treatment to date has not been appropriate and medically reasonable. He was not evaluated for what appears to be indicated for lower extremity weightbearing CRPS type I as of a spinal cord stimulator.

Drs. Armstrong and Schroeder also opined Employee had not reached "preinjury status" with regard to his CRPS and recommended Employee be evaluated for a spinal cord stimulator and at least receive a trial of a temporary catheter placement. They stated if, "he at that time disagrees to participate in anything invasive such as spinal cord stimulator, then indeed he will be MMI because he has had exhausted conservative treatments and will indeed qualify for palliative care regards to treatment of his chronic conditions. . . . These treatments would include pain medication, compressive devices." (EME Report, Drs. Armstrong and Schroeder, October 5, 2012).

42) On November 15, 2012, Scott Grosse, M.D., with Juneau Bone & Joint Center, treated Employee for CRPS follow up and stated, "He remains stable in his current regimen. . . . He recently went through a pain conditioning program, but stopped a week early as he didn't feel he was making any progress and only worsening his symptoms." Dr. Grosse recommended

Nifedipine XL at 30 mg along with full strength Dimethylsulfoxide (DMSO), stating, "Hopefully the two can cause less vasoedema and less generalized edema and help with decreased pain due to the turgidity of his soft tissue and third spacing." He also recommended, "possibly more aggressive retrial of gabapentin if the above-mentioned treatments fail, possibly titrating as high as he can tolerate to see if that can alleviate any of his pain complex." (Chart Note, Dr. Grosse, November 15, 2012).

43) On January 31, 2013, Employer controverted time loss benefits after February 5, 2012, permanent partial impairment benefits greater than 14 percent, and reemployment benefits. (Controversion Notice, January 31, 2013).

44) On January 22, 2013, Dr. Bursell opined Employee could not return to his job at the time of injury. Dr. Bursell reviewed RIW's discharge summary and Employee's Bus Aide job duties and stated, "His job as a Bus Aide required him get onto his knees to secure wheelchairs. It also required him to assist disabled children to their seats and secure their restraints. He does not feel that he can perform these duties and I concur with this. His other work history is as a Librarian, and he could do that level of work with retraining since his experience was in India where a different classification system is used." (Chart Note, Dr. Bursell, January 22, 2013).

45) On February 19, 2013, Dr. Bursell reviewed Drs. Armstrong and Schroeder's EME report, including their recommendation for trial of a spinal cord stimulator for pain control. Dr. Bursell discussed this option with Employee and Employee stated he would like to think about this option. (Chart Note, Dr. Bursell, February 19, 2013).

46) On March 20, 2013, physical therapist Gelber treated Employee with a Flexitouch pump to decrease Employee's significant edema in his left calf. PT Gelber noted if Employee could tolerate the pump and there was significant decrease in fluid, the Flexitouch unit would be sent home with Employee. After use, Gelber noted Employee was able to tolerate the Flexitouch and did lose girth with its use. (PT Note, Gelber, March 20, 2013).

47) On April 2, 2013, Dr. Bursell opined Employee was unable to return to work due to persistent left leg swelling, pain, and dysfunction. Dr. Bursell opined Employee was doing well with the current compression stocking and home compression device and recommended he continue using both. (Chart Note, Dr. Bursell, April 2, 2013).

48) On April 9, 2013, Employee was deposed and testified prior to his physical therapy with RIW in January 2012, his swelling was below the knee. After January 2012, the swelling began

to spread to his upper leg. Employee asked to be discharged early from the RIW program because the swelling continued to get worse. (Deposition of Daniel Vaidhyan, April 9, 2013).

49) On April 22, 2013, Employer again controverted time loss benefits after February 5, 2012, permanent partial impairment benefits greater than 14 percent, and reemployment benefits. (Controversion Notice, April 22, 2013).

50) On July 15, 2013, Dr. Olsen treated Employee for abdominal pain and fever. Dr. Olsen noted on examination Employee's left leg was swollen, stating, "The left leg certainly is warm and swollen, but the patient and his daughter are quite adamant that it has been bad like that for three years and it has been at least this bad for three months and that it is no different than it had been months ago." (Chart Note, Dr. Olsen, July 15, 2013).

51) On November 6, 2013, Dr. Bursell referred Employee to physical therapy for his lymphedema. (Chart Note, Dr. Bursell, November 6, 2013).

52) On November 14, 2013, Employee began physical therapy with physical therapist Sandra Gelber to treat his lymphedema. (Chart Note, PT Gelber, November 14, 2013).

53) On November 15, 2013, physical therapist Gelber treated Employee and opined there was significant decrease in Employee's left lower extremity lymphedema. (Chart Note, Gelber, November 15, 2013).

54) On December 2, 2013, Gelber treated Employee and opined there was marked decrease in foot and ankle lymphedema. (Chart Note, Gelber, December 2, 2013).

55) On December 6, 2013, Gelber treated Employee for increased thigh cramping, and stated Employee's, "left lower extremity girth measurements have considerably increased, almost back to pre-tx levels." Gelber stated Employee's wrapping was on very loosely and Employee explained the wrapping causes cramping in his leg. Gelber discussed with Employee and his family the stages of lymphedema, treatment for it, and the fact it is an uncomfortable procedure, but needs to be tolerated to achieve a reduction in the lymphedema limb girth to improve function. If Employee was unable to tolerate the wrapping, Gelber recommended a return to using a compression stocking. (Chart Note, Gelber, December 6, 2013).

56) On December 10, 2013, Dr. Bursell opined Employee, "showed excellent progress right after starting with the wrapping, but that has slowed possibly as he is not tolerating the wrap at night." (Chart Note, December 10, 2013).

57) At a January 30, 2014 prehearing conference, Employee's claims were scheduled to be heard on July 15, 2014. (Prehearing Conference Summary, January 30, 2014).

58) On February 4, 2014, Dr. Bursell stated Employee, "is essentially unchanged with his left lower extremity CRPS. He is able to exhibit his exercises well. Will continue with current medications for pain control." (Chart Note, Dr. Bursell, February 4, 2014).

59) On March 4, 2014, Dr. Bursell said Employee, "has been using the Flexi Touch which seems to have helped with edema control… Overall his left lower extremity swelling is essentially unchanged. He is still hypersensitive to the touch on the dorsum of his left foot." Dr. Bursell opined Employee, "is essentially stable overall" and recommended physical therapy to obtain a Flexi Touch for permanent use as well as a new compression stocking. (Chart Note, Dr. Bursell, March 4, 2014).

60) On April 1, 2014, Dr. Bursell opined Employee was not medically stable, stating he was still in the process of treating his lymphedema with physical therapy. (Dr. Bursell Response to Letter from John Franich, April 1, 2014).

61) On April 11, 2014, Gelber fitted Employee with a custom compression garment. She opined Employee's left foot and ankle lymphedema had decreased and these areas "look great," but noted Employee still had extreme calf, knee and upper thigh lymphedema. (Chart Note, Gelber, April 11, 2014).

62) At a June 12, 2014 prehearing conference, the July 15, 2014 hearing issues were narrowed to 1) TTD, 2) medical stability, and 3) attorney's fees and costs. The parties were reminded witness lists and hearing briefs were due by close of business on July 8, 2014. Exhibits or other documentary evidence were due by close of business on June 25, 2014. (Prehearing Conference Summary, June 12, 2014).

63) On June 16, 2014, Dr. Bursell opined Employee was medically stable. (Dr. Bursell Response to June 6, 2014 Letter from Krista Schwarting, June 16, 2014).

64) On July 3, 2014, the parties stipulated to moving the deadline for briefs and witness lists to July 14, 2014. (Email from Employer and Employee to Hearing Officer Marx, July 3, 2014).

65) On July 3, 2014, the board accepted the parties' stipulation as long as the briefs were emailed to the board by noon on July 14, 2014, so that they could be distributed to the board members prior to hearing. (Email from Hearing Officer Marx to Employee and Employer, July 3, 2014).

66) On July 14, 2014, Employer emailed its hearing brief, without exhibits, to the board and Employee. At 12:25 pm on July 14, 2014, the board designee emailed the parties and requested hearing brief exhibits be emailed along with the hearing briefs, because the hearing was to take place the next day. The board designee also requested Employee email his hearing brief as soon as possible, as the board had not yet received it. Employer emailed its hearing brief exhibits to the board and Employee at 12:29 pm. Employee emailed his hearing brief to the board and Employer at 1:30 pm. Employee had no exhibits to attach to his brief. (Emails between Employer, Employee, and Hearing Officer Marie Marx, July 14, 2014).

67) On July 9, 2014, Dr. Bursell testified no treatment would make Employee better or allow him to "get over this condition. The treatment that he's getting is going to help him to manage the swelling and the pain, and so he'll need that ongoing treatment." He also opined because of his work injury, Employee could not return to his regular work and could only work in a relatively sedentary, light-duty job that did not require much walking or long standing. Regarding Employee's condition, Dr. Bursell stated the, "swelling in his leg has spread substantially to include the entire leg and foot. Most of the time these conditions stabilize over time, but in some cases the swelling spreads. It seems to have stopped spreading at this point, and his treatment primarily is through compression garments and wraps to help control the swelling in his leg, in addition to medication to help with pain control." Dr. Bursell also stated that typically swelling and pain will increase for a time, a number of weeks to months and then subside within a year or two. Until Employee's case, Dr. Bursell had never seen it actually spread throughout the entire limb, stating: "This is the most effuse case I've seen." Dr. Bursell recommended ongoing physical therapy treatments for Employee's lymphedema, "in an attempt to optimize that treatment and stabilize him." He opined Employee was medically stable at the point where he did not require physical therapy interventions and his leg had become stable, which was March 4, 2014. Regarding RIW's opinion of medical stability, Dr. Bursell opined, "I think that time has shown that his condition has progressed since that time, and that he, in fact, wasn't stable." (Deposition of John Bursell, M.D., July 9, 2014).

68) Employee contends he is not medically stable because his condition has worsened over time. He also contends even if his condition has not improved, numerous physicians recommended additional medical treatment that would be expected to result in improvement of his condition and symptoms. Employee contends this constitutes clear and convincing evidence sufficient to

overcome any presumption he is medically stable, which may have arisen due to lack of objectively measurable improvement for a period of 45 days. (Employee Hearing Arguments; Employee's Hearing Brief, July 14, 2014).

69) Employer contends Employee's treating physicians at RIW opined Employee became medically stable in February 2012, and released Employee to return to work with restrictions. Employer also contends Employee's condition has not improved with treatment, and under AS 23.30.395(27), Employee's is presumed to have reached medical stability when he failed to improve for a 45 day period. (Employer's Hearing Arguments; Employer's Hearing Brief, July 14, 2014).

70) As a preliminary hearing matter, Employee's hearing brief, witness list, and affidavits of attorney's fees and costs were accepted as timely filed over Employer's objection. (Record).

71) Employee filed two attorney's fee affidavits. The first itemized 10.2 hours of attorney time at a rate of $420 per hour for experienced workers' compensation attorney John Franich, 17.4 hours of attorney time at a rate of $300 per hour for new and inexperienced workers' compensation attorney Heather Brown, and 10.5 hours of paralegal time at a rate of $210 per hour, for a total of $11,709.00 in fees. He filed an itemization of costs totaling $1,800. A supplemental fee and cost affidavit adjusted an entry and itemized an additional 12.5 hours of attorney time at $420 per hour, and 1.6 hours of paralegal time at rates of $210 and $200 per hour, for a total of $5,574 in additional fees. Employee filed an itemization of additional costs totaling $1,705.40. Total attorney's fees and costs equal $20,788.40. Employer objected to: 1) Employee's inclusion of fees for issues not set for hearing, such as permanent total disability and reemployment benefits, 2) Employee's attorney John Franich's hourly rate, 3) Employee's paralegal Heidi Wilson-Amato's hourly rate, 4) Employee's attorney Heather Brown's hourly rate, and 5) hours billed by Ms. Brown to a) re-review medical records previously reviewed by Mr. Franich, b) compile documents for deposition, and c) conduct statutory research regarding definitions. (Affidavit of Attorney's Fees, July 14, 2014; Supplemental Affidavit of Attorney's Fees, July 18, 2014; Objection to Supplemental Attorney Fees, July 25, 2014).

72) Employee's attorneys' hourly rates of $420 for John Franich and $300 for new attorney Heather Brown are not reasonable. The requested hourly rates for Employee's attorneys are considerably higher than those seen in other cases with similarly experienced legal representatives. (Experience, judgment, observations).

73) Employee's paralegal's $210 hourly rate is not reasonable. The requested hourly rate for Employee's paralegal is considerably higher than those seen in other cases with similarly experienced paralegals. *Id.*

74) Compiling documents is a clerical or paralegal function, not an attorney function, and 1.4 hours of Brown's time will be deducted. *Id.*

75) Dr. Bursell and Employee are credible. *Id.*

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 . . . quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at . . . reasonable cost to . . . employers . . . subject to . . . this chapter; . . . .
>
> **AS 23.30.005. Alaska Workers' Compensation Board.**
> . . .
>
> (h) The department shall adopt rules . . . and . . . regulations to carry out the provisions of this chapter. . . . Process and procedure under this chapter shall be as summary and simple as possible. . . .

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

A finding reasonable persons would find employment was or was not a cause of the Employee's disability and impose or deny liability is, "as are all subjective determinations, the most difficult to support." *Rogers & Babler*, 747 P.2d at 534.

> **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 or her injury and the employment. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 610 (Alaska 1999). The evidence necessary to raise the presumption of compensability varies depending on the claim. In claims based on highly technical medical considerations, medical evidence is often necessary to make that connection. *Burgess Construction Co. v. Smallwood,* 623 P.2d 312, 316 (Alaska 1981). In less complex cases, lay evidence may be sufficiently probative to establish causation.

For injuries occurring after the 2005 amendments to the Act, if the 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,* Alaska Workers' Comp. App. Comm'n Dec. No. 150 at 7 (March 25, 2011). Because the board considers the employer's evidence by itself and does not weigh the employee's evidence against the employer's rebuttal evidence, credibility of the parties and witnesses is not examined at the second stage. *Veco, Inc. v. Wolfer*, 693 P.2d 865, 869-70 (Alaska 1985).

If the board finds the employer's evidence is sufficient, in the third step the presumption of compensability drops out, the employee must prove her case by a preponderance of the evidence, and must prove in relation to other causes, employment was the substantial cause of the disability or need for medical treatment. *Runstrom* 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 the evidence is conflicting. *Harnish Group, Inc. v. Moore*, 160 P.3d 146, 153 (Alaska 2007). The board has the sole discretion to determine the weight of the medical testimony and reports. When doctors' opinions disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.*, Alaska Workers' Comp. App. Comm'n Dec. No. 087 at 11 (Aug. 25, 2008).

> **AS 23.30.135. Procedure before the board**. (a) In making an investigation or inquiry or conducting a hearing the board is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by this chapter. The board may make its investigation or inquiry or conduct its hearing in the manner by which it may best ascertain the rights of the parties. . . .

> **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.

AS 23.30.145(b) requires an employer to pay reasonable attorney's fees when the employer delays or "otherwise resists" payment of compensation and the employee's attorney successfully prosecutes his claim. *Harnish Group, Inc.*, 160 P.3d at 150-51. AS 23.30.145(b) also requires an award of attorney's fees to be reasonable.

In workers' compensation cases, "the objective is to make attorney fee awards both fully compensatory and reasonable so that competent counsel will be available to furnish legal services to injured workers." *Wise Mechanical Contractors v. Bignell*, 718 P.2d 971, 973 (Alaska 1986). In *Judith Lewis-Walunga and William J. Soule v. Municipality of Anchorage*, Alaska Workers' Comp. App. Comm'n Dec. No. 123 (December 28, 2009), the Alaska Workers' Compensation Appeals Commission stated:

> The commission recognizes that promoting the availability of counsel for injured workers is a legitimate legislative goal of the attorney fee statute. This goal is served in the current statute by provision of a statutory minimum fee that may result in disproportionate fees in some cases, a mandate to examine the complexity of services provided, and a barring of most fee awards against injured workers when the employer prevails. Thus, a small value claim that involves a novel application of the law or an injured worker's claim that succeeds against heavy opposition, may result in fee awards that recognize the particular complexity or difficulty of the case.
>
> . . .
>
> The legislature's choice represents a balance between assuring the injured worker access to representation and freedom to file claims without fear of financial consequences on one hand and avoiding unnecessary litigation of doubtful claims and unreasonable costs to the public and employers on the other. The commission will not disturb the balance struck by the legislature.

Id. at 13-15.

> **AS 23.30.185. Compensation for temporary total disability.** In case of disability total in character but temporary in quality, 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the disability. Temporary total disability benefits may not be paid for any period of disability occurring after the date of medical stability.
>
> **AS 23.30.395. Definitions**. In this chapter
> . . .

> (10) "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;
> . . .
>
> (21) "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 at 8 (March 17, 2010). 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.*).

> **8 AAC 45.180. Costs and attorney's fees**.
> . . .
>
> (b) A fee under AS 23.30.145(a) will only be awarded to an attorney licensed to practice law in this or another state. An attorney seeking a fee from an employer for services performed on behalf of an applicant must apply to the board for approval of the fee; the attorney may submit an application for adjustment of claim or a petition. An attorney requesting a fee in excess of the statutory minimum in AS 23.30.145(a) must (1) file an affidavit itemizing the hours expended, as well as the extent and character of the work performed, and (2) if a hearing is scheduled, file the affidavit at least three working days before the hearing on the claim for which the services were rendered; at the hearing, the attorney may supplement the affidavit by testifying about the hours expended and

> the extent and character of the work performed after the affidavit was filed. If the request and affidavit are not in accordance with this subsection, the board will deny the request for a fee in excess of the statutory minimum fee, and will award the minimum statutory fee.
>
> (c) Except as otherwise provided in this subsection, an attorney fee may not be collected from an applicant without board approval. A request for approval of a fee to be paid by an applicant must be supported by an affidavit showing the extent and character of the legal services performed. . . .
>
> (d) The board will award a fee under AS 23.30.145(b) only to an attorney licensed to practice law under the laws of this or another state.
>
> > (1) A request for a fee under AS 23.30.145(b) must be verified by an affidavit itemizing the hours expended as well as the extent and character of the work performed. . . . Failure by the attorney to file the request and affidavit in accordance with this paragraph is considered a waiver of the attorney's right to recover a reasonable fee in excess of the statutory minimum fee under AS 23.30.145(a), if AS 23.30.145(a) is applicable to the claim, unless the board determines that good cause exists to excuse the failure to comply with this section.
> >
> > (2) In awarding a reasonable fee under AS 23.30.145(b) the board will award a fee reasonably commensurate with the actual work performed and will consider the attorney's affidavit filed under (1) of this subsection, the nature, length, and complexity of the services performed, the benefits resulting to the compensation beneficiaries from the services, and the amount of benefits involved.
>
> . . .
>
> (f) The board will award an applicant the necessary and reasonable costs relating to the preparation and presentation of the issues upon which the applicant prevailed at the hearing on the claim. The applicant must file a statement listing each cost claimed, and must file an affidavit stating that the costs are correct and that the costs were incurred in connection with the claim…

ANALYSIS

1) Was the oral order accepting Employee's hearing brief correct?

Employer's objection to Employee's filed hearing brief was overruled at hearing. On July 3, 2014, the parties stipulated to moving the deadline for briefs and witness lists to July 14, 2014, the day before the July 15, 2014 hearing, because Dr. Bursell's deposition was scheduled to be taken on July 9, 2014. The parties' stipulation was accepted, but the parties were asked to email-file their

briefs by noon on July 14, 2014, so they could be distributed to panel members prior to hearing. On July 14, 2014, Employer email-filed its hearing brief, without exhibits, and email-served Employee. At 12:25 pm on July 14, 2014, the designated chair emailed the parties and requested hearing brief exhibits be email-filed along with the hearing briefs, because the hearing was to take place the next day. The designated chair also requested Employee email his hearing brief as soon as possible, as it had not yet been filed. Employer email-filed its hearing brief exhibits and email-served Employee at 12:29 pm. Employee email-filed his hearing brief and email-served Employer at 1:30 pm without exhibits, as Employee had no exhibits.

As a practical matter, Employee's hearing brief was emailed to Employer and received by it sooner than it would have been had Employee served it by mail. The parties stipulated the hearing brief could be filed by July 14, 2014. The designated chair's 12:25 pm email to the parties on July 14, 2014, requesting Employee's hearing brief and both parties' hearing exhibits by email evidences the noon hearing brief filing deadline extension and email request was to accommodate the hearing panel's need to review the documents before the end of the business day. AS 23.30.135. Employee responded to the designated chair's request an hour later. Employee's hearing brief was timely filed. Consequently, the oral order accepting Employee's hearing brief was correct.

2) Is Employee entitled to additional TTD benefits?

There is no dispute Employee suffered a work-related injury and this injury caused CRPS following work-related surgery. Employer's EME physicians and Dr. Bursell agree Employee's CRPS is one of the most severe cases they have ever encountered. On January 3, 2012, Employee began a structured pain program at RIW, with the goal to get more physically fit and reduce his lower extremity swelling. However, during his participation in the program, Employee's swelling and pain began to worsen and Employee asked to be discharged early from the program. On February 2, 2012, RIW opined Employee had achieved maximum medical improvement following early discharge from the program and released Employee to light duty work as of February 6, 2012. Employer stopped paying Employee TTD following his discharge from the RIW program. The parties' dispute relates to whether Employee is entitled to additional TTD following his discharge from RIW.

Employee contends he is entitled to additional TTD benefits for the period beginning when Employer stopped paying TTD until such time as he is medically stable. Employee contends his condition worsened despite treatment and he could not have reached medical stability while his condition was worsening. Employer contends Employee became medically stable in February 2012 and was released to work with restrictions. Employer also contends Employee's condition has not improved with treatment, and under AS 23.30.395(27), Employee's is presumed to have reached medical stability when he failed to improve for a 45 day period.

This issue raises factual disputes to which the statutory presumption of compensability applies. AS 23.30.120; *Meek.* Employee satisfied the presumption analysis' first step with Dr. Bursell's records and deposition testimony. Without regard to credibility, Dr. Bursell opined Employee was disabled because of his work-related injuries and could not return to his job at the time of injury. He also opined Employee was not medically stable until March 4, 2014. This is adequate evidence to raise the presumption and cause it to attach to his TTD claim. Viewing the evidence in isolation, and without regard to credibility, physicians at RIW stated Employee was medically stable in February 2012 and could return to work with restrictions. Their opinions provide substantial evidence to rebut the presumption, cause it to drop out, and require Employee to prove he was totally temporarily disabled from the period beginning when Employer stopped paying TTD, by a preponderance of the evidence.

However, because Employer 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. Bursell recommended physical therapy on February 10, 2012, at the first appointment following Employee's discharge from RIW. He opined he recommended physical therapy treatments to stop the spread of and reduce Employee's lower extremity swelling, which occurred after Employee's discharge from RIW. 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.

The medical record shows Employee's condition worsened significantly after his discharge from RIW. Prior to his physical therapy with RIW, Employee's swelling was below the knee. After his discharge, as Dr. Bursell explained, the, "swelling in his leg has spread substantially to include the entire leg and foot. Most of the time these conditions stabilize over time, but in some cases the swelling spreads." Dr. Bursell also stated that typically swelling and pain will increase for a period of time, a number of weeks to months and then subside within a year or two. Until Employee's case, Dr. Bursell had never seen it actually spread throughout the entire limb, stating, "This is the most effuse case I've seen." Dr. Bursell recommended various treatment via physical therapy, including a custom compression stocking and a Flexitouch pump, with the goal of reducing and stabilizing Employee's effuse lower extremity swelling. Dr. Bursell opined Employee was medically stable at the point where he did not require physical therapy interventions and his leg had become stable, which was March 4, 2014. Regarding RIW's medical stability opinion, Dr. Bursell opined, "I think that time has shown that his condition has progressed since that time, and that he, in fact, wasn't stable." Dr. Bursell's credible opinion is supported by Employee's credible testimony that prior to his physical therapy with RIW in January 2012, his swelling was below the knee but after January 2012, the swelling began to spread to his upper leg.

Dr. Bursell's opinion is also supported by Drs. Armstrong and Schroeder's opinion on October 5, 2012, that Employee's treatment to date had not been appropriate or medically reasonable. Drs. Armstrong and Schroeder explained that although Employee was taken to Seattle at great expense and underwent multidisciplinary pain management course including multiple therapists for hopes to improve his functional status, he was not treated with a pain intervention that could serve as a permanent treatment of his condition to improve his functional status, improve his stance phase, and pain and weightbearing tolerance in his left involved lower extremity. Rather, the specialist only opined as regards to an immediate pain medication and pain management epidural catheter which would help him participate in a pain program. He was not evaluated for a permanent device such as

a spinal cord stimulator. They thus opined, Employee was not evaluated "for what appears to be indicated for lower extremity weightbearing CRPS type I, including a spinal cord stimulator. This shows that at least as of October 5, 2012, both Employer's EME physicians and Dr. Bursell recommended further treatment for Employee's work-related condition.

Drs. Armstrong and Schroeder also opined if Employee disagreed to participate in anything invasive such as spinal cord stimulator, he would then be medically stable because he would have exhausted conservative treatments and would qualify for palliative care. However, Dr. Bursell credibly opined Employee was medically stable at the point where he did not require physical therapy interventions and his leg had become stable, which was March 4, 2014. Although Dr. Bursell offered a different medical stability date opinion prior to his deposition, at his deposition Dr. Bursell further reviewed his records and credibly and persuasively explained the basis for his March 4, 2014 date.

RIW's opinions of Employee's medical stability and ability to return to work were made before it became apparent Employee's condition had significantly changed for the worse. Although Employee may have been medically stable and able to return to work with restrictions at his discharge from RIW, the medical evidence shows Employee's condition immediately thereafter worsened to the point where he was no longer medically stable or could return to work.

Dr. Bursell's opinion has the greatest credibility of all physicians in this case and is given the greatest weight on the issue of when Employee was medically stable and could return to work. *Harnish*; *Moore*; AS 23.30.122. Accordingly, Employee's claim for additional TTD benefits will be granted. Employee is entitled to TTD from the period beginning when Employer stopped paying TTD until March 4, 2014.

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

Employer vigorously resisted this case, so fees and costs under AS 23.30.145(b) may be awarded. *Harnish.* Employee retained an attorney who was successful in prosecuting the most significant and complex claim in this case. This decision awarding additional TTD is a significant benefit to Employee.

Employee submitted two attorney's fee affidavits. Total attorney's fees and costs equal $20,788.40. AS 23.30.145(b) requires an award of attorney's fees to be reasonable. Employer objected to 1) Employee's inclusion of fees for issues not set for hearing, 2) attorney Franich and Brown's hourly rates, 3) paralegal Wilson-Amato's hourly rate, and 4) hours billed by Brown to a) re-review medical records previously reviewed by Mr. Franich, b) compile documents for deposition, and c) conduct statutory research regarding definitions.

A) Inclusion of fees for issues not set for hearing.

Employer contends Employee should not be entitled to an award of fees for services performed on claims withdrawn prior to hearing. Employer cites no legal authority for this position. To reduce every fee award by attorney time spent evaluating and investigating a claim when specific benefits were not later pursued would have a chilling effect on an attorney's willingness to represent injured workers in cases in which the outcome is not immediately clear. Such a result would be contrary to the legislative intent to promote the availability of counsel for injured workers. *Wise; Lewis-Walunga.* Employee's fee award will not be reduced for time incurred in evaluating and investigating benefits Employee did not ultimately pursue at hearing.

B) Employee's attorneys' hourly rates.

Employee's attorneys' hourly rates of $420 for Franich and $300 for new attorney Heather Brown are not reasonable. The requested hourly rates for Employee's attorneys are considerably higher than those seen in other cases with similarly experienced legal representatives. This conclusion is based on experience with other attorneys representing injured workers in workers' compensation cases, with equal or more experience than Franich and Brown. Considering the nature, length, and complexity of the services performed, Employer's resistance, and the benefits resulting to the claimant from the services obtained, a rate of $350.00 per hour for Franich and $200.00 per hour for Brown is within the reasonable range for similarly experienced claimant's counsel in other cases and is also consistent with other recent fee awards for Mr. Franich in particular.

C) Employee's paralegal Wilson-Amato's hourly rate.

Employee's paralegal's $210 hourly rate is not reasonable. The requested hourly rate for Employee's paralegal is considerably higher than those seen in other cases with similarly

experienced paralegals. This conclusion is based on experience with other paralegals working for attorneys representing injured workers in workers' compensation cases, with equal or more experience than Wilson-Amato. Considering the nature, length, and complexity of the services performed, Employer's resistance, and the benefits resulting to the claimant from the services obtained, a rate of $150.00 per hour for Wilson-Amato is within the reasonable range for similarly experienced paralegals in other cases.

> *D) Hours billed by Brown to a) re-review medical records previously reviewed by Franich, b) compile documents for deposition, and c) conduct statutory research regarding definitions.*

Employer objects to Brown's review of records previously reviewed by Franich. However, there is no duplication of services. Brown billed for reviewing medical records prior to taking Dr. Bursell's deposition. Franich did not bill any time for reviewing medical records in preparation for the deposition. He did bill for time spent preparing for hearing, when he reviewed the file and drafted the hearing memorandum, but this service is distinct from Brown's deposition preparation. It is reasonable for an attorney to review a file prior to deposition and also while preparing for hearing. Employer also objects to Brown's billing for time spent compiling documents for deposition. Compiling documents is a clerical or paralegal function, not an attorney function, and 1.4 hours of Brown's time will be deducted.

Finally, Employer objects to Brown's time spent conducting statutory research regarding definitions. Considering one of the issues in this case turns on interpretation of the statutory definition of "medical stability," it is reasonable for an attorney to have conducted research on statutory definitions. *Rogers & Babler*.

Employer did not otherwise object to Employee's attorney's hourly rate, hours or costs. Considering the nature, length, and complexity of the case and services performed, Employer's resistance and the benefits resulting to Employee from the services obtained, Employee is awarded 22.7 hours of attorney time at $350 per hour for Franich, 16 hours of attorney time at $200 per hour for Brown, and $3,505.40 in costs, for a total of $14,650.40 in attorney's fees and costs.

CONCLUSIONS OF LAW

1) The oral order accepting Employee's filed hearing brief was correct.
2) Employee is entitled to additional TTD benefits.
3) Employee is entitled to attorney's fees and costs.

ORDER

1) The oral order accepting Employee's filed hearing brief is affirmed as correct.

2) Employee's claim for additional TTD benefits is granted. Employee is awarded TTD from the date beginning when Employer stopped paying TTD until March 4, 2014.

3) Employee's claim for an award of attorney's fees and costs award is granted. Employee is awarded $14,650.40 in attorney's fees and costs.

Dated in Juneau, Alaska, on August 26, 2014.

ALASKA WORKERS' COMPENSATION BOARD

Marie Marx, Designated Chair

Charles M. Collins, 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

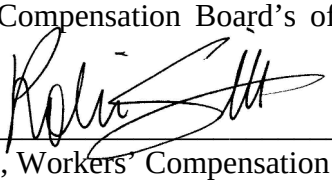
A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accord with 8 AAC 45.050. The petition requesting reconsideration must be filed with the board within 15 days after delivery or mailing of this decision.

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 DANIEL T. VAIDHYAN, employee / claimant v. FIRST STUDENT, INC., employer; NEW HAMPSHIRE INSURANCE COMPANY, insurer / defendants; Case No. 201007080; dated and filed in the Alaska Workers' Compensation Board's office in Juneau, Alaska, and served on the parties on August 26, 2014.



Robin Silk, Workers' Compensation Technician