ALASKA WORKERS' COMPENSATION BOARD

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

SUSAN PIASINI-BRANCHFLOWER,	)	
	)	
Employee,	)	FINAL
Claimant,	)	DECISION AND ORDER
	)	
v.	)	AWCB Case No. 200901607
	)	
ANCHORAGE SCHOOL DISTRICT,	)	AWCB Decision No. 17-0041
	)	
Employer,	)	Filed with AWCB Anchorage, Alaska
Defendant.	)	on April 11, 2017
	)	

Susan Piasini-Branchflower's (Employee) claims were heard on November 30, 2016, in Anchorage, Alaska, a date selected on June 29, 2016. Attorneys Lawrence Perle and Michael Jensen appeared and represented Employee who appeared and testified. Attorney Michelle Meshke appeared and represented the self-insured Anchorage School District (Employer). The record initially closed on December 14, 2016, when the parties submitted final attorney fee and cost affidavits and objections. The record reopened on that date until December 31, 2016, so parties could present evidence and argument addressing Employer's request for Employee's past benefits to be "suspended" or "forfeited" for her alleged failure to file a petition for a protective order or timely sign and return discovery releases. The parties needed additional time to prepare and present the requested evidence and arguments and stipulated to the record closing on January 13, 2017. Given the additional issue and need for more evidence, and the panel members' schedules, the record closed March 23, 2017, when panel members deliberated. This decision addresses several preliminary issues, decides Employee's claims on their merits and resolves the subsequently briefed, post-hearing benefit suspension or forfeiture issue.

ISSUES

As a preliminary matter, Employee objected to the factfinders considering evidence showing Gregory Konrath, M.D., had committed a crime. She contended this evidence is irrelevant because Dr. Konrath's crime had nothing to do with treatment he provided to Employee years earlier.

Employer contended evidence demonstrating Dr. Konrath's crime is relevant because it demonstrates his character. Employer contended the factfinders should consider this evidence.

1) Is collateral evidence of a physician's crime admissible?

As another preliminary matter, Employee contended the factfinders should not consider nurse case manager Tracy Davis' reports because Employee filed a request for cross-examination and Employer did not produce Davis for questioning. Employee also contended Davis "manipulated doctors" and inappropriately affected Employee's medical treatment and ultimately her claim.

Employer contended numerous depositions reference Davis' reports. Consequently, Employer contended the factfinders should consider Davis' reports over Employee's *Smallwood* objection.

2) Are Davis' documents admissible over Employee's objection?

As a third preliminary issue, Employer contended the factfinders should not consider Dr. Konrath's medical records because Employer timely filed a *Smallwood* objection and Employee did not produce Dr. Konrath for cross-examination. Employer also contended the subject records are not an exception to the *Smallwood* doctrine.

Employee contended Dr. Konrath's records are admissible as "business record" exceptions to the *Smallwood* doctrine. She contended Employer's *Smallwood* objections were also untimely and the factfinders should consider Dr. Konrath's records over Employer's objection.

3) Are Dr. Konrath's records admissible over Employer's *Smallwood* objection?

Employee contends she injured multiple body parts when she slipped and fell down on the job while working for Employer in 2009. Specifically, she claims benefits for her right trigger thumb, right

basilar joint, right knee and right ankle. Employee seeks an order finding her claims for various benefits under the Act related to these body parts compensable.

Employer contends Employee suffered only cervical and thoracic strains and sprains when she fell on the job in 2009. It contends her work-related symptoms resolved within months and she is not entitled to any additional benefits under the Act.

4) Are Employee's injuries to her right trigger thumb, right hand basilar joint, right knee and right ankle compensable?

Employee contends she is entitled to temporary total disability (TTD) from March 11, 2009, and continuing until medical stability and her disability ends.

Employer contends Employee is not entitled to any disability benefits after March 11, 2009.

5) Is Employee entitled to TTD benefits?

Employee contends she is entitled to permanent partial impairment (PPI) benefits.

Employer contends Employee is entitled to little or no PPI for her work injuries.

6) Is Employee entitled to PPI benefits?

Employer contends any awardable benefits should be suspended or forfeited because Employee refused to sign discovery releases.

Employee contends her benefits should not be suspended or forfeited, because she signed releases.

7) Should Employee's benefits be suspended or forfeited for failure to sign discovery releases?

Employee contends she is entitled to permanent total disability (PTD) benefits resulting from her work injury with Employer.

Employer contends Employee is not entitled to PTD benefits because she can return to work.

8) Is Employee entitled to PTD benefits?

Employee contends she is entitled to past and future medical costs and related transportation expenses for her various injuries arising from her January 26, 2009 work injury.

Employer contends Employee is not entitled to any additional past or future medical costs or related transportation expenses arising from her work injury.

9) Is Employee entitled to past or future medical costs and related transportation expenses?

Employee contends she is entitled to a vocational reemployment eligibility evaluation because she can no longer return to work as a teacher. She further contends she is entitled to benefits under AS 23.30.041(k) during periods for which she is not entitled to other indemnity benefits.

Employer contends Employee is not entitled to vocational reemployment benefits because she can return to work as a teacher and, alternately, has not vigorously pursued vocational reemployment benefits. It contends equitable principles like laches should prohibit her claim.

10) Is Employee entitled to a vocational reemployment eligibility evaluation or §041(k) compensation?

Employee contends she is entitled to statutory interest on all benefits awarded.

Employer contends as no benefits are awardable Employee is not entitled to interest.

11) Is Employee entitled to interest?

Employee contends she is entitled to attorney fees and costs on all issues on which she prevails.

Employer contends as no benefits are awardable Employee is not entitled to attorney fees or costs.

12) Is Employee entitled to attorney fees or costs?

FINDINGS OF FACT

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

1) On March 7, 2006, Employee said, "She is only 1 yr. from retirement & maybe she should consider taking a medical early retirement." (Orthopedic Physicians Anchorage, March 7, 2006).

2) On June 1, 2007, Dale Trombley, M.D., wrote to Employee's principal suggesting "health-wise and emotion-wise," it was better for Employee to continue working with "intermediate level children" rather than younger children, "until her retirement." (Trombley letter, June 1, 2007).

3) On April 3, 2008, Employee had an automobile accident. (Employee).

4) On August 19, 2008, Employee said she fell approximately four weeks earlier and landed on her right knee. Since then, Employee had difficulty kneeling because her kneecap was tender. (Trombley chart note, August 19, 2008).

5) On October 28, 2008, Lawrence Stinson, M.D., diagnosed Employee with among other things cervical spondylosis with ongoing cervicalgia and right upper extremity radiculitis symptoms. (Stinson report, October 28, 2008).

6) Employee's past medical records show no significant right thumb, hand, or ankle injuries or symptoms. (Judgment, observations and inferences drawn from the above).

7) On January 26, 2009, Employee slipped on the ice and fell while at work as a teacher for Employer, twisting her back from her neck to her hips. Employee hit her knees, caught herself with both hands, over-extended both wrists and lost bladder control. (Report of Occupational Injury or Illness, January 29, 2009).

8) On January 26, 2009, the school nurse completed an incident report. Employee did not provide written details but the nurse examined her and gave medical treatment noting Employee twisted her back and landed on her knees and wrists. The nurse found no "point tenderness, bruising or redness" and noted Employee had a prior neck condition making her susceptible to injury. The nurse noted Employee lost bladder control when she fell and diagnosed "sprain/strain," "repeat trauma" and "other." Affected body parts included "knee," "neck," "back (lower)," and "wrist." The nurse recommended rest, ice and pain medication as required. (Anchorage School District Incident Report Form, January 26, 2009).

9) On January 27, 2009, paramedics went to Employee's home at her request. Employee's chief complaint was "back/neck pain -- traumatic." Employee said she fell the prior day and now felt "10 of 10 thoracic pain" secondary to the fall. She reported slipping on the ice and "landing on her

chest." Employee said the fall aggravated a "current long term back injury to include a recent lumbar fusion." She had increasing pain since the fall but could walk. The paramedics found no lower extremity edema or any visible trauma and assessed chronic back pain aggravated by a recent fall. They gave intravenous Fentanyl and Employee self-administered Nitronox, with "no relief of symptoms." Employee told paramedics she was already taking numerous medications including Percocet. (Anchorage Fire Department Prehospital Care Worksheet, January 27, 2009).

10) On January 27, 2009, emergency room staff said Employee's chief complaints included "chest pain" per the paramedics and "neck pain" per the patient. Employee said she had severe neck and upper back pain and felt like her neck and upper back were "on fire." She recalled the previous day slipping on the ice at school and falling forward but not striking her head. She denied "pain in her extremities." She felt "her chronic pain, but markedly worse," after the fall. Employee had to call the ambulance to bring her to the emergency room. Employee's routine pain medication did not help. She reported no numbness or tingling in her extremities. Michele McCall, M.D., found Employee lying on the gurney crying, with neck pain. "She is without lower extremity edema." Employee had normal gait, symmetric extremity movement and sensation to light touch in her legs. Following the initial physical examination, Dr. McCall provided intravenous Toradol, Morphine, Phenergan and Dilaudid. Cervical magnetic resonance imaging (MRI) was unchanged from an MRI in October 2008. Dr. McCall discussed the case with Tim Cohen, M.D., Employee's neurosurgeon and with her family physician Dr. Trombley. Dr. McCall noted:

> The patient has been very demanding and belligerent here in the emergency department, demanding that I have Dr. Cohen operate on her emergently. I have discussed with her that there is not an emergent problem that requires surgery.

Dr. McCall's diagnoses were cervical degenerative disease and cervical and upper back strain. (PMAC Emergency Room Note, January 27, 2009).

11) On January 31, 2009, Employee said she had fallen at work on January 26, 2009, and landed on her hands and knees and "twisted her right leg." Employee said it felt like she had an "ice pick in her back." She now had right shoulder pain and requested a sling. Employee said her right knee felt "squishy" and swollen more than the left knee. Employee was looking for an alternative to neck surgery. She presented with a soft cervical collar, Velcro elastic belt around her waist, and a wrist and thumb brace on her right hand. Employee refused a right wrist and knee exam but PA-C Froiland noted Employee had "a bit of discomfort" on her patellar tendon and observed a

"very minimal amount of swelling to the knee." Employee said when she fell at work, her right "knee went out from under her and twisted." She "noticed thumb was hurt or mid-hand on Wednesday." PA-C Froiland diagnosed right knee and shoulder pain and multiple injuries as well as a history of multiple problems and anxiety. Employee requested an off-work slip and PA-C Froiland restricted her from work on February 2, 2009, pending appointment with her pain management physician, Lawrence Stinson, M.D. PA-C Froiland gave Employee a fitted, right arm sling and a hinged brace for her right knee. (Christina Froiland, PA-C report, January 31, 2009).

12) On February 2, 2009, Employee told Dr. Stinson she injured her "neck, back, upper extremities and lower extremities in that fall, particularly her right knee and right hand." Employee did not think she could return to work. She refused to remove her soft cervical collar for a neck examination. Dr. Stinson noted an antalgic gait and a mildly swollen right knee without discoloration. Employee's right knee was tender to and the right hand thenar eminence swollen with a "significant contusion and discoloration." Dr. Stinson checked Employee's lower extremity motion and sensation, found them grossly symmetric and intact except for decreased right knee extension and flexion secondary to pain. He diagnosed a traumatic fall at work with multiple injuries including a right hand contusion, multiple other contusions over the extremities, increased cervicalgia necessitating a soft cervical collar, right knee injury and increased thoracic and lumbar discomfort. Dr. Stinson's treatment plan included cervical and thoracic diagnostic imaging and physical therapy for her right upper extremity and knee. He removed Employee from work for at least one week. (Stinson report, February 2, 2009).

13) The intake form for Employee's February 2, 2009 visit with Dr. Stinson, noted her right wrist was "achy" and she wrenched her right knee when she fell on the ice at school. The form noted a hematoma at her right thenar eminence. (Patient Visit Form, February 2, 2009).

14) The "thenar eminence" is in the area on the palm near the base of the thumb. (Experience).

15) On February 9, 2009, Employee still had "significant" right knee pain and Dr. Stinson ordered additional imaging. Employee's right knee was "very tender along the medial joint line and with any attempted meniscal testing." Among other things, Dr. Stinson diagnosed right knee internal derangement, "likely a meniscal injury." He ordered a right knee MRI and a referral to Adrian Ryan, M.D., for an orthopedic evaluation. (Stinson report, February 9, 2009).

16) On February 11, 2009, Dr. Stinson stated Employee had a traumatic fall at work "from which she sustained a right knee meniscal injury. . . ." (Procedure Note, February 11, 2009).

17) On February 13, 2009, Employee presented to the emergency room for intractable back pain. Employee said she was upset because "she has been forced to retire since her slip and fall in January 26, 2009. . . ." (Emergency Room report, February 13, 2009).

18) On February 19, 2009, Employee described her work injury and said she fell forward on the ice and landed mostly on her right side. Employee said she landed on both knees and her right knee was locking, swelling, painful and "gives up." She said her right ankle "twists on her for no reason" and her right wrist and hand were sore. (Current History form, February 19, 2009).

19) On February 19, 2009, Employee had anterior knee, lateral ankle, and right hand, wrist, shoulder, and elbow pain. She described falling on the playground, landing on her right side, outstretched right hand and wrist. Employee was concerned about "a lack of confidence in the right knee and the right ankle" and pain "at the base of the right thumb." Employee appeared for examination wearing multiple sleeves and braces for her knee, hand and wrist and a soft cervical collar, which she had purchased at Walmart. Stephen Tower, M.D., states:

> She has worked in the school district for many years. She is nearing retirement age. She has a lot of concerns about retirement because her injury occurred just before a critical time frame to calculate her pension compensation.

Employee's gait was "a little bit guarded" but not "outwardly antalgic." Employee had focal tenderness "at the base of her right thumb." Her right ankle had lateral tenderness but no ecchymosis or swelling. Her ankles were symmetric in stability testing with "perhaps slight increase in anterior drawer." Employee's right knee was stable in flexion and extension, had no effusion and was "a little bit" tender. There was no ecchymosis or bruising. Dr. Tower noted Employee's emergency room presentation listed neck and back pain but no extremity issues. He reviewed a right knee MRI and agreed Employee had degenerative changes in the medial meniscus' posterior horn without an "unstable tear." Otherwise, he found the knee "reasonably well preserved" with no major ligament damage or osteochondral injury. Dr. Tower took right ankle x-rays, which showed a well-preserved tibiotalar joint, no fractures and no arthritis. He also took right hand and wrist x-rays, which showed no acute fractures, well preserved joint surfaces, and no overt arthritis at the basal joint. Dr. Tower diagnosed an anterior knee contusion with patellofemoral irritability and opined the degenerative findings in the medial meniscus were unrelated to her work injury. He also diagnosed a right "minor lateral ankle sprain." Dr. Tower stated Employee jammed her thumb and aggravated her basal joint. For the right knee, he

recommended physical therapy and discontinuing the knee brace. For the right ankle, Dr. Tower recommended an air cast and physical therapy. He recommended no treatment to the right thumb area. He deferred to Dr. Cohen and Dr. Stinson for spinal issues. Dr. Tower did not think Employee's "appendicular" issues would interfere with her unrestricted work as a teacher. (Tower report, February 19, 2009).

20) The February 19, 2009 reports are the first time Employee's records mention any right ankle symptoms. These reports occurred 21 days after Employee's work injury. (Observations).

21) On February 26, 2009, Employee signed a termination notice and ended her employment with Employer who stated she was "not eligible for rehire." Employee did not understand this comment and never got an explanation from Employer. (Employee).

22) On March 13, 2009, Employee called Dr. Tower's office requesting a right ankle MRI. Dr. Tower did not approve an MRI and the nurse told Employee who became "very upset" and stated she could not bear weight on her right ankle. (Physician's Report, March 13, 2009).

23) Later on March 13, 2009, Employee went to the emergency room for right ankle pain and inability to bear weight. Ivan Ramirez, M.D., noted Employee seemed intoxicated and had "slurred speech." Employee attributed her ankle issue to her January 26, 2009 slip and fall, which she said caused pain "all over her body" but especially in her right wrist and ankle. Employee said she needs something to make the pain go away, since Percocet she had at home was not doing the job. Employee said any time she stands up on her ankle "she just falls over." Dr. Ramirez found a normal right wrist examination with no swelling, ecchymosis or bruising. Similarly, his right ankle examination found no tenderness, instability or swelling. Employee became "quite belligerent" and demanded pain medication when Dr. Ramirez suggested she needed an ankle x-ray for a full evaluation. Dr. Ramirez removed himself from the room to "deescalate the situation" when Employee became "more agitated, argumentative, confrontational." Employee voluntarily left when threatened with a security escort. However, she continued to aggressively seek treatment at the front desk and eventually received an ankle x-ray, which Dr. Ramirez found "completely normal, no evidence of fracture, dislocation or degenerative joint disease." Dr. Ramirez's assessment included "reported ankle instability" with "no evidence thereof," and drug-seeking behavior. (Ramirez report, March 13, 2009).

24) On March 20, 2009, Employee requested a vocational reemployment eligibility evaluation. (Employee letter, March 19, 2017).

25) On March 26, 2009, Employee told her physical therapist her ankle did well until about 4:00 PM, "then it starts aching." (Treatment Note, March 26, 2009).

26) On March 30, 2009, Employee's right hand was still "swollen and sore." Her "right knee and now right ankle are both continuing to be problematic." Employee told Dr. Stinson, "She is either seeking or has already been medically retired from the Anchorage School District." Employee planned to move to Indiana to be near her family for ongoing care. On examination, she had antalgic gait favoring the right lower extremity. Her right hand still had mild swelling and tenderness involving the right thenar eminence. There was no ecchymosis or point tenderness to palpation. Her right knee was tender but swelling was "equivocal." Dr. Stinson diagnosed a resolving soft tissue injury on the right thenar eminence, intra-articular right knee derangement with ongoing symptoms and "minimal ankle sprain." (Stinson report, March 30, 2009).

27) Mild to moderate ankle sprains are immediately painful and often remain painful for several weeks. Mild to moderate ankle sprains frequently cause swelling and discoloration. Employee did not suffer a mild to moderate or severe right ankle sprain on January 26, 2009. (Experience, judgment and inferences drawn from the above).

28) On March 31, 2009, Dr. Stinson signed a form stating cervical spondylosis and cervicalgia disable Employee permanently beginning January 27, 2009. (Attending Physician's Statement, March 31, 2009).

29) On April 3, 2009, Stephen Marble, M.D., saw Employee for an employer's medical evaluation (EME) at nurse case manager Tracy Davis' request. During the examination, Employee voiced her desire for "them to allow retraining." Dr. Marble observed a small bruise on Employee's right wrist, which she said came from a "stumble getting out of the tub." Other than subjective tenderness, Employee had a negative right ankle and knee examination. Dr. Marble said he had never seen pre- and post-injury thoracic spine films demonstrating so many levels with significant disc herniations. Employee also has a syrinx and possibly a smaller syrinx developing in the thoracic spine. In Dr. Marble's opinion, Employee is "at high risk for falling because of the advanced spinal pathology with neurologic sequela." Dr. Marble opined the January 26, 2009 work injury is not the substantial cause of Employee's symptoms, disability or need for ongoing medical care and did not permanently aggravate, accelerate or combine with any preexisting condition to lead to any current condition or need for ongoing medical care. He said the "alternative cause for the current condition" is the "preexisting condition, as outlined in the medical records." In

Dr. Marble's opinion, medical care had been reasonable and necessary to this point. The first emergency room visit was reasonable and necessary but subsequent visits to the emergency room were not because Employee had already established care with physicians who were actively managing her case. Dr. Marble opined Employee had a temporary "jarring exacerbation" on January 26, 2009, and needed no further medical care to address this injury. The injury in his opinion did not permanently alter Employee's functional capacity. Psychosocial issues compound Employee's pain and disability in Dr. Marble's opinion. In his view, Employee reached medical stability by March 2009 following reevaluation, various MRIs and physical therapy. He attributed no PPI to this injury. (Marble report, April 3, 2009).

30) On April 8, 2009, Employee told her physical therapist she was still unable to bear full weight on her right foot but her weight bearing tolerance was improving. Employee's right knee still ached. (Progress Report, April 8, 2009).

31) On April 9, 2009, Employee was still using right wrist and ankle splints though she admitted discomfort in these areas was improving over time with physical therapy. Dr. Tower said Employee presented "festooned with multiple braces and using a cane with a somewhat non-physiological gait pattern." Her reported sensations were inconsistent when she was distracted. Dr. Tower found no significant swelling or ecchymosis in any affected area. He opined Employee walked better without her cane and he found no instability in any extremity. Her functional examination was inconsistent, in his opinion. Dr. Tower opined Employee would have no long-term PPI or inability to work given her "appendicular" injuries from the fall at work. He again deferred to other specialists in respect to her spinal condition. (Tower report, April 9, 2009).

32) On April 13, 2009, Employee visited Dr. Stinson for the last time before moving to Indiana the next day. A recent garage sale had aggravated her neck, back, knee and leg pain and she had continued difficulty with pain, swelling and discoloration in her right hand. Dr. Stinson stated, "All of these conditions were aggravated by her fall at work." Her progress was "very slow." Employee continued to wear a right ankle brace. Dr. Stinson noted a "mildly antalgic" gait. Employee's right knee still had discoloration from her fall at work. He assessed "a very significant fall at work" causing a right ankle sprain, right knee contusion with intra-articular derangement, and ongoing right thenar eminence swelling and pain. (Stinson report, April 13, 2009).

33) On April 17, 2009, Employer reported it had paid Employee TTD benefits from February 4, 2009 through March 1, 2009, at $987 per week. Employer stated benefits terminated because a

physician had released Employee to regular work on April 3, 2009, and Employer controverted Employee's right to continuing benefits. (Compensation Report, April 16, 2009).

34) On April 17, 2009, Employer denied Employee's right to benefits based on Dr. Marble's EME report. (Controversion Notice, April 16, 2009).

35) On May 4, 2009, the division wrote to Employer stating it had received Employee's request for a reemployment benefits eligibility evaluation. Noting it had been 90 days since Employee's injury, the division asked Employer to advise if Employee had been off work for 90 consecutive days due to her work injury. (Division letter, May 4, 2009).

36) On May 7, 2009, adjuster Sandi Robinson said Employee's claim was under controversion based on Dr. Marble's EME report. (Workers' Compensation Reemployment Verification for 90 Consecutive Days of Time Loss, May 7, 2009).

37) On May 7, 2009, Carolyn Kochert, M.D., saw Employee in Indiana for her work injury. Upper-, mid- and low-back pain were Employee's "chief complaints." Employee described her January 26, 2009 fall at work and said resultant injuries included "right ankle badly sprained." Employee's second complaint included right-neck pain. Her third complaints encompassed left and right "hand pain." Employee's fourth complaint was left and right knee pain. Dr. Kochert found right ankle swelling and right knee clicking and popping. She diagnosed "right ankle sprain" and knee internal derangement with osteoarthritis, and referred Employee to a psychiatrist for evaluation and prescribed narcotics to control pain. (Kochert report, May 7, 2009).

38) Contrary to her report to Dr. Kochert, Employee's right ankle was not "badly sprained" on January 26, 2009. (Experience, judgment and inferences drawn from all the above).

39) Dr. Kochert's report did not expressly link Employee's right ankle sprain and knee internal derangement with osteoarthritis to her work injury with Employer. (Kochert report, May 7, 2009).

40) On June 2, 2009, the division advised Employee it could not act on her reemployment benefits eligibility evaluation request because Employer controverted her claim on compensability grounds. The letter further advised:

> Until the insurer accepts your claim, or until the Alaska Workers' Compensation Board hears your claim and overturns the denial, we cannot act on your request for an evaluation. (Division letter, June 2, 2009).

41) Employer never accepted Employee's claim thereafter. (Observations).

42) On June 3, 2009, Dr. Kochert's follow-up report stated Employee's hand hurt and her thumb was aching. Employee said her ankle continued to hurt with weight bearing and "it swelled to twice its size last week" requiring Employee to lay down and keep the ankle elevated for two days to reduce swelling. (Kochert report, June 3, 2009).

43) On June 3, 2009, Dr. Kochert performed anesthetic injections into Employee's right knee, ankle, and thumb "PIP and MCP" joints for internal derangement in each joint and for chronic pain syndrome. (Procedure Note, June 3, 2009).

44) The June 3, 2009 report is the first time Employee's medical records mention any right thumb symptoms other than at the thenar eminence. This report occurred 129 days after Employee's injury at work. (Observations).

45) On June 9, 2009, a provider with initials "MDK," saw Employee for her work injury. Employee described continuing right knee symptoms and problems with her "right dominant wrist" and ankle. X-rays showed "mild early changes at the CMC joint of the right thumb," while right ankle x-rays were normal. The physician diagnosed right wrist and thumb pain "status post fall," right medial meniscus tear and articular cartilage defect on the medial cartilage condyle and right ankle sprain with persistent lateral pain. The physician recommended right ankle and thumb therapy but Employee requested MRI scans of both, which were scheduled on her request. Employee requested right knee treatment as soon as possible. (MDK report, June 9, 2009).

46) On June 10, 2009, Employee underwent a right wrist and ankle MRI for "pain in the thumb side of the wrist and in the ankle since a fall 1/26." The radiologist found a "normal wrist." He also found no ankle joint effusion, fracture, osteochondritis or other abnormality. The ankle and subtalar joint ligaments were normal. Increased fluid in the posterior, tibial and flexor-digitorum tendon sheaths represented "moderate tenosynovitis." (MRI report, June 10, 2009).

47) On June 10, 2009, Gregory Konrath, M.D., reviewed the right knee MRI and found a posterior horn medial meniscus tear and a medial femoral condyle cartilage defect. The right wrist MRI was negative and the right ankle MRI showed tenosynovitis. He found a "moderately severe right trigger thumb" on the right hand and ordered physical therapy for the ankle, a partial medial meniscectomy and a trigger thumb release. (Konrath report, June 10, 2009).

48) The June 10, 2009 report is the first time a physician diagnosed right trigger thumb. This diagnosis occurred 136 days after Employee's injury at work. (Observations).

49) On June 23, 2009, Dr. Konrath performed a right knee arthroscopy with partial medial meniscectomy, and a right trigger-thumb release on Employee. Dr. Konrath found "an unstable tear" in the medial meniscus. (Operative Report, June 23, 2009).

50) On August 6, 2009, PA-C Froiland and Dr. Trombley co-authored a "To Whom It May Concern" letter stating it was not possible to objectively confirm Employee's belief her January 26, 2009 fall at work exacerbated her problems, because she had so many aches without objective evidence. (Froiland and Trombley letter, August 6, 2009).

51) On August 8, 2009, Employee called the division with vocational rehabilitation and general questions about her case. Division staff told Employee that Employer controverted her case and reemployment request. Division staff mailed claim and request for conference forms to Employee's address. The telephone call lasted 70 minutes. (ICERS, accessed March 31, 2017).

52) On August 19, 2009, Employee's thumb was "doing well" with no pain and full motion. Employee still had some knee discomfort. (Konrath report, August 19, 2009).

53) On August 24, 2009, Employee said she had "difficulty standing up" and fell frequently. Employee did not describe why this occurred. Dr. Kochert wrote a "To Whom It May Concern" letter stating Employee had "several severe injuries to her hands, knees, ankles which resulted from a fall on the ice." Dr. Kochert opined Employee needed to be in a warmer climate from October through March. (Kochert report, August 24, 2009).

54) On August 25, 2009, Dr. Konrath wrote a "To Whom It May Concern" letter at Employee's request. He opined Employee's trigger thumb "can indeed be traumatically induced and can be caused by a fall on ice and jamming the hand." Dr. Konrath stated Employee's right-knee meniscal tear "could be caused by a fall." Employee told him she had no right thumb or right knee problems prior to her work injury so he concluded, "most likely these problems did occur from her injuries she sustained at work." Dr. Konrath based his opinions on Employee's report, and on his MRI and physical examination findings. He did not have Employee's previous medical records to review. (Konrath letter, August 25, 2009).

55) This decision considered Dr. Kochert's August 24, 2009 and Dr. Konrath's August 25, 2009 letters for the reasons set forth below. (Judgment).

56) On October 26, 2009, Employee said "ankle and thumb all right." Employee had uncomfortable "body twitching," some "quite violent." She had difficulty with both feet becoming numb and had problems walking "because I can't feel them." (Kochert report, October 26, 2009).

57) On November 5, 2009, Dr. Stinson's office filed a claim for unpaid medical bills. (Workers' Compensation Claim, October 28, 2009).

58) On February 2, 2010, Dr. Stinson's representative Letitia Jensen attended a prehearing conference for his claim, but Employee did not attend. "Upon learning that EE was not pursuing her WC claim, Ms. Jensen elected not to pursue Advanced Pain Center's claim through the workers' compensation system." The division served a prehearing conference summary for this meeting on Employee. (Prehearing Conference Summary, February 2, 2010).

59) On March 1, 2010, Dr. Kochert said Employee was disabled. Dr. Kochert did not state a reason for her disability. (Kochert report, March 1, 2010).

60) On March 11, 2010, Employee fell while getting out of the tub. Employee had resultant pain in her hands, ankles, back, and knee. (Avon Urgent Care report, March 11, 2010).

61) On March 15, 2010, Stacia Groover-Maltby, M.D., prescribed a home health care evaluation and treatment for Employee's chronic back pain, herniated discs and urinary incontinence. On this form, Employee wrote, "I hurt so much." (Groover-Maltby prescription, March 15, 2010).

62) On May 21, 2010, Employee reported she fell three times the prior week because her right knee "gave way, totally unexpected." (Groover-Maltby report, May 21, 2010).

63) In summer 2010, Employee utilized extensive home health care services. This included reminders to take medication, assistance with getting out of bed and with personal care. The attendant also took Employee on a daily walk for exercise. (Home Instead reports, 2010).

64) On July 21, 2010, Employee fell "from about eight steps" while performing walking exercises and hurt her back, legs, ankle, shoulder and neck. (Home Instead report, July 21, 2010).

65) On September 24, 2010, Employee testified by deposition in an unrelated third-party lawsuit and said she "had to" retire from teaching following her work injury with Employer because she "couldn't walk, couldn't stand on my feet, I was . . . injured." Employee also testified she retired because she ran out of leave and would otherwise have to pay for her own insurance if she did not retire. (Videotape Deposition of Susan A. Piasini-Branchflower, September 24, 2010, at 78). Employee had a stroke on May 22, 2008, and seizures briefly thereafter. (*Id*. at 111). Employee explained her fall with Employer as follows:

> So when I fell I started to fall backwards so my head went all the way back and then you -- you know, it's just a natural thing to try and straighten yourself so in that process when I did that my head came all the way forward and I fell, landed on my

> hands and knees and my chin hit my chest and I bit my tongue, it was like whack. (*Id*. at 118).

66) On September 25, 2010, Anthony Woodward, M.D., performed an independent medical evaluation on Employee for her unrelated April 3, 2008 car accident. Employee said she began developing severe "Charlie horses" in her legs in June 2008. Employee slipped on the ice at work on January 26, 2009, and fell onto her hands and knees. She reported right hand, knee and elbow contusions and said she "tore her knee apart" and had a right ankle sprain. After moving to Indiana, Employee "slid down the steps and then she fell in the house." Employee attributed these falls to her knee giving way. Dr. Woodward disagrees with Dr. Konrath's opinion stating a trigger finger could be due to the January 26, 2009 fall. He opined trigger finger does not arise from a fall. Dr. Woodward further noted only Dr. Konrath diagnosed a right trigger thumb. Employee told Dr. Woodward she had pain in the thenar eminence of both hands, with the left being present for six weeks. (Woodward report, September 25, 2010).

67) In October 2010, Employee relocated to California to begin assisted living. (Employee).

68) On February 11, 2011, Mohinderpal Thaper, M.D., stated Employee has ventricular white matter brain disease "which will affect her balance & stability & her walking." (Thaper report, February 11, 2011).

69) On April 8, 2011, Employee called the division stating she understood the statute of limitations was about to run out and she needed assistance. Division staff directed Employee to file a claim and a hearing request immediately. (ICERS, accessed March 31, 2017).

70) On April 12, 2011, Employee filed her first claim requesting PTD, medical care and related transportation expenses, review of the Rehabilitation Benefits Administrator's decision, a compensation rate adjustment, penalties, interest, and a finding Employer filed an unfair or frivolous controversion. She also filed a hearing request on the same day. (Workers' Compensation Claim; Affidavit of Readiness for Hearing, April 11, 2011).

71) On April 18, 2011, the division rejected Employee's hearing request noting she filed it prematurely, at the same time as her claim. The division advised Employee she had to wait 20 days after the division served her claim or until Employer answered it, before she could re-file her hearing request. The division invited Employee to call the division if she had any questions. (Division letter, April 18, 2011).

72) On April 25, 2011, attorney David Floerchinger sent Employee a letter with releases attached. Floerchinger asked her to sign and return these releases within 14 days. The letter also told Employee she could request a protective order under AS 23.30.107(a) if she objected to the releases. The letter also stated in bold-faced type, "Failure to sign and return the release(s) or file a request for a protective order within the 14-day period may result in a suspension of benefits until the release(s) is signed. AS 23.30.108(a)." The letter advised Employee to contact the board if she had any questions. (Floerchinger letter, April 25, 2011).

73) On April 27, 2011, Employer denied Employee's April 11, 2011 claim based on Dr. Marble's EME report. (Controversion Notice, April 25, 2011).

74) On May 10, 2011, Employer denied Employee's claim based on her failure to sign and return releases requested on April 25, 2011, or file a petition for protective order. (Controversion Notice, May 10, 2011).

75) On May 24, 2011, Employee requested a prescription for right hand, knee and ankle braces. (Access Healthcare report, May 24, 2011).

76) On August 5, 2011, Employee said in a psychiatric exam she was able to function "until a fall at work after an earthquake in 2008." (Eric Foxman, M.D., report, August 8, 2013).

77) On August 24, 2011, the parties attended a prehearing conference about discovery but the designee did not order Employee to sign and return any informational releases. Employee said she was seeking legal counsel in California. (Prehearing Conference Summary, August 24, 2011).

78) On September 13, 2011, Michael Lewis, M.D., evaluated Employee's ankles. Employee said she had bilateral ankle pain for two and one-half years with acute, right ankle pain after a fall when she slipped on ice. Employee claimed to have had persistent swelling and painful instability in the right ankle since the fall. The left ankle recently started bothering her. Dr. Lewis reviewed bilateral ankle x-rays and found the right ankle had "very mild tibiotalar degenerative changes." Dr. Lewis diagnosed a "possible chronic lateral ankle instability, right ankle; very mild tibiotalar degenerative osteoarthritis, right ankle; and insertional Achilles tendinopathy, right ankle. The left ankle was normal. (Lewis report, September 13, 2011).

79) Dr. Lewis did not expressly relate his findings and diagnoses to the work injury. (*Id.*).

80) Contrary to her account, Employee did not have acute, right ankle pain, persistent swelling and instability in her right ankle since her 2009 work injury. (Inferences drawn from the above).

81) On September 16, 2011, a radiologist could not well-visualize Employee's right ankle anterior talofibular ligament on MRI and suspected a chronic tear. Otherwise, the MRI disclosed nothing abnormal, including the articular surfaces. (MRI report, September 16, 2011).

82) On October 4, 2011, Dr. Lewis referred Employee to a surgeon for possible lateral ligament reconstruction, even though he found no ankle instability. (Lewis report, October 4, 2011).

83) On October 6, 2011, Employee reported having fallen onto both hands in January 2009. She said she had pain to both thumbs since then and a right trigger thumb release in June 2009. Employee still had moderate pain especially on the right thumb. Robert Roth, M.D., examined Employee, took x-rays and found "objective findings are quite minimal." Employee had "no significant arthritis" in her right thumb. He found inflammation "secondary to overuse and strain" and noted there was no cure for this "since she is required to use her hands to help herself ambulate." Dr. Roth provided a thumb splint and advised Employee to see her primary care physician for anti-inflammatories if needed. (Roth report, October 6, 2011).

84) On October 6, 2011, Babak Kosari, DPM, examined Employee for chronic pain in her right lateral ankle. Employee told Dr. Kosari she fell on the ice on January 26, 2009 during work and went to the hospital the next day. Employee said "someone" told her she had "a bad sprain." Employee exhibited severe tenderness on the TAL and CF ligaments. Dr. Kosari found edema but no ecchymosis. He found no ankle joint crepitus. Dr. Kosari diagnosed an ankle sprain and tenosynovitis. He does not mention ankle ligament instability. Dr. Kosari recommended a lateral, collateral right ankle reconstruction. (Kosari report, October 6, 2011).

85) Dr. Kosari's report does not expressly state the January 26, 2009 work injury caused his diagnoses or the need for medical treatment. (*Id.*).

86) No medical provider to this point had documented Employee had a "bad sprain" on her right ankle resulting from the January 26, 2009 fall. (Judgment; inferences drawn from the above).

87) On October 21, 2011, Dr. Kosari performed a lateral collateral ankle ligament reconstruction on Employee's right ankle using an allograft. He found a torn ligament and loosening in the lateral ankle. (Operative report, October 21, 2011).

88) Dr. Kosari's right ankle surgery and operative findings did not result from the January 26, 2009 fall. Surgical findings most probably resulted from Employee's fall down steps on July 21, 2010, which most probably resulted from Employee's thoracic issues, white matter brain disease, and prescription medication side effects. (Marble; Thaper; inferences drawn from all the above).

89) On November 2, 2011, Employee said she had an attorney and the board's designee told her the board had not received an entry of appearance from her attorney. (Prehearing Conference Summary, November 2, 2011).

90) On November 12, 2011, Employer's attorney attended a prehearing conference. The designee did not order Employee to sign and return any informational releases. (Prehearing Conference Summary, November 12, 2011).

91) On November 25, 2011, Employee had bilateral knee pain, more on the right. X-rays showed a "likely patellofemoral compartment, particularly cartilage defects" in both knees. Employee needed bilateral knee arthrograms. (Adam Dietz, M.D., report, November 25, 2011).

92) On November 26, 2011, Employee signed a notice authorizing Perle to represent her in her workers' compensation case. (Notice of Appearance, November 26, 2011).

93) On December 9, 2011, Employee, now using the name Susan Perle, saw a new physician in California to establish care for "chronic pain syndrome." Imad Rasool, M.D., diagnosed syringomyelia, post-lumbar laminectomy syndrome and chronic pain disorder. Dr. Rasool did not attribute these diagnoses to any particular injury. (Rasool report, December 9, 2011).

94) On January 18, 2012, Employee underwent a right hand and wrist computerized tomography (CT) scan. The CT disclosed mild osteoarthritis at the basilar joint. (CT report, January 18, 2012).

95) On February 16, 2012, Employee seemed "lethargic" with "slurred speech" and reported falling the prior Sunday. She did not give a reason for her fall. (Kosari report, February 16, 2012).

96) On February 29, 2012, Employee fell again because she had no help removing her wheelchair from her car. (Kosari report, February 29, 2012).

97) On April 12, 2012, Employee had right thumb pain and said her symptoms "have developed over time." Employee referenced a remote, right hand and wrist injury in 2009. However, on this visit Employee said her pain worsened "after a recent fall." Raymond Raven III, M.D., found swelling and tenderness over the base of the right thumb, mostly over the thenar eminence. He diagnosed posttraumatic basal joint arthritis with recent aggravation in the right thumb. He administered a steroid injection and prescribed physical therapy. (Raven report, April 12, 2012).

98) On July 5, 2012, Employee said she had twisted her right ankle 10 days earlier. Dr. Kosari ordered an MRI to check the right "CF" ligament for re-rupture. (Kosari report, July 5, 2012).

99) On July 10, 2012, Dr. Raven diagnosed severe basal joint arthritis with failed conservative management. He explained options and Employee wanted surgery. (Raven report, July 10, 2012).

100) On July 23, 2012, Dr. Raven performed right basal joint reconstruction surgery on Employee's right thumb and wrist. (Operative Report, July 23, 2012).

101) On November 15, 2012, Dr. Raven's office released Employee to activities as tolerated without right thumb restrictions. (Raven report, November 15, 2012).

102) On November 21, 2012, Employee told Dr. Foxman she planned to marry on December 31, 2012, and said, "We are taking dancing lessons." (Foxman report, November 21, 2012).

103) On February 13, 2013, Employee told Dr. Kosari her right ankle pain had worsened without any recent trauma or injury. He recommended another MRI. (Kosari report, February 13, 2013).

104) On February 15, 2013, Employee told Dr. Rasool she had increased right ankle pain secondary to multiple surgeries. (Rasool report, February 15, 2013).

105) On April 19, 2013, a party filed a medical summary including Dr. Kochert's August 24, 2009 and Dr. Konrath's August 25, 2009 letters. This medical summary is not in Employee's division file. (Request for Cross-Examination, September 3, 2015; observations).

106) On April 22, 2013, Employee filed a claim amending her April 9, 2011 claim. Her amended claim sought TTD from January 26, 2009 and ongoing, PTD for the same dates, PPI, medical costs and related transportation expenses, "other" reemployment benefits, a compensation rate adjustment, penalty, interest, a finding Employer made an unfair or frivolous controversion, attorney fees and costs and "other." (Workers' Compensation Claim, April 4, 2013).

107) On April 22, 2013, Employee filed a hearing request on her April 12, 2011 and April 4, 2013 claims. (Affidavit of Readiness for Hearing, April 22, 2013).

108) Employee's April 19, 2013 hearing request triggered the 10-day period for parties to "*Smallwood*" filed and served, but un-Smallwooded, medical records, or request the right to cross-examine authors of previously filed and served non-medical records. The 10 days expired on April 29, 2013. (Experience; judgment; observations).

109) On May 2, 2013, Employee continued to have anterior knee pain bilaterally, worse on the right. Her symptoms were similar to her November 2011 visit. Employee said her 2009 right knee arthroscopy was not helpful. Both knees had moderate atrophy but no effusion and the knee examinations were similar. Dr. Dietz diagnosed likely patellofemoral-compartment cartilage defects in bilateral knees, with a more symptomatic right knee. Dr. Dietz did not attribute these conditions or findings to any particular injury. (Dietz report, May 2, 2013).

110) On May 2, 2013, Employee's bilateral knee x-rays were negative. (X-rays, May 2, 2013).

111) On May 16, 2013, Employer denied Employee's April 4, 2013 claim based on Dr. Marble's EME report. (Controversion Notice, May 14, 2013).

112) On May 29, 2013, Dr. Konrath wrote an opinion letter to Employee's attorney. (Konrath letter, May 29, 2013).

113) This decision did not consider Dr. Konrath's May 29, 2013 letter for the reasons set forth below. (Judgment).

114) On June 10, 2013, Floerchinger sent Perle a letter asking Employee to sign attached releases. This letter included a petition-for-a-protective-order warning and referenced AS 23.30.108(a) regarding benefit suspension. (Floerchinger letter, June 10, 2013).

115) On June 13, 2013, Employee underwent a right knee MRI, which showed no acute ligamentous or tendinous injury but showed her prior collateral ligament complex reconstruction without acute disruption. (MRI report, June 13, 2013).

116) On June 13, 2013, Employee also had a thoracic spine MRI for "chronic pain syndrome," a condition with which doctors had diagnosed her throughout 2013. (MRI report, June 13, 2013; observations).

117) On June 18, 2013, Dr. Kochert responded to a letter from Employee's attorney. Dr. Kochert said she treated Employee for low back pain radiating into the thigh, neck pain, occipital pain, and bilateral hand and knee pain. Employee received right knee, ankle and thumb PIP and MCP joint injections. Dr. Kochert did not restrict Employee from work. She treated Employee for "acute ankle sprain." Dr. Kochert recommended Employee should see a "regenerative medicine" doctor and a psychiatrist. When Employee left Dr. Kochert's care, she still had multiple medical issues and needed continued treatment. Dr. Kochert opined Employee received "some permanent partial impairment" although Dr. Kochert did not perform ratings. She said Employee should live in a warm, dry climate because she has chronic pain and knew of "no other reason" for Employee's pain "than the January 26, 2009 accident." Based on Employee's accident description and physical examination, Dr. Kochert opined, "This accident disabled her from working from the time of the accident through the entirety of her treatment at my office." (Kochert letter, June 18, 2013).

118) This decision considered Dr. Kochert's June 18, 2013 letter for the reasons stated below. (Judgment).

119) On June 18, 2013, Dr. Kosari operated on Employee's right second and third hammertoes and a right bunion. (Operative report, July 18, 2013).

120) On June 25, 2013, Dr. Kosari operated on Employee's right foot bunion and hammertoes. (Operative Report, June 25, 2013).

121) On June 25, 2013, Pearl wrote to Floerchinger and returned the requested releases, "modified to allow for records to be released only to your law firm." (Perle letter, June 25, 2013).

122) On July 12, 2013, Dr. Konrath responded to a letter from Employee's attorney. Dr. Konrath summarized the medical records and provided his opinions on various issues involved in Employee's claims. Notably, Dr. Konrath opined Employee injured her right knee medial meniscus when she fell at work and the work injury caused a traumatic, right trigger thumb. He diagnosed mild, persistent right ankle pain from a sprain attributable to this fall. In his opinion, "The injury was the sole cause of the aforementioned injuries without any evidence of predisposing conditions." (Konrath letter, July 12, 2013).

123) This decision considered Dr. Konrath's July 12, 2013 letter for the reasons set forth below. (Judgment).

124) On July 17, 2013, Floerchinger re-sent Perle a Social Security and "General" medical release, which Employee had not signed and returned previously. Floerchinger told Perle he could not limit discovery to only providers Perle identified. (Floerchinger letter, July 17, 2013).

125) On July 19, 2013, Perle sent Floerchinger 17 signed medical releases for "additional medical providers that she has seen in relation to her workers' compensation case for which you had not previously requested records. . . ." (Perle letter, July 19, 2013).

126) On July 23, 2013, Dr. Kosari operated on Employee's right ankle to address degenerative joint changes, arthritis and ankle pain. Dr. Kosari found "white deposits" described as "chunks" in the ankle joint. There was significant synovitis. (Operative Report, July 23, 2013).

127) On August 28, 2013, Perle advised Floerchinger that Employee had never received Social Security benefits. He also requested legal authority for Employee's duty to sign a release for an "unknown" provider. (Perle letter, August 28, 2013).

128) On September 4, 2013, Floerchinger explained why he wanted Employee to sign and deliver various discovery releases. Floerchinger asked Employee to return the releases or agree to have the board's designee address the issue at the September 11, 2013 prehearing conference. (Floerchinger letter, September 4, 2013).

129) On September 10, 2013, Perle wrote to Floerchinger stating Employee would sign and return a Social Security release, though she had never received any Social Security benefits. Perle

objected to "blank" releases and contended that without knowing the providers' names, Employee could not know whether she wanted to object to producing such records. Perle agreed to have a prehearing conference at which the designee would address the authorization issues. (Perle letter, September 10, 2013).

130) On September 11, 2013, the parties attended a prehearing conference and discussed informational releases. Employee did not want to sign a release without the providers' names. Employer's attorney "in the spirit of accommodation" agreed to redraft releases with providers' names included. Employee agreed, if Employer redrafted the releases, she would "remove her objections." The designee did not order Employee to sign and return any releases. (Prehearing Conference Summary, September 11, 2013).

131) On September 11, 2013, Dr. Kosari stated he began treating Employee on October 6, 2011. On this first visit, Dr. Kosari diagnosed a lateral collateral ankle ligament injury with ankle enthesopathy along with a "severe ankle sprain injury." He concluded, "It is possible that patient's injury on January 26, 2009 has led to the above sequelae and subsequently the need for multiple surgical management episodes." (Kosari letter, September 11, 2013).

132) Employee did not have a "severe ankle sprain injury" on January 26, 2009. (Judgment; inferences drawn from all the above).

133) On September 18, 2013, Floerchinger wrote to Peale asking Employee to sign and return within 14 days, provider-specific releases altered in conformance with the September 11, 2013 prehearing conference. This letter does not include any reference to AS 23.30.108. (Floerchinger letter, September 18, 2013).

134) On October 1, 2013, Perle wrote to Floerchinger and enclosed several signed releases, modified to allow records "to be released only to your law firm." Perle sought additional information about several providers and service dates so Employee could "determine if she received care at these facilities" for her work injury with Employer. (Perle letter, October 1, 2013).

135) On October 10, 2013, Employee was post, right basal joint reconstruction surgery but had soreness in the hand and thumb radiating to the elbow and shoulder, with numbness and tingling in the ulnar hand. Dr. Raven found no significant swelling or deformity. He made no diagnosis but referred Employee to physical therapy. (Raven report, October 11, 2013).

136) On November 25, 2013, Floerchinger sent Employee a letter with attached releases for her to sign and return. (Floerchinger letter, November 25, 2013).

137) On December 3, 2013, Perle sent Floerchinger Employee's signed releases for 25 medical providers. Employee through counsel refused to sign releases for plastic surgeons and a psychiatrist on privacy and relevancy grounds. Perle also requested additional information about 23 other medical providers for whom Employer requested Employee sign releases, before she would sign them. (Perle letter, December 3, 2013).

138) On December 9, 2013, Perle objected to Employer's requested release for a plastic surgeon and a psychiatrist. Employee contended releasing these privileged records would be an invasion of privacy. She requested Board relief. (Objection to Requests for Release of Information Pursuant to AS 23.30.108, December 2, 2013).

139) On December 10, 2013, Dr. Raven responded to a letter from Employee's attorney. Dr. Raven noted on April 12, 2012, Employee told him her right hand pain following a fall on January 26, 2009, went as high as "9 on a scale from 0 to 10," and she had right hand weakness. Right thumb surgery did not result in any improvement. Dr. Raven opined Employee developed basal joint arthritis after falling on January 26, 2009. This condition did not improve after a corticosteroid injection therapy so Employee underwent surgery. Prior to her basal joint surgery, Dr. Raven gave Employee no work restrictions. Following surgery and hand therapy, Employee did well and Dr. Raven released her to resume full duty as tolerated. On October 11, 2013, she returned with soreness in her hand and thumb radiating to the elbow and shoulder. Dr. Raven prescribed more therapy. He opined Employee's right basal joint "condition" resulted from the January 26, 2009 work injury. Her prognosis was "good to excellent." Additional treatment for this condition is "uncommon" but may include physical examinations, hand or occupational therapy, steroid injections or surgery, in Dr. Raven's opinion. (Raven letter, December 10, 2013).

140) On December 24, 2013, Floerchinger sent Perle addresses for the 23 medical providers for which Employee had not yet signed medical releases. He requested Employee sign and return the releases within 14 days. (Floerchinger letter, December 24, 2013).

141) On January 15, 2014, Perle sent Floerchinger a letter with 24 signed releases attached. Perle stated Employee did not recall having seen Gina A. Wilson-Ramirez, M.D., and did not enclose a release for this physician pending information from Employer showing Dr. Wilson-Ramirez had examined her. (Perle letter, January 15, 2014).

142) On March 27, 2014, Employee had a right knee arthrogram. The radiologist had nothing with which to compare this but found a horizontal tear in the posterior horn of the medial meniscus; and chondromalacia on the patella and medial femoral condyle. (MRI report, March 27, 2014).

143) On April 10, 2014, Dr. Dietz reviewed the right knee MRI results and found a previous, partial medial meniscectomy with persistent posterior horn defect, and mild, medial and patellofemoral compartment osteoarthritis. Because Employee had no "painful mechanical symptoms," and her pain was anterior rather than medial, Dr. Dietz concluded Employee did not need a revision, partial medial meniscectomy. (Dietz report, April 10, 2014).

144) On May 28, 2014, Employee said, "I fell down the stairs twice" and advised she was moving to a single-story home, because "I can't afford to fall." Employee also said Adderall makes her sleepy. She did not say why she fell down the stairs. (Foxman report, May 28, 2014).

145) On June 4, 2014, Employee said she fell down the stairs "yesterday." Imaging showed no acute injuries and diagnoses included neck and back strain. She did not explain why she fell down the stairs. Employee had "slurred speech . . . appears drowsy," and complained of chronic back pain and leg numbness. (West Hills Hospital and Medical Center report, June 4, 2014).

146) On July 15, 2014, Employee told Michael Lewis, M.D., she had recently fallen down the stairs and injured her neck. She also slammed her left hand in a door. Employee did not give a reason for her recent fall. (Lewis report, July 15, 2014).

147) On July 29, 2014, Employee told Dr. Foxman her Vyvanse wears off at 3:00 PM and she has difficulty focusing well in the evening. Employee typically takes up to three Oxycodone 15 milligrams per day. Adderall still makes her sleepy. (Foxman report, July 29, 2014).

148) On July 30, 2014, Employee told Dr. Rasool she had fallen twice in the past month. Employee had also recently burned her hand and arm at home. (Rasool report, July 30, 2014).

149) On August 8, 2014, Employee filed a medical summary including Dr. Kochert's June 18, 2013, Dr. Konrath's July 12, 2013, and Dr. Raven's December 10, 2013 medical opinion letters to Employee's attorney. (Medical Summary, August 8, 2014).

150) On September 3, 2014, Employer filed a *Smallwood* objection to Dr. Kochert's "June 28, 2013" record and Dr. Konrath's July 12, 2013 letter. There is no June 28, 2013 Kochert record in Employee's agency record. Employer did not object to Dr. Kochert's June 18, 2013 letter, so this decision considered it. (Request for Cross-examination, September 2, 2014; judgment).

151) On December 17, 2014, Employee underwent bilateral knee x-rays for "left knee pain." The radiologist compared these with May 2, 2013 films. The radiologist found no acute fractures, dislocations or joint effusion within the right knee, but found mild joint space narrowing, chondrocalcinosis, and "in particular," a calcific density suggesting a partially calcified protruded meniscus. He found minimal defects in the left knee. (X-ray report, December 17, 2014).

152) On March 5, 2015, Dr. Kosari recommended additional arthroscopic surgery for Employee's left ankle to address ankle pain and degenerative joint disease. (Kosari report, March 5, 2015).

153) On April 7, 2015, Dr. Kosari operated on Employee's left ankle to address degenerative joint disease and ankle pain. (Operative Report, April 7, 2015).

154) On May 12, 2015, Employee requested a hearing on her April 12, 2011 and April 4, 2013 claims. (Affidavit of Readiness for Hearing, May 11, 2015).

155) Employee's May 12, 2015 hearing request triggered the 10-day limit for parties to *Smallwood* previously filed, but un-Smallwooded, medical records, or request the right to cross-examine authors of previously filed non-medical records. The 10 days expired on May 22, 2015. (Experience; judgment; observations).

156) Employee timed her claims and hearing requests to prevent barred and denied claims under applicable statutes of limitations. (Experience; judgment and inferences drawn from the above).

157) On September 4, 2015, Employer filed a *Smallwood* objection to Dr. Kochert's August 24, 2009 letter and Dr. Konrath's August 25, 2009 letter, which was more than 10 days after Employee's April 22, 2013 and May 12, 2015 hearing requests. (Request for Cross-Examination, September 3, 2015; Affidavit of Readiness for Hearing, May 11, 2015; judgment and inferences drawn from all the above).

158) On September 11, 2015, Employee filed three Tracy Davis authored documents, one dated February 17, 2009, and two dated March 21, 2009. (Legal Memorandum of Applicant, Susan Piasini-Branchflower Re: SIME Hearing, September 8, 2015, attachments).

159) Employee filed the three above-referenced Davis authored documents more than 20 days before the November 30, 2016 hearing. Employee did not demand the right to cross-examine Davis at least 10 days before the hearing. (Observations).

160) On October 28, 2015, Perle sent Meshke a letter to which was attached a medical record release for West Hills Hospital. (Perle letter, October 28, 2015).

161) On December 15, 2015, Employee reported she had fallen three weeks earlier onto her outstretched left hand. She also had right shoulder pain caused from reaching into her washing machine and dryer but denied any major right shoulder injury. (Raven report, December 15, 2015).

162) On December 21, 2015, Employee reported left basal joint pain. She provided a history of similar right basal joint symptoms and joint reconstruction surgery years earlier. Employee sought left hand basal surgery. (Raven report, December 21, 2015).

163) On March 25, 2016, neurosurgeon Bruce McCormack, M.D., examined Employee in a second independent medical examination (SIME). (Deposition of Bruce McCormack, November 21, 2016, at 5). In Dr. McCormack's opinion, the right knee and right trigger thumb injuries "should be accepted," but not the right thumb basal joint problem. The work injury with Employer was the substantial cause of the need to treat the right knee and right trigger thumb in his opinion. He did not accept the right ankle as a work injury. (*Id*. at 11-13). In his opinion, Employee reached medical stability by September 1, 2009 for these two work-related injuries. (*Id*. at 15). He attributed a one percent PPI rating for the right knee injury but found no impairment for the right trigger thumb. (*Id*. at 16). Dr. McCormack opined Employee needed no further medical care for the right knee or right trigger thumb after September 2009. (*Id*. at 16-17). He did not attribute the two right ankle surgeries to the work injury because early physicians found no evidence of a torn ligament either on physical examination or on MRI. (*Id*. at 18-19). Further, Dr. McCormack said the fact Employee had both ankles operated on made it more likely her ligament issues requiring surgery arose from normal aging. (*Id*. at 21). In his opinion, Employee could return to sedentary work effective September 30, 2009. (*Id*. at 22; 81). Dr. McCormack agreed a schoolteacher is not a sedentary position and Employee could not return to that job. (*Id*. at 24). However, in his view a combination of work and non-work-related medical conditions in totality prevent her from working as a schoolteacher. Her right knee condition "in and of itself" does not prevent her from working as a teacher. (*Id*. at 25). Similarly, her right ankle condition would not by itself prevent her from working as a schoolteacher. (*Id*. at 26). The right knee and right ankle combined, in his view, would not prevent Employee from teaching. (*Id*.).

164) On cross-examination, Dr. McCormack conceded he had not done ankle surgery since medical school. (*Id*. at 35). He did not attribute the right ankle to the work injury because there were no objective findings and Employee had a plethora of injured body parts. (*Id*. at 38-39). He agreed the medical records and evidence showed no injury source to the right ankle other than the

January 26, 2009 work injury with Employer. (*Id*.). Dr. McCormack's main concern included the lack of any instability findings in the right ankle after the work injury. (*Id*. at 42). The fact it took several years for the right ankle surgery to occur post-injury also concerned him. (*Id*. at 45). Dr. McCormack opined the work injury was not the substantial cause of her inability to return to work as a teacher. (*Id*. at 86). The work injury was also not the substantial cause for any back surgery Employee had after 2009 and did not contribute "even a little bit." (*Id*. at 88).

165) Sidney Levine, M.D., is a board-certified orthopedic surgeon who also performed an SIME on Employee. (Deposition of Sidney Levine, M.D., July 11, 2016, at 5). Employee's work injury with Employer necessitated her right meniscal surgery. (*Id*. at 12). Dr. Levine also attributed the right ankle to the work injury because the symptoms existed "right from the beginning," persisted, and eventually "someone performed surgery." (*Id*. at 15). Dr. Levine compared a 2009 right ankle MRI with a 2011 right ankle MRI and noted the first showed only an inflamed tendon but no ligament issues while the second MRI showed a chronic, anterior talofibular ligament tear on the opposite side of the ankle. (*Id*. at 16-18). After hearing Dr. McCormack's opinion stating the right ankle was not work-related, Dr. Levine concluded, "I can't disagree with him," but noted several doctors found an ankle sprain early on following the work injury and "sometimes these things do progress" and Employee "eventually had an MRI that showed some abnormality." Dr. Levine also agreed there could have been an intervening ankle injury, but opined nothing in the records describe a new injury. (*Id*. at 24). He agreed the ankle injury was "progressive." (*Id*.). Dr. Levine agreed Employee did not complain about her right ankle until three weeks after her work injury but he concluded this is common when multiple body parts are injured. (*Id*. at 97). In Dr. Levine's opinion, bruising is unusual and swelling would be "more usual" with an ankle sprain. (*Id*. at 98).

166) Dr. Levine provided a one percent PPI rating for Employee's right knee but no other rating for any other work-related condition. (*Id*. at 31).

167) In his opinion, Employee did not suffer an injury to her hand or thumb when she fell. (*Id*. at 36). Dr. Levine opined Employee has a "very significant" psychological factor. (*Id*.). In his view, Employee's medical records show she exaggerates her pain. (*Id*. at 36-37).

168) Dr. Levine opined Employee is employable in a sedentary position. (*Id*. at 37). In his opinion, Employee's right knee and right ankle restrict her from prolonged standing, repetitive squatting, kneeling or stairclimbing. (*Id*. at 62). Dr. Levine opined Employee's teaching position is not sedentary. (*Id*. at 64).

169) He does not think Employee was medically stable, as Dr. Marble stated. (*Id*. at 67).

170) Dr. Levine opined Employee does not take medications, including narcotics, for her work injury. (*Id*. at 76).

171) As of June 2009, when she was in Indiana, Employee did not need basilar thumb joint surgery in Dr. Levine's opinion, given her normal MRI. (*Id*. at 84). He agrees with Dr. McCormack that the work injury may have caused the right trigger thumb. (*Id*. at 86). He finally stated the work injury necessitated the right trigger-thumb surgery and Employee was not medically stable for six months after trigger thumb surgery, because it occurred at the same time as her right knee surgery. (*Id*. at 114). Dr. Levine also agrees right basilar arthritis is more common in women and especially middle-aged women. (*Id*. at 87). However, he relied upon the examining physician who saw a big bruise on Employee's thumb shortly after the work injury. Dr. Levine opined this means Employee had an injury and, even though she had some underlying condition, the injury moved her arthritis forward "at a more rapid pace" and caused the need for the basilar thumb surgery. (*Id*. at 89-90). However, if Employee had a "recent fall" in April 2012, in Dr. Levine's view "that [basilar thumb surgery] would not be due to the initial fall, especially if there was that two-year hiatus." (*Id*. at 91). Dr. Levine opined this latter fall is probably what contributed to Employee's right basilar symptoms leading to surgery. (*Id*. at 91; 111).

172) Dr. Levine deferred to Dr. McCormack's PPI rating for the "right thumb," as he did not perform a rating himself. (*Id*. at 93). In his view, Employee became medically stable for her knee and right trigger thumb injuries by September 2009. (*Id*. at 94).

173) Dr. Levine stated the substantial cause of Employee's inability to do prolonged standing is her "low back." The substantial cause of the restriction on repetitive squatting, kneeling and stairclimbing is her right knee. (*Id*. at 99-100). In his opinion, six months after Employee's knee and ankle surgery she could have returned to modified work as a teacher. (*Id*. at 118).

174) Dr. Raven is a board-certified orthopedic surgeon specializing in the upper extremity. (Videotaped Deposition of Raymond Benjamin Raven III, M.D., November 15, 2016, at 7). He first saw Employee on April 12, 2012. (*Id*. at 34). Employee told Dr. Raven she had an injury in January 2009, when she slipped on the ice but also had worsening pain "after a recent fall." (*Id*. at 28). Dr. Raven initially opined the January 26, 2009 fall with Employer was the substantial cause of the osteoarthritis in her right basal joint. (*Id*. at 29). However, upon reviewing records from April 2009, Dr. Raven concluded Employee was not having symptoms at the base of her thumb

related to the injury early on, as he would have expected. (*Id*. at 51). Dr. Raven eventually concluded a "genetic predisposition" is the substantial cause of Employee's need for basal joint reconstruction surgery. (*Id*. at 52).

175) Dr. Kosari is a board-certified podiatrist and foot surgeon. He first saw Employee on October 6, 2011, for her work injury. (Deposition of Babak Kosari, DPM, November 15, 2016, at 7, 50). He initially opined the January 26, 2009 work injury was the substantial cause of Employee's need for ligament reconstruction and debridement surgery on her right ankle. (*Id*. at 40). He based this opinion on Employee's work-injury history including "severe ankle sprain." (*Id*. at 49). However, after reviewing additional medical records he had not seen before, Dr. Kosari agreed Employee's initial medical records and symptom reporting did not include a severe ankle sprain. (*Id*. at 54). Dr. Kosari agreed he did not find instability in Employee's right ankle and admitted he performed ligament surgery based on Employee's pain complaints. (*Id*. at 66-67). He was not aware Employee had several falls including a fall in the bathtub. (*Id*. at 70). Dr. Kosari agreed it was possible some other event caused Employee's need for right ankle surgery in 2011. (*Id*. at 70). He noted Employee, on July 5, 2012, reported a recent right ankle strain for which he ordered an MRI. About one year later, on July 23, 2013, Dr. Kosari performed the right ankle debridement. Ultimately, Dr. Kosari concluded the work injury was not the substantial cause of the need for right ankle ligament reconstruction or debridement, based on Employee's earliest records following the work injury. (*Id*. at 76-77).

176) Scot Youngblood, M.D., is a board-certified orthopedic surgeon who performed an EME on Employee for her injury with Employer. About 50 percent of his practice is in foot and ankle surgery, and he treats sports injuries related to the knee and shoulder. Employee initially moved around the examining room "pretty well." However, during the directed examination, Employee moved gingerly, slowly and deliberately, grimaced and used a cane. Employee's strength examination demonstrated weakness in her upper and lower right extremity, inconsistent with her earlier movement around the examining room. Her speech seemed slurred and Dr. Youngblood observed Employee falling asleep during the history-taking portion, consistent with Employee being "under the influence of something." (Youngblood).

177) Dr. Youngblood diagnosed a soft-tissue cervical and thoracic sprain and strain without internal derangements, fractures, radiculopathy or other injuries. Employee had preexisting multilevel cervical, thoracic and lumbar degenerative disc disease. The work injury did not

aggravate these preexisting conditions, in his opinion. The right knee medial meniscus tear was also preexisting, related to age and genetics, and not related to the subject fall, in his view. Her right trigger thumb was preexisting and Dr. Youngblood believed not related to her work injury. In his opinion, Employee's right ankle sprain, though present, was also unrelated. Employee had other complaints including a bunion, hammertoes, and basilar arthritis in her thumb, which he opined preexisted and were unrelated to the industrial injury. (*Id.*).

178) Dr. Youngblood opined a fall from standing height onto her chest would not support an injury to Employee's feet or ankles. He stated the way Employee described her fall, first falling backwards and then thrusting forward, was "physiologically impossible." He relies primarily on Employee's earliest medical records, which include complaints only to her chest, mid-back and neck. In these reports, she expressly denied extremity pain. Nurses' notes state Employee was moving about the examining room "rather well." These records form the basis for Dr. Youngblood's opinions. He cannot understand how she could twist her knee or sprain her ankle simply falling forward. In his experience, typically people falling forward try to break their fall with their hands, and while doing so do not normally land on their chests. The emergency room records state Employee was "belligerently demanding neck surgery." Emergency room physicians did not note gait issues or limping. Five days later, Employee complained of numerous issues, including her neck, low back, and right wrist and knee, but no right ankle symptoms. Employee's first right ankle complaint was to Dr. Tower in February 2009. Dr. Youngblood did not think Employee would have waited nearly four weeks before noticing right ankle symptoms if she had injured her ankle when she fell. Sometimes patients have "distracting injuries" so severe these injuries overcome symptoms from lesser injuries. Fractures are typical examples and Employee had no such distracting injuries, in his opinion. People with moderate to severe ankle sprains walk with a limp and are in extreme pain the next day. (*Id.*).

179) Dr. Youngblood noted Dr. Tower thought Employee had struck her kneecap on the ground. In Dr. Youngblood's opinion, this injury mechanism could not cause a meniscal tear. Further, Employee did not have typical signs and symptoms supporting a meniscal tear when examined on February 19, 2009. Diagnostic imaging showed no fluid in the knee 15 days following the injury. The tear appeared "degenerative" on diagnostic imaging, with multiple tear lines going in all directions. Acute tears typically show a single line on MRI. Employee's kneecap pain should have

improved quickly. He agrees with Dr. Tower and Dr. Marble that aging caused the torn meniscus. The medical records show no twisting injury to Employee's right knee. (*Id*.).

180) Dr. Youngblood found June 2009 was the first mention of a trigger thumb problem following the work injury. In his opinion, it "strains credibility" to think Employee sustained a trigger thumb injury when she fell in January without expressing symptoms before June. Further, he has never seen a traumatic trigger-thumb condition. Repetitive use and aging causes trigger thumb. Using the right hand predominately and performing repetitive actions like painting are consistent with developing a trigger thumb. He disagrees with Dr. McCormack's opinion the right trigger thumb is a compensable injury. In Dr. Youngblood's view, bruising seen by only one examiner does not mean the patient has a trigger thumb condition, which is not a post-traumatic disorder. (*Id*.).

181) Dr. Youngblood opined arthritis causes the need for basilar thumb surgery, which is also not a traumatic condition. Basil thumb arthritis is more prevalent in women. He agrees with Dr. Raven's opinion that age and genetics were responsible for Employee's need for bilateral basal thumb surgeries. The basilar condition and the right trigger thumb are completely different conditions and are unrelated to each other. (*Id*.).

182) Dr. Youngblood noted an MRI from Indiana in June 2009 showed no ligament tears in Employee's ankles. The ligaments were normal and ankle ligaments do not degenerate with time as other tissue does. A September 2011 MRI showed ligament tears in the ankles. In Dr. Youngblood's opinion, the ankle injuries observed on MRI therefore occurred sometime between June 2009 and September 2011. Employee must have had a significant sprain between these two MRI scans to account for the 2011 MRI findings. Dr. Youngblood noted Employee has a significant history of various falls noted throughout the medical records. Regardless of causation, Dr. Youngblood would not have operated on the right ankle. Employee's main complaint was right ankle pain, and this is not why a surgeon performs ligament surgery on an ankle. Dr. Youngblood questions Dr. Kosari's decision to operate on the right ankle absent any evidence Employee had ligament laxity or instability on examination. Furthermore, Employee's chief ankle complaint continued following surgery and required follow-up arthroscopic surgery. Dr. Youngblood disagrees with Dr. Levine's opinion about the right ankle progressing through time to require ligament surgery. He opined this was a "novel concept" not accepted in the foot and ankle surgical community. "You either have ankle instability or you do not," in his opinion. Employee's off-work injury, which he surmises occurred sometime after the June 2009 MRI, is the substantial cause for

the need for ligament reconstruction surgery, and even then, Dr. Youngblood questions why a surgeon operated on Employee's right ankle absent documented instability. Employee's work injury, in his view, was not the substantial cause of the need for the initial right ankle surgery. (*Id*.).

183) As for the subsequent right ankle debridement, a loose body or an ankle sprain may require debridement. Employee's surgeon performed debridement to address pain, which in Dr. Youngblood's opinion is a poor reason to debride, since Employee's articular surfaces were normal and there was no arthritis found on diagnostic imaging. The "white chunks" the surgeon found during right ankle debridement were steroid injection residue, in his opinion. (*Id*.).

184) Dr. Youngblood agreed with Dr. McCormack's opinion the work injury had nothing to do with Employee's 2012 lumbar surgery, since Employee did not complain about lumbar spine pain for the first several weeks following her work injury. He found no differences in cervical, thoracic and lumbar MRI pre- and post-injury. Dr. Youngblood agrees with Dr. McCormack's opinion that given Employee had several previous low back surgeries, another surgery was predictable. In Dr. Youngblood's view, Employee's work-related cervical and thoracic strains and sprains would have resolved in about a month and she should have been able to return to work as a teacher. (*Id*.).

185) On cross-examination, Dr. Youngblood said he performs 15 to 20 defense medical examinations per month since 2009. He charges $475 to $550 per hour and estimates he incurred $6,000 to $7,000 in this case, which he said was "complex."

186) Dr. Youngblood eventually conceded Employee's initial Labor Department injury report would possibly support a contusion diagnosis to her knees and hands. Medications Employee received in the ambulance and in the emergency room may have dulled her pain. Dr. Youngblood reviewed medical records from February 2, 2009, stating Employee had right knee swelling and bruising near the right thumb. He does not believe these findings were important because they were not included in the emergency room records. Dr. Youngblood agreed Employee had surgery after she complained about her right ankle, knee, thumb and wrist. He further conceded the records did not show Employee had any pre-injury right ankle, knee or thumb complaints, though there was mention of a 2006 wrist injury. (*Id*.).

187) In Dr. Youngblood's opinion, Employee has significant psychological issues, since surgery did not improve her symptoms. Employee had a pre-injury chronic pain syndrome diagnosis for her lumbar spine. Dr. Youngblood is not qualified to opine if Employee has a chronic pain syndrome in respect to her other conditions, but in his view, her response to surgery was "atypical." In his

opinion, the ankle, knee, hand and back surgeries were not reasonable or necessary because there were no significant objective findings. In retrospect, Dr. Youngblood admitted he would have performed some of these surgeries because some had objective evidence. He agreed in certain circumstances, a medical condition can get worse and later require surgery. (*Id*.).

188) On May 25, 2016, Employee filed and served a medical summary including Dr. Konrath's May 29, 2013 opinion letter. (Medical Summary, May 24, 2016).

189) On May 31, 2016, Employer filed a *Smallwood* objection to Dr. Konrath's May 29, 2013 opinion letter. (Request for Cross-examination, May 27, 2016).

190) Employee did not produce Dr. Konrath for cross-examination. Therefore, this decision did not consider Dr. Konrath's May 29, 2013 letter. (Judgment; record; observations).

191) On November 22, 2016, Employee objected to Employer's November 10, 2016 evidence including news about Dr. Konrath's criminal conviction. Employee contended this evidence was irrelevant to treatments Dr. Konrath had earlier given to Employee. Employee also requested cross-examination on Davis' February 17, 2009, February 22, 2009 and March 23, 2009 reports. (Objection to Employer's November 10, 2016 Filing of Evidence, November 21, 2016).

192) This decision did not consider evidence concerning Dr. Konrath's criminal conviction but did consider Davis' documents, which were not helpful. (Judgment).

193) Bob Medinger is a teacher and supervisor who first met Employee around 1981. He saw Employee annually until she left the state. Medinger currently teaches and administers the small school in Slana, Alaska and is familiar with physical requirements for teaching. In his opinion, good elementary teachers change activities frequently to keep the children engaged and are more physically active than are middle and high school teachers. In his view, there is less bending with fifth and sixth graders than there is with younger children. He does not consider an elementary teacher position sedentary. Over the 22 years Employee lived in Alaska, he saw her usually twice per year. Employee often cared for Medinger's animals and participated with him and his wife in hunting and fishing activities. After the work injury with Employer, Employee could not fish anymore because her "hands didn't work." Medinger identified a photograph showing Employee holding a King salmon she caught on his boat about two years before the injury. He knew Employee had a preexisting back problem and prior back surgeries, from which she always seemed to recovered. These issues did not prevent her from doing her normal activities including teaching. Medinger sometimes visited Employee in her classroom prior to the injury and observed her

physical ability to teach. In his opinion, Employee was not interested in retiring because he knew her pension would soon increase significantly and she loved her job. Employee was renovating her "dream house" when she was injured. Employee never told Medinger her preexisting back pain was prompting her to retire early. Employee had discussed retirement "years down the road" with him. Post-injury, Medinger saw Employee frequently using canes and wheelchairs and having difficulty ambulating. He assisted Employee in packing her belongings in Indiana and drove her to California when she moved there. Medinger noticed Employee had balance issues. He visited Employee thereafter annually. In his view, Employee could not return to the classroom over the intervening years because she was not physically capable. Employee complained the most to Medinger about her right leg and ankle symptoms. Prior to her work injury with Employer, Employee had no difficulty driving the five and one-half hours to his homestead. Since the injury, he picks her up. Medinger did not recall any right knee complaints until the work injury in 2009. When he lived in Sitka, Alaska, Medinger never observed Employee having difficulty getting in or out of a fishing boat, or beachcombing. (Medinger).

194) On cross-examination, Medinger conceded he last saw Employee at his home around two years ago. He has never worked for the Anchorage School District. Medinger was not aware Employee's physician in June 2007 asked her principal to assign Employee to work with only older children. He has not reviewed Employee's medical records. Medinger is aware some teachers require accommodations at work. He was not aware Employee had physical problems in August 2007. Medinger could not recall Employee's right knee surgery in 1988 or 1989. (*Id.*).

195) Barbara Amberg has known Employee since around 1980. She has been a teacher for about 30 years. She corroborated Medinger's observations of Employee's abilities before and after her injury with Employer. In Amberg's opinion, good teaching requires the teacher's "total physical response." Employee told Amberg she had to retire because Employer told her it would affect her insurance if she did not retire. In Amberg's view, Employee retired because she could no longer function physically after the work injury. Amberg is unaware Employee in 2005 told her principal she wanted to retire in two years, and believes she would have known about Employee retiring as she and Employee discussed retirement frequently. In Amberg's opinion, Employee could not perform as a primary school teacher given her physical limitations. She would have difficulty teaching fifth and sixth graders too. Amberg wears a "Fit Bit" while at work teaching and averages

about 7,600 steps per day. In her opinion, this compares favorably to what Employee would do at her school in Anchorage. (Amberg).

196) On cross-examination, Amberg admitted she is Employee's friend, attended her wedding as maid of honor and did her hair for the wedding. She agreed sixth graders do not require as much attention for personal issues like tying shoes and zipping jackets. Amberg was aware of Employee's April 2008 automobile accident but was not aware she had arm problems. Before her work injury, Employee took pain pills early in the morning before arising so she would be ready to attend to her teaching duties. (*Id*.).

197) For her last 15 years with the Anchorage School District, Employee taught fifth and sixth graders. She had two prior back injuries -- one at school while lifting a pumpkin and the other in a motor vehicle accident at a roundabout. Employee opined she recovered fully from these low back injuries and resultant surgeries. While working for Employer, she would arise at 4:45 AM and take a pain pill to ensure she had no issues with her back during the school day. (Employee).

198) Employee had no right knee symptoms after her right knee surgery in the late 80s. She never had any difficulties with her right hand or right ankle prior to the work injury with Employer. Employee thought the fish photograph offered at hearing depicted summer, 2006. (*Id*.).

199) On the injury date, Employee fell on the ice at work and landed face first on her thumb and her right knee. Employee said she twisted her right ankle and over-extended both wrists. She described it as "such a hard fall," which made her back hurt and her whole body "hum." (*Id*.).

200) Employee did not go to a doctor on the injury date but the next morning, she was in too much neck pain to get out of bed. Employee's neck was her main concern. The ambulance crew and emergency room staff heavily sedated her with narcotics. Within a day or two, Employee became more aware of her injured body parts. For example, Employee said when she saw her first treating physician after leaving the emergency room, she could not drive and took a cab to the doctor's office because she could not put weight on her right side and could not push the automobile pedals with her right foot. Her entire right leg hurt from her knee down. Within 48 hours from the accident, Employee had "aches and pains everywhere." Employee recalled the doctor telling her within two weeks that she had a torn meniscus in her right knee. Her right shoulder pain resolved on its own, but Employee's right thumb, knee and ankle pain did not. (*Id*.).

201) According to Employee, her 2008 motor vehicle accident caused a syrinx in her thoracic spine, which she kept under control with the same morning and evening pain pills she took for her

lower back pain. Employee's mid- and low-back pain increased following the work injury with Employer. Her increased back pain never returned to the same level it was before the work injury. She ended up having her lumbar spine fused. Pre-injury, Employee's spine pain from her syrinx would sometimes be "horrifying" for a minute, but it would come and go. Rating her post-work-injury low back pain on a "1 to 10" scale, Employee said it was either "10 or nothing." (*Id.*).

202) When asked why her doctor in 2007 wrote a letter to Employee's principal asking him to keep her at the intermediate grade level, Employee explained she did not want to teach third grade because the children were always touching her and she did not want to become ill. Additionally, it would have been more difficult on her back bending over because classroom furniture for primary children is considerably smaller while furniture for intermediary ages is adult size. (*Id.*).

203) Employee said she retired because a woman from Employer's accounting and someone from retirement told her she would no longer have any insurance. If she wanted her injury taken care of, her only option was to retire and use her related medical insurance. Employee said she never considered not returning to work but retired simply so she could have her medical needs met. She hoped to return to teaching even sans benefits. When injured, Employee was out of debt for the first time in her life except for her car and house. Employee said she would still be teaching but for the work injury with Employer. She worked hard to improve her modest home in which she and her mother were living. Employee agreed with Amberg's account of their discussions regarding continued teaching. When injured, Employee earned about $76,000 per year and expected higher wages in the first year of her new teaching contract. Had she continued working for Employer, Employee's earnings at the end of the district's four-year contract would have put her annual earnings over $90,000. Her retirement at age 54 was $2,200 per month. Employee's Master's degree credentials put her on a higher earning level and she earned many "teacher of the year" and other awards. (*Id.*).

204) Employee's right knee still "goes out." Her right ankle "rolls." References in medical records to Employee falling are in her opinion caused by her work injury with Employer and the lack of timely medical attention. Right ankle surgeries in 2011 and 2013 improved her condition "to some extent" by relieving constant pain, but her ankle still rolls occasionally. (*Id.*).

205) Employee said she wants to return to elementary school teaching. She does not think she is physically able to return to the classroom. Walking is too difficult given her right ankle condition. Further, Employee believes she "over used" her left leg trying to compensate for her right leg

difficulties. Employee would at least like to return to work developing curricula. Currently, Employee occasionally takes a pain pill. Taking into account her chronic pain and her right hand, knee, and ankle, Employee thinks she could perform work 40 hours per week but is not certain unless and until she has an opportunity to try. She needs to use a cane, exercise and avoid falling down. Current and continuing treatment recommendations include continued pain management. Employee said, "This injury altered my life." She lost her home, savings, annuities and "everything" she had except for her $2,200 per month pension. (*Id*.).

206) On cross-examination, Employee denied she selected Dr. Tower. Employee said Davis talked to Dr. Tower before and after her visits causing Employee to think, "He was not my doctor." Employee did not consider herself retired when she left Alaska, but considered herself "hurt." She moved to Indiana to live near her son and get treatment. Employee said she did not refuse to sign releases. She does not remember even seeing medical releases. (*Id*.).

207) Employee recalls attending several prehearing conferences and advising the board she was contemplating several surgeries and needed more time before continuing with her pending claim. She was living in an assisted living facility. (*Id*.).

208) Employee agreed she had a "mini-stroke" in the classroom in May 2008. A brain MRI showed brain bruising from a car accident Employee had at age 17. Employee said the diagnosed "seizure disorder" in May 2016 is not "the kind in her brain," but relates to her leg. (*Id*.).

209) Employee recalls asking Davis if Employer would retrain her. According to Employee, Davis did nothing to help her obtain retraining benefits, but pointed her finger at Employee and said if she got an MRI, "you will pay for it." (*Id*.).

210) On November 23, 2016, Employer Smallwooded Dr. Konrath's August 25, 2009 letter, Dr. Konrath's May 29, 2013 letter, and Dr. Kochert's June 18, 2013 and Dr. Konrath's July 12, 2013 letters to Employee's attorney. (Objection to Written Records, November 23, 2016).

211) This decision considered Dr. Konrath's August 25, 2009 letter over Employer's objection but did not consider his May 29, 2013 letter for the reasons stated above. (Judgment).

212) Employee contends she complained of injuries to her neck, back, right knee, right shoulder, right ankle and right wrist within months of her injury. She claims 11 surgeries are attributable to her work injury with Employer including those to her back, right knee, left knee, right hand, left hand, left and right feet and ankles and trigger-thumb. However, Employee's claim is limited to her right-side injuries and surgeries including her right knee, ankle, thumb and wrist. Employee

contends her symptoms never resolved following her 2009 work injury with Employer. She contends the physicians opposing her focused primarily on her physical conditions, rather than on her symptoms. Employee contends "symptoms matter." She contends if her symptoms are disabling, impair her or prevent her from returning to her normal job she is entitled to benefits. Employee contends her PTD claim covers times during which she is not entitled to TTD, PPI or reemployment benefits, but still cannot return to work. Nonetheless, she contends TTD benefits should continue until all work-related symptoms are medically stable. Employee contends all physicians agree she has chronic pain, which in her view still disables her. Employee contends she is also entitled to continuing medical care and an order requiring Employer to reimburse health insurers that have paid for her work-related benefits in the past. (Employee's hearing arguments).

213) Employer contends Employee slipped and fell at work but exaggerated her symptoms. It contends Employee decided this injury would be the vehicle for her to retire. Employer contends Employee told her long-time family physician in 2007 she planned to retire in two years and her behavior is consistent with what she told her doctor. It contends Employee "abandoned" her claim and did nothing to pursue any benefits including retraining. From Employer's viewpoint, Employee retired and moved so Employer closed the case. Employer claims prejudice because Employee waited for years to obtain medical treatment, then sought benefits while obstructing discovery. It contends equitable principles like laches or equitable estoppel should apply to bar Employee's claim. Employer contends it was not aware Employee was even getting treatment or requesting surgeries until 2013. It requests Employee's benefits be suspended or forfeited between 2011 and 2013 for her failure to sign and return discovery releases. It contends both SIME physicians opined Employee's work-related treatment ended in 2009. Employer relies on Dr. McCormack as the best-qualified physician offering relevant opinions. Employer contends only Dr. Levine attributes the right ankle surgery to the work injury. It contends Dr. Kosari's initial opinion on the right ankle is weak because he relied exclusively on Employee's report of a severe right ankle sprain and limited records her attorney provided. However, Employer contends Dr. Kosari hedged his opinion after further reviewing Employee's medical records. Employer contends the two lay witnesses are Employee's friends and, while having no ulterior motive, are simply not familiar with Employee's medical records and reports she gave her doctors. Consequently, Employer contends these witnesses' testimony is worthy of little weight. Employer says Employee's "symptom" argument is

not Alaska law because it would result in every injured worker receiving non-stop benefits simply by continually stating, "I hurt, I hurt, I hurt." (Employer's hearing arguments).

214) On December 7, 2016, Employee's counsel filed and served their attorney fee and cost affidavits. Jensen bills at $400 per hour and incurred 82.7 attorney hours from February 12, 2010 through December 7, 2016. Jensen's paralegal Bryan Haugstad bills at $195 per hour and incurred 24.9 paralegal hours. Jensen incurred $517.03 in other out-of-pocket costs in this case. (Final Affidavit of Attorney's Fees and Costs Regarding Services of the Law Office of Michael Jensen, December 7, 2016; Affidavit of Bryan Haugstad, December 7, 2016).

215) Perle also bills at $400 per hour and incurred 193.90 attorney hours from June 7, 2011 through October 6, 2016. Perle incurred $4,886.78 in out-of-pocket costs including postage, photocopying, telephone calls, travel expenses and medical expert fees during the same period. Perle signed an affidavit stating these itemized attorney fees and out-of-pocket costs were accurate and expended in this case. (Interim Billing Statement, October 13, 2016; Affidavit of Attorney's Fees and Costs, October 27, 2016).

216) Perle incurred 36.30 attorney hours from October 7, 2016 through November 21, 2016. Perle incurred $6,000 in out-of-pocket costs during the same period, including postage, photocopying, telephone calls, travel expenses and medical expert fees. Perle signed an affidavit stating these itemized attorney fees and out-of-pocket costs were accurate and expended in this case. (Supplemental Billing Statement, November 23, 2016; Affidavit of Attorney's Fees and Costs, November 23, 2016).

217) Perle incurred 51.20 attorney hours from November 22, 2016 through December 3, 2016, including travel time to and from Anchorage for Employee's hearing. Perle incurred $3,637.36 in out-of-pocket costs during the same period, including "medical expert fees." These costs include $1,468 in travel expenses for Employee and Perle to travel to and from Anchorage for Employee's hearing and $1,814 for "food and lodging" for Employee and Perle to attend the hearing. The balance of Perle's out-of-pocket costs include postage, photocopying, telephone calls and witness fees. Perle signed an affidavit stating these itemized attorney fees and out-of-pocket costs were accurate and expended in this case. (Supplemental Billing Statement, December 6, 2016; Affidavit of Attorney's Fees and Costs, December 6, 2016). Perle's out-of-pocket cost itemization lists a $2,000 cost for "retainer for expert witness services" and $625 for "additional fee for expert report"

in respect to Dr. Raven in July and September 2013, respectively. Other payments Perle made to physicians were for records or paid as a "medical consultation fee." (Costs, October 13, 2016).

218) Perle's references to paying physicians for an "expert report," were references to seeking opinions from attending physicians who are also medical experts. (Observations; judgment).

219) Perle's resume states he has over 42 years' experience as an attorney specializing in personal injury and "workers' compensation subrogation." Between 1974 and 1987, Perle specialized in insurance defense in civil and workers' compensation cases. (Perle *Curriculum Vitae*, undated).

220) On December 9, 2016, Employee objected to Employer's closing argument request for suspension of Employee's benefits for her alleged failure to sign and return releases. Employee contends no such petition was before the panel for decision and the issue was not ripe. (Objection to Employer's Request for Suspension of Benefits, December 7, 2016).

221) On December 9, 2016, Employer responded to Employee's objection. Employer contends benefit suspension is mandatory under AS 23.30.108 and Employer need not file a petition to utilize this defense. Employer also noted it controverted Employee's benefits on May 11, 2011, for her failure to return releases. Employer contends the suspension and forfeiture issues are properly before the board for decision. (Response to Objection to Employer's Request for Suspension of Benefits, December 9, 2016).

222) On December 14, 2016, Employer objected to attorney Perle's request for $400 per hour in attorney fees. Employer contends Perle has no experience representing injured workers in workers' compensation cases and his attorney fee should be limited to $250 per hour. It contends Perle failed to itemize or provide travel expense receipts for airfare, food and lodging. Employer contends it is not responsible for personal expenses to bring a claimant back to Alaska for a hearing when she voluntarily relocated to another state. Employer contends Perle should not receive an attorney fee for conversations, meetings and emails with his wife, the claimant. Employer objects to Perle's fee entries for faxes, notes or conversations with staff pressing them to get physicians to provide supporting letters, and other specified effort, which it argues is "paralegal work." It further contends Perle mishandled simple issues and unnecessarily increased costs. Employer contends Perle should not receive an attorney fee for modifying informational releases and reviewing Alaska law regarding releases. It contends Perle's unfamiliarity with Alaska law further supports a reduced hourly rate and reduced overall time. Employer also contends Jensen and Perle should not receive an attorney fee for "duplicate work." Employer objects to Employee's "retention of expert

witnesses" and costs associated with their opinions or testimony. Lastly, Employer objects to attorney fees for any issue on which Employee does not prevail. Employer's specific objections to Employee's requested attorney fees and costs are as follows:

TABLE I

Date Incurred	Purpose	Time/Amount	Reason for Objection
	Perle travel to hearing	10.5	Excessive time
	Perle travel from hearing	11.0	Excessive time
	Airfare	$1,468	Not a compensable cost
	Food and lodging	$1,814	Not a compensable cost
June 7, 2011	Perle interface with wife	2.5	Unspecified, non-compensable
July 14, 2011	Perle interface with wife	.1	Unspecified, non-compensable
August 7, 2011	Perle interface with wife	2.0	Unspecified, non-compensable
August 9, 2011	Perle interface with wife	.1	Unspecified, non-compensable
November 14, 2011	Perle interface with wife	.1	Unspecified, non-compensable
November 15, 2011	Perle interface with wife	.1	Unspecified, non-compensable
February 1, 2012	Perle interface with wife	.1	Unspecified, non-compensable
March 7, 2012	Perle interface with wife	.1	Unspecified, non-compensable
November 26, 2012	Perle creating lists	2.4	Paralegal work
April 16, 2013	Controversion objection	1.0	Unnecessary
April 18, 2013	Perle interface with wife	2.5	Unspecified, non-compensable
April 19, 2013	Perle medical summary	2.0	Paralegal work
June 21, 2013	Perle interface with wife	.1	Unspecified, non-compensable
Unspecified	Perle staff meetings	Unspecified	Paralegal work
June 24, 2013	Perle revising releases	1.5	Unnecessary and incorrect
June 24, 2013	Letter regarding releases	1.0	Unnecessary and incorrect
July 18, 2013	Perle revising releases	1.5	Unnecessary and incorrect
July 19, 2013	Letter regarding releases	1.0	Unnecessary and incorrect
September 15, 2013	Perle reviewing law	2.0	Unnecessary and incorrect
September 30, 2013	Perle revising releases	.5	Unnecessary and incorrect
October 1, 2013	Perle revising releases	2.6	Unnecessary and incorrect
December 12, 2013	Perle revising releases	2.6	Unnecessary and incorrect
December 12, 2013	Letter regarding releases	3.5	Unnecessary and incorrect
January 14, 2014	Perle revising releases	2.0	Unnecessary and incorrect
March 26, 2014	Declaration preparation	2.1	Never signed by declarant
	Perle protective order	3.4	Did not prevail
	Perle EME/SIME research	2.2	Unnecessary research/denied
August 28, 2015	Perle EME travel	5.1	Not a compensable fee
August 29, 2015	Perle attend EME with wife	5.0	Not a compensable fee
August 30, 2015	Perle EME return travel	5.4	Not a compensable fee
September 8, 2015	Perle EME/SIME research	2.1	Unnecessary research/denied
September 9, 2015	Perle EME/SIME research	2.6	Unnecessary research/denied
September 11, 2015	Perle EME/SIME research	.3	Unnecessary research/denied
September 16, 2015	Perle EME/SIME research	1.0	Unnecessary research/denied

October 19, 2015	Perle EME/SIME research	.3	Unnecessary research/denied
November 24, 2015	Perle SIME questions	3.5	Unnecessary/duplicate
November 25, 2015	Perle SIME questions	3.5	Unnecessary/duplicate
March 23, 2016	Perle travel Levine SIME	5.5	Not a compensable fee
March 24, 2016	Perle attend Levine SIME	5.0	Not a compensable fee
March 24, 2016	Perle travel to McCormack SIME	4.5	Not a compensable fee
March 25, 2016	Perle attend McCormack SIME	3.0	Not a compensable fee
March 25, 2016	Perle return travel from SIME	4.0	Not a compensable fee
	Payment to Dr. Konrath	$500	Non-compensable expert cost
	Payment to Dr. Raven	$2,625	Non-compensable expert cost
	Payment to Dr. Kosari	$350	Non-compensable expert cost
All issues on which Employee does not prevail		Unspecified	Did not prevail

(Objection to Attorney Fee Affidavits, December 14, 2016).

223) On December 14, 2016, the designated chair read Employee's objection to Employer's suspension and forfeiture requests made in its closing argument at hearing and Employer's response to the objection. On the same date, the designated chair reopened the record to allow the parties to provide additional evidence and argument on this issue because the parties did not address it adequately at hearing. The chair also left the record open so Employee could supplement her attorney fee and cost itemizations for addressing this issue. (Soule letter, December 14, 2016).

224) On December 21, 2016, the parties agreed to present additional evidence and argument on the suspension and forfeiture issue by filing affidavits. Because some affiants were not available and the parties needed additional time, they stipulated to the hearing record closing on January 13, 2017. (Prehearing Conference Summary, December 21, 2016).

225) On December 30, 2016, Employer filed its affidavit on the suspension and forfeiture issue as follows: Paralegal Kari Miranda handled the case early on for Employer and determined she needed additional medical records. On April 25, 2011, Miranda sent medical, employment, insurance, and Social Security releases to Employee by certified mail with return receipt requested. Three days later, Employee called Miranda to express displeasure with a recent EME report and with the informational releases. Employer controverted Employee's right to benefits, suspending them because Employee failed to return the releases or petition for a protective order. On September 1, 2011, Miranda sent a general medical release to Employee at her updated address. On September 14, 2011, Miranda spoke with Employee who discussed the release and objected to signing it, further stating her cervical spine should not be included on any release. On November 2, 2011, Employee left a voice-mail message with an attorney at Miranda's firm requesting another copy of the general medical release and again questioning why her cervical spine was included on the

releases. Miranda sent another general release to Employee on November 3, 2011, and explained the cervical spine was included because some physicians diagnosed it as an aggravation from the work injury and could cause her claimed shoulder pain. On April 22, 2013, Employer's attorney subsequently received new medical records from attorney Perle causing Miranda's office to send new informational releases to Employee on June 11, 2013. Through June 2013 and January 2014, Perle and Miranda corresponded over the informational release issue. Miranda asserts Employee never returned all the requested releases and never filed a petition for a protective order. (Affidavit of Kari L. Miranda, December 22, 2016).

226) Employer does not contend Employee violated an order to sign and return releases. Neither the board nor a Board designee ever ordered her to sign releases. (*Id*.; observations).

227) On January 6, 2017, Employee filed Perle's affidavit on the suspension and forfeiture issue as follows: Perle affied for two years following Employee's work injury, she handled her workers' compensation claim herself, seeking procedural advice from the board. Employee was also receiving home health care and living in three separate assisted-living facilities. Employee had privacy issues with some proffered releases. Referring to a September 11, 2013 prehearing conference summary, and prior and subsequent conferences, Perle stated the board's designee never gave Employee advice concerning benefit suspension or forfeiture. Perle asserts the first notice he received from defense counsel concerning releases occurred on June 11, 2013. On June 25, 2013, Perle sent defense counsel a letter with signed authorizations attached. In his view, notwithstanding her myriad surgical procedures, Employee and her lawyer made every attempt to provide all appropriate relevant medical information to defense counsel. Perle attests Employee continued to sign written authorizations at Employer's request from June 25, 2013 through October 28, 2015. Perle contends since Employee received no benefits since April 2009, there is nothing to suspend during the time when she disputed certain releases. He further contends no Board order required Employee to sign releases and consequently she did not refuse to obey any such order. Accordingly, under the applicable statute, there is no basis for benefit forfeiture. Perle contends Employer's attorney knew he represented Employee as of December 2, 2011. However, Perle contends Employer sent no releases or release-related correspondence to him and did not contact him until June 11, 2013. Perle states Employee did not refuse or thwart discovery. He contends any delay in signing and returning releases did not prejudice Employer in defending against Employee's claims. Perle asserts Employer has a right to defend against Employee's claim but also

has a "fiduciary duty" to treat her fairly and equitably. He contends all relevant medical records are in the parties' possession. Perle states the parties had an agreement at a prehearing conference that Employer would modify releases and Employee would sign them. He contends Employee met this agreement and the issue was resolved. (Affidavit of Lawrence P. Pearl, Esq. Re: Authorizations, January 5, 2017).

228) On January 12, 2017, Employee filed supplemental affidavits of attorney fees and costs for both counsel. Employee's final attorney fee and costs claims are summarized as follows:

TABLE II

Simon Law Office (Perle)	**Attorney Fees**	**Attorney Costs**
June 7, 2011-October 6, 2016	$77,560	$4,886.78
October 7, 2016-November 21, 2016	$14,520	$6,000
November 22, 2016-December 3, 2016	$20,480	$3,637.36
December 5, 2016-January 13, 2017	$2,920	$3,864.95
Jensen Law Office		
February 12, 2010-December 7, 2016	$33,080	$4,885.50
December 8, 2016-January 12, 2017	$1,560	$360.80
Subtotal Perle	**$115,480**	**$18,389.09**
Subtotal Jensen	**$34,640**	**$5,216.30**

229) On January 13, 2017, Perle responded to Employer's objection to his attorney fee affidavits. This decision did not consider Perle's objection because Employee filed it post-hearing and this pleading exceeds the scope of allowable post-hearing filings ordered at the December 21, 2016 prehearing conference. (Response to Objection to Attorney Fee Affidavits, January 12, 2017; Prehearing Conference Summary, December 21, 2016; judgment; observations).

230) Before the record closed on January 13, 2017, Meshke replied to Perle's affidavit addressing the suspension and forfeiture issues. Meshke affied Perle did not have personal knowledge of the information in his affidavit, paragraph two. Meshke contends Employee provided no medical records until April 22, 2013, and no releases until June 26, 2013. She contends Employee "intentionally and willfully withheld releases until after her examinations and surgeries were largely completed." Meshke contends this is a "brazen refusal" and an intentional effort to thwart discovery. She contends Employer was substantially prejudiced and hampered in its ability to investigate and obtain timely EMEs while Employee actively sought numerous surgeries. Employer wants Employee's benefits during this time forfeited. (Affidavit of Michele M. Meshke in Response to Affidavit of Lawrence P. Perle, January 13, 2017).

231) Employee claims TTD benefits beginning March 11, 2009, but also says she received TTD benefits through March 31, 2009. (Employee's Hearing Brief, November 22, 2016, at 10, n. 10).

232) Employee timely filed her claims for benefits and her hearing requests under the Act. (Observations, judgment and inferences drawn from the above).

233) This decision found the physicians' depositions very helpful. (Judgment).

234) According to Westlaw, the board's ICERS electronic filing record and the division's legal research database, at least $400 per hour attorney fees (or in attorney Constantino's case, a comparable $395 per hour) have been awarded after hearing to attorneys with varying experience handling workers' compensation cases. These attorneys' approximate board caseloads, based on appearances entered may be compared visually to Perle's approximate board caseload based on his appearances as follows:

Table III

Attorney's Name	Workers Represented in Alaska	Years' Experience
Chancy Croft	2,168	40+
Joseph Kalamarides	1,491	40+
Robert Rehbock	1,341	30+
Michael Patterson	973	30+
Michael Jensen	320	30+
John Franich	300	30+
Robert Beconovich	148	16+
Steve Constantino	153	18+
Keenan Powell	123	30+
Eric Croft	103	6+
Lawrence Perle	1	40+

235) Perle's experience representing injured workers in Alaska workers' compensation cases does not compare favorably with even the least experienced lawyers who have been awarded $400 per hour in attorney fees. (Observation).

236) The issues addressed in this hearing were complex, difficult and time consuming. (Experience, judgment, observations and inferences from the above).

237) Perle's and Jensen's attorney fees in this case are contingent. (*Id*.).

238) A claimant's attorney cannot easily predict how evidence will pan out when agreeing to take an injured worker's case. (*Id*.).

PRINCIPLES OF LAW

The board may base its decision on not only 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).

In *Egemo v. Egemo Construction Co.*, 998 P.2d 434, 441 (Alaska 2000), the Alaska Supreme Court addressed a prematurely filed a claim for benefits and noted:

> 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.

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

> **AS 23.30.041. Rehabilitation and reemployment of injured workers**. . . .
> . . . .
>
> (c) An employee and an employer may stipulate to the employee's eligibility for reemployment benefits. . . . If the employee is totally unable to return to the employee's employment at the time of the injury for 90 consecutive days as a result of the injury, the administrator shall, without a request, order an eligibility evaluation unless a stipulation of eligibility was submitted. . . .
>
> (d) Within 30 days after the referral by the administrator, the rehabilitation specialist shall perform the eligibility evaluation and issue a report of findings. . . . Within 14 days after receipt of the report from the rehabilitation specialist, the administrator shall notify the parties of the employee's eligibility for reemployment preparation benefits. Within 10 days after the decision, either party may seek review of the decision by requesting a hearing under AS 23.30.110. The hearing shall be held within 30 days after it is requested. . . .
> . . . .

> (g) Within 30 days after the employee receives the administrator's notification of eligibility for benefits, an employee shall file a statement under oath . . . to notify the administrator and the employer of the employee's election to either use the reemployment benefits or to accept a job dislocation benefit. . . .
>
> . . . .
>
> (h) Within 90 days after the rehabilitation specialist's selection under (g) of this section, the reemployment plan must be formulated and approved. . . .
>
> . . . .
>
> (i) Reemployment benefits shall be selected from the following in a manner that ensures remunerative employability in the shortest possible time. . . .
>
> . . . .
>
> (k) Benefits related to the reemployment plan may not extend past two years from date of plan approval or acceptance, whichever date occurs first, at which time the benefits expire. If an employee reaches medical stability before completion of the plan, temporary total disability benefits shall cease, and permanent impairment benefits shall then be paid at the employee's temporary total disability rate. If the employee's permanent impairment benefits are exhausted before the completion or termination of the reemployment process, the employer shall provide compensation equal to 70 percent of the employee's spendable weekly wages, but not to exceed 105 percent of the average weekly wage, until the completion or termination of the process, except that any compensation paid under this subsection is reduced by wages earned by the employee while participating in the process to the extent that the wages earned, when combined with the compensation paid under this subsection, exceed the employee's temporary total disability rate. . . . An employee may not be considered permanently totally disabled so long as the employee is involved in the rehabilitation process under this chapter. . . .

In *Carlson v. Doyon Universal-Ogden Services*, 995 P.2d 224 (Alaska 2000), an injured worker sought vocational reemployment benefits, while also pursuing other claims. The rehabilitation specialist recommended the injured worker for reemployment benefits but the designee suspended the reemployment process pending an SIME. Dueling reemployment experts gave testimony at hearing on the employee's PTD claim and the board relied on the employer's expert to find her unentitled. Subsequently, the designee found her eligible for reemployment benefits. The employee contended she should have received PTD benefits for the time between when her PPI benefits expired and when she eventually received reemployment benefits. (*Id.* at 226-27). Noting the employee made a "valid point" about a potential "gap" in benefits following PPI benefits expiring and rehabilitation benefits starting, *Carlson* stated:

> Because the legislature intended the rehabilitation process to be voluntary, (footnote omitted) the onus was on Carlson to pursue rehabilitation vigorously.
>
> Although the RBA suspended consideration of her application pending the outcome of the secondary independent medical evaluation that Carlson requested, the record before us does not indicate that Carlson made any attempt to reinitiate processing of her rehabilitation benefits application after the secondary evaluation (footnote omitted). Instead, she chose to emphasize her pursuit of PTD benefits. Because she did not actively pursue her rehabilitation benefits during the period she sought PTD benefits, however, no retroactive award of rehabilitation benefits is warranted in this case. (*Id*. at 230-31).

Carlson said if the injured worker had presented evidence showing she repeatedly attempted to reinitiate the reemployment process while she pursued other benefits, or showing her employer had used tactics delaying reemployment benefits, a retroactive reemployment benefit award might be appropriate. (*Id*. at 231, n. 45).

In *Carter v. B&B Construction, Inc*., 199 P.3d 1150 (Alaska 2008), an injured worker requested a reemployment benefits eligibility evaluation. One week later, under a former statute, the division told the employee it could not act on his request until he submitted a statement showing unusual and extenuating circumstances prevented him from timely filing for these benefits. The following month, the employee filed a claim for benefits including Board review of what he called the division's "decision" regarding his vocational rehabilitation eligibility evaluation request. (*Id*. at 1152). He continued medical treatment and in early September the following year, the board heard his case and decided he was entitled to PPI benefits but had waited too long to request vocational reemployment benefits. The employee immediately petitioned the board for rehearing or modification, and upon denial, promptly appealed to the superior court. The superior court remanded the case to the board to reconsider his eligibility evaluation request. (*Id*. at 1153). Five years later in August 1999, the division on remand determined Carter was entitled to an eligibility evaluation. After the employer unsuccessfully appealed this decision to the board and the superior court, Carter asked for and received a rehabilitation specialist to perform the evaluation. In April 2002, the division found Carter eligible for reemployment benefits. (*Id*.).

Meanwhile, between Carter's 1995 petition for rehearing and the April 2002 determination he was eligible for reemployment benefits, Carter experienced significant medical difficulties, some work-

related and some not. (*Id*. at 1154). In December 2002, Carter filed a claim requesting PTD and in the alternative §041(k) reemployment benefits for nearly five years, from July 14, 1994 to January 30, 1999. The board denied the PTD claim but awarded Carter two years' reemployment benefits under AS 23.30.041(k). (*Id*. at 1154-55). Carter appealed the PTD denial and the superior court affirmed. The Alaska Supreme Court affirmed the board's award of two years' §041(k) reemployment benefits. The court found the board implicitly held Carter had begun the reemployment process "when he initially applied for an eligibility evaluation." The employer contended Carter was merely using §041(k) benefits as an income-replacement vehicle without regard to his progress in the reemployment process.

Carter asked the pertinent question: "When does an employee begin participating in the reemployment process?" (*Id*. at 1159). Answering this question, *Carter* stated:

> When an employee exhausts PPI benefits before completion or termination of the reemployment process, AS 23.30.041(k) 'provides a fall-back source of income.' (Citation omitted). Given this purpose, we think that the legislature did not intend that there should be a gap between the expiration of PPI benefits and the commencement of reemployment benefits for employees who are vigorously pursuing eligibility evaluations before their PPI benefits expire. We therefore conclude that the reemployment process begins when the employee begins his active pursuit of reemployment benefits. (*Id*.).

Carter then addressed the implied second question: When does a person begin actively to pursue reemployment benefits? *Carter* answered:

> Because Carter began to actively pursue reemployment benefits on April 27, 1993 when he requested an eligibility evaluation, and because he continued to actively pursue those benefits by petitioning the board for review of the division's May 4, 1993 'decision,' by petitioning the board for a rehearing, and by appealing to the superior court, we conclude that the board did not err in awarding him reemployment benefits, beginning when his PPI payment was exhausted on July 14, 1994, for the statutory maximum period that a reemployment plan can last -- two years. We do not decide whether subsection .041(k) benefits may be payable for more than two years if they start before acceptance or approval of a reemployment plan. That issue has not been briefed or argued here. (*Id*. at 1160).

> **AS 23.30.095. Medical treatments, services, and examinations.** (a) . . . When medical care is required, the injured employee may designate a licensed physician to provide all medical and related benefits. . . .

AS 23.30.105. Time for filing of claims. (a) The right to compensation for disability under this chapter is barred unless a claim for it is filed within two years after the employee has knowledge of the nature of the employee's disability and its relation to the employment and after disablement. . . .

AS 23.30.107. Release of information. (a) Upon written request, an employee shall provide written authority to the employer, carrier, rehabilitation specialist, or reemployment benefits administrator to obtain medical and rehabilitation information relative to the employee's injury. The request must include notice of the employee's right to file a petition for a protective order with the division and must be served by certified mail to the employee's address on the notice of injury or by hand delivery to the employee. . . .

AS 23.30.108. Prehearings on discovery matters; objections to requests for release of information; sanctions for noncompliance. (a) If an employee objects to a request for written authority under AS 23.30.107, the employee must file a petition with the board seeking a protective order within 14 days after service of the request. If the employee fails to file a petition and fails to deliver the written authority as required by AS 23.30.107 within 14 days after service of the request, the employee's rights to benefits under this chapter are suspended until the written authority is delivered.

(b) If a petition seeking a protective order is filed, the board shall set a prehearing within 21 days after the filing date of the petition. At a prehearing conducted by the board's designee, the board's designee has the authority to resolve disputes concerning the written authority. If the board or the board's designee orders delivery of the written authority and if the employee refuses to deliver it within 10 days after being ordered to do so, the employee's rights to benefits under this chapter are suspended until the written authority is delivered. During any period of suspension under this subsection, the employee's benefits under this chapter are forfeited unless the board, or the court determining an action brought for the recovery of damages under this chapter, determines that good cause existed for the refusal to provide the written authority.

(c) At a prehearing on discovery matters conducted by the board's designee, the board's designee shall direct parties to sign releases or produce documents, or both, if the parties present releases or documents that are likely to lead to admissible evidence relative to an employee's injury. If a party refuses to comply with an order by the board's designee or the board concerning discovery matters, the board may impose appropriate sanctions in addition to any forfeiture of benefits, including dismissing the party's claim, petition, or defense. . . .

> **AS 23.30.110. Procedure on claims**. . . .
> . . . .
>
> (c) . . . If the employer controverts a claim on a board-prescribed controversion notice and the employee does not request a hearing within two years following the filing of the controversion notice, the claim is denied.
>
> **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; . . . .

Benefits sought by an injured worker are presumptively compensable and the presumption is applicable to any claim for compensation under the Act. *Meek v. Unocal Corp*., 914 P.2d 1276 (Alaska 1996). The presumption's application involves a three-step analysis. To attach the presumption, an injured employee must first establish a "preliminary link" between his injury and the employment. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 610 (Alaska 1999). Once the presumption attaches, the employer must rebut the raised presumption with "substantial evidence." *Huit v. Ashwater Burns, Inc*., 372 P.3d 904 (Alaska 2016). The fact-finders do not weigh credibility at this stage. *Veco, Inc. v. Wolfer*, 693 P.2d 865 (Alaska 1985).

If the employer's evidence rebuts the presumption, it drops out and the employee must prove his case by a preponderance of the evidence. *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 at 8 (March 25, 2011) (reversed on other grounds, *Huit v. Ashwater Burns, Inc*., 372 P.3d 904 (Alaska 2016)). This means the employee must "induce a belief" in the fact-finders' minds that the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). In the third step, evidence is weighed, inferences drawn and credibility considered. *Wolfer*. An injured worker is entitled to a presumption of continued work-related disability. *Kodiak Oilfield Haulers v. Adams*, 777 P.2d 1145 (Alaska 1989).

> **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 credibility findings and weight accorded evidence are "binding for any review of the Board's factual findings." *Smith v. CSK Auto, Inc.*, 204 P.3d 1001, 1008 (Alaska 2009).

In a medical malpractice case, *Snyder v. Foote*, 822 P.2d 1353 (Alaska 1991), the defendant tried to impeach the plaintiff's expert medical witness with evidence showing the physician had testified falsely about his credentials in an unrelated case three years earlier in a different jurisdiction. The plaintiffs appealed, contending the trial court erred by allowing their primary witness to be cross-examined with hearsay findings made by another judge. The plaintiffs argued the other judge's findings were not admissible because they raised collateral issues. They contended collateral evidence was inadmissible because it was not relevant. The defendants contended using the evidence to impeach the medical expert was proper because "credibility was a material issue." The defendants cited *Hutchings v. State*, 518 P.2d 767, 769 (Alaska 1974) in which the court stated, "The credibility of witnesses is always a material issue."

Snyder acknowledged *Hutchings* established "a very lenient test for admissibility," but noted the issue in *Hutchings* was witness bias, "an issue which is never collateral." *Snyder* 822 P.2d at 1358. *Snyder* further stated, "Our cases make clear, the *Hutchings* test does not apply to all impeachments by use of collateral evidence." *Id*. *Snyder* noted the physician's false statements in a separate case were relevant only to the extent they implied he had committed previous bad acts. Such evidence would impeach his testimony in a separate case only so far as to imply he was likely to commit future bad acts in the current trial. *Snyder* reiterated such evidence is normally not admissible. *Id*. *Snyder* reversed and remanded the case finding the trial court's error was prejudicial.

> **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. . . . 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. . . .

Wise Mechanical Contractors v. Bignell, 718 P.2d 971, 974 n. 7 (Alaska 1986), applied factors from the Alaska Code of Professional Responsibility in determining a "reasonable fee" including:

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

Bignell further noted:

> If an attorney who represents claimants makes nothing on his unsuccessful cases and no more than a normal hourly fee in his successful cases, he is in a poor business. He would be better off moving to the defense side of the compensation hearing room where attorneys receive an hourly fee, win or lose. . . . (*Id.* at 975).

Attorney fees in workers' compensation cases should be fully compensatory and reasonable so injured workers can have competent counsel available. *Cortay v. Silver Bay Logging*, 787 P.2d 103 (Alaska 1990). In one of his first hearings, *Widmer v. Municipality of Anchorage*, AWCB Decision No. 11-0014 (February 9, 2011), Eric Croft, who was an experienced attorney but an inexperienced workers' compensation lawyer, received $250 per hour as a reasonable attorney fee.

> **AS 23.30.155. Payment of compensation**. . . .
> . . . .
>
> (p) An employer shall pay interest on compensation that is not paid when due. Interest required under this subsection accrues at the rate specified in AS 09.30.070(a) that is in effect on the date the compensation is 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.

Vetter v. Alaska Workmen's Compensation Board, 524 P.2d 264 (Alaska 1974) reversed a board decision denying TTD. 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 *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).

Vetter found "considerable evidence in the record that [Vetter] was unable to return to work due to complications resulting from her injury." Though the employee's "main reason for not returning to work was that she wanted no more fights or arguments with anyone," she testified headaches and kidney problems she suffered from her work injury also limited her activities. Vetter declined a server job at another restaurant because she was physically unable to perform. (*Id*. at 268).

> **AS 23.30.180. Permanent total disability**. (a) In case of total disability adjudged to be permanent 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the total disability. . . .
> . . . .
>
> (b) Failure to achieve remunerative employability as defined in AS 23.30.041(r) does not, by itself, constitute permanent total disability.
>
> **AS 23.30.190. Compensation for permanent partial impairment; rating guides**. (a) In case of impairment partial in character but permanent in quality, and not resulting in permanent total disability, the compensation is $177,000 multiplied by the employee's percentage of permanent impairment of the whole person. . . . The compensation is payable in a single lump sum, except as otherwise provided in AS 23.30.041. . . .
>
> **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;
> . . . .

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

8 AAC 45.052. Medical summary. . . .

. . . .

(1) If the party filing an affidavit of readiness for hearing wants the opportunity to cross-examine the author of a medical report listed on the medical summaries that have been filed, the party must file with the board, and serve upon all parties, a request for cross-examination, together with the affidavit of readiness for hearing and an updated medical summary and copies of the medical reports listed on the medical summary, if required under this section.

(2) If a party served with an affidavit of readiness for hearing wants the opportunity to cross-examine the author of a medical report listed on the medical summaries filed as of the date of service of the affidavit of readiness for hearing, a request for cross-examination must be filed with the board, and served upon all parties, within 10 days after service of the affidavit of readiness for hearing.

(3) After an affidavit of readiness for hearing has been filed, and until the claim is heard or otherwise resolved,

(A) all updated medical summaries must be accompanied by a request for cross-examination if the party filing the updated medical summary wants the opportunity to cross-examine the author of a medical report listed on the updated medical summary; and

(B) if a party served with an updated medical summary and copies of the medical reports listed on the medical summary wants the opportunity to cross-examine the author of a medical report listed on the updated medical summary, a request for cross-examination must be filed with the board and served upon all parties within 10 days after service of the updated medical summary.

. . . .

(5) A request for cross-examination must specifically identify the document by date and author, generally describe the type of document, state the name of the person to be cross-examined, state a specific reason why cross-examination is requested, be timely filed under (2) of this subsection, and be served upon all parties.

> (A) If a request for cross-examination is not in accordance with this section, the party waives the right to request cross-examination regarding a medical report listed on the updated medical summary.
>
> (B) If a party waived the right to request cross-examination of an author of a medical report listed on a medical summary that was filed in accordance with this section, at the hearing the party may present as the party's witness the testimony of the author of a medical report listed on a medical summary filed under this section.

8 AAC 45.060. Service. . . .

. . . .

(b) A party may file a document with the board, other than the annual report under AS 23.30.155(m), personally, by mail. . . . If a right may be exercised or an act is to be done, three days must be added to the prescribed period when a document is served by mail. . . .

8 AAC 45.082(d). Medical treatment. . . .

. . . .

(d) Medical bills for an employee's treatment are due and payable no later than 30 days after the date the employer received the medical provider's bill . . . and a completed report in accordance with 8 AAC 45.086(a) . . . and an itemization of the prescription numbers or an itemization of the dates of travel, destination, and transportation expenses for each date of travel. . . .

8 AAC 45.084. Medical travel expenses. (a) This section applies to expenses to be paid by the employer to an employee who is receiving or has received medical treatment.

(b) Transportation expenses include

> (1) a mileage rate, for the use of a private automobile, equal to the rate the state reimburses its supervisory employees for travel on the given date if the usage is reasonably related to the medical examination or treatment;
>
> (2) the actual fare for public transportation if reasonably incident to the medical examination or treatment; and
>
> (3) ambulance service or other special means of transportation if substantiated by competent medical evidence or by agreement of the parties.

. . . .

(d) Transportation expenses, in the form of reimbursement for mileage, which are incurred in the course of treatment or examination are payable when 100 miles or more have accumulated, or upon completion of medical care, whichever occurs first.

(e) A reasonable amount for meals and lodging purchased when obtaining necessary medical treatment must be paid by the employer if substantiated by receipts submitted by the employee. Reimbursable expenses may not exceed the per diem amount paid by the state to its supervisory employees while traveling.

8 AAC 45.120. Evidence. . . .
. . . .

(e) . . . Any relevant evidence is admissible if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil actions. . . . Irrelevant . . . evidence may be excluded on those grounds.

(f) Any document . . . that is served upon the parties, accompanied by proof of service, and that is in the board's possession 20 or more days before hearing, will, in the board's discretion, be relied upon by the board in reaching a decision unless a written request for an opportunity to cross-examine the document's author is filed with the board and served upon all parties at least 10 days before the hearing. The right to request cross-examination specified in this subsection does not apply to medical reports filed in accordance with 8 AAC 45.052; a cross-examination request for the author of a medical report must be made in accordance with 8 AAC 45.052. . . .

8 AAC 45.142. Interest. (a) If compensation is not paid when due, interest must be paid . . . at the rate established in 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 or, if deceased, to the employee's beneficiary or estate;

(2) on late-paid death benefits to the widow, widower, child or children, or other beneficiary who is entitled to the death benefits, or the employee's estate;

(3) on late-paid medical benefits to

(A) the employee or, if deceased, to the employee's beneficiary or estate, if the 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.

8 AAC 45.180. Costs and attorney's fees. . . .

. . . .

(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. The following costs will, in the board's discretion, be awarded to an applicant:

(1) costs incurred in making a witness available for cross-examination;

. . . .

(3) costs of obtaining medical reports;

(4) costs of taking the deposition of a medical expert, provided all parties to the deposition have the opportunity to obtain and review the medical records before scheduling the deposition;

. . . .

(9) expert witness fees, if the board finds the expert's testimony to be relevant to the claim;

. . . .

(13) reasonable travel costs incurred by an applicant to attend a hearing, if the board finds that the applicant's attendance is necessary;

. . . .

(17) other costs as determined by the board. . . .

Former 8 AAC 45.510, in effect on Employee's injury date, stated in pertinent part:

8 AAC 45.510. Request for reemployment benefits eligibility evaluation. . . .

. . . .

(b) the administrator will consider a . . . request for an eligibility evaluation . . . if the compensability of the injury has not been controverted. . . .

Current 8 AAC 45.510 states in pertinent part:

> **8 AAC 45.510. Request for reemployment benefits eligibility evaluation**. . . .
>
> (b) The administrator shall consider a written request for an eligibility evaluation for reemployment benefits, unless the employer controverts on grounds the employee's injury did not arise out of and in the course of employment, on grounds the employee's total inability to return to the employee's employment at the time of injury is not a result of the injury. . . . If reemployment benefits have been controverted on any of these grounds, the administrator shall forward the matter to the board to conduct a prehearing conference regarding the controversion no later than 30 days after the board receives the matter. If a claim is filed and if requested by the employee, the board will conduct a hearing no later than 90 days after the prehearing conference in accordance with 8 AAC 45.060(e) and 8 AAC 45.070(b)(3), limited to the grounds set out in this subsection. . . .
>
> **8 AAC 45.900. Definitions**. (a) In this chapter
> . . . .
>
> (11) 'Smallwood objection' means an objection to the introduction into evidence of written medical reports in place of direct testimony by a physician; see *Commercial Union Insurance Companies v. Smallwood*, 550 P.2d 1261 (Alaska 1976);

ANALYSIS

1) Is collateral evidence of a physician's crime admissible?

Employer filed and served evidence showing Dr. Konrath committed a crime. It relies on this evidence to show Dr. Konrath's medical opinions are not weight worthy and are not credible. Employee objects to these documents. The Alaska Supreme Court in *Snyder* explained and clarified its *Hutchings* decision and noted witness "bias" evidence, as opposed to witness "credibility" evidence, is never collateral. The evidence detailing Dr. Konrath's criminal conviction does not demonstrate his bias for or against any party. Documents highlighting his criminal conviction are collateral evidence and are not relevant or material to any issue in this case. *Snyder*; *Hutchings*. Evidence describing Dr. Konrath's crime is not admissible. 8 AAC 45.120(e).

2) Are Davis' documents admissible over Employee's objection?

Though she is a registered nurse, Davis' documents are not "medical records" and fall under a different regulation for requesting cross-examination. On September 11, 2015, Employee filed and

served Davis' February 17, 2009 initial report and two, March 21, 2009 letters Davis wrote to EME Dr. Marble. On November 10, 2016, Employer filed and served additional evidence including Davis' February 25, 2009 and March 23, 2009 reports. Employee did not object to these reports until November 22, 2016, less than 10 days before the November 30, 2016 hearing. Accordingly, Davis' February 17, 2009 report, March 21, 2009 letters, February 25, 2009 and March 23, 2009 reports are admissible over Employee's untimely objection. 8 AAC 45.120(f). However, Davis' documents are not helpful and are lightly weighted. AS 23.30.122; *Smith*.

3) Are Dr. Konrath's records admissible over Employer's *Smallwood* objection?

A *Smallwood* objection is a request to cross-examine medical record authors. 8 AAC 45.900(11). On April 12, 2011, Employee filed her first Affidavit of Readiness for Hearing, which the division returned as premature. This hearing request did not trigger the duty to file *Smallwood* objections because it was ineffective. Employee filed and served her earliest, valid hearing request on April 22, 2013. Though this request prematurely and ineffectively listed her April 4, 2013 claim, it effectively requested a hearing on her April 12, 2011 claim. 8 AAC 45.052(c)(2). Employee's hearing request filed on April 22, 2013, triggered an ongoing duty on parties to *Smallwood* medical records filed and served on "updated" medical summaries. 8 AAC 45.052(c)(3)(B).

On April 19, 2013, Employer filed and served Dr. Konrath's August 25, 2009 letter on a medical summary. Employee's hearing request filed and served on April 22, 2013, triggered the time to *Smallwood* this letter. 8 AAC 45.052(c). Employer had 10 days from April 22, 2013 to *Smallwood* Dr. Konrath's August 25, 2009 letter. 8 AAC 45.052(c)(3)(B). Employer did not file and serve its *Smallwood* objection to this letter until September 4, 2015, more than 10 days after Employee's hearing request filed April 22, 2013. Therefore, Employer waived its right to cross-examine Dr. Konrath on this August 25, 2009 letter and it is admissible over the objection. 8 AAC 45.052(c)(2). The fact a party may have subsequently timely Smallwooded the same letter, filed and served later on another medical summary, is immaterial. Once a party misses the earliest deadline to *Smallwood* a medical record, it is admissible. 8 AAC 45.052(c)(5)(B).

On August 11, 2014, Employer filed and served Dr. Konrath's July 12, 2013 letter to Employee's attorney, on a medical summary. Given the April 22, 2013 hearing request, Employer had only 10

days from August 11, 2014, to *Smallwood* Dr. Konrath's July 12, 2013 letter. Taking into account weekends and adding three additional days for mail service, Employer had until August 25, 2014 to *Smallwood* Dr. Konrath July 12, 2013 letter. 8 AAC 45.052(c)(3)(B); 8 AAC 45.060(b). On September 3, 2014, Employer Smallwooded this letter. Employer untimely objected and Dr. Konrath's July 12, 2013 letter is admissible over Employer's objection. 8 AAC 45.052(c).

On May 24, 2016, Employer filed and served Dr. Konrath's May 29, 2013 letter to Employee's attorney, on a medical summary. On May 31, 2016, Employer timely filed and served its *Smallwood* objection to this letter. Employee did not provide Dr. Konrath for cross-examination. Dr. Konrath's May 29, 2013 letter is not admissible. 8 AAC 45.052(c)(3)(B).

4) Are Employee's injuries to her right trigger thumb, right hand basilar joint, right knee and right ankle compensable?

It is undisputed Employee slipped and fell on the ice at work on January 26, 2009. However, there is considerable, conflicting medical evidence addressing each claimed body part injury. This compensability issue raises factual questions to which the presumption of compensability analysis applies. *Meek*. Without regard to weight or credibility, Employee raised the presumption as to her right trigger thumb, right hand basilar joint, right knee and right ankle injuries with her own testimony combined with medical opinions from Drs. McCormack, Stinson, Levine and Tower, respectively. *Tolbert*; *Wolfer*. Each physician provided a medical opinion which, when combined with Employee's testimony, provides evidence Employee had a compensable injury to each claimed body part. Again disregarding weight or credibility, Employer rebutted the raised presumption with opinions from Drs. Marble and Youngblood, both of whom provide opinions stating Employee had no more than minimal strains and sprains, which quickly resolved. *Huit*; *Wolfer*. Consequently, Employee must prove her claims to compensable injuries to each body part by a preponderance of the evidence. *Runstrom*; *Saxton*. This presumption of compensability analysis applies to each subsection below by reference and incorporation.

The following analyses take into consideration the fact Employee was already taking daily narcotics to address her chronic back pain when she fell at work on January 26, 2009. It also takes into account the fact paramedics gave Employee additional narcotics on the way to the emergency room

the next day and emergency room staff gave her more upon arrival. It is difficult to assess how much these medications affected Employee's pain response and thus her symptom reporting. Further, experience shows first responders and the average attending physician do not cross-examine an injured worker about injury specifics and detailed symptoms like an attorney would. *Rogers & Babler*. However, Employee's records totaling some 3,000 pages show she is able to articulate her symptoms plainly, regularly and easily. The following analysis also considered but discounted causation testimony from Medinger and Amberg. Though credible, these witnesses lacked important information about Employee's conditions and symptoms disclosed in her medical records, which they did not review. AS 23.30.122; *Smith*. Given this contextual background:

a) Employee's right trigger-thumb injury is not compensable.

Several medical providers directly through their observations and opinions or implicitly through Employee's reports support Employee's claim to a compensable, right trigger-thumb injury. These include PA-C Froiland, and Drs. Konrath, Kochert, McCormack and a waffling Levine. By contrast, numerous medical providers in the same way do not support Employee's trigger thumb injury as compensable. These include the paramedics, emergency room physician Dr. McCall, and Drs. Marble, Youngblood, Tower, Woodward, and a waffling Levine.

Employee had no significant right thumb symptoms before her work injury with Employer. She did not list her thumb or trigger thumb symptoms on her injury report three days following her slip and fall. Employee did not tell the school nurse, the paramedics, or Dr. McCall in the emergency room she had trigger thumb symptoms. She told the paramedics she hurt her chest and told the emergency room staff she hurt her neck and back. By January 31, 2009, Employee told PA-C Froiland her "thumb or mid-hand" hurt a few days following the injury, but this report is too vague to imply trigger thumb symptoms. By February 2, 2009, Employee told Dr. Stinson her "right hand" hurt. However, upon examination, Employee did not mention trigger thumb symptoms. By February 19, 2009, Dr. Tower said Employee "jammed her thumb," which supports a possible injury to thumb joints other than at the thenar eminence. Employee did not tell Dr. Marble she had trigger thumb symptoms on April 3, 2009. Dr. Stinson observed swelling and discoloration in the right hand on April 13, 2009, but not expressly in the trigger thumb area. On May 7, 2009, Employee told Dr. Kochert her complaints included left and right "hand pain," which is again too

vague to imply trigger thumb symptoms. By June 3, 2009, 129 days post-injury, Employee told Dr. Kochert her hand and thumb hurt and Dr. Kochert injected Employee's "PIP and MCP" thumb joints, which is the first time anyone specifically identified symptoms possibly correlating to a trigger thumb. On June 10, 2009, 136 days post-injury, Dr. Konrath became the first physician to diagnose a "moderately severe right trigger thumb" and supported the trigger thumb as a compensable injury. A June 10, 2009 MRI for "pain in the thumb side of the wrist" demonstrated a "normal wrist." On August 25, 2009, Dr. Konrath said Employee's fall on the ice at work could have dramatically caused her trigger thumb. On July 12, 2013, he specifically attributed the right trigger thumb to the work injury. Dr. Konrath based his opinion on Employee's reports without reviewing her prior medical records.

By contrast, Employee did not mention trigger thumb symptoms to the paramedics or emergency room staff. More importantly, Drs. Woodward, Tower, Youngblood and a waffling Levine all ultimately agreed trigger thumb is not a traumatic condition. It most commonly occurs through repetitive use and not from a specific injury. Experience shows people develop trigger thumb, like trigger finger, through aging and repetitively grabbing something tightly in their hand -- hence the name "trigger" thumb or finger. *Rogers & Babler*. Although there is evidence on both sides, Drs. Woodward, Tower, Youngblood and the fact-finders' personal experiences deserve the greatest weight and credibility on this issue. AS 23.30.122; *Smith*; *Rogers & Babler*. The substantial cause of Employee's need to treat her right trigger thumb is aging, and not her work injury. Employee's right trigger thumb is not a compensable injury. AS 23.30.010(a).

b) Employee's right hand basilar joint injury is compensable.

Similarly, several medical providers directly through their observations and opinions or implicitly through Employee's reports support Employee's claim to a compensable, right basilar injury. These include the school nurse who examined Employee on the injury date and noted a "wrist" injury, PA-C Froiland who observed Employee wearing a wrist and thumb brace on her right hand a few days following the injury, and Drs. Stinson, Tower, Kochert, and a waffling Levine. By contrast, numerous medical providers do not support Employee's right basilar injury as compensable. These include the paramedics, emergency room physician Dr. McCall, and Drs. Marble, Youngblood, Ramirez, Tower, McCormack, Raven and a waffling Levine.

As was the case with the right trigger thumb, Employee did not tell the paramedics or emergency room staff about symptoms near the base of her right thumb. Unlike the right trigger thumb, however, Employee told the school nurse she hurt her "wrist," which generally correlates to the area where the basilar joint is located. Further, from the beginning, Employee told medical providers she fell and landed on her hands and knees. Her injury report says she caught herself with both hands. The fact Employee told paramedics she landed on her chest is immaterial as it is unlikely Employee could fall from a standing height and only make ground contact with her chest. Experience shows, and EME Dr. Youngblood noted most people break their fall with their hands. *Rogers & Babler*. By January 31, 2009, Employee told PA-C Froiland her "mid-hand" began hurting days after the injury. On February 2, 2009, Employee told Dr. Stinson she injured her right hand when she fell. Most notably, Dr. Stinson objectively saw a swollen right thenar eminence with "significant contusion and discoloration." Dr. Stinson's observations are credible and given significant weight. AS 23.30.122; *Smith*. A few days later, on February 19, 2009, Dr. Tower stated Employee jammed her thumb and aggravated her basal joint when she fell on the job. Dr. Tower's earliest opinion is credible and given considerable weight. AS 23.30.122; *Smith*.

Dr. Stinson continued to note objective discoloration and ongoing swelling in the right thenar eminence on April 13, 2009, 78 days post-injury. Objective swelling and discoloration observed by a physician continuously more than 11 weeks following the fall at work supports the inference Employee injured the basal area on her right hand when she fell at work on January 26, 2009. A January 18, 2012 CT scan disclosed mild osteoarthritis at the basilar joint in the right hand. On June 18, 2013, Dr. Kochert reviewed Employee's situation and, in reference to all her pain complaints including her right basilar joint, said she knew of "no other reason" for Employee's symptoms "than the January 26, 2009 accident." Further, experience shows if a person falls from standing height and, as Dr. Youngblood noted, breaks their fall with their hands and wrist regions, an injury can occur to these areas. *Rogers & Babler*. Employee's consistent reporting of falling at work and hurting the basilar region of her right hand, combined with an objective physician observing discoloration and swelling for months following the injury all credibly support Employee's right basal injury claim as compensable. AS 23.30.122; *Smith*.

By contrast, on March 13, 2009, Dr. Ramirez in the emergency room examined Employee's right hand and wrist and found no swelling, ecchymosis or bruising. Dr. Ramirez's opinion gets less weight than Dr. Stinson's does because his interaction with Employee was highly charged and confrontational. Dr. Ramirez had to threaten Employee with a security escort from the emergency room when she became agitated and argumentative. This negative interaction with Employee probably, though understandably, affected Dr. Ramirez's examination and his observations. *Rogers & Babler*. By April 9, 2009, Dr. Tower was backpedaling from his earlier opinions, for reasons not entirely clear from the record. Employee implied Davis interfered with her patient-physician relationship with Dr. Tower. Whatever the reason, by this second visit Dr. Tower reported on Employee's progress in dismissive tones. For example, it is unusual for an unbiased attending physician to refer in his notes to a patient being "festooned" with braces, implying these devices were decorative rather than functional. For this reason, Dr. Tower's findings including no significant swelling or ecchymosis is entitled to less weight and credibility. AS 23.30.122; *Smith*.

On October 6, 2011, Dr. Roth examined Employee's right thumb, took x-rays and found "no significant arthritis." Dr. Roth's report suggests Employee's work-related right basilar injury had resolved by this date. *Rogers & Babler*. Dr. Roth's opinion is credible and is entitled to some weight. AS 23.30.122; *Smith*.

Employee had at least two falls in February 2012. On April 12, 2012, Employee told Dr. Raven her pain and swelling over the right thenar eminence developed over time but worsened "after a recent fall." Dr. Raven initially opined Employee developed basal joint arthritis after her January 26, 2009 fall on the ice, and this necessitated basal joint reconstruction. However, at his deposition Dr. Raven concluded Employee was not having symptoms at the basilar thumb area early on, as one would expect. Dr. Raven eventually opined a "genetic predisposition" is the substantial cause of Employee's need for basal joint reconstruction surgery. Dr. Raven's deposition testimony is entitled to less weight because the medical records show Employee consistently reported symptoms in the right basilar area, and physicians repeatedly found objective discoloration and swelling. AS 23.30.122; *Smith*. Likewise, Dr. Levine initially opined the work injury caused basal thumb arthritis to move forward at "a more rapid pace" and necessitated surgery. However, Dr. Levine modified his opinion and said if Employee had a "recent fall" in April 2012, the basilar

thumb surgery would not have been due to the initial fall "especially if there was that two-year hiatus." Dr. Levine's revised opinion on this point is credible. AS 23.30.122; *Smith.*

Dr. Youngblood's opinion regarding the right basilar injury is entitled to less weight because he did not focus on the basilar injury and gave a conclusory opinion that age and genetics caused this condition, making it unrelated. Further, Dr. Youngblood discounted objective evidence of physician-observed swelling and bruising near the right thumb, finding it unimportant simply because it was not included in emergency room records. This opinion made Dr. Youngblood sound more like an advocate for Employer rather than an objective medical evaluator. Lastly, Dr. Youngblood performs 15 to 20 EMEs per month and in a complex case like this one, bills approximately $7,000. If Dr. Youngblood averaged 17 examinations per month in less complex cases and billed $5,000 for each, he would earn approximately $85,000 per month performing EMEs, which raises a question of bias. *Rogers & Babler*. AS 23.30.122; *Smith*.

On balance, the most credible medical evidence shows Employee had a compensable right basilar joint injury when she slipped and fell on January 26, 2009, while working for Employer. The work injury was initially the substantial cause of Employee's need for treatment for the basilar joint injury. AS 23.30.010(a). Therefore, the right basilar joint injury is compensable. However, the medical evidence also shows Employee's right basilar injury resolved by October 6, 2011, when Dr. Roth found no significant objective findings or arthritis on examination. Thereafter, something had to account for Employee's July 23, 2012 right basal joint reconstruction surgery. Employee has a post-injury history of repeatedly falling in the bathtub, on the stairs, and while simply walking. She attributes all her falls to her right knee or ankle giving way, resulting from her work injury. While Employee's view is understandable, it is not credible and not supported by the medical records. AS 23.30.122; *Smith*.

For example, on April 3, 2009, Dr. Marble said Employee's pre- and post-injury thoracic spine films showed more levels with significant disc herniations than he had ever seen. This, combined with Employee's thoracic syrinx made Employee "at high risk for falling because of the advanced spinal pathology with neurologic sequela." Employee does not claim her work injury with Employer caused or permanently aggravated her thoracic spine condition. On August 24, 2009,

Employee told Dr. Kochert she had difficulty standing up and fell frequently, without attributing this propensity to any particular cause. On October 26, 2009, Employee told Dr. Kochert her ankle was "all right." She nonetheless reported uncomfortable and violent "body twitching" and difficulty with both feet becoming numb and consequently had problems walking because she said, "I can't feel them," meaning her feet. There is no evidence linking these symptoms to Employee's work injury. On February 11, 2011, Dr. Thaper said Employee has ventricular white matter brain disease "which will affect her balance & stability & her walking." It is undisputed this condition is not related to Employee's work injury. Furthermore, on many occasions, physicians noted Employee demonstrated slurred speech, as if intoxicated with prescription medications. The preceding reports and opinions are entitled to great weight and credibility. AS 23.30.122; *Smith*.

Given the above and reasonable inferences drawn therefrom, Employee's work injury is the substantial cause initially for her right basal injury making it compensable, but its compensability ended by October 6, 2011. Thereafter, Employee fell numerous times but not because of her work injury. Medical evidence does not support Employee's suggestion that her right knee injury causes her knee to "give out" suddenly, causing her to fall. Rather, expert medical opinion shows the combined effects of her unrelated thoracic spine conditions that cause lower extremity numbness, her ventricular white matter brain disease that interferes with her stability and walking, her 2008 stroke and the deleterious side effects from prescription medications including Adderall and Vyvanse are what cause Employee to fall. These medications affect her "focus," and Employee takes them to address non-work-related medical conditions. The medical record shows narcotic medication also contributes to Employee's falls but she takes these medications to address chronic pain from her severe spinal issues, which she does not include in her claim. As SIME Dr. Levine stated, Employee does not take pain medication for her work injury. Consequently, as Dr. Levine also stated Employee's "recent fall" in April 2012 is the substantial cause of her need for right basilar reconstructive surgery. *Rogers & Babler*; AS 23.30.122; *Smith*; AS 23.30.010(a).

c) Employee's right knee injury is compensable.

Numerous medical providers directly through their observations and opinions or implicitly through Employee's reports support Employee's claim to a compensable, right knee injury. These include the school nurse who examined Employee on the injury date and noted a "knee" injury, PA-C

Froiland who noted Employee "twisted her right leg" when she fell and who objectively saw knee swelling, and Drs. Stinson, Kochert, McCormack, Konrath and Levine. Some medical providers do not support Employee's right knee injury as compensable. These include the paramedics who found no lower extremity edema or trauma, emergency room physician Dr. McCall to whom Employee denied lower extremity pain, and Drs. Marble, Youngblood and Tower.

Employee's account of how she fell, given under careful cross-examination in this case and in an unrelated automobile accident deposition, are generally consistent and credible. AS 23.30.122; *Smith.* From the injury date, Employee said she hurt her knee when she hit the ground. Contrary to assumptions by several physicians who minimize the right knee injury, Employee told PA-C Froiland she twisted her right knee when she fell. This could cause a right knee injury. *Rogers & Babler*. On April 13, 2009, Dr. Stinson observed right knee discoloration from Employee's fall at work. He diagnosed intra-articular derangement. On June 9, 2009, a physician diagnosed a right medial meniscus tear and articular cartilage defect on the medial cartilage condyle, status post fall. A June 10, 2009 MRI confirmed this diagnosis. Upon surgery in June 2009, Dr. Konrath found an unstable medial meniscus tear. Dr. Levine opined Employee's work injury necessitated her right meniscal surgery. Similarly, Dr. McCormack opined the work injury caused the need for right knee surgery based on physicians' objective observations of swelling, and a concurrent MRI showing meniscal tears. Employee's consistent, right knee complaints post-injury and these credible medical opinions are entitled to significant weight. AS 23.30.122; *Smith.*

The lack of lower extremity complaints noted in paramedic and emergency room records is troubling, but is reasonably explainable by Employee's fixated focus on her spinal issues. *Rogers & Babler*. Employee's demand for immediate cervical surgery while in the emergency room reflects her focus. Given the other medical findings, Dr. Marble's "negative" knee examination is suspect and given lesser weight. AS 23.30.122; *Smith.* Dr. Tower's opinion concerning Employee's right knee deserves lesser weight because he thought Employee's knee did not have an "unstable tear," which proved incorrect according to the knee surgeon. Dr. Tower opined Employee's meniscal findings were degenerative. The question is not what caused the underlying condition. The work injury need only be the substantial cause of the need to treat Employee's right knee symptoms. AS 23.30.010(a). Dr. Tower's opinion does not address this legal question. Lastly, weight to

Dr. Youngblood's right knee opinion is minimal because he misunderstood how Employee slipped, fell and landed. AS 23.30.122; *Smith*; *Rogers & Babler*.

On balance, the evidence preponderates heavily in favor of the work injury as the substantial cause of the need to treat Employee's right knee. Her right knee injury is compensable. AS 23.30.010(a).

d) Employee's right ankle injury is not compensable.

Lastly, a few medical providers directly through their observations and opinions or implicitly through Employee's reports support Employee's claim to a compensable, right ankle injury. These include initially, Dr. Tower, and Drs. Stinson, Kochert, Konrath and Kosari. Numerous medical providers do not support Employee's right ankle injury as compensable. These include the paramedics who found no lower extremity edema or trauma, emergency room physician Dr. McCall to whom Employee denied lower extremity pain, and Drs. Marble, Youngblood, Ramirez, McCormack, Levine and eventually Tower and Kosari.

This is Employee's weakest claim. Experience shows if one has even a mild to moderate ankle sprain, the associated long-lasting pain is instant, intense and difficult to ignore. Ankle sprain pain causes swelling, which frequently lasts for weeks, often with associated discoloration. *Rogers & Babler*. Employee did not mention ankle pain to the paramedics or emergency room staff. She never mentioned ankle pain at all until Dr. Tower diagnosed a sprained ankle 21 days post-injury. It is inconceivable Employee, notwithstanding painkillers in her system, could feel symptoms from her right basilar injury and other pain sensations but not feel and report even a mildly sprained ankle for 21 days. AS 23.30.122; *Smith*; *Rogers & Babler*.

Dr. Stinson diagnosed a "minimal" ankle sprain. Dr. Tower diagnosed a "minor" ankle sprain. Employee's best medical support, Dr. Kochert, relied on Employee telling her she had a "badly sprained" right ankle. The overwhelming medical evidence shows Employee did not have even a mild to moderate ankle sprain, much less a severe one. Therefore, Dr. Kochert's opinion is not entitled to significant weight. AS 23.30.122; *Smith.* Similarly, Dr. Kosari's supporting opinion assumes Employee's statement that someone told her she had a "bad sprain," is correct. The medical record does not support Employee's assertion. No medical provider told Employee she had

a "bad sprain." Dr. Kosari's opinion is worthy of little weight. AS 23.30.122; *Smith.* Dr. Konrath's opinion based on Employee's incorrect history and incomplete medical records is similarly weightless. AS 23.30.122; *Smith.*

The fact Dr. Kosari during surgery found a torn ligament and loosening in the lateral ankle does not mean Employee prevails on this issue. On October 26, 2009, Employee told Dr. Kochert her right ankle was "all right." Seven months later on May 21, 2010, Employee told Dr. Groover-Maltby she had fallen three times the week prior because her knee gave way. The medical record shows and this decision determined Employee falls frequently due to non-work-related medical issues. Thus, there is no medical evidence linking the work injury and Employee's repeated falls. Employee fell again on July 21, 2010 from about eight steps and claims to have injured her ankle. No previous examiner had found any significant ankle instability to this point.

Over a year later on September 13, 2011, Dr. Lewis evaluated Employee's ankles. Contrary to the medical evidence, Employee said she had acute, right ankle pain after falling at work, implying "immediately" after the fall. Contrary to the medical evidence, Employee told Dr. Lewis she had persistent swelling and painful instability in the right ankle since the fall. Dr. Lewis found "very mild tibiotalar degenerative changes" and diagnosed "possible chronic lateral ankle instability" but did not expressly relate his findings and diagnoses to the work injury. The medical record belies Employee's historical report, as it shows no persistent swelling or painful instability continuously since her January 26, 2009 fall. Therefore, something else must account for Dr. Kosari's surgical findings on October 21, 2011. The probable explanation for these findings is Employee's July 21, 2010 fall down the stairs, in which she admittedly injured her ankle. This fall resulted from lower extremity numbness, balance problems, instability and focus issues, the substantial cause of which is not Employee's work injury with,, but include Employee's thoracic issues, white matter brain disease, her 2008 stroke and prescription medication side effects. *Rogers & Babler*.

Overwhelming substantial evidence preponderates against Employee's right ankle claim. Experience shows, as Dr. Youngblood stated, either a person has ankle instability or they do not. Ankle instability resulting from torn ligaments is a hallmark to performing surgery for a sprained ankle according to several physicians in this case. Dr. McCormack did not support Employee's

right ankle claim because no doctor initially found a torn ligament either on physical examination or on MRI. Dr. McCormack's opinion is entitled to considerable weight. AS 23.30.122; *Smith.* Employee told Dr. Levine her right ankle symptoms existed "right from the beginning," but the record shows this is not true. After hearing Dr. McCormack state the right ankle was not work-related, Dr. Levine said, "I can't disagree with him." Dr. Levine also incorrectly concluded the medical record showed no intervening ankle injury. The record shows Employee fell down the stairs and injured her right ankle on January 21, 2010. A 2011 right ankle MRI showed for the first time a chronic, anterior talofibular ligament tear in the right ankle. For these reasons, Dr. Levine's opinion on the right ankle injury is entitled to no weight. AS 23.30.122; *Smith*.

Dr. Kosari's initial supporting opinion based on Employee's history including a "severe ankle sprain," is not supportable from the medical record. He was also unaware Employee had several post-injury falls. Dr. Kosari noted Employee reported a "recent" right ankle strain on July 5, 2012. He eventually concluded the work injury was not the substantial cause of the need for right ankle ligament reconstruction surgery or subsequent debridement. Dr. Kosari's credible, ultimate opinion is consistent with the medical record and is entitled to great weight. AS 23.30.122; *Smith*.

Given the above analysis, the January 26, 2009 work injury was never the substantial cause of the need to treat Employee's right ankle. Her right ankle injury is not compensable. AS 23.30.010(a).

5) Is Employee entitled to TTD benefits?

There is conflicting medical evidence addressing TTD. This issue raises factual questions to which the compensability presumption applies. *Meek.* Without regard to weight or credibility, Employee raised the presumption on her TTD claim with her testimony combined with medical opinions from PA-C Froiland and Drs. Stinson, Kochert and Raven. *Tolbert*; *Wolfer*. Each physician provided a medical opinion which, when combined with Employee's testimony, provides evidence Employee had temporary total disability resulting from her compensable work injuries. Disregarding weight or credibility, Employer rebutted the presumption with opinions from Drs. Marble, Tower and Youngblood who opined Employee had no additional disability. *Huit*; *Wolfer.* Employee must prove her TTD claim by a preponderance of the evidence. *Runstrom*; *Saxton*.

Given the analyses in subsection 4, above, the only work injuries for which Employee could be entitled to TTD are her right basilar joint and right knee injuries. Employee's agency file shows she received TTD benefits from February 4, 2009 through March 1, 2009. Employee's hearing brief states she received TTD benefits from January 26, 2009 through March 31, 2009, yet she claims TTD beginning March 11, 2009. Employee's TTD claim is somewhat confusing. This decision will analyze Employee's TTD claim as requested beginning March 11, 2009.

This decision found Employee's right basilar joint and right knee injuries arose out of and in the course of her employment. AS 23.30.010(a). It also found the January 26, 2009 slip and fall at work is the substantial cause of her need to treat these injuries, and the substantial cause of any related disability, except compensability for the right basilar injury ended on October 6, 2011. To obtain additional TTD, Employee must demonstrate her right basilar joint or right knee injuries disabled her temporarily and totally and these injuries were not medically stable. AS 23.30.185; AS 23.30.395(16); AS 23.30.395(28).

a) *The right knee*:

On January 31, 2009, PA-C Froiland examined Employee for her work injury, including her right knee. At Employee's request, PA-C Froiland gave her an off-work slip pending Employee's appointment with Dr. Stinson. Employee has a presumption to continuing disability. *Adams*. On February 2, 2009, Dr. Stinson examined Employee for her work injury, including her right knee. Dr. Stinson removed Employee from work for at least a week. One week later, he referred Employee to Dr. Ryan for an orthopedic knee evaluation. On February 19, 2009, Employee saw another physician at Dr. Ryan's clinic, Dr. Tower. Dr. Tower opined Employee's "appendicular" issues would not interfere with unrestricted work as a teacher. In other words, Dr. Tower released Employee to return to work in respect to her knee injury, thus rebutting the continuing disability presumption. On March 31, 2009, Dr. Stinson said cervical spondylosis and cervicalgia, rather than her right knee, disabled Employee permanently beginning January 27, 2009. Thus, in reference to her right knee injury, Dr. Tower released Employee to return to work and Dr. Stinson subsequently said Employee was disabled but not due to her right knee injury.

On April 3, 2009, Dr. Marble performed an EME on Employee and specifically stated the work injury, which necessarily includes the right knee, was not the substantial cause of Employee's disability. Dr. Marble also stated Employee reached medical stability by March 2009 when she completed her physical therapy. Dr. Marble also rebutted the continuing disability presumption and raised the counter-presumption Employee was medically stable by March 31, 2009.

On June 3, 2009, Dr. Kochert performed anesthetic injections into Employee's right knee but did not restrict her from work. There is no evidence any physician restricted Employee's work due to her right knee injury and prescribed treatment likely to result in objectively measurable improvement in her right knee condition between February 19, 2009 and June 10, 2009. On June 10, 2009, Dr. Konrath recommended a right knee arthroscopy and partial medial meniscectomy. Objectively measurable improvement is the expected result from knee surgery. *Rogers & Babler*. Therefore, Employee was no longer medically stable effective June 10, 2009. AS 23.30.395(28).

However, no physician restricted Employee's work due to her right knee until Dr. Konrath performed right knee surgery on June 23, 2009. Employee's right knee disability began on that date and she enjoys a continuing disability presumption. *DeYonge*. On June 18, 2013, Dr. Kochert in retrospect said the work injury disabled Employee "from working from the time of the accident through the entirety of her treatment of my office." Dr. Kochert's report is entitled to less weight because she treated Employee for everything from spinal complaints to her bilateral hands and knees and her opinion is too general to affix disability to only the right knee. AS 23.30.122; *Smith*.

On March 25, 2016, SIME physician Dr. McCormack testified Employee became medically stable for her right knee injury by September 1, 2009. He also opined Employee could return to sedentary work effective September 30, 2009. This latter opinion implies Employee continued in disabled status from her right knee surgery date until September 30, 2009. SIME physician Dr. Levine agreed Employee's right knee became medically stable by September 1, 2009. As Drs. McCormack and Levine are impartial SIME physicians, their opinions are entitled to significant weight on the disability issue. AS 23.30.122; *Smith*. Employer's physicians primarily addressed causation issues and did not provide disability dates for the compensable right knee injury. Therefore, their opinions not helpful on disability dates. AS 23.30.122; *Smith*. Since TTD is not payable after the medical

stability date, Employee's TTD attributable to her compensable right knee injury is limited from June 23, 2009, when she had right knee surgery, until September 1, 2009, when she became medically stable. AS 23.30.185. Employee is entitled to TTD benefits from June 23, 2009 through September 1, 2009, in respect to her right knee injury.

b) The basilar thumb injury:

A similar analysis applies to disability for Employee's compensable right basilar thumb injury. On January 31, 2009, PA-C Froiland examined Employee for her work injury, including her right basilar thumb symptoms. At Employee's request, PA-C Froiland gave her an off-work slip pending Employee's appointment with Dr. Stinson. Employee has a presumption to continuing disability for her basilar thumb injury. *DeYonge*. Dr. Stinson examined Employee for her work injury, including her right thumb. He removed Employee from work for at least a week and referred her for orthopedic evaluation. As was the case with Employee's right knee, Dr. Tower did not think Employee's "appendicular" injuries, which includes her upper extremity, would prevent her from working as a teacher. Thus, Dr. Tower released Employee to return to unrestricted work as a teacher, in respect to her right basilar thumb injury.

On March 31, 2009, Dr. Stinson opined cervical spondylosis and cervicalgia disable Employee permanently effective January 27, 2009, but did not say Employee's right basilar thumb injury disabled her. On April 3, 2009, Dr. Marble said Employee's work injury was not disabling. Dr. Marble's opinion rebutted the continuing disability presumption. On April 9, 2009, Dr. Tower said Employee could return to work. By August 19, 2009, Employee had undergone trigger thumb surgery and overall her thumb was "doing well" with no pain and full-motion. Had the basilar thumb area been producing symptoms, Employee would have so stated. She did not. At this point, the right basilar thumb injury was not disabling. Similarly, on October 26, 2009 Employee said her thumb was "all right." Dr. Roth did not restrict Employee's work due to her right thumb in October 2011. This decision found Employee's compensable, right basilar injury ended and her work injury was no longer the substantial cause of the need to treat it after October 6, 2011. There is no credible medical evidence removing Employee from work between March 11, 2009 and October 6, 2011, due to her right basilar injury. Therefore, she is entitled to no TTD for the right basilar injury

during the claimed period and any disability after October 6, 2011 was attributable to a non-work-related fall, which necessitated surgery.

This analysis shows Employee's compensable right knee injury disabled her temporarily and totally from June 23, 2009 through September 1, 2009. Her compensable right basilar joint injury resulted in no disability through October 6, 2011, when compensability for this condition ended.

The last consideration on the TTD claim is Employer's objection to TTD based on its defense that Employee voluntarily removed herself from the labor market. *Vetter*. Although there is pre-injury evidence suggesting Employee wanted to retire in 2009, Employee's credible testimony on this issue, wholly supported by Medinger and Amberg, is entitled to significant weight. AS 23.30.122; *Smith*. Employee believed she had to retire to obtain medical care for her work-related injuries. He did not remove herself from the labor market for reasons wholly unrelated to her work injuries. She is entitled to TTD benefits from June 23, 2009 through September 1, 2009. AS 23.30.185.

6) Is Employee entitled to PPI benefits?

There is conflicting medical evidence addressing PPI. This issue raises factual questions to which the presumption of compensability analysis applies. *Meek*. Without regard to weight or credibility, Employee raised the presumption on her PPI claim with medical opinions from Drs. Levine and McCormack. *Tolbert*; *Wolfer*. Each physician provided a medical opinion stating Employee has a PPI rating resulting from her compensable right knee injuries. Disregarding weight or credibility, Employer rebutted the presumption with opinions from Drs. Marble and Tower who opined Employee had no ratable PPI. *Huit*; *Wolfer*. Therefore, Employee must prove her PPI claim by a preponderance of the evidence. *Runstrom*; *Saxton*.

Both SIME physicians Drs. Levine and McCormack agree Employee has a one percent PPI rating attributable to her compensable, right knee injury. Employee takes issue with Dr. McCormack's reduction from his initial two percent right knee rating for Employee's 1990 right knee arthroscopy. However, Employee presented no contrary medical evidence suggesting Dr. McCormack's reduction was improper. *Saxton*. Further, Employee seeks an award for Dr. Levine's overall four percent PPI rating, which includes chronic pain. The medical record shows Employee had chronic

pain before she fell on the job working for Employer. Employee presented no convincing, contrary medical evidence suggesting the right knee and right basilar thumb joint injuries justify a PPI rating for chronic pain. Dr. Levine stated Employee takes narcotics for conditions other than her work injury. AS 23.30.122; *Smith*. Drs. Levine and McCormack's one percent PPI ratings deserve significant weight. AS 23.30.122; *Smith*. Employee is entitled to one percent PPI for her right knee injury. AS 23.30.190.

7) Should Employee's benefits be suspended or forfeited for failure to sign discovery releases?

The parties' suspension and forfeiture arguments are confusing. Employee contends she timely signed and delivered all releases. AS 23.30.107. Employer contends she did not timely sign and deliver releases and did not file for a protective order. Therefore, Employer contends any benefits to which Employee may be entitled were suspended and this decision should order forfeiture. AS 23.30.108. It is unclear which releases Employer contends Employee failed to return.

Apparently, there were no release issues vis-à-vis these parties early on. Miranda's post-hearing affidavit states the release dispute began on April 25, 2011. Is unlikely the legislature intended AS 23.30.108(a) through (c) to apply retroactively to suspend benefits owed for periods occurring before the parties had medical release issues. Therefore, as to the June 23, 2009 through September 1, 2009 TTD, medical benefits and any other benefits this decision awards during this period, this issue is moot. These benefits arose prior to the dispute over releases.

How the suspension and forfeiture issues apply to benefits awarded after April 25, 2011, is more difficult to determine. Two sections in the applicable statute address forfeiture -- AS 23.30.108(b) and (c). Subsection (b) only applies if a party filed a petition for a protective order. Employer contends Employee never filed a petition for protective order. Subsection (c) only applies if a party refused to comply with an order to sign and deliver releases. It is undisputed Employee never violated an order requiring her to sign and return releases because no such order ever issued. Therefore, there is no legal basis to order benefits forfeiture. AS 23.30.108(b), (c).

The record and Miranda's affidavit show activity concerning medical releases began around April 25, 2011. On May 10, 2011, Employer controverted Employee's benefits based on her alleged failure to sign and return releases or file a petition for a protective order. On August 24, 2011, the parties appeared at a prehearing conference and discussed discovery issues. On November 30, 2011, Perle signed an appearance notice, becoming Employee's attorney. Thereafter, the parties addressed disputes concerning releases between themselves with Perle and Miranda corresponding regularly. Perle thereafter provided numerous releases, some modified, to Employer without apparent objection. Miranda asserts Employee never returned "all" requested releases without offering specifics. Employer relies on her statement to justify continuing benefit suspension.

Employer did not petition for an order to compel Employee to sign releases, and mentioned the suspension and forfeiture issue only in passing in its closing argument. Employee objected to Employer's last-minute argument, post-hearing. The panel reopened the hearing record so the parties could adequately address this issue. The file contains medical records totaling approximately 3,000 pages. Employer's suggestion Employee's benefits remain suspended because Employee failed to sign and return releases or petition for a protective order in April 2011, is unsupported by the facts or the law. Employee provided written authority for Employer to complete its discovery. Employee's benefits awarded in this decision do not remain suspended.

8) Is Employee entitled to PTD benefits?

Employee contends she is entitled to PTD benefits for periods since her injury when other benefits are inapplicable but she is still unable to work due to her work injury. AS 23.30.180. Employee requested a vocational rehabilitation eligibility evaluation, which has not yet occurred. As a matter of law, her failure to this point to achieve remunerative employability as defined in the Act does not constitute permanent total disability. AS 23.30.180(b). In short, Employee's PTD claim is premature. This decision will deny the PTD claim without prejudice. *Egemo*.

9) Is Employee entitled to past or future medical costs and related transportation expenses?

There is conflicting medical evidence addressing medical care. This issue raises factual questions to which the presumption of compensability analysis applies. *Meek*. Without regard to weight or

credibility, Employee raised the presumption on her medical care claim with medical opinions from Drs. Levine and McCormack. *Tolbert*; *Wolfer*. Each physician provided a medical opinion stating Employee needed medical treatment resulting from her compensable right knee and right basilar joint injuries. Disregarding weight or credibility, Employer rebutted the presumption with opinions from Drs. Marble and Youngblood who opined Employee needed no compensable medical care. *Huit*; *Wolfer*. Therefore, Employee must prove her medical treatment claim by a preponderance of the evidence. *Runstrom*; *Saxton*.

This decision previously found Employee prevails on her right knee and right basilar thumb injuries. Therefore, she is entitled to all reasonable and necessary medical care related to these two compensable injuries to the extent Employee properly filed and served appropriate medical records and billing statements. AS 23.30.095(a); 8 AAC 45.082(d). As detailed above, Employee's right to medical treatment for her right knee continues, while her right to medical care for her right basilar joint injury ended effective October 6, 2011. Employer retains its right to challenge additional right knee care. AS 23.30.095(a). Similarly, Employee is entitled to medical travel expenses for the right knee and right basilar thumb injuries to the extent she provided appropriate documentation, though her right to travel expenses for her right basilar injury ended October 6, 2011. 8 AAC 45.084. Employer also retains its right to challenge additional travel expenses for Employee's right knee. AS 23.30.095(a).

10) Is Employee entitled to a vocational reemployment eligibility evaluation or §041(k) compensation?

In her brief, Employee narrowed her vocational reemployment claim to an eligibility evaluation and weekly compensation under AS 23.30.041(k). Employer controverted Employee's claim based on Dr. Marble's opinion. Consequently, the only way Employee could pursue reemployment benefits vigorously would be to pursue a hearing vigorously. Employee filed her claims and requested hearings timely but not "vigorously." *Carlson*; *Carter*.

For example, on March 20, 2009, Employee formally requested an eligibility evaluation. *Carter* suggests in some cases, this begins an injured worker's active participation in the reemployment process. On April 3, 2009, Employee told Dr. Marble she wanted retraining. However, Dr. Marble

has no authority over the retraining process. On April 17, 2009, Employer controverted her claim based on Dr. Marble's EME report. Under then-present and current law, this controversion stopped the reemployment process. 8 AAC 45.510(b). On May 4, 2009, the division asked Employer to verify if Employee's work injury disabled her from her job for 90 consecutive days. On May 7, 2009, Employer advised it had controverted Employee's claim. On June 2, 2009, the division told Employee it could take no action on her request for an eligibility evaluation until Employer accepted her claim or a decision and order overturned the controversion. Employer never accepted the claim. Vocational reemployment is supposed to be a speedy process, with tight time limits. AS 23.30.041(c), (d), (g), (h), (i), (k). (Employee's claim for compensation under AS 23.30.041(k) turns on what Employee did next. *Carter*.

On August 8, 2009, Employee called the division and spent 70 minutes discussing her case, including retraining benefits. Yet, she filed no claim and requested no hearing. Meanwhile, on February 2, 2010, a medical provider attended a prehearing conference to discuss its claim for medical bills. The provider dropped its claim when the designee advised the provider that Employee was not pursuing her case, probably because the designee noted Employee had not filed a claim. The division served a prehearing conference summary recording this observation, on Employee. Employee still did nothing to pursue reemployment benefits.

On April 8, 2011, Employee called the division because she thought a statute of limitations was about to expire. AS 23.30.105. Division staff "directed" Employee to file a claim and concurrently seek a hearing. On April 12, 2011, Employee filed a claim and requested a hearing. The record shows Employee filed her initial claim only to toll a statute of limitations, and only upon division staff's advice. The division returned her Affidavit of Readiness for Hearing as premature, and expressly advised Employee she could re-file it 20 days after she filed her claim. On April 27, 2011, Employer controverted Employee's April 11, 2011 claim. Still, Employee did nothing procedurally to pursue her claim to hearing, and thus pursue vocational reemployment benefits.

On November 2, 2011, Employee said she had obtained an attorney. On November 12, 2011, Perle attended a prehearing conference. Still, Employee did not request a hearing on her claim. Not coincidentally, almost two years from the day on which Employer controverted the initial claim

Perle filed another claim amending the first, and filed a hearing request on the initial and amended claims. The record shows Employee filed her April 2013 hearing request solely to prevent claim dismissal under AS 23.30.110(c). *Rogers & Babler*. Yet, though she could have, Employee still did not demand a hearing date. On May 16, 2013, Employer controverted the amended claim.

Similarly, and again not coincidentally, almost exactly two years from the date Employer controverted the April 2013 claim, Employee on May 12, 2015, filed another hearing request on both claims. Again, Employee filed her May 2015 hearing request solely to prevent claim dismissal under AS 23.30.110(c). *Rogers & Babler*. She did not demand a prompt hearing. While Employee's claims and hearing requests were timely and prevented issues with applicable statutes of limitation, their timing shows Employee did not actively pursue reemployment benefits for several years. No eligibility evaluation could occur until a hearing and a resultant decision and order reversed the controversion. Litigation continued and the parties eventually selected the November 30, 2016 hearing date on June 29, 2016.

Employee implies she could not have pursued her claims more promptly given her health concerns with related home health care and assisted living requirements. The record belies this assertion. AS 23.30.122; *Smith*. Employee and later her attorney carefully calendared her contact with the division and her procedural filings to correspond with applicable statutes of limitations. Employee presents no convincing evidence showing she could not have pursued her claim more actively, including earlier requesting an SIME and demanding a hearing. *Saxton*. Given this evidence, Employee was not pursuing her right to reemployment benefits actively or vigorously. *Carter*.

When did Employee begin actively and vigorously pursuing her reemployment benefits? The first time Employee actively and vigorously pursued her reemployment claim, was on June 29, 2016, when she stipulated to the November 30, 2016 hearing. The November 30, 2016 hearing and this decision resolves the compensability issue partially in Employee's favor. It also awards Employee one percent PPI. Since Employee has actively pursued her reemployment benefits by a agreeing to a hearing on June 29, 2016, and since she partially prevailed on her claims, she is entitled to receive one percent PPI bi-weekly at her TTD rate. AS 23.30.190(a). When her PPI is exhausted,

Employee is entitled to compensation under AS 23.30.041(k) beginning June 29, 2016 and continuing pursuant to the Act. This case is also now ready for an eligibility determination.

The Act grants initial responsibility to determine eligibility for reemployment benefits to the rehabilitation benefits administrator (RBA). AS 23.30.041(d). Whether Employee's compensable right knee or right basilar joint injuries entitle her to vocational reemployment benefits is yet to be determined. This decision will direct the RBA to arrange for an eligibility evaluation.

11) Is Employee entitled to interest?

Interest is mandatory. AS 23.30.155(p). Employee is entitled to interest on the TTD and PPI awarded in this decision. To the extent she properly filed and served medical records and bills for her compensable right knee and right basilar joint injuries, Employee and her medical providers are entitled to interest in accordance with 8 AAC 45.142(a), (b)(1), (3).

12) Is Employee entitled to attorney fees or costs?

Employer requests attorney fees and costs. AS 23.30.145(a); 8 AAC 45.180. This is a complex case with voluminous medical records. There are numerous physicians' depositions, which were helpful. *Rogers & Babler*. This decision addresses 12 issues, some procedural and some substantive. Employee prevails on her collateral evidence objection. She prevails partially on admissibility of Dr. Konrath's records. These procedural victories have little effect on this decision. Employee distilled her claim from widely divergent body part injuries down to her right trigger thumb, right hand basilar joint, right knee and right ankle. On these substantive issues, Employee prevailed on her right hand basilar joint to October 6, 2011, and on her right knee injury. She did not prevail on the other two alleged injuries.

Employee prevailed on TTD and PPI claims related to the compensable injuries. Her TTD rate is $987 per week. This decision awards her 10 weeks TTD worth $9,870, plus interest. It also awards her one percent PPI worth $1,770, and §041(k) compensation from June 29, 2016 and continuing, plus interest. She did not prevail on her request for disability benefits from March 11, 2009, through the present and continuing or on her full PPI claim. Employee prevailed on the benefits suspension or forfeiture issue, which means she is entitled to receive the awarded benefits.

This decision dismisses Employee's PTD claim without prejudice, as premature, which at this stage in the litigation is neither a win nor a loss. She partially prevailed on her claim for past and future medical costs and related transportation expenses for her compensable right knee and right basilar thumb injuries. Employee prevailed on her request for a vocational reemployment eligibility evaluation, which may or may not result in additional benefits. Lastly, Employee prevailed on her claim for interest.

Employee controverted Employee's claim, which allows this decision to award actual attorney fees under AS 23.30.145(a). Employer objects to Perle's hourly rate and to specific itemized attorney fee entries. The hourly rate objection has merit. Admissible evidence shows Perle has over 40 years' experience as an attorney. His experience includes representing parties who held subrogated interests in workers' compensation claims. However, he has no experience representing injured workers in Alaska workers' compensation cases, in other than the instant case. Employer contends Perle is not entitled to on-the-job training learning the Alaska workers' compensation system. However, the Alaska Supreme Court encourages lawyers to represent injured workers in these cases, and a fully compensatory and reasonable attorney fee is the primary incentive. *Cortay*. Perle's limited experience representing one injured workers' compensation claimants in Alaska does not justify $400 per hour. On the other hand, his services including his learning curve are worth more than $0 per hour as Employer suggests. *Bignell*. Perle provided many valuable services to his client in this case, including his excellent cross-examination of Dr. Youngblood at hearing. *Rogers & Babler*.

Considering Perle's efforts and the results for his client, and referring to Table III above, Perle compares most favorably with attorney Eric Croft, who in one of his first hearings received $250 per hour as a reasonable attorney fee. *Widmer*. Accordingly, this decision will award Perle $250 per hour as a fully compensatory and reasonable attorney fee. AS 23.30.145(a); *Cortay*.

Employer also objects to numerous itemized attorney fee entries on Perle's affidavits. Table I, above, sets forth the specifics. Employer objects to Perle speaking to his client, simply because she is his wife. Employer presents no legal authority for this objection. Perle's affidavit does not suggest they were talking about what to have for dinner, but rather, these conversations involved the

attorney-client relationship. They will not reduce Perle's attorney fees. There is nothing wrong with Perle setting forth the reasons he disagreed with a controversion notice. If anything, Perle's objection clarified his position. Employer objects to Perle "creating lists," preparing a medical summary and attending staff meetings as "paralegal work." Employer's bald assertion is not convincing. AS 23.30.122; *Smith*. These tasks will not reduce Perle's fees. Employer objects to several hours Perle spent addressing releases as "unnecessary" and "incorrect." However, this decision did not suspend or forfeit Employee's benefits based in large measure on the parties amicably resolving their release issues. Perle's efforts on releases will not reduce his attorney fees. Employer's contention that Perle's efforts preparing a declaration the declarant never signed should reduce his attorney fees, without more explanation, is conclusory.

Similarly, Employer does not cite legal authority supporting its objection to Perle's attorney fees for time spent traveling to, from and attending an EME and SIMEs with his client and attending the hearing. Perle's travel and attendance prevented him from accepting other employment. *Bignell*; *Rogers & Babler*. Employer cites no legal basis for reducing Perle's fees for his legal research or his EME and SIME research and SIME questions. Lastly, it is impossible for an attorney to predict how evidence will develop or change during a case's course. For example, claims for certain benefits, which may appear valid early on, may eventually appear weak and not worthy of further pursuit as the parties develop further evidence or cross-examine physicians. *Rogers & Babler*. Accordingly, this decision will not reduce Perle's attorney fees under Table I.

Perle claims 288.7 hours attorney time at $400 per hour totaling $115,480 (Table II; $115,480 / $400 per hour = 288.7 hours). Given the extent and character of Perle's work, the issues' complexity, the results obtained and the above analysis, this decision will award Perle reasonable attorney fees totaling $72,175 (288.7 hours X $250 per hour = $72,175). *Cortay*.

Jensen is an experienced Alaska Worker's Compensation claimant lawyer. Employer did not object to his requested hourly rate or itemized attorney fees. Therefore, this decision will award Jensen reasonable fees totaling $34,640 (Table II). *Cortay*.

Both Perle and Jensen affied they incurred out-of-pocket costs in respect to this claim and the costs are correct. Employer objects to some as not compensable (Table I). As a successful claimant, Employee is entitled to necessary and reasonable costs relating to issues upon which she prevailed at hearing. 8 AAC 45.180(f). Nothing in the applicable regulation requires a claimant to produce anything other than an affidavit supporting the claimed costs. Receipts are not required. *Id.*

The applicable regulation gives considerable discretion in awarding legal costs. Employer objects to $1,468 in airfare and $1,814 in food and lodging. Employer bases its objection in large measure on Employee's failure to file receipts, which are not required under the regulation. *Id*. It also objects, without citing legal authority, to paying Employee's costs to return to Alaska for her hearing when she voluntarily moved. Lastly, Employer objects to "expert" costs Employee paid to Drs. Konrath, Raven and Kosari. Compensable costs include making Employee, a witness, available for cross-examination at hearing. 8 AAC 45.180(f)(1). Awardable costs for obtaining medical reports include those Employee incurred obtaining letters from her physicians, and she is entitled to costs associated with taking physicians' depositions. 8 AAC 45.180(f)(3), (4). Reasonable travel costs Employee incurred to attend her November 30, 2016 hearing are awardable. 8 AAC 45.180(f)(13). Other discretionary and compensable costs include costs associated with Perle's in-person attendance at hearing. 8 AAC 45.180(f)(17). Accordingly, Employer's specific objections are without merit. There being no other objection, Perle is entitled to $18,389.09 and Jensen is entitled to $5,216.30 in compensable legal costs. Table II; 8 AAC 45.180(f)(1), (3), (4), (13), (17).

CONCLUSIONS OF LAW

1) Collateral evidence of a physician's crime is not admissible.
2) Davis' documents are admissible over Employee's *Smallwood* objection.
3) Dr. Konrath's August 25, 2009 and July 12, 2013 letters are admissible over Employer's *Smallwood* objection.
4) Employee's injuries to her right trigger thumb and right ankle are not compensable; her right hand basilar joint and right knee injuries are compensable.
5) Employee is entitled to TTD benefits.
6) Employee is entitled to PPI benefits.

7) Employee's benefits should not be suspended or forfeited for failure to sign discovery releases.

8) Employee is not entitled to PTD benefits.

9) Employee is entitled to past and future medical costs and related transportation expenses.

10) Employee is entitled to a vocational reemployment eligibility evaluation and §041(k) compensation.

11) Employee is entitled to interest.

12) Employee is entitled to attorney fees and costs.

ORDER

1) Employee's claims for benefits for her right trigger thumb and right ankle are denied.

2) Employee's claims for benefits for her right hand basilar joint and right knee are granted.

3) Employee's right hand basilar joint injury ceased being compensable effective October 6, 2011.

4) Employer shall pay Employee TTD for her right knee disability beginning June 23, 2009 through September 1, 2009.

5) Employer shall pay Employee one percent PPI for her right knee injury in accordance with this decision.

6) Employee's benefits are not suspended or forfeited.

7) Employee's PTD claim is dismissed without prejudice.

8) Employer shall pay Employee's past medical costs and related transportation expenses for her right hand basilar joint injury through October 6, 2011, and shall pay past and future medical costs and related transportation expenses for her right knee, all in accordance with this decision.

9) This case is redirected to the RBA for appropriate action under AS 23.30.041(c).

10) Employer shall pay Employee compensation under AS 23.30.041(k) beginning once her one percent PPI benefits are exhausted, in accordance with this decision.

11) Employer shall pay Employee and her medical providers interest on all past benefits awarded, in accordance with this decision.

12) Employer shall pay Perle $72,175 in attorney fees and $18,389.09 in costs.

13) Employer shall pay Jensen $34,640 in attorney fees and $5,216.30 in costs.

Dated in Anchorage, Alaska on April 11, 2017.

ALASKA WORKERS' COMPENSATION BOARD

_____/s/_____
William Soule, Designated Chair

_____/s/_____
Dave Ellis, Member

_____Unavailable for signature _____
Mark Talbert, Member

If compensation is payable under the 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 is awarded, but not paid within 30 days of this decision, the person to whom the 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 Board and all other parties to the proceedings before the Board. If a request for reconsideration of this final decision is timely filed with the Board, any proceedings to appeal must be instituted within 30 days after the reconsideration decision is mailed to the parties or within 30 days after the date the reconsideration request is considered denied due to the absence of any action on the reconsideration request, whichever is earlier. AS 23.30.127.

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

RECONSIDERATION

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

MODIFICATION

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

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of Susan Piasini-Branchflower, employee / claimant v. Anchorage School District, self-insured employer/defendant; Case No. 200901607; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on April 11, 2017.

/s/

Elizabeth Pleitez, Office Assistant