ALASKA WORKERS' COMPENSATION BOARD

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

JAMES "STEVE" CANNADY, Employee, Claimant, v. TEMPTEL, INC., Employer, and LM INSURANCE CORPORATION, Insurer, Defendants.	FINAL DECISION AND ORDER AWCB Case No. 201416197 AWCB Decision No. 17-0060 Filed with AWCB Anchorage, Alaska on May 25, 2017

James "Steve" Cannady's (Employee) August 11, 2015 claim was heard on February 8, 2017, in Anchorage, Alaska, a date selected on August 30, 2016. Attorney Michael Jensen appeared and represented Employee who appeared and testified. Attorney Nora Barlow appeared and represented Temptel, Inc. and its insurer (Employer). Witnesses included Jeanne Lazzara who testified for Employee, and Michael Fraser, M.D., who testified for Employer. At hearing as preliminary matters, Employee and Employer withdrew their previously filed requests for cross-examination on medical providers. Employer wanted to cross-examine Jensen on his attorney fees. Jensen objected contending it was inappropriate. Employee wanted an order requiring Employer to pay any awarded medical benefits directly to the providers, even though Medicaid had already paid his providers. He contended the providers would reimburse Medicaid. Employer objected, contending it should pay any awarded medical benefits to Medicaid, not to the previously paid providers. The panel directed the parties to file post-hearing briefs

addressing Employer's request to cross-examine Jensen, and the medical payment issue. Post-hearing, Employer withdrew its request to cross-examine Jensen, rendering this issue moot. The parties filed their post-hearing briefs and Employee filed his attorney fee and cost affidavit on March 24, 2017. The record closed when the panel met to deliberate on May 12, 2017.

ISSUES

Employee contends his July 21, 2014 work injury with Employer continues to be the substantial cause of his need for medical treatment and any disability. His primary claim is for an order finding his injury is still compensable.

Employer contends Employee had only a temporary aggravation of his preexisting left knee condition, which resolved by April 20, 2015. Employer contends it paid Employee all benefits to which he is entitled and Employee no longer has a compensable injury.

1) Is Employee's work injury compensable after April 20, 2015?

Employee contends his work injury with Employer continues to disable him. He seeks an order awarding temporary total disability (TTD) from April 21, 2015, until he becomes medically stable from his work injury.

Employer contends its employer medical evaluator (EME) determined Employee became medically stable on April 20, 2015. Employer contends it appropriately terminated Employee's TTD thereafter and it seeks an order denying his ongoing TTD claim.

2) Is Employee entitled to additional TTD benefits?

Employee contends although Employer paid him permanent partial impairment (PPI) benefits, if this decision finds he is not yet medically stable and awards additional TTD benefits it should order Employer to reclassify the past-paid PPI to TTD. Employee contends he is still entitled to PPI benefits once he is medically stable and rated fully.

Employer contends it properly paid Employee PPI benefits based on a valid rating. As Employer contends Employee's knee surgery is not compensable, it seeks an order denying Employee's claim for additional PPI benefits.

3) Is Employee entitled to additional PPI benefits?

Employee contends his knee replacement surgery and other treatments are compensable. He seeks an order requiring Employer to pay his medical providers directly for services they rendered for his work injury. Employee contends the previously paid providers will reimburse Medicaid as required by law.

Employer contends Employee is entitled to no additional medical benefits. However, if it loses, Employer contends it need only reimburse Medicaid for the actual amounts Medicaid paid to Employee's providers.

4) Are Employee and his providers entitled to medical benefits?

Employee contends he is entitled to statutory interest on all benefits awarded. He contends his attorney provided valuable legal services. Employee seeks interest, attorney fees and costs.

Employer contends Employee is entitled to no additional benefits. Therefore, it seeks an order denying his claim for interest, attorney fees and costs.

5) Is Employee entitled to interest, attorney fees and costs?

FINDINGS OF FACT

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

1) On June 25, 2012, Employee injured his left knee while working for Norcon. (Employee).

2) On June 29, 2012, Samuel Schurig, D.O., saw Employee for left knee pain. Employee was ascending steps at work and kicked dirt off his boots. His left knee hyperextended. Pain kept Employee awake and his knee felt like it would buckle when he walked. Dr. Schurig's report says, "His knees don't usually swell when they get hurt, but this time the left knee is a little

swollen." Employee reported a right-knee meniscus surgery in 1998. Dr. Schurig examined Employee and diagnosed a left lateral meniscus tear. (Schurig note, June 29, 2012).

3) On July 2, 2012, a magnetic resonance imaging (MRI) showed a torn left lateral meniscus, a swollen anterior crucial ligament but no tear, mild degenerative changes with "mild to moderate chondromalacia," a small Baker's cyst and mild patellar tendinopathy. (MRI, July 2, 2012).

4) On July 5, 2012, Henry Krull, M.D., diagnosed a left "medial" meniscus tear and released Employee to full-duty work. (Dr. Krull report; Return to Work form, July 5, 2012).

5) On July 18, 2012, Scott Innes, M.D., reviewed Employee's left knee MRI and suggested a partial meniscectomy. Dr. Innes opined the MRI showed a posterior horn tear in the lateral meniscus and "mild arthritis." He said the meniscectomy would relieve pain from the meniscus tear, but would not relieve "pain coming from the arthritis." (Dr. Innes report, July 18, 2012).

6) On July 29, 2012, radiologist Harold Cable, M.D., read Employee's left knee x-ray to show "minor degenerative changes only." (X-ray report, July 29, 2012).

7) On July 30, 2012, Dr. Innes performed a left partial meniscectomy and found normal cartilage in the medial femoral condyle and medial tibial plateau. The medial meniscus had no tears. The lateral femoral condyle and lateral tibial plateau had normal cartilage. Dr. Innes trimmed a horizontal tear in the posterior horn of the lateral meniscus. (Operative Report, July 30, 2012).

8) On August 28, 2012, Dr. Innes released Employee to work. He "may use stairs and ladders, but if these become painful, patient must avoid them. May walk on uneven terrain, however must use caution." (Dr. Innes report, August 28, 2012; Work/School Status form, undated).

9) By September 2012, Employee was working full time "doing his regular job" and his knee continued to improve. Dr. Innes referred Employee to a back specialist and suggested a knee brace. (Employee; Dr. Innes report, September 18, 2012).

10) On October 1, 2012, Employee had a right shoulder injury while working for Norcon. (Dr. Schurig Note, October 1, 2012).

11) In December 2012, Employee had right shoulder surgery for the Norcon injury, which disabled him from October 1, 2012 into August 2013. He had left knee pain from about June 25, 2012, until he returned to work in fall 2013. (Employee; MediCenter report, October 14, 2013).

12) Effective August 6, 2013, Dr. Innes released Employee to return to work without restrictions following his right shoulder surgery. (Work/School Status form, undated).

13) On October 14, 2013, Employee had "sciatica," which included tingling and numbness on the side of his left leg from his hip down to the lateral proximal "section of knee." This report diagnosed no left knee issue. (*Id*.).

14) On February 3, 2014, Dr. Innes completed a form for Employee's unemployment benefits. The form asked him to provide information for the period July 1, 2012 to June 30, 2013. Dr. Innes stated Employee's disability began June 25, 2012 for "left knee pain, right shoulder pain," and he became able to work full-time on August 6, 2013, without limitations. (Employment Security Division Medical Report, February 3, 2014).

15) When asked about the February 3, 2014 Employment Security Division report, Employee said the form did not say he was disabled by left knee pain from June 25, 2012 through August 6, 2013. Rather, he said the form noted left knee pain disabled him for a time followed by right shoulder pain for a time and the form simply reflects the total time. (Employee).

16) Employee was off work for almost a year due primarily to his right shoulder injury. (Inferences drawn from the above).

17) On July 21, 2014, Employee injured his left knee while working for Employer when he stepped in a hole, twisting and wrenching his left knee. He kept working. Over the following month, Employee's left knee became worse. He applied home remedies such as wraps and over-the-counter medication and finally sought medical care in September 2014. Dr. Schurig evaluated Employee's knee and referred him to orthopedic surgeon Herbert Bote, M.D. In November 2014, Dr. Bote performed arthroscopic surgery and found a torn meniscus. Employee had physical therapy but neither physical therapy nor surgery resolved his left knee pain. (First Report of Injury, October 3, 2014; Employee).

18) On October 1, 2014, Employee described his work injury with Employer as follows:

> Pt says he had a partial lateral meniscectomy done by Dr. Innes in July 2012. He reports that he has not been 100% better since the surgery.
>
> On 7/21/14 he was working and walking through head high fireweed. He was stepping forward with his leg when it fell into a hole. He says that at that time, his L knee buckled out from under him and his L heel hit his butt.
>
> The pain was enough to make him yell. Since then, the pain has been on and off with no signs of improvement.

> He says that his L lower calf started swelling about a week ago and he has noticed swelling in his knee. C/O muscle cramps in the back of his calf and thigh. He also reports numbness in his L foot.
>
> Pt's job requires a lot of walking and this has not made the injury any better.
> . . . .
>
> **Problem #1/CC**: L knee pain
>
> **A&P #1**: It is my determination that the injury that happened on July 21, 2014 is causing the pain.
>
> **Problem #2:** DJD L knee
>
> **Problem #3**: Internal derangement, L knee. . . . (Schurig note, October 1, 2014).

Dr. Schurig referred Employee for an MRI and said the work injury "is causing his pain." He released Employee to "full work duty" with caution "walking over uneven terrain." (*Id*.).

19) Employee denied saying "he has not been 100% better since the surgery." (Employee).

20) On October 1, 2014, radiologist John McCormick, M.D., read Employee's left knee x-ray as showing "mild joint space narrowing medially" and an "otherwise unremarkable study." (X-ray report, October 1, 2014).

21) On October 11, 2014, a left knee MRI showed Employee had a complex tear of the posterior horn of the lateral meniscus and a new, "ill-defined" complex posterior horn tear of the medial meniscus with a partial extrusion. Within the medial compartment, there was full-thickness articular cartilage loss in the central weight-bearing femoral tibial articular cartilage, which had progressed since the prior study. Employee had a large Baker's cyst with internal debris. The radiologist read tricompartmental degenerative joint disease most advanced in the medial compartment. (MRI, October 11, 2014).

22) On October 16, 2014, Employee said he "had no problems" after his first left knee surgery and "this new injury is completely different from that last one." Dr. Bote diagnosed a possible anterior crucial ligament tear, medial and lateral meniscus tears and a bone bruise. He referred Employee for physical therapy and prescribed a knee brace. (Dr. Bote report, October 16, 2014).

23) On October 16, 2014, Dr. Bote said Employee "should refrain from any activity that requires lifting, bending, crawling, or kneeling. He may complete tasks that involve walking as long as the walking is limited to one mile or less." (Bote letter, October 16, 2014).

24) On November 7, 2014, Dr. Bote performed left knee surgery on Employee and found a complex posterior medial meniscal tear, a lateral meniscal tear, Grade 3 medial femoral condyle chondromalacia and Grade 2 patellar chondromalacia. (Operative Note, November 7, 2014).

25) On November 11, 2014, Dr. Bote removed Employee from work until further notice. (Return to Work form, November 11, 2014).

26) On December 3, 2014, Susan Creer completed a job analysis for Employee's job with Employer. His tasks included locating buried utilities. This required driving to the site, extensive walking, opening heavy utility-vault lids, using a laptop to report locates and other tasks as needed. (Regular Job Analysis, December 3, 2014).

27) On December 8, 2014, Dr. Bote again removed Employee from work until further notice. (Return to Work form, December 8, 2014).

28) On January 5, 2015, Dr. Bote continued Employee's off-work status until further notice. (Return to Work form, January 5, 2015).

29) On February 6, 2015, Employee had pain from his Baker's cyst, which caused foot numbness. Dr. Bote diagnosed localized osteoarthritis in Employee's left knee. Employee still had severe left knee pain with motion. Dr. Bote prescribed medication and physical therapy. He returned Employee to restricted work, with no kneeling, crawling, squatting, pulling, pushing or lifting. (Dr. Bote report; Return to Work form, February 6, 2015).

30) On February 18, 2015, Dr. Bote said Employee's medical stability date would be determined at a follow-up visit. He did not expect Employee to have a PPI rating for his work injury. (Dr. Bote's responses, February 18, 2015).

31) On March 5, 2015, Dr. Bote said Employee's left knee pain four months post-surgery, in all likelihood, resulted from chondral damage and not the meniscal tear. "Potentially, he may even have an early DJD process." Dr. Bote injected steroids into Employee's left knee and limited him to light or sedentary work, no running, sports, squatting, crawling, climbing, jumping, pushing, pulling or lifting. (Dr. Bote report; Return to Work form, March 5, 2015).

32) On March 5, 2015, Employee's physical therapist discharged him from care after 24 visits. Employee continued to have pain in his left knee. (Physical Therapy Discharge, March 5, 2015).

33) On March 21, 2015, Dr. Fraser performed an employer's medical evaluation (EME) on Employee. Dr. Fraser opined "at the current time" Employee was medically stable but not capable of returning to his normal job. He expected him to return to full duty work in two

months. In Dr. Fraser's opinion, any further restrictions would not be injury related, but caused by Employee's degenerative arthritis. Additional factual findings summarize Dr. Fraser's testimony and opinions, below. (Dr. Fraser report, March 21, 2015).

34) On April 1, 2015, Employee continued to have considerable left knee pain. Dr. Bote assessed post left arthroscopic partial medial meniscectomy with known "significant chondral damage that could lead to an arthritic condition, which the patient is now complaining of." Dr. Bote recommended viscosupplementation, steroid injections and "potentially totally knee arthroplasty in the future." (Dr. Bote report, April 1, 2015).

35) As of April 1, 2015, Dr. Bote said Employee remained continuously unable to work by his left knee meniscus tear and arthritis. (Supplementary Disability Claim Form, April 1, 2015).

36) On April 13, 2015, Dr. Schurig charted Employee's 40-pound weight gain resulting from left knee pain and surgery restricting Employee's walking. (Schurig report, April 13, 2015).

37) Effective April 20, 2015, Employer ceased paying Employee TTD benefits. (ICERS payments data, April 20, 2015).

38) On April 23, 2015, Employer denied Employee's right to TTD, temporary partial disability benefits and medical benefits except for one additional injection, based upon Dr. Fraser's March 21, 2015 EME report. Dr. Fraser determined Employee's work injury was no longer the substantial cause for any disability or need for treatment, and Employee was medically stable and had a three percent left knee PPI rating. (Controversion Notice, April 22, 2015).

39) On May 1, 2015, Dr. Bote stated, in response to the adjuster's questionnaire, the July 21, 2014 work injury is the substantial cause of the need for continued medical treatment including viscosupplementation, steroid injections and potentially total knee arthroplasty. (Dr. Bote responses to questionnaire, May 1, 2015).

40) On May 11, 2015, Dr. Bote said, "The patient has reached medical stability." (Dr. Bote report, May 11, 2015).

41) On July 8, 2015, Employee's standing knee x-rays showed moderate joint space narrowing in the left knee with a subchondral cyst and osteophyte formation and mild joint space narrowing in the right knee. Both knees had osteoarthritic degenerative changes most prominent in the medial femorotibial compartment of the left knee. (X-ray report, July 8, 2015).

42) On July 8, 2015, Dr. Bote said Employee had progressive left knee "DJD" precipitated or "exacerbated" by his work injury. Dr. Bote opined the July 21, 2014 injury was the substantial

cause of Employee's current left knee "symptoms and/or conditions," or was the substantial cause in aggravating, accelerating or making more symptomatic any preexisting left knee condition resulting in his need for treatment. He did not think Employee would have his current left knee symptoms or conditions if he had not had the July 21, 2014 work injury. Dr. Bote recommended left knee replacement or viscosupplementation injections. He opined Employee was medically stable with respect to his meniscus tear but not medically stable for his left knee degenerative joint disease. In Dr. Bote's opinion, Employee could do "no heavy manual labor" and needed rest for pain and swelling. (Dr. Bote's responses to questionnaire, July 8, 2015).

43) On July 8, 2015, Dr. Bote also completed a functional evaluation for Employee. He restricted Employee's sitting, standing, walking and lifting, and prohibited climbing and crawling. In Dr. Bote's opinion, "additional treatment," specifically "surgery," would "increase these physical capacities." (Physical Capacities Evaluation, July 8, 2015).

44) On July 16, 2015, Dr. Schurig opined the joint degeneration in Employee's left knee was so bad he needed a left knee joint replacement. He also stated Employee's left knee condition altered his gait causing increased low back pain. Dr. Schurig agreed the July 21, 2014 work injury was the substantial cause of Employee's current left knee "symptoms and/or conditions." He opined it was also the substantial cause of his low back "symptoms and/or conditions" or the substantial cause in aggravating, accelerating or making more symptomatic any preexisting conditions, resulting in his current need for treatment. Dr. Schurig stated Employee would not have his current left knee or low-back symptoms if he had not had the July 21, 2014 work injury. Dr. Schurig said Employee needed additional treatment for his low back. He did not think Employee was medically stable because treatment would improve his conditions. Dr. Schurig opined Employee was not able to return to his former employment because he could not walk more than an hour in an eight-hour day and could not sit for over two hours. (Dr. Schurig's responses to questionnaire, July 16, 2015).

45) On July 25, 2016, Dr. Fraser reviewed additional medical records and filed an addendum EME report. Dr. Fraser's opinions are set forth below. (Dr. Fraser report, July 25, 2016).

46) On August 12, 2015, Employee filed a claim requesting TTD from March 21, 2015 and continuing, PPI greater than three percent, medical and related transportation expenses, an SIME, interest, attorney fees and costs. (Workers' Compensation Claim, August 11, 2015).

47) On September 21, 2015, Employee had left knee swelling and an abnormal gait. (Dr. Schurig report, September 21, 2015).

48) On March 17, 2016, Floyd Pohlman, M.D., performed an SIME on Employee. His factual findings and opinions are set forth below. (Dr. Pohlman SIME report, March 17, 2016).

49) On December 7, 2016, Dr. Bote performed a left total knee replacement on Employee. (Operative Notes, December 7, 2016).

50) On December 7, 2016, a pathologist reviewed the remains from Employee's left knee. She found frayed articular cartilage with exposed bone "characteristic of osteoarthritis." (Pathology Exam, December 7, 2016).

51) Employee said five or six weeks following surgery for his 2012 Norcon left knee injury, he recovered and went back to work as a journeyman wireman. Employee had no difficulties performing his job. He worked on the Soldotna powerhouse, which he described as "pretty heavy duty stuff," and had no knee problems through December 2013. In late June or early July 2014, Employee took a job with Employer, which was lighter duty by comparison to his prior work. Job duties included locating underground utilities. Employee walked anywhere from 100 feet to five or more miles per day through ditches, woods and dirt roads. On average, Employee walked one to two miles per day, with no difficulties with his knee. (Employee).

52) Employee said Dr. Fraser did a "10 to 15 minute" examination. According to Employee, Dr. Fraser said, "you can't say this is all because of the injury." Dr. Fraser recommended another knee injection but Dr. Bote disagreed, stating the fluid would simply run out from the knee joint. Employee wanted to pursue a total knee replacement, but he lost his health insurance and Employer had denied treatment, so Employee went without any treatment for about a year. Eventually he obtained Medicaid coverage in 2016. By then, Employee's leg would swell if he stood for very long. Elevating his leg in a recliner or using compression stockings would reduce swelling. Sitting and his altered gait caused Employee's back pain to increase. Between the 2014 knee surgery and the time he obtained Medicaid coverage, Employee stated he could not have worked a full-time job. Employee estimated he could have worked perhaps two hours daily before his leg would swell and require him to sit in a recliner for his back and swollen leg. (*Id.*).

53) As soon as Employee knew he had Medicaid coverage, he returned to Dr. Schurig who told him Dr. Bote temporarily lost his license to practice. Dr. Schurig referred him to Stephen Tower, M.D. Employee returned to Dr. Bote once the state restored Dr. Bote's medical license.

Dr. Bote again recommended total knee replacement and explained this procedure's advantages and disadvantages compared to simply removing the Baker's cyst. Employee decided to go forward with a total knee replacement. (*Id*.).

54) Dr. Bote performed a total left knee replacement on December 7, 2016, and Employee continues to recover. He now has minimal knee pain, is regaining his strength, the swelling is gone, he can walk nearly as good as before and he no longer has left foot symptoms from the swelling behind his knee and in his calf. Employee's sleep is better now than before the surgery. Employee's back is also improving. He does not think he can return to his previous work, with an artificial knee. Employee continues with physical therapy twice a week for his knee and takes aspirin to prevent blood clots. He uses a Fentanyl patch and hydrocodone for breakthrough pain to reduce his back pain, especially after physical therapy. His physician referred him to a pain management specialist. Employee's knee range-of-motion and strength are improving. (*Id*.).

55) On January 13, 2017, Dr. Bote a responded to a questionnaire as follows:

> (1) Did Mr. Cannady have significant advanced osteoarthritis present at the time the December 7, 2016 knee replacement was performed? If so, was it observed by the physician at the time of surgery?
>
> ___X___ Yes _____ No
>
> . . . .
>
> (2) Had Mr. Cannady not been injured on July 21, 2014 would he have developed the frayed, worn and eroded articular cartilage and/or osteoarthritis at this time and to this degree? If yes, he would have developed the frayed, worn and eroded articular cartilage and/or osteoarthritis at this time and to this degree even if he had not been injured, what are the pre 2014 injury or non-work related causes which are the cause of the frayed, worn and eroded cartilage and/or osteoarthritis.
>
> _____ Yes _____ No
>
> COMMENTS:
>
> Difficult to definitively answer yes or no. Arthritis has a genetic component that could cause degeneration without trauma. The July 20 trauma exacerbated his symptoms at the very least.
>
> (3) Had Mr. Cannady not suffered the July 21, 2014 injury and resulting November 7, 2014 medial and lateral meniscus surgery would the December 7, 2016 left knee joint replacement surgery have been necessitated at this time or to

> this degree? If yes, the knee replacement surgery would have been necessary at this time and to this degree even if Mr. Cannady had not suffered his 2014 injury and undergone the resulting November 7, 2014 medial and lateral meniscus surgery please identify the non-work related or non-2014 injury related causes which are the substantial cause for the December 7, 2016 knee replacement.
>
> _____ Yes _____ No
>
> COMMENTS:
>
> Difficult to answer as in #2. Same reasons. (Dr. Bote responses, January 13, 2017).

56) On February 2, 2017, Jensen filed an affidavit itemizing his attorney fees and costs for this case. Jensen bills at $400 per hour for his attorney time and $195 per hour for his paralegal's services. In a footnote on his affidavit, Jensen states he took another deposition in a different claim during the same week the parties took Dr. Pullman's deposition in this case. Jensen avers if Employee prevails in this case and the board awards expenses, Jensen will not charge for the same expenses in the other case. This includes travel time in August 2016 to attend "both SIME's." Jensen's time Itemization in this case begins on June 23, 2015. He made no differentiation in his hourly rates from this date to the present. (Affidavit of Attorney's Fees and Costs, February 2, 2017).

57) Jeanne Lazzara is Employee's girlfriend and has been a respiratory therapist for over 26 years. She has known him since they were teenagers. They have been together since November 2013, and went on a trip together in January 2014 to California and Nevada. Employee had no left knee problems while on this trip. Employee enjoyed his job working for Employer. He got hurt in summer 2014 and the injury affected Employee "pretty profoundly." Thereafter, Employee had difficulty walking and standing. He would have to sit for 30 minutes in between activities. She observed Employee's skin on his left leg become taut and shiny and his knee and lower leg swollen. She occasionally measured Employee's legs after workdays and compared their circumference. On bad days, the left leg was five to six centimeters larger than the right leg. Post-injury he began walking by "swinging" his left leg rather than bending his knee. This affected his gait and Employee complained about back pain. The first knee surgery did not provide much improvement. Knee replacement surgery improved his symptoms significantly. Employee had no medical insurance for over a year until he obtained Medicaid. (Lazzara).

58) Dr. Pohlman is an orthopedic surgeon with 40 years' experience, who performed an SIME on Employee (Deposition of Floyd Pohlman, M.D., August 26, 2016, at 5). Employee's October 11, 2014 MRI showed tears in the lateral and medial menisci in the left knee. The medial meniscus was "partially displaced" from its normal position. Employee had thickened cruciate ligaments, which means he probably had a previous injury and recovered (*id*. at 6-10). Findings on this MRI three months post-injury could represent a bruise or contusion. In Dr. Pohlman's opinion, the full-thickness articular cartilage loss is probably due to Employee's work injury. Employee had too "drastic of a change in two years just from arthritis on its own," in his opinion (*id*. at 13). Employee had a Baker's cyst, which became large and caused pain in his anterior knee (*id*. at 18). The way to remove symptoms from an enlarged Baker's cyst system is to remove the cyst, though in 40 years Dr. Pohlman has removed perhaps six. Nevertheless, he stated the proper treatment in this case is to remove Employee's Baker's cyst (*id*. at 19).

59) The significant finding on Employee's 2012 MRI was a lateral meniscus tear (*id*. at 23). Dr. Pohlman opined people put "too much stock" in MRIs. He has seen what looked like a large meniscus tear on MRI; however during surgery he found no tear. The operative report is more definitive for tears because "somebody's looking at something" (*id*. at 24-25). Arthritis shows up better on a plain x-ray (*id*. at 26). According to the operative report for the 2012 left knee surgery, the trochlear groove and cartilage surfaces on both the femur and the tibia "were normal, so there wasn't any arthritic changes there. It was just a normal knee" (*id*. at 28). The 2014 left knee operative report showed medial and lateral meniscus tears, which were new, Grade 2 chondromalacia of the patella similar to 2012, and Grade 3 chondromalacia of the femoral condyle, which was not present in 2012 (*id*. at 29). The surgeon in 2014 partially excised Employee's medial and lateral menisci, which ends up "changing the joint" and reduces the "little cushion" between the two bones in the joint (*id*. at 30-31). The 2014 operation made Employee more susceptible or prone to arthritis (*id*. at 31).

60) In Dr. Pohlman's opinion, "the substantial cause of the injury in 2014, it was the meniscal tears" (*id*. at 33). Dr. Pohlman could not say the injury is the substantial cause in worsening or accelerating the chondromalacia (*id*. at 34). In Dr. Pohlman's opinion, Employee had a preexisting Baker's cyst "that was permanently aggravated by the injury" (*id*. at 36). At surgery in 2014, Employee had "early arthritic changes" (*id*. at 37). As to whether Employee would develop osteoarthritis requiring a total knee replacement, Dr. Pohlman opined:

> A. It's speculation. I mean, okay, if it's already started, it's not going to heal itself. Cartilage doesn't heal. Okay? When he's going to get significant osteoarthritis, I don't know. I mean, the way his knee is right now and the way the -- that op report, there would be no way in hell that we would do a total knee on him. It's not that far advanced.
>
> Q. Okay.
>
> A. I mean, I think he'll develop osteoarthritis maybe five, fifteen, twenty years down the road, you know, because of these injuries. But at this point in time, reviewing my records -- they were talking about a knee replacement. That's just silly at this point in time (*id*. at 36).

Dr. Pohlman would remove the Baker's cyst as the only recommended treatment for Employee's left knee (*id*. at 38). Employee's physician could try Tylenol, anti-inflammatories, exercise, steroid injections and viscosupplementation at appropriate times before excising the Baker's cyst (*id*. at 38-39). In Dr. Pohlman's opinion, the 2014 work injury and resulting surgery in 2014 will probably hasten the degenerative process in Employee's left knee, though the 2012 surgery probably hastened part of it as well (*id*. at 41). As of Dr. Pohlman's August 26, 2016 examination, in his opinion Employee had only early arthritis in the left knee, which will get worse and at some point require a total knee replacement (*id*.). One radiographic image said Employee had "tricompartmental arthritis," which the operative report showed was not correct (*id*. at 41-42). In his opinion, the 2014 left knee surgery was reasonable and necessary (*id*.). Since Dr. Pohlman suggested removing the Baker's cyst, in his opinion Employee is not yet medically stable (*id*.). Dr. Pohlman explained:

> The thing is, right now his pain is in his calf, where this Baker's cyst is. His knee doesn't really bother him. The swelling that he has during the day, it would seem to me logically that that Baker's cyst is filling up just because of gravity, you know, and then when he lays down at night and elevates it, that cyst is draining back out. He has -- he can feel the swelling in it, and that's what hurts him and that's what's making his -- why he can't walk normally (*id*. at 43).

Dr. Pohlman opined the antalgic gait resulting from the swollen calf caused by the large Baker's cyst is causing Employee's low back pain. The low back pain should resolve after excision of the Baker's cyst (*id*. at 44). Dr. Pohlman agrees with the left knee PPI rating (*id*. at 45, 50). Employee's medical care since the 2014 injury has been reasonable, necessary and attributable to the 2014 injury (*id*. at 49).

61) On cross-examination, Dr. Pohlman clarified his opinion about total knee replacement and said effective July 2015 Employee's x-rays did not show arthritis in the left knee significant enough for him to do a total knee replacement. Dr. Pohlman explained the minimal arthritis found during the 2014 left knee surgery arose from the 2012 surgery (*id*. at 53). He corrected an error from page 36 of his SIME report where he said the mild arthritic findings were secondary to the July 21, 2014 work injury. Dr. Pohlman meant to say the 2012 injury (*id*.). However, after considerable discussion, Dr. Pohlman said in reference to the early degenerative changes found in surgery four months after the 2014 injury:

> A. I'm going to reverse my stand and say they were probably due to the 2014. Because he had a meniscus tear that was displaced, that -- when I said -- when you originally asked me and I changed, I was thinking that the tear was on the medial side, and it wasn't. It was on the lateral side. That wouldn't really affect the medial compartment. So what I'm saying is that I think that the chondromalacial changes that were there in 2014 were probably secondary to the 2014 injury that was four months lapsed. He had a displaced meniscus that was, you know, causing him to limp, changed his joint mechanics; that could cause those changes.
>
> Q. In four months, you can develop arthritis?
>
> A. I didn't say arthritis. I said chondromalacia. Okay? That's a precursor to arthritis. He had chondromalacia in his patella, also, in 2012 and 2014, both times, and it looked like it was the same. Okay? It's -- it's really a hard question to answer.
>
> Q. Okay.
>
> A. Because, I mean, I know in 2012 he had a pristine knee with no arthritic changes, because that's in the 2012 op report, that he had normal surfaces. Okay? So he didn't have any arthritis in 2012 when he was scoped (*id*. at 60-61).

After further discussion about the complexities of the knee joint, Dr. Pohlman said:

> A. My final answer -- and I won't use any help lines -- I can't exactly say exactly why the chondromalacia was there. He had a lateral meniscectomy which shouldn't affect the medial compartment. He did have a tear of the medial meniscus four months prior to this that would change the mechanics of the knee that could cause, but I can't say that it did.
>
> Q. Okay.

A. I mean, it's speculative (*id*. at 67).

62) Dr. Pohlman could not say Employee currently did not justify a total knee replacement (*id*. at 54). He conceded Employee's injury is "not a minor injury" (*id*. at 54). Nevertheless, Dr. Pohlman has never seen a patient develop osteoarthritis within two years sufficient to require total knee replacement though he conceded it could happen (*id*. at 55). Similarly, Dr. Pohlman has never seen a patient with a partial, lateral meniscectomy develop osteoarthritis sufficient to require a total knee replacement in only four years post-injury (*id*. at 56).

63) EME Dr. Fraser is an orthopedic surgeon. He did not dispute Employee's representation that he spent only 10 to 15 minutes examining him, but said that sounded "a little short" for a typical exam. Dr. Fraser was confident he performed a thorough examination and took as long as necessary. In his view, Employee's first MRI showed considerable osteoarthritis in the left knee. In Dr. Fraser's opinion, Employee returned to "baseline" about three months following the work injury. It is "possible" Employee confused his pre-injury "sciatica" with left knee symptoms, but this was not discernible. He would expect a person with degenerative arthritis in the knee to have activity-related knee pain with standing or walking, and resultant swelling. Employee's 2-2.5/10 daily pain corresponds to osteoarthritic type knee pain in his opinion. Dr. Fraser is surprised Employee had total knee replacement because he is relatively young. However, in Dr. Fraser's opinion, it was reasonable to proceed with the knee replacement. He opined Employee had arthritis in his left knee at the time he had a knee replacement in 2016. Dr. Fraser "assumes" Employee's left knee "condition" worsened between November 2014 and December 2016. In Dr. Fraser's opinion, the causes for the need to replace Employee's left knee include (1) a genetic predisposition, (2) prior activities, (3) his work (4) Employee's weight; (5) his prior injuries and (6) his prior surgery. He does not consider symptoms a cause for knee replacement. He concedes that without symptoms, there would be no need for total knee replacement. Dr. Fraser said the 2014 injury played a "very minor part" and was not a "substantial cause" or a "substantial factor" in the need for knee replacement. In Dr. Fraser's view, Employee's genetic predisposition for arthritis or preexisting arthritis of unknown etiology is the substantial cause of the need to replace Employee's knee in December 2016. (Fraser).

64) Dr. Fraser noted while Employee's pattern fit a degenerative arthritic knee, some knees degenerate slowly while others degenerate more quickly. It depends upon the person. Employee said he had almost recovered 100 percent following his knee surgery in 2012. In Dr. Fraser's

opinion, the natural degeneration in his left knee would have caused Employee to have "some degree of knee pain" even had the July 2014 injury never occurred. (*Id.*).

65) Employee had new meniscal tears from his 2014 work injury. Dr. Fraser always tells his patients that arthroscopic knee surgery will fix meniscal tears but it will not address arthritic pain. In his opinion, the work injury is not the substantial cause of the need for the total knee replacement in 2016. Employee's old knee is gone, so any area injured in the work event is also gone. Employee will be limited to lifting greater than 50 pounds. (*Id.*).

66) On cross-examination, Dr. Fraser stated he gets $525 per hour performing medical evaluations for insurance companies. He has been doing these for about four years. When he was active-duty in the military, Dr. Fraser started doing EMEs for extra income. For his first report, Dr. Fraser did not have any films to review. He usually relies on film reports from other physicians. As to whether Employee had a prior lateral meniscus tear before the 2014 work injury, Dr. Fraser opined Employee had a previous lateral meniscus tear that underwent debridement. In his view, the 2014 MRI showed complex tears on both sides of the menisci. He saw progressive arthritis especially in the medial compartment, a larger Baker's cyst, full-thickness cartilage loss and a medial meniscus tear on the 2014 MRI compared to the 2012 MRI report. He never actually reviewed the 2012 MRI. Contrary to Dr. Pohlman's opinion, Dr. Fraser did not see a sub-chondral fracture. Dr. Fraser intended his recommended treatments to address chondromalacia, exacerbated by Employee's work injury. In his opinion, Employee already had a three percent PPI rating from his first surgery, resulting in an additional three percent PPI for his work injury. Dr. Fraser "absolutely" considered Employee's work injury something that aggravated the underlying arthritis in his left knee. Nevertheless, the post-injury MRI did not show "new findings." The work-related aggravation caused the symptoms Employee described after his injury. Employee continued to have symptoms in his left knee and "that's why he underwent the knee replacement." Dr. Fraser agreed there is no medical evidence showing Employee had similar symptoms before his work injury. (*Id.*).

67) Employee's left knee treatment, including physical therapy and anti-inflammatory medication, was reasonable and necessary. Dr. Fraser would not recommend simply excising a Baker's cyst. In his opinion, had Employee not had the work injury, he eventually would have needed a total knee replacement. Dr. Fraser conceded the date for the knee replacement without the work injury was "speculation." (*Id.*).

68) Given the typical three-month recovery time, Employee has not yet recovered from his total knee replacement. He is not yet medically stable. Employee would have a higher PPI rating if the board considered the total knee replacement work-related. The rating could not occur until Employee is medically stable. Physicians perform total knee replacement operations expecting improvement. Employee's hyper-flexion work injury could cause meniscal tears and could cause aggravation of degenerative disease. Dr. Fraser would expect Employee's lower back aggravation from his altered gait to resolve within three months. (*Id.*).

69) Employee had a small Baker's cyst in 2012 according to the July 2, 2012 MRI. It got bigger after the 2014 work injury. There is no evidence Employee had similar symptoms from the Baker's cyst before his work injury with Employer. However, a Baker's cyst is not an acute finding. Dr. Fraser has had patients with innocuous looking cartilage on radiographic tests go to "bone-on-bone" within six months. Trauma can cause this result. However, in his opinion in this case, it is not probable "the meniscal tears" caused the knee to go bone on bone. (*Id.*).

70) Dr. Fraser disagrees with Dr. Pohlman when he says Employee had a "pristine knee" in 2012. Nevertheless, Dr. Fraser reviewed the arthroscopic surgery photos and said one could conclude the knee was pristine based upon those pictures. He focuses on the MRI, which shows "mild change," and relies on that more than on the operative report. Similarly, he disagrees with Dr. Pohlman's opinion that the chondromalacia changes present in 2014 were secondary to Employee's 2014 injury. In Dr. Fraser's opinion, the three-month interval was not long enough to cause the chondromalacia. (*Id.*).

71) Employee would have needed a total knee replacement "within the next number of years" had he not had the work injury. Employee definitely has more arthritis on the left knee than on the right. A "genetic component" means some people are genetically predisposed to arthritis in certain joints. There is no "genetic test" to demonstrate this, however. This concept simply refers to a "trend." He cannot say why Employee's left knee at age 44 progressed as quickly as it did, given he was off work for about a year during the relevant period. (*Id.*).

72) Dr. Fraser would have expected Employee to have some left knee symptoms between 2012 through 2014 when his knee was degenerating rather rapidly. He would have expected Employee to have had left knee symptoms if he was walking up to five miles per day over uneven terrain. Dr. Fraser cannot rule out the work injury as the substantial cause of Employee's symptoms, which led to total knee replacement surgery. (*Id.*).

73) Employee contends Dr. Fraser's opinion is entitled to less weight because it never changed even after he found out Employee's 2012 left knee surgery showed "pristine" surfaces, with minimal arthritic changes and only a small Baker's cyst. Further, he contends Dr. Fraser gave a PPI rating but considers the work injury only a "temporary aggravation." Employee contends this is inconsistent. He contends there is no medical evidence showing Employee had "preexisting" symptoms after he recovered from his 2012 knee injury until the 2014 work injury with Employer. Employee contends he and his girlfriend substantiate the medical records. Employee contends he is entitled to treatment for his left knee and his lower back aggravation. (Employee's hearing arguments).

74) Employer contends Employee's attending physician does not support his position. It contends Dr. Fraser's PPI rating was for meniscal tears, not for any preexisting condition, and in Employer's view, Dr. Fraser's testimony is consistent. Employer contends there are "little drops of evidence" throughout the medical records showing Employee was symptomatic earlier. For example, Employee may have confused sciatica with actual left knee pain. Employer contends there is no medical support for Employee's position but concedes it is a difficult case to decide. (Employer's hearing arguments).

75) Jensen contends he has an ethical duty to supervise his paralegal. Therefore, Jensen contends he is legally entitled to bill for reviewing documents and supervising his paralegal, even though some itemized entries may appear duplicative. Jensen billed for the hours he was on the plane traveling to and from Hawaii to attend a medical deposition, since he cannot "materialize" in Anchorage immediately after the deposition is over. Jensen contends he only billed for the time leaving the hotel, traveling to the airport and in-flight time. While he is in such status, Jensen contends he cannot accept other employment or work on other cases. Therefore, he contends his billing is justified. (Employee's hearing arguments).

76) On March 24, 2017, Jensen filed a supplemental affidavit of attorney fees and costs. He claims $63,210.50 in attorney fees and $6,213.08 in costs for all services rendered in this case. (Second Supplemental Affidavit of Attorney's Fees and Costs Regarding Services of the Law Office of Michael Jensen, March 24, 2017).

77) Jensen's attorney fee and cost affidavits state, "The services and costs attached represent the services provided by the Law Office of Michael Jensen. . . ." Jensen avers before a notary on

each attorney fee and cost affidavit that the attached itemizations reflect "the hours expended as well as the extent and character of the work performed by my office." (*Id.*; observations).

78) Employer offered no evidence another attorney works in Jensen's law office. (Record).

79) On March 24, 2017, Employer objected to Employee's attorney fees and costs. Employer objects to Employee's retroactive hourly rate increases for his attorney and paralegal. Employer questioned whether Jensen provided all the attorney services, or if another attorney with possibly less experience provided them. Similarly, Employer contends it needs credentials for the two, billed paralegals to determine if their experience warrants the requested hourly rates. Employer accuses Jensen of "block billing." Employer contends Barlow and Jensen were in Hawaii on two cases, and Barlow "split" the cost between her two clients. Employer contends Jensen should have done the same thing. Employer further contends Jensen could have returned from Hawaii earlier than he did, and Employer should not have to pay for vacationing. Lastly, Employer objects to alleged "duplicate work" performed by Jensen and his paralegals. (Employer's Objection to Affidavit of Attorney's Fees, March 24, 2017; Employer's hearing arguments).

80) The claimant's bar is aging rapidly. Only a handful of competent attorneys represent injured workers. There are few, if any younger attorneys entering the workers' compensation bar representing claimants. It is difficult for injured workers to find a competent attorney, and about half of injured workers who appear at hearings do not have an attorney. (Observations).

81) Medicaid is a "government agency." (Experience, judgment).

PRINCIPLES OF LAW

AS 23.30.001. Legislative intent. It is the intent of the legislature that

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

The board may base its decision 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).

> **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 23.30.020. Chapter part of contract of hire. This chapter constitutes part of every contract of hire, express or implied, and every contract of hire shall be construed as an agreement on the part of the employer to pay and on the part of the employee to accept compensation in the manner provided in this chapter for all personal injuries sustained.

AS 23.30.030. Required policy provisions. A policy of a company insuring the payment of compensation under this chapter is considered to contain the provisions set out in this section.

. . . .

(2) The policy is made subject to . . . this chapter and its provisions relative to the liability of the insured employer to pay physician's fees, nurse's charges, hospital services, hospital supplies, medicines, prosthetic devices, transportation charges to the nearest point where adequate medical facilities are available . . . the acceptance of the liability by the insured employer, the adjustment, trial, and adjudication of claims for the physician's fees, nurse's charges, hospital services, hospital supplies, medicines, prosthetic devices, transportation charges to the nearest point where adequate medical facilities are available . . . compensation . . . and the liability of the insurer to pay the same are considered a part of this policy contract.

. . . .

(4) The insurer will promptly pay to the person entitled to them the benefits conferred by this chapter, including physician's fees, nurse's charges, hospital services, hospital supplies, medicines, prosthetic devices, transportation charges to the nearest point where adequate medical facilities are available . . . and all installments of compensation . . . awarded . . . under this chapter. . . . The policy is a direct promise by the insurer to the person entitled to physician's fees, nurse's charges, fees for hospital services, charges for medicines, prosthetic devices, transportation charges to the nearest point where adequate medical facilities are available, and hospital supplies, charges for burial, compensation . . . and is enforceable in the name of that person. . . .

AS 23.30.095(a). Medical treatments, services, and examinations. (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse

> and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. . . . It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has a right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require. . . .

The term "compensation" as used in the Act includes medical benefits. *Williams v. Safeway Stores*, 525 P.2d 1087 (Alaska 1974). When the board reviews a claim for medical treatment made within two years of an undisputed work-related injury, its review is limited to whether the treatment sought is reasonable and necessary. *Philip Weidner & Associates, Inc. v. Hibdon*, 989 P.2d 727 (Alaska 1999). Hibdon sought and was ready to undergo treatment well within two years of her injury date. However, the employer controverted her claim so she did not go forward with treatment. *Hibdon* held the claim date determined whether the treatment fell within the two-year deadline for restricted board discretion. It further held that corroborating opinions from two physicians that the requested treatment was reasonable and necessary sufficed, and choices between reasonable medical options were a matter between the patient and her physician.

In *Humphrey v. Lowe's HIW, Inc*., AWCB Decision No. 15-0097 (August 13, 2015), an injured worker incurred medical expenses totaling $182,259.76 at University Medical Center in Fairbanks for his work injury. Medicaid paid $5,144.40 of the total charges.

> **AS 23.30.097. Fees for medical treatment and services**. (a) All fees and other charges for medical treatment or service are subject to regulation by the board consistent with this section. . . .

> **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*.

> **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).

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

> **AS 23.30.145. Attorney Fees**. (a). Fees for legal services rendered in respect to a claim are not valid unless approved by the board, and the fees may not be less than 25 percent on the first $1,000 of compensation or part of the first $1,000 of compensation, and 10 percent of all sums in excess of $1,000 of compensation. When the board advises that a claim has been controverted, in whole or in part, the board may direct that the fees for legal services be paid by the employer or carrier in addition to compensation awarded; the fees may be allowed only on the amount of compensation controverted and awarded. . . . 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 to determine 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 find and retain competent counsel. *Cortay v. Silver Bay Logging,* 787 P.2d 103 (Alaska 1990). In *State v. Cowgill*, 115 P.3d 522 (Alaska 2005), the board ruled in Cowgill's favor on her controverted claim (*Cowgill v. State,* AWCB Decision No. 00-0147 (July 18, 2000) at 8). The state appealed, and the superior court reversed. On remand, the *Cowgill* board reviewed its past decisions and came to a similar result. The state appealed again, eventually taking the case to the Alaska Supreme Court. *Cowgill* explained what constitutes adequate board findings to support an attorney fee award:

The board explained that the

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

URESCO Construction Materials, Inc. v. Porteleki, AWCAC Decision No. 152 (May 11, 2011) stated in respect to an attorney fee award at the board level:

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

> **AS 23.30.155. Payment of compensation**. (a) Compensation under this chapter shall be paid periodically, promptly, and directly to the person entitled to it. . . .
> . . . .
>
> (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.

> **AS 23.30.190. Compensation for permanent partial impairment; rating guides**. (a) In case of impairment partial in character but permanent in quality, and not resulting in permanent total disability, the compensation is $177,000 multiplied by the employee's percentage of permanent impairment of the whole person. . . .

> **AS 23.30.395. 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;
> . . . .
>
> (26) 'medical and related benefits' includes, but is not limited to, physicians' fees, nurses' charges, hospital services, hospital supplies, medicine and prosthetic devices, physical rehabilitation, and treatment for the fitting and training for use of such devices as may reasonably be required, that arises out of or is necessitated by an injury, and transportation charges to the nearest point where adequate medical facilities are available;
> . . . .
> (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. . . .
> . . . .
>
> (32) 'physician' includes doctors of medicine, surgeons, chiropractors, osteopaths, dentists, and optometrists. . . .

In *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249 (Alaska 2007), the Alaska Supreme Court addressed a medical stability question. One doctor predicted the Employee's knee would not worsen in the next 45 days and another predicted the knee would improve. The board determined the employee was medically stable notwithstanding its knowledge that these doctors' predictions proved incorrect because another physician recommended additional knee surgery to improve her condition. *Thoeni* held the medical opinions upon which the board relied to come to its conclusion did not constitute substantial evidence to support a medical stability finding.

> **8 AAC 45.082. Medical treatment**. (a) The employer's obligation to furnish medical treatment under AS 23.30.095 extends only to medical and dental services furnished by providers, unless otherwise ordered by the board after a hearing or consented to by the employer. . . .

8 AAC 45.142. Interest. . . .
. . . .

(b) The employer shall pay the interest

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

(3) on late-paid medical benefits to
. . . .

(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. . . .
. . . .

(b) A fee under AS 23.30.145(a) will only be awarded to an attorney licensed to practice law in this or another state. . . . An attorney requesting a fee in excess of the statutory minimum in AS 23.30.145(a) must (1) file an affidavit itemizing the hours expended, as well as the extent and character of the work performed. . . .

8 AAC 45.900. Definitions. (a) In this chapter
. . . .

(15) 'provider,' unless the statutory context requires otherwise,

(A) means any physician, pharmacist, dentist, or other health service worker or any hospital, clinic, or other facility licensed under AS 08 to furnish medical or dental services, including chiropractic, physical therapy, and mental health services;

(B) includes an out-of-state person or facility that meets the requirements of this section and is otherwise qualified to be licensed under AS 08.

Sherrod v. Municipality of Anchorage, 803 P.2d 874 (Alaska 1990), was a joinder case. The claimant suffered a work injury and his employer's workers' compensation insurance and his health insurance both paid related medical bills. The health insurer required him to sign an agreement to repay it from any recovery received from workers' compensation. Later, the health insurer told the claimant it expected reimbursement from him because its health insurance policy

did not cover occupational injuries. The worker filed a petition seeking an order that the employer was liable for the bills the health insurer had paid and seeking to join the health insurer as a party to adjudicate its rights. The health insurer opposed joinder and the board denied the petition stating the worker lacked a recognizable interest in the controversy. The Alaska Supreme Court reversed on grounds the health insurer was a person who may have a right to relief and should be joined as a party as an equitable subrogee of the healthcare providers it had paid. Citing AS 23.30.030(4), *Sherrod* stated the employer was "directly liable to health-care providers for treatment of work-related injuries." (*Id*. at 875). Since the health insurer did not waive its right for reimbursement against the injured worker, he had a legally recognized interest in the controversy and the board should join the health insurer as a party. (*Id*. at 876). *Sherrod* did not address or resolve payment issues.

ANALYSIS

1) Is Employee's work injury compensable after April 20, 2015?

Employee contends his work injury continues to disable him after April 21, 2015, when Employer ceased paying his benefits. Employer contends Employee's work injury resolved effective April 20, 2015, and any continuing disability or need for medical care did not arise out of or in the course of his employment and are not compensable. This issue raises factual disputes to which the compensability presumption analysis applies. AS 23.30.120; *Meek.* Without regard to credibility, Employee raises the presumption with his and his fiancée's testimony, and medical opinions from Drs. Bote, Schurig and Pohlman. *Wolfer*. Employee and his fiancée testified Employee's left knee caused him no difficulties after he recovered from his 2012 left knee injury with Norcon. Following the 2014 work injury with Employer however, Employee's left knee consistently caused him progressive difficulties. Drs. Bote, Schurig and Pohlman offered medical opinions stating the 2014 work injury was the substantial cause of the need for medical treatment and disability arising from the left knee and lower back. *Tolbert*. This shifts the burden to Employer who must rebut the presumption with substantial evidence. *Huit*.

Without regard to credibility, Employer rebuts the presumption with Dr. Fraser's testimony. *Runstrom*. He opined the 2014 work injury had minimal effect on Employee's left knee and the

work injury was not the substantial cause of the need for additional care or any disability after April 20, 2015. This evidence shifts the burden back to Employee who must prove his claim by a preponderance of the evidence. *Saxton*.

To enjoy continuing compensability for his left knee work injury with Employer, Employee must show the work injury continues to be the substantial cause of any disability or need for treatment after April 20, 2015. AS 23.30.010(a). On March 5, 2015, Dr. Bote stated Employee's persistent left knee pain four months post-arthroscopic-surgery came from chondral damage, not meniscal tears. Drs. Bote and Schurig both stated the 2014 work injury is "the substantial cause" of Employee's need for medical care after April 20, 2015. On January 13, 2017, Dr. Bote opined if nothing else, the 2014 work injury exacerbated Employee's left knee symptoms. Employee and his fiancée Lazzara both convincingly testified Employee recovered well following arthroscopic left knee surgery for his 2012 Norcon injury. They enjoyed an extended vacation in Nevada and California and Employee had no difficulty walking. Employee's interim medical records, lacking any significant reported left knee symptoms, support their testimony. Drs. Bote and Schurig, Employee and Lazzara are all credible. AS 23.30.122; *Smith*.

Dr. Pohlman's opinions are equivocal. For example, following the 2014 work injury with Employer, Employee's medial meniscus was "partially displaced" from its normal position, suggesting a serious injury. Three months post-injury, an MRI showed damage that could represent a bone bruise or contusion, again suggesting serious injury. As Dr. Pohlman noted, Employee had too "drastic of a change in two years just from arthritis on its own." He relied on the 2012 left knee operative report, which showed "just a normal knee" with no damage to cartilage surfaces in the knee joint. The 2014 arthroscopic surgery, indisputably related to the work injury with Employer, "changed the joint" and made Employee more susceptible or prone to arthritis, in Dr. Pohlman's view. He also opined the work injury permanently aggravated the preexisting Baker's cyst. These opinions strongly support Employee's position.

On the other hand, after initially correcting a typographical error in his report stating minimal arthritis found during the 2014 left knee surgery arose from the 2012 surgery for the Norcon injury, Dr. Pohlman reversed his view and said the chondromalacia was probably secondary to

the 2014 injury four months earlier. Dr. Pohlman changed his position because he recalled the 2012 injury was to the lateral compartment and not the medial side. Therefore, Dr. Pohlman reasoned, the 2012 injury should have had no effect on the medial side's articular surfaces. However, the displaced medial meniscus arising from the 2014 work injury changed Employee's knee joint mechanics and could cause the changes found in the medial compartment. He described Employee's knee in 2012 as "pristine" with normal surfaces. Dr. Pohlman ultimately conceded he could not say that the 2014 work injury four months prior to arthroscopic surgery caused the chondromalacia on the medial surfaces. Employer maintains this "final answer" diminishes Dr. Pohlman's other opinions and does not ultimately support Employee's case.

However, Dr. Pohlman does not need to state what the substantial cause of the chondromalacia was to support Employee's position. Employee's injury continues to be compensable if in relation to other causes the employment remains the substantial cause of disability or need for medical treatment. AS 23.30.010(a). Though Dr. Pohlman disagrees with the knee replacement surgery, he explicitly agreed Employee's knee symptoms are what drove his medical treatment.

Dr. Pohlman has never seen a patient develop osteoarthritis in a knee joint within two or even four years post-injury though he conceded, "it could happen." Nevertheless, indisputable objective evidence including photographs and orthopedic surgeons' visualization of Employee's left knee joint in 2012, 2014 and 2016 shows that is exactly what happened in this case. In other words, Employee's left knee articular surfaces went from being "normal" or "pristine" in 2012 to having minimal degenerative changes especially in the medial compartment in 2014, to needing total knee replacement by 2016. This decision gives greater weight to objective observations of knee joint surfaces made by physicians during surgery than it does to MRI findings read by radiologists. AS 23.30.122; *Smith*. Drs. Fraser and Pohlman have both seen significant knee MRI findings not confirmed during surgery.

Notwithstanding conventional wisdom that arthritis sufficient to require a total knee replacement takes perhaps five to 20 years to develop, this case is an outlier, which proves the exception to the rule. By 2016, when Dr. Bote replaced Employee's left knee joint, he and a trained pathologist saw exposed bone on the medial joint. Taken overall, and notwithstanding his

equivocation on issues that do not really matter anyway, Dr. Pohlman's opinions support Employee's position and are entitled to some weight. AS 23.30.122; *Smith*.

Employer relies on Dr. Fraser's opinions. He would have expected Employee to have activity-related knee pain with standing or walking and resultant swelling between the 2012 Norcon injury and his July 2014 work injury if he had degenerative arthritis progressing in his left knee. Employee's and Lazzara's credible lay testimony shows Employee had no such symptoms. Employee's medical records support their testimony. AS 23.30.122; *Smith*. Employer's "little drops of evidence" theory suggesting Employee had left knee pain in the relevant interim does not pan out. Even Dr. Fraser said there is no way to tell whether Employee mistook left leg sciatica with left knee joint symptoms. Moreover, there is no medical evidence suggesting any examining physician confused the two.

Dr. Fraser opined the 2014 work injury played a "very minor part" in the need for knee replacement surgery. He opined Employee's "genetic predisposition for arthritis," or his "preexisting arthritis of unknown etiology" is probably the substantial cause of Employee's need to replace his left knee in December 2016. Dr. Fraser conceded there is no genetic test supporting his genetic predisposition theory, and it refers only to an observable "trend." Most notably, Dr. Fraser agreed the aggravation from the 2014 work injury caused the symptoms Employee described after his injury. He affirmed Employee continued to have left knee symptoms and, "that's why he underwent a knee replacement."

Dr. Fraser agreed medical records show no evidence Employee had similar left knee symptoms months before his work injury. Though he disagreed Employee had a "pristine" knee in 2012, Dr. Fraser agreed one could conclude from reviewing the arthroscopic surgery photos that the knee was pristine. It is difficult to weigh Dr. Fraser's opinions heavily given his expressed preference for a radiologist's MRI interpretation over orthopedic surgeons' visual observations, objective photographs and a pathologist's visualization of bone on bone. AS 23.30.122; *Smith*. Furthermore, Dr. Fraser has had patients with normal radiographic imaging go "bone-on-bone" within six months. Lastly, Dr. Fraser could not rule out the work injury as the substantial cause

of Employee's symptoms, which led to his total knee replacement surgery. In these respects, Dr. Fraser's opinions support Employee's position. *Rogers & Babler*; AS 23.30.010(a).

Employer tries to diminish Dr. Bote's opinions by suggesting he retracted prior opinions in a questionnaire on January 13, 2017. Although he admitted difficulty answering the proposed causation question, "definitively . . . yes or no," Dr. Bote said the work injury "exacerbated his symptoms at the very least." This opinion is substantial evidence and supports Employee's position. AS 23.30.010(a).

On balance, the evidentiary weight favors Employee's position. Objective evidence showed the articular surfaces on his left knee were in excellent condition when an orthopedic surgeon looked at them in 2012. A few months following his 2014 work injury, Employee's left knee MRI showed a bone bruise, suggesting a more serious injury. Employee's physicians tried conservative management ranging from anti-inflammatory medication to physical therapy to steroid injections, all to no avail. Employee's symptoms remained. By July 2015, Drs. Bote and Schurig both recommended a total knee replacement and said the 2014 work injury was the substantial cause of the need for this treatment. Dr. Bote saw bone on bone and a pathologist found frayed articular cartilage with exposed bone "characteristic of osteoarthritis." Employee's lay and medical evidence shows the July 21, 2014 work injury continues to be the substantial cause of his ongoing symptoms, including his left knee pain, increasing Baker's cyst and lumbar spine symptoms caused by his altered gait, since April 21, 2015. His work injury continues to be compensable effective April 21, 2015. *Saxton*; AS 23.30.122; *Smith*; *Rogers & Babler*.

2) Is Employee entitled to additional TTD benefits?

a) TTD from April 21, 2015 through May 11, 2015.

Employee contends he is entitled to additional TTD benefits beginning April 21, 2015. AS 23.30.185. Employer contends Employee's work injury was medically stable effective April 20, 2015, so he is not entitled to additional TTD benefits. This issue raises factual disputes to which the compensability presumption analysis applies. AS 23.30.120; *Meek.* Without regard to credibility, Employee raises the presumption for the period April 21, 2015 through May 10, 2015 with Dr. Bote's opinion. *Wolfer*. He recommended additional steroid injections on March 5,

2015, restricted Employee from all work effective April 1, 2015, and on May 1, 2015, said he needed viscosupplementation, steroid injections and potentially total knee arthroplasty. *Tolbert*. The burden shifts to Employer to rebut the presumption with substantial contrary evidence. *Huit*.

Without regard to credibility, Employer rebuts the presumption with Dr. Fraser's testimony. *Wolfer*. He opined the 2014 work injury became medically stable effective March 21, 2015, and no longer disabled Employee. *Runstrom*. This evidence shifts the burden back to Employee who must prove his TTD claim by a preponderance of the evidence. *Saxton*.

To obtain additional TTD benefits, Employee must satisfy a two-part test. He must show he was not medically stable and must show he remained disabled from his work injury since April 21, 2015. AS 23.30.185. Under this decision, Employee's left knee, and low back symptoms resulting from his altered gait, continue to be compensable. Dr. Fraser said Employee became medically stable effective March 21, 2015, and would require two more months, or until May 21, 2015, to return to full duty work. However, Dr. Fraser's prediction proved incorrect. Other physicians recommended additional medical care including total knee replacement surgery. *Thoeni*. Employee's condition worsened and he did not return to work. For these reasons, this decision again reduces the weight accorded Dr. Fraser's opinion on medical stability and disability. AS 23.30.122; *Smith*.

By contrast, on February 18, 2015, Dr. Bote said Employee's medical stability date would be determined at a later visit. On May 1, 2015, he recommended additional medical care, implying Employee was still not yet medically stable. *Rogers & Babler*. Even Dr. Fraser recommended an additional knee injection, which he intended to create improvement in Employee's condition. From March through July 2015, Drs. Schurig and Bote recommended ongoing treatment. Experience shows physicians expect treatment to improve a patient's condition. *Rogers & Babler*. Drs. Pohlman and Fraser agreed physicians perform knee arthroplasty expecting objectively measurable improvement. However, on May 11, 2015, Dr. Bote also opined Employee was "medically stable." This decision weights his opinion on this issue heavily. Thus, Employee's first claimed TTD period is limited from April 21, 2015 through May 11,

2015, the day Employee initially reached medical stability. AS 23.30.122; *Smith*. This satisfies Employee's burden in respect to medical stability for this TTD period. AS 23.30.395(28).

Employee must also meet the disability element in this test, for this period. On January 5, 2015, Dr. Bote continued Employee's off-work status until "further notice." On March 5, 2015, Dr. Bote said Employee's left knee pain post-surgery resulted from chondral damage and not from his meniscal tears. He injected steroids into Employee's left knee and significantly limited his working ability. As Dr. Pohlman stated, chondral damage does not "heal itself." Dr. Bote's work restrictions compared to Creer's December 3, 2014 job analysis shows Employee was not able to earn his normal wages under these restrictions. There is no evidence Employer offered him lighter duty work at a similar wage. He was by definition "disabled." AS 23.30.395(16).

Dr. Fraser did not repudiate Employee's testimony that he spent only 10 to 15 minutes examining him. Dr. Bote saw Employee on many occasions and is actively treating him and observing his symptoms and treatment responses. Consequently, Dr. Bote's opinion is entitled to greater weight. AS 23.30.122; *Smith*. Although he disagreed with Dr. Bote's recommended treatment, Dr. Pohlman also recommended additional treatment including a Baker's cyst excision to relieve Employee's left leg symptoms. Lastly, Employee and Lazzara convincingly testified Employee could not have worked full-time at his regular job during this period. AS 23.30.122; *Smith.* This evidence demonstrates Employee was disabled and not medically stable from April 21, 2015 through May 11, 2015. He is entitled to TTD benefits for this period.

b) TTD from May 12, 2015 through July 7, 2015.

Employee produced no medical evidence showing he became medically unstable following Dr. Bote's May 11, 2015 opinion stating he was medically stable, until July 8, 2015. So long as Employee remained medically stable, he was not entitled to TTD benefits. AS 23.30.185. He is not entitled to TTD benefits from May 12, 2015 through July 7, 2015.

c) TTD from July 8, 2015 and continuing.

On July 8, 2015, Dr. Bote recommended total knee replacement surgery. As Drs. Fraser and Pohlman stated, surgeons intend for this treatment to create improvement in the patient's

condition. Dr. Schurig made the same recommendation on July 16, 2015, and further opined Employee needed additional lumbar spine treatment to reduce symptoms arising from his altered gait. Once a physician prescribed additional medical treatment intended to improve Employee's physical condition, Employee was no longer medically stable. Therefore, Employee became medically unstable effective July 8, 2015. *Thoeni*. This satisfies Employee's burden in respect to medical stability for this TTD period. AS 23.30.395(28).

On April 23, 2015, Employer controverted Employee's right to medical benefits. Employee and Lazzara testified Employee lost his health insurance. It took considerable time for Employee to obtain Medicaid eligibility and get further treatment. There is no contrary evidence. There is no evidence Employee delayed treatment or would not have obtained it more quickly had financial resources been available. To the contrary, Employee convincingly testified as soon as he obtained Medicaid coverage, he returned to Dr. Schurig who told him Dr. Bote temporarily lost his license to practice medicine. Shortly thereafter, Employee returned to Dr. Bote who again recommended total knee replacement surgery, and Employee proceeded with this recommended treatment. Employee and Lazzara convincingly said Employee could have worked perhaps two hours per day before he would have to sit in a recliner to elevate his swelling left leg and relieve his lumbar pain caused by his altered gait. AS 23.30.122; *Smith.*

Again, comparing Dr. Bote's previous and unchanged work restrictions to Creer's December 3, 2014 job analysis shows Employee was not able to earn his normal wages under these restrictions, during this period. Therefore, he was "disabled" and there is no evidence Employer offered him lighter duty work. AS 23.30.395(16). This decision will not penalize Employee's right to TTD benefits because Employer controverted his case and he could not get proper medical treatment more promptly. *Hibdon*. As Employee was not medically stable and was disabled, he is entitled to TTD benefits from July 8, 2015 and continuing, until he reaches medical stability following his left knee replacement surgery or returns to work.

3) Is Employee entitled to additional PPI benefits?

Since Employee is not medically stable from all work-related injuries, Employer's PPI payment was premature. Employer is entitled to characterize prior PPI payments as TTD payments.

Upon reaching medical stability, Employee is entitled to a PPI rating, which takes into account his total left knee replacement. Employer will be liable to pay PPI benefits in accordance with the Act. AS 23.30.190. Employer maintains its right to dispute the future PPI rating.

4) Are Employee and his providers entitled to medical benefits?

There is no factual dispute about Employee's medical care for his left knee, or his lower back symptoms arising from his altered gait. Drs. Schurig and Bote agreed Employee needed his left knee replaced, and Dr. Fraser agreed the surgery was reasonable. Only Dr. Pohlman recommended a Baker's cyst excision to reduce Employee's symptoms. Dr. Fraser disagreed with his opinion and Employee did not follow Dr. Pohlman's advice. Since Drs. Schurig and Bote in July 2015 recommended total knee replacement surgery within two years of Employee's July 2014 work injury, Dr. Pohlman's contrary opinion is immaterial. *Hibdon*. This decision found Employee's left knee medical care beginning April 21, 2015, and continuing, including his left knee replacement surgery and treatments to address spinal symptoms caused by his altered gait, compensable. Therefore, Employer is liable for this medical treatment. AS 23.30.095(a).

The real medical dispute is whom Employer should pay. Medicaid paid for Employee's compensable medical care. Employee contends Employer must pay his medical providers directly under the Act pursuant to the Alaska fee schedule, and his providers must then reimburse Medicaid. Alternately, Employee contends Employer should reimburse Medicaid and then pay providers the difference between what Medicaid paid them, and the fee schedule amounts. By contrast, Employer contends Medicaid is the "person entitled to" payment, not the providers. Therefore, Employer contends it should simply reimburse Medicaid. This is a legal question.

Employee raises public policy and legal concerns. As a public policy matter, he contends Employer should not profit from controverting his claim and receive a windfall by having to repay Medicaid at significantly reduced rates. As a legal matter, Employee contends authority to order medical benefit payments arises from the Act, not from Medicaid. He contends the Act and regulations require payment to "medical providers," and Medicaid is a payor, not a provider. By contrast, Employer contends under *Sherrod*, Medicaid is a proper payee and considers itself "a party in interest." Employer considers Medicaid a person entitled to benefits under the Act.

In response, Employee contends Medicaid regulations do not prevent this decision from ordering medical benefit payments pursuant to the Act. He contends Medicaid rules only prevent a provider from seeking from the patient the difference between what Medicaid pays the provider and higher amounts the provider might otherwise recover from different insurance.

a) Public policy considerations support Employee's position.

There is no doubt the Alaska workers' compensation fee schedule provides greater remuneration to medical providers than does Medicaid for most medical procedures. *Humphrey*. Therefore, it is likely Employer would save considerable expense if all it had to do in this case were to reimburse Medicaid for Employee's compensable medical treatment. Adopting this policy would create an inappropriate incentive for employers to controvert claims, lengthen litigation and hope for Medicaid to provide payment for work-related medical services. This practice contravenes the legislature's intent to ensure quick, fair, efficient and predictable delivery of benefits to injured workers at a reasonable cost to employers. AS 23.30.001(1). Employee also contends taxpayers should not pay medical bills associated with a work-related injury falling under state law. These valid policy concerns support Employee's position. *Rogers & Babler*.

b) The statutes and regulations support Employee's position.

The Act provides a comprehensive system for processing work-related injuries. This decision must construe the Act to ensure benefits paid to injured workers are a "reasonable cost" to employers. AS 23.30.001(1). Every contract for hire is construed as an employers' promise "to pay" compensation in the manner provided in the Act. AS 23.30.020. Every workers' compensation policy requires the insurer to assume the obligation to pay "physician's fees, nurse's charges, hospital services, hospital supplies, medicines, prosthetic devices," and "transportation charges" for a work-related injury. AS 23.30.030(2). The Act requires insurers to pay "to the person entitled to them" all benefits conferred under the Act including medical benefits. AS 23.30.030(4). A fee schedule regulates fees for medical services. AS 23.30.097(a). The enabling statute and the fee schedule, not Medicaid statutes, determine what the "reasonable cost" is to employers for a medical provider's services in a workers' compensation case.

The Act again requires employers to pay compensation "directly to the person entitled to it." AS 23.30.155(a). "Compensation" includes medical benefits. *Williams*. The Act does not expressly state how to determine the person who is "entitled" to the medical benefits. "Medical and related benefits" are defined to include "physician's fees, nurse's charges, hospital services, hospital supplies, medicine and prosthetic devices, physical rehabilitation" and related transportation expenses. AS 23.30.395(26). With the possible exception of transportation expenses, all these benefits refer to providers who provide these treatments or services. The term "physician" refers to various medical practitioners. AS 23.30.395(32). In a compensable case where a medical provider has unpaid bills for services rendered in a work injury, the answer appears simple: The insurer owes the money directly to the provider. What happens if another entity has already paid the provider's bills?

The most definitive answer lies in the administrative regulations. "The employer's obligation to furnish medical treatment under AS 23.30.095 extends only to medical and dental services furnished by providers," unless otherwise ordered after a hearing or if the employer otherwise consents. 8 AAC 45.082(a). Furthermore, "provider," unless the statutory context requires otherwise, means a "physician, pharmacist, dentist, or other health service worker or any hospital, clinic, or other facility licensed under AS 08 to furnish medical or dental services, including chiropractic, physical therapy, and mental health services," and similarly licensed facilities out-of-state. 8 AAC 45.900(15)(A-B).

Given this statutory and regulatory background, the law favors requiring employers to pay medical bills for work-related injuries directly to the providers, even though a third party may have already paid the bills. Interpreting the Act and regulations in this manner insures quick, fair, efficient and predictable delivery of medical benefits to injured workers at the pre-determined reasonable cost to employers set forth in the Alaska fee schedule. AS 23.30.001(1); AS 23.30.097(a). It also prevents Employer from obtaining a windfall at the providers' expense, and requires the liable insurer rather than the taxpayer to pay for Employee's work-related medical needs. AS 23.30.095(a); *Rogers & Babler*. Employer will pay Employee's providers directly for his compensable medical care in accordance with the Alaska fee schedule. Federal law applicable to Medicaid providers will require the providers to reimburse Medicaid and will

prevent Employee's providers from receiving double recovery. *Rogers & Babler*. Employee shall ensure that he promptly provides Employer with itemized bills for his work-related medical care if he has not already done so.

5) Is Employee entitled to interest, attorney fees and costs?

a) Interest.

Interest under the Act is mandatory. AS 23.30.155(p). Employee is entitled to interest on all TTD benefits awarded in this decision, from the date of each installment. 8 AAC 45.142(b)(1). Interest payable to Medicaid and Employee's providers requires a little more analysis. Medicaid paid some of Employee's medical bills for his work injury. However, experience shows Medicaid pays significantly less for most medical procedures than does the Alaska workers' compensation fee schedule. *Rogers & Babler*; *Humphrey*. Medicaid is a "government agency" and, while it paid some of Employee's work-related medical expenses, Medicaid did not pay the billed expenses in full. In that sense, the providers "have not been paid." Medicaid is entitled to interest from Employer on the work-related medical benefits it paid to Employee's providers, to compensate Medicaid for its loss of use of its money. 8 AAC 45.142(b)(3)(B). However, Employee's medical providers also lost the use of the difference between what Medicaid paid them and what Employer should have, and now must, pay them under the Alaska fee schedule. Therefore, Employee's medical providers are entitled to interest on the difference between what Medicaid paid them and what has "not been paid" under the Alaska fee schedule. 8 AAC 45.142(b)(3)(C). Employer shall pay the interest in accordance with this decision.

b) Attorney fees and costs.

Since Employee's claim was repeatedly controverted, Employee's fee request is evaluated under AS 23.30.145(a) and 8 AAC 45.180(b). The Alaska Supreme Court in *Cowgill* affirmed what constitutes adequate findings to support an attorney fee award:

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

Cowgill's analysis applies to this case. The nature length and complexity of services: Employee's medical and legal issues were complex and varied, requiring similar legal services. Employer in its closing argument conceded this is a difficult case to decide. Jensen pursued this challenging case for years. The issues involved complicated interplay between alleged preexisting conditions, various contradictory medical opinions, prior knee surgery and unusually quick developing osteoarthritis in Employee's left knee, post injury. *Rogers & Babler*.

Competent counsel represents Employer: Barlow vigorously defended against Employee's claim. Employer unsuccessfully argued the conflicting medical evidence and legal theories. These arguments contributed to the difficult, complex and lengthy nature of this claim.

Transportation costs: Employer objects to Employee's attorney fees incurred for travel. To the extent Jensen included travel time to and from claim-related activities, he is entitled to compensation for his transportation costs. Employee correctly notes he cannot teleport himself to and from Hawaii. *Rogers & Babler*. While he is between his hotel and the airport, waiting at the airport and on the airplane, Jensen cannot easily work on other cases and cannot accept new clients. *Bignell*. However, in one regard Employer's argument has merit. If Jensen billed this and another client's case for the same attorney fees for travel to and from Hawaii and for the same travel expenses, this is inappropriate. Jensen states if he prevails in this case he will not bill the employer in the other case. However, Jensen should still bill the cases separately. The Act and regulations do not provide for an attorney to receive double recovery in two cases for the same billable time and travel expenses. AS 23.30.145(a); 8 AAC 45.180(b).

Benefits resulting from the services: Had he lost, Employee would have been entitled to nothing. Employee lost on a *de minimis* TTD issue, from May 12, 2015 through July 7, 2015. He prevailed on his primary claim, which was for TTD from April 21, 2015 through May 11, 2015 and from July 8, 2015 continuing until he is again medically stable or has returned to work and is no longer "disabled." Employee prevailed on his continuing medical benefit claim. He also prevailed on his interest claim. This is a significant benefit to Employee. AS 23.30.145(a); *Porteleki*. Jensen's attorney fees are not excessive simply because Employer says they are. Though Employer argues Employee's attorney fees are excessive, it has not demonstrated Jensen performed any legal services

in this case that were unreasonable or unnecessary in presenting Employee's claim or responding to Employer's arguments. Employer's controversions created the need for Employee to retain counsel. Employer has not demonstrated Jensen's current hourly rates for his and his paralegal's services exceeds what similar workers' compensation lawyers in the area commonly receive. Counsel for claimants are entitled to fully compensatory attorney fees to ensure competent counsel is available to represent injured workers in these claims. *Cortay*. Employer provided no evidence showing another attorney works in Jensen's law office, and his notarized affidavit is sufficient. Employer provided no legal support requiring resumes from Jensen's paralegal to improve their experience.

Experience, judgment, observations and inferences drawn from all the above show Jensen's services appear reasonably commensurate with the actual work performed given the nature, length, and complexity of his services, and the actual benefits resulting to Employee. *Rogers & Babler*. Jensen's hourly rate is not unlike or inconsistent with those seen in other cases with similarly experienced legal representatives. However, Employer is correct in stating Employee cannot retroactively increase his previous hourly fee rates. To assist this decision in best ascertaining all parties' rights, Jensen shall resubmit his attorney fee affidavit with revised hourly rates to comport with amounts prior decisions have awarded him in prior months or years in other cases. AS 23.30.135(a).

In summary, the claimant's bar is aging rapidly. It is a limited bar to begin with, with only a handful of competent attorneys willing to represent injured workers. There are few younger attorneys entering the workers' compensation bar representing injured workers or other claimants. It is difficult for injured workers to find a competent attorney, and about half of injured workers who appear at hearings do not have an attorney. *Rogers & Babler*. Because Employee prevailed on the primary issues, Jensen is entitled to attorney fees and costs. AS 23.30.145(a). However, this decision will require Employee to resubmit and serve a revised attorney fee and cost affidavit. Employee's revised affidavit will incorporate previous hourly rates for Jensen and his paralegal awarded in decisions in other cases, and will adjust the requested attorney fees and costs to account for any double-billing of the same services and costs in this and another case, in accordance with this decision. However, Jensen may not bill additional attorney fees for revising and correcting his attorney fee affidavit. As Employer's

other objections to Jensen's fees and costs have no merit, Employer shall pay Jensen's revised attorney fees and costs within 14 days of the date it receives the revised affidavit, in accordance with this decision. This decision reserves jurisdiction to resolve any disputes.

CONCLUSIONS OF LAW

1) Employee's work injury is compensable after April 20, 2015.
2) Employee is entitled to additional TTD benefits.
3) Employee is entitled to additional PPI benefits.
4) Employee and his providers are entitled to medical benefits.
5) Employee is entitled to interest, attorney fees and costs.

ORDER

1) Employee's left knee remains compensable in accordance with this decision.
2) Employee's low back symptoms related to his altered gait remain compensable in accordance with this decision.
3) Employee's claim for TTD from April 21, 2015 through May 11, 2015 is granted. Employer shall pay Employee TTD from April 21, 2015 through May 11, 2015, plus interest, in accordance with this decision.
4) Employee's claim for TTD from May 12, 2015 through July 7, 2015 is denied.
5) Employee's claim for TTD from July 8, 2015 and continuing is granted. Employer shall pay Employee TTD from July 8, 2015 and continuing until he is medically stable for his work injury with Employer or returns to work and is no longer disabled.
6) Employer shall pay Employee's medical providers directly for all medical services incurred for Employee's July 21, 2014 left knee injury, and for his low back symptoms caused by his altered gait, in accordance with this decision.
7) Employer shall pay Medicaid interest on all amounts Medicaid paid on Employee's behalf for his July 21, 2014 left knee injury, and for his low back symptoms caused by his altered gait, in accordance with this decision.
8) Employer shall pay Employee's providers interest on the difference between all amounts Medicaid paid those providers on Employee's behalf for his July 21, 2014 left knee injury, and for his low back symptoms caused by his altered gait, and the amount Employer must now pay

those same providers under the workers' compensation fee schedule, in accordance with this decision.

9) Jensen shall resubmit his attorney fee and cost affidavit. Jensen shall incorporate previous hourly rates for Jensen and his paralegal awarded in prior years in prior decisions, and will adjust the requested attorney fees and costs to account for any double-billing of the same services and costs in this and another case, in accordance with this decision. Employer shall pay Jensen the attorney fees and costs on Employee's revised affidavit within 14 days of receipt.

10) This decision reserves jurisdiction to resolve any disputes over attorney fee and cost issues.

Dated in Anchorage, Alaska on May 25, 2017.

ALASKA WORKERS' COMPENSATION BOARD

_____/s/_____
William Soule, Designated Chair

_____Unavailable for signature_____
David Ellis, Member

_____/s/_____
Rick Traini, Member

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

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

APPEAL PROCEDURES

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

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

RECONSIDERATION

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

MODIFICATION

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

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of James ‘Steve’ Cannady, employee / claimant v. Temptel, Inc., employer; LM Insurance Corporation, insurer / defendants; Case No. 201416197; dated and filed in the Alaska Workers’ Compensation Board’s office in Anchorage, Alaska, and served on the parties on May 25, 2017.

/s/
Nenita Farmer, Office Assistant