ALASKA WORKERS' COMPENSATION BOARD

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

SALLYANNE M. BUTTS, N´EE DECASTRO,	)	
	)	FINAL DECISION AND ORDER
Employee, Claimant,	)	AWCB Case No. 201103811
v.	)	AWCB Decision No. 17-0070
STATE OF ALASKA,	)	Filed with AWCB Anchorage, Alaska on June 19, 2017
Employer, Defendant.	)	

Sallyanne Butt's (Employee) September 21, 2015 claim was heard on May 17, 2017, in Anchorage, Alaska, a date selected on April 18, 2017. Attorney Andrew Wilson appeared and represented Employee who appeared and testified. Assistant Attorney General M. David Rhodes appeared and represented the State of Alaska (Employer). Witnesses included Henry Krull, M.D., who testified for Employee. The record closed June 9, 2017, when the panel met to deliberate.

ISSUES

Employee contends her left knee, right knee and low back injuries were, and remain, compensable injuries. She seeks an order finding these injuries arose out of and in the course of her employment.

Employer contends Employee suffered no more than a left knee contusion when she fell at work. It contends Employee's ongoing left knee, right knee and low back symptoms are not compensable. Employer contends she is entitled to no additional benefits under the Act.

1) What are Employee's compensable injuries?

Employee contends her work injury continued to disable her from November 5, 2013 through January 24, 2017. She contends she was not medically stable during this time and consequently is entitled to temporary total disability (TTD) benefits for this period.

Employer contends Employee suffered no more than a left knee contusion when she fell at work. It contends Employee is not entitled to any additional TTD benefits.

2) Is Employee entitled to additional TTD benefits?

Employee contends she has incurred permanent impairment to her left knee, right knee and low back resulting from her work injury with Employer. She requests permanent partial impairment (PPI) benefits for these injured body parts in accordance with the second independent medical evaluation (SIME) physician's ratings.

Employer contends Employee suffered no more than a left knee contusion when she fell at work. It contends Employee is not entitled to any PPI benefits.

3) Is Employee entitled to PPI benefits?

Employee contends she incurred medical expenses resulting from her work injury with Employer. She contends Employer should reimburse or pay these bills.

Employer contends Employee suffered no more than a left knee contusion when she fell at work. It contends Employee is not entitled to any additional medical benefits.

4) Is Employee entitled to additional medical benefits?

Employee contends she is entitled to interest on all benefits awarded and attorney fees and costs.

Employer contends Employee is not entitled to any additional benefits and therefore is not entitled to interest, attorney fees or costs.

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

FINDINGS OF FACT

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

1) Employee was a recreational weightlifter. (Employee; Second Independent Medical Examination (SIME), January 24, 2017, at 44).

2) On February 8, 2011, Employee complained of low back pain after "doing squats." Nels Anderson, M.D., gave her pain medication and recommended she remain off work. Employee felt she needed to continue working and disregarded his advice. (Anderson record, February 8, 2011).

3) "Squats" in weightlifting involves holding a weighted barbell on one's shoulders behind the neck while at the same time "squatting" up and down repeatedly in a numbered set. (Experience).

4) On March 3, 2011, Employee fell forward from a newly acquired ergonomic chair she was trying out at work. Employee landed on her hands and her left knee. (Employee; Report of Occupational Injury or Illness, March 15, 2011).

5) On March 3, 2011, Employee received massage therapy (MT) and reported low back pain and spasms, which "started few weeks ago." She "fell at work today trying to use new ergonomic chair," and had mid- and low-back, posterior neck and left knee pain. Employee continued massage therapy through July 18, 2011. (MT reports, March 3, 2011 through July 18, 2011).

6) By April 18, 2011, Employee could walk two miles twice per week. Her low back pain was improving and her left knee felt better. Throughout her MT, Employee consistently mentioned her left knee and low back symptoms. (MT report, April 18, 2011; observations).

7) On April 27, 2011, Employee reported low back spasms "last night," and said she had "been icing every night" and was frustrated with her lack of improvement. (MT report, April 27, 2011).

8) On May 6, 2011, Employee was doing better but her back pain had "moved down" to her lower back. (Dr. Krull report, May 6, 2011).

9) On June 9, 2011, Employee's knee was doing better but her low back was still painful even with "simple chores/minimal activity." (MT report, June 9, 2011).

10) On June 13, 2011, Employee reported difficulty with full weight bearing on her left leg. (MT report, June 13, 2011).

11) On June 20, 2011, Employee reported driving from Soldotna to Anchorage increased her low back pain. (MT report, June 20, 2011).

12) On June 23, 2011, Employee said she had difficulty sitting at work the day after she did simple household cleaning. (MT report, June 23, 2011).

13) On July 7, 2011, Employee reported severe pain in her left knee and low back requiring her to leave work early a day prior. The massage therapist determined Employee was not improving and was becoming more frustrated with ongoing pain even with minimal activity. The therapist noted left knee swelling and the kneecap "does not track well." (MT report, July 7, 2011).

14) On July 12, 2011, Employee still had low back and worsening left knee pain. Henry Krull, M.D., recommended knee and lumbar spine physical therapy (PT). (Dr. Krull report, July 12, 2011; Physical Therapy Prescription, July 12, 2011).

15) On July 14, 2011, Employee's left knee was "very bad." (MT report, July 14, 2011).

16) On July 18, 2011, Employee reported her left knee pain was "severe" and her knee "gives out" on her. (MT report, July 18, 2011).

17) On July 25, 2011, Employee had left knee pain moving to the right knee. She related this to her work injury. (PT report, July 25, 2011).

18) Employee's July 25, 2011 PT report was her first reference to any right knee pain since her work injury. (Observations).

19) On August 10, 2011, Employee told her therapist she was not able to walk for six days following her last PT session. Her left knee felt like "there were loose pieces in the knee and it locked up." (PT report, August 10, 2011).

20) On August 18, 2011, given the above, Dr. Krull suggested pain from Employee's left knee "contusion" was "worsening." She still had low back pain. (Dr. Krull report, August 18, 2011).

21) On August 24, 2011, Employee underwent a left knee magnetic resonance imaging (MRI). The MRI disclosed areas of full-thickness cartilage loss involving the medial femorotibial compartment, and moderate to large joint effusion. (MRI report, August 24, 2011).

22) "Joint effusion" refers to increased fluid in a joint. (Experience).

23) On August 25, 2011, in a pre-surgery examination, Dr. Krull said:

> The diagnoses leading to surgery is symptomatic left knee cartilage injury. The primary complaint is pain. Secondary issues include loss of function and stiffness. Symptoms began after an injury. Prior treatment, including physical therapy, NSAID, analgesics, activity restriction/modification, has not been successful thus far in controlling symptoms. An MRI . . . demonstrated full-thickness MCF lesion with associated bone bruise. . . . (Dr. Krull report, August 25, 2011).

24) On August 31, 2011, Dr. Krull performed a left knee arthroscopy on Employee and found moderate synovial hyperplasia in the retropatellar and medial compartments; an osteochondral

lesion on the medial femoral condyle measuring 10 by 20 millimeters; and another osteochondral lesion on the medial tibial plateau. Dr. Krull described these as "kissing lesions" which made contact when the knee was flexed to 90 degrees. (Operative report, August 31, 2011).

25) On September 6, 2011, Dr. Krull released Employee to return to light or sedentary work only using a brace and crutches, effective September 19, 2011. (Dr. Krull report, September 6, 2011).

26) Employee used crutches and attended PT post-surgery. (PT report, September 14, 2011).

27) By October 24, 2011, Employee reported her left knee pain was "very low, even after traveling and vacation." (PT report, October 24, 2011).

28) However, on October 28, 2011, Employee, still using a brace and crutches, said her left knee was not progressing well and her surgeon noted her gait was "noticeably antalgic." Dr. Krull removed Employee from work. (Dr. Krull report, October 28, 2011).

29) By December 16, 2011, following extensive PT, Employee felt "perhaps 20 percent better" in her left knee but did not feel she could return to work. (Dr. Krull report, December 16, 2011).

30) By January 5, 2012, Employee had undergone two left knee viscosupplementation injections. She noticed improvement after the first injection. (Dr. Krull report, January 5, 2012).

31) On January 30, 2012, following her third viscosupplementation injection, Employee said she could walk longer periods without pain, and could move her left knee from side to side, which she was not able to do prior to injections and PT. (PT report, January 30, 2012).

32) On January 31, 2012, Employee's gait was normal and she was ready to return to modified work. Dr. Krull returned her to work effective February 1, 2012, with five-minute breaks from sitting per hour, no ladders and limited kneeling and stooping. (Dr. Krull report, January 31, 2012).

33) On February 2, 2012, she still had "mild gait deviations." (PT report, February 2, 2012).

34) By March 27, 2012, Employee's left knee was much improved and she was back to work. (Dr. Krull report, March 27, 2012).

35) On May 10, 2012, Employee reported decreased "mild" pain and increased function. Her gait was normal and she was doing home exercises and could return to work without restriction except for occasional five-minute breaks to rest, ice, or elevate her left knee as necessary. She was to return to the clinic on an "as-needed basis." Dr. Krull noted:

> She has severe arthritic changes in the medial compartment of her knee that may warrant joint replacement at some point in the future.

Dr. Krull stated Employee was medically stable with no permanent impairment. (Dr. Krull report, May 10, 2012).

36) There is no record indicating Employee had any medical treatment for her left knee or low back thereafter for over two months. (Observations).

37) On August 16, 2012, for the first time in over two months Employee sought medical treatment for her work injury.

> Mrs. DeCastro-Butts returns to clinic today for follow-up. Since last visit, she is worse. Her RIGHT knee started hurting a lot about 2 months ago; seems to be increasing. No injury or event. She attributes the symptoms to overuse, due to prior left knee disability and recovery. Left knee also starting to hurt more, along the inner side in particular. No treatment of late (emphasis in original).

Dr. Krull found "normal gait" on the left but "antalgic gait" on the right. He prescribed another left knee injection and a right knee MRI. (Dr. Krull report, August 16, 2012).

38) On September 6, 2012, Employee's right knee MRI disclosed a complex tear in the medial meniscus with involvement of the inferior articular surface; a moderate sprain of the medial collateral ligament; tricompartmental degenerative changes including chondromalacia of the right knee most pronounced within the medial compartment; and large right knee joint effusion. (MRI report, September 6, 2012).

39) In some respects, Employee's September 6, 2012 right knee MRI was worse than her August 24, 2011 left knee MRI. (Experience, judgment, and inferences drawn from the above).

40) On September 13, 2012, Dr. Krull stated the condition in Employee's right knee was "similar to left knee," she had no right knee symptomatology prior to her left knee work injury and he opined Employee's right knee findings "appear to be at least partially related to her current WC claim." (Dr. Krull report, September 13, 2012).

41) On October 3, 2012, Employee underwent right knee arthroscopic surgery. Dr. Krull did not find a microfracture in the right knee. (Operative Note, October 3, 2012; Keith Holley, M.D. report, September 17, 2016).

42) On October 18, 2012, Dr. Krull removed Employee from work until further notice. (Dr. Krull report, October 18, 2012).

43) On January 28, 2013, Employee began PT for her right knee. For the first time since August 16, 2012, Employee mentioned she was "still having knee problems on the left." Employee

attributed her right knee problems from "favoring" the left leg and having used her right knee for function. (PT report, January 28, 2013).

44) On February 21, 2013, Employee reported a "constant ache in knee" with "swelling present." (PT report, February 21, 2013).

45) By February 25, 2013, Employee said her bilateral knee pain so bad she could not walk after picking up around her home. (PT report, February 25, 2013).

46) On February 26, 2013, Dr. Krull determined the result from Employee's right knee surgery was "poor." He recommended an MRI to check for internal, right knee derangement. (Dr. Krull report, February 26, 2013).

47) By March 7, 2013, Employee's right knee was worse than pre-surgery and PT was making it worse. Dr. Krull opined Employee would not get better without additional surgery and her "worsening arthritic changes" may "preclude return to 100%." (Dr. Krull report, March 7, 2013).

48) On April 3, 2013, Employee had her second right knee arthroscopic surgery. (Operative Note, April 3, 2013).

49) On April 25, 2013, Dr. Krull removed Employee from work until further notice. (Dr. Krull report, April 25, 2013).

50) By June 4, 2013, Employee's bilateral knees were hurting. Dr. Krull diagnosed right knee medial meniscus tear and bilateral knee osteoarthritis. (Dr. Krull report, June 4, 2013).

51) On August 13, 2013, Dr. Krull diagnosed bilateral knee osteoarthritis. (Dr. Krull report, August 13, 2013).

52) On September 5, 2013, Dr. Krull stated:

> Ms. DeCastro-Butts was referred at the time of her 8-22 visit to Kenai Spine for evaluation of back pain and radiculopathy. The patient attributes the symptoms to her initial injury, in 2011. She has not had formal evaluation of her spine, but I have referred her on several occasions for massage therapy for her spine. Pain is worsening, as well as her neurological symptoms, and Spine evaluation is now indicated. (Dr. Krull report, September 9, 2013).

53) On October 3, 2013, Stephanie Winter, PA-C, charted the following:

> The patient comes in today for complaint of lower extremity numbness and shooting pain. There is an extensive history to explain this. The patient had an injury on March 3, 2011 at work. She was sitting in an ergonomic chair when she fell out of it. She caught herself with her hands and her left knee. At the time she was

> complaining of left knee pain and some lower back pain. She was seen and evaluated by Dr. Krull who had sent her to physical therapy for massage, and also gave her some muscle relaxants. Her back did improve. She continued to have left knee pain and had left knee arthroscopy done in 2011. After rehabilitation with the left knee, she started to have right knee pain. She had right knee arthroscopy in October 2012. Shortly after her knee scope procedure she had sharp shooting pains that went from her right knee down into her calf. These pains have continued on and off without any particular trigger. She still had right knee pain and had another knee scope in April 2013. After the second knee scope on the right she noted some lateral anterior thigh numbness. The numbness there is fairly constant and throbs at night.
>
> Overall her back pain is significantly lessened since physical therapy. She continues to complain of knee pain. . . . (PA-C Winter report, October 3, 2013).

PA-C Winter diagnosed right leg numbness and knee pain. Employee was not having "much back pain." She referred Employee to Kristen Jessen, M.D., for bilateral lower extremity electromyography (EMG) tests and for a lumbar MRI. (*Id.*).

54) On November 2, 2013, Keith Holley, M.D., performed an employer's medical evaluation (EME). Dr. Holley diagnosed a left knee contusion caused by the work injury, resolved; bilateral knee osteoarthritis not work-related and caused by obesity and age-related degenerative changes; sensory numbness in the right thigh, cause undetermined but not likely work-related; and post bilateral knee arthroscopies to address age-related degenerative changes. In Dr. Holley's opinion, Employee's medical care had been reasonable and necessary but most of it was not work-related. Initial massage therapy and conservative treatment for the left knee including PT and medications for about two months post-injury was reasonable, necessary and related to the work injury, in his view. No subsequent treatment was work-related, in Dr. Holley's opinion. He opined Employee needed staged, bilateral knee replacements, the substantial cause of which was not her work injury, but rather, was her worsening osteoarthritis. In Dr. Holley's view, Employee was medically stable two months following her March 3, 2011 work injury, without permanent impairment. (Dr. Holley report, November 2, 2013).

55) On November 7, 2013, Employee's lumbar MRI disclosed the following: (1) Moderate to severe right-sided neural foraminal narrowing at L3-4. (2) Grade 1 anteriolisthesis, with associated moderate to severe bilateral neural foraminal narrowing at L4-5. (3) Moderate to severe bilateral neural foraminal narrowing at L5-S1. (MRI report, November 7, 2013).

56) On November 22, 2013, Dr. Jessen performed an EMG and found an "abnormal study" showing polyneuropathy with axonal features and right L3 through S1 radiculopathy. Employee

recited her injury history and told Dr. Jessen she had no back pain for "several weeks." (Dr. Jessen report, November 22, 2013).

57) By November 25, 2013, Employee said her low back pain was "worsening." (PA-C Winter report, November 25, 2013).

58) On December 3, 2013, Dr. Krull opposed Dr. Holley's EME report. He agreed Employee is obese and has age-related degenerative changes. However, in Dr. Krull's view, Employee did not have osteoarthritis signs or symptoms prior to her work injury. He opined her work injury is the significant contributor "to her current state." (Dr. Krull letter, December 3, 2013).

59) On January 2, 2014, Steven Humphreys, M.D., at Kenai Spine saw Employee on referral. He diagnosed leg numbness, knee pain, low back pain, foraminal stenosis in the lumbar region and spondylolisthesis. Dr. Humphreys noted Employee's right-sided leg pain started after her right knee arthroscopy. He referred Employee to Cynthia Kahn, M.D., for pain management. (Dr. Humphreys report, January 2, 2014).

60) On May 14, 2014, Employee completed a pain diagram for Dr. Khan. She noted upper back, low back and right leg pain. Employee did not indicate she had left leg or knee symptoms. (Questionnaire: Pain Management, May 14, 2014).

61) On July 15, 2014, Employer denied Employee's right to benefits for her low back and for sensory numbness in her right thigh, based on Dr. Holley's November 2, 2013 EME report. (Controversion Notice, July 11, 2014).

62) On October 16, 2014, Employee returned to Dr. Krull stating her bilateral knee pain was worse. He diagnosed bilateral knee osteoarthritis. (Dr. Krull report, October 16, 2014).

63) On September 22, 2015, Employee filed a claim for TTD, PPI, medical costs, transportation costs, interest, attorney fees and costs, for her bilateral knees and low back. (Workers' Compensation Claim, September 21, 2015).

64) On October 26, 2015, Dr. Krull reiterated his opinion that the substantial cause of Employee's "medical condition" requiring ongoing treatment is her March 2011 work injury. He opined Employee's left knee injury resulted in a meniscus tear and she subsequently developed right knee pain because she favored the left knee. Employee now has advanced arthritis in both knees that, in Dr. Krull's opinion, "is in large part due to her meniscus tears." He recommended bilateral knee replacements because Employee had failed all other conservative treatment. Until Employee has both knees replaced, she will not be medically stable in Dr. Krull's view. He stated Employee is not

eligible for any work and has not been for "some time," due to her pain and inability to sit, stand or walk for long. (Dr. Krull letter, October 26, 2015).

65) On October 26, 2015, Employer denied Employee's claim for all benefits, based on Dr. Holley's November 2, 2013 EME report. (Controversion Notice, October 23, 2015).

66) On January 21, 2016, Dr. Humphreys reviewed Employee's case and noted, "It is difficult to believe" Employee's grade 1-2 spondylolisthesis with foraminal stenosis "actually happened at the accident, but certainly it could have aggravated a preexisting condition." Dr. Humphreys described Employee's situation as "a cascade of events." (Dr. Humphreys report, January 21, 2016).

67) On January 21, 2016, Dr. Humphreys also reviewed Employee's films and the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, Sixth Edition, to derive a 13 percent whole person impairment for Employee's low back, which he attributed to her March 3, 2011 work injury. (Humphreys report, January 21, 2016). Dr. Humphreys' PPI rating did not mention a reduction for any preexisting lumbar condition. (Observations).

68) On January 26, 2016, Employee saw Dr. Krull for the first time in over a year. She reportedly was worse and wanted to proceed with total knee replacement. (Krull report, January 26, 2016).

69) On May 18, 2016, Dr. Krull replaced Employee's left knee. (Operative Note, May 18, 2016).

70) On September 7, 2016, Dr. Krull replaced Employee's right knee. (Operative Note, September 7, 2016).

71) On September 17, 2016, Dr. Holley performed a medical record review to update his EME. His opinions stated in his prior EME report did not change. In Dr. Holley's opinion, Employee suffered only a left knee contusion when she fell on March 3, 2011, and any other disability or need for medical treatment for her bilateral knees or her low back arose from non-occupationally-related degenerative disease. Dr. Holley stated it was "medically possible, but not medically probable," that Employee's gait alterations contributed to aggravating her low back pain. (Dr. Holley report, September 17, 2016).

72) Dr. Krull is a board-certified orthopedic surgeon who has practiced for 16 years. (Deposition of Henry Krull, M.D., December 15, 2015, at 7-8). He began treating Employee for her knees on March 24, 2011. (*Id*. at 9). Dr. Krull would defer spinal opinions to Dr. Humphreys. (*Id*. at 13). In Dr. Krull's view, Employee's knee injury at work was more likely than not the cause of her then-current condition, "knee arthritis," which caused her need for continuing treatment. (*Id*.). He did not allocate a "percentage of fault" to the knee injury versus other "issues." (*Id*. at 14). It can take

an acute injury "many months to years" to cause the type of degeneration he saw in Employee's left knee in 2011. (*Id*. at 16). Employee told Dr. Krull she had no symptoms consistent with knee osteoarthritis until after her work accident. He based his opinion upon this history. Dr. Krull conceded that if a person has memory issues it would make relying upon their memory for purposes of forming a causation opinion potentially problematic. (*Id*. at 19). On the other hand, if evidence showed Employee's history was correct, Dr. Krull's opinion about the cause of her need for treatment for her knee would remain the same. (*Id*. at 20).

73) Dr. Krull's hearing testimony was generally consistent with his deposition opinions. He based his causation opinion on (1) Employee had normal x-rays on her first visit; (2) her left knee MRI showed a focal injury; and (3) her left knee did not have widespread arthritic changes. Though acknowledging he is a "patient advocate," Dr. Krull means this in the general sense that the patient comes first and his goal is to make Employee better. He would not go "to great lengths" testifying for Employee, but Dr. Krull firmly believes her work injury was the substantial factor requiring her knee surgeries, including total knee replacements. (Dr. Krull).

74) Dr. Humphreys is a board-certified orthopedic physician specializing in spines. (Deposition of Dr. Craig Humphreys, September 6, 2016, at 5). Dr. Humphreys reviewed a chiropractor's note from March 3, 2011, which stated Employee complained of back pain on that date. (*Id*. at 10). He reviewed another report from May 6, 2011, which also mentioned low back pain. (*Id*. at 11). After several visits, Dr. Humphreys diagnosed Employee with spondylolisthesis, which caused symptoms in both legs with the right being the worse. (*Id*. at 13). Weight is not a risk factor for spondylolisthesis. (*Id*. at 15). Electromyography (EMG) confirmed right-sided radiculopathy, meaning that some of her leg numbness and pain was coming from her back and it was not all coming from her knee. (*Id*. at 15-16). Limping around on a bad knee can aggravate spondylolisthesis, or vice-versa. (*Id*. at 16). In "probability," the spondylolisthesis existed but was asymptomatic before her injury. (*Id*. at 18). Nevertheless, Dr. Humphreys stated absent a history of low back treatment prior to the work injury, it was most likely her unresolved knee issues caused her back to be symptomatic. (*Id* .at 20). After reading Employee's injury description from the EME report, Dr. Humphreys opined the "mechanism of injury" is sufficient to cause spondylolisthesis in Employee's back. (*Id*. at 24). However, he favors his opinion that an altered gait from Employee's knee injury aggravated the preexisting spondylolisthesis. (*Id*. at 25). Dr. Humphreys prescribed non-addictive medicines and lumbar injections. (*Id*. at 26). In his

opinion, if Employee's altered gait resolved, her "back would settle down." (*Id*. at 28). Employee's spondylolisthesis has progressed. In Dr. Humphreys opined at some point Employee's disc affected by the spondylolisthesis will require surgery because it will degenerate faster than it would normally. (*Id*. at 32). Dr. Humphreys hopes total knee replacement surgery to fix Employee's antalgic gait will reduce symptoms arising from spondylolisthesis. (*Id*.). He expects objectively measurable improvement from Employee's knee surgery and spine treatment. (*Id*. at 35). He defers to Dr. Krull about Employee's knees. (*Id*. at 39). Dr. Humphreys bases his opinions about Employee's pre-injury low back symptoms on her history. (*Id*. at 40-41). As a physician, he tries to be "a patient advocate when it makes sense." (*Id*. at 41). On January 21, 2016, Employee was medically stable for her low back unless she has surgery. (*Id*. at 42-43). He does not believe Employee's low back symptoms preclude secretarial work. (*Id*. at 45). He would not qualify his opinions simply because he has not seen every medical record because he has seen thousands of patients with this condition. (*Id*. at 49). If Employee's low back spasms started "a few weeks" before her work injury, as stated to her chiropractor on the injury date, this fact would "definitely" change his opinion, especially if she had a history that also included leg pain. (*Id*. at 52).

75) Dr. Holley is a board-certified orthopedic surgeon (Telephonic Deposition of Keith Gregory Holley, M.D., March 28, 2017, at 4-5). His medical opinions in Employee's case did not change after reviewing additional medical records including Dr. Langen's SIME report. (*Id*. at 9-10). Dr. Holley said he accurately recorded Employee's statement to him that she had periods lasting weeks without lumbar spine pain. He agreed Dr. Jessen's similar report confirms this is what Employee told him in November 2013. (*Id.* at 11). Dr. Holley agrees it is "not unusual" for a patient's history to differ from the medical records. He attributes such differences to the patient's "human memory" deficits and prefers to rely on the "history documented in contemporaneous medical reports" taken around the injury date. (*Id.* at 12). In Dr. Holley's opinion, a fall straightforward onto one's knee would not damage cartilage, which is typically strong and resists direct compressive loading forces. (*Id.* at 17-18). He agrees there is no credible medical literature suggesting a change in a person's gait to lessen the burden on a knee results in problems for the opposite knee. He agrees with this conclusion as set forth in an AMA *Guides Newsletter* article entitled *Evaluating Causation for the Opposite Lower Limb*. (*Id*. at 22). In Dr. Holley's view, a sudden worsening in Employee's left knee pain in July or August 2011 is more consistent with a flare-up of symptoms due to preexisting osteoarthritis than to a left knee contusion months earlier.

(*Id*. at 24). Similarly, he opined if it was work related, Employee's low back pain would have started after not before her work injury and would not have waxed and waned. (*Id*. at 25).

76) Dr. Holley specializes in the lower extremities, and he has not performed any back surgery since his training. (*Id*. at 30). In his view, Dr. Holley has considerable experience "with the mindset of patients" in workers' compensation settings. (*Id*. at 31). He cannot say when obesity causes symptomatic knee arthritis because "it varies." (*Id*. at 35).

77) Three physicians known to the board as prior or current EME doctors wrote the AMA *Guides Newsletter* article referenced and attached to Dr. Holley's deposition. (Observations; experience).

78) On December 15, 2016, Robert Langen, M.D., performed a second independent medical evaluation (SIME) on Employee. He reviewed 703 pages of medical records. The earliest record Dr. Langen reviewed was the MT report dated March 3, 2011. He also reviewed Drs. Krull's and Humphreys' depositions. Dr. Langen reviewed the medical records with Employee who disagreed she told Drs. Holley and Jessen in November 2013 that she had no low back pain for several weeks. Employee also disputed telling PA-C Winter in November 2013 that she was able to walk with a normal gait. Since having her knees replaced, Employee no longer has knee pain. Pre-injury, Employee enjoyed gardening, walking three to five miles a day without difficulty and lifting weights. Dr. Langen diagnosed a left knee contusion; left knee, right knee and lumbar spine degenerative disease; scoliosis; lumbar spine spondylolisthesis; and obesity. He opined Employee had significant preexisting left knee degenerative disease and the work injury caused symptomatology for approximately six weeks, but no permanent impairment. He found no objective evidence to indicate the work injury produced a temporary or permanent change in the left knee condition. Accordingly, Dr. Langen opined the work injury did not precipitate the left knee surgeries. Similarly, in his view the work injury did not necessitate any right knee treatment. The substantial cause of the need to treat the left knee six weeks after the work injury, and the right knee in totality was preexisting degenerative disease. As for the low back, Dr. Langen stated degenerative disease is the substantial cause of the need for back treatment. He bases this opinion on the fact Employee had pre-injury back symptoms and on the waxing and waning nature of her subsequent low back complaints. Dr. Langen said the work injury was not the cause of any disability. Further, since Employee remained at full-duty work until August 2011 when she underwent left knee arthroscopic surgery, in his opinion there was no work-related disability arising from the work injury. Though he opined the treatments to Employee's knees and low back were not

work-related, Dr. Langen agreed they were reasonable and necessary to treat her medical conditions. Dr. Langen provided two, 21 percent lower extremity PPI ratings for Employee's left and right knees, based solely on knee replacement criteria. He provided a nine percent whole-person lumbar PPI rating, without any reduction. (Dr. Langen report, January 24, 2017).

79) Dr. Langen ultimately opined, "The work-related injury was not the cause for any of the knee treatment." (*Id.*).

80) On April 25, 2017, Employee filed 58 pages including itemized billing statements showing amounts incurred and paid for care she relates to her work injury with Employer. Hand-written notes on some pages purport to show what Employee paid from her own pocket and for which she seeks reimbursement. (Notice of Intent to Rely, April 25, 2017).

81) On May 12, 2017, Employee filed an affidavit itemizing her attorney fees and costs. Attorney Wilson bills at $300 per hour and bills his paralegal at $150 per hour. Wilson's affidavit and attachment itemized 150.23 hours and claims $40,196.25 in attorney fees and $2,801.74 in litigation costs. (Affidavit of Fees and Costs, May 12, 2017).

82) Attorney Wilson incurred the following reasonable and necessary attorney fees in obtaining Employee's successful results, as discussed in the analyses below: Discussing the case with Employee (.5); reviewing the case and filing appropriate pleadings (3.0); discussing the case with Dr. Humphreys' office (.25); considering subrogation and medical billing issues (.5); services related to Dr. Humphreys (1.50); reviewing medical bills (.5); preparing a Notice of Intent (.13); preparing an Affidavit of readiness and a *Smallwood* objection (.75); preparing for and attending a prehearing conference (.38); services related to Dr. Krull (.18); responding to discovery (.98); reviewing and selecting photo exhibits (.25); briefing (.68); and hearing participation (2.0). These efforts total 12.05 hours attorney time, which at attorney Wilson's hourly rate equals $3,615 in reasonable and necessary attorney fees for the limited issues on which Employee prevailed. (*Id.*; experience; judgment).

83) At hearing, Employee provided photographs showing her December 11, 2010 wedding. She danced with high heels on after the wedding without difficulty. Employee's pre-injury hobbies included walking three to five miles per day three to five times per week, gardening, fishing, hunting, camping, canning, golfing, swimming, weightlifting and housecleaning. Prior to March 3, 2011, Employee never saw a chiropractor for adjustments; she only went to a chiropractor's office to utilize massage services. On March 3, 2011, Employee was using an ergonomically correct

chair, which she had never used before. Employee did not explain why she had an ergonomic chair. Beneath her chair was a plastic runner. Employee got up and fell when the chair tipped forward. She put out her hands and her left knee hit the floor. In Employee's view, she did not just fall out of the chair, the chair "kind of threw" her onto the floor. Employee felt symptoms in her upper back, both hands and left knee. At no point did Employee feel like she was "healed" between her injury date and her August 2011 knee surgery. Employee felt a "crunch" in her knee, and it turned "green." Employee said her back started hurting "a couple days" after the work injury. She was taking pain medication for her left knee and these helped with her back pain. Employee said Employer's controversion delayed her knee treatment. In 2003, Employee's left knee pain became "really bad" when she was helping her family. She last worked on January 24, 2013, and believes she remained disabled since then. Her back still hurts and she cannot sit, stand or walk for long. If her back did not hurt, Employee could return to work. (Employee).

84) Employer paid Employee TTD benefits at a $532.11 weekly rate. Employee's claim seeks TTD from November 5, 2013 through January 24, 2017, for approximately 168 weeks. Were Employee to prevail on her TTD claim, she would be entitled to approximately $89,000, plus interest. (Compensation Report, March 20, 2013; Employee's hearing arguments; experience; judgment; and inferences drawn from the above).

85) Employee's claim seeks PPI based on Dr. Langen's ratings for her left and right knees and her lumbar spine. According to Table 16-10 and the Combined Values Table from the AMA *Guides to the Evaluation of Permanent Impairment*, Sixth Edition, (*Guides*) Dr. Langen's 21 percent lower-extremity PPI ratings convert to eight percent whole-person PPI per extremity. Combined with nine percent whole-person PPI for the lumbar spine, Dr. Langen's total whole-person PPI rating equals 23 percent. Were Employee to prevail on her PPI claim, she would be entitled to $40,710, plus interest. (Employee's September 22, 2015 Workers' Compensation Claim; Employee's hearing arguments; Dr. Langen report, January 24, 2017; *Guides*; experience; judgment; and inferences drawn from the above).

86) Employer contends the board cannot rely on Employee's *post hoc ergo proptor hoc* cause-and-effect logical fallacy, and provided medical literature to support its position. Employer further contends the board should reduce Wilson's attorney fees if Employee loses on some issues. Employer objects to Employee's February 17, 2016 petition to strike a *Smallwood* objection and contends Wilson should not get attorney fees for forcing Dr. Humphreys' deposition. It further

objects to "duplicate work" the attorney and his paralegal performed on Employee's hearing brief. Employer had no objection to Employee's litigation costs. (Employer's hearing arguments).

87) Competent counsel on both sides vigorously litigated this case. The benefits at issue were significant. Board-certified orthopedic surgeons support each party's position and consequently substantial evidence supports each position. Employee's left leg injury and lower back aggravation interacted and created complex medical questions. (Experience; judgment; and inferences drawn from the above).

88) Employee did not timely file a medical transportation log. (Employee's hearing arguments).

PRINCIPLES OF LAW

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

> **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 23.30.095(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. . . .

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.

> **AS 23.30.120. Presumptions.** (a) In a proceeding for the enforcement of a claim for compensation under this chapter it is presumed, in the absence of substantial evidence to the contrary, that
>
> (1) the claim comes within the provisions of this chapter; . . . .

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

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

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

> The findings of the board are subject to the same standard of review as a jury's finding in a civil action.

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

> **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, 975 (Alaska 1986) 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. . . .

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. The court in *Cowgill* explained what constitutes adequate board findings to support an attorney's fee award:

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

> **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. . . . The compensation is payable in a single lump sum, except as otherwise provided in AS 23.30.041. . . .

In *Stonebridge Hospitality Associates, LLC v. Settje,* AWCAC decision No. 153 (June 14, 2011), a *pro se* claimant brought a PPI claim to hearing before the board. However, she did not have a PPI rating from her doctor. The board held the PPI claim was not ripe. On appeal, the commission reversed stating the injured worker's PPI claim was ripe for adjudication. *Settje* held the injured worker is required to obtain a PPI rating and presented at hearing if she wants a PPI award.

ANALYSIS

1) What are Employee's compensable injuries?

Employee contends her work injury with Employer caused compensable injuries to her left knee, right knee and low back. She contends these injuries continued to disable her and required medical treatment long after Employer controverted her right to benefits on July 15, 2014 and controverted her claim on October 26, 2015. Employer contends Employee's work injury, a left knee contusion, resolved in May 2011, and any continuing disability or need for medical care did not arise out of or in the course of her 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 her testimony, and medical opinions from Drs. Krull and Humphreys. *Wolfer*. Employee testified her knees caused her no difficulties before her work injury with Employer. Following the 2011 work injury with Employer however, Employee said her low back and left knee and later her right knee consistently caused her progressive difficulties. Drs. Krull and Humphreys offered medical opinions stating the March 3, 2011 work injury was the substantial cause of the need for medical treatment and disability arising from the left

and right knees 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 Drs. Holley's and Langen's opinions. *Runstrom*. Dr. Holley opined the 2011 work injury caused nothing more than a left knee contusion and the work injury was not the substantial cause of the need for additional care or any disability after six to eight weeks. Dr. Langen mostly agreed with this assessment. Both doctors opined the substantial cause of any ongoing need for knee and low back treatment was preexisting and continuing degenerative processes, and not the work injury. This evidence shifts the burden back to Employee who must prove her claim by a preponderance of the evidence. *Saxton*.

a) The left knee.

Employer concedes Employee suffered a knee contusion when she fell at work, but contends this work-related injury resolved within six to eight weeks. To prove continuing compensability for her left knee work injury, Employee must show the work injury continued to be the substantial cause of disability or need for left knee medical treatment after approximately May 3, 2011. *Adams*; AS 23.30.010(a). Employee convincingly testified she had no left knee symptoms prior to her injury and was active, walking three to five miles per day without difficulty. There is no medical evidence Employee had any left knee symptoms before March 3, 2011, which supports her testimony. Further, Employee consistently mentioned her new and ongoing left knee pain for months following her injury. On July 7, 2011, Employee reported severe left knee pain and her massage therapist noted left knee swelling and found her knee "does not track well." By August 10, 2011, Employee reported difficulty walking after a PT session and said her left knee felt like it had "loose pieces" inside and it "locked up." Dr. Krull stated the 2011 work injury is "the substantial cause" of Employee's need for medical care after the injury and continuing. He based this opinion in part on the "kissing lesions" he found in Employee's left knee, which he opined resulted in a traumatic meniscus injury when Employee landed on the floor with her knee flexed 90 degrees. Dr. Krull and Employee are both credible. AS 23.30.122; *Smith*.

By contrast, Drs. Holley and Langen agree Employee's left knee symptoms after approximately May 3, 2011, resulted from preexisting degenerative changes and not her work injury. Dr. Holley

examined Employee once, a year and eight months post-injury. Dr. Langen examined her once almost six years post-injury. Employee's left knee 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).

Employee relies on Dr. Krull's opinions and her own testimony. Employer relies on Drs. Holley's and Langen's opinions. All three surgeons are board-certified in orthopedics. On balance, the evidentiary weight initially favors Employee's position, but only to a point. As Dr. Krull noted, Employee's left knee symptoms began after her work injury. There is simply no contrary evidence. Employer suggests causation in this case cannot be based upon a *post hoc ergo proptor hoc* cause-and-effect logical fallacy. For example, one cannot argue a black cat running across the road in front of a car is the cause of the car getting into an accident five miles down the road. However, there is no expert evidence in this hypothetical example possibly connecting the cat to the car accident. By contrast, "substantial evidence" supports Employee's claim at least in part. Dr. Krull opined the injury caused a kissing lesion in Employee's left knee, damaging cartilage and ultimately requiring her first, left knee arthroscopic surgery. He did not need to go that far, as the work injury only had to be the substantial cause of the "need for medical treatment," not the substantial cause of the underlying condition itself. AS 23.30.010(a). Dr. Krull followed Employee's left knee injury beginning July 12, 2011, and continuing through August 31, 2011, when he performed a left knee arthroscopy. His opinion, to this point, is credible, is consistent with Employee's testimony and is entitled to considerable weight. AS 23.30.122; *Smith*.

Assuming Drs. Holley and Langen are correct and Employee had degenerative changes in her left knee pre-injury, there is no evidence she needed any medical treatment to address her left knee or suffered any disability from any existing but undiagnosed degenerative changes. Conservative treatment proved unsuccessful. Eventually, Dr. Krull suggested Employee have left knee arthroscopy. Employee had a right to follow her doctor's advice, and, while disagreeing as to causation, all knee specialists in this case agree Dr. Krull's arthroscopic surgery was reasonable and necessary to address her then-existing left knee condition. *Hibdon*. Given this evidence and analysis, Employee has proven her left knee work injury continued to arise out of and in the course

of her employment and continued to be compensable through at least August 31, 2011. *Saxton*; AS 23.30.122; *Smith*; *Rogers & Babler*.

However, the credible medical record shows Employee returned to work and by October 24, 2011, her left knee pain was "very low, even after traveling and vacation." Four days later, Dr. Krull removed Employee from work when he noted her gait was "noticeably antalgic." She continued with PT and her left knee improved. By January 30, 2012, Employee had undergone three viscosupplementation injections, could walk without pain and could finally move her left knee from side to side. Dr. Krull released Employee to return to work effective February 1, 2012, with minimal restrictions. Employee returned to work. On May 10, 2012, she had "mild" left-knee pain and increased function. Most notably, at this point Employee's gait was "normal," she was doing home exercises, could return to work without restriction except for occasional five-minute breaks if necessary, was medically stable and Dr. Krull said she had no left knee permanent impairment. He released her from treatment to return "as-needed" and noted she had "severe arthritic changes" in her left knee that "may warrant knee replacement at some point in the future."

Employee went for over two months without any left knee treatment. Suddenly, on August 16, 2012, following a summer of unknown activity Employee returned complaining her left knee was "starting to hurt more," and her right knee started hurting about two months earlier. Two months earlier would be approximately the time Dr. Krull released her from care. Employee did not explain why, if both knees started hurting about the same time Dr. Krull released her from his care, she did not return "as needed" until August 16, 2012. At this point, Drs. Holley's and Langen's opinions concerning Employee's preexisting degenerative left knee condition are entitled to greater weight. AS 23.30.122; *Smith*. By May 10, 2012, Employee's left knee had improved and she had minimal if any remaining left knee symptoms. The evidence shows by August 16, 2012, after Employee's summer activities, both knees started hurting, the right greater than the left. On balance, a preponderance of the evidence shows Employee's March 3, 2011 left knee injury was the substantial cause of her need for medical treatment and disability for the left knee from the injury date through May 10, 2012, but was not the substantial cause thereafter. Drs. Holley's and Langen's opinions support this result and under these facts are entitled to greater weight than Dr. Krull's lone opinion. Employee's left knee was a compensable injury from March 3, 2011,

through May 10, 2012. However, beginning May 11, 2012, and continuing, Employee's preexisting and ongoing left knee degeneration was the substantial cause of her need for medical treatment and any associated disability. *Saxton*.

b) The right knee.

Employee contends favoring her left knee put extra weight and pressure on her right knee, which caused right knee symptoms. Therefore, she contends the right knee arose out of and in the course of her employment injury and is compensable. AS 23.30.010(a). She relies on Dr. Krull's opinions. Employer contends, based on Drs. Holley's and Langen's opinions, the substantial cause of the need to treat Employee's right knee and any associated disability is her preexisting right-knee degeneration. Employer further relies on an AMA *Guides Newsletter* stating there is no reliable scientific evidence showing that favoring one lower extremity causes damage in the other. The newsletter piece is of questionable value because three physicians known to perform EMEs on a regular basis authored the article. AS 23.30.122; *Smith*; *Rogers & Babler*. As discussed below, the article is not material to the result.

Employee does not contend she landed on her right knee when she fell at work. This is purely a "favoring" theory. The medical record shows no evidence Employee had any right knee symptoms or treatment pre-injury. Employee initially mentioned right knee symptoms only once after her work injury, on July 25, 2011, nearly four months post-injury. This lapse could be consistent with her theory, supported by Dr. Krull, that favoring her left knee gradually caused her degenerative right knee to become symptomatic. However most notably, Employee mentioned her right knee once on July 25, 2011, had left knee arthroscopy on August 31, 2011, used crutches, had an altered gait, went through PT and returned to work but never again mentioned her right knee until over a year after first mentioning it, on August 16, 2012. These facts support ordinary degeneration as the substantial cause of subsequent right knee treatment. *Rogers & Babler*. Given these facts, Drs. Holley's and Langen's opinions are entitled to greater weight. AS 23.30.122; *Smith*. Employee has not met her burden of showing her right knee is a compensable injury arising out of and in the course of her employment. AS 23.30.010(a); *Saxton*.

c) The low back.

Employee contends her work-related left knee injury aggravated her low back and caused symptoms. Employer contends the low back symptoms result from degenerative changes and not from the work injury. Employee was a recreational weightlifter. Sometime prior to February 8, 2011, she had low back pain and spasms after doing "squats," a well-known weightlifting activity. *Rogers & Babler*. Dr. Anderson suggested she remain off work and gave her pain medication. Understandably, Employee felt she needed to continue working and did not follow Dr. Anderson's advice. After her work injury about a month later on March 3, 2011, Employee received MT and reported to her therapist that low back pain and spasms had "started a few weeks ago," correlating exactly with her February 8, 2011 report to Dr. Anderson. Dr. Humphreys, a back specialist, initially opined the work injury might have actually caused Employee spondylolisthesis. On further reflection, he favored his alternate opinion that the work injury aggravated the preexisting but asymptomatic spondylolisthesis causing Employee to need medical treatment. However, once Dr. Humphreys saw the March 3, 2011 MT report referencing back pain beginning "a few weeks" earlier, he equivocated on his opinion. Dr. Humphreys affirmed, however, that limping around on a bad knee could aggravate spondylolisthesis. Further, Dr. Humphreys suggested he would "definitely" change his opinion if Employee had a history that included "leg pain." There is no medical record suggesting Employee had any pre-injury leg pain symptoms consistent with spondylolisthesis. *Rogers & Babler*.

Drs. Holley and Langen both opined Employee's need for low back treatment did not arise out of her work injury and the substantial cause was her preexisting lumbar degenerative changes. On the other hand, Employee consistently mentioned low back pain throughout her MT post-injury. Simple household chores and driving increased her low back pain. There is no evidence she had these difficulties before the work injury. In July 2011, Dr. Krull recommended lumbar spine PT along with Employee's left knee PT. Just as he did in respect to her left knee, by September 6, 2011, Dr. Krull released Employee to return to light or sedentary work effective September 19, 2011. She used crutches and had PT after her left knee surgery. By January 31, 2012, Dr. Krull released Employee to return to regular work with minimal restrictions. She returned to work.

Other than PT, Dr. Krull had not referred Employee for any lumbar spine evaluation or treatment. On May 10, 2012, he released her to work without restrictions, except for occasional breaks as necessary for her left knee. Dr. Krull made no restrictions regarding her back. Employee was to return "as-needed." There is no evidence Employee sought any medical care for her low back until she told Dr. Krull her low back symptoms were worsening, on September 5, 2013. Though she denied it, Employee also told Drs. Holley and Jessen she went for long periods without any lumbar spine symptoms. This medical history with gaps in her low back symptoms is consistent with gradual degenerative progression relating to spondylolisthesis, not to her work injury. Drs. Holley's and Langen's consistent opinions addressing this issue are credible and are entitled to greater weight. AS 23.30.122; *Smith*.

In summary, substantial evidence shows Employee injured her low back and aggravated her spondylolisthesis lifting weights before her work injury. While no one addressed the point, it would not be surprising if Employee obtained the ergonomically correct chair because she hurt her back lifting weights and sitting at work was uncomfortable. *Rogers & Babler*. Regardless, the result would be the same. When she fell from the chair at work, Employee further but only temporarily aggravated her preexisting spondylolisthesis. Employee injured her left knee enough to require arthroscopic surgery, and as Dr. Humphreys said, Employee's injured left knee altered her gait, which also further but temporarily aggravated her low back. However, the record shows Employee's work-related, temporary low back aggravation ended by May 10, 2012. By this date she was back to work with no restrictions related to her back. Therefore, Employee's low back was a compensable injury from March 3, 2011 through May 10, 2012. Beginning May 11, 2012, and continuing, Employee's preexisting non-work-related and ongoing low back degeneration was the substantial cause of her need for lumbar treatment and any associated disability. *Saxton*.

2) Is Employee entitled to additional TTD benefits?

Employee claims TTD benefits from November 5, 2013 through January 24, 2017. AS 23.30.185. The above analyses demonstrate Employee's work-related injuries resolved by May 10, 2012. Consequently, any disability Employee incurred after May 10, 2012, is not injury related. Therefore, she is not entitled to any additional TTD for the requested dates. *Saxton.*

3) Is Employee entitled to PPI benefits?

Employee also seeks PPI benefits for both knees and for her low back. AS 23.30.190. She relies on Dr. Langen's PPI ratings. However, Dr. Langen rated both knees as total knee replacements and included a rating for Employee's lumbar spine. As analyzed above, Employer is not liable for Employee's bilateral total knee replacements or for any low back PPI rating for the work injury because the work injury was only a temporary aggravation of preexisting conditions, which resolved by May 10, 2012. Therefore, Dr. Langen's PPI ratings based on bilateral knee replacements and Drs. Langen's and Humphreys' ratings for Employee's low back are irrelevant. Had Employee relied on Dr. Humphreys' low back rating, it would be entitled to lesser weight because Dr. Humphreys did not discuss any potential rating reduction for Employee's preexisting spondylolisthesis. AS 23.30.190; AS 23.30.122; *Smith*.

On the other hand, Employee's left knee, including her August 31, 2011 arthroscopic surgery, is compensable through May 10, 2012. Dr. Langen performed the only left knee PPI rating in this case, after Employee's left knee replacement. The AMA *Guides* provide a method to determine PPI for Employee's work-related meniscal injury, based on Dr. Krull's opinion. It is unlikely Employee or any physician involved in this case considered providing a PPI rating for a left knee meniscal injury that occurred before Employee's left knee replacement surgery. Once the knee was gone, so was the damaged meniscus. PPI was an issue at hearing. Employee provided evidence supporting PPI ratings, but not for the compensable left knee meniscal injury. Consequently, precedent requires an order denying Employee's PPI claim. If Employee obtains a valid PPI rating following this decision and order, she can file a petition seeking modification and explain why she could not have obtained the PPI rating for her left knee, as it existed on May 10, 2012, prior to the May 17, 2017 hearing. *Settje*.

4) Is Employee entitled to additional medical benefits?

Employee seeks additional medical care for her work injury. AS 23.30.095(a). Employee's left knee and her low back aggravation are compensable from March 3, 2011 through May 10, 2012. Therefore, Employer is liable for medical treatment for Employee's left knee and her low back aggravation through May 10, 2012. *Hibdon*. Employee filed documentation purporting to show medical treatment incurred, and bills paid, related to her work injury. Most of this documentation

relates to periods after May 10, 2012. Given the above findings and analyses, this information is mostly irrelevant. Further, it is also difficult to discern who paid the bills, and for what period. Nevertheless, to the extent Employee's evidence proves she paid medical bills related to her left knee and low back aggravation from March 3, 2011 through May 10, 2012, Employer shall reimburse her for these expenses. Employee is not entitled to any additional medical benefits for her work injury after May 10, 2012. Because she failed to file a transportation log, Employee is not entitled to medical mileage.

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

a) Interest.

To the extent Employee's evidence proves she paid medical bills related to her left knee and low back aggravation from March 3, 2011 through May 10, 2012, Employer shall pay interest to Employee on these out-of-pocket payments. Employee is not entitled to any other interest.

b) Attorney fees and costs.

Employee filed a claim and Employer controverted. Therefore, to the extent Employee prevailed in her claim her lawyer is entitled to an attorney fee award under AS 23.30.145(a). Employee made a claim for significant TTD and PPI. Had she prevailed, Employee would have been entitled to approximately $130,000 (about $89,000 in TTD and $40,710 in PPI) not including interest. *Bignell*. Her health care providers and third-party health benefit payers would have also been entitled to significant reimbursements for all left and right knee and low back medical treatment Employee received after May 10, 2012. These were her main claims. *Rogers & Babler*. Employee lost on these claims. At best, she won on her out-of-pocket medical expenses and interest on those payments through May 10, 2012.

On the other hand, the Alaska Supreme Court encourages fully compensatory and reasonable attorney fees so injured workers can find and retain competent counsel. *Cortay*. Competent counsel on both sides vigorously litigated this case. The benefits at issue were significant. Board-certified orthopedic surgeons supported each party's position. Substantial evidence supports each position. Employee's left leg injury and lower back aggravation interacted and created complex medical questions. *Cowgill*; *Rogers & Babler*. Lastly, though she did not prevail on most issues,

she did prevail on her left knee injury and lower back aggravation claim through May 10, 2012. Employer did not object to her litigation costs. Therefore, Employee is entitled to $2,801.74 in costs. Attorney Wilson had to incur minimal attorney fees simply filing claims and other pleadings and preparing supporting evidence and a brief. He had to appear at hearing. Attorney Wilson presented medical evidence relied upon to some degree on the minimal issues upon which Employee prevailed, as set forth in factual finding 83, above. Therefore, reasonable attorney fees for these efforts total $3,615 (12.05 hours x $300 per hour = $3,615). *Cortay*. Given this analysis, Employer's objections to Employee's specific itemized fees are immaterial.

CONCLUSIONS OF LAW

1) Employee's compensable injuries are her left knee and her lower back through May 10, 2012.
2) Employee is not entitled to additional TTD benefits.
3) Employee is not entitled to PPI benefits.
4) Employee may be entitled to additional medical benefits.
5) Employee may be entitled to interest, and is entitled to attorney fees and costs.

ORDER

1) Employee's claims for benefits for her left knee and low back from March 3, 2011 through May 10, 2012, are granted.
2) Employee's claims for benefits for her left knee and low back after May 10, 2012, are denied.
3) Employee's claims for benefits for her right knee are denied.
4) Employee's claim for TTD benefits is denied.
5) Employee's claim for PPI benefits is denied.
6) Employee's claim for additional medical benefits after May 10, 2012, is denied.
7) Employer shall pay attorney Wilson $3,615 in attorney fees and $2,801.74 in litigation costs.

Dated in Anchorage, Alaska on June 19, 2017.

ALASKA WORKERS' COMPENSATION BOARD

_____/s/_____
William Soule, Designated Chair

_____/s/_____
Amy Steele, Member

_____/s/_____
Aaron Plikat, 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 Sallyanne M. Butts n'ee Decastro, employee / claimant v. State Of Alaska, employer and insurer / defendants; Case No. 201103811; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on June 19, 2017.

/s/
Nenita Farmer, Office Assistant 1