ALASKA WORKERS' COMPENSATION BOARD

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

MIRANDA DIEL, Employee, Claimant, v. SAFWAY SERVICES, Employer, and ACE AMERICAN INSURANCE CO., Insurer, Defendants.	FINAL DECISION AND ORDER AWCB Case No. 200519312 AWCB Decision No. 16-0084 Filed with AWCB Anchorage, Alaska on September 21, 2016

Miranda Diel's (Employee) March 19, 2014 and March 19, 2016 amended claims were heard on August 24, 2016, in Anchorage, Alaska, a date selected on March 9, 2016. Attorney Michael Patterson appeared and represented Employee, who appeared and testified. Attorney Constance Livsey appeared and represented Safway Services and its insurer (Employer). David Vines testified by telephone for Employee. The record remained open until September 1, 2016, for Employee to file a supplemental attorney's fee affidavit and until September 7, 2016, for Employer's response, and closed on September 7, 2016.

ISSUES

Employee contends she has been disabled by her work injury with Employer since January 15, 2016, and is not medically stable. Therefore, Employee contends she is entitled to temporary total disability (TTD) benefits beginning January 15, 2016, and continuing.

Employer contends Employee's attending physicians released her to work as a secretary and a waitress. It contends Employee returned to work for several years until she voluntarily left the labor market. Employer contends she is also medically stable and not entitled to TTD benefits.

1) Is Employee entitled to TTD benefits?

Employee alternately contends she has been disabled by her work injury with Employer since January 15, 2016, and if she is medically stable, her disability is permanent. Therefore, Employee contends she is entitled to permanent total disability (PTD) beginning January 15, 2016, and continuing.

Employer contends Employee's disability, if any, from January 15, 2016, and continuing, is not the result of her work injury. Employer contends Employee failed to provide any evidence demonstrating she is entitled to PTD benefits. Rather, Employer contends Employee is physically capable of working, has been working, but now chooses not to work.

2) Is Employee entitled to PTD benefits?

Employee contends she needs continuing medical care and treatment. She seeks an order requiring Employer to pay for all medical benefits necessitated by her injury.

Employer contends medical opinions from one attending physician should be given no weight because he has been accused of fraud. Further, Employer contends Employee is not entitled to more medical care for her injury based on its employer medical evaluator's (EME) opinions.

3) Is Employee entitled to medical care?

Employee contends she is entitled to benefits resulting from her contested claim, and as her attorney obtained these benefits, she contends she is also entitled to attorney's fee and costs.

Employer contends she is entitled to no benefits so attorney's fees and costs should be denied.

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

FINDINGS OF FACT

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

1) On August 29, 2005, Employee was dismantling scaffolding approximately 13 feet above the ground when she fell, landing on her back on construction debris and hitting her head. (Report of Occupational Injury or Illness, August 29, 2005; Employee).

2) On August 29, 2005, Employee told emergency room physicians she had low back and bilateral elbow pain. Bilateral elbow, pelvis and spine x-rays were negative except for the lumbar spine, which showed an L1 vertebral fracture. Computerized tomography (CT) scans showed a small subarachnoid hemorrhage and the L1 fracture without retropulsed fragments. Employee was admitted for observation. (Emergency Room report, August 29, 2005).

3) On September 10, 2005, the hospital released Employee from care with a prescription for pain medication and advice to avoid lifting greater than 10 pounds and to wear a "TLSO brace." (Discharge Summary, September 10, 2005).

4) On September 26, 2005, Employee's magnetic resonance imaging (MRI) and cervical x-rays showed no significant abnormality. (MRI reports; cervical spine x-rays, September 26, 2005).

5) On October 4, 2005, Employee's lumbar spine films showed a stable L1 vertebral body fracture. (X-ray report, October 4, 2005).

6) On October 6, 2005, Employee saw Timothy Cohen, M.D. Her cervical pain had resolved but her "slight" low back pain continued. (Cohen report, October 6, 2005).

7) On October 20 and October 24, 2005, Paul Craig, PhD, saw Employee at Dr. Cohen's request for a neuropsychological evaluation. Employee said she had word-finding problems when first discharged from the hospital and felt more irritable and "meaner" than she was before the injury. Employee's friend said Employee's short-term memory was disrupted and Employee reported difficulty recalling old information. Employee had post-injury headaches, which improved. Her vision was affected and Employee thought she needed new glasses. Dr. Craig noted the cingulate gyrus, "a very important structure with regard to emotional functioning," is located deep in the fissure where Employee had the "tiny intracranial bleed." Dr. Craig performed 23 neuropsychological tests on Employee who performed "very well" on the malingering test, indicating good effort during "objective testing." Dr. Craig diagnosed two months status post work-related fall with L1 vertebral fracture and closed head injury with about one hour post-traumatic amnesia and a small subarachnoid hemorrhage. He noted:

> She evidences a very mild cognitive disorder not otherwise specified, as well as some self-reported personality changes presumably related to her head injury. She may be experiencing some problems with adjustment to disability as well, given her current symptoms of anxiety and depression.

Dr. Craig concluded her cognitive and emotional functioning should progress; her cognitive limitations "could very easily" be caused by her head injury; given "measurable neurocognitive limitations," she should participate in cognitive rehabilitation and hone her neurocognitive abilities consistent with office work; referral to a psychiatrist may be helpful for anxiety and depression; she may benefit from psychotropic and cognitive-behavioral psychotherapy and antidepressants; a physiatrist and physical therapy may be useful; she may need new glasses; and she should be reevaluated in nine months. (Craig report, October 20 and 24, 2005).

8) By December 13, 2005, she moved to Andalusia, Alabama. (Report, December 13, 2005).

9) On January 31, 2006, Barry Lurate, M.D., provided a five percent permanent partial impairment (PPI) rating for Employee's lumbar spine fracture and suggested she get a physical capacity evaluation. (Lurate report, January 31, 2006).

10) On May 12, 2006, Employee's knee x-rays were normal. (Reports, May 12, 2006).

11) On September 27, 2006, Stanley Barnes, M.D., approved Employee to work as a secretary and as a waitress. (Barnes' responses, DOT Occupational Descriptions, September 27, 2006).

12) "Waitress" is "light" work with lifting up to 20 pounds occasionally while "Secretary/Receptionist" is "sedentary" requiring lifting up to 10 pounds occasionally. (DOT Occupational Descriptions, November 15, 2006).

13) On December 5, 2006, Quest Diagnostics reported Employee's laboratory tests were negative for rheumatoid arthritis. (Quest report, December 5, 2006).

14) On January 17, 2007, the rehabilitation specialist did a labor market survey for "Waitress" and "Secretary/Receptionist" in Employee's area and identified 20 employers with six accepting "Waitress" and four accepting "Secretary/Receptionist" applications. (Reemployment Benefits Eligibility Evaluation Report, January 17, 2007).

15) On January 19, 2007, Employee saw Robert White, M.D., at Coastal Neurological Institute in Mobile, Alabama for her injury. Employee had right shoulder, upper lumbar and neck pain. Dr. White diagnosed post subarachnoid hemorrhage, traumatic, with residual head pain; status post L1 chip fracture and compression; cervical sprain; and bilateral knee joint injury. Dr. White

prescribed Naprosyn, Zanaflex and Ultram, suggested updated brain and lumbar spine MRIs and referred Employee to a knee specialist. (White report, January 19, 2007).

16) On February 12, 2007, Employee's brain MRI was "normal" with "no evidence of prior subarachnoid hemorrhage." Her lumbar spine MRI showed a remote anterior compression fracture but no significant disc bulge, herniation or stenosis. (MRI reports, February 12, 2007).

17) On February 16, 2007, Dr. White reviewed the recent MRI scans, noted no neural compression, Employee's spinal alignment was normal and there was no instability. Employee's neurologic exam and cervical motion were normal but lumbar motion was "somewhat restricted." Dr. White diagnosed Employee as post head injury with subarachnoid hemorrhage and an L1 compression fracture with a Schmorl's node, and suggested she see a physiatrist. (White report, February 16, 2007).

18) On April 5, 2007, Employee's right knee MRI was "normal" and her left showed minimal, degenerative changes. (MRI reports, April 5, 2007).

19) On April 13, 2007, the rehabilitation specialist submitted an eligibility evaluation for Employee to the Rehabilitation Benefits Administrator (RBA). Two attending physicians had opined Employee could work as a secretary and waitress, jobs held in the relevant 10-year period. A formal labor market survey showed these jobs were available in her area. (Reemployment Benefits Eligibility Evaluation Report, April 13, 2007).

20) On May 9, 2007, the RBA-designee found Employee not eligible for reemployment benefits. (RBA-designee letter, May 9, 2007).

21) Employee did not appeal the RBA-designee's decision. (Agency file).

22) Employer last paid Employee TTD and PPI in 2006 and §041(k) in 2007. Her TTD rate while she lived in Alaska was $187 a week. (Compensation Report, June 8, 2007).

23) On July 27, 2007, Employee told her physical therapist her bilateral knee pain was reduced to "1" on a "1-10" scale. (Report, July 27, 2007).

24) On December 13, 2007, Robert Leyen, M.D., saw Employee for an EME. Employee reported stabbing pain in her head every four to eight weeks, lasting for several hours. She had pain in her right knee and low back. Employee said her knee did not begin hurting until after she removed her brace and stopped using crutches. Dr. Leyen diagnosed a healed, work-related L1 compression fracture; work-related subarachnoid hemorrhage, resolved; head pain with unknown etiology; and non-work-related bilateral knee pain not requiring treatment. Dr. Leyen found no

evidence Employee had knee pain weeks following her injury and said the work injury was not the substantial cause of her knee pain, she needed no further knee treatment and she had no knee PPI. (Leyen EME report, December 13, 2007).

25) On March 14, 2008, Employee's lumbar spine MRI scan showed an old L1 deformity with a mild disc bulge at T12-L1 but no spinal herniations or stenoses. (MRI report, March 14, 2008).

26) On February 17, 2009, Employee began treating off and on with John Youngblood, DC, for her injury. He diagnosed chronic low back facet joint pain and dysfunction secondary to trauma and an L1 compression fracture. Employee's periodic chiropractic care ceased on July 16, 2012. (Youngblood reports, February 7, 2009, through July 16, 2012).

27) On September 30, 2011, Employee's cervical MRI showed minimal disc bulging at C4-5 and C5-6 without disc herniation or stenosis. Her thoracic MRI was normal. Employee's lumbar MRI showed a stable, old L1 compression fracture and no significant disc bulges, herniations or stenoses. (MRI reports, September 30, 2011).

28) On October 5, 2011, James Crumb, M.D., performed electromyography (EMG) on Employee's upper extremities, and the results were normal. (EMG report, October 5, 2011).

29) On June 15, 2012, Maria Armstrong-Murphy, M.D., saw Employee for an EME. Employee had diffuse joint pain in her knees, ankles, hips, neck, mid-back and low back. Employee was treated with Botox injections in her lumbar spine and hips, which offered two or three days' relief. She had word finding difficulties for a time. Dr. Armstrong-Murphy diagnosed a work-related L1 compression fracture; a resolved work-related subarachnoid hemorrhage; and non-work-related diffuse joint pain with Plaquenil prescribed for systemic arthritis. Dr. Armstrong-Murphy opined:

> It seems unreasonable to develop diffuse joint pain and discomfort seven years beyond the described industrial injury and to attribute all of life's aches and pains to one day's events.

Though she diagnosed arthritis, Dr. Armstrong-Murphy could not confirm it from Employee's records. She opined Employee needed no further treatment unless she developed radiculopathy or spinal cord compression. Employee did not need Botox, chiropractic care, physical therapy, a formal exercise program or prescription medication. Dr. Armstrong-Murphy recommended a self-directed home exercise program. (Armstrong-Murphy EME report, June 15, 2012).

30) On March 19, 2013, Dr. Crumb diagnosed Employee with a closed lumbar vertebral fracture; degenerative cervical intervertebral disc; meniscal derangement; and the need for medical monitoring for medication. He saw Employee every six months for routine evaluation and monitoring. Dr. Crumb said Employee's needs were "highly variable" and she may require a lumbar laminectomy or fusion, cervical laminectomy or fusion, knee arthroscopy or replacement, may require physical therapy before or after surgery, and currently required intermittent physical therapy. She may require evaluation or referrals to specialists, so Dr. Crumb suggested not closing Employee's medical benefits. (Crumb report, March 19, 2013).

31) On November 15, 2013, Employee returned to Dr. Youngblood for treatment for her neck and low back for the first time in 16 months. Employee said she had a gradual increase in low back pain from her old L1 compression fracture. (Dr. Youngblood report, November 15, 2013).

32) On March 19, 2014, Dr. Crumb said Employee's work injury diagnoses included a lumbar vertebral fracture; idiopathic torsion dystonia; cervical disc degeneration; and bilateral knee degeneration. In his opinion, Employee's injury caused her complaints and dysfunction and it was necessary for her to receive continued medication, therapy, radiological evaluation and possibly surgery to treat her ongoing symptoms. (Crumb letter, March 19, 2014).

33) On March 19, 2014, Dr. Crumb stated Employee's work injury was a substantial factor in her need for further care. (Crumb responses, March 19, 2014).

34) On March 20, 2014, Employee filed a claim stating she fell from scaffolding at work resulting in head, low back, neck and bilateral knee injuries. Employee claimed ongoing chronic pain monitoring, a second independent medical evaluation (SIME) and attorney's fees and costs. (Workers' Compensation Claim, March 19, 2014).

35) On April 24, 2014, the parties stipulated to an SIME. "Causation" and "treatment" were the only two SIME issues in dispute. (SIME form, April 21-23, 2014).

36) On July 22, 2014, Judy Silverman, M.D., saw Employee for an SIME. Employee was working full time as a health food store manager. Dr. Silverman diagnosed post fall August 29, 2005, with L1 compression fracture and subarachnoid hemorrhage; mild cognitive disorder with one or more hours of post-traumatic amnesia, anxiety and depression per October 2005 neurological testing; neck pain; knee pain; underlying hypermobility; and chronic pain. Dr. Silverman said Employee did not have preexisting head, neck, back or knee conditions but had preexisting, asymptomatic hypermobility. In her opinion, Employee's work injury caused her

back pain and subdural hematoma. The underlying hypermobility impacted, or combined with, her ability to recover from her injury. Employee needed to regain strength to stabilize her muscles, and though she had physical therapy, Employee never had a strengthening program. Dr. Silverman said, "The 8/29/2005 injury was a substantial factor in causing disability and need for treatment," though she did not specify a disability period. Dr. Silverman deferred to neuropsychological testing regarding any traumatic brain injury but opined Employee's pain needs to be addressed as well as potential depression or anxiety, and assessment is needed to determine if cognitive changes persist. Employee's underlying hypermobility is "preventing her from fully recovering from her work-related injury." Dr. Silverman recommended reevaluation with psychiatry or psychology and possible neuropsychological testing to compare with the October 2005 Craig study, non-opioid medication to assist Employee with pain management, and Gabapentin or Lyrica for anxiety. She also suggested a structured work-hardening program or functional restoration program to provide Employee with better coping skills to deal with persisting pain and to focus on increased function. Employee needed to be "self-structured" in her rehabilitation. Adding a psychological component would be helpful, but she disapproved Dr. Crumb's treatments because they will not "allow her further recovery" as she had reached a "plateau." A "biopsychosocial" approach "may allow her to return to work," and Employee had chronic pain since her injury, which needs ongoing care. Dr. Silverman found no evidence Employee has rheumatoid arthritis. The injury, combined with her hypermobility as well as her fear and pain catastrophizing, contributed to Employee's pain. However, Dr. Crumb's treatment plan was neither reasonable nor necessary. (Silverman report, August 4, 2014).

37) On April 15, 2015, Employer agreed to pay for Employee's reassessment with a neuropsychologist. (Prehearing Conference Summary, April 15, 2015).

38) On July 28, 2015, neuropsychologist Jake Epker, PhD, saw Employee who said though Dr. Crumb's prescriptions helped, she wanted "a more holistic approach" to health care. Employee rated her pain level at "9/10," but Dr. Epker noted less pain behavior than would be expected. He performed 15 tests on Employee, some done by Dr. Craig in 2005. Employee's test scores on several measures were consistent with good effort, but one or two tests showed "suboptimal effort." Dr. Epker concluded Employee's test results "need to be interpreted with a degree of caution, particularly as it relates to her cognitive functioning." She was not significantly exaggerating or magnifying symptoms, but Employee's cognitive scores were "significantly

lower than would be expected based on the patient's intellectual abilities," which suggested "global cognitive decline and inefficiency." Dr. Epker ruled out medication side-effects as a contributing factor. Employee's brain injury was "mild," and he would have expected "a full recovery of cognitive abilities." However, given Employee's subarachnoid brain hemorrhage, Dr. Epker suggested further evaluation "to clarify the nature of any injury she may have experienced." Employee's test scores suggested she may have difficulty attending to, learning and remembering information including medical instructions. She had no significant psychological problems or psychopathology and scored low on an opioid abuse test. Dr. Epker noted "pain catastrophizing" is a risk factor for poor outcomes from medical treatment, but Employee scored low on related tests, suggesting her primary influence is a "sense of helplessness." Dr. Epker found Employee psychologically healthy, coping relatively well and had no need for behavioral treatment. She had no mood disturbance, somatization, symptom dependency, or pain catastrophizing. Dr. Epker cleared Employee for opioid use if necessary to address her physical symptoms and endorsed reinstating her medical treatment to improve Employee's "quality of life." He suggested "encouragement of functional restoration" along with settling her claim. (Epker report, July 28, 2015).

39) Dr. Epker's exam satisfied Dr. Silverman's recommendation for a neuropsychological evaluation to compare with the 2005 study, though he suggested additional testing might be necessary. (Experience, judgment and inferences from the above).

40) On March 9, 2016, Employee filed an amended claim requesting alternately TTD or PTD from January 15, 2016, and ongoing; medical costs; transportation costs; and attorney's fees and costs. (Workers' Compensation Claim, March 9, 2016).

41) On March 9, 2016, attorney Patterson recorded on his attorney's fee itemization "1.8" for reviewing Employee's file, calling her, preparing for and attending a prehearing conference and amending Employee's claim to "add TTD." (Billing Schedule, March 9, 2016).

42) On March 21, 2016, Employer controverted Employee's claims for TTD; PTD; unnecessary, unreasonable or unrelated medical care and transportation costs; and attorney's fees and costs. (Controversion Notice, March 17, 2016).

43) On May 17, 2016, The United States of America (USA) filed a civil fraud action against Coastal Neurological Institute, Dr. Crumb and his practice Mobility, Metabolism & Wellness. The USA claimed Dr. Crumb committed fraud against Medicare and other insurance programs

by making false diagnoses, entering false claims for payment and in some cases not providing services for which he billed. The USA also claimed Dr. Crumb "cloned" medical diagnoses and services in patients' charts. Among the allegedly fraudulently diagnosed, billed and cloned services was "dystonia" and related Botox treatments. The record does not disclose this suit's current status. (United States' First Amended Complaint, May 17, 2016).

44) On May 19, 2016, Employee said she was employed "pet sitting" and selling advertising for a local newspaper, the latter approximately five to six hours a week. Employee cared for 15 animals at her home, including six dogs and nine cats. She fed and watered the animals, picked up dog feces and emptied litter boxes and spent about an hour a day caring for the animals. Following her work injury, Employee returned to Alabama where she was unemployed for "a few years." Her first post-injury job was working in a cookie shop, where she baked for a "couple years." Thereafter, Employee worked at a health food store for "two to three years," two to three days per week. Employee left this job because the owner expected her to do "too much." Following this job, which she left "a couple years ago," Employee said she had not applied for work, thinking her pain made her not "helpful," and her hometown is small and jobs are few. Employee recalled Dr. Crumb telling her not to lift over 20 pounds. Before her work injury, Employee was "fully employed" and worked in offices, and in Denver as an office manager. Employee said she applied for a job with FedEx but cannot sit or stand very long and local businesses do not pay enough. Employee felt unable to hold down a sedentary job because sometimes she cannot get out of bed due to migraines and would not feel good about taking a job. Employee thought her work-related condition was getting worse. Her medical care helped but the insurer cut her off and it was not completed. In her view, not having chiropractic care or medications made her condition worse. She did not disagree with Dr. Silverman's suggestions. (Employee's deposition, May 19, 2016).

45) On May 21, 2016, Dr. Crumb opined Employee's injury is a substantial factor in the need for treatment he prescribes. According to Dr. Crumb, the L1 fracture is stable and healed but has not returned to its normal anatomic state and, because Employee has a malformed, fractured L1 vertebra, she has a persistent twist in her spine, which compresses the facet joints. This, he said, causes her body to turn in a reflex reaction so he diagnosed Employee with "torsion dystonia," which causes muscle spasms in relation to movement. Dr. Crumb said this changes the way Employee walks and stands and affects her knee pain. The knee pain occurred very close to the

work injury and, in Dr. Crumb's opinion, is entirely consistent with a fall and "unobserved trauma." In his judgment, Employee's other injuries may have distracted her from her knees until her initial symptoms subsided. In his opinion, Employee's lumbar spasms are caused by dystonia caused by her L1 fracture. He does not think Employee should have a work-hardening program, but agreed with Dr. Silverman's suggestion for a biopsychosocial treatment model so long as the person providing care is familiar with traumatic brain injuries. He noted Employee has difficulty following instructions and could not follow a self-directed exercise program. Dr. Crumb opined Employee was not able to work presently because she had been without treatment for a year. He recommended either Botox injections or chiropractic care along with physical therapy to return Employee to work. Dr. Crumb likened Employee's "tone" (presumably short for "dystonia") problems to arthritis because the facet joints were pushed together, but stated she does not have arthritis. In his opinion, Employee had "sub-clinical cerebral palsy" her entire life and the L1 compression fracture "activated the predisposition." Dr. Crumb said Employee had a "predisposition to tone," probably since birth. Employee's dystonia correlates physically with her L1 fracture and was caused by it, in his opinion. However, normal degeneration, not the work injury, caused dystonia in Employee's neck. His suggested treatment would "reset" the "tone" in her lumbar spine. In Dr. Crumb's view, when Employee's lumbar "tone" acts up, it causes her knee pain to increase. He prescribed Plaquenil for Employee as an anti-inflammatory, just to see if it would help. (Dr. Crumb deposition, May 21. 2016).

46) No other examiner diagnosed Employee with dystonia or cerebral palsy. (Observations).

47) On August 18, 2016, attorney Patterson stated he represented Employee from December 7, 2012, through August 18, 2016. He billed $400 per hour and his paralegal $125 per hour. Employee incurred $36,330 in attorney's fees and paralegal cost and $6,015.48 in costs, totaling $42,345.48. (Affidavit of Attorney's Fees and Costs, August 18, 2016).

48) On August 22, 2016, attorney Patterson recorded 1.7 attorney hours preparing for hearing, drafting hearing questions for Employee, emails and an opening statement and reviewing emails from his client. Reasonable witness preparation for Employee's and Vines' hearing testimony related to TTD was 20 minutes each. (Supplemental Affidavit of Attorney's Fees and Costs, September 1, 2016; experience, judgment and inferences drawn from the above).

49) On August 22, 2016, Employer objected to Employee's attorney's fee and cost request because it did not identify "the timekeeper." Employer contended this made it hard to assess

whether the attorney performing the services had the "requisite experience and skills to justify a fee of $400 per hour." Employer requested Employee resubmit the itemization and affidavit. Employer also objected to "block-billing," and requested Employee "attribute time to each task" after which Employer would have an opportunity to further object. It objected to the detail with which Employee's attorney listed his services and requested sufficient details to determine whether the attorney's fees were reasonable and necessary. Employer objected to specific tasks, which Employer said were "excessive" including "1.4" hours on May 14, 2014, preparing SIME questions because there were only six questions, and "1.4" billed on June 24, 2014 for emailing the questions to the board. Employer objected to ".2" on March 28, 2016, to arrange transportation for a deposition and ".5" billed on May 9, 2016 for finalizing travel reservations for Employee, stating this was "administrative work." It further objected to "8.0" hours on May 21, 2016, for traveling to and attending Dr. Crumb's deposition, stating Employee should be allowed no more than five hours. Lastly, Employer objected to Employee's hotel, rental car and per diem for five days for Employee's and Dr. Crumb's depositions in Florida and contended there was no need for the attorney to travel to Florida two days early. (Employer's Objection to Affidavit of Attorney's Fees and Costs Dated 08/18/16, August 22, 2016).

50) David Vines, a FedEx manager, has known Employee for 14 years and in his opinion she had good social skills and was "high functioning" before her work injury. He was unaware she had any physical or mental impairments before her injury. Vines is Employee's friend, sees her several times a week and assists her by lifting heavy bags and noticed Employee has "no sense of time" and will often miss appointments by two hours. In Vines' view, since her injury Employee is forgetful, easily distracted, has no "filter" and has a "shorter fuse." As for her pet care, Vines likened it to taking care of one's own pets at home. Notwithstanding his friendship with her, Vines would not hire Employee because in his view she needs some assistance to "refocus." He had not known Employee to consistently hold a job since her work injury. Vines' TTD-related hearing testimony took about 10 minutes. (Vines; observations).

51) Employee said her neck, back and knees hurt since her 2005 injury with Employer. Employee stated she had back and neck pain while she was hospitalized post-injury, never had any prior neck or back issues or treatment and had been active outdoors prior to her injury. When Employee got to Alabama she went to a clinic and complained about back, neck and knee pain. Whenever Employee told doctors her "neck pain was gone," this meant at times she had

little or no neck pain, but it always came back. Employee said she cannot currently participate in physical therapy or home exercises due to pain. She prefers yoga but said even simple yoga is not possible because she has to twist her back, which causes pain. Though Employee's knees felt better after physical therapy, the relief did not last. Dr. Crumb's Botox injections for dystonia were "painful." Since her injury, Employee has never been pain free in her neck, spine or knees except temporarily. She believes chiropractic and physical therapy assisted in realigning her spine. Employee feels she is disabled even though she tried to work "for years" and did not think she would ever be disabled. Over the past "six weeks," Employee said she "came to terms" and realized she is disabled because she can no longer care for herself. Employee said she worked perhaps five hours per month in early 2016 but can no longer sell newspaper advertising because it hurts to sit or stand. In her view, she cannot work even 20 hours per week. She is certain something serious happened to her brain when she hit her head because Employee has word-finding difficulties and trouble keeping time and remembering simple things like people's names. She still cares for her six dogs and nine cats but no longer cares for other people's pets. As for why her claim was amended to claim disability beginning January 15, 2016, Employee was not certain but looking back said it should have earlier. In her view, she has done everything she can to keep her body in good shape but she still feels disabled. Employee has not seen a psychiatrist but found the Mayo Clinic in Florida, a functional restoration clinic, which she would like to attend. Employee knows she needs help with memory and feels like she has "retardation." She has not had non-opioid medication since she saw Dr. Silverman, has not tried Gabapentin or Lyrica and has not had a program like Dr. Silverman recommended. Employee has not worked 40 hours a week since her injury and disagrees she could work as a waitress because it requires "lots" of physical ability. Employee thinks she cannot be a secretary because she cannot sit for very long and cannot remember things, a secretarial requisite. She has not applied for Social Security disability, because until six weeks before hearing, Employee did not think she was disabled. Dr. Crumb told her he she was disabled beginning January 15, 2016. Employee's TTD-related hearing testimony took about 10 minutes. (Employee; observations).

52) Employee wants to attend a program to assist her in becoming functional in conformance with Dr. Silverman's opinions, and she requests the treatment Dr. Silverman suggested. Her lawyer contends Dr. Armstrong-Murphy's report is "caca" because all arthritis tests and Drs.

Crumb and Silverman agree Employee does not have arthritis. Employee wants treatment for her pain complaints, which she contends started with this injury regardless if the injuries are mental, physical, psychological or a combination. If she is medically stable, she is entitled to PTD because she cannot compete for jobs. If care will improve her situation, Employee is not medically stable and she is entitled to TTD. (Employee's closing argument).

53) Employer contends Employee failed to demonstrate entitlement to TTD because her physicians said she was medically stable years ago. Her subarachnoid hemorrhage resolved by 2007 and no evidence supports her claim because Dr. Crumb's opinions should be given no weight. Employee has worked and only Dr. Crumb says she is unable to work. Employer suggests Employee chose to live in a small town where jobs are limited. It contends any work-related cervical injury has been ruled out, and there are no work-related knee injuries. Lastly, Employer insists the fractured L1 vertebra healed years ago. Employer says if this decision orders Dr. Silverman's recommended treatment it should order Employee to attend and fully cooperate, and end Employee's entitlement to medical care. If Employee is awarded a functional restoration program, she would still be medically stable because this program would make "subjective" not "objective" improvement, though Employer agreed she would be entitled to TTD during any such program. When queried how Employee could be entitled to TTD benefits after medical stability, Employer said TTD would be paid based upon "common practice" among insurers since treatment would remove Employee from work. (Employer's closing argument).

54) Employee was vague concerning her annual earnings from 2005 to the present. The agency record contains no income tax or other earnings information for Employee since 2005. (Judgment, observations, agency record).

55) On September 1, 2016, Employee's lawyer filed a supplemental attorney's fee and cost affidavit including attorney Patterson's additional, incurred attorney's fees from August 22, 2016, through September 1, 2016, along with the previously filed attorney's fees from the initial affidavit. The billing style, detail and format remained the same. Employee's revised attorney's fees totaled $42,330 while her costs remained at $6,015.48, totaling $48,345.48. (Supplemental Affidavit of Attorney's Fees and Costs, September 1, 2016).

56) On September 1, 2016, in response to Employer's objection and request for additional information, attorney Patterson said he performed the work billed at $400 per hour. Paul Atkins, a paralegal with eight years' experience, performed work billed at $125 per hour. Attorney

Patterson objected to "specific billing" because it may enable Employer to monitor case preparation and theories, client discussions, and concerns with particular evidence and may violate the attorney-client privilege. Further, he contended the evidence offered and time spent at hearing on issues should be sufficient to weigh time spent on each. Employer's "*Smallwood*" objection necessitated Dr. Crumb's deposition. Attorney Patterson stated if Employee loses on minor issues, his fees should not be reduced. As for Employer's objection to time incurred preparing SIME questions, attorney Patterson said he had to review the entire medical record to formulate questions. He conceded the June 24, 2014 "1.4" email entry was an error and should have read ".1" and agreed making travel arrangements was administrative. Attorney Patterson defended time spent at Dr. Crumb's deposition because he met with Dr. Crumb before the deposition, and was stuck in traffic jams on his way back to his lodging. He stated time spent in Florida and Alabama was necessary since he had a flight exceeding 12 hours, was unable to check into his room for hours and had to interview his client in Alabama. (Reply to Employer's Objection to Employee's Affidavit of Attorney's Fees and Costs, September 1, 2016).

57) Attorney Patterson has represented claimants for nearly 40 years and $400 per hour is justifiable in comparison to similar claimant lawyers. A paralegal with eight years' experience may reasonably bill $125 per hour. (Experience, judgment and observations).

58) Attorney Patterson's client "Billing Schedule" does not mention "PTD" and his entry for preparing an amended claim which includes PTD says the claim was amended only to "add TTD." His hearing brief, which focuses mainly on causation and medical care, mentions "PTD" once as an issue on the first page but never cites any facts, law or analysis supporting a PTD claim. In his closing argument, attorney Patterson mentioned PTD only once in passing. PTD was an insignificant issue in this case. (Supplemental Affidavit of Attorney's Fees and Costs, September 1, 2016; Employee's Hearing Brief, August 16, 2016; Employee's closing argument, August 24, 2016; experience, judgment and inferences drawn from the above).

PRINCIPLES OF LAW

This decision cites statutes and case law applicable to Employee's August 29, 2005 injury date. The board may base its decision not only on direct testimony and other tangible evidence, but also on its "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 23.30.095. Medical treatments, services, and examinations.** (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, 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 the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require. . . .

Medical benefits including continuing care are covered by the AS 23.30.120(a) presumption of compensability. *Municipality of Anchorage v. Carter*, 818 P.2d 661 (Alaska 1991).

> **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
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> (1) the claim comes within the provisions of this chapter. . . .

Under AS 23.30.120(a)(1), benefits sought by an injured worker are presumed to be compensable. *Meek v. Unocal Corp*., 914 P.2d 1276 (Alaska 1996). The presumption of compensability is applicable to any claim for compensation under the workers' compensation statute. (*Id.*). The presumption application involves a three-step analysis. To attach the presumption an employee must first establish a "preliminary link" between his injury and the employment. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 610 (Alaska 1999). Credibility is not examined at the first step. *Veco, Inc. v. Wolfer*, 693 P.2d 865 (Alaska 1985).

If the employee's evidence raises the presumption, it attaches to the claim and in the presumption analysis' second step the production burden shifts to the employer. Credibility is not examined at the second step. *Id.* If the employer's evidence is sufficient to rebut the presumption, it drops out and in the analysis' third step the employee must prove her case by a preponderance of evidence. 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 analysis' third step, the evidence is weighed, inferences are drawn, and credibility is considered.

Steffey v. Municipality of Anchorage, 1 P.3d 685 (Alaska 2000). Medical evidence may be needed in complex cases. *Veco, Inc. v. Wolfer*, 693 P.2d 865 (Alaska 1985).

> **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 board's credibility finding "is binding." *Smith v. CSK Auto, Inc.*, 204 P.3d 1001, 1008 (Alaska 2009). When doctors disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.*, AWCAC Decision. No. 087 (August 25, 2008).

> **AS 23.30.145. Attorney Fees.** (a) . . . 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. . . .

Attorney's fees in workers' compensation cases should be fully compensatory and reasonable so injured workers have competent counsel available to them. *Cortay v. Silver Bay Logging*, 787 P.2d 103 (Alaska 1990). Fees for time spent on minor issues will not be reduced if the employee prevails on the primary issues. *Uresco Construction Materials, Inc. v. Porteleki*, AWCAC Decision No. 152 (May 11, 2011).

> **AS 23.30.180. Permanent total disability**. (a) In case of total disability adjudged . . . permanent 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the total disability. . . . In all other cases permanent total disability is determined in accordance with the facts. In making this determination the market for the employee's services shall be
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> (1) area of residence;
> (2) area of last employment;
> (3) the state of residence; and
> (4) the State of Alaska. . . .

In *Sulkosky v. Morrison Knudsen*, 919 P.2d 158, 166 (Alaska 1996), the Alaska Supreme Court said, "To avoid paying permanent total disability benefits, an employer need show only that there

is 'regularly and continuously available work in the area suited to the [employee's] capabilities,'" *i.e.*, he is not an "odd lot" worker.

In *Carlson v. Doyon Universal Ogden Services*, 995 P.2d 224, 229 (Alaska 2000), the injured worker appealed the board's denial of her PTD claim. On appeal, the employer argued the employee failed to provide medical evidence she was PTD. *Carlson* stated this argument "oversimplifies" the total disability concept because Alaska adopted the "odd lot doctrine" in defining what constitutes PTD. Under the odd lot analysis, a vocational reemployment expert's testimony demonstrated evidence of disability despite overwhelming medical evidence Carlson could perform "light duty" work. A competing vocational expert said a regular, stable labor market existed for people with Carlson's skills and capabilities. *Carlson* explained:

> The Board concluded that the three doctors' unanimous view that Carlson was not PTD and Jacobsen's testimony identifying continuous and suitable work sufficed to overcome the presumption. . . . The Board considered Carlson's medical limitations and her competitiveness in the job market, specifically referring to the testimony of [the] rehabilitation expert . . . and her . . . labor market survey.

Carlson affirmed the board's reliance on a vocational expert who reviewed Carlson's file and a labor market survey and identified suitable jobs given her limitations. (*Id.*).

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

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

> **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. . . .
> . . . .

> (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. . . .

An employer may rebut the continuing disability presumption and gain a "counter-presumption" by producing substantial evidence proving medical stability. *Anderson*, AWCAC Decision No. 130 at 8. Once an employer overcomes the injured worker's presumption, the employee must prove all elements of the TTD claim by a preponderance of the evidence. However, if the employer raised the medical stability counter-presumption, "the claimant must first produce clear and convincing evidence" he has not reached medical stability. (*Id*. at 9). One way an employee rebuts the counter-presumption with clear and convincing evidence is by asking his treating physician to offer an opinion on "whether or not further objectively measurable improvement is expected." The 45 day provision signals when "proof is necessary." *Municipality of Anchorage v. Leigh*, 823 P.2d 1241, 1246 (Alaska 1992).

In *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249 (Alaska 2007), the Alaska Supreme Court said it is the employer's burden to prove "noncompensability." The employer tried to show Thoeni had reached medical stability and was thus not entitled to further benefits. Thoeni argued she should not have been declared medically stable because she "not only failed to improve but suffer[ed] deterioration and additional injury." The board found Thoeni was medically stable based on two physicians' reports, one which predicted no "major changes in the next 45 days" and the other which said Thoeni's knee would improve with a diligent exercise regime. But ultimately, the doctors' predictions "proved incorrect." *Thoeni* noted:

> By the time the board determined medical stability, it knew [the two predictions] . . . were incorrect. It also knew that another knee surgery to improve the knee was recommended on January 25, 2001. . . . Indeed, another surgery to improve the knee was . . . performed in April 2001. Thus, the board knew [the two doctors'] . . . predictions proved incorrect.

In *Thoeni*, the court held the two incorrect predictions were not substantial evidence upon which the board could reasonably conclude Thoeni had achieved medical stability. The court reversed the determination Thoeni was medical stable from late 2000 to early 2001.

> **8 AAC 45.180. Costs and attorney's fees**. . . .
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> (b) . . . 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. . . .
> . . . .
>
> (f) The board will award an applicant the necessary and reasonable costs relating to the preparation and presentation of the issues upon which the applicant prevailed at the hearing on the claim. The applicant must file a statement listing each cost claimed, and must file an affidavit stating that the costs are correct and that the costs were incurred in connection with the claim. . . . .

ANALYSIS

1) Is Employee entitled to TTD benefits?

a) Is Employee medically stable?

Employee claims entitlement to TTD benefits beginning January 15, 2016 and continuing. AS 23.30.185. Employer contends Employee was found medically stable and released to return to work in 2007, worked in suitable employment and quit her job. This creates a factual dispute regarding disability to which the presumption must be applied. AS 23.30.120(a)(1); *Meek.*

Without regard to credibility, Employee raises the presumption with Drs. Silverman's and Dr. Crumb's opinions Employee will improve with more treatment. *Tolbert*; *Wolfer*. Without regard to credibility, Employer rebuts the presumption with Dr. Barnes' release for Employee to return to work as a secretary or waitress, Dr. Lurate's PPI rating, which he would not have provided if Employee was not medically stable and Dr. Leyen's opinion Employee's knees were medically stable. *Id*. This shifts the production burden to Employee. *Saxton*; *Anderson.*

Employee must show she was not medically stable beginning January 15, 2016, to qualify for TTD. AS 23.30.395(28); *Anderson*. Employer raised the "counter presumption" with substantial

evidence including Dr. Lurate's PPI rating and related, implied medical stability opinion and with Dr. Leyen's opinion. Employee must produce "clear and convincing evidence" she was not medically stable effective January 15, 2016, the date on which her TTD claim begins. *Anderson*. Dr. Crumb's opinion Employee needs more medical care implies he thinks Employee is not yet medically stable. However, Dr. Crumb's opinions will be given little weight and credibility because he is the only physician to diagnose Employee with "torsion dystonia," the reason he thinks she continues to be disabled, and to suggest she had quiescent "cerebral palsy." These diagnoses taint all his opinions. AS 23.30.122; *Smith*. The USA's lawsuit against Dr. Crumb, while calling his diagnoses and treatments into question, plays no role in this determination, as that litigation's merits have yet to be determined. *Rogers & Babler*.

EME Dr. Leyen's opinions are given some weight as he found Employee's L1 compression fracture and subarachnoid hemorrhage were both resolved with no further treatment needed, again implying medical stability. Dr. Leyen found no basis to attribute Employee's head pain to her injury with Employer, making any medical instability it may cause immaterial, and expressly found her knees medically stable. EME Dr. Armstrong-Murphy's opinions are given little weight and credibility as she attributed Employee's symptoms to rheumatoid arthritis, a condition no other doctor diagnosed and laboratory tests demonstrated Employee does not have. AS 23.30.122; *Smith*.

By contrast, SIME Dr. Silverman said Employee needs additional care to regain strength and stabilize her muscles, given her underlying joint hypermobility. Dr. Silverman recommended a psychiatric or psychological evaluation, possible neuropsychological testing, non-opioid medication to assist with pain management, other medication to address anxiety and a structured work-hardening program or functional restoration plan to "allow her to return to work." Implicit in Dr. Silverman's opinions is an expectation Employee will improve. *Rogers & Babler*. Dr. Silverman's credible SIME opinions are given the greatest weight and are clear and convincing evidence Employee is not medically stable. AS 23.30.122; *Smith*; *Leigh*; *Moore*; *Steffey*. Employer contends Dr. Silverman's recommended treatment would only result in "subjectively" rather than "objectively" measurable improvement, making it impossible for Employee to show she is not medically stable. But Employer provided no factual or legal support for this argument.

Dr. Craig said even neuropsychological testing provides "objective" evidence and Dr. Epker opined Employee may need additional testing. Therefore, Employee demonstrated she was not medically stable effective July 22, 2014, when Dr. Silverman recommended additional evaluation and treatment. *Thoeni*. But, the TTD analysis does not end here.

b) Is Employee disabled?

Employee also contends she has been disabled since January 15, 2016, due to her work injury and is entitled to TTD. AS 23.30.395(16); AS 23.30.185. Employer contends Employee worked for years post-injury and now chooses not to work. This creates a medical dispute to which the presumption analysis must be applied. AS 23.30.120(a)(1); *Meek*.

Employee raises the presumption with Dr. Crumb's opinion Employee is disabled. *Tolbert*; *Wolfer*. Without regard to credibility, Employer rebuts the presumption with Dr. Barnes' release for Employee to return to work as a secretary or waitress. *Id*. Employee must show her injury with Employer was a substantial factor in causing her to be temporarily totally disabled since January 15, 2016, when her TTD claim begins. *Saxton*; *Lowes*. Employee testified she still has symptoms caused by her injury, and while she tried returning to work she was largely unsuccessful. Vines corroborated Employee's testimony and said she was never the same following her work injury, particularly in respect to her memory. Employee's and Vines' lay hearing testimony on this point is credible and is given some weight. AS 23.30.122; *Smith*.

However, Employee cites several conditions and body parts she contends render her disabled from her work injury with Employer. Regarding Employee's cervical complaints, the overwhelming evidence demonstrates the minimal degenerative changes in her neck are not resultant from her work injury, and the injury is not a substantial factor in causing any cervical-spine-related disability. Dr. Crumb agreed the work injury is not a substantial factor causing Employee's neck symptoms. Employee is not disabled by any work-related cervical injury.

While Employee claims to have injured her knees in her fall, the overwhelming medical evidence suggests otherwise. EME Dr. Leyen found no evidence Employee injured her knees when she fell and stated the work injury was not a substantial cause of Employee's knee pain.

Though sequela arising from her work-injury-related medical treatment or altered gait from her L1 fracture would be compensable consequences, the credible evidence shows no evidence the injury or treatment caused knee-related disability. Employee's x-rays, MRI scans and knee examinations were normal exception for mild degeneration in one knee. Dr. Crumb's lone opinion Employee's altered gait somehow affects her knees is given lesser weight because it, along with his "dystonia" and "cerebral palsy" theories, is not supported by any other physician. Employee is not disabled due to any work-related knee injury. Similarly, Employee produced no credible evidence showing her work injury caused her occasional headaches, or headaches caused any disability. She is not disabled by work-related headaches. AS 23.30.122; *Smith*.

However, Dr. Silverman noted Employee has had a biopsychosocial chronic pain problem since her injury. The work injury combined with Employee's underlying hypermobility, as well as with her psychological fear, to contribute to Employee's ongoing symptoms. In Dr. Silverman's view, unless and until Employee gains strength to compensate for her hypermobility and gets medication or psychiatric or psychological assistance in dealing with pain management, her function will not improve -- she has reached "a plateau." Dr. Silverman suggested an approach that may allow Employee "to return to work," suggesting Employee may be disabled from muscle weakness, pain and its related biopsychosocial aspects, all caused by her injury. *Saxton*.

The remaining question is when did, or when will, Employee's temporary total disability begin? Employee was vague concerning her post-injury employment. She provided no written evidence demonstrating post-injury earnings and her testimony about when and how long she was employed post-injury was unhelpful. *Rogers & Babler*. Dr. Silverman implied disability when she said her recommended treatment "may allow" Employee "to return to work." However, Dr. Silverman did not expressly state Employee was disabled. The only evidence Employee presented to support her TTD claim was Dr. Crumb's disability opinions, which are given little weight for the reasons stated above, Employee's lay testimony she felt disabled and Vines' lay opinion he would not hire her and she needed medical treatment to "refocus." This lay evidence is not particularly compelling or accorded great weight. AS 23.30.122; *Smith*.

By contrast, two prior attending physicians in 2006 and 2007 released Employee to return to work as a secretary or waitress, positions a 2007 labor market survey identified existed near Employee's residence. The RBA-designee found Employee not eligible for reemployment training based upon these opinions. She did not appeal this determination and worked off and on post-injury for years. In 2007, Dr. Leyen found no basis for additional treatment for the work injury, implying there would be no work-related disability. Employee's visits starting in 2009 with Dr. Youngblood did not result in removal from the work force. Beginning in 2014, Dr. Crumb began providing opinions concerning Employee's need for additional medical care, but he did not address disability. The medical dispute over additional reasonable and necessary medical care between Drs. Armstrong-Murphy and Crumb gave rise to a 2014 SIME with Dr. Silverman. "Functional capacity," or in other words "disability," was not even an issue for the SIME. Dr. Silverman mentioned disability only because of the way some SIME questions were worded. This evidence, or lack thereof, makes it difficult for Employee to meet her burden and show entitlement to past TTD benefits beginning January 15, 2016. *Saxton*; *Moore*.

While it is conceivable Employee may have been disabled by her work injury from January 15, 2016, and continuing, disability caused by biopsychosocial issues combined with hypermobile joints is an unusual, medically complex basis for disability and requires medical evidence to support a TTD award. Employee's medical and lay evidence does not support a TTD award beginning January 15, 2016, because Dr. Crumb's opinions are given little weight and Employee's and Vines' lay opinions are not adequate to address a complex medical and psychological issue. *Saxton*. Dr. Silverman offered treatment opinions showing Employee is not yet medically stable but did not say she was disabled. Employee has proven the medical instability prong but the not the complex disability element for TTD entitlement. *Wolfer*. Once she begins participating in treatment, Employee will be unable to earn wages "because of injury" as opposed to some other reason, will be disabled and will be entitled to TTD benefits. AS 23.30.185; AS 23.30.395(16); AS 23.30.395(28); *Thoeni*. Therefore, Employee's claim for TTD benefits beginning January 16, 2015, to the present and continuing will be denied. However, Employer will be ordered to pay Employee TTD benefits on the date she begins her authorized medical care as discussed below.

2) Is Employee entitled to PTD benefits?

Employee alternately contends she is entitled to PTD benefits effective January 15, 2016. AS 23.30.180. Employer contends she is not. This creates a factual dispute to which the presumption analysis applies. AS 23.30.120(a)(1); *Meek*. PTD status is usually determined administratively through evidence including medical opinions, functional capacity evaluations and expert vocational testimony. Employee failed to raise the presumption in respect to her PTD claim as she presented no medical, physical capacity or vocational evidence suggesting she was unable to perform services other than those which are so limited in quality, dependability or quantity that a reasonably stable market for them does not exist, and her disability is permanent. *Sulkosky*. Employee's and Vines' lay testimony is inadequate to raise the PTD presumption. Neither is an expert in what Employee can or cannot do physically or vocationally and how her work injury medically affects her job performance. Therefore, Employee must prove she has been permanently totally disabled since January 15, 2016, when her claim begins. *Saxton*.

Had Employee raised the presumption, Employer would have rebutted it with medical opinions from 2006 and 2007 stating Employee could return to work as a waitress or secretary, and with a vocational expert's 2007 labor market survey showing these jobs existed in Employee's labor market, which is the same labor market in which Employee now lives. *Tolbert*; *Wolfer*; *Carlson*.

Employee contends she is the "odd lot" worker. *Carlson*. Employer can defeat her PTD claim by showing there is regularly and continuously available work in the area suited to her capabilities. *Sulkosky*. Employee's physicians released her to work as a waitress or secretary in 2006 and 2007. Based on these opinions, and on a labor market survey showing openings in Employee's locale for these jobs, Employee was found not eligible for reemployment benefits, she did not appeal this decision and worked off and on for years post-injury. This evidence alone would be adequate to defeat Employee's PTD claim absent some contrary evidence.

Employee also defeated her PTD claim by failing to present credible evidence. She failed to satisfactorily explain what changed beginning January 15, 2016, making her no longer able to work. While Employee's lay testimony shows she has work-related chronic pain issues, absent medical, functional capacity or expert vocational evidence, Employee failed to meet her burden

and has not demonstrated she was PTD status beginning January 15, 2016. *Saxton*. Employer proved a labor market exists to which Employee's doctors released her years ago, and there is no credible evidence the labor market has changed or Employee's functional capacity was different beginning January 15, 2016. Her PTD claim beginning January 15, 2016, will be denied.

3) Is Employee entitled to medical care?

Employee contends she needs additional treatment for her work injury. AS 23.30.095(a). Employer contends she does not. This creates a factual dispute to which the presumption analysis must be applied. AS 23.30.120(a)(1); *Meek*; *Carter*. Without regard to credibility, Employee raises the presumption with Drs. Crumb and Silverman stating Employee needs treatment. *Tolbert*; *Wolfer*. Without regard to credibility, Employer rebuts it with Drs. Leyen's and Armstrong-Murphy's opinions Employee needs no further treatment for her work injuries. *Id*. Employee must prove her medical benefit claim by a preponderance of the evidence. *Saxton*.

Dr. Craig noted Employee's subarachnoid hemorrhage occurred in a brain area responsible for emotion and her head injury could account for reduced cognitive scores. Dr. Craig's opinion is given some weight. Dr. Leyen's EME report was mostly limited to Employee's knees, and while it is credited and given weight for her knee issues, it is given less weight in reference to Employee's neuropsychological and chronic pain issues. Dr. Armstrong-Murphy's EME report is given little weight because she premised her opinions on an erroneous belief Employee had rheumatoid arthritis, a fact disproved by laboratory tests and other physicians' opinions. Dr. Crumb's opinions are given little weight because his treatment did not result in any demonstrable, long-term benefit and Employee had reached "a plateau," according to Dr. Silverman. Furthermore, his diagnoses stand alone and are unsupported by other examiners. Employee's and Vine's credible lay testimony about Employee's cognitive difficulties, combined with a complete lack of any evidence Employee is exaggerating or malingering, further support Employee's need for additional medical care. Lastly, Dr. Silverman's impartial SIME opinion is given the most weight as she identified Employee's preexisting joint hypermobility, her lack of a strengthening program, and the complex biopsychosocial aspects involved in Employee's injury and recovery. *Wolfer*. Dr. Silverman's opinion is also supported by Dr. Epker who suggested Employee may need additional neuropsychological evaluation to

clarify any unresolved brain injury, and identified Employee's need to focus on "functional restoration." AS 23.30.122; *Smith*; *Steffey*; *Moore*.

This decision found Employee's headaches, cervical spine and bilateral knee complaints unrelated to her work injury. To the extent Employee requests medical care and treatment for these areas, her claim will be denied. Employee's request to continue Dr. Crumb's treatments including Botox injections and referrals to stand-alone physical therapy and chiropractic adjustments will also be denied based on Dr. Silverman's opinions. However, pursuant to Dr. Silverman, Employee's request for a structured work-hardening program or functional restoration clinic will be granted. Additionally, to the extent the clinic providing this care deems it appropriate, Employer will be ordered to pay for non-opioid medication to assist Employee with pain management and Gabapentin or Lyrica to address anxiety. If the clinic believes Employee needs physical therapy or a psychiatric or psychological treatment component, or further neuropsychological testing or treatment to assist in her recovery, Employer will be ordered to pay for such evaluation and treatment, based on Drs. Epker's and Silverman's recommendations. While opioid medication should be avoided, pursuant to Dr. Epker's opioid clearance, Employer will be ordered to pay for such medications if the clinic deems it reasonable and necessary. Employer will also be ordered to pay for future transportation expenses in relation to this treatment. AS 23.30.095(a).

This decision expresses no opinion on the Mayo Clinic Employee identified in Florida and does not require Employer to pay for treatment for Employee at that facility at this time. The parties may stipulate to Employee attending this clinic. The Florida Mayo Clinic may or may not be the nearest place where the medical care ordered in this decision is available. The parties are encouraged to agree on an appropriate facility where Employee can participate in a structured work-hardening or functional restoration program and any recommended adjunct treatment in conformance with this decision. In accordance with Employer's request, Employee will be ordered to participate fully in her structured work-hardening or functional restoration program. The parties may seek further relief if they are unable to agree on a facility.

Contrary to Employer's request, Employee's right to obtain additional medical care beyond what is awarded in this decision will not be terminated. Employer likens this case to a personal injury lawsuit where parties present expert evidence setting forth the plaintiff's life-long damages, including medical expenses, to the judge or jury. The plaintiff gets whatever the judge or jury awards, and the case is over. In workers' compensation cases, absent a settlement or an order finding no further liability, employers are liable to injured workers for the period which the "nature of the injury or the process of recovery requires." AS 23.30.095(a).

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

On March 21, 2016, Employer controverted Employee's claims for TTD, PTD, medical care and transportation costs. Employee has partially prevailed on her TTD claim and on her claim for medical care and related transportation expenses. She has not prevailed on her PTD claim. Therefore, as a controverted claim on which she was to some extent successful, Employee is entitled to fully compensatory and reasonable, though not necessarily actual, attorney's fees under AS 23.30.145(a) and 8 AAC 45.180 and costs under 8 AAC 45.180. *Cortay*.

Employer objected to Employee's attorney's fee affidavit and associated itemization on several grounds and requested a revised pleading. Attorney Patterson responded affirming he alone performed attorney duties in this case and an experienced paralegal performed the paralegal duties. Attorney Patterson has nearly 40 years' experience handling workers' compensation cases and his requested $400 per hour fee is commensurate with his experience and rates charged by similarly experienced attorneys. A paralegal with eight years' experience justifies $125 per hour. *Rogers & Babler*. Neither the attorney's nor the paralegal's hourly rates will be adjusted.

Attorney Patterson's explanation for his attorney's fee and cost itemization is well-taken. The regulation requires, in addition to time expended, the "extent and character of the work performed." 8 AAC 45.180(b). While the latter are subjective requirements, Employer failed to present evidence showing attorney Patterson's itemization was insufficient. Employer did not object to any specific item "block-billed" as being individually inappropriate or not necessary, suggesting the "sum of the parts" would similarly not be objectionable. Neither the attorney's nor the paralegal's fees will be reduced for lack of adequate description or block-billing.

Attorney Patterson adequately addressed Employer's objection to specific time entries. It is conceivable an attorney could spend 1.4 hours reviewing voluminous records to formulate SIME questions. *Rogers & Babler*. This time is reasonable and will not be reduced. Attorney Patterson agreed "1.4" for emailing SIME questions to the division was an error and should have read ".1." The email was an administrative task and should not have been billed at the attorney's rate. He conceded ".2" and ".5" for making travel arrangements was an administrative duty. Employee's attorney's fees will be reduced by 2.1 hours overcharged (1.4 +.2 + .5 = 2.1 x $400 = $840). Attorney Patterson's affidavit justified his time billed for traveling to Dr. Crumb's and Employee's depositions. Employer's arguments to the contrary are not evidence. Attorney Patterson's attorney's fees and costs will not be reduced for this event. Employer has not shown other costs to be unreasonable or unnecessary. 8 AAC 45.180(f). They will not be reduced.

The larger question is whether attorney's fees should be reduced because Employee did not prevail on every issue. Employee contends her attorney's fees should not be reduced if she loses on minor issues. *Porteleki*. Employee did not prevail on her PTD claim. Given the "Billing Schedule," hearing brief, evidence presented, and hearing arguments, PTD was a throwaway issue not seriously advanced. Employee only added PTD as an issue on March 9, 2016, just a few months before her August 24, 2016 hearing and presented no evidence, law or analysis to support a PTD claim. The itemized billing for the 2016 claim where PTD was added says the claim was amended only to "add TTD" not PTD. Her attorney's itemization shows no effort attributed to the PTD claim. Nonetheless, attorney Patterson thought about PTD and whether he should or should not make a PTD claim, or else he would not have amended Employee's claim to add PTD. Employee's attorney's fees will be reduced by $400 to account for one hour attorney time spent considering an unsuccessful PTD claim. *Rogers & Babler*.

Employee did not prevail on her claim for TTD from January 15, 2016, and continuing. Had she prevailed, the benefit would have been relatively small considering her $187 weekly rate. While more seriously contended, TTD was still not the main issue. Employee's fee affidavit uses block-billing and precise time expended on each task characterized in the billing descriptions cannot be discerned. Employee's TTD evidence was limited Dr. Crumb's opinions and to Employee's and Vines' lay testimony. TTD was only mentioned twice in Employee's hearing

brief and once at hearing, in passing, and she conceded Dr. Crumb's opinions would be weighted lightly, at best. Because Dr. Crumb's deposition was necessitated by a *Smallwood* objection, Employee's attorney's fees will not be reduced in relation to Dr. Crumb's involvement.

Attorney Patterson expended 1.7 hours preparing for hearing, drafting questions and an opening statement, and drafting and reviewing emails to and from Employee. Employee's 1.7 hour TTD-related hearing preparation will be reduced to account for her unsuccessful TTD claim. Vines' TTD-related hearing testimony took approximately 10 minutes. Preparation for his examination reasonably took 20 minutes. *Rogers & Babler*. Employee's TTD-related hearing testimony took no more than 10 minutes. Preparation for her TTD-related testimony reasonably took 20 minutes. *Rogers & Babler*. Employee prevailed on her future TTD claim in an amount not yet determinable. Employee's attorney fees will be reduced by $400 to account for one hour spent on the unsuccessful TTD claim as analyzed above. AS 23.30.145(a); 8 AAC 45.180(b).

Though Employee initially requested Dr. Crumb's treatments, she ultimately amended her claim to request Dr. Silverman's recommended care and prevailed on this issue. Though the recommended treatment cost is unknown, experience shows medical care is not inexpensive. *Rogers & Babler*. It is expected the care will benefit Employee, according to Dr. Silverman. Furthermore, Employer wanted this decision to end Employee's case forever, a request that has been denied. Depending upon Employee's response to the treatment ordered in this decision, and other issues which may arise with her L1 compression fracture as she ages, she may need additional care for her work injury, which is a long-term benefit. Given the above analysis, a fully compensable, reasonable attorney's fee and cost award for Employee in this case will be $40,890 and $6,015.48, respectively ($42,330 requested fees - $840 overcharged = $41,490 - $800 for unsuccessful issues = $40,690).

CONCLUSIONS OF LAW

1) Employee is entitled to TTD benefits.
2) Employee is not entitled to PTD benefits.
3) Employee is entitled to medical care.
4) Employee is entitled to attorney's fees and costs.

ORDER

1) Employee's claim for TTD beginning January 15, 2016 is denied. TTD beginning when she enters medical treatment in accord with this decision is granted.

2) Employee's claim for PTD is denied.

3) Employee's claim for medical care is granted in part and denied in part.

4) Employer is ordered to pay for a structured work-hardening or functional restoration program as recommended by Dr. Silverman, and related transportation expenses.

5) The parties are directed to attempt to stipulate to an appropriate facility. If they cannot agree, either party may seek additional relief.

6) Employer is ordered to pay for any additional neuropsychological evaluation or other testing to clarify any unresolved brain injury if the facility providing the structured work-hardening or functional restoration program agrees Employee needs such testing.

7) Employee's request for medical care for her headaches, neck and knees is denied.

8) Employee's request for continuing treatments from Dr. Crumb including Botox injections and referrals to stand-alone physical therapy and chiropractic care is denied.

9) Employer is ordered to pay for non-opioid medication to assist Employee with pain management, and Gabapentin or Lyrica to address anxiety if recommended by the facility providing the structured work-hardening or functional restoration program.

10) Employer is ordered to pay for physical therapy or a psychiatric or psychological treatment component if recommended by the clinic providing the structured work-hardening or functional restoration program, or by a provider to whom the clinic refers Employee.

11) Employer is ordered to pay for opioid medication if recommended by the clinic providing the structured work-hardening or functional restoration program.

12) Employer's request to terminate Employee's right to benefits is denied.

13) Employer is ordered to pay Employee's attorney $40,690 in fees and $6,015.48 in costs.

Dated in Anchorage, Alaska on September 21, 2016.

ALASKA WORKERS' COMPENSATION BOARD

_____/s/_____
William Soule, Designated Chair

_____/s/_____
Ron Nalikak, Member

_____/s/_____
Mark Talbert, 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 Miranda Diel, employee / claimant v. Safway Services, employer; ACE American Insurance Co, insurer / defendants Case No. 200519312; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on September 21, 2016.

_____/s/_____
Pamela Hardy, Office Assistant