ALASKA WORKERS' COMPENSATION BOARD

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

THEODORE M. NIELSEN, Employee, Claimant, v. ALASKA TEAMSTER LOCAL 959 TRAINING TRUST, Employer, and COMMERCE AND INDUSTRY INSURANCE COMPANY, Insurer, Defendants.	FINAL DECISION AND ORDER AWCB Case No. 200804795 AWCB Decision No. 19-0019 Filed with AWCB Anchorage, Alaska on February 15, 2019

Theodore M. Nielsen's June 7, 2018 claim was heard on January 2, 2019, in Anchorage, Alaska, a date selected on October 4, 2018. An October 4, 2018 prehearing conference stipulation gave rise to this hearing. Attorney J.C. Croft appeared and represented Employee who appeared and testified. Attorney Krista Schwarting appeared and represented Alaska Teamster Local 959 Training Trust and its insurer (Employer). The record closed when the parties filed written closing arguments on January 16, 2019.

ISSUES

Employee contends he prevails on his claim for continuing prescription medication solely because Employer has not rebutted the raised presumption.

Employer contends its employer medical evaluator's (EME) opinions rebut the presumption.

1) Does Employer's EME evidence rebut the raised presumption of compensability?

Employee contends his "palliative treatment" is reasonable and necessary to relieve chronic, debilitating pain arising from his work injury. He seeks continuing prescription medications.

Employer contends Employee's requested care does not enable him to return to work and does not improve his daily functioning. Therefore, Employer contends his medical treatment is not "palliative" and Employee is not entitled to continuing medical care.

2) Is Employee entitled to palliative medical care?

Employee contends Employer frivolously or unfairly controverted his right to compensation and ultimately his claims because the EME report upon which Employer relied to support its denial did not rebut the statutory presumption. He seeks an associated finding and a director's referral to the Division of Insurance for further action.

Employer contends it properly relied upon its EME report when it denied Employee's right to benefits and later his claim. Employer contends it did not frivolously or unfairly controvert Employee's claim and therefore an associated finding and related referral is not appropriate.

3) Did Employer frivolously or unfairly controvert Employee's right to benefits or his claims?

Employee contends he prevails on his claim. Therefore, he contends he is entitled to an associated attorney fee and cost award.

Employer contends Employee is entitled to no additional benefits. Therefore, it contends he is not entitled to attorney fees or costs.

4) Is Employee entitled to an attorney fee and cost award?

FINDINGS OF FACT

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

1) On April 21, 2008, Employee rammed his head onto a truck differential housing while working as a mechanic for Employer. (Report of Occupational Injury or Illness, April 29, 2008; Employee; Deposition of Theodore Matt Nielsen, July 23, 2015).

2) On April 22, 2008, Duane Odland, M.D., recorded Employee was having muscle spasms in his neck. (Odland report, April 22, 2008).

3) On June 25, 2011, Scott Fechtel, D.C., M.D., saw Employee for an EME. There was no evidence of preexisting neck or head pain. Dr. Fechtel found "rigid paraspinal muscles" and diagnosed among other things severe neck pain with severe guarding, muscle spasm and limited motion, which appeared to be neurogenic, and a possible posttraumatic cervical dystonia. He offered the posttraumatic dystonia as why Employee's magnetic resonance imaging (MRI) findings were not sufficient to explain all his symptoms, particularly the muscle rigidity. Dr. Fechtel found posttraumatic cervical dystonia present in the medical literature and associated with past, violent neck movements, which could suggest an alternative therapeutic approach to Employee's symptoms. He recommended electromyography (EMG) with an evaluator "comfortable with cervical dystonia evaluation." Dr. Fechtel endorsed recommendations from Thomas Grissom, M.D., and added Botox injections as an added treatment. (Dr. Fechtel EME report, June 25, 2011).

4) On February 20, 2012, Larry Kropp, M.D., gave Employee a selective cervical nerve root block for a displaced cervical disc. (Kropp report, February 20, 2012).

5) On March 26, 2012, Employee reported his recent nerve root block worked well and took away some symptoms, until he tore a trapezius muscle at work. (Kropp report, March 26, 2012).

6) On October 19, 2012, Dr. Kropp administered an anesthetic discogram at C6-7, which gave Employee "almost complete relief." (Procedure Note, October 19, 2012).

7) On December 31, 2012, Employee told Louis Kralick, M.D., he had a "long-standing history of neck pain with cervical spondylosis" present "following a work injury in April 2008." (Kralick report, December 31, 2012).

8) On January 7, 2013, Dr. Kralick performed an anterior discectomy, spinal canal nerve root decompression and total disc arthroplasty at C6-7. (Operative Report, January 7, 2013).

9) On May 8, 2013, Employee returned to Dr. Kropp who reported:

> . . . Dr. Kralick has done a disc replacement at C6/7, and now he has some post op facet pain. I reassured him that this is very common after disc replacement, and usually we can get this to go away. He was encouraged by that. . . . (Kropp report, May 8, 2013).

10) On May 15, 2013, Dr. Kropp performed a nerve root block at C6-7 to address Employee's post-surgical symptoms. (Kropp report, May 15, 2013).

11) On May 21, 2013, Employee told Franklin Ellenson, M.D., his headaches were "constantly at 9-10/10 prior to surgery and 6/10 postoperatively." (Ellenson report, May 21, 2013).

12) On August 28, 2013, EME physicians Karl Goler, M.D. and William Stump, M.D., disagreed with prior EME Dr. Fechtel's treatment recommendations stating they made "no sense clinically." The panel opined Employee's cervical spine was medically fixed and stable and "[n]o further curative treatment is available." (Goler, Stump report, August 28, 2013).

13) On September 19, 2013, Bret Mason, D.O., diagnosed among other things thorax and neck pain and "C5-C6 radiculopathy." (Mason report, September 19, 2013).

14) By October 28, 2013, Employee had neck pain and numbness in his left hand in certain digits with left upper extremity weakness post-surgery. (Kralick report, October 28, 2013).

15) On October 29, 2013, Eric Kussro, M.D., performed electrodiagnostic testing and found "one finding consistent with (but not diagnostic for) a mild old or chronic left C6/7 radiculopathy. . . ." (Kussro report, October 29, 2013).

16) On February 4, 2014, Dr. Kralick stated Employee was medically stable and he had no further treatment recommendations. (Kralick report, February 4, 2014).

17) On March 19, 2014, Michael Gevaert, M.D., said Employee was medically stable and Dr. Gevaert provided an impairment rating. (Gevaert report, March 19, 2014).

18) On May 12, 2014, on referral from Dr. Kralick, Darrel Brett, M.D. examined Employee and reviewed his "large volume of medical records" and imaging studies. Dr. Brett stated Employee's C6-7 arthroplasty was healing nicely with good placement. He found no residual or recurrent nerve impingement or any adjacent new pathology. Dr. Brett said, "I suspect he has chronic nerve root injury from the original work exposure on 4-21-08." On examination, Employee had "mild to moderate posterior paracervical spasms noted in his neck," a "trace weakness" in the left arm and some numbness and paresthesia into the forearm and second and third digits of his left hand "in what appears to be C7 dermatome." Dr. Brett concluded Employee "is likely now suffering from permanent nerve damage with chronic pain for which

we have no surgical remedy." He had little to offer from a neurosurgical viewpoint and encouraged Employee to continue under Dr. Kralick's care. (Brett letter, May 12, 2014).

19) On June 19, 2014, Dr. Grissom diagnosed cervical radiculopathy, cervical degenerative disc disease and status post-cervical disc arthroplasty. (Grissom report, June 19, 2014).

20) On August 18, 2014, Matthew Peterson, M.D., diagnosed Employee with chronic cervical spine pain, cervical spondylosis and postsurgical pain syndrome with previous disc replacement at C6-7. (Operative Report, August 18, 2014).

21) On September 17, 2014, Dr. Peterson opined Employee had exhausted all medical treatment options and was at "maximum medical improvement." His ongoing care was for "palliative pain management." (Peterson report, September 17, 2014).

22) On December 14, 2014, Dr. Peterson said Employee's condition was medically stable. (Peterson report, December 16, 2014).

23) On February 10, 2015, Employee had "very limited" range of motion with neck pain and observable muscle spasms. (Byron Perkins, D.O., February 10, 2015).

24) On February 13, 2015, Dr. Peterson again said Employee's condition was medically stable. (Peterson report, February 13, 2015).

25) On February 24, 2015, Employee reported headaches and neck and back pain. His opioid management was "adequate" and provided approximately 20 to 30 percent relief. Percocet caused nausea and Employee's symptoms changed after his arthroplasty. Dr. Peterson opined Employee has "chronic pain" and said he "likely has mechanical or structural defect associated with previous disk replacement surgery." He further stated, "At this point patient is likely at maximum medical improvement and suffers with chronic pain and dysfunction due to pain. This will likely lead to permanent impairment." (Peterson report, February 24, 2015).

26) On May 6, 2015, Dr. Perkins said Employee "should continue in pain management for chronic pain." (Physician's Report, May 6, 2015).

27) On May 7, 2015, Dr. Peterson stated Employee "is at maximum medical improved." (Physician's Report, May 7, 2015).

28) On June 26, 2015, Dr. Perkins wrote a letter requesting accommodations for Employee's travel to an EME. He noted Employee can sleep for two hours at a time and is in constant pain. (Perkins letter, June 26, 2015).

29) On March 25, 2016, the parties settled Employee's previous claims and his right to all benefits except medical care and related transportation costs. In their agreement, the parties said:

> It is agreed the employer and carrier/adjuster will be responsible under the terms of the Alaska Workers' Compensation Act for reasonable and necessary medical benefits and related travel expenses, which although incurred in the future, and [sic] are attributable to any condition described herein and for which the employer and carrier/adjuster have paid medical benefits in the past. Is also agreed that the right of the employer and carrier/adjuster to contest liability for future medical benefits is not waived under the terms of this settlement agreement. (Compromise and Release, March 25, 2016, at 8).

30) On March 22, 2018, Dennis Chong, M.D., examined Employee for an EME. He interviewed Employee and reviewed his medical records, including those recording his consistent complaints of neck and head pain through 2017. There were no imaging studies for review. Employee's then-current medications, which he had been taking "for a number of years," included: OxyContin 30 mg, two tablets a day; Hydromorphone, 2 mg, three tablets per day; Celebrex, 200 mg, two tablets a day; Baclofen, 10 mg, one to two tabs per day; Hydroxyzine for nausea; and Amitiza for constipation. His "Chief Complaints" were:

> Mr. Nielsen presents today with symptoms to his head, neck, and upper torso, as well as left upper limb to the thumb, index, and middle fingers.

Historically, Employee reportedly said:

> With persistent neck pain, he underwent a C6-7 disc arthroplasty 2013, which has unfortunately resulted in his current constellation of symptoms. . . .

Employee's then-current symptoms included:

> Presently, he states that what is most disabling is a global headache from the neck on up. He states he awoke from this postoperative disk arthroplasty. This is present constantly, daily, with intensity variable throughout the day. There are no associated factors which he can identify as what causes it to be greater or lesser. He also has photosensitivity, and wears sunglasses all day long.
>
> Second is circumferential neck pain, and upper torso pain. He states that this also has been there since post-op. This is constant. Any activity increases the symptoms.

> The third is to the left upper limb, which refers in a lateral/radial distribution, terminating in the thumb, index, and middle fingers. This is constant, and symptoms are increased with activity.
>
> The fourth, is a sense of dysequilibrium which he describes as that of getting off a boat. This is intermittent, occurring three to four times per week, and had its onset sometime postoperatively. The duration of this dysequilibrium is anywhere from 10 minutes to 1-1/2 hours. As a result of this, he has not driven since 2013. . . .

Based on his "Review of Symptoms," itself based on the medical documentation and "an interview with the examinee," Dr. Chong knew Employee had nausea, sleep problems and neck pain. He diagnosed a cervical and left shoulder "sprain/strain" substantially caused by Employee's work injury "and long since resolved"; bilateral, curative shoulder surgeries; preexisting cervical spine multilevel degenerative disease and spondylosis, unrelated to, not caused by and not aggravated by the work injury; and a C6-7 disc arthroplasty, with a "postoperative explosion of subjective pain complaints" including headache, worsened left upper extremity symptoms, circumferential neck pain, upper torso pain and dysequilibrium. Dr. Chong opined Employee's symptoms "cannot be explained by an uncomplicated, technically successful C6-7 disc arthroplasty." (Chong report, March 22, 2018).

31) The adjuster asked Dr. Chong to "identify all causes" of Employee's disability or need for medical treatment following his work injury (emphasis in original). He listed no causes and said no "anatomical or physiological cause" explained Employee's "current constellation of disparate symptoms to result in disability." The adjuster stated and asked Dr. Chong the following:

> The Alaska Workers' Compensation Act requires that a determination of 'the substantial cause' must be made relative to the contribution of different causes. To apply the statute, all causes of the disability or need for medical treatment must first be identified. Substantiality must then be determined relative to the contribution of the different causes. In your opinion, which of the identified causes is 'the substantial cause' of Mr. Nielsen's current and ongoing need for treatment?

In response to this question, again identifying no "causes," Dr. Chong stated the work injury has not been the substantial cause for any medical treatment since 2013, when Employee underwent cervical surgery assuming the disc arthroplasty was administratively accepted. He recommended no further care or prescription medication because, in his view, chronic opiate therapy "has not

resulted in any functional improvement" and there was no evidence of signs or symptoms to support other medications. The adjuster further asked:

> Please indicate whether Mr. Nielsen's ongoing need for medical treatment, if any, is palliative. Palliative care means 'medical care or treatment rendered to reduce or moderate temporarily the intensity of pain caused by an otherwise stable medical condition, but does not include those medical services rendered to diagnose, heal, or permanently alleviate or eliminate a medical condition.'
> . . . .
>
> If Mr. Nielsen is receiving palliative care, (a) does it enable him to continue in his work at the time of treatment; (b) does it enable him to participate in an approved reemployment plan; or (c) does it relieve chronic debilitating pain? Chronic debilitating pain means 'pain that is of more than six months duration and that is of sufficient severity that it significantly restricts the employee's ability to perform activities of daily living.'

In response to both questions, Dr. Chong stated, "Ongoing medical treatment is not palliative, in that it has not resulted in return to employment. It has not resulted in improvement of function, and therefore it has not been beneficial for debilitating pain." (*Id*.).

32) Dr. Chong is a pain specialist. Employee had a C6-7 disc arthroplasty in January 2013. He continued to have pain symptoms although Dr. Chong could find no objective reason for his symptoms. Dr. Chong opined there is "no medical explanation, meaning an anatomical or physiological explanation for this widespread despair of pain complaints." A few months before his disc replacement surgery, Employee underwent a discogram which showed positive results and pain reproduction at the C6-7 level, which led to disc replacement at that level. Dr. Chong would expect symptoms to resolve post-surgery and improved cervical range-of-motion. However, in this case Employee did not have symptom resolution and had decreased motion. He conceded range of motion following disc arthroplasty "varies by patient" but always results in improvement, not decrease. In his opinion, Employee's post-surgical symptoms cannot be explained by an uncomplicated, technically successful C6-7 disc arthroplasty. Dr. Chong found no evidence of any surgical complications. He reiterated diagnoses from his written report and explained cervical spondylosis is an aging condition describing degenerative arthritis in the spine, common with individuals beginning about age 30, but did not attribute Employee's symptoms to this condition. He found no evidence Employee had any permanent nerve damage. Dr. Chong defined posttraumatic "cervical dystonia" as a condition caused by nerve damage,

which activates the nerve in an abnormal manner resulting in muscle contraction. In his view, posttraumatic cervical dystonia occurs only within one year from a trauma and beyond that period, "it would be from some other reason, but not from trauma." Previous epidural steroid and medial branch block injections did not improve Employee's symptoms and additional injections were not likely to either, because unsuccessful injections show radiculopathy is not the pain generator. In his opinion, a spinal cord stimulator is highly unlikely to benefit Employee because there is no evidence he has any nerve injury. Continued osteopathic manipulation is not likely to help him because they failed in the past and there is no evidence Employee has acute musculoskeletal pain. Such manipulations based on chronic mechanical pain are also not indicated for Employee because these should assist or facilitate him to be functional and independent in his activities of daily living as well as in vocational and avocational pursuits. In Dr. Chong's view, Employee fits into neither of these categories. His disequilibrium could be caused by a central lesion in the brain causing visual issues, or it could result from auditory issues. He did not say Employee had these conditions. Dr. Chong opined there is no possibility such conditions could be caused or aggravated by a cervical injury. He did not comment on whether disequilibrium could arise from Employee's medication he takes for his work injury. Employee takes medication including opiates for nonmalignant, chronic pain. According to Dr. Chong, the Centers for Disease Control (CDC) does not recommend opioids for long-term usage "unless there is clear benefit with regards to function, that the dosage is smaller low dose, and that there is very careful monitoring of this use." He did not say what a "smaller" dosage was and did not suggest Employee's physician were not carefully monitoring his opioid use. In his opinion, Dr. Chong said Employee has "absolutely not" had clear benefits in his function from taking prescribed opioid medications. He based this opinion on his observations during his physical examination where Employee's wife assisted in dressing his upper and lower body. Employee also used a walking stick, and in Dr. Chong's view Employee cannot perform activities of daily living and does not participate in employment. He recommended no further treatment because Employee had the gold-standard cervical treatment when he had his disc replaced, and all subsequent medical care did not solve his symptoms, proving they were not coming from his neck. When asked to identify the cause of Employee's complaints, Dr. Chong said, "There is no focal, meaning no anatomical location that can explain his diffuse complaints." He completely disagrees with PA-C Kile's opinion regarding palliative care because the only

objective measure of success from treatment are activities of daily living, instrumental activities of daily living and vocational and avocational functional activities. In his view, none of these "domains" were affected by Employee's medications or other treatments. Dr. Chong opined the opioids were not reducing or moderating temporarily Employee's pain intensity because pain is a subjective descriptor not recognized by the CDC. The only way to document improvement in function is by reviewing the three domains he mentioned. Dr. Chong could not find either atrophy around the neck musculature or muscle spasms, both objective measures and findings. (Deposition of Dennis Chong, M.D., November 19, 2018).

33) Dr. Chong is not a surgeon and is unfamiliar with the disc arthroplasty surgical technique. He has no opinion on whether an artificial disc replacement can cause pain for any reason. Employee's October 29, 2013 EMG test suggested a possibility of radiculopathy, which neither proves nor disproves radiculopathy. A physician's job is to "identify the cause of pain," and it "is not to determine whether there is or is not pain." He stated, "So pain cannot be seen or shown." Dr. Chong opined absent objective evidence of "anatomy" from diagnostic imaging, or "physiology" from electro diagnostic testing and physical examination it is not possible Employee's disc arthroplasty causes Employee's pain. Dr. Chong testified:

> Q. Are you able to identify any other cause of Mr. Nielsen's symptoms outside of the neck surgery?
>
> A. As I testified earlier, there's no anatomical or physiological cause for his complaints.

Activities of daily living include: self-care, including personal hygiene, dressing and feeding oneself and toileting; mobility such as transferring from bed to standing, from bed to a chair or from the chair to standing; moving between point A and point B including walking; and bowel or bladder incontinence. He cannot recall if he discussed Employee's sleeping abilities, with and without pain management, with him. Dr. Chong did not record if Employee needed assistance in bathing, getting out of bed, out of a chair, or doing dishes or laundry. He asked Employee about outdoor activities and Employee did not talk about church or caring for his grandchildren. Employee said he "performs some self-care with his pain medications." When asked if, based on the definition of "palliative care" in Alaska law, Employee was able to perform some activities of daily living while using pain medication, Dr. Chong answered, "Assuming he was using pain

medication when he was performing some activities of daily living." Dr. Chong said he always asks patients how they feel if not on their pain medications, though he conceded it is not reported in this instance because "it is almost universal in terms of the response from examinees that they will inform me that they want their pain medications." His report does not mention or discuss activities of daily living. (*Id.*).

34) Dr. Chong performs 13 to 15 EMEs per week mostly all for insurance companies. About 99 percent are for the defense. (*Id.*).

35) On April 26, 2018, Employer denied Employee's right to further medical treatment including palliative care after March 22, 2018, based solely on Dr. Chong's March 22, 2018 EME report. (Controversion Notice, April 26, 2018; Employer's Hearing Brief, December 28, 2018, at 11).

36) On May 25, 2018, Employee claimed a penalty, interest, attorney fees and costs and requested an order finding Employer's controversion was unfair or frivolous. (Claim for Workers' Compensation Benefits, May 25, 2018).

37) On May 25, 2018, Employee asked his medical provider Zachary Kile, PA-C:

> Alaska law requires that the employee prove that the work is the substantial cause of the disability or need for treatment. However, all bodies have natural degenerative changes and many have preexisting conditions. Alaska law makes clear that the employer 'takes the employee as he finds him' with any underlying medical conditions or weaknesses. To avoid liability, the insurance company must identify a specific non-work cause of the disability that has a greater contribution than the work. The 'mere possibility' or unknown causes are not sufficient.
>
> Is work the substantial cause or is there an identifiable non-work cause that is more substantial?

Employee also asked PA-C Kile for his diagnoses, his opinion about Employee's medical stability, whether treatment to date had been reasonable and necessary and whether Employee needed continued palliative care to relieve chronic debilitating pain caused by his work injury. (Croft letter, May 25, 2018).

38) On May 30, 2018, PA-C Kile answered Employee's May 25, 2018 questions and diagnosed cervical radicular pain, muscle spasms and knee pain. He opined, "Palliative care IS reasonable and necessary to relieve chronic pain caused by the work injury." As for any

additional palliative care, PA-C Kile said Employee has had cervical fusion, epidural cervical steroid injections, cervical medial branch blocks and "medication management." (Kile letter, May 30, 2018).

39) On June 7, 2018, Employee claimed ongoing prescription medications; medical transportation; interest; reimbursement of out-of-pocket expenses; attorney fees and costs; and an order stating the substantial cause of his current condition and need for treatment is his work injury. (Claim for Workers' Compensation Benefits, June 7, 2018).

40) On June 22, 2018, Employer denied Employee's May 25, 2018 claim based solely on Dr. Chong's report. (Controversion Notice, June 22, 2018).

41) On July 2, 2018, Employer denied Employee's June 7, 2018 claim again based solely on Dr. Chong's report. (Controversion Notice, July 2, 2018).

42) On October 4, 2018, the parties stipulated to a January 2, 2019 hearing. Employee clarified his hearing issues as: medical costs; unfair or frivolous controversion; penalty; interest; and attorney fees and costs. (Prehearing Conference Summary, October 4, 2018).

43) Employee contends his post-surgery symptoms are his main problem. He has post-surgery pain, which he treats with medication. Employee contends this treatment helps him function. He contends Employer's controversion was unfair and frivolous because Dr. Chong's EME report does not discuss all aspects of palliative care, nor does it even mention "activities of daily living." Employee contends his ongoing medication is palliative and helps him deal with chronic debilitating pain from his work injury and its related treatment. He contends Employer's EME report does not meet the affirmative-evidence or negative-evidence tests to rebut the statutory presumption. Employee contends Dr. Chong could not rule out the cervical surgery as a cause for his pain, which again does not rebut the presumption. He contends his medication allows him to be more active by reducing his chronic pain symptoms. Employee seeks an award of continued medical treatment and a referral to the Division of Insurance for an unfair and frivolous controversion. He also seeks attorney fees and costs. (Employee's hearing arguments).

44) Employer does not deny Employee had a work injury in 2008 but contends this case involves a "complex medical question." It contends the real issue is whether or not Employee's ongoing palliative treatment relates to the 2008 injury and whether it is reasonable and necessary. Employer contends greater weight and credibility is attributable to Dr. Chong's opinions as a medical doctor and less weight should be accorded PA-C Kile's opinions.

Employer contends Dr. Chong's opinions "easily" rebut the raised presumption of compensability. As for weight and credibility, it contends PA-C Kile incorrectly believed Employee had a cervical fusion and disc arthroplasty rather than only a disc arthroplasty. It contends Dr. Chong reviewed Employee's entire medical record, while PA-C Kile did not. In Employer's view, with respect to the frivolous and unfair controversion claim, if there is "a report that supports a controversion," that is sufficient to protect Employer against a frivolous or unfair controversion claim. As for the substantial cause issue, Employer relies on Dr. Chong who said "the cause of Mr. Nielsen's symptoms was nonphysiologic, literally there is no physiologic explanation for them." It also relies on Dr. Chong's opinion "there was no medical probability the disc implant could be causing the pain." (Employer's hearing arguments).

45) Employee worked for many years as a truck and heavy equipment mechanic. In February 2003, he began working for Employer at its request. On April 21, 2008, Employee was working under a Kenworth tractor disassembling suspension parts when parts came loose suddenly and he accidentally rammed his head into the differential housing. He suffered a neck and shoulder injury. Shoulder surgery resolved his shoulder issues. Employee obtained conservative care for his neck and continued working after his shoulders healed. Neck treatment included injections, manipulations and ultimately neck surgery. After his work injury but before his cervical surgery, Employee had headaches frequently, reduced cervical motion and lost sleep. Employee changed jobs to work for Matanuska Electric Association and in 2012 was working for them when his "neck quit functioning." A local neurosurgeon performed surgery in 2013. Comparing and contrasting symptoms pre- versus post-surgery, Employee explained: Post-surgery, he had disequilibrium, which he did not have before. The surgery "changed the discomfort." The numbness in his upper extremity increased after surgery. His headache also changed but remained, though Employee admits difficulty articulating his post-surgery pain. Employee still has sleeplessness; he now sleeps mostly in a recliner. Driving is now difficult. He stopped working December 12, 2012, due to his symptoms and has not returned to work. Since Employee settled his indemnity claims, he continued with medical care including physical therapy, numerous injections, myofascial treatments and medication pain management for swelling in his neck, cervical muscle spasm pain and medication to address symptoms related to his pain and to his other medications. When Employee does not take his pain medication, he basically "sits in a recliner" and does nothing except eat and use the bathroom. When taking his

medications, Employee can help care for his adopted grandchildren, work in the garden lightly, attempt fishing once, perform personal hygiene, dress and feed himself, use the restroom, get up and down from his recliner or a chair, walk, sleep somewhat better, bathe himself though he needs assistance from his wife to wash his back, attend church services, teach his grandchildren, toss a ball to them, help them build models or do homework, take out the garbage, help with dishes, perform light housework such as dusting, wash a window, run the vacuum or wipe the counter. Employee cannot do these activities independently when he is not on his medications, with exception of toileting. He could attempt to help his grandchildren with their homework. As an example of his functioning with and without medication, Employee said he assists his in-laws with mechanical questions about their motor home while he is on medication. If he does not have medication, he cannot help them. Employee's pain began on April 21, 2008. In his view, his pain significantly interferes with his ability to perform some activities of daily living. Employee was as non-functional pre-surgery as he is post-surgery. (Employee).

46) PA-C Kile is a certified physician's assistant who received his training at the University of Washington and has been a practicing PA-C since 2008. He previously worked for Algone Interventional Pain Clinic as a PA-C and most recently worked for Anchorage Fracture & Orthopedic as a PA-C in orthopedics. While working for Algone, Kile treated Employee for cervical radicular pain, chronic pain and postsurgical pain. At Algone, he or his physicians provided Employee epidural steroid injections, medial branch blocks and medication management. When he answered Employee's questionnaire, he still worked at Algone and was able to review Employee's chart. Kile understood Employee had "multiple surgeries" including "an anterior cervical fusion and a disc replacement with Dr. Kralick." In his opinion, "the injury was probably more of a source of his pain than -- than the surgery" and Employee's work "is the substantial cause of Mr. Nielsen's need for treatment." He could not identify any other causes outside of work for Employee's neck pain. Among other things, potential continued treatment for Employee's pain would include "medication management." Kile could not currently state if Employee was medically stable or not. He is aware Employee had chronic pain for over six months. In his view, Employee's pain makes his ability to perform activities of daily living "more difficult." Since he could not specifically recall him, Kile would defer to Employee's testimony about his activities of daily living and how pain medication helps him perform these activities. PA-C Kile thinks palliative care to treat Employee's chronic debilitating pain is "most

certainly" reasonable and necessary and his work is the substantial cause of Employee's need for palliative care. (Deposition of Zachary Kile, PA, December 27, 2018).

47) PA-C Kile's understanding Employee had a cervical fusion and a disc replacement is based on his reviewing Employee's chart while Kile still worked at Algone. He reviewed no medical records or imaging studies to prepare for his testimony and could not recall how Employee was injured. PA-C Kile recalled Employee's most recent cervical spine imaging showed a fusion, a disc replacement, facet arthritis and degenerative changes. While Employee did not have any complications from his surgery, "He still had chronic pain." Kile did not have specific recollection of any activities of daily living in which Employee was limited. In PA-C Kile's opinion, electro diagnostic testing for radiculopathy can be "faulty." (*Id.*).

48) PA-C Kile's understanding of the surgery Employee had is incorrect. Employee did not have a cervical fusion in addition to the cervical arthroplasty. (Agency file).

49) Employee's chronic pain in his neck and head following his work injury and subsequent cervical surgery is not a medically complex issue. All people have felt pain, which is a common, subjective experience. (Experience, judgment and observations).

50) On December 28, 2018, Employee provided an affidavit signed only by JC Croft, itemizing attorney fees and costs incurred in this case. In Croft's affidavit, he affirmed he incurred 43.50 attorney hours at $225 per hour (a typographical error in his chart says $200 per hour), totaling $9,787.50 for his attorney fees. He also lists attorney Eric Croft as expending .10 attorney hours at $400 per hour totaling $40. JC Croft's affidavit says "PJ" and "CC" a paralegal and legal assistant, respectively, incurred 4.4 hours at $170 an hour for "PJ" and .4 hours at $75 per hour for "CC." Neither Eric Croft, nor "PJ" or "CC" signed the affidavit or provided their own affidavits. (Affidavit of Services and Costs, December 28, 2018).

PRINCIPLES OF LAW

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

> **AS 23.30.010. Coverage.** (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for . . . medical treatment of an employee if the . . . employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the . . . need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the . . . need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the . . . need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the . . . 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 . . . need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.

If an accidental injury is connected with any incident of one's employment, then the injury both would "arise out of" and be "in the course of" employment. The "arising out of" and the "in the course of" tests should not be kept in separate compartments but should be merged into a single concept of "work connection." *Northern Corp. v. Saari*, 409 P.2d 845, 846 (Alaska 1966).

In 1 *Larson's Workers' Compensation Law*, at §10.01 (2014 Ed.), Professor Larson examines compensability of a "secondary injury":

> When the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury likewise arises out of the employment, unless it is the result of an independent intervening cause attributable to claimant's own intentional conduct.
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> . . . The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable injury.

> **AS 23.30.095. Medical treatments, services, and examinations.** (a) The employer shall furnish medical . . . treatment . . . medicine . . . 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.
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> . . . .

> (o) Notwithstanding (a) of this section, an employer is not liable for palliative care after the date of medical stability unless the palliative care is reasonable and necessary (1) to enable the employee to continue in the employee's employment at the time of treatment, (2) to enable the employee to continue to participate in an approved reemployment plan, or (3) to relieve chronic debilitating pain. A claim for palliative care is not valid and enforceable unless it is accompanied by a certification of the attending physician that the palliative care meets the requirements of this subsection. . . .

According to *Stedman's Medical Dictionary*, 28th Edition, (2006) at 1670, "relieve" means, "To free wholly or partly from pain or discomfort, either physical or mental."

Phillip Weidner & Assocs., Inc. v. Hibdon, 989 P.2d 727, 732 (Alaska 1999) addressed the issue of reasonableness of medical treatment:

> The question of reasonableness is 'a complex fact judgment involving a multitude of variables.' However, where the claimant presents credible, competent evidence from his or her treating physician that the treatment undergone or sought is reasonably effective and necessary for the process of recovery, and the evidence is corroborated by other medical experts, and the treatment falls within the realm of medically accepted options, it is generally considered reasonable. (Citations omitted).

> **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. . . .

This presumption applies to any claim for compensation under the Act. *Meek v. Unocal Corp.*, 914 P.2d 1276 (Alaska 1996). It specifically applies to continuing, palliative medical care. *Municipality of Anchorage v. Carter*, 818 P.2d 661 (Alaska 1991).

A three-step analysis determines claim compensability. First, the claimant need only adduce "some," "minimal" relevant evidence establishing a "preliminary link" between the injury claimed and employment. *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.,* 742 P.2d 239, 244 (Alaska 1987). In claims based on highly technical medical considerations, medical evidence is often necessary to make a connection. *Burgess Construction Co. v. Smallwood*, 623 P.2d 312 (Alaska 1981). In less complex cases, lay evidence may be enough to establish causation.

VECO, Inc. v. Wolfer, 693 P.2d 865 (Alaska 1985). If complications from the injury or treatment occur, subsequent treatment is compensable, and the employer is liable for continuing medical benefits. *Ribar v. H&S Earthmovers*, 618 P.2d 582 (Alaska 1980). Credibility is not weighed at this step. *Resler v. Universal Services Inc.*, 778 P.2d 1146 (Alaska 1989).

At the second step, the employer has the burden to overcome the presumption with substantial evidence. In *Huit v. Ashwater Burns, Inc.*, 372 P.3d 904 (Alaska 2016), the appeals commission had reversed the board's decision at the analysis' second stage and decided the employer had rebutted the presumption. The commission said "the presumption can be rebutted through . . . substantial evidence that work was not the substantial cause of the disability." The commission focused on SIME reports to find the employer rebutted the presumption and noted one physician could not say "there was a reasonable medical degree of probability that the scratch" alleged to have caused an infection in fact caused it even though the same physician admitted it was possible a scratch could have been the entry point for the infection. The commission also relied on another physician's opinion stating while it was medically reasonable that a scratch as the employee described it could cause his illness, it was "possible but again not probable" because no scratch had been documented in medical records three to four weeks after the event.

On appeal, the employee argued since there was no cause with which to compare the work-related scratch, the employer did not rebut the presumption because it could not rule work out as the cause for his infection, since all doctors agreed the scratch was a possible entry point for bacteria. The employer argued against this position citing the potential for an "irrebuttable presumption." It contended under "the substantial cause" analysis, to rebut the presumption it need only provide an expert opinion stating the scratch was not the substantial cause of the infection. Analyzing these contentions, the Alaska Supreme Court in *Huit* reviewed the pre-2005 presumption analysis and found an employer previously could rebut the presumption by presenting substantial evidence that either (1) provided an alternative explanation that would exclude work-related factors as a substantial cause of the disability, or (2) directly eliminated any reasonable possibility that employment was a factor in causing the disability. *Huit* further noted under current law the presumption may be rebutted "by a demonstration of substantial evidence that the . . . need for medical treatment did not arise out of and in the course of the employment."

Huit held in determining whether or not the need for medical treatment arose out of and in the course of employment, the factfinders in the third step must evaluate the relative contribution of different causes of the need for treatment.

Huit found since "no other cause was identified" as contributing to the employee's infection, the board did not need to evaluate the relative contribution of different causes in the third step. Nonetheless, the board still had to consider whether the employer had provided substantial evidence showing the disability or need for treatment did not arise out of and in the course of employment in the second step. After reviewing legislative history and distinguishing its prior cases, *Huit* concluded the old presumption analysis remains intact after 2005 changes to the Act.

Huit overruled the commission's interpretation of the current statute as abrogating the "negative-evidence" test from prior case law. It further held in cases where there is no "competing cause" for the disability or need for treatment, the standard for rebutting the presumption is unchanged from prior cases. Under the current statute, the employer could rebut the presumption by showing the worker's infection did not arise out of his employment. To show this, the employer needed to show the work-related scratch could not have caused the infection (the negative-evidence test) or show that another source of the bacteria caused the infection (the affirmative-evidence test). In *Huit*, the employer argued its experts gave opinions that work was probably not the substantial cause of the disability. *Huit* disagreed and said, "merely reciting the proper words as an opinion is not necessarily enough to rebut the presumption of compensability, because the employer must provide *substantial evidence* that the disability was not work-related" (emphasis in original). *Huit* concluded the employer did not meet the "negative-evidence test" because its doctors did not show that the work-related scratch could not have been the entry point for the bacteria that caused the infection. The experts agreed bacteria can enter the bloodstream through minor scratches like the one the employee described. Similarly, *Huit* determined the employer failed to meet the "affirmative-evidence test" because no expert provided substantial evidence of another cause for the bacteria in the injured worker's bloodstream.

Huit held the mere possibility of another injury as an infection source is not substantial evidence sufficient to overcome the presumption. It also stated an "unknown cause" for an infection is not

substantial evidence to rebut the presumption. Further, identifying other possible causes for an infection, without identifying the injured worker has any of those causes, is not substantial evidence rebutting the presumption.

"Substantial evidence" is such "relevant evidence" as a "reasonable mind might accept as adequate to support a conclusion." *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 611-12 (Alaska 1999). Whether the amount of evidence is substantial is a legal question. When medical evidence offered to rebut the presumption is uncertain or inconclusive, the presumption is not overcome. *Bouse v. Fireman's Fund Insurance Co.*, 932 P.2d 222 (Alaska 1997). At the second step, the employer's evidence is viewed in isolation and credibility and evidentiary weight are deferred. *Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051 (Alaska 1994).

In *Kessick v. Alyeska Pipeline Service Co.*, 617 P.2d 755 (Alaska 1980), the Alaska Supreme Court discussed objective medical evidence, and substantial evidence to support a board decision. Reversing the board's denial of benefits, *Kessick* said:

> Nor does the lack of objective signs of an injury in and of itself preclude the existence of such an injury. (Citation omitted). There are many types of injuries which are not readily disclosed by objective tests.
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> The Board's findings that Kessick's right knee jerk had returned and that there was no longer any atrophy in his right leg are also unpersuasive. Although these facts do indicate that Kessick was recovering, we believe that no reasonable person would infer that the effects of Kessick's injury had totally subsided, particularly in light of Dr. Lindig's testimony.
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> Finally, we believe that the Board's reliance on Dr. Mead's estimate of a six to nine recovery period is misplaced. First, we do not believe that a reasonable person would accept as conclusive a nine-month old prediction that recovery would take approximately six to nine months when a subsequent diagnosis indicates that the patient has not yet recovered. . . . (*Id*. at 758).

If the presumption is raised but not rebutted, the claimant prevails and need not produce further evidence. *Williams v. State*, 938 P.2d 1065 (Alaska 1997). In the third step, if the employer successfully rebuts the presumption, it drops out, and the employee must prove his case by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379. At this last step, evidence is weighed and credibility is considered. To prevail, the claimant must "induce a

belief" in the minds of the fact-finders the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71 (Alaska 1964).

> **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.

> **AS 23.30.155. Payment of compensation.** (a) Compensation under this chapter shall be paid periodically, promptly, and directly to the person entitled to it, without an award, except where liability to pay compensation is controverted by the employer. To controvert a claim, the employer must file a notice, on a form prescribed by the director, stating
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> . . . .
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> (5) the type of compensation and all grounds upon which the right to compensation is controverted.
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> (o) The director shall promptly notify the division of insurance if the board determines that the employer's insurer has frivolously or unfairly controverted compensation due under this chapter. After receiving notice from the director, the division of insurance shall determine if the insurer has committed an unfair claim settlement practice under AS 21.36.125.

In *Harp v. Arco Alaska, Inc.*, 831 P.2d 352, 358 (Alaska 1992) the Alaska Supreme Court held that an employer must have specific evidence for a "good faith controversion notice":

> A controversion notice must be filed in good faith to protect an employer from imposition of a penalty. . . . For a controversion notice to be filed in good faith, the employer must possess sufficient evidence in support of the controversion that, if the claimant does not introduce evidence in opposition to the controversion, the Board would find that the claimant is not entitled to benefits.

In *Harp*:

> The evidence which the employer possessed at the time of controversion was, at best, neutral evidence that Harp was not entitled to benefits. . . . The employer points out that when Dr. Berkeley examined Harp in December 1987, he was 'at a loss to understand what [was] going on and why she had recurrent symptoms.' This statement alone would not constitute substantial evidence that Harp is not entitled to benefits. . . .
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> Because neither reason given for the controversion was supported by sufficient evidence to warrant a Board decision that Harp is not entitled to benefits, the controversion was made in bad faith and was therefore invalid. . . . (*Id*. at 358-59).

In *Harris v. M-K Rivers*, 325 P.3d 510, 517 (Alaska, 2014), the Alaska Supreme Court said, "*Harp* does not require an inquiry into the motives of the controversion's author. We have never overruled *Harp*, and it is still the law." *Harris* further stated:

> When the Board finds that an employer has unfairly or frivolously controverted 'compensation due,' AS 23.30.155(o) says that the Director of the Division of Workers' Compensation must notify the Division of Insurance. In its regulations, the Board has interpreted 'compensation due' in AS 23.30.155(o) to mean 'the benefits sought by the employee, including . . . medical . . . benefits . . . whether paid or unpaid at the time the controversion was filed.' (Citation omitted). Although we do not decide here whether a controversion that is not made in good faith under *Harp* is always frivolous or unfair under AS 23.30.155(o), both the Board and the Commission linked the penalty provisions of AS 23.30.155(e)-(f) to the unfair or frivolous controversion provision of AS 23.30.155(o).

In *Runstrom v. Alaska Native Medical Center*, 280 P.3d 567, 575 (Alaska 2012), the Alaska Supreme Court reviewed an EME report, cited *Harp*'s rule and said:

> Runstrom argues that the employer's controversions were frivolous and unfair in large part because they were based on Dr. Goranson's reports, which she does not regard as substantial evidence. The employer counters that the Board's decision was correct because it could rely on Dr. Goranson's opinion to controvert Runstrom's care.
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> A controversion must be made in good faith in order for an employer to avoid a penalty: 'the employer must possess sufficient evidence in support of the controversion that, if the claimant does not introduce evidence in opposition to the controversion, the Board would find that the claimant [was] not entitled to benefits.' (Citing *Harp*). Whether the employer acted in good faith is a factual issue. (Citation omitted).

> Dr. Goranson's report met this standard. If Runstrom had introduced no evidence opposing the controversion, the Board could have found she was not entitled to benefits based on Dr. Goranson's report.

Runstrom found the EME doctor's report met the standard because he diagnosed the claimant with preexisting conditions that contributed to her need for medical treatment for anxiety. He conceded that for the first several weeks post-injury, the claimant's accident was the major contributing cause of her need for treatment but as time went on, non-work-related factors were "contributing to a more significant part of her ongoing symptoms and need for treatment," and work-related factors were no longer the main contributing cause. (*Id.* at 570).

In *State v. Ford*, AWCAC Decision No. 133 (April 9, 2010), at 11, the appeals commission set forth its two-step analysis to determine in a "fact-based" controversion case whether an employer frivolously or unfairly controverted compensation due:

> Thus, the board here was required to make a two-step analysis of the controversion before concluding that referral to the Division of Insurance or the Commissioner's designee was required under AS 23.30.155(o). First, examining the controversion, and the evidence on which it was based in isolation, without assessing credibility and drawing all reasonable inferences in favor of the controversion, the board must decide if the controversion is a 'good faith' controversion. Second, if the board concludes that the controversion is not a good faith controversion, the board must decide if it is a controversion that is frivolous or unfair. If the controversion lacks a plausible legal defense or lacks the evidence to support a fact-based controversion, it is frivolous; if it is the product of dishonesty, fraud, bias, or prejudice, it is unfair. But, to find that a frivolous controversion was issued in bad faith requires a third step -- a subjective inquiry in to the motives or belief of the controversion author.

> **AS 23.30.395. Definitions.** In this chapter,
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> . . . .
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> (3) 'attending physician' means one of the following designated by the employee under AS 23.30.095 (a) or (b):
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> . . . .
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> (D) a licensed physician assistant acting under supervision of a licensed medical doctor or doctor of osteopathy;
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> . . . .

(9) ‘chronic debilitating pain’ means pain that is more than six months duration and that is of sufficient severity that it significantly restricts the employee’s ability to perform the activities of daily living. . . .
. . . .

(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;

(29) ‘palliative care’ means medical care or treatment rendered to reduce or moderate temporarily the intensity of pain caused by an otherwise stable medical condition, but does not include those medical services rendered to diagnose, heal, or permanently alleviate or eliminate a medical condition;

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

(b) A fee under AS 23.30.145(a) will only be awarded to an attorney licensed to practice law in this or another state. An attorney seeking a fee from an employer for services performed on behalf of an applicant must apply to the board for approval of the fee; the attorney may submit an application for adjustment of claim or a petition. An attorney requesting a fee in excess of the statutory minimum in AS 23.30.145(a) must

(1) file an affidavit itemizing the hours expended, as well as the extent and character of the work performed, and

(2) if a hearing is scheduled, file the affidavit at least three working days before the hearing on the claim for which the services were rendered; at the hearing, the attorney may supplement the affidavit by testifying about the hours expended and the extent and character of the work performed after the affidavit was filed.

If the request and affidavit are not in accordance with this subsection, the board will deny the request for a fee in excess of the statutory minimum fee, and will award the minimum statutory fee.
. . . .

(f) The board will award an applicant the necessary and reasonable costs relating to the preparation and presentation of the issues upon which the applicant prevailed at the hearing on the claim. The applicant must file a statement listing each cost claimed, and must file an affidavit stating that the costs are correct and

> that the costs were incurred in connection with the claim. The following costs will, in the board's discretion, be awarded to an applicant:
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> (14) fees for the services of a paralegal or law clerk, but only if the paralegal or law clerk
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> (A) is employed by an attorney licensed in this or another state;
> (B) performed the work under the supervision of a licensed attorney;
> (C) performed work that is not clerical in nature;
> (D) files an affidavit itemizing the services performed and the time spent in performing each service; and
> (E) does not duplicate work for which an attorney's fee was awarded. . . .
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> **8 AAC 45.182. Controversion**. . . .
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> (d) After hearing a party’s claim alleging an insurer or self-insured employer frivolously or unfairly controverted compensation due, the board will file a decision and order determining whether an insurer or self-insured employer frivolously or unfairly controverted compensation due. Under this subsection,
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> (1) if the board determines an insurer frivolously or unfairly controverted compensation due, the board will provide a copy of the decision and order at the time of filing to the director for action under AS 23.30.155(o); . . .
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> (e) For purposes of this section, the term ‘compensation due,’ and for purposes of AS 23.30.155(o), the term compensation due under this chapter,’ are terms that mean the benefits sought by the employee, including but not limited to disability, medical, and reemployment benefits, and whether paid or unpaid at the time the controversion was filed.

ANALYSIS

1) Does Employer’s EME evidence rebut the raised presumption of compensability?

Employee contends Employer’s EME does not rebut the raised presumption and he should, therefore, prevail on his claim for continuing medical care on the raised but unrebutted presumption. AS 23.30.120(a)(1); *Williams*. Employer contends Dr. Chong’s EME report and his deposition “easily” rebut the presumption. Employer does not contend Employee failed to raise the statutory presumption of compensability and both parties seem to agree the presumption is raised. Thus, this decision turns directly to the presumption analysis’ second step.

The Alaska Supreme Court in *Huit* held the pre-2005 presumption analysis still applies to cases arising under current law. Applying *Huit* to the medical treatment issue in this case, in the second stage of the presumption analysis, Employer must provide "substantial evidence" showing the need for medical treatment is not work-related. *Koons*. *Huit* said the "negative-evidence" and "affirmative-evidence" tests still apply and Employer must meet one or the other test to rebut the raised presumption. In this case, the "negative-evidence" test requires Employer to provide substantial evidence in a medical opinion showing the need for treatment "did not arise out of or in the course of the employment." AS 23.30.010(a). Because this case involves continuing medical care, Employer must show the work injury can no longer be a cause of the need for medical care. *Huit*. To meet the "affirmative-evidence" standard, Employer needs to provide substantial evidence ruling out the injury as a cause for continuing medical treatment by identifying another explanation for the need for care that excludes the work injury. *Id*.

Employer's defense to Employee's presumption contention relies solely on Dr. Chong's written report and on his deposition testimony. Dr. Chong's report and his testimony are similar in many ways to the physicians' opinions analyzed in *Huit*, discussed in detail below.

(a) Dr. Chong's EME report does not rebut the presumption.

Dr. Chong said Employee's symptoms "cannot be explained by an uncomplicated, technically successful C6-7 disc arthroplasty." He never said Employee has no symptoms, is lying, malingering or is in any way exaggerating his symptoms. On this "causation" issue, when expressly asked to identify "all causes" (emphasis in original) of Employee's need for treatment, Dr. Chong listed no causes and instead said no "anatomical or physiological cause" explains Employee's symptoms. This statement implies Dr. Chong concedes Employee has symptoms. It also suggests Dr. Chong simply has no explanation for what is causing them.

Still on the "causation" issue, when asked to determine the relative contribution of different causes and pick which identified cause is "the substantial cause" of Employee's ongoing need for treatment, Dr. Chong again identified no causes but opined the work injury has not been the substantial cause for any medical treatment since 2013 when Employee had a cervical disc arthroplasty. On the "continuing treatment" issue, he recommended no further prescription

medication because Employee's chronic opiate use had not resulted in any functional improvement in his opinion and he found no need for the other medications. When given the definition of "palliative care," Dr. Chong opined Employee's opioid therapy was not palliative because it did not result in a return to employment and, based on CDC "domains," because it also did not result in improvement of function, it "has not been beneficial for debilitating pain."

While factfinders cannot weigh evidence at the presumption analysis' second stage, the evidence offered to rebut the raised presumption must nevertheless still be "substantial evidence." *Resler*; *Norcon, Inc*. Whether evidence is "substantial" is a legal question. *Bouse*. Contrary to Employer's contention, to be substantial evidence "a report that supports a controversion" requires more than a physician "merely reciting the proper words" in a conclusory way. "Substantial evidence" is relevant evidence a reasonable mind might find adequate to support a conclusion. *Tolbert*; *Huit*. Dr. Chong's EME report fails in this regard for two reasons:

First, addressing "causation," he identified no cause for Employee's symptoms while at the same time not disputing he has them. His inability to set forth any explanation for Employee's symptoms, much less an alternative one, is the same as stating he has no idea why Employee has symptoms. If Dr. Chong does not know what causes Employee's undisputed symptoms, the cause is unknown and his conclusory statement that the work injury has not been the substantial cause for the need to treat those symptoms since 2013 rings hollow. Much like the physicians in *Huit*, if a physician says the cause for the need for treatment is "unknown," or as in *Harp* when a physician is "at a loss" to explain why the injured worker has continuing symptoms, a physician cannot also state the work injury is not the substantial cause. Such a statement is not "substantial evidence" to rebut the raised presumption. *Huit*; *Harp*.

Second, addressing "treatment," Dr. Chong's report fails to apply the correct legal test for "palliative care." The Act defines "palliative care" as care or treatment rendered to reduce or moderate temporarily pain caused by an otherwise stable medical condition. AS 23.30.395(29). The Act sets goals for Employer's liability for palliative care. The care must be reasonable and necessary to (1) enable Employee to continue employment; (2) enable him to participate in a reemployment plan, or (3) relieve his chronic debilitating pain. AS 23.30.095(o). Since

Employee is not working or retraining, the first two goals do not apply. However, the third "relieve chronic debilitating pain" goal does apply. When speaking to these three possible goals to justify palliative care, Dr. Chong addresses (1), which is irrelevant here, does not address (2), which is also irrelevant, and attempts but fails to address (3). Rather than apply Alaska law to (3), Dr. Chong concludes that because in his view based on CDC "domains" prescription medications did not result in functional improvement, they have not been helpful for debilitating pain. He combines goal (2) and (3) and improperly treats them as one. The Act does not require relief of "chronic debilitating pain" to be demonstrated by increased function and does not use the CDC "domains" to which he refers. AS 23.30.095(o). Therefore, Dr. Chong's opinion on (3) is irrelevant because it does not address the correct legal test. "Substantial evidence" must be "relevant evidence" upon which a reasonable mind might rely to support a conclusion. Because this opinion is irrelevant, it cannot be substantial evidence to rebut the presumption. *Huit*.

In summary, on "causation" Dr. Chong's report does not provide "substantial evidence" adequate to rebut the raised presumption because, like the physicians in *Huit*, Dr. Chong identified no other cause, and in fact said there was no cause, for Employee's symptoms without disputed he has them. Given that opinion, Dr. Chong "merely reciting the proper words" and stating the work injury has not been the substantial cause for any medical treatment since 2013 "as an opinion is not necessarily enough to rebut the presumption of compensability." *Huit*. Stated differently, a reasonable person would not rely on Dr. Chong's internally inconsistent opinion because as a matter of law it is not "substantial evidence." *Bouse*. As was true with physicians' opinions in *Huit*, Dr. Chong's report did not meet the negative-evidence test because it does not demonstrate with "substantial evidence" that the work injury did not cause Employee's ongoing need for medical care. "No cause" for Employee's undisputed symptoms, like an "unknown cause," is not substantial evidence to rebut the presumption. Dr. Chong's report did not meet the affirmative-evidence test because he offered no substantial evidence of an alternative cause requiring Employee to continue with medical care to address his symptoms. On the "treatment" issue, Dr. Chong's report applies incorrect factors to AS 23.30.095(o)(3) in the palliative care analysis so his opinion on that point is irrelevant and thus also not substantial evidence adequate to rebut the presumption as a matter of law. *Huit*.

(b) Dr. Chong's deposition does not rebut the presumption.

In addition to Dr. Chong's report, Employer relies on his deposition. In it, Dr. Chong reiterates his opinions set forth in his written report. To that extent, Dr. Chong's deposition also fails to rebut the raised presumption for the reasons addressed above. Furthermore, Dr. Chong again fails to opine that Employee has no symptoms. He disagrees with a prior EME's opinion concerning cervical dystonia, which could account for his symptoms, and suggests if Employee still has this diagnosis "it would be from some other reason, but not from trauma." As in *Huit*, the mere possibility of another injury or reason requiring treatment is not substantial evidence sufficient to overcome the presumption.

Since Dr. Chong did not say Employee does not have symptoms, and implicitly concedes he does, nothing in his testimony rebuts the presumption that Employee has pain as he states. He admits Employee's function improves while he is taking prescription medication. More importantly, Dr. Chong's testimony weakens his causation opinion because he admits he is not a surgeon and when asked if disc replacement surgery can cause pain, affirmatively testified he does not "have any opinion about that because I'm not versed in the surgical technique of disc replacement." Nevertheless, he testified the work injury has not been the substantial cause of Employee's pain and thus his need for treatment since 2013. This internally inconsistent testimony is not substantial evidence adequate to rebut the presumption because no reasonable person would rely on it. *Bouse*. Furthermore, in discussing Employee's disequilibrium, Dr. Chong suggests two medical conditions could cause Employee's occasional instability. However, he does not say Employee has these conditions. Pointing to possible causes of disequilibrium without opining Employee has these conditions is not substantial evidence to rebut the presumption. *Huit*.

On the "treatment" issue, Dr. Chong disapproved various modalities, all but one of which are irrelevant because Employee is only seeking prescription medications. Dr. Chong relies on CDC standards and substitutes his understanding of those recommendations for the Act's requirement that palliative care simply "relieve chronic debilitating pain." He applies three CDC "domains" to assess whether opioid medication was reducing or moderating temporarily Employee's pain. The Act does not apply CDC domains and simply states to be compensable, the palliative care

must only be found to "relieve chronic debilitating pain." AS 23.30.095(o)(3); AS 23.30.395(9). "Relieve" means to free, in whole or part, from pain or discomfort. *Stedman's* at 1670. Without his inappropriate opinion in reliance on CDC "domains," which is irrelevant, nothing in Dr. Chong's testimony amounts to "substantial evidence" stating Employee does not have pain and his medications are ineffective in relieving it to some extent. Based on the above analysis, neither Dr. Chong's report nor his deposition testimony is substantial evidence adequate to rebut the presumption and Employee prevails on his claim for continued prescription medications and related doctor appointments on the raised but unrebutted presumption. *Huit*; *Williams*.

(c) Alternately, Employee also prevails under the full presumption analysis.

This decision also applies an alternative approach as if Dr. Chong's evidence rebutted the presumption. The presumption applies to all claims, including palliative medical treatment. *Meek*; *Carter*. Employee's testimony and his pre- and post-surgery medical records raise the presumption regarding both "causation" and "continuing treatment." *Cheeks*. Contrary to Employer's assertion, this is not a "medically complex case." *Smallwood*. Employee's lay testimony alone is enough to raise the presumption. *Wolfer*. Employee reported to his physicians and testified he had neck and head pain since his work injury and has had somewhat different pain since his 2013 arthroplasty. Several doctors saw and charted cervical muscle spasms. Some prescription medications relieve his pain while others address side effects from the pain relievers. These are simple concepts. Though arthroplasty may be a medically complex procedure, Employee's pain is not medically complex. Everyone at some point has felt pain. *Rogers & Babler*. Employee has an undisputed and accepted work injury and had a significant surgical procedure done to his neck. Without pinpointing the actual source of his pain, Employee recognizes pain comes from his neck and head area, the area he injured at work. His pre-surgery symptoms have changed somewhat but have continued post-surgery. This "minimal" evidence raises the presumption. *Cheeks*. The burden shifts to Employer to rebut the presumption with substantial evidence.

Assuming for this analysis only that Dr. Chong's EME report or his deposition testimony rebuts the presumption, the burden shifts to Employee to prove his claim by a preponderance of the evidence. *Saxton*. There is no evidence of any significant preexisting neck or head pain. On the

"causation" issue, Employee's testimony that he has had neck and head pain continuously since his injury and following the surgery is credible. AS 23.30.122. Whether the pain emanates from nerves, tissues or structures injured by the original work injury or by an undetected problem with the cervical arthroplasty is immaterial. All injuries and "secondary injuries" are covered under the Act. *Ribar*; *1 Larson's*. It is not unusual for patients to have continuing pain following "successful" spinal surgeries. *Rogers & Babler*. Referring to this case, Dr. Kropp said it is "very common after disc replacement" for a patient to have neck pain.

As part of his surgery, Dr. Kralick decompressed Employee's nerves at C6-7. Dr. Mason then diagnosed post-surgical cervical radiculopathy. Nearly a year post-surgery, Dr. Kralick found Employee still had neck pain and numbness in his left hand and had left upper extremity weakness. Dr. Kussro found post-surgery evidence of C6-7 radiculopathy. In May 2014, Dr. Brett opined Employee has "chronic nerve root injury from the original work exposure." He found paracervical spasms, left arm weakness and numbness and paresthesia in the forearm and concluded Employee is likely "suffering from permanent nerve damage with chronic pain for which we have no surgical remedy." In June 2014, Dr. Grissom diagnosed cervical radiculopathy. In August 2014, Dr. Peterson diagnosed chronic cervical spine pain and postsurgical pain syndrome with previous disc replacement at C6-7. In September 2014, Dr. Peterson opined Employee's care was for "palliative pain management." By February 2015, Dr. Perkins found Employee had limited neck motion, neck pain and observable muscle spasms. The same month Dr. Peterson said Employee "likely has mechanical or structural defect associated with previous disc replacement surgery" and has resultant "chronic pain." Dr. Perkins said in May 2015 Employee should continue in pain management for chronic pain. No physician suggested Employee was faking his symptoms. No non-work-related alternative cause is suggested for Employee's chronic pain. This credible evidence all points to Employee's work injury, or his arthroplasty to treat it, as the substantial cause of his need for continuing doctor visits so he can obtain prescriptions. AS 23.30.122. His need for continuing treatment therefore still arises out of and in the course of his employment. *Saari*.

PA-C Kile agrees Employee's 2013 surgery remains the substantial cause of his need for continuing medications. Kile is a licensed physician's assistant and thus an "attending

physician." AS 23.30.395(3)(D). Neither Employee nor Kile need to describe precisely how or why Employee's head or neck injury or related surgery continues to cause him pain. Complications from an injury or from treatment for the injury, including pain as Dr. Kropp stated, remain compensable. *Ribar; 1 Larson's*. Therefore, the fact PA-C Kile inaccurately described Employee's surgery as a fusion and arthroplasty rather than just an arthroplasty is immaterial -- Employee had the surgery to address his work injury. Simply put, there is no substantial evidence in the record suggesting any alternative explanation for Employee's continuing symptoms other than his work injury or the surgery performed to treat it.

Dr. Chong's report and deposition testimony do nothing to clarify causation for Employee's continuing disequilibrium, head, left arm and neck symptoms post-surgery. He says there is no cause for Employee's pain but he never opines Employee has no pain. His opinion makes it impossible to evaluate the relative contribution of different causes of the need for medical treatment, since according to Dr. Chong, there is no cause. AS 23.30.010(a). Since there is no cause for the symptoms, he offers no cause with which to compare the work injury. *Huit*.

Dr. Chong admits he is not a surgeon and is unfamiliar with arthroplasty surgical techniques and expressly said he has no opinion on whether a cervical arthroplasty could cause post-surgical pain. Nevertheless, Dr. Chong concludes the work injury has not been the substantial cause of Employee's need for medical treatment since 2013. He could find no objective explanation for Employee's continued disequilibrium, cervical, left arm and head symptoms, because the arthroplasty was "technically successful." But the Alaska Supreme Court has held the lack of objective signs of an injury does not preclude its existence because there are many injuries which are not readily disclosed by objective tests. *Kessick*. As Dr. Chong conceded, "any surgery . . . can possibly result in any complications." But he opines this surgery did not cause pain or other symptoms as a post-surgery complication apparently only because he cannot pinpoint the cause. Dr. Chong admitted there "is no machine that tells the truth about pain" and no way to objectively measure Employee's subjective pain. "So pain cannot be seen or shown." Given this testimony, it is difficult to accept Dr. Chong's causation opinions as credible because they are simply conclusory and he offers no alternative explanation for Employee's undisputed symptoms. Further, though Dr. Chong applied, albeit incorrectly, CDC "domains" to derive his

continued medical treatment opinion, his report never mentions activities of daily living upon which the CDC domains are reportedly based and cannot recall discussing them with Employee. Given this analysis, Dr. Chong's opinion is not credible and is given no weight. AS 23.30.122. Employee prevails on the entire presumption analysis as well.

2) Is Employee entitled to palliative medical care?

Although Employee prevails on the general "causation" and "treatment" issues on the raised but unrebutted presumption, and on the complete presumption analysis, the medical care he seeks must still be "reasonable and necessary." AS 23.30.095(o); *Hibdon*. The only treatment Employee currently claims includes continued doctor visits for prescription medications, and the medicine itself, to address his symptoms and the side effects arising from painkillers. He seeks medical care to reduce or moderate temporarily his pain caused by a stable medical condition. In other words, he seeks "palliative care." AS 23.30.395(9), (28), (29).

The Act relevant to this issue says Employer is not liable for palliative care after medical stability unless the care is "reasonable and necessary" to (3) "relieve chronic debilitating pain." AS 23.30.095(o)(3). Numerous physicians including Drs. Goler, Stump, Kralick, Gevaert and Peterson agree Employee is medically stable. These opinions on this issue are given considerable weight. AS 23.30.122. He is medically stable. AS 23.30.395(28). Employee's medical records and testimony present compelling evidence showing he has "chronic debilitating pain." AS 23.30.095(o)(3). Several physicians recommend continued palliative treatment.

The Alaska Supreme Court said "reasonableness" is a complex factual judgment involving multiple variables. However, where an injured worker presents credible, competent evidence from a treating physician that the treatment sought is reasonably effective and necessary for recovery and this evidence is corroborated by other medical experts, and the treatment falls within the realm of medically accepted options, it is generally considered reasonable. *Hibdon*.

Dr. Chong agreed Employee takes opiates for "nonmalignant, chronic pain." He implies opioid management for chronic pain is within the realm of medically acceptable options so long as (1) there is a clear benefit to function, (2) the dosages are low and (3) opioid use is monitored

carefully. These assertions are examined in order: (1) Dr. Chong's opinion that Employee's medication does him no good is based upon a mistaken impression that it does not improve Employee's function. Dr. Chong in his deposition conceded Employee said he had functional improvement while he was taking medication. Employee's credible testimony shows he benefits functionally from opioid medications. AS 23.30.122. (2) "Low" is a relative term and there is no evidence Employee's opioid dosages are not "low." *Rogers & Babler*. (3) There is no evidence Employee's doctors fail to carefully monitor his opioid usage. *Saxton*.

The law defines "chronic debilitating pain" as pain for more than six months duration and of sufficient severity that it significantly restricts Employee's ability to perform activities of daily living. AS 23.30.395(9). It is undisputed Employee has not worked since his 2013 arthroplasty. He credibly testified pain following surgery is the reason he quit his most recent job because he could no longer continue working. Employee further convincingly said his pain causes sleep loss. Without medication he cannot clean his house, do dishes, garden, dress himself without some assistance, get out of his recliner, walk without some assistance, or help his father-in-law diagnose and repair problems with his motorhome. AS 23.30.122. This has continued since 2013, well in excess of six months duration. Employee successfully demonstrated his work-related pain is of sufficient severity that it significantly restricts his ability to perform activities of daily living. AS 23.30.395(9). His "attending physician" PA-C Kile provided a certification stating "palliative care IS reasonable and necessary to relieve chronic pain caused by the work injury." AS. 23.30.095(o); AS 23.30.395(3)(D)..

Dr. Chong "absolutely" disagrees with PA-C Kile that prescription medication has made any functional improvement in Employee's life. Therefore, he states it is not reasonable or necessary for Employee to continue to use these medications. He necessarily also disagrees with Employee, who should know whether or not he functions better while taking his medications. Dr. Chong bases his functionality opinion primarily on observing Employee during his examination when Employee, after sitting in a car for six hours prior to the EME, required assistance from his wife in robing. Dr. Chong uses CDC "domains" to determine if prescription medication has been effective in temporarily relieving Employee's "chronic debilitating pain"

and concludes it does not. But the Act does not adopt CDC "domains" to resolve this question. Thus, Dr. Chong's opinion is given no weight. AS 23.30.122.

Dr. Chong found no muscle spasms or "evidence of inflammation" on the day he saw Employee. Consequently, he concluded Employee does not need Baclofen for spasms or Celebrex for inflammation and, since he also did not need opiates, Employee has no need for hydroxyzine for nausea, or for an anti-constipation drug. However, Dr. Chong does not say Employee never has cervical spasms, and he fails to state what factors led to his conclusion Employee had no inflammation or other symptom justifying Celebrex. His opinions are given little weight. AS 23.30.122. By contrast, numerous physicians including Drs. Fechtel, Brett and Perkins charted observable muscle spasms pre- and post-surgery. Notwithstanding Dr. Chong's contrary opinion, Dr. Kropp said post-operative facet pain is "very common after disc replacement." These medical opinions are given considerable weight. AS 23.30.122. Furthermore, Dr. Chong admitted, based on the proper definition of palliative care in Alaska law and assuming Employee was taking his prescription medication, Employee could perform some activities of daily living while taking his pain medicine. This testimony contradicts his own conclusion. He also concedes there is no way to prove or disprove pain. Weighing all this evidence, Employee prevails on this alternative presumption analysis as well. *Saxton*.

3) Did Employer frivolously or unfairly controvert Employee's right to benefits or his claims?

Benefits under the Act must be paid or controverted. AS 23.30.155(a). Employee claims Employer frivolously or unfairly controverted compensation due under the Act. AS 23.30.155(o). He seeks a referral to the Division of Insurance. *Ford*. The relevant facts on this issue are the evidence upon which Employer relied to controvert. Employer controverted Employee's right to benefits on April 26, 2018, and controverted his claims for benefits on June 22 and July 2, 2018. Employer based all controversions solely on Dr. Chong's EME report. Therefore, the focus of this issue is on Dr. Chong's March 22, 2018 report.

The Alaska Supreme Court has not yet addressed this issue directly, but hinted at a procedure using the *Harp* penalty analysis to determine the frivolous and unfair controversion issue. *Harp*;

Harris. However, the commission in *Ford* set forth a two-step analysis for determining whether an employer has frivolously or unfairly controverted: (a) was the controversion a "good faith" controversion; and (b) if not, was it a frivolous or unfair controversion?

(a) The controversions were not "good faith controversions."

In this step, the relevant controversion notices are examined in isolation along with the evidence on which they were based. Credibility is not assessed at this step and all reasonable inferences are drawn in favor of the controversion. *Ford*. The controversion notices are clear on their face and require no inferences. All three controversions at issue denied Employee's right to and claims for continuing medical benefits based solely on Dr. Chong's EME report.

Harp and *Huit* are used to determine if the controversions were "good faith" controversions. *Runstrom*. Under *Harp* and *Huit*, a good faith controversion notice is one that demonstrates with "substantial evidence that the . . . need for medical treatment did not arise out of and in the course of the employment." The evidence upon which Employer relied to controvert Employee's right to and claims for medical care needed to show that the work injury could not have caused his need for treatment or that another non-work-related cause is what required the continuing care. The quantum of evidence upon which the controversion notices were based had to be "substantial evidence" and not just "merely reciting the proper words." *Bouse*; *Huit*.

Viewed in isolation and without considering weight or credibility, Dr. Chong's report does not meet the negative-evidence test because his conclusory statement that the work injury has not been the substantial cause of the need for treatment since 2013 is not supported by "substantial evidence" in his report. To summarize and incorporate here by reference the lengthy analyses above, it does not meet the affirmative-evidence test because Dr. Chong's report does not offer an alternative explanation that excludes work as a cause of Employee's need for continuing treatment, and in fact says there is "no cause." He never says Employee has no symptoms. *Huit*. Under *Harp*, to be a "good-faith controversion" Dr. Chong's report had to present a sufficient quantum of evidence in support of the controversion that, if Employee did not introduce evidence in opposition to the controversion, factfinders would find Employee was not entitled to benefits. Given all the above analyses, if Dr. Chong's report was the only evidence reviewed, it

would not rebut the raised presumption of compensability, and therefore a factfinder could not rely upon it to declare Employee was not entitled to benefits. Therefore, these three controversion notices were not "good faith controversions." *Harp*.

(b) The controversions were frivolous.

Having found these were not good faith controversions, in the second step, the relevant controversion notices are reviewed to determine if they were frivolous or unfair. *Ford*. Employee does not contend the controversion notices were "the product of dishonesty, fraud, bias, or prejudice." Therefore, whether or not they were "unfair" is not at issue. However, if the controversions lacked "a plausible legal defense" or lacked "the evidence to support a fact-based controversion," they were "frivolous." *Id*. Here, the three relevant controversion notices were "fact-based," meaning Employer denied Employee's right to and claims for continuing medical benefits not based upon a statutory or legal defense, but based solely on Dr. Chong's medical opinions. As discussed in detail in the above analyses, the controversion notices lacked the evidence necessary to support a "fact-based controversion." Dr. Chong in his report did not deny Employee had the symptoms for which he was receiving prescription medication, said there was "no cause" for his symptoms and yet opined the work injury has not been the substantial cause of Employee's need for medical care since 2013. A reasonable person would not rely upon this internally inconsistent opinion as "substantial evidence" to rebut the raised presumption, benefits would not be denied based solely on this report, and therefore, the controversion notices relying upon it were "frivolous." *Huit*; *Harp*; *Ford*.

AS 23.30.155(o) only requires a finding Employer "frivolously or unfairly controverted" compensation due. Employer frivolously controverted benefits Employee sought. 8 AAC 45.182(e). It is irrelevant if these frivolous controversions were "issued in bad faith" and this decision need not go to the third step, a subjective inquiry in to the motives or belief of the controversion's author. *Ford*. Employee's request for a finding that Employer frivolously controverted compensation due will be granted. This decision will be sent to the director with a request that he notify the Division of Insurance. AS 23.30.155(o); 8 AAC 45.182(d)(1).

4) Is Employee entitled to attorney fees and costs?

Employer raised only a general objection to attorney fees and costs based on its contention Employee should not prevail. It offered no objections to his hourly rate or to the amounts billed. In his December 28, 2018 affidavit, attorney JC Croft said he incurred 43.5 hours of his attorney time at $225 (a typographical error says $200) per hour totaling $9,787.50. He also adds .10 hours for attorney Eric Croft at $400 per hour totaling $40. His affidavit includes paralegal costs for “PJ” at 4.4 hours billed at $170 per hour totaling $748 and for “CC” for 4.4 hours at $75 per hour totaling $30. JC Croft is the only person signing the affidavit as an affiant.

Employee prevails on all issues raised at hearing. Employer controverted his claims and a fee is awardable under AS 23.30.145(a). Continuing prescription medication is a substantial benefit to Employee who functions better when he has access to these medicines. *Rogers & Babler*. Employee’s attorney’s fees are modest at $225 per hour and the hours billed are commensurate with the work he performed. Therefore, this decision will award Employee $9,787.50 in actual attorney fees for JC Croft’s services. Since the regulation is unclear on whether or not each attorney must file an individual affidavit, this decision will award an additional $40 for Eric Croft’s attorney’s fees. 8 AAC 45.182(d)(1). The total attorney fee award will be $9,827.50. However, paralegal fees are “costs” pursuant to 8 AAC 45.180(f). Consequently, paralegals must file separate affidavits itemizing his or her services performed and the time spent in performing each service. 8 AAC 45.180(f)(14)(D). Neither “PJ” nor “CC” filed an affidavit affirming they provided the services listed in JC Croft’s affidavit. Therefore, $778 ($748 + $30 = $778) will be deducted from the $1,770.59 in litigation costs, and this decision will award Employee $992.59 in litigation costs.

CONCLUSIONS OF LAW

1) Employer’s EME evidence does not rebut the raised presumption of compensability.
2) Employee is entitled to palliative medical care.
3) Employer frivolously controverted Employee’s right to benefits and his claims.
4) Employee is entitled to attorney fees and costs.

ORDER

1) Employer is ordered to pay for Employee's prescription medications for his work injury in accordance with this decision and pursuant to the Act and applicable regulations.

2) Employee's request for an order finding Employer frivolously controverted his right to benefits and his claims is granted.

3) A copy of this decision and order will be sent to the director of the Workers' Compensation Division with a request that he forward it to the director of the Division of Insurance for further action under AS 23.30.155(o).

4) Employee's request for attorney fees and costs is granted. Employer shall pay Employee's attorney $9,827.50 in attorney fees and $992.59 in litigation costs.

Dated in Anchorage, Alaska on February 15, 2019.

ALASKA WORKERS' COMPENSATION BOARD

/s/
William Soule, Designated Chair

/s/
Justin Mack, Member

DAVE KESTER, MEMBER, DISSENTING

The dissent respectfully disagrees with the majority's opinion on all points. Dr. Chong's EME report, echoed by his succinct and detailed deposition testimony, clearly and unequivocally rebuts the raised presumption. *Koons*. Specifically, in his report Dr. Chong stated Employee's subjective pain complaints "cannot be explained by an uncomplicated, technically successful C6-7 disc arthroplasty." He further explained, "There is no anatomical or physiological cause to explain Mr. Nielsen's current constellation of disparate symptoms to result in disability." Dr. Chong stated unequivocally, "The industrial event of 2008 has not been the substantial cause for need for treatment since 2013. . . ." (Emphasis in original). He stated, "No further treatment is recommended. Specifically, the use of chronic opiate therapy has not resulted in any functional improvement. This should therefore be discontinued. There is no evidence of inflammation for use of Celebrex. There is no evidence of spasticity for us of Baclofen. Therefore, there would not be need for hydroxyzine for nausea or an anti-constipation drug." Lastly, in his report Dr. Chong said, "Ongoing medical treatment is not palliative, in that it has not resulted in return to employment. It has not resulted in improvement of function, and therefore it has not been beneficial for debilitating pain." In the dissent's view, those statements alone are adequate to rebut the raised presumption of compensability. *Tolbert*.

Furthermore, in his deposition Dr. Chong stated Employee takes medication including opiates for nonmalignant, chronic pain. He testified the CDC does not recommend opioid for long-term usage "unless there is clear benefit with regards to function, that the dosage is smaller low dose, and that there is very careful monitoring of this use." Dr. Chong opined Employee has "absolutely not" had clear benefit in his function from taking prescribed opioid medications. He based this opinion on his observations during his physical examination where Employee's wife

assisted in dressing his upper and lower body. Employee also used a walking stick, and cannot perform activities of daily living and does not participate in employment. He recommended no further treatment because Employee had the gold-standard cervical treatment when he had his disc replaced, and all subsequent medical care did not solve his symptoms, proving they were not coming from his neck. Dr. Chong said, "There is no focal, meaning no anatomical location that can explain his diffuse complaints." He completely disagrees with PA-C Kile's opinion regarding palliative care because the only objective measure of success are activities of daily living, instrumental activities of daily living and vocational and avocational functional activities. In his view, none of these domains were affected by Employee's medications or other treatments. Opioids were not reducing or moderating temporarily Employee's pain intensity because pain is a subjective descriptor not recognized by the CDC. He clearly testified that the only way to document improvement in function is by reviewing the three domains he mentioned. Therefore, in the dissent's opinion, this testimony further rebuts the raised presumption and shifts the burden of production and persuasion to Employee. *Tolbert*; *Koons*.

The dissent also disagrees with the majority in the third stage of the presumption analysis. The dissent would give PA-C Kile's responses from his deposition less weight, especially since he did not recall any specific treatment he performed on Employee, appeared to have not reviewed any files prior to his deposition and only referred to a treatment outline. He misunderstood the surgery Employee had and believed he had a fusion and a disc replacement surgery, which is incorrect. He could not recall the mechanism of injury nor recall what medications Employee was taking. AS 23.30.122. Weighing the evidence and credibility at the third stage of the presumption analysis, the dissent would give far greater weight to Dr. Chong's expert medical opinion. He was much more aware of Employee's medical history, condition and treatment. In Dr. Chong's EME report and deposition, he consistently identifies objective medical evidence to support his conclusions. In his deposition, Dr. Chong stated, "There is no medical explanation, meaning an anatomical or physiological explanation for this widespread despair of pain complaints. It especially does not originate from the neck." Regarding his diffused pain complaints, Dr. Chong stated, "there is no physiological explanation for this diffused pain complaints." He explained all the medical treatment Employee has had since 2013 has not relieved his symptoms, and Employee had all the medical care he needs for this injury, including

the "gold standard" treatment, and needs no more. AS 23.30.122. Based on this and what has been stated before, Employee failed to prove his claim by a preponderance of evidence. *Saxton*.

On the third issue, the frivolous or unfair controversion contention, the dissent necessarily disagrees with the majority because the dissent would find Dr. Chong's initial report adequate to support the April 26, 2018 controversion. *Huit*; *Harp*.

Because the dissent would find Employee not entitled to any additional medical care for his work injury, it would similarly find Employee is not entitled to an associated award of attorney fees and costs. The dissent would deny Employee's claim in all respects.

/s/
Dave Kester, 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 Theodore M. Nielsen, employee / claimant v. Alaska Teamster Local 959 Training Trust, employer; Commerce And Industry Insurance Company, insurer / defendants; Case No. 200804795; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on February 15, 2019.

/s/
Charlotte Corriveau, Office Assistant