ALASKA WORKERS' COMPENSATION BOARD

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

GARY R. DAVIS, Employee, Claimant, v. WRANGELL FOREST PRODUCTS, Employer, and WAUSAU UNDERWRITERS INSURANCE COMPANY, Insurer, Defendants.	)	FINAL DECISION AND ORDER AWCB Case No. 198803834 AWCB Decision No. 19-0121 Filed with AWCB Juneau, Alaska on November 21, 2019

Gary R. Davis' (Employee) August 7, 2013 and July 10, 2019 claims were heard on October 8, 2019 in Juneau, Alaska, a date selected on April 18, 2019. A March 22, 2019 affidavit of readiness for hearing (ARH) gave rise to this hearing. Employee appeared telephonically, represented himself and testified. Attorney Martha Tansik appeared and represented Wrangell Forest Products and its insurer (Employer). As a preliminary issue, Employer objected to consideration of several medical records and an oral order was issued. This decision examines the oral order and Employee's claims. The record closed on October 22, 2019, to provide Employee the opportunity to file a cost affidavit and for Employer to file a response.

ISSUES

As a preliminary issue, Employer contended medical records from Brent Adcox, M.D., and Kristen Jessen, M.D., were not admissible as a business record over its objection because they

were hearsay and prepared for litigation as they were prompted by a letter from counsel. It contended the records should not be considered.

Employee contended the medical reports were admissible because they are medical records and should be considered. An oral order denied Employer's request to exclude the medical records.

1) Was the oral order denying Employer's request to exclude medical records from Drs. Adcox and Jessen correct?

Employee contends the work injury is a substantial factor in his need for left knee medical treatment. He contends he sustained a low back work injury which caused radicular pain and the radicular pain caused him to misstep while on a treadmill and injure his left knee. Employee seeks an order granting his claim for past and continuing left knee medical benefits.

Employer contends the work injury is not a substantial factor in his need for left knee medical treatment because there is no evidence that but-for the work injury Employee would have needed left knee medical treatment and a reasonable person would not regard the work injury as a cause for his need for medical treatment. It seeks an order denying his claim.

2) Is Employee entitled to medical benefits for his left knee?

Employee contends he is entitled to attorney's fees for the time he spent pursuing his claims and costs he incurred while litigating his claims. He requests the same amount of fees paid to Employer's attorney to defend against his claims and reimbursement for travel expenses and copy and postage costs.

Employer contends the Alaska Workers' Compensation Act (the Act) does not provide compensation for time spent by a *pro se* claimant pursuing his own claim and that Employee is not an attorney. It contends he is entitled to costs on issues upon which he prevailed at hearing. Employer also contends Employee failed to itemize his costs. It requests Employee's request for attorney's fees and costs be denied. Alternatively, Employer requests the costs be reduced.

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

FINDINGS OF FACT

The following facts are reiterated from *Davis and Wrangell Forest Products v. C&R Logging Company*, AWCB Decision No. 89-0064 (March 9, 1989) (*Davis I*), *Davis v. Wrangell Forest Products*, AWCB Decision No. 17-0049 (May 2, 2017) (*Davis II*), and Davis v. Wrangell Forest Products, AWCB Decision No. 18-0018 (February 27, 2018) (*Davis III*) are undisputed or are established by a preponderance of the evidence:

1) On January 21, 1987, Employee injured his back while employed with C&R Logging Company when a log rolled on him. (*Davis I*).

2) On March 9, 1988, Employee reported he injured his back again carrying coils of haywire while employed with Employer. (*Id.*).

3) On May 5, 1988, John Gibson, M.D., performed an L3-4 micro discectomy. He noted, "There were epidural adhesions present binding down the nerve root. In addition, there was a bulging disc." (*Id.*).

4) On December 26 and 28, 1988, David Samani, M.D., evaluated Employee's right knee. Employee reported he injured his right knee on December 25, 1988, when he slipped on ice, and his left knee gave out causing him to twist his right knee. Dr. Samani diagnosed a right medial meniscal tear and recommended a diagnostic arthroscopy. (*Id.*).

5) On January 11, 1989, Joseph Shields, M.D., recommended arthroscopic right knee surgery and opined Employee's "back and subsequent nerve difficulties with his left leg caused his left leg to give way and that is the direct cause of the fall and the injury to Employee's right knee." He opined Employee's right knee difficulties are attributable to the March 1988 work injury. (*Id.*).

6) On January 12, 1989, Employee underwent right knee trochlea debridement and arthroscopic partial medial meniscectomy. Dr. Shields diagnosed a medial meniscus tear with minimal fraying of the anterior cruciate ligament and traumatic chondromalacia of the trochlear side of the patella-femoral joint. (*Id.*).

7) On June 6, 1989, Hamid Mehdizadeh, M.D., performed a bilateral laminectomy at L3-4 with cauda equine decompression and exploration of the L3-4 nerve root bilaterally, a laminectomy at L4-5, a left sided discectomy at L3-4 with decompression of the L3-4 nerve root on the left side, a posterior interbody fusion of L3-4 using a cadaver back bone, and placed Harrington rods

between L3-4 with a cross link between the Harrington rods. Dr. Mehdizadeh also performed a posterior and anterior and posterolateral fusion at the L3-4 levels. (*Id.*).

8) On December 3, 1990, a compromise and release (C&R) settlement agreement was approved. It settled indemnity benefits for Employee's March 3, 1988 work injury; medical benefits remained open. (*Davis II*).

9) On January 25, 1994, Employee reported twisting his left knee on January 12, 1993, when he jumped off a piece of equipment. (Alaska Native Medical Center signature illegible, chart note, January 25, 1994).

10) On January 26, 1994, J. Michael Holloway, M.D., performed a left knee arthroscopy with partial medial meniscectomy for left knee pain and a torn medial meniscus. (Holloway operative report, January 26, 1994).

11) On October 25, 2005, Employee complained of middle lower back pain radiating to the left side of his back, hip and left leg. (Gail Krivan, M.D., chart note, October 25, 2005).

12) On November 29, 2006, Employee reported left buttock and posterolateral thigh pain down to his knee and sometimes down into the lateral aspect of his leg with occasional numbness and tingling into his foot. (Michael Fry, M.D., chart note, November 29, 2006).

13) On March 30, 2007, Employee continued to experience mainly back pain with some leg numbness and tingling. (Fry chart note, March 30, 2007).

14) On June 5, 2007, Phelps Kip, M.D., examined Employee for an Employer Medical Evaluation (EME). Employee reported left leg and back pain with a sensation of weakness and numbness in his legs. Dr. Kip opined Employee's back and leg pain was consistent with the stenosis seen on the March 7, 2006 magnetic resonance imaging (MRI) and the instability seen in the March 2006 flexion and extension x-rays. (Kip EME report, June 5, 2007).

15) On December 12, 2007, Employee complained of back pain radiating sometimes into the anterior thighs and leg pain. (Fry chart note, December 12, 2007).

16) On December 13, 2007, Dr. Fry performed a takedown of the L4-5 pseudoarthrosis, mass exploration at the L4-5 fusion, L3-5 bilateral lateral intertransverse process fusion and posterior segmental instrumentation using Synthes Click X. (Fry operative report, December 13, 2007).

17) On February 20, 2008, Employee said he had a little bit of right anterior thigh weakness and pain but it was not as noticeable as before. (Rebecca Pelkola, PA-C, chart note, February 20, 2008).

18) On February 28, 2008, Employee had lower back pain radiating through his right hip. (Krivan chart note, February 28, 2008).

19) On April 7, 2008, Employee reported lower back pain and sharp pain in the right hip area to his buttocks. (Krivan chart note, April 7, 2008).

20) On July 7, 2010, Employee reported lower back pain with more right- sided weakness and pain through buttock to knee. (Krivan chart note, July 7, 2010).

21) On August 31, 2011, Employee reported pain throughout the lumbar spine but very little left leg pain. (South Peninsula Hospital signature illegible, progress report, August 31, 2011).

22) On January 17, 2012, Dr. Adcox performed an L3-4 and L4-5 fusion exploration, hardware removal at L3, 4 and 5, an instrumentation revision at L4-5 using Stryker Xia 3 and a posterolateral fusion revision using BNP Stryker Vitoss, autograft and cancellous bone chips. (Adcox operative note, January 17, 2012).

23) On November 13, 2012, Employee said his low back still hurt but the radicular pattern was better. Upon examination, he had good lower extremity strength and "some hesitancy in hip flexion on the right side" which appeared to be a "manifestation of weakness as opposed to strength loss." (Soot D. Hines, M.D., chart note, November 13, 2012).

24) On December 12, 2012, Dr. Adcox, an orthopedic spine surgeon, examined Employee's left knee and ordered an MRI. Dr. Adcox noted:

> [Employee] has a history of left knee pain for quite some time. He has a little genu varum in that knee with a history of some torn cartilage in that knee and surgical treatment of that. The knee hurts when he is walking on unsteady ground. It feels like it catches. . . . He has no effusion, no erythema or signs of infection in the knee.

Dr. Adcox opined the medial aspect of Employee's knee had some early degenerative change, secondary to his previous meniscectomy. (Adcox chart note, December 12, 2012).

25) On December 12, 2012, Employee's left knee x-ray showed significant medial compartment narrowing with subchondral sclerosis consistent with degenerative osteoarthritis. (X-ray report, December 12, 2012).

26) On December 12, 2012, Employee's left knee posteromedial meniscus MRI demonstrated an absent free edge consistent with a vertical tear or bucket-handle-type tear, possible small displaced meniscal fragments in the medial compartment, focal loss of articular cartilage on the

medial femoral condyle with corresponding subcondylar edema in the femoral condyle, a small Baker's cyst and small joint effusion. (MRI report, December 12, 2012).

27) On December 28, 2012, Employee requested his left knee hydrocodone prescription be refilled because Dr. Adcox was out of town until January 3, 2012. He stated he injured his knee while walking on a treadmill in December 2012 and he had an MRI and was waiting to review the results with Dr. Adcox. (Margit Walker, D.O., chart note, December 28, 2012).

28) On January 3, 2013, Dr. Adcox diagnosed Employee with a left medial meniscus tear and left medial femoral condyle chondromalacia and recommended left arthroscopic knee surgery for a partial medial meniscectomy. Dr. Adcox noted Employee "had no specific injury" to his left knee. (*Davis II*).

29) On January 21, 2013, Dr. Adcox responded to a November 27, 2012 letter from Employer asking whether Employee reached medical stability from his January 2012 surgery and for an outline of expected ongoing palliative care. He replied Employee reached medical stability but did not provide a date of medical stability. Dr. Adcox said Employee would need continued medical care, including medication, and a future surgery was possible due to the potential of adjacent level breakdown associated with the fusion. (Adcox response, January 21, 2013).

30) On January 22, 2013, Dr. Adcox performed a left knee partial medial meniscectomy and subchondral medial femoral condyle drilling. He observed patellofemoral joint grade II chondromalacia on the superior and superolateral facet, significant synovitis, a very large swath of cartilage missing from the medial femoral condyle down to the subchondral bone and a medial meniscus tear. Employee had knee pain for "quite some time" and he had a "history of a previous medial meniscectomy" that did well. (Adcox operative note, January 22, 2013).

31) On July 1, 2013, Employer filed Dr. Adcox's January 21, 2013 response. (Medical Summary, July 2, 2013).

32) On September 25, 2013, Employee complained of continuing left knee pain. He had left knee genu varum with significant osteoarthritis. Dr. Adcox assessed an osteoarthritic left knee and a failed arthroscopic meniscus debridement and chondroplasty and recommended a total knee replacement. (Adcox chart note, September 25, 2013).

33) On December 2, 2013, Dr. Adcox diagnosed left knee osteoarthritis and recommended weight loss, exercise and another serious of viscosupplementation injections because his knee pain was slowly improving. (Adcox chart note, December 2, 2013).

34) On April 30, 2014, Employee reported increased back pain since torqueing a wrench last week. He woke up the next day with severe back pain on both sides of his lumbar spine and occasional shooting left thigh pain. (Adcox chart note, April 30, 2014).

35) On May 6, 2013, Dr. Adcox stated Employee "is better than he was prior to surgery but he still has some startup pain. This is all related to his osteoarthritis he has in his knee." He noted Employee "understands his preexisting osteoarthritis is the likely underlying source of all of his pain, as it is startup pain and it gets better with time." (*Davis II.*).

36) On May 29, 2013, Michael R. Fraser, Jr., M.D., an orthopedist, performed an EME. Dr. Fraser stated Employee reported he injured his left knee in December 2012, while walking on a treadmill when Employee got a shooting pain down the right leg which caused Employee to stumble and twist his left knee. He noted he had constant pain shooting down his left leg until after the fusion surgery in 2007; afterwards, it moved to the right side. Employee complained of continuing low back pain radiating into his left back, hip and leg and reported a left knee surgery in the 1990s. Dr. Fraser reviewed the December 2012 left knee x-ray and observed collapse of the medial compartment consistent with end stage arthritis and the December 2012 MRI which confirmed the x-ray findings with diffuse cartilage thinning and loss and a degenerative type meniscal tear. He diagnosed Employee with left knee osteoarthritis with varus gonarthrosis. Dr. Fraser opined Employee's left knee condition was unrelated to the March 1988 work injury and the March 1988 work injury was not the substantial factor for the left knee arthritis and need for treatment. He stated the substantial cause of Employee's left knee arthritis was Employee's weight, activity level and genetic disposition. (Fraser EME report, May 29, 2013).

37) On June 24, 2013, Dr. Fraser wrote an addendum EME report after reviewing additional medical records from 1983 to 1990 stating the records did not change his opinion. (Fraser addendum EME report, June 24, 2013).

38) On July 2, 2013, Employer denied all benefits for Employee's left knee based on Dr. Fraser's EME report and the C&R settlement agreement. (*Davis III*).

39) On August 7, 2013, Employee claimed a lower back injury but did not indicate which benefits he was seeking on the claim form. (*Id*.).

40) On August 30, 2013, Employer denied all benefits for Employee's left knee based on Dr. Fraser's EME report and the December 3, 1990 C&R. (*Id*.).

41) On September 3, 2013, Employee explained he is seeking medical benefits for his lower back and left knee. (*Id.*).

42) On October 27, 2014, Employee visited Dr. Adcox to discuss if work was a substantial factor in the need for medical treatment for his left knee. Dr. Adcox noted:

> [Employee] had a note from [Employer] regarding his request for my opinion on the left knee and its [sic] relevance to a work-related low back injury and a right knee injury that occurred back in 1988. [I had an] in-depth conversation with [Employee] [about] his history of intermittent radicular pain stemming from his low back injury. He was on a treadmill when he had radicular pain emanating from his lumbar spine, which caused him to wince, have a misstep onto the rail twisting the knee with a subsequent injury; therefore, I believe as this individual's treating physician to a reasonable degree of medical certainty that his left knee injury is related in consequence to his lumbar spine injury from 03/09/88 as the cause of the twisting to his left knee.

Dr. Adcox diagnosed a left knee meniscus tear subsequent to an injury precipitated by radicular pain from his back causing an "unfortunate accident on a treadmill." (Adcox chart note, October 27, 2014).

43) On January 12, 2015, Employer filed a copy of Dr. Adcox's October 27, 2014 chart note. (Medical Summary, January 12, 2015).

44) On May 4, 2015, Employee complained of chronic lower back pain radiating down into his left leg. He had five low back surgeries after a log hit him and nerve damage into both legs. After the injury Employee had pain and numbness in his left leg but after the 2007 surgery, it started going down his right leg. The 2011 surgery resolved the right leg pain but he currently had left leg pain, numbness and tingling into his feet and toes. (Christie Brubaker, FNP-C, chart note, May 4, 2015).

45) On September 11, 2015, Dr. Fraser performed an EME and diagnosed Employee with left knee osteoarthritis with varus gonarthrosis. He opined the March 1988 work injury is not the substantial factor for Employee's left knee arthritis and Employee's need for additional treatment. Dr. Fraser stated the substantial cause of Employee's left knee arthritis was Employee's weight, activity level, prior injury requiring arthroscopy and genetic deposition. (Fraser EME report, September 11, 2015).

46) On November 3, 2015, Employee saw Dr. Jessen for a neurological consultation for work-related and non-work-related complaints. Employee stated he fell on a treadmill in 2013,

injuring his left knee during the fall. She assessed Employee with diabetic polyneuropathy and lumbosacral radiculopathy. Dr. Jessen suspected Employee "had an episode of radicular pain which caused the left lower extremity to buckle which in turn caused the left knee damage, which was sustained during the fall." (Jessen progress note, November 3, 2015).

47) On November 15, 2015, Employer filed Dr. Jessen's November 3, 2015 progress note. (Medical summary, November 15, 2015).

48) On March 8, 2016, Peter E. Diamond, M.D., an orthopedist, performed a second independent medical evaluation (SIME). Employee reported stabbing pain in his lower back radiating down his left leg, causing him to fall and twist his right knee in the 1990s. He recalled receiving pain management treatment with Dr. Krivan for continuing, gradually worsening low back pain and described a stabbing pain down the posterior aspect of his left leg. After another back surgery in January 2012, he experienced another change in symptoms when the right leg pain resolved but the left leg pain returned. Employee injured his left knee when he felt a shocking pain from his back to his left leg causing him to fall while walking on a treadmill. Dr. Diamond diagnosed Employee with (1) lumbar sprain/strain secondary to the January 1987 incident; (2) L3-4 herniated disc secondary to the March 1988 incident; (3) status post multiple surgeries with failed back syndrome secondary to L3-4 herniated disc; (4) history of right knee arthroscopy with right knee partial medial meniscectomy and chondromalacia of trochlea; (5) and history of left knee arthroscopy, partial medial meniscectomy and treatment of grade IV chondromalacia, medial femoral condyle of the left knee. He opined the March 1988 work injury was a substantial factor in causing disability and the need for treatment for Employee's lumbar and right knee injuries but was not a substantial factor in the recent medical treatment for the left knee. Dr. Diamond said he would revise the left knee opinion if there was documentation that the treadmill incident resulted in a left knee injury but would conclude that the meniscus tear alone was the consequence of the treadmill incident because the underlying arthritic condition, described as a grade IV lesion in the medial femoral condyle, was not substantially caused by the treadmill episode. He stated a small percentage of subsequent medial compartment arthritis would be attributable to the subject injury because it necessitated a partial medial menisectomy.

Dr. Diamond analyzed Employee's medical record and stated:

> The etiology of the left leg giving out is unclear, but it would be reasonable to conclude, to a reasonable degree of medical probability, that the left leg collapse on 12/28/88 was related to the lumbar injury, and therefore, that the right knee problem with subsequent medical meniscectomy is attributable to the [March 1988] injury.
> . . . .
>
> The first mention of knee pain is by Dr. Adcox on 12/12/12, noting that [Employee] had a history of left knee pain for 'sometime,' noting a history of prior surgery for a cartilage tear from which the examinee recovered. However, the records available to me do not document previous left knee surgery. It is unclear whether a left knee injury and arthroscopy had previously occurred, or if Dr. Adcox and/or [Employee] are conflating the left knee with the right knee.
>
> Moreover, there is a reference in an Independent Medical Evaluation to a note by Dr. Adcox on 10/27/1[sic], documenting an injury specifically secondary to radicular pain while [Employee] was on a treadmill for his lumbar spine injury, causing him to wince, misstep, and twist the knee. Unfortunately, the laterality is not specified in this note, and all I have is a second-hand copy, rather than the original note. However, a further note by Dr. Adcox on 1/3/13 again indicates no specific injury to the left knee, just chronic, intermittent knee pain.
> . . . .
>
> I cannot determine, to a reasonable degree of medical probability, the etiology of the left knee pain, but it appears clear that the examinee had pre-existent arthritis prior to the 1/22/13 left knee arthroscopy. It would therefore be my opinion, based on the records available to me, that the right knee meniscus tear and a portion of subsequent arthritis are secondary to the [March 1988] injury, but that the left knee condition is not, in fact, demonstrably secondary to the lower back injury. Ascribing the right knee is based on the assumption that [Employee]'s left leg gave out because of radicular pain and/or weakness. . . .

Dr. Diamond said an examination of Employee's left knee by a neurosurgeon is inappropriate and further treatment for either knee would "most reasonably be performed by an orthopedic surgeon." (Diamond SIME report, March 8, 2016).

49) On November 9, 2017, Employer filed Dr. Hines' November 13, 2012 chart note, Dr. Walker's December 28, 2012 chart note, and another copy of Dr. Adcox's October 27, 2014 chart note. (Medical Summary, November 9, 2017).

50) On May 2, 2017, *Davis II* denied Employee's January 20, 2017 petition for an additional SIME with a neurosurgeon. (*Davis II*).

51) Employee appealed *Davis II* and on June 23, 2017, the Alaska Workers' Compensation Appeals Commission (Commission) affirmed *Davis II*'s denial of Employee's petition for an

additional SIME. *Gary R. Davis v. Wrangell Forest Products and Wausau Underwriters Insurance Company*, AWCAC Decision No. 17-0049 (June 23, 2017).

52) On October 27, 2017, Dr. Diamond testified there was no record of an acute left knee injury around December 2012. (*Id*. at 13). Normally the medial compartment, the gap between the knee bones, is filled with five millimeters of cartilage. (*Id*. at 14). As patients become arthritic, the cartilage wears away like a tire tread so eventually the bony surfaces become bone-on-bone. (*Id*.). Employee's December 2012 x-rays showed significant medial compartment narrowing. (*Id*. at 14-15). The subchondral sclerosis shown on the x-ray was sign of a chronic process and the sclerosis was a reaction of the bone to irritation and inflammation and was not an acute finding. (*Id*. at 15). The x-ray revealed no abnormal fluid in the left knee joint. (*Id*. at 16-17). Fluid in the joint would be a reaction to irritation in the joint, some arthritic joints have quite a bit of fluid and others are dry. (*Id*. at 17). In an acute injury, meaning with sudden trauma, there would be fluid in the knee joint. (*Id*.). If a patient had an acute injury and effusion, it would be a sign that something significant had been damaged in the knee joint. (*Id*.). If there was no effusion, it would be non-probative because there can easily be significant nonvascular structural damage to the knee, such as to the surface cartilage or meniscus cartilage, and not have fluid because there is no bleeding. (*Id*. at 17-18). The December 2012 MRI revealed a vertical tear which suggested an acute injury, as opposed to a horizontal tear which would suggest a degenerative meniscus. (*Id*. at 19). The marrow edema shown in the MRI was nonspecific because it is seen in arthritic conditions and acute injuries. (*Id*.). The small Baker's cyst shown in the MRI was a sign there had been fluid in the knee joint and implied it had been chronically inflamed and filled with fluid. (*Id*. at 20). The focal cartilage loss was a bit more suggestive of an acute injury than a generalized "wearing away." (*Id*. at 21). MRIs are not one hundred percent accurate and are subject to interpretive variability. (*Id*.). The January 22, 2013 operative note showed Employee had mild to moderate arthritic change between the knee cap and the femur and significant synovitis which was indicative of a chronic, long-term process caused by inflammation of the soft tissue joint lining. (*Id*. at 24-25). A very large swath of cartilage was missing from the medial femoral condyle down the subchondral bone and its implication was the arthritic and structurally compromised cartilage was traumatized and a portion broke off. (*Id*. at 25). Dr. Adcox's December 12, 2012 chart note included a history of left knee pain and genu varum which is a bending in of the knee; both implied there has been a long-term arthritic

change in the medial compartment. (*Id*. at 26). The first medical record that mentioned the treadmill incident was Dr. Fraser's May 29, 2013 EME report. (*Id*. at 27). The first mention of the treadmill incident from a treating physician was Dr. Adcox's October 27, 2014 record. (*Id*. at 27-28). Dr. Diamond did not think the work injury was a substantial factor in Employee's left knee injury occurring "when it did or as it did." (*Id*. at 35). The work injury was not so important a factor that a reasonable person would regard it as the cause of his left knee surgery. (*Id*. at 36). Dr. Diamond characterized the work injury as a remote factor in Employee's need for left knee medical treatment. (*Id*.). Degenerative changes in the knee are multifactorial, including weight, body habit, angular structures of the knee, chronic trauma and genetic factors in the production of the quality of the cartilage matrix. (*Id*.). The only contemporaneous medical evidence to support a finding that the work injury caused Employee's need for the medial meniscus surgery was the vertical meniscus tear, which would be more typical of an acute tear. (*Id*. at 37). But that was outweighed by the presence of significant degenerative change, the ambiguity of the injury history and the relatively ambiguous connection between the activity on the treadmill and the work injury. (*Id*. at 37-38). Dr. Diamond recommended anti-inflammatory medication and a single corticosteroid injection or a series of viscosupplementation injections. (*Id*. at 38). However, the work injury was not a substantial factor in the need for the recommended treatment as that was aimed at treating the degenerative condition. (*Id*. at 38-39). Dr. Diamond believed Employee sustained an injury to the sciatic nerve from the L3-4 level from the work injury and it would cause leg weakness and pain. (*Id*. at 41-46). He noted there was a contemporaneous record for the right knee injury in the December 1988 note from Dr. Samani stating he had an episode in which the left leg gave out while he was walking and he twisted his right knee and experienced immediate swelling. (*Id*. at 47-48). He agreed with Dr. Fraser's reasoning and opined the work injury was a remote factor and not a substantial factor of his left knee injury because medical considerations on balance made it a lot more likely that the left knee injury would have happened anyway. (*Id*. at 50). Dr. Diamond did not think Employee lied; he felt Employee presented things without magnifying them and to the best of his recollection. (*Id*. at 51-52). For Employee's left knee injury, there was no clear contemporaneous record as the first record documenting the treadmill incident was dated six months after the left knee injury. (*Id*. at 53). He placed more emphasis on contemporary records

rather than Employee's subsequent recollection. (*Id*. at 53-54). There was also no correlative evidence of ongoing radiculopathy in 2012. (*Id*. at 56).

53) On February 27, 2018, *Davis III* granted Employer's request to dismiss Employee's August 7, 2013 claim under AS 23.30.110(c). (*Davis III*).

54) On April 12, 2018, Employee's left knee was painful due to severe grade 4 osteoarthritis and eventually he planned to get it replaced. (Adcox chart note, April 12, 2018).

55) On January 2, 2019, the Commission reversed and remanded the dismissal of Employee's August 7, 2013 claim under AS 23.30.110(c). *Gary R. Davis v. Wrangell Forest Products and Wausau Underwriters Insurance Company*, AWCAC Decision No. 256 (January 2, 2019).

56) On March 22, 2019, Employee requested a hearing on his August 7, 2013 claim. (ARH, March 22, 2019).

57) On March 28, 2019, Employer requested cross-examination of Dr. Adcox for the January 21, 2013 response and October 27, 2014 chart notes and of Dr. Jessen for the November 3, 2015 progress report "to ascertain the basis and rationale of the doctor's opinions." (Request for Cross-Examination, March 28, 2019).

58) On July 10, 2019, Employee requested attorney's fees and costs stating, ". . . . I've been representing myself the past 7 years and I feel I should be compensated for my efforts (If I should win). I wish to be compensated for the exact amount of billing hours the attorneys charged Liberty Northwest. . . ." (Claim for Workers' Compensation Benefits, July 10, 2019).

59) On September 6, 2019, Dr. Fraser testified he looks very closely at the medical records immediately around the injury first presented to get an idea of symptom onset, the events that occurred around that time and any chronicity when a patient's injury history changed over time. (Fraser Deposition at 7). He gave a lot of weight to the medial records when the injury first presented. (*Id*.). Employee told him he had a prior left knee arthroscopy sometime in the 1990s and that he had no residual problems afterwards. (*Id*. at 11). To diagnose Employee, he looked at the December 2012 x-ray and MRI which showed significant degeneration, mainly in the medial compartment, a vertical meniscus tear, subchondral sclerosis and narrowing of the joint. (*Id*. at 18). The vertical tear would not be uncommon to find in a knee with degeneration. (*Id*.) The narrowing of the joint and subchondral sclerosis were signs of chronic degenerative process. (*Id*.) If there was an acute recent injury tearing the medial meniscus, Dr. Fraser would expect to see a fairly swollen knee. (*Id*. at 19). The initial reports showed genu varum and ongoing knee

pain which he would expect for a degenerative arthritis and no specific injury. (*Id*.). The arthroscopy showed cartilage loss with bare bone called a grade IV chondralmalacia. (*Id*. at 20-21). Generally, the grade IV chondralmalacia would be part of the degenerative arthritic pattern. (*Id*. at 21). Dr. Fraser believed that at some point, Employee would have sought left knee medical treatment despite the work injury. (*Id*. at 23). Employee's chronic degeneration caused his need for left knee medical treatment. (*Id*. at 23-24). A reasonable person would not regard the work injury as so important a factor to cause the knee degeneration. (*Id*. at 24). The original contemporaneous medical records do not indicate the work injury had a role in causing Employee's left knee injury because the treadmill incident was not disclosed at the time and it would have been. (*Id*. at 24-25). Employee needed ongoing left knee medical treatment to manage the arthritis, including anti-inflammatory use, additional injections and knee replacement if the symptoms persist. (*Id*. at 25).

60) On October 8, 2019, Employee requested reimbursement for $3,500 in costs, including $2,800 in fuel for trips to Anchorage for doctor's appointments, physical therapy, a "board of governors" meeting and trips to the post office, $450 for stamps, envelopes and copying costs, and $300 for room and board for trips to Anchorage. He stated, "I will admit right now that there is no way I can be completely accurate but I will try to be objective as possible." Employee did not provide any receipts or breakdown the costs by item. (Employee letter, October 8, 2019; Experience, judgment and inferences drawn from above).

61) On October 10, 2019, Employer opposed Employee's request for costs. It contended the total actual costs related to the left knee litigation could be $697.74, including: $590.99 for trips to Anchorage for hand delivery of a brief and to attend a hearing, $16.90 for physical therapy trips, $86.25 to see Dr. Jessen on November 3, 2015, $1.70 for a January 22, 2013 physician visit, $6.75 for trips to the post office as the nearest post office is less than a half mile from Employee's residence and $100 for postage and copying. (Employer Opposition to Employee's Request for Costs, October 10, 2019).

62) Employer accepted compensability for Employee's March 1988 back injury and December 1988 right knee injury. (Record).

63) Employee testified he injured his left knee in December 2012 while walking on a treadmill when he experienced radicular pain which caused him to misstep and twist his knee. He did not remember the January 26, 1994 left knee surgery. (Employee).

64) Dr. Diamond's SIME report and Dr. Fraser's EME reports failed to include Dr. Hines' November 13, 2012 chart note and Dr. Walker's December 28, 2012 chart note in the medical records review. (Diamond SIME report, March 8, 2016; Fraser EME report, May 29, 2013; Fraser addendum EME report, June 24, 2013; Fraser EME report, September 11, 2015).

PRINCIPLES OF LAW

The board may base its decisions on not only direct testimony 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, 533-534 (Alaska 1987).

> **AS 23.30.010. Coverage.** Compensation is payable under this chapter in respect of disability or death of an employee.

At the time of Employee's March 9, 1988 injury, decisional law interpreted former AS 23.30.010 to require payment of benefits when the employment is "a substantial factor" in bringing about the disability or need for medical care. *Ketchikan Gateway Borough v. Saling*, 604 P.2d 590, 597-98 (Alaska 1979). Employment is "a substantial factor" in bringing about the disability or need for medical care where "but for" the work injury, a claimant would not have suffered disability at the time he did, in the way he did, or to the degree he did, and reasonable people would regard it as the cause and attach responsibility to it. *Rogers & Babler* at 532-33.

> **AS 23.30.095. Medical examinations.** (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. However, if the condition requiring the treatment, apparatus, or medicine is a latent one, the two-year period runs from the time the employee has knowledge of the nature of the employee's disability and its relationship to the employment and after disablement. 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. . . . .

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

Benefits sought by an injured worker are presumed to be compensable. *Meek v. Unocal Corp*., 914 P.2d 1276 (Alaska 1996). The presumption of compensability is applicable to any claim for compensation under the workers' compensation statute, including medical benefits. *Id.* To attach the presumption of compensability, an employee must establish "some preliminary link" between the disability and employment, or between a work-related injury and the existence of the disability; the claimant need only present "some evidence that the claim arose out of, or in the course of, employment before the presumption arises." *Burgess Constr. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). The evidence necessary to raise the presumption of compensability varies. In claims based on highly technical medical considerations, medical evidence is often necessary to make that connection. *Smallwood* at 316. In less complex cases, lay evidence may be sufficiently probative to establish the link. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Credibility is not weighed at this stage of the analysis. *Id*. at 869-70 (Alaska 1985).

Once the preliminary link is established, the employer has the burden to overcome the raised presumption by producing substantial evidence the injury is not work-related. *Smallwood* at 316. "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). To rebut the presumption, the employer's evidence must either:

> (1) Provide an alternative explanation that, if accepted, would exclude work related
> factors as a substantial cause of the disability; or
>
> (2) Directly eliminate any reasonable possibility that employment was a factor in causing the disability. *Grainger v. Alaska Workers' Comp. Bd*., 805 P.2d 976, 977 (Alaska 1991).

The presumption of compensability may be rebutted by presenting a qualified expert who testifies that, in his or her opinion, the claimant's work was probably not a substantial cause of the disability." *Big K Grocery v. Gibson*, 836 P.2d 941, 942 (Alaska 1992). At this second step of the analysis, the employer's evidence is viewed in isolation, without regard to any evidence presented by the claimant. Issues of credibility and evidentiary weight are deferred until after a determination whether the employer has produced a sufficient quantum of evidence to rebut the presumption. *Wolfer* at 871.

If the employer successfully rebuts the presumption, it drops out, and the employee must prove all elements of his case by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379 (Alaska 1991). 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, 72 (Alaska 1964). At this last step of the analysis, evidence is weighed, inferences are drawn from the evidence and credibility is considered. *Steffey v. Municipality of Anchorage*, 1 P.3d 685, 691 (Alaska 2000).

The fact that an employee has suffered a non-work related injury does not, standing alone, rebut the presumption of compensability. *Alaska Pacific Assur. Co. v. Turner*, 511 P.2d 12 (Alaska 1980) (holding that where an employee suffers a work-related injury and then suffers an aggravation unrelated to his employment, the employer must show the work-related injury was not a "substantial factor contributing to the later injury" in order to rebut the presumption of compensability). If an earlier compensable injury is a substantial factor contributing to the later injury, then the later injury is compensable. *Cook v. Alaska Workmen's Compensation Board*, 476 P.2d 29, 35 (Alaska 1970).

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

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

> **8 AAC 45.052. Medical summary. . . .**
> . . . .
>
> (3) After an affidavit of readiness for hearing has been filed, and until the claim is heard or otherwise resolved,
> . . . .
>
> > (B) If a party served with an updated medical summary and copies of the medical reports listed on the medical summary wants the opportunity to cross examine the author of a medical report listed on the updated medical summary, a request for cross-examination must be filed with the board and served upon all parties within 10 days after service of the updated medical summary.
>
> (4) If an updated medical summary is filed and served less than 20 days before hearing, the board will rely upon a medical report listed in the updated medical summary only if the parties expressly waive the right to cross-examination, or if the board determines that the medical report listed on the updated summary is admissible under a hearsay exception of the Alaska Rules of Evidence.
>
> (5) A request for cross-examination must specifically identify the document by date and author, generally describe the type of document, state the name of the person to be cross-examined, state a specific reason why cross-examination is requested, be timely filed under (2) of this subsection, and be served upon all parties.
>
> > (A) If a request for cross-examination is not in accordance with this section, the party waives the right to request cross-examination regarding a medical report listed on the updated medical summary.
> >
> > (B) If a party waived the right to request cross-examination of an author of a medical report listed on a medical summary that was filed in accordance with this section, at the hearing the party may present as the party's witness the testimony of the author of a medical report listed on a medical summary filed under this section.

> **8 AAC 45.084. Medical travel expenses**. (a) This section applies to expenses to be paid by the employer to an employee who is receiving or has received medical treatment.
>
> (b) Transportation expenses include
>
> > (1) a mileage rate, for the use of a private automobile, equal to the rate the state reimburses its supervisory employees for travel on the given date if the usage is reasonably related to the medical examination or treatment;
>
> . . . .
>
> (e) A reasonable amount for meals and lodging purchased when obtaining necessary medical treatment must be paid by the employer if substantiated by receipts submitted by the employee. Reimbursable expenses may not exceed the per diem amount paid by the state to its supervisory employees while traveling.
>
> **8 AAC 45.180. Costs and attorney's fees**.
>
> . . . .
>
> (b) A fee under AS 23.30.145 will only be awarded to an attorney licensed to practice law in this state or another state. . . .
>
> (d) The board will award a fee under AS 23.30.145(b) only to an attorney licensed to practice law under the laws of this or another state.
>
> . . . .
>
> (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. . . .

Courts will typically not award attorney fees to victorious *pro se* litigants in the absence of specific statutory authorization. Instead, each party must bear the costs of bringing or defending a suit. *Alyeska Pipeline Service Co. v. Wilderness Society*. 421 U.S. 240, 247-71 (1975); *Fleischmann Distilling Corp. v. Maier Brewing Co.*, 386 U.S. 714, 717 (1967). Whether prevailing lay *pro se* litigants may recover attorney fees was addressed by the Alaska Supreme Court in *Alaska Federal Savings & Loan Association of Juneau v. Bernhardt*, 794 P.2d 579 (Alaska 1990). It summarized the policy reasons to deny *pro se* litigants attorney fees:

> (1) the difficulty in valuing the non-attorney's time spent performing legal services, *i.e.,* the problem of over compensating *pro se* litigants for "excessive

> hours [spent] thrashing about on uncomplicated matters," *Culebras Enter. Corp. v. Rivera Rios,* 660 F.Supp. 540, 546 (D.P.R.1987) *vacated on other grounds,* 846 F.2d 94 (1st Cir.1988); (2) the danger of encouraging frivolous filings by lay *pro se* litigants and creating a "cottage industry" for non-lawyers, *see Crooker v. United States, Dep't of the Treasury,* 634 F.2d 48, 49 (2nd Cir.1980); (3) our view that the express language of Civil Rule 82 specifying "*attorney's* fees" is not easily susceptible to a construction allowing awards to non-attorneys, *see also Hannon v. Security Nat'l Bank,* 537 F.2d 327, 328-29 (9th Cir.1976); and (4) the argument that, in cases where a litigant incurs no actual fees, the award amounts to a penalty to the losing party and a windfall to the prevailing one, *Crooker v. United States Parole Comm''n.,* 632 F.2d 916, 921 (1st Cir.1980), *vacated on other grounds,* 469 U.S. 926, 105 S.Ct. 317, 83 L.Ed.2d 255 (1984).

Under existing Alaska statutes and regulations, attorney fee awards to unsupervised paralegals fees for services rendered in workers' compensation cases are not authorized. A person who has not been admitted to the practice of law in Alaska or another state would be engaging in the unauthorized practice of law if that person collected fees for legal services provided in workers' compensation cases. Alaska law expressly prohibits a person from engaging in the practice of law unless the person is licensed to practice. AS 08.08.210. Further, AS 08.08.230 makes unlawful practice of law a misdemeanor. (April 2, 1996, Op. Att'y Gen. (Alaska)).

> **8 AAC 45.900. Definitions**. (a) In this chapter
> . . . .
>
> (11) "Smallwood objection" means an objection to the introduction into evidence of written medical reports in place of direct testimony by a physician. . . .

In *Commercial Union Insurance Companies v. Smallwood*, 550 P.2d 1261 (Alaska 1976), the Alaska Supreme Court found "the statutory right to cross-examine is absolute and applicable to the board." *Id*. at 1265. In a previous case, the court suggested procedures the board could adopt to ensure parties have the right to cross-examination. In response, the board amended 8 AAC 45.052(c) and 8 AAC 45.120 to provide for notice and an opportunity for cross examination.

> **Alaska Rules of Evidence**. . . .
> . . . .
>
> **Rule 801. Definitions.** The following definitions apply under this article:
>
> (a) **Statement.** A statement is (1) an oral or written assertion or (2) nonverbal

> conduct of a person, if it is intended by the person as an assertion.
>
> (b) **Declarant.** A declarant is a person who makes a statement.
>
> (c) **Hearsay.** Hearsay is a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted.
> . . . .
>
> **Rule 803. Hearsay Exceptions -- Availability of Declarant Immaterial**. The following are not excluded by the hearsay rule, even though the declarant is available as a witness:
> . . . .
>
> (4) **Statements for purposes of medical diagnosis or treatment**. Statements made for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment.
> . . . .
>
> (6) **Business Records**. A memorandum, report, record, or data compilation, in any form, of acts, events, conditions, opinions, or diagnoses, made at or near the time by, or from information transmitted by, a person with knowledge acquired of a regularly conducted business activity, and if it was the regular practice of that business activity to make and keep the memorandum, report, record, or data compilation, all as shown by the testimony of the custodian or other qualified witness, unless the source of information or the method or circumstances of preparation indicate lack of trustworthiness. The term 'business' as used in this paragraph includes business, institution, association, profession, occupation, and calling of every kind, whether or not conducted for profit.

In *Frazier v. H.C. Price*, 794 P.2d 103 (Alaska 1990) Frazier gave notice he intended to introduce into evidence a medical report prepared at H.C. Price's request and expense. The employer asserted a right to cross-examine the reports' authors and the Board held Frazier should bear the costs of the cross-examination. The Board's holding was reversed. The Supreme Court held written medical reports prepared at the employer's request and expense and which the employee intends to introduce are not hearsay, and thus the employee is not obligated to bear the costs of employer's cross-examination of the reports' authors. The employer, by requesting that the employee submit to examination by clinical physicians of its choice, vouches for credibility and competence of those physicians. *Id.* at 105.

In *Dobos v. Ingersoll*, 9 P.3d 1020 (Alaska 2000), a personal injury case, the Alaska Supreme Court held "medical records, including doctors' chart notes, opinions, and diagnoses, fall squarely within the business records exception to the hearsay rule," unless there is some reason to doubt the records' authenticity. *Id*. at 1027. Ingersoll asked Dobos to admit that Ingersoll's medical records were genuine under the Alaska Civil Rules. Dobos refused, arguing the evidence was hearsay. He wanted Ingersoll to put the witnesses on the stand at her expense so he could question them. During trial, Ingersoll called her doctors to testify and lay a foundation for the records. On appeal, the Alaska Supreme Court noted medical records are exceptions to the hearsay rule under Evidence Rule 803(6) and remanded back for sanctions against Dobos for failing to admit the genuineness of Ingersoll's medical records. The court reasoned, "Requiring testimony that medical records were made and kept in the regular course of business is a waste of time unless there is some reason to believe that the records are not genuine or trustworthy." *Id*. at 1028. Further, the Court said Dobos could have called Ingersoll's doctors to the stand himself after he denied Ingersoll's request to admit their records. *Dobos*, 9 P.3d at 1028.

In *Noffke v. Perez*, 178 P.3d 1141 (Alaska 2008), another personal injury case, the Alaska Supreme Court said evidence of the plaintiff's medical treatment and diagnosis, even in the form of a doctor's letter to the Social Security Disability Determination Unit, could be admissible under *Dobos* provided litigants established "it was the regular practice" of the doctor to prepare and send such reports. *Id*. at 1146. *Parker v. Power Constructors*, AWCB Decision No. 91-0150 (May, 17, 1991), addressed "trustworthiness" under Alaska Rule of Evidence 803(6), noted:

> Statements by professionals, such as doctors, expressing their opinion on a relevant matter, should be excluded only in rare circumstances, particularly if the expert is independent of any party, and especially if the reports have been made available to the other side through discovery so that rebuttal evidence can be prepared. (*Id*. at 7, *citing* 4 Weinstein's Evidence Rule 803 at 803-211 (1990)).

In *Parker*, an insurer petitioned the board to admit three documents, contending they fell within exceptions to the hearsay rule. The employee contended the documents should not be admitted over his cross-examination request. The three documents pertaining to the employee included:

(1) a discharge summary from a nursing home; (2) a physical examination report prepared during the employee's residence at the nursing home; and (3) a letter written to the employee's attorney from the employee's attending physician giving an opinion on compensability. After discussing the history of the *Smallwood* objection, the board reviewed relevant Alaska Supreme Court cases and relied heavily upon *Frazier*. *Parker* noted Alaska Supreme Court precedent, including *Frazier*, represented an "extension rather than a limitation of our regulation permitting admission of certain documents over *Smallwood* objections." *Parker* determined the three documents in question had long been in the employee's possession and were trustworthy enough to permit admission under exceptions to the hearsay rule. *Parker* also noted while *Frazier* did not agree to "re-examine *Smallwood*," it also did not overrule or refuse to apply the board's regulations permitting certain documents to be admitted over *Smallwood* objections. (*Id*. at 11).

ANALYSIS

1) Was the oral order denying Employer's request to exclude medical reports from Drs. Adcox and Jessen correct?

On March 28, 2019, Employer timely filed a *Smallwood* objection and demanded a right to cross-examine Dr. Adcox on his January 21, 2013 response and October 27, 2014 chart notes and Dr. Jessen on her November 3, 2015 progress note. Employee filed no witness list offering Drs. Adcox and Jessen for cross-examination. Employer contended the medical records were hearsay and were not routine medicals record because they were prepared for litigation. Employee contended they were routine medical records because they were made for the purpose of diagnosing and treating his work injury.

Any relevant evidence is admissible if it is the sort of evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil actions. 8 AAC 45.120(e). Dr. Adcox's January 21, 2013 response is about Employee's low back and his October 27, 2014 chart notes and Dr. Jessen's chart note are about Employee's left knee and all are clearly relevant. *Rogers & Babler*. Hearsay is defined as a statement, other than one made by the declarant while testifying at hearing, offered in evidence to prove the truth of the matter asserted. Evidence Rule 801(c). Employee seeks to use the

medical records to prove the work injury caused radiculopathy and the radiculopathy caused him to misstep on a treadmill and twist his left knee. All of the records include statements not made while testifying at hearing and are offered to prove the truth of the matters asserted. The statements are hearsay. *Id*.

Dr. Adcox's January 21, 2013 response answered questions in a letter sent by Employer to follow up after the lumbar spine fusion he performed and contains his medical opinion regarding Employee's low back injury. Employee saw Dr. Adcox on October 27, 2014, because Employer again sought his opinion regarding the relevance to the left knee injury to the low back work injury. Written medical reports prepared at the employer's request and expense and which the employee intends to introduce are not hearsay. *Frazier*. There is no reason to doubt the authenticity or trustworthiness of either the January 21, 2013 response or October 27, 2014 chart notes. *Dobos*. The July 1, 2013 medical summary proves Employer had the January 21, 2013 response since at least that date and the January 12, 2015 summary proves Employer had Dr. Adcox's October 27, 2014 chart note since at least that date and was able to obtain rebuttal evidence. *Noffke*; *Parker*.

Dr. Jessen performed a neurological examination of Employee on November 3, 2015 and issued a progress note. She relied upon Employee's description of his medical history and pain complaints to diagnose work-related and non-work-related neurological symptoms and offer an opinion regarding the work-related neurological issue. Evidence Rule 803(4), (6). There is no reason to doubt the authenticity or trustworthiness of Dr. Jessen's November 3, 3015 progress note. *Dobos*. The November 15, 2015 medical summary proves Employer had Dr. Jessen's November 3, 2015 progress note since at least that date and was able to obtain rebuttal evidence. *Noffke*; *Parker*. The oral order denying Employer's objection to Dr. Adcox's January 21, 2013 response and October 27, 2014 chart note and Dr. Jessen's November 3, 2015 progress note was correct.

2) Is Employee entitled to medical benefits for his left knee?

Employee underwent a left knee surgery on January 22, 2013, and several physicians recommended left knee injections and a total knee replacement. He contends the work injury

was a substantial factor in his need for left knee medical treatment because the work injury caused radiculopathy, which caused him to misstep while on a treadmill and he twisted his left knee. Employer denied medical benefits for the left knee based upon Dr. Fraser's May 29, 2013 EME report. Whether Employee is entitled to medical benefits for his left knee as a result of the work injury is a factual issue to which the presumption of compensability applies. AS 23.30.010; AS 23.30.120; *Meek*; *Saling*. Without weighing credibility, Employee raises the presumption with his own testimony and through Drs. Adcox's and Jessen's medical reports identifying the work injury as a substantial factor contributing to Employee's need for left knee medical treatment. *Smallwood*; *Wolfer*.

Because Employee raises the presumption, Employer has the burden to rebut the presumption. *Smallwood*. Employer rebutted the presumption with Dr. Fraser's opinion excluding the work injury as a substantial factor in his need for left knee medical treatment; rather Employee's severe non-work related end stage osteoarthritis is the cause for his need for left knee medical treatment as it caused the cartilage thinning and loss and meniscal tear. *Tolbert*; *Grainger*; *Gibson*; *Wolfer*.

Because Employer rebutted the presumption of compensability, Employee must prove his claim by a preponderance of the evidence. *Koons*; *Saxton*. Evidence must be weighed and credibility must be considered. *Steffey*. Employee contends radiculopathy, which was caused by the work injury, caused him to misstep while on a treadmill and he twisted his left knee in December 2012. He failed to recall his 1994 left knee surgery during Dr. Diamond's 2016 SIME and at this hearing but remembered it during Dr. Fraser's May 29, 2013 EME. Employee's recollection of whether the radiculopathy that caused his left knee injury was right- or left-sided changed over time as well because he told Dr. Fraser he had right-sided leg pain on May 29, 2013, Dr. Jessen relied on this history to conclude he had left radicular pain on November 13, 2015. Employee told Dr. Diamond it was left-sided radiculopathy on March 8, 2016. Employee's medical record goes back many years, he has had five back surgeries and three knee surgeries and his radiculopathy has been right- and left-sided. There is no evidence he intentionally misrepresented his medical history; rather his memories appear to have faded over time.

Because memories fade, medical histories recorded closer in time to actual events are usually more reliable. *Rogers & Babler*.

There are contemporaneous medical records indicating the treadmill incident occurred in December 2012. Employee visited Dr. Walker on December 28, 2012, to request a refill of his pain medication because he injured his knee while walking on a treadmill in December 2012 and Dr. Adcox was out of town. There is also evidence Employee experienced right-sided radiculopathy due to low back pain shortly before December 2012, as he had right-sided weakness upon examination by Dr. Hines on November 13, 2012. Employee's statements to Dr. Fraser during the May 29, 2013 EME that he had a previous left knee surgery in the 1990s and that shooting pain down his right leg caused him to stumble and twist his left knee are compelling because they are consistent with the contemporaneous medical records. Employee's statements in December 2012 and May 2013 regarding the treadmill incident are credible. AS 23.30.122. Therefore, Employee's credible statements prove the treadmill incident occurred in December 2012. *Rogers & Babler*.

Both Drs. Fraser and Diamond opined the work injury was not a substantial factor in Employee's need for left knee medical treatment because there was a lack of contemporaneous medical evidence to indicate the treadmill incident occurred in December 2012 as a result of the work injury. Both noted Dr. Adcox's December 12, 2013 and January 3, 2013 medical reports stated Employee had left knee pain for quite some time, a history of surgical repair of torn cartilage and no specific injury. However, as determined previously, there is such credible documentation.

Both Drs. Fraser's and Diamond's opinions were flawed because they did not review the December 28, 2012 and November 13, 2012 medical records as they were not filed until November 9, 2017, and neither Dr. Fraser nor Dr. Diamond included them in their reports. *Rogers & Babler*. The other medical opinions in the record are also flawed. Dr. Adcox's medical reports failed to include the December 2012 treadmill incident until October 27, 2014. However, like Drs. Fraser and Diamond, he acknowledged Employee has left knee osteoarthritis. Dr. Jessen's opinion is given the least weight because she did not review the medical record to form her opinion; she relied on Employee's somewhat inaccurate account of the treadmill

incident and medical history to attribute the left knee injury to left-sided radiculopathy. AS 23.30.122.

Dr. Fraser testified Employee's December 2012 left knee MRI and x-ray indicated only a chronic degenerative process. Dr. Diamond opined the imaging records indicated both an acute injury and a degenerative process because the vertical bucket-handle tear and focal cartilage loss suggested an acute injury; the missing cartilage implied the cartilage, which was structurally compromised by the underlying degenerative process, had been traumatized and torn. He stated he would change his opinion regarding the work-relatedness of the left knee meniscus tear if there was documentation the treadmill episode occurred as a result of the work injury. As determined previously, there is such credible documentation. Dr. Diamond's explanation of the torn and missing cartilage was more believable since it corresponded with the medical record documenting an acute left knee injury on the treadmill and right-sided radiculopathy. The preponderance of the evidence is the work injury was a substantial factor contributing to Employee's need for treatment of the left knee injury because it caused right-sided radiculopathy which caused Employee to twist his left knee while walking on a treadmill. *Koons*; *Saxton*.

Drs. Adcox, Fraser and Diamond all concluded Employee had left knee pain prior to the December 2012 treadmill incident. Initially, Dr. Adcox diagnosed early degenerative change secondary to his previous left knee surgery. However, after discussing the left knee history with Employee, he changed his opinion and diagnosed a left knee meniscus tear caused by the work injury. Dr. Adcox never opined the left knee injury combined with, accelerated or aggravated the pre-existing left knee osteoarthritis to cause Employee's need for injections or a knee replacement. Dr. Diamond opined the work injury was not a substantial factor in Employee's need for anti-inflammatory usage, injections and a knee replacement because his pre-existing left knee osteoarthritis was the cause of his need for that medical treatment and he would have needed it despite the work injury. The preponderance of the evidence is the work injury was not a substantial factor in Employee's need for left knee anti-inflammatory usage, injections and a knee replacement. *Koons*; *Saxton*. Therefore, Employee's August 7, 2013 claim will be granted in part and denied in part.

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

Employee requests attorney's fees for time spent pursuing his claims. Attorney fees can only be awarded to attorneys licensed to practice law in Alaska or another state. *Alyeska Pipeline*; 8 AAC 45.180(b), (d). There is no statutory authority to award Employee fees and an attorney's fee award for pro se litigants has been prohibited. *Alaska Federal Savings and Loan*; April 2, 1996, Op. Att'y Gen. Fees will not be awarded.

A claimant will be awarded necessary and reasonable costs relating to the preparation and presentation of the issues upon which he prevailed at hearing on the claim. 8 AAC 45.180(f). The claimant must file a statement listing each cost claimed, and an affidavit stating the costs are correct and were incurred in connection with the claim. *Id*. The cost regulation does not require receipts. However, costs must be plead with some specificity in order to determine whether they are reasonable, necessary and in connection with the claim. Employee's costs do not show what he made copies of, what the postage was for etc.; his statement only estimated totals per cost types. The costs are not detailed enough to determine whether they are necessary and reasonable. Reimbursement for travel costs related to medical treatment, including mileage reimbursement and meals and lodging, is a benefit under the Act called transportation costs, and Employee did not request transportation costs until he filed his cost affidavit and failed to submit receipts for meals and lodging. 8 AAC 45.084(a), (b)(1), (f). Costs will therefore not be awarded.

CONCLUSIONS OF LAW

1) The oral order denying Employer's request to exclude medical reports from Drs. Adcox and Jessen was correct.
2) Employee is entitled to medical benefits for his left knee.
3) Employee is not entitled to attorney's fees or costs.

ORDER

1) Employee's August 7, 2013 claim is granted in part.
2) Employer shall pay for Employee's January 22, 2013 left knee surgery.

3) Employee's July 10, 2019 claim is denied.

Dated in Juneau, Alaska on November 21, 2019.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Kathryn Setzer, Designated Chair

/s/
Charles Collins, Member

/s/
Bradley Austin, 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 GARY R DAVIS, employee / claimant v. WRANGELL FOREST PRODUCTS, employer; WAUSAU UNDERWRITERS INSURANCE COMPANY, insurer / defendants; Case No. 198803834; dated and filed in the Alaska Workers' Compensation Board's office in Juneau, Alaska, and served on the parties on November 21, 2019.

/s/
Dani Byers, Acting Workers' Compensation Officer II