ALASKA WORKERS' COMPENSATION BOARD

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

ARTHUR R. BARBAZA,	)	
	)	
Employee,	)	FINAL DECISION AND ORDER
Claimant,	)	
	)	AWCB Case No. 201508217
v.	)	
	)	AWCB Decision No. 20-0058
STATE OF ALASKA, DEPARTMENT OF	)	
HEALTH AND SOCIAL SERVICES	)	Filed with AWCB Anchorage, Alaska
	)	on July 15, 2020.
Self-insured Employer,	)	
Defendant.	)	
	)	

Arthur Barbaza's (Employee) May 16, 2016 and June 12, 2018 claims were heard on February 19, 2020, in Anchorage, Alaska, a date selected on October 15, 2019. Employee's August 5, 2019 hearing request gave rise to this hearing. *Barbaza v. State of Alaska*, AWCB Decision No. 20-0022 (April 13, 2020) (*Barbaza I*) held the merits of Employee's permanent total disability (PTD) benefits could not be decided because his reemployment process did not end; it retained continuing jurisdiction to issue a merits decision upon receipt of a reemployment plan report. On June 8, 2020, Employee requested issuance of a merits decision contending reemployment specialist Loretta Cortis could not develop his reemployment plan. On June 18, 2020, Employee filed the response of Mark Simonson, M.D., declining to offer an opinion regarding reemployment plan. Attorney Michael Jensen represents Employee. Attorney Daniel Cadra represents State of Alaska, Department of Health and Social Services (Employer). The record was reopened upon receipt of Dr. Simonson's June 18, 2020 response and closed on the same date. This decision determines whether Employee's reemployment process ended and decides his claim's merits.

ISSUES

Employee contends his reemployment process ended because Dr. Simonson declined to offer an opinion about his reemployment plan, and consequently, Cortis could not develop a plan. He contends this decision should rely on the opinions of Drs. Lynn Carlson, M.D., Steven Humphreys, M.D., and Eugene Chang, M.D., stating Employee could not return to full-time employment.

Employer contends Employee's reemployment process did not end because Cortis should have consulted with Dr. Simonson, or alternately with Alan Roth, M.D., to develop a plan as set forth in the October 23, 2018 Partial Compromise and Release Agreement (the Partial Agreement).

1) Did Employee's reemployment process end?

Employee contends he became PTD due to his work injury, and seeks PTD benefits from August 29, 2019, and continuing.

Employer contends Employee is not PTD because he does not have complex regional pain syndrome (CRPS). It contends Employee can be retrained to return to work.

2) Is Employee entitled to PTD benefits?

Employee contends his hypertension is related to his work injury and seeks compensation for related medication costs.

Employer contends Employee's hypertension preexisted his work injury, is an idiopathic condition and unrelated to the work injury; thus, he is not entitled to related medication costs and/or a penalty.

3) Is Employee entitled to hypertension medication costs?

Employee contends because PTD benefits should have been awarded retroactive to August 29, 2019, but remained unpaid, he is entitled to a late-payment penalty. Employee also contends

Employer's controversion for his hypertension medication costs should have been withdrawn after Dr. Miller reversed his opinion. Because it refused to do so, he contends he is entitled to a penalty.

Employer contends Employee is not entitled to penalties because he is not entitled to PTD benefits and evidence or law support its controversion notices.

4) Is Employee entitled to penalties?

Employee contends he is entitled to past and ongoing benefits resulting from his attorney's efforts. Therefore, he seeks interest and attorney fees and costs.

Employer contends Employee is not entitled to additional benefits. Therefore, it contends there is no basis for interest, attorney fees or costs.

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

FINDINGS OF FACT

All factual findings and conclusions from *Barbaza I* are incorporated herein. The following additional facts are undisputed or established by a preponderance of the evidence:

1) On March 23, 2010, Gonzalo Araoz-Fraser, M.D., saw Employee and diagnosed lumbosacral sprain, backache, and insomnia. Employee reported "difficulty falling asleep, difficulty staying asleep, early morning awakening, unable to sleep after awakening." (Araoz-Fraser report, March 23, 2010).

2) On May 13, 2015, an echocardiogram showed Employee with (1) borderline to mild left ventricular hypertrophy (LVH) with normal appearing left ventricular systolic function and no RWMA, (2) mild left atrial enlargement, and (3) valves: trivial atrial insufficiency, mild mitral regurgitation, and trace tricuspid regurgitation. (John Bramante, M.D., report, May 13, 2015).

3) On May 14, 2015, Samuel Schurig, D.O., wrote, "Dr Bramante did an ECHO because in the ER the EKG showed LVH. The ECHO done on 5-13-2015 shows minimal LVH." (Schurig report, May 14, 2015).

4) On May 25, 2015, Employee injured his left ankle and low back while working for Employer. (First Report of Injury, May 28, 2015).

5) Prior to his May 25, 2015 work injury, Employee had "three clinic visits with slightly elevated blood pressure (144/82, 140/80, 140/80)." (Employee's Hearing Brief, Carlson letter, February 11, 2020, Exhibit K).

6) On May 28, 2015, a lumbar magnetic resonance imaging (MRI) showed L5-S1 degenerative disc bulge/protrusion worse than in 2010 and an osseous component of bridging along the adjacent endplates of L5-S1. It also showed mild spinal stenosis which might result in asymmetric L5 radiculopathy. A left ankle MRI showed no signs of bone bruising or fracture; there was soft tissue edema surrounding the ankle joint without focal hematoma. No ligamentous injury, tenosynovitis or osteochondral injury was present. A left foot MRI showed nonspecific finding of mild joint effusion at the first metatarsophalangeal joint, likely due to mild trauma without evidence of injection or adjacent fracture. It showed alignment was normal and ligamentous disruption was not present. There was dorsal edema along the midfoot and forefoot, similar to that seen surrounding the ankle. (Scott Harrison, M.D., report, May 28, 2015).

7) On June 1, 2015, Danny Romman, D.P.M., saw Employee and diagnosed reflex sympathetic dystrophy (RSD). (Romman report, June 1, 2015).

8) On June 2, 2015, Dr. Simonson saw Employee and diagnosed sprain and strain of deltoid ligament of ankle, pain in limb, lumbar sprain, lumbago, and CRPS. (Simonson report, June 2, 2015).

9) On July 9, 2015, Dr. Carlson saw Employee and diagnosed left foot pain, left ankle pain and swelling, and RSD. (Carlson report, July 9, 2015).

10) On August 17, 2015, Sean Green, M.D., a neurologist, conducted a records review employer medical evaluation (EME) and opined Employee did not have a neurologic condition. He said there was "no evidence in the records provided to support a diagnosis of CRPS, RSD, or peroneal neuropathy," and Employee's "lumbar spondylosis was preexisting and idiopathic." Dr. Green also opined the substantial cause of Employee's disability or need for treatment initially was the work injury to his left foot and ankle; however, there was no explanation for the current "subjective symptoms of pain and nonphysiologic symptoms of weakness and sensory alteration." He recommended no further treatment and noted Dr. Carlson's proposed treatments, such as oxygen, Cialis, montelukast, hydroxyzine, lorazepam, or Zofran, were extremely unusual and would not be considered reasonable and necessary care even if CRPS were present. (Green report, August 17, 2015).

11) On August 18, 2015, Marilyn Yodlowski, M.D., an orthopedic surgeon, saw Employee for an EME and diagnosed (1) left foot contusion and minor sprain/strain, (2) subjective complaints of pain and other symptoms out of proportion to objective findings beyond left foot and ankle, (3) prolonged disuse of the left lower extremity, (4) no RSD or CRPS, (5) possible chronic pain disease due to prolonged use of narcotics, and (6) possible narcotics dependence, both psychological and physical. Dr. Yodlowski said there was no evidence, such as significant swelling, atrophy, contractures or trophic changes, to support the RSD/CRPS diagnosis. She explained the May 25, 2015 injury was the cause of the left foot contusion and minor sprain/strain, which were resolved. She noted the May 28, 2015 MRI did not reveal any significant orthopedic injury, such as fracture, dislocation, disruption of any tendon, ligament or muscle, or any objective evidence of trauma, beyond a minor contusion. Dr. Yodlowski, therefore, said Employee's current disability or need for treatment was "likely due to a combination of iatrogenic factors in combination with certain preexisting conditions, possibly psychogenic factors, as well as the previous history of prolonged pain requiring narcotics in the past." (Yodlowski report, August 18, 2015).

12) On September 21, 2015, Employer denied Employee's ongoing treatment for RSD and CRPS based on Drs. Green and Yodlowski's EMEs. (Controversion Notice, September 21, 2015).

13) On September 25, 2015, Dr. Chang saw Employee and diagnosed second metatarsal cuneiform joint avulsion secondary to dorsiflexion injury and underlying RSD of left lower extremity. (Chang report, September 25, 2015).

14) On October 8, 2015, Employer denied Employee's ongoing treatment for RSD and CRPS, and Lamotrigine and Amlodipine Besylate prescriptions for RSD treatment based on Drs. Green and Yodlowski's EMEs. (Controversion Notice, October 8, 2015).

15) On October 12, 2015, Andrea Trescot, M.D., saw Employee and diagnosed CRPS and S1 pathology. On the same date, Dr. Carlson diagnosed CRPS type I. (Trescot report; Carlson Flowsheet, October 12, 2015).

16) On October 14, 2015, Dr. Carlson saw Employee and diagnosed CRPS type II. (Carlson report, October 14, 2015).

17) On November 3, 2015, a bone scan showed an increased blood pool activity on the left foot compared to the right. The findings were "suspicious" for CRPS/RSD involving left foot. (Jesse Kincaid, M.D., report, November 3, 2015).

18) On November 6, 2015, Employer denied all of Employee's medical benefits except treatment with an orthopedic surgeon based on Drs. Green and Yodlowski's EMEs. (Controversion Notice, November 6, 2015).

19) On December 11, 2015, a computerized tomography (CT) scan showed severe midfoot degenerative changes involving the region of the Lisfranc interval and the dorsal aspect of the navicular medial cuneiform joint. It also showed loose body within both the medial and lateral gutters of the ankle. (Mark Beck, M.D., report, December 11, 2015).

20) On January 28, 2016, Employee underwent arthrodesis of the first medial cuneiform, the second middle cuneiform, and the medial and mid cuneiform with allograft and infuse. (Operative Report, January 28, 2016).

21) On February 1, 2016, Dr. Yodlowski conducted a records review EME and diagnosed posttraumatic arthritis across Lisfranc midfoot joints secondary to an unappreciated Lisfranc dislocation with associated avulsion fracture. She opined this condition caused the posttraumatic arthritis, which would have accounted for Employee's ongoing midfoot pain, supported by degenerative arthritic changes seen on the CT scan. Dr. Yodlowski concluded the May 25, 2015 work injury was the substantial cause of Employee's current disability and need for treatment of the midfoot arthritis and arthrodesis. However, she did not identify him having or ever having had CRPS. Dr. Yodlowski said "[t]he diagnosis of CRPS is appropriate ONLY when there is no other explanation of a physically-based diagnosis to account for the symptoms and findings. In the case of [Employee], all of his clinical presentation, including his initial severe swelling and ecchymosis, right up until the recent bone scan, is explained by the unappreciated Lisfranc dislocation." (Yodlowski report, February 1, 2016).

22) On May 16, 2016, Employee claimed permanent partial impairment (PPI) benefits, medical and transportation costs, interest, attorney fees and costs. (Workers' Compensation Claim, May 16, 2016).

23) On September 1, 2016, Employee saw Dr. Carlson and reported having left shoulder, left arm and neck pain after falling down the stairs; his left foot "went out," and as he was trying to catch himself on the wall, he fell to the left side and hit his head on the corner of the stairs. His

left arm felt weak and was hypersensitive to touch. Dr. Carlson diagnosed left shoulder pain, neck pain, and RSD/left foot pain. (Carlson report, September 1, 2016).

24) On September 14, 2016, a cervical MRI showed a minimal bulge and a very mild dorsal endplate osteophyte formation with minimal ventral cord deformity. A left shoulder MRI showed (1) non distracted tear of the labrum from the posterior aspect superior labrum to the mid posterior superior quadrant, (2) moderate subscapularis tendinosis, (3) severe diffuse edema and thickening of the inferior glenohumeral ligament capsule most consistent with sprain, (4) approximately 5x5mm thin cortical and cartilage defect central superior humeral head, and (5) mid long head bicipital hemorrhagic tenosynovitis. (Gary Howell, M.D., report, September 14, 2016).

25) On February 16, 2017, Owen Ala, M.D., saw Employee and diagnosed biceps tendinosis of left shoulder, chronic left shoulder pain, and other chronic pain. (Ala report, February 16, 2017).

26) On February 17, 2017, Dr. Ala performed left shoulder arthroscopy with limited debridement of the glenohumeral joint, subacromial decompression, and open subpectoral biceps tenodesis. (Operative Report, February 17, 2017).

27) On March 21, 2017, Dr. Roth saw Employee for a second independent medical evaluation (SIME) and diagnosed trauma to the left foot with sprain and probable osseous trauma to the bony forefront, moderately severe preexisting degenerative lumbar spine and disc disease, and CRPS/RSD. Dr. Roth opined the May 25, 2015 work injury was the substantial cause of Employee's disability or need for medical treatment; not only did it result in CRPS, but also permanently changed his preexisting lumbar conditions. Dr. Roth said "Turning to Table 16-15 of the AMA Guides, 6th Edition, Complex Regional Pain Syndrome, [Employee] has skin color changes; has had edema; there is joint stiffness and decreased passive motion; positive bone scan consistent with CRPS. Therefore, [Employee], in my opinion, does have complex regional pain syndrome." Dr. Roth gave a 13 percent lower extremity impairment rating and said, "[Employee] can work at a sedentary job with the standard breaks. He may sit, in my opinion, a total of eight hours a day, and is limited to two hours a day of standing, half hour at a time, and no lifting." (SIME report, March 21, 2017).

28) On May 19, 2017, the parties stipulated Employee is eligible for reemployment benefits. (Stipulation, May 19, 2017).

29) On May 23, 2017, Employer withdrew its prior controversions and accepted "the compensability of the employee's left lower extremity chronic pain and CRPS (Complex Regional Pain Syndrome) conditions and symptoms" based on Dr. Roth's March 21, 2017 SIME. It agreed to pay "the past medical and medical related transportation expenses" for CRPS treatment and reserved "the right to controvert future medical care" that is not reasonable and necessary. (Stipulation, May 23, 2017).

30) On November 6, 2017, Employee told Dr. Carlson that two to three weeks earlier, he fell in the shower causing headache, right shoulder and neck pain and new left foot pain. (Carlson report, November 6, 2017).

31) On December 19, 2017, a right shoulder MRI showed (1) mild to moderate subscapularis tendinosis, (2) minimal subacromial/subdeltoid bursitis, (3) very mild thickening and increased signal of the inferior glenohumeral ligament suggestive of adhesive capsularis, and (4) Goutallier classification grade 1 supraspinatus, infraspinatus and teres minor muscles. A cervical spine MRI showed (1) mild disc bulge, minimal right paracentral disc protrusion and mild left uncovertebral hypertrophy at C3-4 causing mild to moderate left neural foraminal stenosis contacting the exiting left C4 nerve root and mild right neural foraminal stenosis without impingement, (2) minimal central disc protrusion at C5-6 causing no impingement, (3) small left foraminal disc protrusion at C6-7 causing mild to moderate left neural foraminal stenosis contacting the exiting left C7 nerve root. (Gary Howell, M.D., report, December 19, 2017).

32) On February 27, 2018, Dr. Roth saw Employee for another SIME and diagnosed status post Lisfranc fracture with ORIF, secondary CRPS/RSD, preexisting lumbosacral degenerative spine and disc disease, and depression. He reiterated Employee had CRPS/RDS and opined he is capable of working a sedentary job and would be able to work as a medical record coder. Dr. Roth said Employee is limited to "lift and carry on a frequent basis less than 10 pounds" and "stand and walk less than two hours a day." However, when asked whether Employee could perform as a medical record coder, a job that would exceed his physical limitations, Dr. Roth answered "In my opinion, the patient is able to perform the job of a medical record coder," but did not elaborate. Dr. Roth did not recommend orthotic devices, scooter or other treatment for CRPS/RSD, except use of a cane. Dr. Roth opined Employee's low back condition predated his work injury, and no other treatment resulting from his work injury was necessary. He also said Employee "has received a fair amount of unnecessary medical treatment [from Dr. Carlson],

which should be considered experimental and not founded in the basis of science. Oxygen through nasal cannula to treat RSD, oxygen generator prescription, Cialis, ultraviolet blood irradiation procedures, prescription of methadone Nucynta, all of the heavy narcotics, rectal ozone, are examples of treatments which are not reasonably expected to offer any improvement in the level of function or decrease of pain." Dr. Roth concluded "at this point there is very little hope of improvement in [Employee's] condition given the totality of the circumstances" and revised his March 21, 2017 lower extremity impairment rating to 25 percent. (SIME report, February 27, 2018).

33) On May 31, 2018, Employer denied spine treatment, orthotic devices, and temporary total disability (TTD) and temporary partial disability (TPD) benefits based on Dr. Roth's February 27, 2018 SIME. (Controversion Notice, May 31, 2018).

34) On June 12, 2018, Employee claimed TTD and §041(k) benefits from February 27, 2018, and continuing, PTD, PPI and benefits, medical and transportation costs (orthotics), interest, attorney fees and costs. (Workers' Compensation Claim, June 12, 2018).

35) On June 27, 2018, Employer answered and denied Employee's June 12, 2018 claim in its entirety. (Answer, June 27, 2018).

36) On July 24, 2018, Dr. Ala opined Employee's left shoulder condition was caused by his August 30, 2016 fall, which resulted from his left foot CRPS and chronic pain conditions related to the May 25, 2015 work injury. (Ala report, July 24, 2018).

37) On September 6, 2018, Dr. Simonson saw Employee and diagnosed an L5-S1 annular tear, right paracentral. He opined "the back injury and ongoing lumbar problem is work related inasmuch as his fall was secondary to his left lower extremity dyscontrol, which is a result of his work related injury." (Simonson report, September 6, 2018).

38) On October 23, 2018, the parties filed the Partial Agreement; in pertinent part it states:

> 1. Through the present, compensability of the following conditions is not disputed by the Employer:
>
> a. Left foot – including orthotics
> b. Left shoulder
> c. Low back
> d. CRPS

> Reasonable and necessary medical treatment for CRPS or left foot Lisfranc fracture does not include rectally injected ozone, irradiated blood transfusion, off-label use of prescription medications, or other unproven, experimental treatments (such as Ketamine therapy, etc.).
>
> . . . .
>
> 2. SOA retains the right to obtain its own medical expert opinion regarding reasonable and necessary medical treatment and retains its defenses under the Act based upon new evidence.
>
> . . . .
>
> 6. Mr. Barbaza will cooperate with Loretta Cortis to develop a retraining plan under the following criteria:
>
> a. If Mr. Barbaza has low back surgery within four months of October 16, 2018, a plan will be developed within the seven months after surgery and plan participation will commence within one year after surgery.
>
> b. If surgery is not recommended, then a plan will be developed and plan participation will commence within one year of October 16, 2018.
>
> c. Loretta Cortis shall consult with Dr. Simonson for plan approval.
>
> d. If Dr. Simonson does not approve the developed plan, the parties stipulate to send the plan approval issue to SIME physician Dr. Roth. . . . (Partial Agreement, October 23, 2018)

39) On November 8, 2018, Employer denied rectally injected ozone, irradiated blood transfusions, off label use of prescription medications, IV Ketamine treatments or other unproven experimental treatments for CRPS or left foot Lisfranc fracture based on the Partial Agreement. (Controversion Notice, November 8, 2018).

40) On November 14, 2018, Dr. Carlson opined Employee's CRPS pain caused "different sleep disorders including insomnia alternating with times of severe somnolence (due to never getting restful sleep). These sleep disorders together with decreased overall fitness and loss of muscle have [led] to sleep apnea. Sleep apnea therefore is also largely due to CRPS. His Hypertension is also largely caused by CRPS, partly through inflammatory mediators from insomnia and sleep apnea, as well as decreased overall activity." (Carlson report, November 14, 2018).

41) On January 16, 2019, Timothy Miller, D.O., opined the May 25, 2015 injury was not the substantial cause to prescribe Simvastatin for dyslipidemia, Losartan for hypertension, and Bystolic for hypertension; Employee's hypertension was a chronic condition unrelated to his work injury. (Miller report, January 16, 2019).

42) On January 28, 2019, Dr. Humphries performed an L5-S1 disc arthroplasty on Employee. (Operative Report, January 28, 2019).

43) On February 5, 2019, Employer denied Simvastatin, Losartan, and Bystolic prescriptions based on Dr. Miller's opinion. It again denied rectally injected ozone, irradiated blood transfusions, off label use of prescription medications, IV Ketamine treatments or other unproven experimental treatments for CRPS or left foot Lisfranc fracture based on the Partial Agreement. (Controversion Notice, February 5, 2019).

44) On February 25, 2019, Jensen filed a petition for prehearing and protective order on behalf of Employee. (Petition for Prehearing and Protective Order, February 25, 2019).

45) On February 27, 2019, Dr. Carlson wrote a "To Whom it May Concern" letter,

> Concerning Mr. Barbaza's CRPS and high blood pressure. There are several ways that CRPS can increase blood pressure and affect heart and cardiovascular function. . . .
>
> Patients with CRPS are in sympathetic overdrive which causes severe pain and vasoconstriction and can also directly increase inotropy and chronotropy of the heart. I am following several CRPS patients who have had severe heart problems and arrhythmias since their CRPS began.
>
> Mr. Barbaza had three clinic visits with slightly elevated blood pressure (144/82, 140/80, 140/80) before the work related injury. His systolic blood pressure was well below 144 most of the visits (9 recorded blood pressures between 112-136 systolic and 72-82 diastolic). After the injury, the blood pressure has gradually increased and there have been many blood pressure readings with SBP well over 145. We should assume that this happened due to CRPS related vasoconstriction, increased pain and sympathetic overdrive. . . .
>
> Dr. Miller, on a busy day, was asked to help out with refills of medications. He was not familiar with Mr. Barbaza's case. He acknowledges that Mr. Barbaza's increased blood pressure is likely due largely to his work related injury. We will be more careful in the future to have providers who are familiar with complex patients consult about refilling medicine. He did not understand the need for increasing nitric oxide (and resultant vasodilation which can be accomplished with Bystolic.).

This letter was signed both by Drs. Carlson and Miller. (Carlson and Miller letter, February 27, 2019; Employee's Hearing Brief, February 11, 2020, Exhibit K).

46) On March 7, 2019, Employer denied experimental or unproven treatment for CRPS or left foot Lisfranc fracture based on the Partial Agreement. (Controversion Notice, March 7, 2019).

47) On March 8, 2019, Employer denied off-label use of Hydroxyzine and experimental or unproven treatment for CRPS or left foot Lisfranc fracture based on the Partial Agreement. (Controversion Notice, March 8, 2019).

48) On April 5, 2019, Dr. Chang said, "[Employee] asked me to sign a form where it states that he will likely not be able to work a 40-hour week. I tend to agree considering his foot situation, back situation, as well as his shoulder. It is hard to imagine that this patient is going to comfortably and productively be able to work 40 hours a week indefinitely." On the same date, Dr. Chang signed a form stating Employee is permanently precluded from performing any type of full-time employment. (Chang reports, April 5, 2019).

49) On April 10, 2019, Dr. Humphreys signed a form stating Employee is permanently precluded from performing any type of full-time employment. (Humphreys note, April 10, 2019).

50) On June 19, 2019, Dr. Green conducted a records review EME and diagnosed (1) left foot contusion, resolved; (2) left foot fracture/dislocation of the midfoot joints (Lisfranc fracture, with associated avulsion fracture), medically stable; (3) midfoot posttraumatic arthritis, secondary to misdiagnosed Lisfranc fracture; and (4) status post technically successful midfoot fusion procedure by Dr. Chang. Dr. Green opined these conditions were related to the May 25, 2015 injury but left foot fracture/dislocation of the midfoot joints was misdiagnosed by several providers, "most emphatically by Dr. Carlson," as CRPS or RSD. He stated "the misdiagnosis was evident by September 2015, following neurology and orthopedic surgery specialty IME/MRR evaluations." Further, Dr. Green stated, "[t]here is an additional complication: reportedly, there is a stipulation regarding the existence and compensability of non-existent CRPS. From a medical perspective, CRPS is not present, and the Lisfranc fracture and consequential post-traumatic arthritis are the sole work-related causes of pain. . . . [P]retending that nonexistent conditions are present is not helpful. It is likely only to result in misdirected and ineffective treatment, with objectively worse health outcomes. Physicians are human, and diagnostic errors do occur. Physicians are expected to practice with sufficient thought, care, and humility to recognize and correct errors in their practice. A diagnostic error should not be misunderstood as established or immutable fact." Dr. Green opined "it is likely that the pain symptoms presented were not substantially caused by the midfoot arthritis and the work injury, because they persisted unchanged following the surgery." He said "probable somatic symptom

disorder (pain predominant)" is the most likely explanation for Employee's "disproportionate report of somatic symptoms." However, he also said it is outside of "[his] primary area of expertise, and because malingering is an important consideration in the differential diagnosis, [he was] not specifically making a diagnosis of somatic symptom disorder based on review or records." Dr. Green diagnosed the following preexisting conditions unrelated to the May 25, 2015 injury: (1) probable somatic symptom disorder; (2) probable personality disorder; (3) probable depression and/or anxiety; (4) hypertension (possible contribution from obstructive sleep apnea); (5) obstructive sleep apnea; (6) cervical and lumbar spondylosis; (7) degenerative arthritis and tendinosis of the shoulders associated impingement; (8) dyslipidemia; and (9) right knee partial anterior cruciate ligament tear. With regard to Employee's hypertension, Dr. Green stated the May 13, 2015 echocardiogram showed mild LVH and mild left atrial enlargement, which was associated with trivial atrial insufficiency, mild mitral regurgitation and trace tricuspid regurgitation, and concluded "to the degree that this study is abnormal, it indicates anatomical changes of the heart that are most consistent with chronic hypertension." He stated Dr. Carlson's November 14, 2018 opinion that CRPS caused sleep apnea and hypertension was "absurd." Dr. Green stated "[i]nsomnia and hypersomnia are symptoms, not causes of obstructive sleep apnea. CRPS has never been described in the literature as a cause of obstructive sleep apnea," and "[h]ypertension is a common condition in the general population and is frequently exacerbated by obstructive sleep apnea. There is no evidence in the scientific literature to support Dr. Carlson's theory that CRPS (or healed Lisfranc fracture, the actual condition) is a cause of hypertension." (Green report, June 19, 2019).

51) In contrast to his August 17, 2015 records review EME, which covered Employee's medical records from May 25, 2015, through July 23, 2015, Dr. Green's June 19, 2019 EME was more extensive covering medical records from August 1991 through May 9, 2019. (Observation).

52) On August 29, 2019, Cortis submitted a reemployment plan report, which concluded:

> Arthur Barbaza has undergone many surgical interventions in an attempt to ease his pain. He has CRPS and related left foot weakness, hip pain and bilateral knee pain. Dr. Carlson has noted that any trauma can worsen his CRPS symptoms. Mr. Barbaza's physicians, Drs. Carlson, Humphreys and Chang have all opined that Mr. Barbaza is not able to return to full-time gainful employment; therefore, a Reemployment Plan cannot be developed. (Cortis report, August, 2019).

53) On December 20, 2019, Dr. Green said, "Regarding the work condition, the midfoot arthritis, I believe that he should follow up with his orthopedic surgeon, Dr. Chang, and really have a well-supported evaluation in terms of what work he can do and what he can't do given the midfoot fracture." Dr. Green further said he would defer to Dr. Chang regarding the need for treatment as well as the restrictions in Employee's work activities based on the best available medical science. (Deposition of M. Sean Green, MD, December 20, 2019, at 41-42, 88-89).

54) On December 20, 2019, Dr. Green testified neither CRPS nor midfoot arthritis caused LVH and LVH diagnosis prior to the May 25, 2015 injury meant there was and had been chronic, clinically significant hypertension. He said Employee had "somatic symptom disorder, pain predominant," and pain could elevate blood pressure; however, it did not explain "his chronic, inadequately treated hypertension. . . . Other factors than the pain are more likely to explain his hypertension, in particular the condition. . . that is called essential hypertension, which has considerable heritability and is likely caused by unknown genetic factors." He also said Employee's high blood pressure was idiopathic. (Deposition of M. Sean Green, M.D., December 20, 2019, at 63, 79).

55) On February 12, 2020, Employee sought $34,380.00 in attorney fees and $2,492.72 in costs, totaling $36,872.72. (Fee Affidavit, February 12, 2020).

56) On February 13, 2020, Employer objected to attorney fees and costs from November 13, 2018, to May 6, 2019, contending Employee's attorney was not representing Employee for that period. It did not dispute the remaining hours billed but asked reduction of hours as the issue presented was a re-characterization of TTD benefits to PTD benefits resulting no monetary change in compensation. Employer also asked reduction of billing rate to $400.00 per hour. (Employer's Opposition to Affidavit of Attorney Fees and Costs, February 13, 2020).

57) On February 18, 2020, Employee sought an additional $2,610.00 in attorney fees. (Supplemental Fee Affidavit, February 18, 2020).

58) On February 19, 2020, at the *Barbaza I* hearing, Employer abandoned "its argument for another SIME with Dr. Roth" because the parties previously agreed it would be "unnecessary" and would not be "a fair game." (*Barbaza I* at 3).

59) On February 19, 2020, at the *Barbaza I* hearing, Dr. Carlson testified CRPS type II involves a specific nerve; however, he admitted he did not identify any specific nerve in making

the October 14, 2015 CRPS type II diagnosis. Also, he said Employee was "genetically susceptible" to CRPS but did not provide medical evidence to support this. (Carlson).

60) *Barbaza I* found Employee's reemployment process did not end because Cortis failed in her duty by concluding a reemployment plan could not be developed based on Drs. Carlson, Chang, and Humphreys' opinions, instead of consulting with Dr. Simonson for plan approval as set forth in the Partial Agreement. It ordered Cortis to develop a plan and consult with Dr. Simonson for its approval; it retained jurisdiction to issue a merits decision upon receipt of her reemployment plan report. (*Barbaza I* at 7).

61) On February 24, 2020, Employee sought an additional $5,130.00 in attorney fees and $2,944.72 in costs, totaling $8,074.72. To this date, he seeks $45,839.72, $42,507.50 in attorney fees and $3,332.22 in costs. (Supplemental Fee Affidavit, February 24, 2020).

62) On May 14, 2020, Cortis submitted a reemployment plan to retrain Employee as an Accounting Clerk or Medical Receptionist to Dr. Simonson for review as ordered by *Barbaza I*. However, on May 20, 2020, Dr. Simonson responded, "I have not seen Mr. Barbaza seen 8/19. I am currently working part-time with practice limited to EMG and injections. Suggest review by Dr. Shawn Johnston or other provider." (Cortis email, June 2, 2020).

63) On June 2, 2020, Cortis emailed the parties and the division, "Hello, I have heard back from Dr. Simonson. He has stated the following: 'I have not seen Mr. Barbaza seen 8/19. I am currently working part-time with practice limited to EMG and injections. Suggest review by Dr. Shawn Johnston or other provider.' He has put this in writing and I am attaching his correspondence to this letter. Please let me know how you would like to proceed. Thanks, Loretta." (Cortis email, June 2, 2020).

64) On June 5, 2020, Dr. Simonson responded to Employee's question whether Employee can or cannot perform a job on a full-time basis, "Recommend evaluation by Dr. Johnston or other independent medical evaluator." (Simonson response, June 5, 2020).

65) Employee did not graduate from high school and does not have a GED; he scored below average in aptitude testing, and six grade level overall in academic testing. His past employments are cook, long line fisherman, and juvenile justice officer. (Reemployment Benefits Plan Reports, October 11, 2017; September 13, 2018, Employee).

66) The division's records show July 29, 2019, is the last date Employee received any disability, impairment or §.041(k) benefits. (Agency file).

67) Although Employee's reemployment process did not end until Cortis consulted with Dr. Simonson and he declined to offer an opinion pursuant to the Partial Agreement, it was more likely than not that he could no longer be expected to be able to work full time from August 29, 2019, Cortis' report date, in any continuously available work given his education, aptitude, experience and physical limitations. (Judgment; observation; inferences drawn from above).

68) Jensen began representing Employee in this case from 2016. His hourly billing rate of $450.00 is within the range of contingent fee customarily charged in Anchorage for workers' compensation cases. (Agency file, observation).

PRINCIPLES OF LAW

> **AS 23.30.001. Legislative intent.** It is the intent of the legislature that
>
> (1) this chapter be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter;
> . . . .

The board may base its decisions not only on 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, 533-34 (Alaska 1987).

Taylor v. Southeast-Harrison Western Corp., 694P.2d 1160 (Alaska 1985), held the Act's sections should not be viewed "in isolation" because they are "part of a comprehensive scheme." *Id*. at 1162. The exclusive remedy provision is "merely one feature of a program designed to provide compensation in a wide variety of cases." It also noted the Act serves "the goal of securing adequate compensation for injured employees without the expense and delay inherent in a determination of fault as between the employee and employer." *Id*.

Nelson v. Municipality of Anchorage, 267 P.3d 636, 642 (Alaska 2011), explained when construing a statute, the Alaska Supreme Court "presume[s] that the legislature intended every word, sentence, or provision of a statute to have some purpose, force, and effect, and that no

words or provisions are superfluous. . . . [A]ll sections of an act are to be construed together so that all have meeting and no section conflicts with another. . . . [If one statutory] section deals with a subject in general terms and another deals with a part of the same subject in a more detailed way, the two should be harmonized, if possible; but if there is a conflict, the specific section will control over the general. . . . [I]f two statutes conflict, then the later in time controls over the earlier."

> **AS 23.30.005. Alaska Workers' Compensation Board**. . . .
> . . . .
>
> (h) . . . Process and procedure under this chapter shall be as summary and simple as possible. . . .
>
> **AS 23.30.010. Coverage**. (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. . . .
>
> **AS 23.30.012. Agreements in regard to claims.**
> . . . .
>
> (b) . . . If approved by the board, the agreement is enforceable the same as an order. . . of the board. . . . The agreement shall be approved by the board only when the terms conform to the provisions of this chapter, and, if it involves or is likely to involve permanent disability, the board may require an impartial medical examination and a hearing in order to determine whether or not to approve the agreement. . . .

Seybert v. Cominco Alaska Exploration, 182 P.3d 1079, held a workers' compensation settlement is a contract, in which common law standards of contract formation and rescission apply to the extent these standards are not overridden by statute.

> **AS 23.30.041. Rehabilitation and reemployment of injured workers.**
> . . . .
>
> (k) Benefits related to the reemployment plan may not extend past two years from date of plan approval or acceptance, whichever date occurs first, at which time the benefits expire. If an employee reaches medical stability before completion of the plan, temporary total disability benefits shall cease, and permanent impairment benefits shall then be paid at the employee's temporary total disability rate. If the

> employee's permanent impairment benefits are exhausted before the completion or termination of the reemployment process, the employer shall provide compensation equal to 70 percent of the employee's spendable weekly wages, but not to exceed 105 percent of the average weekly wage, until the completion or termination of the process, except that any compensation paid under this subsection is reduced by wages earned by the employee while participating in the process to the extent that the wages earned, when combined with the compensation paid under this subsection, exceed the employee's temporary total disability rate. If permanent partial disability or permanent partial impairment benefits have been paid in a lump sum before the employee requested or was found eligible for reemployment benefits, payment of benefits under this subsection is suspended until permanent partial disability or permanent partial impairment benefits would have ceased, had those benefits been paid at the employee's temporary total disability rate, notwithstanding the provisions of AS 23.30.155(j). A permanent impairment benefit remaining unpaid upon the completion or termination of the plan shall be paid to the employee in a single lump sum. An employee may not be considered permanently totally disabled so long as the employee is involved in the rehabilitation process under this chapter. . . .
>
> **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. . . .

The presumption applies to any claim for compensation. *Meek v. Unocal Corp*., 914 P.2d 1276 (Alaska 1996). In the first step, the claimant need only adduce "minimal" relevant evidence establishing a "preliminary link" between the injury and employment. *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.,* 742 P.2d 239, 244 (Alaska 1987). Credibility is not weighed here. *Resler v. Universal Services Inc.*, 778 P.2d 1146 (Alaska 1989).

In the second step, to rebut the presumption, an employer must present substantial evidence that either (1) a something other than work was the substantial cause of the disability or need for medical treatment or (2) that work could not have caused the disability or need for medical treatment. *Huit v. Ashwater Burns, Inc*., 372 P.3d 904 (Alaska 2016). The defendant has the burden to overcome the presumption with substantial evidence to the contrary. "Substantial evidence" is such "relevant evidence" as a "reasonable mind might accept as adequate to support

a conclusion." *Tolbert*, 973 P.2d at 611-12. Credibility is not examined at the second step either. *Resler*.

In the third step, if the defendant's evidence rebuts the presumption, it drops out and the claimant must prove his claim by a preponderance of the evidence. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). The evidence is weighed, inferences drawn and credibility determined. *Steffey v. Municipality of Anchorage*, 1 P.3d 685 (Alaska 2000). The presumption analysis does not apply to undisputed issues. *Rockney v. Boslough Construction Co*., 115 P.3d 1240 (Alaska 2005).

> **AS 23.30.122. Credibility of witnesses.** The board has the sole power to determine the credibility of a witness. . . .

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

> **AS 23.30.145. Attorney Fees**. (a). Fees for legal services rendered in respect to a claim are not valid unless approved by the board, and the fees may not be less than 25 percent on the first $1,000 of compensation or part of the first $1,000 of compensation, and 10 percent of all sums in excess of $1,000 of compensation. When the board advises that a claim has been controverted, in whole or in part, the board may direct that the fees for legal services be paid by the employer or carrier in addition to compensation awarded; the fees may be allowed only on the amount of compensation controverted and awarded. . . . In determining the amount of fees, the board shall take into consideration the nature, length, and complexity of the services performed, transportation charges, and the benefits resulting from the services to the compensation beneficiaries. . . .

The Alaska Supreme Court in *Wise Mechanical Contractors v. Bignell*, 718 P.2d 971, 974-75 (Alaska 1986), held attorney fees should be reasonable and fully compensatory, considering the contingency nature of representing injured workers, in order to ensure adequate representation. In *Bignell*, the court required consideration of a "contingency factor" in awarding fees to employees' attorneys in workers' compensation cases, recognizing attorneys only receive fee awards when they prevail on a claim. *Id*. at 973. The court instructed the board to consider the nature, length, and complexity of services performed, the resistance of the employer, and the benefits resulting from the services obtained, when determining reasonable attorney fees for the successful prosecution of a claim. *Id*. at 973, 975.

In *Childs v. Copper Valley Elec. Ass'n*, 860 P.2d 1184, 1190 (Alaska 1993), the Alaska Supreme Court held "attorney's fees in workers' compensation cases should be fully compensatory and reasonable," so injured workers have "competent counsel available to them." Nonetheless, when an employee does not prevail on all issues, attorney fees should be based on the issues on which the employee prevailed.

Rusch & Dockter v. SEARHC, 453 P.3d 784, 803 (Alaska 2019), held an award of attorney fees will only be reversed if it is "manifestly unreasonable" -- this differs from the "substantial evidence" test used for review of factual determinations. The Alaska Supreme Court explained "[a] determination of reasonableness requires consideration and application of various factors that may involve factual determinations, but the reasonableness of the final award is not in itself a factual finding." *Rusch & Dockter*. It also held the board must consider all of the following eight non-exclusive factors set out in Alaska Rule of Professional Conduct 1.5(a) when determining the reasonableness of a fee:

> (1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;
>
> (2) the likelihood, that the acceptance of the particular employment will preclude other employment by the lawyer;
>
> (3) the fee customarily charged in the locality for similar legal services;
>
> (4) the amount involved and the results obtained;
>
> (5) the time limitations imposed by the client or by the circumstances;
>
> (6) the nature and length of the professional relationship with the client;
>
> (7) the experience, reputation, and ability of the lawyer or lawyers performing the services; and
>
> (8) whether the fee is fixed or contingent.

State of Alaska v. Wozniak, AWCAC Decision No. 276 (March 26, 2020), held a lump sum award of fees incurred to the date of hearing and a separate award of ongoing fees on Employee's ongoing PTD benefits is a "reasonable and compensatory award of fees for the benefit obtained, based on the statutory ten percent of compensation awarded."

> **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. . . .
>
> (e) If any installment of compensation payable without an award is not paid within seven days after it becomes due, as provided in (b) of this section, there shall be added to the unpaid installment an amount equal to 25 percent of the installment.
> . . . .
>
> (p) An employer shall pay interest on compensation that is not paid when due. Interest required under this subsection accrues at the rate specified in AS 09.30.070(a) that is in effect on the date the compensation is due. . . .

AS 23.30.155(e) provides penalties when employers fail to pay compensation when due. *Haile v. Pan Am. World Airways*, 505 P.2d 838 (Alaska 1973). An employee is also entitled to penalties on compensation due if compensation is not properly controverted by the employer. *Williams v. Abood*, 53 P.3d 134 (Alaska 2002). If an employer neither controverts employee's right to compensation, nor pays compensation due, §155 imposes a penalty. *Harp v. ARCO Alaska, Inc.*, 831 P.2d 352 (Alaska 1992). To avoid a penalty, a controversion must be filed in good faith. *Id.* For it 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. *Id*.

Land and Marine Rental Co. v. Rawls, 686 P.2d 1187 (Alaska 1984), the Supreme Court held a workers' compensation award, or any part thereof, shall accrue lawful interest from the date it should have been paid.

> **AS 23.30.180. Permanent total disability.** (a) In case of total disability adjudged to be permanent 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the total disability. . . . Loss of both hands and both arms, or both feet, or both legs, and both eyes, or of any two of them, in the absence of conclusive proof to the contrary, constitutes permanent total disability. In all other cases permanent total disability is determined in accordance with the facts. In making this determination the market for the employee's services shall be (1) area of residence; (2) area of last employment; (3) the state of residence; and (4) the State of Alaska. . . .

For workers' compensation purposes permanent total disability does not necessarily mean a "state of abject helplessness." It means the inability because of injuries to perform services other than those that are so limited in quality, dependability or quantity that a reasonably stable market for them does not exist. *J. B. Warrack Co. v. Roan*, 418 P.2d 986, 988 (Alaska 1966). For an employer to rebut the presumption of compensability, it must produce substantial evidence that shows work within an employee's abilities is regular and continuously available in the relevant labor markets described in (a) of the statute. *Leigh v. Seekins Ford*, 136 P.3d 214 (Alaska 2006). This burden may be satisfied with labor market surveys of the specific and relevant markets. *Id*.

> **8 AAC 45.120. Evidence.**
> . . . .
>
> (e) Technical rules relating to evidence and witnesses do not apply in board proceedings, except as provided in this chapter. Any relevant evidence is admissible if it is the sort of evidence on 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. Hearsay evidence may be used for the purpose of supplementing or explaining any direct evidence, but it is not sufficient in itself to support a finding of fact unless it would be admissible over objection in civil actions. . . . Irrelevant or unduly repetitious evidence may be excluded on those grounds. . . .

> **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. . . .

ANALYSIS

1) Did Employee's reemployment process end?

Barbaza I found Employee's reemployment process had not ended because Cortis had not consulted with Dr. Simonson for plan approval as set forth in the Partial Agreement. Thus, it ordered her to develop a plan and consult with Dr. Simonson for its approval. Since, Cortis submitted a reemployment plan for Medical Receptionist and Accounting Clerk to Dr. Simonson for review. However, he declined to offer an opinion; instead, Dr. Simonson recommended a plan review by "Dr. Johnston or other independent medical evaluator." Cortis emailed the parties and the division, "Please let me know how you would like to proceed."

Employer contends Employee is still in the reemployment process because "[t]he provision that Ms. Cortis consult with Dr. Simonson for plan approval did not occur" because he refrained from doing so, instead recommending review by Dr. Johnston or other provider. It contends "[p]ursuant to the parties' agreement as expressed in the partial C&R, the developed plan(s) should therefore be referred to SIME physician Dr. Roth." This is incorrect.
The Partial Agreement is a contract, in which common law standards of contract formation and rescission apply to the extent these standards are not overridden by statute. *Seybert*. Also, as it was approved, it is "enforceable the same as an order." AS 23.30.012(b). Paragraph 6, section "c" of the Partial Agreement states "Loretta Cortis shall consult with Dr. Simonson for plan approval." It is undisputed she developed a plan and consulted with Dr. Simonson for approval. Next, Paragraph 6, section "d," states "If Dr. Simonson does not approve the developed plan, the parties stipulate to send the plan approval issue to SIME physician Dr. Roth. . . ." However, *Barbaza I* held this section null and void because Employer abandoned "its argument for another SIME with Dr. Roth"; the parties had previously agreed it would be "unnecessary" and would not be "a fair game." Therefore, even though by declining to review the plan, Dr. Simonson did not approve it, the parties are not bound to send it to Dr. Roth because under *Barbaza I*, all terms and conditions of the Partial Agreement regarding reemployment process have been satisfied. *Rogers & Babler*. Dr. Simonson's recommendation for Dr. Johnston or other provider is irrelevant because the Partial Agreement does not bind the parties to his recommendation.

Absent contractual duties limiting use of other medical opinions, Cortis' August 29, 2019 report can now be considered. *Id*; 8 AAC 45.120(e). Proceeding in this fashion will help ensure "quick, efficient, fair, and predictable" delivery of benefits to Employee if he is entitled to them, at a reasonable cost to Employer, and will create a more "summary and simple" adjudicative process. AS 23.30.001(1); AS 23.30.005(h). As Employer said, another SIME would be "unnecessary" and would not be "a fair game." In her August 29, 2019 report, Cortis concluded a reemployment plan could not be developed because "Drs. Carlson, Humphreys and Chang have all opined that [Employee] is not able to return to full-time gainful employment." These doctors have been treating Employee's medical conditions for a substantial period and are familiar with his physical capacity; her reliance on their opinions is reasonable. AS 23.30.122; *Smith*. Therefore, Employee is no longer deemed to be involved in the reemployment process; consequently, this decision can decide his PTD claim. AS 23.30.041(k).

2) Is Employee entitled to PTD benefits?

Employee contends he became permanently totally disabled due to the May 25, 2015 work injury and seeks PTD benefits from August 29, 2019, and continuing. In contrast, Employer contends Employee is not permanently totally disabled because he does not have CRPS and is not permanently totally disabled from his left foot Lisfranc fracture; further, regardless of CRPS and/or Lisfranc fracture, his disability was not substantially caused by the work injury.

a) Employee has work-related CRPS.

Employee's entitlement to PTD benefits is a question to which the presumption of compensability applies. AS 23.30.120(a)(1); *Meek*. Without regard to credibility, Employee raised the presumption for PTD benefits based on Dr. Carlson's opinion that his CRPS is a work-related condition that prevents Employee from returning to full-time employment. *Cheeks*; *Resler*.

Employee contends Dr. Green's June 19, 2019 opinion is not "new evidence" and does not overcome the presumption of compensability because it is the same as his August 17, 2015 opinion. This is incorrect. Dr. Green's August 17, 2015 records review EME covered

Employee's medical records from May 25, 2015, through July 23, 2015; his June 19, 2019 records review EME covered medical records from August 1991 through May 9, 2019. Also, the latter EME report was significantly more extensive and thorough than the first one. Just because both opinions reached the same conclusion, it does not mean they are the same evidence. *Rogers & Babler*. Also, Dr. Green does not have to agree with the parties' CRPS compensability stipulation. *Id*. Nonetheless, this "new evidence" is irrelevant. Pursuant to the May 25, 2017 stipulation, Employer withdrew its prior controversions, accepted "the compensability of the employee's left lower extremity chronic pain and CRPS," agreed to pay "the past medical and medical related transportation expenses" for CRPS treatment and reserved "the right to controvert future medical care" that is not reasonable and necessary. Under the Partial Agreement, Employer agreed "through the present," it did not dispute Employee's CRPS compensability but retained "the right to obtain its own medical expert opinion regarding reasonable and necessary medical treatment" and "its defenses under the Act based upon new evidence." In both instances, Employer reserved only the right to scrutinize reasonableness and necessity of medical care, not the right to challenge the diagnosis or causation of CRPS. AS 23.30.012(b); *Seybert*. In short, Dr. Green's opinion is "new evidence," but it is irrelevant evidence; thus, it cannot be used to dispute CRPS. Employee has work-related CRPS because Employer failed to provide substantial evidence to rebut the presumption. *Id*; *Huit*; *Rockney*.

Arguendo, if Employer had not agreed to limit its right to challenge the diagnosis or causation of CRPS, Dr. Green's opinion would be relevant, and without regard to credibility, Employer may rebut the preliminary presumption with it. *Resler*. Dr. Green said the Lisfranc fracture and consequential posttraumatic arthritis are the sole work-related causes of pain. Further, Dr. Green opined "it is likely that the pain symptoms presented were not substantially caused by the midfoot arthritis and the work injury, because they persisted unchanged following the surgery." *Huit*; *Tolbert*. Employer also relies on SIME Dr. Roth's opinion that Employee is capable of working a sedentary job and would be able to work as a medical record coder. Then, the burden of proof would shift back to Employee who would have to prove his CRPS is work-related by a preponderance of the evidence. *Saxton*; *Steffey*.

Dr. Carlson has maintained his CRPS diagnosis and provided Employee with different treatment options. However, his opinion would be given less weight. AS 23.30.122; *Smith*. SIME Dr. Roth said Employee "has received a fair amount of unnecessary medical treatment [from Dr. Carlson], which should be considered experimental and not founded in the basis of science. Oxygen through nasal cannula to treat RSD, oxygen generator prescription, Cialis, ultraviolet blood irradiation procedures, prescription of methadone Nucynta, all of the heavy narcotics, rectal ozone, are examples of treatments which are not reasonably expected to offer any improvement in the level of function or decrease of pain." Further, Dr. Carlson testified CRPS type II involves a specific nerve; however, he admitted he did not identify any specific nerve in making the CRPS type II diagnosis. Also, he said Employee was "genetically susceptible" to CRPS but did not provide any medical evidence to support this opinion.

Dr. Green's June 19, 2019 EME report and December 20, 2019 deposition reiterated his August 17, 2015 diagnosis denying CRPS. He said several providers misdiagnosed "Lisfranc fracture and consequential post-traumatic arthritis" as CRPS, and there is an additional complication caused by a stipulation of compensability of non-existent CRPS. Dr. Green rebuked CRPS diagnosis: "[P]retending that nonexistent conditions are present is not helpful. It is likely only to result in misdirected and ineffective treatment, with objectively worse health outcomes. Physicians are human, and diagnostic errors do occur. Physicians are expected to practice with sufficient thought, care, and humility to recognize and correct errors in their practice. A diagnostic error should not be misunderstood as established or immutable fact." Dr. Green said "probable somatic symptom disorder (pain predominant)" is the most likely explanation for Employee's "disproportionate report of somatic symptoms." But he also said it is outside of "[his] primary area of expertise, and because malingering is an important consideration in the differential diagnosis, [he was] not specifically making a diagnosis of somatic symptom disorder based on review or records." In short, Dr. Green went to great lengths to explicate standards of medical diagnosis but failed to provide his own clear diagnosis. His opinion would be given less weight. AS 23.30.122; *Smith*. Again, given the above analysis, his CRPS opinion is irrelevant.

Overwhelming evidence would show Employee has work-related and compensable CRPS/RSD: on June 1, 2015, Dr. Romman diagnosed RSD; on June 2, 2015, Dr. Simonson diagnosed CRPS;

on July 9, 2015, Dr. Carlson diagnosed RSD, though his opinion is given less weight for the reasons stated above; on September 25, 2015, Dr. Chang diagnosed RSD; on October 12, 2015, Dr. Trescot diagnosed CRPS; on November 3, 2015, Dr. Kincaid said bone scan findings were "suspicious" for CRPS/RSD; on March 21, 2017, SIME Dr. Roth diagnosed CRPS. On February 27, 2018, Dr. Roth reiterated his CRPS/RSD diagnosis. These medical opinions would be given the greatest weight. AS 23.30.122; *Smith*. As mentioned above, Employer had agreed the CRPS compensability in two separate instances. These facts would prove his CRPS is work-related by a preponderance of the evidence. *Saxton*; *Steffey*.

In short, Employee has work-related CRPS because: (1) Dr. Green's opinion is not relevant evidence; (2) Employer failed to rebut the preliminary presumption with substantial evidence; and (3) even if Dr. Green's opinion were relevant evidence and Employer rebutted the presumption with it, Employee would have proved the CRPS compensability by a preponderance of evidence. *Huit*; *Rockney*; *Saxton*; *Steffey*.

b) Employee's work-related injuries render him permanently and totally disabled.

The remaining question is whether Employee is permanently precluded from performing full-time employment due to CRPS/RSD or other work-related injuries. Without regard to credibility, Employee raised the presumption that work-related injuries render him permanently and totally disabled based on Dr. Carlson's opinion that his work-related conditions prevent him from returning to full-time employment. *Cheeks*; *Resler*. Without regard to credibility, Employer has to rebut the presumption with substantial evidence. *Huit*; *Resler*.

Employee did not graduate from high school and does not have a GED; he scored below average in aptitude testing, and six grade level overall in academic testing. Employee's past employments were cook, long line fisherman and juvenile justice officer. He is limited to "lift and carry on a frequent basis less than 10 pounds" and "stand and walk less than two hours a day." His physical and vocational abilities are limited. *Rogers & Babler*. Employer's reliance on Dr. Roth's opinion that Employee would be able to work as a medical record coder is misplaced; he is not an employment specialist familiar with labor markets. When asked, Dr.

Roth did not elaborate how Employee could perform as a medical record coder, a job that exceeds his physical limitations and for which he has no experience, education or training. *Id*. To rebut the presumption of compensability, Employer should have produced substantial evidence, such as labor market surveys, showing work within Employee's abilities is regular and continuously available in Employee's area of residence, area of his last employment, and the State of Alaska. *Leigh*. It failed to do so. Therefore, Employee is entitled to PTD benefits. AS 23.30.010(a); AS 23.30.180.

Arguendo, even if Employer rebutted the presumption with substantial evidence, which it did not, Employee would be able to prove his work-related injuries render him permanently and totally disabled by a preponderance of the evidence. *Saxton*; *Steffey*. Dr. Chang said, "[Employee] asked me to sign a form where it states that he will likely not be able to work a 40-hour week. I tend to agree considering his foot situation, back situation, as well as his shoulder. It is hard to imagine that this patient is going to comfortably and productively be able to work 40 hours a week indefinitely." He signed a form stating Employee is permanently precluded from performing any type of full-time employment. Dr. Ala opined Employee's left shoulder condition was caused by his August 30, 2016 fall, which resulted from his left foot CRPS and chronic pain conditions related to the May 25, 2015 work injury. Dr. Simonson opined "the back injury and ongoing lumbar problem is work related inasmuch as his fall was secondary to his left lower extremity dyscontrol, which is a result of his work related injury." Further, Dr. Green said he would defer to Dr. Chang regarding restrictions in Employee's work activities based on the best available medical science. Additionally, Dr. Humphreys, who performed Employee's low back surgery, agreed Employee is permanently precluded from performing any type of full-time employment. Dr. Chang's opinion shows, more likely than not, Employee has CRPS and other work-related injuries that permanently preclude Employee from performing full-time employment. *Saxton; Steffey*. Cortis concluded a reemployment plan cannot be developed relying on Dr. Chang's opinion. 8 AAC 45.120(e); *Roan*.

In short, Employee is entitled to PTD benefits because Employer failed to rebut the preliminary presumption with substantial evidence. AS 23.30.010(a); AS 23.30.180; *Huit*. Even if it rebutted the presumption, he would still be entitled to PTD benefits because he would be able to

prove his work-related injuries render him permanently and totally disabled by a preponderance of the evidence. *Saxton*; *Steffey*.

c) Employee's PTD benefits are awarded retroactive to August 29, 2019

Workers' compensation benefits are paid with "money." *Rogers & Babler*. Section 041(k) states, "[a]n employee may not be considered permanently totally disabled so long as the employee is involved in the rehabilitation process." However, it is instructive to review its language in context rather than just one sentence in isolation. *Taylor*. Section 041(k) has interrelated provisions providing a benefit payment scheme: (1) If an employee reaches medical stability before completion of the plan, TTD benefits ceases, and PPI benefits are paid at the TTD rate; (2) If PPI benefits are exhausted before the completion or termination of the reemployment process, §041(k) benefits are paid; (3) If disability or partial impairment benefits were paid in a lump sum before the employee requested or was found eligible for reemployment benefits, §041(k) benefits are suspended until disability or impairment benefits would have ceased; and (4) An impairment benefit remaining unpaid upon the completion or termination of the plan has to be paid to the employee in a single lump sum. It provides a series of steps to provide monetary benefits to an injured worker in a continuous fashion during the rehabilitation process. In other words, §041(k) presumes an injured worker is receiving some kind of benefits while he is going through a sometimes lengthy process. Thus, when read *in pari materia* with AS 23.30.001(1), which ensures the Act is interpreted to ensure fairness, it can be interpreted that the legislature intended to provide monetary benefits to an injured worker while he navigates through the reemployment process. *Nelson*. The legislature did not intend to sever monetary benefits to a permanently totally disabled worker just because he or she was involved in the rehabilitation process. *Id*; *Taylor*.

Employee was not eligible for PTD benefits on August 29, 2019, because his reemployment process did not end until Cortis consulted with Dr. Simonson and he declined to offer an opinion pursuant to the Partial Agreement. But also, he was not receiving any disability, impairment or §041(k) benefits since July 29, 2019, and it was more likely than not that Employee could no longer be expected to be able to work full time in any continuously available work given his education, aptitude, experience and physical limitations, from August 29, 2019, based on the

medical evidence and Cortis' report. *Roan*. Section 041(k) only limits consideration of permanent total disability during the reemployment process; it is silent on the retroactive award of PTD benefits once an injured worker's reemployment process is over and he is found to have been permanently and totally disabled even before the process ended. Therefore, it would be unreasonable to not award PTD benefits retroactive to August 29, 2019, as there would be a significant period without any monetary benefits, despite Employee being permanently totally disabled at no fault of his own. AS 23.30.001(1); *Nelson*. Employee's PTD benefits will be awarded retroactive to August 29, 2019. AS 23.30.010(a); AS 23.30.180.

3) Is Employee entitled to compensation for his hypertension medication costs?

Employee contends his hypertension is caused by CRPS, which this decision found is a work-related injury, and seeks compensation for his medication costs. Conversely, Employer contends Employee's hypertension preexisted his work injury and is an idiopathic condition unrelated to the work injury; thus, he is not entitled to compensation for his related medication costs.

Employee's entitlement to compensation and penalty for his hypertension medication costs is a question to which the presumption of compensability applies. AS 23.30.120(a)(1); *Meek*. Without regard to credibility, Employee raised the presumption based on Dr. Carlson's opinion that CRPS, a work-related condition, caused his hypertension. *Cheeks*; *Resler*.

Without regard to credibility, Employer rebuts this presumption with Dr. Green's opinion that neither CRPS nor midfoot arthritis caused LVH; an LVH diagnosis prior to the May 25, 2015 injury meant there had been chronic, clinically significant hypertension. *Huit*; *Resler*. Dr. Miller also opined the May 25, 2015 injury was not the substantial cause for hypertension prescriptions and Employee's hypertension was a chronic condition unrelated to his work injury. This shifts the burden of proof back to Employee who must prove his work with Employer is the substantial cause of the need to treat his hypertension by a preponderance of the evidence. *Saxton*; *Steffey*.

Dr. Carlson wrote Dr. Miller was not "familiar" with Employee's case; Dr. Miller later acknowledged his error. According to Dr. Carlson, Employee's CRPS caused "different sleep disorders including insomnia alternating with times of severe somnolence (due to never getting

restful sleep). These sleep disorders together with decreased overall fitness and loss of muscle have [led] to sleep apnea. Sleep apnea therefore is also largely due to CRPS." He said Employee's "hypertension is also largely caused by CRPS, partly through inflammatory mediators from insomnia and sleep apnea, as well as decreased overall activity." However, medical records show Employee reported "difficulty falling asleep, difficulty staying asleep, early morning awakening, unable to sleep after awakening" prior to the May 25, 2015 work injury. Dr. Carlson did not address the significance of the LVH diagnosis in relation to hypertension; also, he did not provide medical evidence other than his own words that CRPS causes sleep apnea or hypertension. Further, considering Dr. Carlson provided unnecessary experimental medical treatment and assumed Employee was "genetically susceptible" to CRPS without citing any medical evidence, his opinion is given less weight. AS 23.30.122; *Smith*.

By contrast, Dr. Green said the May 13, 2015 echocardiogram showed mild LVH and mild left atrial enlargement and concluded "to the degree that this study is abnormal, it indicates anatomical changes of the heart that are most consistent with chronic hypertension." He also said Dr. Carlson's opinion that CRPS caused sleep apnea and hypertension was "absurd" as "[i]nsomnia and hypersomnia are symptoms, not causes of obstructive sleep apnea. CRPS has never been described in the literature as a cause of obstructive sleep apnea." Dr. Green emphasized "[h]ypertension is a common condition in the general population and is frequently exacerbated by obstructive sleep apnea. There is no evidence in the scientific literature to support Dr. Carlson's theory that CRPS (or healed Lisfranc fracture, the actual condition) is a cause of hypertension."
Dr. Green's opinion is given greater weight. AS 23.30.122; *Smith*. Therefore, Employee failed to prove his hypertension is work-related by a preponderance of evidence; he is not entitled to compensation for his hypertension medication costs. AS 23.30.010(a); *Saxton*; *Steffey*.

4) Is Employee entitled to a late-payment penalty?

An employee is entitled to penalties on compensation due if it is neither timely paid, *Haile*, nor properly controverted by an employer, *Abood*.

a) Employee is not entitled to a late-payment penalty on PTD.

Employee's PTD benefits are awarded retroactive to August 29, 2019. AS 23.30.001(1). Under *Barbaza I*, pursuant to the Partial Agreement, Employee's reemployment process did not end until Cortis prepared a plan, consulted with Dr. Simonson and he did not approve it. AS 23.30.041(k). This decision makes the first PTD award. There was no late payment of PTD benefits; thus, Employee is not entitled to a late-payment penalty. AS 23.30.155(a); (e).

b) Employee is not entitled to a penalty on hypertension medication.

Employer controverted Employee's hypertension medication based on Dr. Miller's January 16, 2019 opinion denying their work-relatedness. Yet, Employee contends he is entitled to a penalty because Employer should have withdrawn its controversion after Dr. Miller reversed his opinion. In support of his positions, Employee cites the following portion of Dr. Carlson's February 27, 2019 letter, which was signed by Dr. Miller: "Dr. Miller, on a busy day, was asked to help out with refills of medications. He was not familiar with Mr. Barbaza's case. He acknowledges that Mr. Barbaza's increased blood pressure is likely due largely to his work related injury."

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, it would be found the claimant is not entitled to benefits. *Harp*. Here, at the time Employer filed the controversion notice, it had Dr. Miller's report showing Employee's hypertension was not work-related. Based on this evidence alone, a panel would have found Employee was not entitled to medical care for his hypertension; Employer's controversion was issued in good faith. *Id*. Because this decision finds Employee is not entitled to compensation for his hypertension medication costs, whether Employer should have withdrawn the controversion is moot. *Rogers & Babler*. Thus, Employee is not entitled to any penalty. *Harp*.

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

Interest is mandatory. AS 23.30.155(p). Employee is entitled to accrued interest on unpaid benefits. *Id*; 8 AAC 45.142(a); *Rawls*. This decision finds Employee is entitled to PTD benefits

from August 29, 2019, and continuing. Employer will be directed to calculate and pay interest in accordance with the Act and regulations.

Employee requests attorney fees and costs. AS 23.30.145(a). Attorney fees may be awarded when an employer controverts payment of compensation, and an attorney is successful in prosecuting the employee's claim. *Id*; *Childs*. This is a complex case with voluminous medical records. *Rogers & Babler*. Employee prevails on his PTD claim. Employer controverted Employee's claim, which allows this decision to award actual attorney fees under AS 23.30.145(a). Employee has to comply with 8 AAC 45.180(b), which requires an attorney requesting fees in excess of statutory fees to file an affidavit "itemizing the hours expended as well as the extent and character of the work performed." Employee submitted an itemized fee affidavit with $42,507.50 in attorney fees and $3,332.22 in costs, totaling $45,839.72.

Employer contends attorney fees and costs should not be awarded from November 13, 2018, to May 6, 2019, because Employee's attorney was not representing Employee for that period. The time between when Jensen withdrew representation and when he re-entered his appearance was relatively short, and nothing in the Act or case law suggests that is a reason to reduce attorney fees. *Rogers & Babler*. With Jensen's assistance, Employee was able to deal with protective orders, which can be difficult for a layperson. *Bignell*; *Rogers & Babler*. In fact, Jensen filed a petition for a prehearing and protective order on February, 25, 2019, on Employee's behalf. Attorneys often provide valuable legal services such as advising and counseling with clients before entering an appearance. Thus, attorney fees and costs will not be reduced on that basis.

Employer did not dispute the remaining hours billed but asked for reduction of hours as one issue presented was a "re-characterization of TTD benefits to PTD benefits resulting [in] no monetary change in compensation." This is incorrect as Employee was not receiving any disability, impairment or §.041(k) benefits since July 29, 2019, and this decision awards him PTD benefits from August 29, 2019, and continuing. Thus, attorney fees and costs will not be reduced on that basis.

Employer also asked reduction of billing rate to $400 per hour. Jensen represented many workers' compensation claimants; he is one of few experienced workers' compensation lawyers in Anchorage who represent injured workers. His rate is contingent upon a successful outcome of his efforts. *Bignell*. Jensen successfully prosecuted Employee's PTD claim, and his fees should be fully compensatory and reasonable. *Childs*. Therefore, based on Jensen's competence and experience, his hourly rate will not be reduced.

Jensen began representing Employee in this case from 2016. This case involved complex medical questions and required extensive research and lawyering skills to prevail on Employee's PTD claim. *Rogers & Babler*. It is very likely that the acceptance of this case precluded Jensen from taking other cases. *Id*. The hourly billing rate of $450 is within the range of contingent fee customarily charged in Anchorage for workers' compensation cases. *Id*. Thus, Employee is entitled to $45,839.72 in actual attorney fees and costs. *Rusch*.

Since PTD benefits continue during the continuance of Employee's disability, Jensen is also entitled to a statutory minimum attorney fee on ongoing PTD benefits because Employer controverted paying permanent total disability compensation and Employee prevailed on his claim. AS 23.30.145(a); *Wozniak*. Employer will pay Jensen statutory minimum fees on ongoing permanent total disability benefits, during the continuance of those benefits, beginning with the next bi-weekly payment following this decision and order.

CONCLUSIONS OF LAW

1) Employee's reemployment process ended.
2) Employee is entitled to PTD benefits.
3) Employee is not entitled to hypertension medication costs.
4) Employee is not entitled to a penalty.
5) Employee is entitled to interest, attorney fees and costs.

ORDER

1) Employer shall pay Employee PTD benefits effective August 29, 2019, and during the continuance of his total disability, in accordance with the Act.

2) Employer shall pay interest on unpaid benefits pursuant to 8 AAC 45.142(a).

3) Employer shall pay Jensen $42,507.50 in attorney fees and $3,332.22 in costs, totaling $45,839.72.

4) Employer shall also pay Jensen statutory minimum fees on ongoing PTD benefits, during the continuance of those benefits, beginning with the next bi-weekly payment following this decision and order.

Dated in Anchorage, Alaska on July 15, 2020.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Jung M. Yeo, Designated Chair

/s/
Bob Doyle, 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 Arthur R. Barbaza, employee / claimant v. State of Alaska, Department of Health and Social Services, self-insured employe / defendant; Case No. 201508217; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on July 15, 2020.

/s/

Nenita Farmer, Office Assistant