ALASKA WORKERS' COMPENSATION BOARD

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

GREGORY GUERRISSI,	)	
	)	
Employee,	)	
Claimant,	)	
	)	FINAL DECISION AND ORDER
v.	)	
	)	AWCB Case No. 201902745
STATE OF ALASKA,	)	
	)	AWCB Decision No. 22-0020
Self-Insured	)	
Employer,Defendant.	)	Filed with AWCB Anchorage, Alaska
.	)	on March 23, 2022.
	)	

Gregory Guerrissi's July 20, 2021 claim was heard in Anchorage, Alaska on November 4, 2021, a date selected on September 22, 2021. Employee's August 10, 2021 hearing request gave rise to this hearing. Attorney Keenan Powell appeared and represented Gregory Guerrissi (Employee). Attorney Henry Tashjian appeared telephonically and represented the State of Alaska (Employer). Witnesses included Employee, who testified on his own behalf and Ashley Moser, claims adjuster, who testified on Employer's behalf. The record was held open until December 23, 2021, for the receipt of David Glassman, M.D.'s deposition. The record closed on December 23, 2021. On January 18, 2022, the parties stipulated to reopen the record for the receipt of additional evidence. The board panel met to deliberate on February 15, 2022. The record closed at the conclusion of deliberations on February 15, 2022.

ISSUES

Employee contends his February 13, 2019 work injury was the substantial cause of his need for cervical spine and left shoulder treatment. Therefore, he contends he is entitled to medical and transportation costs, including reimbursement to himself and his health insurance.

Employer contends Employee's need for medical treatment after March 12, 2019 is due to pre-existing degenerative conditions, not his work injury, and he is not entitled to additional medical and transportation benefits.

1) Is the February 13, 2019 work injury the substantial cause of Employee's need for medical treatment for his cervical spine and left shoulder?

Employee contends he is entitled to past, continuing and future medical and related transportation benefits for his work-related cervical spine and left shoulder injuries. He contends Employer should reimburse or pay these bills.

Employer contends Employee suffered no more than a temporary exacerbation of his cervical spine and left shoulder conditions and he is not entitled to any additional medical benefits.

2) Is Employee entitled to medical benefits?

Employee contends he is entitled to permanent partial impairment (PPI) benefits based on employer's medical examination (EME) physician Dr. Glassman's November 17, 2021 deposition testimony, which rated Employee with a 17 percent whole person impairment (WPI) for the cervical spine and six percent WPI for the left shoulder, for a combined WPI of 22 percent, pursuant to the Rondinelli, R.D., (2008). *Guides to the Evaluation of Permanent Impairment*, (6th ed.). American Medical Association. (AMA Guides) combined values chart, pgs. 604-605.

Employer contends Employee is not entitled to any PPI benefits based on Dr. Glassman's opinion since the work injury was not the cause of any of Employee's PPI.

3) Is Employee entitled to PPI benefits?

Employee contends he is entitled to a unfair and frivolous controversion finding and a referral to the Division of Insurance as the Employer's controversion was not supported by substantial evidence. Specifically, he contends, Employer's controversion was based on Dr. Glassman's EME report, but that report is not substantial evidence because it used the wrong legal standard for causation to controvert benefits.

Employer contends its controversion is based on Dr. Glassman's report and when viewed in isolation, it is sufficient to support denial of benefits, so it's controversion was neither unfair nor frivolous.

4) Is Employee entitled to a finding of unfair and frivolous controversion?

Employee contends he is entitled to penalty and interest based on the same contention for which he seeks a finding of unfair and frivolous controversion. Employee also contends he is entitled to a penalty and interest on any late paid benefits.

Employer contends it relied on Dr. Glassman's report, which when viewed in isolation, is sufficient to support a denial of benefits, so no penalty or interest is due.

5) Is Employee entitled to penalty and interest?

Employee's attorney contends she is entitled to attorney's fees and costs, including a $400 hourly rate through August 12, 2021 and $425 per hour thereafter.

Employer contends should Employee prevail on his claims, Employee's attorney is not entitled to an increase in her hourly rate, because awards of attorney's fees for success in interlocutory decisions reduces the risks inherent in contingent representation. Employer also contends Employee requested and was denied 3.4 hours of fees in the *Guerrissi v. State of Alaska*, AWCB Decision No. 20-0109, (December 4, 2020), and she cannot now request them.

6) Is Employee entitled to attorney fees and costs?

FINDINGS OF FACT

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

1) On February 13, 2019, Employee was climbing s short ladder at work when he felt something pull in the left side of his neck, which became very painful. (First Report of Injury, February 27, 2019).

2) Prior to the February 13, 2019 work injury, Employee had the following prior relevant medical issues and injuries:

(1) On October 17, 2005, Employee followed up with Creed Mamikunian, M.D., for Bell's palsy on the left. Employee reported the previous week he had numbness along the posterior aspect of his left arm to his left wrist. Although he still had numbness in his left arm, he had been recovering quickly and had approximately 80 to 90 percent muscle strength on the left side of his face. (Dr. Mamikunian's clinic note, October 17, 2005).

(2) On October 24, 2005, Dr. Coalwell evaluated Employee for complaints of left shoulder pain radiating down to his elbow for about four weeks. Employee reported his Bell's palsy was improving. Employee pointed to the lateral scapula and beneath the scapula itself as well as the lateral aspect of the upper arm as where the pain and numbness goes. On physical examination, Dr. Coalwell noted pressure on the midline of the sixth thoracic vertebra caused symptoms at the left lateral chest and the left arm. There was full range of motion in the neck and shoulder. Dr. Coalwell noted a cervical spine x-ray was done because of the radiation down the arms, but the cervical spine looked "great." Dr. Coalwell diagnosed thoracic back pain with radiation to the left. (Dr. Coalwell clinic note, October 24, 2005).

(3) On October 24, 2005, a cervical spine x-ray showed no significant degenerative changes. There was minor uncovertebral spurring that narrowed the foramina at C3-4 and C5-6. The impression was mild degenerative changes. (Dr. Cable's x-ray report, October 24, 2005).

(4) On June 16, 2008, Employee treated with Timothy Coalwell, M.D., his primary care provider. Employee reported having been involved in a motor vehicle accident on June 14, 2008, in which the car he was driving left the road and flipped to rest on its side. He was wearing his seatbelt and the airbags deployed. He did not suffer any loss of consciousness. He did have pain in his left hand and left lateral knee as well as some chest wall pain in the seatbelt area. Employee also reported having been involved in another motor vehicle accident that very day, June 16, 2008, when he was rear-ended. The areas of those pains are distinct from his June 14, 2008 auto accident. On physical examination, Dr. Coalwell noted bruising across the anterior chest and across the left shoulder. Employee's neck had about 50 percent range of motion with pain going down bilaterally. There was tenderness bilaterally in the rhomboid area down to the suprascapular and tenderness at in the mid shaft and metacarpal joint of the

fifth finger of the left hand. Dr. Coalwell noted an x-ray of the hand showed no fracture. (Dr. Coalwell clinic note, June 16, 2008).

(5) On June 16, 2008, x-rays of the cervical spine showed straightening of the normal lordosis and mild disc space narrowing at C5. There was no neural foraminal encroachment. The impression was mild degenerative disc disease at C5 with muscle spasm. The thoracic spine x-ray showed mild anterior wedging of several thoracic vertebrae, possibly from osteoporosis. Left hand and left knee x-rays showed minor degenerative changes only. (Harold Cable, M.D., x-ray report, June 16, 2008).

(6) On June 26, 2008, Employee followed up with Dr. Coalwell for continued pain in his left fifth finger. His neck was sore, but he could tolerate it. Dr. Coalwell noted a left fifth finger x-ray was normal. (Dr. Coalwell clinic note, June 26, 2008).

(7) On June 16, 2010, Dr. Coalwell evaluated Employee for an injury to his right shoulder which had occurred the previous night at work when he jerked on a heavy luggage that was jammed up on the baggage line. He felt pain at the time, but it had been hurting a lot more since. There was no neck pain. Dr. Coalwell diagnosed right shoulder strain and prescribed anti-inflammatory and pain medication. (Dr. Coalwell clinic note, June 16, 2010).

(8) On June 28, 2010, Dr. T. Noah Laufer evaluated Employee for worsening right shoulder pain. Dr. Laufer ordered a right shoulder MRI, which showed a complex partial tear at the supraspinatus tendon with a small partial tear involving the infraspinatus tendon and an anterior labral tear that was possibly a superior labrum anterior posterior (SLAP) tear. Employee was referred to orthopedic surgeon Bret Mason, D.O. (Dr. Laufer clinic note, June 18, 2010; Lawrence Wood, M.D.'s right shoulder MRI report, July 1, 2010).

(9) On August 10, 2010, Dr. Mason repaired Employee's right shoulder SLAP lesion, and performed arthroscopic subacromial decompression and anterior acromioplasty, as well as mini-open repair of a 2.5cm rotator cuff tear. (Dr. Mason's operative report, August 10, 2010).

(10) On January 2, 2013, Dr. Laufer evaluated Employee for pain he was still experiencing after a May 6, 2012, 4-wheeler accident where Employee fractured his proximal left femur, requiring open reduction and internal fixation with pinning and a femoral neck screw. Dr. Laufer noted Employee had healed nicely from the surgery, but still had pain. On physical exam, Dr. Laufer noted tenderness and a scar over the right trochanteric bursa. He assessed

pain due to trochanteric bursitis and prescribed pain medication. (Dr. Laufer's clinic note, January 2, 2013).

3) On February 14, 2019, Employee treated with Timothy Coalwell, M.D., for his left shoulder pain from the work injury. He reported he was crossing a baggage ramp and grasped the rung of a ladder to pull himself up and felt a sharp pain when pulling. He also complained of numbness in the front part of his shoulder with radiation down the left arm and into the hand. He had decreased range of motion in his left shoulder. Employee had a history of right shoulder issues, but no previous left shoulder issues. On physical examination, there was decreased range of motion in the neck to 75 percent on the right and 50 percent on the left. Neck extension caused pain across the top of the scapula. Dr. Coalwell opined the cervical spine was the cause of the problems. Dr. Coalwell referred Employee for x-rays of the cervical spine, with flexion and extension views, and a left shoulder x-ray. He also referred Employee for physical therapy. (Dr. Coalwell's clinic note, February 14, 2019).

4) On March 12, 2019, on referral from Dr. Coalwell, orthopedic surgeon Michael McNamara, M.D., evaluated Employee for his left shoulder pain. Employee reported numbness and tingling into his arm and hand. His left shoulder range of motion was good, but somewhat limited overhead due to pain. Physical examination revealed 5 out of 5 external rotation motor strength, and 5 out of 5 subscapularis, belly press and lift off testing. The supraspinatus muscle tendon testing was still fairly strong, although patient grimaced. His superior labrum anterior posterior (SLAP) O'Brien's test was also fairly strong. Dr. McNamara noted Employee had very guarded neck flexion and extension with 50 percent reduction in motion in lateral bending. He -thought Employee's left upper extremity pain and numbness appeared to be more radicular, emanating from Employee's neck, but he could not rule out shoulder symptomatology, either a partial-thickness cuff tear or a SLAP tear. Dr. McNamara referred Employee for a left shoulder MRI and to Alaska Spine Institute for evaluation of his neck for radicular symptoms in his left upper extremity. (Dr. McNamara clinic note, March 12, 2019).

5) On March 15, 2019, Employee followed up with Dr. Coalwell for his left shoulder and neck. On physical examination, Dr. Coalwell noted tenderness across the top of the left shoulder and Employee's triceps felt somewhat atrophied. Employee's neck pain radiated through and past his left shoulder and into his triceps and forearm. The flexor and extensor surfaces of Employee's left

thumb were numb and fingers 2-5 had normal sensation. Dr. Coalwell referred Employee for physical therapy. (Dr. Coalwell's clinic note and referral order, March 15 2019).

6) On March 15, 2019, Employee's left shoulder MR arthrogram was interpreted by radiologist John McCormick, M.D. The impressions were a full-thickness tear of the supraspinatus tendon with a 2.6 cm medical retraction, an interstitial tear of the anterior aspect of the infraspinatus tendon, an early articular surface tear of the distal subscapularis tendon, an intact labrum, and no fractures. (Dr. McCormick's MRI report, March 15, 2019).

7) On March 25, 2019, on referral from Dr. McNamara, osteopath Erik Olson, D.O, evaluated Employee. Dr. Olson noted, when Employee had treated with Dr. McNamara for evaluation of his left shoulder pain, he reported paraesthesias in his left arm, as well as a positive Spurling's maneuver on the left side. Therefore, Dr. McNamara referred Employee to him for evaluation of his neck. On physical examination, Dr. Olson noted Employee's sensation was diminished down Employee's left arm over the lateral epicondyle, as well as the radial aspect of the wrist, first, second and third digits. Strength was intact and symmetric throughout the upper extremities, except for the left deltoid, biceps, triceps, and wrist extensors. Spurling's maneuver was markedly positive on the left and negative on the right. There was no atrophy in the upper extremities. Dr. Olson's impression was a cervical disc herniation, probably at the C5-6 versus C6-7, as he had weakness, sensory changes, and decreased reflexes in a C6 or C7 pattern and a markedly positive Spurling's on the left. Dr. Olson ordered a cervical spine MRI as well as x-rays. (Dr. Olson's clinic note, March 25, 2019).

8) On March 29, 2019, Employee underwent a cervical spine MRI. The impression was degenerative changes at multiple levels with mild central stenosis at C3-4, C5-6, and C6-7. There was bilateral foraminal encroachment at C5-6, moderate foraminal encroachment on the left at C3-4, and more severe foraminal encroachment at C6-7 on the left. (Harold Cable M.D.'s MRI report, March 29, 2019),

9) On April 1, 2019, Employee followed up with Dr. Olson. Employee reported he was still in a significant amount of pain, stating his pain was 6 out of 10 on that day, and had averaged an 8 out of 10 over the past week. He also reported constant paraesthesias and weakness in his left arm. Neuromuscular exam showed diminished sensation over the lateral epicondyle, radial aspect of the forearm, first, and at the second, third and fourth digits on the left. Spurling's maneuver was positive on the left. Dr. Olson scheduled a midline C6-7 intralaminar epidural steroid injection

(ESI) that would allow some spread to the corticosteroid at both the C6-7 and C5-6 segments. He also referred Employee to physical therapy and to neurosurgeon Benjamin Rosenbaum, M.D., for a surgical consult. Dr. Olson planned to follow up with Employee four weeks after the ESI and then proceed with an electromyogram (EMG) and nerve conduction study of the left upper extremity. (Dr. Olson's clinic note, April 1, 2019).

10) On April 3, 2019, Employee underwent a midline C6-7 translaminar ESI under fluoroscopy. (Dr. Olson's procedure note, April 3, 2019).

11) On April 9, 2019, Employee followed up with Dr. McNamara and reported worsening symptoms since his prior visit. He also reported he had had an epidural injection at Alaska Spine Institute and was told he might need a fusion. Employee stated he had mild improvement after the epidural injection but still had severe tingling in his hand. Dr. McNamara noted Employee's physical examination was unchanged with marked weakness of the supraspinatus and marked guarding of his neck. Dr. McNamara noted the left shoulder MRI showed a full-thickness tear, retracted, some early upper rotator cuff tear arthropathy changes, but a possibly reparable cuff. There was also an upper subscapularis tear with subluxing biceps, probably a SLAP. The cervical spine MRI showed a C5-6 and C6-7 herniated nucleus pulposus on the left. Employee had an appointment to see a neurosurgeon, so Dr. McNamara planned to get him on the schedule for shoulder surgery after he was evaluated by Dr. Rosenbaum. (Dr. McNamara clinic note, April 9, 2019).

12) On May 1, 2019, Employee underwent an electrodiagnostic study of his left upper extremity. The nerve conduction velocity (NCV) study was normal. The EMG study revealed subacute denervation changes in the left triceps, pronator teres, anconeus, and cervical paraspinal muscles. The impression was left C7 radiculopathy, subacute and moderate. There was no electrodiagnostic evidence of left upper extremity brachial plexopathy, polyneuropathy, or myopathy. Dr. Olson noted the dermatomal distribution of Employee's symptoms followed more of a C6 pattern and the myotomal distribution more of a C7 pattern. (Dr. Olson's EMG and nerve conduction study report, May 1, 2019).

13) On May 3, 2019, on referral from Dr. Olson, Dr. Rosenberg and physician assistant Jennifer Hermanson, PA-C, evaluated Employee. They reviewed the history of Employee's February 13, 2019 injury as well as the cervical MRI, which revealed a C6-7 disc herniation, and left arm EMG/NCV studies, which revealed a left C7 subacute radiculopathy. Employee's examination

revealed weakness in the left grip, wrist extension and wrist flexion. Due to ongoing symptoms, evidence of left C7 radiculopathy and weakness on examination, they discussed surgical intervention and informed Employee of the risks and benefits of surgery. Employee indicated he would like to proceed with surgical intervention. (PA Hermanson clinic note, May 3, 2019).

14) On June 5, 2019, Dr. Rosenbaum performed an anterior cervical discectomy and fusion (ACDF) to repair Employee's disc herniation. (Dr. Rosenbaum operative report, June 5, 2019).

15) On July 18, 2019, Employee followed up with PA Hermanson and reported his left arm pain, numbness and tingling had significantly improved. However, he also reported occasional pain in the left arm and some difficulty with left hand dexterity and left thumb numbness. PA Hermanson noted July 18, 2019 cervical spine x-rays demonstrated stable anterior C6-C7 fusion with no evidence of hardware complications. Dr. Rosenbaum also met with Employee and stated he was pleased with Employee's progress. A physical therapy referral was offered, but Employee indicated he preferred to do home exercises. Employee was cleared to proceed with shoulder surgery from a neurological standpoint. (PA Hermanson clinic note, July 18, 2019).

16) On August 7, 2019, Dr. McNamara performed surgery on Employee's left shoulder to repair the rotator cuff tear, impingement syndrome, acromioclavicular joint and SLAP tear. He referred Employee for postoperative physical therapy. (Dr. McNamara's operative report, August 7, 2019).

17) On August 12, 2019, Dr. McNamara ordered shoulder therapy two to three times per week for 16 to 20 weeks, referring Employee to Alaska Hand Rehabilitation. (Dr. McNamara's order, August 12, 2019).

18) On August 19, 2019, Employee followed up with physician assistant Robert Thomas, PA-C, after his left shoulder surgery. Employee reported he was doing well but having some discomfort in his left shoulder as well as numbness and tingling in his left thumb. He had begun physical therapy two times per week and was participating in a home exercise program. (PA Thomas clinic note, August 19, 2019).

19) On September 7, 2019, orthopedic surgeon David Glassman, M.D., evaluated Employee in an employer's medical evaluation (EME). Dr. Glassman reviewed Employee's medical history and imaging studies and performed a physical examination. He also reviewed Employee's work history, including the physical demands of his job at the time of injury. Employee described his work injury as having occurred when he had to climb up a ladder over a baggage carousel. As there was a chair blocking the ladder, he twisted his body around the chair, then reached forward

with his left arm and pulled himself up to climb the ladder. He felt a pop in his left superior shoulder and radiating pain down his left arm to his left thumb, as well as diffuse left arm weakness. After his C6-7 surgery on June 5, 2019, his left arm weakness resolved and the pain radiating down his left arm also decreased. He continued to have left thumb numbness. Employee was wearing a sling after his August 7, 2019 left shoulder surgery. Employee reported he was having pain at 7 on a scale of 10, with stabbing, burning, aching, numbness and pins-and-needles on the anterior and posterior aspects of his neck and entire left arm and hand. Dr. Glassman diagnosed multilevel cervical spondylosis, including central and foraminal stenosis, as well as left C7 radiculopathy, which were not related to the work event of February 13, 2019. He noted the physical exam on February 14, 2019 mentioned no cervical spine tenderness and no cervical spine muscle spasm. He opined there were no consistent, objective findings that supported an acute diagnosis for Employee's cervical symptoms related to the work injury. He further opined the mechanism of injury, pulling at the shoulder level, would not result in a cervical disc herniation. Employee's neck symptoms were a result of age-related degenerative changes, with additional risk factors being a history of neck pain and a history of traumatic diagnoses, including previous motor vehicle collisions and a diagnosis of whiplash. There was insufficient evidence to support that heavy work is related to neck pain. Employee's neck symptoms were 100 percent related to nonoccupational risk factors and zero percent to the work injury. In addition, the work injury did not aggravate, accelerate, or combine with a preexisting condition of age-related degenerative changes of the cervical spine to cause any disability or need for medical treatment. Regarding the left shoulder, the diagnoses were multifocal degenerative changes including rotator cuff and SLAP tears, acromioclavicular joint arthrosis, and impingement syndrome, none of which were related to the work injury. Employee's risk factors for the rotator cuff disease were repetitive abduction and flexion, especially with overhead arm activity. Acromioclavicular joint arthritis is also associated with regular, heavy overhead activities, and his job history indicated occupational risk factors for his left shoulder pathology. The work injury was not the significant cause of his symptoms. His left shoulder symptoms were related to age-related degenerative changes, occupational risk factors of overhead activities and repetitive microtrauma, as well as non-occupational risk factors including football and weightlifting. The work injury caused a temporary exacerbation of his left shoulder symptoms, but only until March 12, 2019, when physical exam revealed intact rotator cuff strength. After March 12, 2019, the substantial cause of any left

shoulder disability or need for medical treatment would have been the preexisting conditions. Therefore Dr. Glassman apportioned causation of the left shoulder need for medical treatment as 65 percent to the non-occupational risk factors and 35 percent to the occupational risk factors of regular, heavy, overhead activities. The medical care Employee received was medically reasonable and acceptable under the facts of the case, but the cervical injections and surgery, and left shoulder surgery, were not related to the work injury. He opined Employee would require physical therapy, recurrent clinic visits, and radiographic evaluation to complete his post-operative rehabilitation. Employee would require physical therapy after his left shoulder surgery for up to six months. Dr. Glassman predicted Employee would be medically stable one year after each of the surgeries and would have zero percent PPI related to the work injury. (Dr. Glassman's EME report, September 7, 2019).

20) On September 25, 2019, Employer controverted all benefits related to the neck and cervical spine, including cervical injections and cervical surgery based on Dr. Glassman's September 7, 2019 EME report. (Controversion, September 25, 2019).

21) On September 30, 2019, Dr. Glassman provided an addendum EME report to respond to additional questions. He again opined occupational factors were not the substantial cause of Employee's need for treatment for his left shoulder. The substantial cause and greater percentage were related to individual factors including age-related degenerative changes, individual anatomy of impingement, and history of non-occupational trauma, specifically the multiple motor vehicle collisions in 2008 and 2009, which resulted in injury to his left upper extremity. He clarified the source of information concerning occupational risk factors of repetitive abduction and/or flexion, especially with arm overhead activity were the medical record and Employee interview. The risk factors of playing football and weightlifting, both of which include repetitive overhead motions with force, were included in Employee's reporting of his off-work activities. Concerning the March 12, 2019 physical examination, which Dr. Glassman had opined in his EME report demonstrated full rotator cuff strength, he stated he agree with the author of that report (Dr. Coalwell) the physical exam did not rule out a rotator cuff tear, as additional muscles can compensate for a torn rotator cuff tendon. (Dr. Glassman's supplemental EME report, September 30, 2019).

22) On October 15, 2019, Employer controverted all benefits related to Employee's left shoulder after March 12, 2019, including left shoulder surgery, based on Dr. Glassman's September 7, 2019

EME report and September 30, 2019 supplemental EME report. (Controversion, October 15, 2019).

23) On October 31, 2019, Dr. Rosenbaum responded to Employee's request for a written statement regarding whether his cervical pathology could have been caused by his work injury. Dr. Rosenbaum noted Employee described an injury on February 13, 2019 in which he was pulling himself onto a ladder with his left arm and feeling a sudden left shoulder pain that radiated into the left arm. The symptoms were consistent with a left C7 radiculopathy, which was confirmed by imaging and EMG/NCV studies. Dr. Rosenbaum opined, based on Employee's account of his symptom onset, and with no similar symptoms prior to February 13, 2019, the work-related injury appears to have been the cause of the symptoms and subsequent care required. Per Employee's account, the underlying pathology was asymptomatic until the trigger of the work injury rendered the circumstances irreversibly symptomatic. (Dr. Rosenbaum's October 31, 2019 letter).

24) On January 6, 2020, Dr. Olson responded to questions from Employer concerning Employee's neck and left shoulder. Dr. Olson opined that on a more likely than not basis, Employee's neck injury was associated with his work injury after February 13, 2019. His opinion was based on Employee's reported history, physical examination findings, MRI findings, and EMG findings. Dr. Olson thus disagreed with Dr. Glassman's opinion on the causation of the neck injury. Dr. Olson also disagreed with Dr. Glassman's apportionment for the cause of Employee's work injury, as he opined the apportionment would be 49 percent at the most. He also disagreed with Dr. Glassman's opinion the work injury did not accelerate, aggravate, or combine with the pre-existing condition to cause the initiation of the work-related injury. Further, Dr. Olson disagreed with Dr. Glassman's opinion the cervical injections and surgery were not necessary due to the work injury. Finally, he disagreed with Dr. Glassman's zero percent PPI rating. (Dr. Olson's responses to Employer's questions, January 6, 2020).

25) On January 19, 2020, Dr. McNamara responded to questions from Employer. He stated he only treated Employee for his left shoulder and the diagnoses were massive retracted degenerative supraspinatus and infraspinatus cuff tears, chronic low grade upper subscapular tear, a degenerative SLAP tear and AC joint degenerative arthritis. He opined the primary cause was degenerative, due to age and activity. However, he could not rule out some acute on chronic cause of the cuff tear. Delamination and joint grade I chondromalacia were indicative of degenerative and chronic changes. Dr. McNamara stated he had read Dr. Glassman's September 7, 2019 EME

report and agreed with his summary, assessment, and causality. Dr. McNamara opined more likely than not, the neck and shoulder diagnoses preexisted the reported injury, but there might be some acute component present. There was no easy way to determine this in the setting of such multiple diagnoses. He agreed with the diagnoses, recommendations and discussions sections of Dr. Glassman's report and addendum. (Dr. McNamara's letter, January 19, 2020).

26) On January 23, 2020, Dr. Coalwell responded to questions put forth in a January 3, 2020 letter from Employer concerning Employee's neck and left shoulder diagnoses. Dr. Coalwell was asked to review Dr. Glassman's September 7, 2019 EME report as well as the September 30, 2019 addendum to that report. Dr. Coalwell responded he did not disagree with Dr. Glassman's EME report. However, Employee was able to perform his job without issue until the work injury occurred. Dr. Coalwell opined if the work injury had not occurred, Employee would still be running around with his shoulder and neck conditions. He opined the primary cause of Employee's need for medical treatment relating to his left shoulder and neck was the February 2019 work injury. He further opined the work injury was 75 percent of the cause and his baseline, used, arthritic body, which had functioned well until the work injury, was 25 percent of the cause. Dr. Coalwell stated he conferred with his partners to get their opinions and they agreed with his view. (Dr. Coalwell's response to Employer's questions, January 23, 2020).

On June 25, 2021, second independent medical evaluation (SIME) physician neurosurgeon Bruce McCormack, M.D., evaluated Employee. Dr. McCormack performed an in-person history and physical examination as well as reviewing Employee's medical history and imaging study reports. Dr. McCormack opined the February 13, 2019 work injury caused neck and left shoulder strain and aggravation of the pre-existing asymptomatic degenerative changes. He further opined one cause of Employee's need for medical treatment was the pre-existing degenerative changes and the work injury aggravated, accelerated, and combined with the pre-existing degenerative changes to cause the disability and need for treatment, and produced a permanent change in the pre-existing condition. Dr. McCormack noted Employee's left arm symptoms began immediately after the February 13, 2019 work injury and there was no history of prior neck or left arm nerve complaints. In addition, the May 1, 2019 electromyography (EMG) confirmed acute left C7 radiculopathy, and the March 29, 2019 cervical spine magnetic resonance imaging (MRI) revealed left C6-7 disc herniation, which was confirmed during the June 2019 cervical spine operation. The mechanism of injury was consistent, as he was looking up while reaching with a left arm to grab the metal

frame and turning his head to look at a fellow worker. This could cause a disc herniation. He also opined looking up or neck extension while climbing a ladder can aggravate a cervical stenosis to become symptomatic, as neck extension further narrows the nerve channel and can pinch a nerve. Thus, the work incident may have worsened or caused the left C6-7 disc herniation to cause left arm radicular symptoms. He noted Employee had radiographic findings of aging in his neck but denied prior neck pain and there were no medical records indicating he had prior neck pain.

Dr. McCormack opined the left shoulder derangement was also due to the work injury. There was no prior evidence of left shoulder pain. While the left shoulder MRI showed a retracted rotator cuff tear, which was likely pre-existing and longstanding, reaching over head with a non-dominant arm to pull one's body weight up could worsen the rotator cuff injury to cause pain. In addition, the acute C7 radiculopathy due to disc herniation could cause left shoulder pain, as the nerves to the shoulder and C7 sensory nerves to the distal arm end at the same nerve in the dorsal root entry zone. Thus, there is convergence of nerve fibers from the shoulder joint and sensory nerves to the left arm. If the acute C7 radiculopathy is accepted as an acute work injury, the acute left shoulder joint pain is also accepted. Dr. McCormack opined the work injury was the substantial cause for Employee's disability. He opined Employee was medically stable by April 1, 2020, or eight months after his shoulder surgery and 11 months after the neck surgery. Employee could return to his job at the time of injury. There was some slight impairment due to the C6-7 disc fusion.

Dr. McCormack did not recommend any additional medical treatment. He rated Employee's cervical spine PPI at six percent WPI based on cervical spine impairment table 17-2, page 565, with cervical spine stenosis at a single level with radiculopathy that resolved with surgery. Dr. McCormack rated Employee's functional history, physical examination, and radiographic findings all at grade I. Dr. McCormack rated Employee's left shoulder PPI at one percent WPI based on his normal range of motion with no rotator cuff weakness or positive orthopedic tests. Thus, there was zero impairment for range of motion deficit, or grade modifier zero per table 15-35, page 477. The functional history grade adjustment per table 15-36 on page 477 was one higher. He rated Employee's total impairment as seven percent based on the combined values chart. He apportioned 85 percent to the work injury and 15 percent to degenerative changes. The ratings

were performed using the American Medical Association Guides to the Evaluation of Permanent Impairment, 6th Edition.

Dr. McCormack stated he disagreed with Dr. Glassman's opinion the mechanism of injury on February 13, 2019, pulling at shoulder level, would not result in a cervical disc herniation. Dr. McCormack stated Employee was reaching overhead to pull himself upwards and also looked over his shoulder at a co-worker. Reaching over head to climb the ladder requires some degree of neck extension, which can aggravate cervical stenosis as the channel and foramina are further narrowed with neck extension. Disc herniation can occur like this as well. In addition, on February 14, 2019, Dr. Coalwell found neck pain and numbness radiating to the hand. Neck extension caused pain. Thus, there is documentation of new cervical spine symptoms within a day of the date of injury. The lack of tenderness on the neck itself is insignificant when there is acute radiculopathy overshadowing neck pain. The objective medical evidence supporting Employee's claim he suffered an acute injury on February 13, 2019 that is the substantial cause of his disability or need for medical treatment include: (1) Employee's acute neck pain on neck extension, limited neck range of motion, worse on the left, as well as radiating left arm numbness documented on February 14, 2019 by Dr. Coalwell; (2) On follow up on March 15, 2019 left shoulder and neck pain was again noted; (3) the March 29, 2019 cervical spine MRI showed left C6-7 disc protrusion; (4) the May 15, 2019 EMG showed acute left C7 radiculopathy; (5) the June 6, 2019 operative findings there was a left C6-7 herniation; and (6) Employee got better after the cervical fusion. With regard to the left shoulder, Employee's retracted rotator cuff tear, which was likely old, may have been aggravated by overhead reaching and pulling his body weight up. In addition, there is a lot of pain overlap between the shoulder internal joint derangement and cervical disc with radiculopathy. The somatosensory cortex cannot distinguish between the two. The two conditions are intertwined. As the cervical disc is clearly industrial and because concurrent shoulder pathology cannot be excluded, it is industrial as well. Dr. McCormack apportioned 85 percent of Employee's left shoulder disability and need for medical treatment to the work injury and 15 percent to the pre-existing degenerative changes that were asymptomatic. Finally, he opined the February 13, 2019 work incident injured Employee's neck and left shoulder and led to the need for treatment. (Dr. McCormack SIME report, June 25, 2021).

27) On June 28, 2021, orthopedic surgeon John Lane, M.D. examined Employee in an SIME. Dr. Lane reviewed Employee's medical records, including imaging and EMG and NCS reports as well as Dr. Glassman's prior EME reports. Dr. Lane also performed a history and physical examination. Dr. Lane noted Employee complained of some ongoing paresthesias in the left thumb, index finger, and forearm. Employee also complained of some pain when sleeping on his back, with popping, but had minimal cervical pain. He also had some left shoulder weakness with pain on repetitive use and sleeping on his side. On physical examination, there was decreased sensation in the C6 distribution on the left. Dr. Lane ordered cervical spine three-view radiographs. The x-rays showed the anterior cervical discectomy with fusion at C6-C7 and a healed intervertebral body bone graft. There were some mild spurring changes at C5-C6 with minimal decrease in the disc height. There was straining of the normal lordosis. The cervical spine x-rays from February 14, 2019 had demonstrated mild degenerative disc disease at C5-C6 with slight decreased disc height and spurring. At C6-C7, there was no significant loss of disc height and minimal spurring. Four-view x-rays of the left shoulder demonstrated no degenerative joint disease at either the acromioclavicular or glenohumeral joint. The left shoulder x-rays from February 14, 2019 demonstrated mild irregularity of the greater tuberosity. Dr. Lane diagnosed the following: 1) cervical strain; 2) acute herniated nucleus pulposus, left C6-C7; 3) left C6-C7 radiculopathy; 4) preexisting C5-C6 degenerative disc disease with temporary exacerbation; 5) left shoulder strain; 6) left shoulder rotator cuff tear secondary to February 13, 2019 injury, with 2.6 cm retraction; 7) status post anterior cervical discectomy with fusion, C6-C7; and 8) status post left shoulder arthroscopic rotator cuff repair with distal clavicle excision. Dr. Lane opined it was within reasonable medical probability Employee sustained a work injury with the onset of a left herniated nucleus pulposus at C6-C7 and the occurrence of a full-thickness left supraspinatus rotator cuff tear.

Dr. Lane disagreed with Dr. Glassman's opinion Employee's multilevel cervical spondylosis, including central and foraminal stenosis, and also the left sided C7 radiculopathy, were not related to the February 13, 2019 work injury. He disagreed with Dr. Glassman's attribution of the changes being due to age-related degenerative changes, a prior motor vehicle collision and a prior whiplash diagnosis. Dr. Lane disagreed with Dr. Glassman's opinion these resulted in a temporary exacerbation of cervical spondylosis and left C7 radiculopathy, without being the substantial cause

of the symptoms. Dr. Lane noted Dr. Glassman focused on the physician's assessment there was no cervical spine tenderness and no muscle spasm on February 14, 2019. However, Employee was noted to have pain and numbness radiating into the left arm and hand, which would in all probability be due to the radicular findings. Specifically, the March 29, 2019 cervical MRI revealed small disc protrusions at C3-C4, C4-C5, and C5-C6 with a large herniation at C6-C7, which began centrally and extended strongly to the left of midline. The herniation markedly impinged on the medical aspect of the left neural foramen and the exiting C7 nerve root. In addition, it was noted Employee's symptoms were caused by the disc herniation, not the degenerative changes present at the C5-C6 level. Dr. Lane reviewed the x-rays from the date of injury on February 14, 2019, which showed mild degenerative changes at C5-C6, but this is not the level that generated the radiculopathy, which was the acute change. Employee had numbness radiating down the arm from the acute herniation at C6-C7, which impinged on the exiting C7 nerve root, and which caused the need for treatment. Employee was noted to have progressively developed weakness in the left upper extremity and underwent a single-level decompression and fusion. Employee was also noted to have the same spondylosis which Dr. Glassman writes of in his report, but no symptoms to palpation, no pain, and excellent function. Employee only reported limitations of activities of daily living with reclining and tactile feelings, as he had some residual radiculopathy with numbness of the left upper extremity. Dr. Lane opined this supports the fact have the underlying spondylosis condition to which Dr. Glassman referred is not a causative factor and not symptomatic. Dr. Lane opined considering all the factors, 90 percent of the cervical impairment was due to the work injury and 10 percent due prior injury and degeneration.

Regarding the left shoulder, Dr. Lane noted he agreed with Dr. Glassman that rotator cuff disease is multifactorial, including age-related changes, repetitive microtrauma, or acute significant trauma. He opined in the work injury Employee was reaching overhead to pull himself up and this would have activated the rotator cuff as he was pulling himself over toward a ramp. He opined 60 percent of Employee's left shoulder injury was from the work injury, given he was asymptomatic before the work injury, and 40 percent would have been due to repetitive trauma as well as genetic issues and other findings.

Dr. Lane opined the Employee did sustain aggravation of both the cervical spine and left shoulder as a result of the February 13, 2019 work injury and he did have a permanent change in his preexisting condition. He also opined the substantial cause of both the cervical spine and left shoulder disabilities was the work injury. He found Employee was medically stable, with permanent impairment. He opined the treatment Employee had received was medically necessary and appropriate and allowed him to reach a plateau. Dr. Lane also opined Employee might require future medical treatment including physician visits and prescriptions for medications and therapy. There was also a slight chance he might require further left shoulder surgery. (Dr. Lane's SIME report, June 28, 2021).

28) On July 20, 2021, Dr. Lane provided PPI ratings based on the Sixth Edition of the AMA Guides. He rated Employee for the cervical fusion at C6-C7 with residual left radiculopathy at one level. Per Table 17-2 on page 564, Employee was placed in a Class 2 for one level of Alteration of Motion Segment Integrity (AOMSI) with residual radiculopathy at the clinically appropriate level, default grade C, for 11 percent WPI. For the left shoulder, per table 15-5 on page 403, for a distal clavicle excision. He was placed in Class 1 at the default of C at 10 percent upper extremity impairment. Per Table 15-7, on page 406, Employee had a functional grade modifier of 1 and per Table 15-8 on page 408, a physical exam grade modifier of 1, and per Table 15-9, pages 410-411, he has a clinical studies grade modifier of 2. Thus, the net adjustment was +1, resulting in Class 1, Grade D, at 11 percent upper extremity impairment of the shoulder. (Dr. Lane's SIME supplemental report, July 20, 2021).

29) An 11 percent upper extremity rating is reduced to a seven percent WPI per Table 15-11 on page 420. (AMA Guides, page 420).

30) The combined cervical spine 11 percent WPI, the left shoulder seven percent WPI, and the prior right shoulder two percent PPI result in a 17 percent combined WPI per Appendix A of the combined values chart on pages 604 and 605. (AMA Guides, pages. 604-605).

31) On July 20, 2021, Employee filed copies of his medical bills, and receipts for out-of-pocket medical expenses. (Certificate of Service (COS), July 20, 2021)

32) On August 4, 2021, Employee filed his Four Point by Sheraton invoice for SIME travel for the dates June 27, 2021 and June 28, 2021, in the amount of $384.66, which had been paid by Employee. (Certificate of Service, August 4, 2021).

33) On October 28, 2021, Employer provided proof Employee was paid $3,540.00 on December 16, 2015 for his two percent right shoulder whole person impairment. (Employer's hearing brief, Exhibit B, October 28, 2021).

34) On October 28, 2021, Employee filed documentation of his work injury medical costs, which were paid either by his own insurance Public Employee Local 71 Trust or Aetna insurance through AlaskaCare Retiree Plan, or out-of-pocket by Employee himself. (Employee's hearing exhibit 11, pgs. 1-30 and exhibit 12, pgs. 1-3, October 28, 2021).

35) On October 28, 2021, Employee filed documentation of his out-of-pocket pharmacy and other medical costs. (Employee's hearing exhibit 13, pgs. 1-18, October 28, 2021).

36) On October 28, 2021, Employee filed his travel log documenting his medical related travel from February 14, 2019 through November 25, 2019 for a total of 330.4 miles. (Travel log, October 28, 2021 hearing exhibit 14, pgs. 1-25).

37) The reimbursement rate for transportation for medical treatment in 2019 was $0.58 per mile. (Alaska Department of Labor and Workforce Development Division of Workers' Compensation Bulletin 19-01).

38) On October 28, 2021, Employee filed his receipt for payment to Four Points Hotel for his SIME travel, for the dates June 27, 2021 to June 28, 2021 in the amount of $384.66. (Employee's hearing exhibit 15, pgs. 1-3).

39) On October 28, 2021, Employee filed a summary of unpaid medical and travel expenses from his hearing exhibits 11 through 15. The total unpaid medical expenses for Employee's health care providers and/or his own health care insurance are $107,760.68. The total out-of-pocket expenses paid by Employee for medical costs are $1,248.57, for travel costs $191.63, and for SIME travel $384.66. (Employee's hearing exhibit 16, pgs. 1-2, October 28, 2021).

40) On November 4, 2021, Employee testified that on February 13, 2019 he was employed as a building facilities and construction supervisor for the State of Alaska Department of Transportation at Ted Stevens International Airport. He testified on the day he was injured he performed his job just as he did every other day, except for one thing. That is, he had to climb up on a ladder on a piece of equipment he had to use to cross another piece of equipment. When he reached the top, he felt a sharp twinge in his neck and shoulder area. The pain when away, but about one half hour later, it started to become more and more painful. He did not finish his shift that day as he needed to see a doctor. His wife made an appointment for him to see Dr. Coalwell

on February 14th. He had never experienced pain in his neck and shoulder like that previously. He had never experienced numbness in his hand before the work injury either. He still has numbness in his hand. The numbness has never gone away. He had surgery on his neck on June 6, 2019. From the date of his work injury on February 13, 2019 and the surgery on June 6, 2019, he experienced excruciating pain in his neck. He could barely use his hand and barely turn his neck. He was unable to lie flat and had to sleep sitting up. The neck pain and the pain in the back of his shoulder did increase over time before he had his surgery. The pain was so bad his left side was basically useless. He called the adjustor before he had surgery to make sure his neck surgery was approved and would be paid for. He was assured it was approved. If it had not been approved, he would have used his regular insurance through his work. Since his June 6, 2019 surgery, his pain has gone away, and he has pretty good range of motion. The only symptoms he still experiences are the numbness in his thumb and forehand. He does have trouble with his grip as he cannot judge the strength of his grip. He drops things a lot.

Employee testified, prior to the February 13, 2019 work injury, his left shoulder felt fine. He had never before had pain in his shoulder like he experienced after the work injury. On August 7, 2019, he had shoulder surgery. His shoulder was very, very painful between February 13, 2019 and when he finally had shoulder surgery, although the pain did not increase during that time. Since the surgery, his shoulder is doing pretty good. He is getting the range of motion back and the strength back. He did call the adjustor to make sure everything was in order and the surgery would be paid for. Employee was contacted several times by health care providers after the surgeries, but after the controversion, he had not been contacted. Employee testified the bills from health care providers in Exhibit11 were the ones he provided, some of which he had paid. Exhibit 11, page 13 was a bill from Dr. McNamara for $327.00 for his left shoulder surgery that Employee paid as Dr. McNamara was demanding payment as the workers' compensation carrier had not paid. Employee also had some prescriptions that were never reimbursed. He testified Exhibit 13 consists of pharmacy receipts and bills from Alaska Spine Institute and Alaska Imaging, which he paid. Concerning Exhibit 14, a travel log which reflected his travel from his home to his doctor appointments, Employee testified the only thing he was disputing was the hotel bill. Employee testified Exhibit 15 was a copy of the bill he was given when he checked out. He realized he had been charged by the hotel when he received the credit card statement.

Employee testified concerning Dr. Glassman's statement in his EME report on page four that Employee had been in three different auto accidents that contributed to either his neck or shoulder conditions. He had been involved in a roll-over accident in a pickup in 2008 in which he received bruises on his left knee and left hand, but it was "minor stuff." He had not suffered any neck or shoulder pain from the 2008 accident. He was also in another accident in 2008 in which the car he was in was rear ended and Dr. Coalwell diagnosed a whiplash injury. He had a couple of days of sore muscles. He did not receive any other treatment aside from the one visit to Dr. Coalwell. The pain resolved in a couple of days. From 2008 until the date of injury on February 13, 2019, he did not experience any neck pain or pain, numbness or tingling extending into his left hand or fingers. He did not experience any weakness in his lefthand grip. Nor did he experience any left shoulder pain or weakness from 2008 until the February 13, 2019 work injury. Employee had been employed by the State since 2003. His job description was included in the SIME records, pages one through fourteen. It was hard to explain to people what his job was. He worked on all kinds of equipment, and everything related to the airport, inside and outside the buildings, the mechanical and plumbing systems, bag line, and jet ways. On SIME page seven, were the physical requirements of his job, including the frequencies with which they needed to be performed. The physical requirement for reaching overhead above shoulder level was frequent, or over 33 percent of the time. Employee testified he did that every day. He also had to reach below shoulder level frequently. He had to lift and carry 25 to 50 pounds frequently and lift and carry 50 pounds every day. He also had to push and pull more than 50 pounds every day. It was a very physical job. They had to maintain the baggage lines, move steel belts, motors, transmissions, computer systems, as well as maintain the buildings.

Employee testified when the February 13, 2019 work injury occurred, he was going to climb over some equipment so he could check some inventory levels with his clerk. The items were stored in the middle of the piece of equipment. There was a chair in front of the ladder used to climb up on the equipment. When he put his foot on the first rung of the ladder, he reached over with his left arm and pulled himself up. At the very same time, he noticed an airline employee to his right, so he looked over to acknowledge her. When he reached the top of the equipment, he felt a pull and a sharp pain between his neck and his shoulder. The pain then went away for awhile. He checked

for the parts he was looking for, then went on with his other duties, including checking on the bag line before 4 a.m., and all his other duties. When he went back to his office, he noticed a numbness and pain in his shoulder. He could not even turn his head at that time. He left work early that morning to make a doctor's appointment. Employee could not say whether the injury occurred when he turned his head to the right. He felt the pull and sharp pain when he reached the top of the equipment. Employee reported turning his head to the right to his treating physicians. None of his physicians discussed with him whether they considered the turning of the head to the right significant.

Employee testified his job required him to do work with his arms above shoulder level every day, frequently, but he could not give a percentage. A lot of their equipment is overhead. He frequently had to lift parts up overhead when repairing and maintaining equipment. He had to work with his arms below shoulder level frequently as well. He was required to lift and carry items weighing more than 50 pounds frequently, up to 30 percent of the time.

Employee testified after the 2008 rollover accident he had bruises on his left hand and left knee. Also in 2008, after the rollover accident, when he was rear ended on his way to the doctor's office, he just had a little bit of pain in his back and left thigh. He did not have any neck or shoulder pain after either accident.

Employee testified he had talked on the telephone with someone by the name of Ashley at Penser North America to verify his neck surgery was approved. He was told to go ahead with the surgery. Later, before his shoulder surgery, he also checked with someone by telephone at Penser North America to make sure the shoulder surgery was approved. He was told to go ahead with the shoulder surgery. (Employee's hearing testimony, November 4, 2021).

41) Employee's presentation was forthright and sincere. He is credible. (Experience, judgment, observations, and inferences from all the above).

42) On November 4, 2021, Ashley Moser, adjustor for Penser North America, Inc., testified she had reviewed the claim for the 2019 injury and did not see any evidence Employee's surgeries were pre-approved, either in writing or in verbal conversations. She also did not see any evidence Employee had sought approval for the surgeries or discussed it. She was assigned to Employee's

case after both surgeries, so she personally had never had any discussion with Employee about pre-approval. (Hearing record).

43) When questioned by Employee's attorney, Ms. Powell, concerning whether she had in her possession the Four Points by Sheraton Hotel in San Diego bill for June 17, 2021 to June 29, 2021, which Ms. Powell had served on Employer's attorney on August 4, 2021, Ms. Moser testified she did not have it. (*Id*.).

44) Employer's attorney, Mr. Tashjian, conceded the SIME hotel needs to be reimbursed to Employee. (Hearing record).

45) Ms. Moser testified she reviewed Dr. Glassman's EME report before the controversion, and she as not familiar with the Alaska Supreme Court cases *DeYonge* or *Morrison*. (*Id*.).

46) On October 28, 2021, Employee's attorney filed her attorney fee affidavit showing her many years' experience as an attorney, having been admitted to the bar in 1983. In addition, starting in 2005 she began to handle workers' compensation cases exclusively. She was first awarded $400 per hour five years ago in *Williams v. Arctic Terra*, Dec. No. 16-0095 (October 26, 2016) and consistently thereafter. Employee's attorney has spent an extraordinary amount of time dealing with the resistance of the state's attorneys in this case. One of her peers, who was admitted to the bar 16 years after she was, received $450 per hour in *LaBlanc v. Ak Inga's Gallery LLC*, Dec. No. 20-0098 (October 23, 2020). Another, who was admitted to the bar three prior to her own admission date, also received $450 per hour in *Mitchell v. State*, Dec. No. 21-0039 (May 4, 2021). She is now requesting $400 per hour through August 12, 2021, and $425 per hour after August 12, 2021. Her October 28, 2021 attorney fee affidavits documented attorney fees totaling $24,979.50 and costs totaling $130.50. (Attorney fees affidavit, October 28, 2021).

47) On November 17, 2021, Dr. Glassman testified by deposition, referring to his September 7, 2019 EME report. He stated the temporary aggravation of Employee's cervical spine preexisting conditions would have ended six to eight weeks after the injury based on his experience with soft tissue injuries. The mechanism of injury, as described to him, which was a pulling with the left shoulder – an abduction extension motion of the left shoulder while pulling himself up and over an object, would not cause an injury to the cervical spine, including herniation or facet hypertrophy. Turning the head to one side while pulling himself up would not cause enough force to result in structural change or injury to the cervical spine. Regarding the left shoulder, he opined the age-related degenerative changes were the most important cause of Employee's left shoulder

pathology. Historical studies show 55 percent of 60-year-olds with no shoulder pain will have some level of rotator cuff tear. Dr. Glassman also noted Employee had a history of left shoulder pain after a motor vehicle collision. His opinion that the work injury aggravation ended on March 12, 2019 was based on the physical examination that day, which showed intact left shoulder rotator cuff strength, meaning the muscle strength and reduced pain symptoms allow for full strength. The temporary exacerbation may have ended six to eight weeks after the injury. His opinion was based on the length of time required for soft tissue injury to heal from surgery. Dr. Glassman testified the most important cause for the need for medical treatment for Employee's left shoulder was the age-related degenerative changes. Historical studies have shown up to 55 percent of 60-year-olds with no shoulder pain will have some level of rotator cuff tear. Employee had a history of left shoulder pain after a previous motor vehicle collision. Dr. Glassman also opined Employee had a history of a right shoulder rotator cuff tear and degenerative changes, which indicated a genetic predisposition to having a rotator cuff tear and associated symptoms of subacromial impingement syndrome. If the work injury had resulted in acute trauma to the left shoulder, one would expect to see the presence of muscle spasm indicating muscle strain on physical exam, and an increased fluid signal or edema on the MRI indicating acute trauma to the muscles themselves. In addition, the mechanism of injury, which he understood as a shoulder extension, a deduction-abduction motion without shoulder dislocation, would not create the conditions in Employee's left shoulder. This is true even if Employee turned his head at the same time. Dr. Glassman testified he based his diagnoses and causation on the objective findings that were available. He again testified, based on the medical record, there was a history of neck pain and left shoulder pain prior to the February 13, 2019 work injury.

Dr. Glassman testified Employee had a 17 percent whole person impairment (WPI) for the cervical spine and six percent WPI for the left shoulder, for a combined WPI of 22 percent. The work injury was not the substantial cause of the 22 percent WPI. The PPI rating was performed based on Dr. Glassman's September 7, 2019 physical examination when neither Employee's cervical spine nor his left shoulder were medically stable, as well as medical records.

Dr. Glassman testified his assessment of diagnosis and causation would be the result of the objective evidence from the medical record and imaging. If pain complaints affected Employee's

subjective complaints in the medical record and on physical exam, he would have taken those complaints into account. For example, he did not take the positive Spurling's test into account when he determined causation for the cervical spine, as it is not an objective test and does not indicate acuity. Whereas Dr. Glassman's EME report stated there was a temporary exacerbation of Employee's cervical spine, it was not related to the work injury, at his deposition he testified the work injury was the cause of this temporary exacerbation, which may have lasted as long as six to eight weeks, based on the understanding of soft tissue injury recovery after surgical wounds and other soft tissue injuries. Then when asked if it was his assessment the injury caused soft tissue injury, or cause more than that, Dr. Glassman testified soft tissue injury was not created as a result of the work injury. Dr. Glassman referred to the medical records when questioned about the cause of Employee's 2010 right shoulder rotator cuff tear, which he had testified indicated a genetic predisposition to have rotator cuff tears. The medical records revealed it was a work injury that precipitated the need for treatment for the right shoulder. Dr. Glassman admitted there was no evidence in the medical records Employee had treated for neck pain or left shoulder pain in the ten years prior to the February 13, 2019 work injury. There was also no evidence in the medical records Employee had suffered from or been treated for left shoulder weakness or left-hand grip weakness prior to the work injury. (Glassman deposition testimony. November 17, 2021).

48) Dr. Glassman's testimony revealed an incomplete understanding of Employee's medical history related to his cervical spine and left shoulder conditions. His testimony was also inconsistent. Therefore, Dr. Glassman's opinions are given less weight. (Experience, judgment, observation, experience, and inferences from all the above).

49) On December 6, 2021, Employee's attorney filed her fee affidavits, documenting attorney fees of $16,192.50. (Affidavit of counsel, December 6, 2021).

50) On December 23, 2021, Employer filed its response to Employee's December 6, 2021 supplemental fees. Employer objected to the increase in Employee's attorney's increased rate from $400 to $425 per hour. Employer also objected to the September 25, 2020 charges for 4.1 hours, which were a partial duplication of the specific hours requested and denied in *Guerrissi v. State of Alaska*, AWCB Dec. No. 20-0109 (December 4, 2020), where that decision denied 3.4 hours or $1,360. (Employer's response to supplemental fees, December 23, 2021).

51) On January 12, 2022, Employee petitioned to reopen the record for the filing of the supplemental cost for the certified transcript of Dr. Glassman's deposition in the amount of $585.50. (Employee's petition, January 12, 2022).

52) On January 18, 2022, Employer answered Employee's January 12, 2022 petition. It did not oppose Employee's request to add the transcript bill to the requested fees and costs. (Employer's answer, January 18, 2022).

PRINCIPLES OF LAW

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

> **AS 09.30.070. Interest on judgments; prejudgment interest**.
> (a) Notwithstanding AS 23.23.010, the rate of interest on judgments and decrees for the payment of money, including prejudgment interest, is three percentage points above the 12th Federal Reserve District discount rate in effect on January 2 of the year in which the judgment or decree is entered, except that a judgment or decree founded on a contract in writing, providing for the payment of interest until paid at a specified rate not exceeding the legal rate of interest for that type of contract, bears interest at the rate specified in the contract if the interest rate is set out in the judgment or decree.
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> **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. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this

> chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.
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> **AS 23.30.095(a) Medical treatments, services, and examinations**. (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches and apparatus for the period which the nature of the injury or process of recovery requires, not exceeding two years from and after the date of injury to employee….It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has a right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require….
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> **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
> . . . .

Under AS 23.30.120, benefits sought by an injured worker are presumed to be compensable, and the burden of producing substantial evidence to the contrary is placed on the employer. *Miller v. ITT Arctic Services*, 577 P.2d 1044 (Alaska 1978). The presumption of compensability applies to any claim for compensation under the Act. *Meek v. Unocal Corp.*, 914 P.2d 1276, 1279 (Alaska 1996). An employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski v. Best Western Golden Lion Hotel,* 813 P.2d 286, 292 (Alaska 1991).

A three-step analysis is used to determine the compensability of a worker's claim. At the first step, the claimant need only adduce "some minimal" relevant evidence establishing a "preliminary link" between the injury claimed and employment. *McGahuey v. Whitestone Logging, Inc.*, 262 P.3d 613, 620 (Alaska 2011); *Smith v. Univ. of Alaska, Fairbanks*, 172 P.3d 782, 788 (Alaska 2007); *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987). The evidence necessary to attach the presumption of compensability varies depending on the claim. In claims based on highly technical medical considerations, medical evidence is often necessary to make that connection. *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). In less complex cases, lay evidence may be sufficiently probative to establish causation. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Witness credibility is not weighed at this step in

the analysis. *Resler v. Universal Services Inc.*, 778 P.2d 1146, 1148-49 (Alaska 1989).

At the second step, once the preliminary link is established, the employer has the burden to overcome the presumption with substantial evidence. *Smallwood*. To rebut the presumption, an employer must present substantial evidence that either (1) 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). "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, 611-612 (Alaska 1999). At the second step of the analysis, the employer's evidence is viewed in isolation, without regard to the claimant's evidence. Issues of credibility and evidentiary weight are deferred until after it is determined the employer has produced substantial evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051, 1054 (Alaska 1994); *Wolfer* at 869-870. When evidence offered to rebut the presumption is uncertain or inconclusive, the presumption is not overcome. *Bouse v. Fireman's Fund Insurance Co*., 932 P.2d 222 (Alaska 1997).

If the presumption is raised but not rebutted, the claimant prevails and need not produce further evidence. *Williams v. State*, 938 P.2d 1065, 1075 (Alaska 1997). If the employer successfully rebuts the presumption, it drops out, and the employee must prove all elements of her case by a preponderance of the evidence. *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 at 8 (March 25, 2011) (reversed on other grounds); *Huit v. Ashwater Burns, Inc*., 372 P.3d 904 (Alaska 2016)). At this last step of the analysis, evidence is weighed, inferences are drawn, and credibility considered. To prevail, the claimant must "induce a belief" in the factfinders' minds the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

A fundamental principle in workers' compensation law is the "eggshell skull doctrine," which states an employer must take an employee "as he finds him." *Fox v. Alascom, Inc.*, 718 P.2d 977, 982 (Alaska 1986), citing *S.LW, v. Alaska Workmen's Compensation Board*, 490 P.2d 42, 44 (Alaska 1971); *Wilson v. Erickson, All* P.2d 998, 1000 (Alaska 1970). A pre-existing condition does not disqualify a claim if the employment aggravated, accelerated, or combined with the pre-

existing condition to produce the disability or need for medical treatment for which compensation is sought. Under the Act, there is no distinction between the aggravation of symptoms and the aggravation of the underlying condition. *DeYonge v. NANA/Marriott*, 1 P.3d 90, 96 (Alaska 2000); *Peek v. SKW/Clinton*, 855 P.2d 415, 416 (Alaska 1993).

In *City and Borough of Juneau v. Olsen*, AWCAC Decision No. 11-0185 (August 21, 2013), the commission explained the application of "the substantial cause" in cases where a work injury "aggravates or accelerates" or "combines" with a preexisting condition. When an employee asserts a work injury caused the aggravation or acceleration of a preexisting condition, the board must evaluate the relative contribution of both the preexisting condition and the work injury. To establish causation, the employee must show the work injury played a greater role in the disability or need for medical treatment than did the preexisting condition. *Olsen,* 17-18. When an employee asserts his disability or need for medical treatment arose as a result of a combination of his work injury and a preexisting condition, the employee must establish two additional facts to prevail, first, that the disability or need for treatment would not have happened "but for" the work injury, and second, that reasonable persons would regard the work injury as the substantial cause of the disability or need for medical treatment. *Olsen,* 18-19.

In *Tinker v. Veco, Inc.*, 913 P.2d 488 (1996), a worker with a long-standing diabetic foot condition suffered frostbite and a blister on his right foot while at work. His right foot became infected, as did his left foot. He returned to work and injured his left ankle when he slipped on ice. He was diagnosed with Charcot arthropathy and underwent surgery on both feet. He returned to work again but was evacuated after becoming ill with food poisoning. His left leg was later amputated below the knee, and he filed workers' compensation claims. The board held the employee had failed to timely notify the employer of the frostbite injury and rejected that claim. The Supreme Court determined the employee's failure to give timely notice of the frostbite injury was excusable. The Court remanded to the board for further consideration, noting: "Tinker's diabetes would not have barred his compensation claim, so long as the injury he received on the job aggravated, accelerated, or combined with his medical condition in a manner that resulted in the loss of the leg." *Id.*, footnote 2.

DeYonge held a temporary, symptomatic worsening constitutes an injury. Preexisting conditions do not disqualify a claim under the work-connection requirement if the employment injury aggravated, accelerated, or combined with the preexisting infirmity to produce the disability for which compensation is sought. So long as the work injury worsened the injured person's symptoms, the increased symptoms constitute an aggravation, "even when the job does not actually worsen the underlying condition." *Id*. at 96.

In *Morrison v. Alaska Interstate Construction, Inc*., 440 P.3d 224 (Alaska 2019), the Alaska Supreme Court for the first time construed AS 23.30.010(a) and its relationship to the *DeYonge* doctrine and the "last injurious exposure rule." *Morrison* found the legislature did not abrogate the *DeYonge* rule when it amended the coverage statute in 2005. It held the Commission's inquiry improperly focused on what qualifies as an injury, "which is not how the legislature chose to reduce the number of potentially compensable claims." *Id*. at 233. Interpreting AS 23.30.010(a), *Morrison* held the board decides whether "the employment" was "the legal cause," *i.e.*, "a cause important enough to bear legal responsibility for the medical treatment needed for the injury," by looking at the "*causes* of the injury or symptoms" rather than considering the injury type. *Id*. at 233-234 (emphasis in original).

Morrison held AS 23.30.010(a) is not complex and requires the board to consider different causes "of the benefit sought" and the extent to which each contributed to the need for the specific benefit. The board must then identify one cause as "the substantial cause," meaning, the cause which "is the most important or material cause related to that benefit." Based on legislative history, Morrison found the legislature did not intend to require that the substantial cause be a "51% or greater cause, or even the primary cause, of the disability or need for medical treatment." The comparison made is "among the causes identified, not in isolation or in comparison to an abstract idea." It is a "flexible" and "fact dependent" determination. *Id*. at 237-238. *Morrison* held the board has the right and responsibility to interpret evidence and draw its own inferences. *Id*. at 239. Finding no error, *Morrison* reversed the Commission and remanded the case with instructions to reinstate the board's award. *Id*. at 240.

Traugott v. ARCTEC Alaska, 468 P.3d 499 (Alaska 2020) held the new causation standard in AS

23.30.010 required the board to identify factors contributing to the disability and need for medical treatment and decide which among them was the most material or important one. *Id*. at 514. *Traugott* held "the statute permits the board to determine which cause among all those identified is the most important or material cause of the current disability and need for medical treatment, even if an expert does not regard it as having more than 50% responsibility for the condition." *Id*. at 511 (citing *Morrison*). The board, and not a medical expert, is required to consider the possible cause of an employee's disability and need for medical treatment and determine which of the possible causes is the most important in causing the disability and need for medical care. And the board, not a medical expert, is charged with determining legal responsibility. The board as the fact finder has the authority to interpret an expert's opinion and decide what weight to give it. *Id*. at 514.

> **AS 23.30.097. Fees for medical treatment and services.**
> (a) All fees and other charges for medical treatment or service are subject to regulation by the board consistent with this section.
> . . . .
>
> (f) An employee may not be required to pay a fee or charge for medical treatment of service provided under this chapter.
>
> **AS 23.30.122. Credibility of witnesses**. The board has the sole power to determine the credibility of a witness. A finding by the board concerning the weight to be accorded a witness's testimony, including medical testimony and reports, is conclusive even if the evidence is conflicting or susceptible to contrary conclusions. The findings of the board are subject to the same standard of review as a jury's finding in a civil action.

The board's credibility finding "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).

An SIME is not a discovery tool exercised by the parties; it is an investigative tool exercised by the board to assist it by providing disinterested information. *Olafson v. State Department of Transportation*, AWCAC Decision No. 06-0301 (October 25, 2007) at 15.

> **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.
>
> (b) If an employer fails to file timely notice of controversy or fails to pay compensation or medical and related benefits within 15 days after it becomes due or otherwise resists the payment of compensation or medical and related benefits and if the claimant has employed an attorney in the successful prosecution of the claim, the board shall make an award to reimburse the claimant for the costs in the proceedings, including reasonable attorney fees. The award is in addition to the compensation or medical and related benefits ordered.
>
> . . . .

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

Rusch v. Southeast Alaska Regional Health Consortium, 453 P.3d 784 (Alaska 2019), held the AS 23.30.120 presumption does not apply to attorney fee amounts or reasonableness. It further held the board must consider all factors set out in Alaska Rule of Professional Conduct 1.5(a) when

determining a reasonable attorney fee and either make findings related to each factor or explain why that factor is not relevant. *Rusch* held attorney fee reasonableness is not a factual finding but is a discretionary exercise.

Childs v. Copper Valley Electric Ass'n, 860 P.2d 1184, 1190 (Alaska 1993), cited AS 23.30.145 and distinguished it from Civil Rule 82, noting AS 23.30.145 provides "attorney's fees in workers' compensation cases should be fully compensatory and reasonable, in order that injured workers have competent counsel available to them." Fees incurred on lost, minor issues will not be reduced if the employee prevails on primary issues. *Uresco Construction Materials, Inc. v. Porteleki*, AWCAC Decision No. 152 (May 11, 2011).

> **AS 23.30.155. Payment of compensation**. (a) Compensation under this chapter shall be paid periodically, promptly, and directly to the person entitled to it, without an award, except where liability to pay compensation is controverted by the employer. To controvert a claim, the employer must file a notice, in a format prescribed by the director ...
>
> ....
>
> (b) The first installment of compensation becomes due on the 14th day after the employer has knowledge of the injury or death. On this date all compensation then due shall be paid. Subsequent compensation shall be paid in installments, every 14 days, except where the board determines that payment in installments should be made monthly or at some other period.
>
> ....
>
> (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. This additional amount shall be paid at the same time as, and in addition to, the installment, unless notice is filed under (d) of this section or unless the nonpayment is excused by the board after a showing by the employer that owing to conditions over which the employer had no control the installment could not be paid within the period prescribed for the payment. The additional amount shall be paid directly to the recipient to whom the unpaid installment was to be paid.
>
> ....
>
> (o) The director shall promptly notify the division of insurance if the board determines that the employer's insurer has frivolously or unfairly controverted

> compensation due under this chapter. After receiving notice from the director, the division of insurance shall determine if the insurer has committed an unfair claim settlement practice under AS 21.36.125.
>
> (p) An employer shall pay interest on compensation that is not paid when 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). To avoid a penalty, a controversion must be filed in good faith. *Harp v. ARCO Alaska, Inc.*, 831 P.2d 352 (Alaska 1992). 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 the claimant not entitled to benefits. *Id*.

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

> **AS 23.30.190. Compensation for permanent partial impairment; rating guides.**
>
> (a) In case of impairment partial in character but permanent in quality, and not resulting in permanent total disability, the compensation is $177,000 multiplied by the employee's percentage of permanent impairment of the whole person. The percentage of permanent impairment of the whole person is the percentage of impairment to the particular body part, system, or function converted to the percentage of impairment to the whole person as provided under (b) of this section. The compensation is payable in a single lump sum, except as otherwise provided in AS 23.30.041 but the compensation may not be discounted for any present value considerations.
>
> . . . .
>
> (b) All determinations of the existence and degree of permanent impairment shall be made strictly and solely under the whole person determination as set out in the American Medical Association Guides to the Evaluation of Permanent Impairment, except that an impairment rating may not be rounded to the next five percent. The board shall adopt a supplementary recognized schedule for injuries that cannot be rated by use of the American Medical Association Guides.
>
> (c) The impairment rating determined under (a) of this section shall be reduced by a permanent impairment that existed before the compensable injury. If the

> combination of a prior impairment rating and a rating under (a) of this section would result in the employee being considered permanently totally disabled, the prior rating does not negate a finding of permanent total disability.
>
> . . . .

PPI ratings must be for an impairment which is partial in character and permanent in quality and calculated under the AMA *Guides*. The board has consistently followed this statute in its decisions and orders. S*ee, e.g., Nickels v. Napolilli*, AWCB Decision No. 02-0055 (March 28, 2002); *Jarrard v. Nana Regional Corp*., AWCB Decision No. 90-0299 (December 14, 1990).

Effective March 31, 2008, all PPI determinations and ratings must be conducted using the sixth edition of the AMA *Guides*. Alaska Workers' Compensation Division Bulletin Number 08-02, issued January 15, 2008.

> **8 AAC 45.082. Medical treatment**.
>
> ....
>
> (d) Medical bills for an employee's treatment are due and payable within 30 days after the date the employer received the medical provider's bill and a completed report on form 07-6102. Unless the employer controverts the prescription charges or transportation expenses, an employer shall reimburse an employee's prescription charges or transportation expenses for medical treatment no later than 30 days after the employer received ... an itemization of the dates of travel, destination, and transportation expenses for each date of travel.
>
> **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;
>
> ....
>
> (c) Transportation expenses, in the form of reimbursement for mileage, which are incurred in the course of treatment or examination are payable when 100 miles or more have accumulated, or upon completion of medical care, whichever occurs first....

8 AAC 45.142. Interest. (a) If compensation is not paid when due, interest must be paid at the rate established in . . . AS 09.30.070(a) for an injury that occurred on or after July 1, 2000. If more than one installment of compensation is past due, interest must be paid from the date each installment of compensation was due, until paid. If compensation for a past period is paid under an order issued by the board, interest on the compensation awarded must be paid from the due date of each unpaid installment of compensation.

(b) The employer shall pay the interest

(1) on late-paid time-loss compensation to the employee. . . .
. . . .

(3) on late-paid medical benefits to

(A) the employee, or if deceased, to the employee's beneficiary or estate, if the employee has paid the provider or the medical benefits.

(B) to an insurer, trust, organization, or government agency, if the insurer, trust, organization, or government agency has paid the provider of the medical benefits; or

(B) to the provider if the medical benefits have not been paid.

The Alaska Supreme Court has consistently instructed interest for the time-value of money must be awarded, as a matter of course. E.g., *Land and Marine Rental Co. v. Rawls*, 686 P.2d 1187, 1192 (Alaska 1984).

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

(b) . . . 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.

. . . .

(d) The board will award a fee under AS 23.30.145(b) . . . .

(1) A request for a fee under AS 23.30.145(b) must be verified by an affidavit itemizing the hours expended as well as the extent and character of the work performed, and, if a hearing is scheduled, must be filed at least three working days before the hearing on the claim for which the services were rendered; at hearing the attorney may supplement the affidavit by testifying about the hours expended and the extent and character of the work performed after the filing of the affidavit. Failure by the attorney to file the request and affidavit in accordance with this paragraph is considered a waiver of the attorney's right to recover a reasonable fee in excess of the statutory minimum fee under AS 23.30.145(a), if AS 23.30.145(a) is applicable to the claim, unless the board determines that good cause exists to excuse the failure to comply with this section.

. . . .

8 AAC 45.182. Controversion....

....

(b) After hearing a party's claim alleging an insurer frivolously or unfairly controverted compensation due, the board will file a decision and order determining whether an insurer or self-insured employer frivolously or unfairly controverted compensation due. Under this subsection,

(1) if the board determines an insurer frivolously or unfairly controverted compensation due, the board will provide a copy of the decision and order at the time of filing to the director for action under AS 23.30.155 (o); or

(2) if the board determines a self-insured employer frivolously or unfairly controverted compensation due, the board will, at the time of its decision and order are filed, provide a copy of the decision and order to the commissioner's designee for consideration in the self-insured employer's renewal application for self-insurance.

ANALYSIS

1) Is the February 13, 2019 work injury the substantial cause of Employee's need for medical treatment for his cervical spine and left shoulder?

A. Cervical Spine

The substantial cause of Employee's need for medical treatment is a factual issue subject to the presumption analysis. *Meek*; *Sokolowski*. Relevant to the presumption analysis in this case is the

"eggshell doctrine," under which the employer takes an employee as he finds him. Employee's C6-7 disc herniation pain and other symptoms and need for medical treatment may be compensable if the work injury aggravated, accelerated, or combined with the pre-existing condition leading to Employee's need for medical treatment. *Fox*; *DeYonge*; *Olsen*; *Morrison*. If however the pre-existing pathologies are ultimately found to be the substantial cause of the need for medical treatment, then Employer will prevail. AS 23.30.010(a); *Olsen*; *Morrison*.

At the first step of the analysis, Employee must show a preliminary link between his cervical spine symptoms and his employment. *McGahuey*; *Smith*; *Cheeks*. At this stage neither credibility nor evidence's weight is considered. *Resler*. Employee successfully raises the presumption through his testimony describing the work injury in which he suddenly felt a pull and a sharp pain between the side of his neck and his shoulder when he was crossing a baggage ramp and used his left arm to grasp a rung on the ladder to pull himself up. The pain subsided initially, but later the same night while still at work, he noticed a numbness and pain in his shoulder and he could not turn his head. *Wolfer*. Dr. McCormack's opinion the cervical spine symptoms and need for medical treatment were caused by the work injury also raises the presumption. *Smallwood*.

Because Employee raised the presumption, Employer must rebut it and may do so with substantial evidence that either: (1) provides an alternative explanation excluding work-related factors as a substantial cause of the disability; or (2) directly eliminates any reasonable possibility employment was a factor in causing the disability. *Tolbert*; *Huit*. Substantial evidence is the amount of relevant evidence a reasonable mind might accept as adequate to support a conclusion. *Miller*. Again, neither credibility nor the weight of the evidence is considered at the second step. Employer rebutted the presumption with Dr. Glassman's opinion the mechanism of the February 13, 2019 work injury would not result in a cervical disc herniation. Dr. Glassman diagnosed multilevel cervical spondylosis, including central and foraminal stenosis and C7 radiculopathy, but opined none of these diagnoses were related to the work injury. Dr. Glassman maintained Employee's neck symptoms and need for medical treatment were 100 percent related to nonoccupational risk factors and zero percent to the work injury. Nor had the work injury aggravated, accelerated, or combined with these preexisting degenerative changes to cause a need for medical treatment.

As Employer rebutted the position, the analysis proceeds to the third step, where Employee must prove by a preponderance of the evidence the work injury was the substantial cause of his need for medical treatment for his cervical spine. In making this determination, credibility is considered, the evidence weighed, and the relative contribution of other causes is considered. *Norcon*; *Olsen.*

The SIME physician Dr. McCormack's causation opinion is given the most weight. *Moore*. The SIME physician is the board's physician. *Olafson*. Although an employee's treating physician might be predisposed to give favorable opinions on a patient's behalf and EME physicians might be predisposed to give opinions favorable to their clients, SIME physicians are the board panel's physicians and are not similarly constrained. *Id*. Dr. McCormack opined, although Employee had preexisting degenerative changes in his cervical spine, the work injury aggravated, accelerated, and combined with those preexisting changes to cause the need for medical treatment and produced a permanent change in the pre-existing condition. *DeYonge*; *Morrison*. Dr. McCormack also opined the mechanism of injury was consistent with producing the C6-7 disc herniation. In addition, looking up, or neck extension, such as while climbing a ladder can cause a disc herniation and can aggravate a cervical stenosis to become symptomatic. Thus, the work injury could have worsened or caused the left C6-7 disc herniation and the left arm radicular symptoms. Dr. McCormack specifically disagreed with Dr. Glassman's opinion the mechanism of injury could not cause a disc herniation and disagreed with Dr. Glassman's opinion Dr. Coalwell's February 14, 2019 evaluation of Employee's neck did not reveal any neck pain, as in fact Dr. Coalwell documented decreased neck range of motion and pain with neck extension.

Dr. Glassman's opinion the work injury did not aggravate, accelerate, or combine with the preexisting cervical spine degenerative changes to cause the need for medical treatment is not credible and given little weight. AS 23.30.122. In both Dr. Glassman's September 7, 2019 EME report and November 17, 2021 deposition, Dr. Glassman relied on his impression Employee had had previous neck pain complaints. However, at the November 17, 2021 deposition, Dr. Glassman admitted there were no medical records in the ten years prior to Employee's injury date indicating Employee had complained of neck pain. The medical records and Employee's credible testimony demonstrate Employee had not had any complaints of neck pain for the ten years prior to the work injury. AS 23.30.122. Dr. Glassman's opinion is based upon an erroneous assumption and entitled

to no weight when determining the substantial cause of Employee's need for neck treatment. *Id*.

SIME physician Dr. Lane's opinion is also given great weight. AS 23.30.122. Dr. Lane noted Employee's complaints of ongoing paraesthesias in the left thumb, index finger and forearm. He diagnosed an acute herniated nucleus pulposus at C6-7, with left C6-7 radiculopathy and opined it was within reasonable probability these were caused by the work injury. He disagreed with Dr. Glassman's attribution of the changes in Employee's cervical spine symptoms to age-related degenerative changes, a prior motor vehicle collision and a prior whiplash diagnosis.

The relative contribution of different causes of any disability and need for medical treatment must be evaluated. Employee's preexisting age-related cervical spine degenerative changes, whether that included a C6-7 herniated disc or not, are factors which must be considered to determine if they contributed to Employee's disability and need for medical treatment. The preexisting degenerative changes in Employee's cervical spine caused no pain or other symptoms prior to the February 13, 2019 work injury. But for the work injury, Employee could have remained asymptomatic and not required medical treatment. Based on SIME physicians Dr. McCormack's and Dr. Lane's opinions, as well as the opinions of Employee's treating physicians, Drs. Coalwell, Rosenbaum, and Olson, all of whom opined the work injury was the cause of Employee's cervical spine symptoms and need for medical treatment, Employee has demonstrated by a preponderance of the evidence the substantial cause of his need for medical treatment for his cervical spine was the February 13, 2019 work injury. AS 23.30.122; *Tinker*; *Morrison*; *Traugott*; *Moore*; *Rogers and Babler.*

B. Left Shoulder

At the first stage of the presumption analysis, Employee has raised the presumption the work injury is the substantial cause of his need for left shoulder medical treatment through his testimony describing the work injury in which he suddenly felt a pull and a sharp pain between the side of his neck and his shoulder when he was crossing a baggage ramp and used his left arm to grasp a rung on the ladder to pull himself up. The pain subsided initially, but later the same night, while still at work, he noticed a numbness and pain in his left shoulder and he could not turn his head. *Wolfer*

At the second stage Employer rebutted the presumption with Dr. Glassman's EME report the work injury caused only a temporary exacerbation of his left shoulder symptoms, but only until March 12, 2019, when physical examination revealed intact rotator cuff strength. Dr. Glassman opined after March 12, 2019, any need for medical treatment for the left shoulder would have been the preexisting conditions of age-related degenerative changes, occupational risk factors of overhead activities and repetitive microtrauma. Employee's treating physician Dr. McNamara's opinion the work injury was not the substantial cause of his need for medical treatment for his left shoulder also rebuts the presumption. *Huit*; *Tolbert*.

As Employer has rebutted the presumption, Employee must prove the work injury is the substantial cause of his left shoulder need for medical treatment by a preponderance of the evidence. *Runstrom*; *Huit*. The opinions of SIME physicians Dr. McCormack and Dr. Lane are given the most weight. AS 23.30.122. Dr. McCormack opined the left shoulder need for medical treatment was due to the work injury. While the left shoulder MRI showed a retracted rotator cuff tear, which was likely preexisting and longstanding, reaching overhead with a non-dominant arm to pull one's body weight up could worsen the rotator cuff injury to cause pain. *Morrison*; *Traugott*. Dr. McCormack also opined the February 13, 2019 work injury led to the need for medical treatment. His opinion apportioning 85 percent of Employee's left shoulder disability and need for medical treatment to the work injury and 15 percent to the pre-existing degenerative changes that were asymptomatic is equivalent to stating the work injury is the substantial cause for Employee's need for medical treatment for his left shoulder. Dr. Lane opined the left shoulder rotator cuff tear was caused by the February 13, 2019 work injury. Employee's treating physician Dr. Coalwell's opinion is also given great weight. AS 23.30.122. Dr. Coalwell is Employee's primary care provider and has treated him for many years. Dr. Coalwell opined the work injury aggravated the pre-existing asymptomatic degenerative changes and caused the need for medical treatment and produced a permanent change in the preexisting condition. Dr. Coalwell apportioned 75 percent of the cause for Employee's need for medical treatment for his left shoulder was the work injury and 25 percent of the cause was Employee's baseline, used, arthritic body, which had functioned well prior to the work injury. Dr. Glassman's opinions regarding the left shoulder are given less weight as he did not have a thorough understanding of Employee's medical

history and record. For example, he stated Employee had a genetic predisposition to rotator cuff tears as he had suffered a right shoulder rotator cuff tear in the past. However, it was apparent from his deposition testimony he did not realize that prior right rotator cuff tear was caused by a prior work injury. He also relied on Employee's prior complaints of left shoulder pain, but it was apparent from his deposition testimony he had not realized Employee had not complained of left shoulder pain for the ten years prior to the February 13, 2019 work injury. Dr. Glassman's opinions do not induce a belief that his assertions and opinions are true and are given no weight. AS 23.30.122; *Saxton*; *Rogers & Babler*.

Employee has demonstrated by a preponderance of the evidence the substantial cause of his need for medical treatment for his left shoulder was the February 13, 2019 work injury. *Tinker*; *Morrison*; *Traugott*; *Moore*; *Rogers and Babler.*

2) Is Employee entitled to medical and transportation benefits?

Employee claims medical and related transportation costs from the date of injury, February 13, 2019, until he is medically stable. As the substantial cause of Employee's need for medical treatment for his cervical spine and left shoulder is the February 13, 2019, Employer must pay costs for reasonable and necessary medical treatment, including medical, surgical and other attendance of treatment, such as transportation and medicine for the period the process of recovery from his cervical spine and left shoulder injuries requires. AS 23.30.095(a). Whether the medical benefits Employee is requesting are reasonable and necessary is a question of fact to which the presumption analysis applies. Employee raises the presumption the medical and transportation benefits he is requesting are reasonable and necessary based on the opinions of his treating physicians Drs. Coalwell, McNamara, Olson, and Rosenbaum. Employer rebutted the presumption with EME physician Dr. Glassman's opinion. Although he opined the medical treatment Employee received was reasonable and necessary, he also said work was not the substantial cause of Employee's need for treatment. Dr. Glassman's opinions are given little weight because his understanding of the mechanism of injury and Employee's pre-existing neck and shoulder complaints were erroneous. It has been determined work is the substantial cause of Employee's need for treatment for his neck and shoulder and there is no dispute the treatment he

received was reasonable and necessary. *Williams*. Therefore, Employer is required to pay for the medical treatment for Employee's cervical spine and left shoulder work injury from February 13, 2019 and ongoing, according to the Alaska Workers' Compensation Medical Fee Schedule in effect for the year medical services are provided. AS 23.30.097. On September 25, 2019, Employer controverted all benefits for the neck and cervical spine including cervical injections and surgery. On October 15, 2019, Employer controverted all benefits related to the left shoulder after March 12, 2019. Employee's own health insurances paid his medical expenses for treatment for his cervical spine and left shoulder. Employee himself paid out-of-pocket for any deductibles, co-pays, and medications as well medical-related transportation costs.

Employer must pay Employee's personal health insurances, Public Employees Local 71 Trust Fund and AlaskaCare Retiree Plan through Aetna, interest on the amount they paid for Employee's medical treatment. Interest must be paid from the date each medical payment was made by the insurance companies on Employee's behalf for work injuries medical treatment until the interest is paid. AS 23.30.155; AS 09.30.070(a); 8 AAC 45.142(a) and (b)(3)(B).

Employer must pay Employee interest on out-of-pocket medical treatment and pharmacy costs of $1,248.57, plus interest, and mileage reimbursement of $191.63, plus interest. AS 23.30.155; AS 09.30.070(a); 8 AAC 45.142(a) and (b)(3)(B).

Employee is requesting future medical and transportation costs. There are no current specific recommendations for medical treatment, so the presumption is not raised. Dr. Lane opined Employee should have the option for future medical treatment, which he stated would include the need for physician visits with medication prescriptions and therapy, as well as a slight chance he might need further left shoulder surgery. If Employee does need cervical spine or left shoulder treatment in the future, he may file a claim.

3) Is Employee entitled to PPI benefits?

The parties dispute with respect to PPI is largely on whether the work injury is the substantial cause of his PPI ratings. Whether Employee is entitled to PPI is a factual dispute to which the

presumption of compensability applies. *Sokolowski*. Employee has established the presumption he is entitled to PPI with the 11 percent WPI rating for cervical spine and 11 percent upper extremity rating for the left shoulder, by the SIME physician Dr. Lane. *Smallwood*. The Employer has rebutted the presumption with EME physician Dr. Glassman's opinion that Employee has a 22 percent PPI, but zero percent of the PPI is work related.

As Employer has rebutted the presumption, Employee must prove he is entitled to PPI by a preponderance of the evidence. The greatest weight is given to SIME physician Dr. Lane's PPI rating. AS 23.30.122. His PPI rating was performed based on a physical examination when Employee was medically stable. Although Dr. Lane did not correct the 11 percent upper extremity to a WPI, nor combine the ratings, this can be done by referring to the AMA guides charts. Thus, Dr. Lane's 11 percent upper extremity rating is corrected to a seven percent WPI rating. The combined WPI for the cervical spine and the left shoulder is seventeen percent, which is reduced by Employee's prior two percent WPI rating for his right shoulder. AS 23.30.190(c). Less weight is given to SIME physician Dr. McCormack's PPI rating as he did not consider the residual C7 radiculopathy manifested by Employee's ongoing left-hand weakness and left thumb numbness. Both Drs. Lane and McCormack opined the work injury was the substantial cause of Employee's PPI. No weight is given to Dr. Glassman's PPI rating as it was based on a September 2019 physical examination and a record review rather than a physical examination after Employee was medically stable. Employee has proven by a preponderance of the evidence he is entitled to PPI benefits for a 15% PPI rating. *Saxton*.

4) Is Employee entitled to a finding of an unfair or frivolous controversion?

Benefits under the Act must be either paid promptly or controverted. AS 23.30.155(a). Employee contends Employer frivolously or unfairly controverted benefits due under the Act as it used the wrong legal standard. He seeks a finding and referral to the Division of Insurance. AS 23.30.155(o). On September 25, 2019, Employer controverted Employee's right to all benefits related to the neck and cervical spine based on Dr. Glassman's September 7, 2019 EME report. On October 15, 2019, it controverted Employee's claim for all benefits related to treatment for his left shoulder after March 12, 2019, also based on Dr. Glassman's September 7, 2019 EME report.

Employer relied solely on Dr. Glassman's EME report to controvert. Therefore, this analysis focuses solely on Dr. Glassman's report; his deposition testimony is irrelevant because Employer did not rely upon it to controvert.

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*. The Alaska Supreme Court adopted the *Harp* penalty analysis to resolve frivolous and unfair controversion issues. AS 23.30.155(o); *Harp; Harris*. *Harp* and *Huit* are used to find if the denials were "good faith" controversions. Under *Harp* and *Huit*, a good faith controversion notice is one that demonstrates with "substantial evidence that the disability ... or need for medical treatment did not arise out of and in the course of the employment." Dr. Glassman's report needed to show that the work injury could not have caused Employee's need for treatment or that another non-work-related cause is what caused his medical care. His report had to be "substantial," not uncertain or inconclusive, and not just "merely reciting the proper words." *Bouse; Huit*. Dr. Glassman is a licensed, board-certified orthopedic surgeon. He reviewed Employee's medical records and diagnostic imaging, or the imaging reports, and conducted a physical examination before giving his opinions. Dr. Glassman's opinions were substantial evidence that non-work-related causes were the substantial cause for the need for medical treatment for both Employee's cervical spine and left shoulder.

Therefore, since Employer had a good faith legal basis for controverting benefits, its controversion was not unfair or frivolous. *Harp*. There is no basis for a referral under AS 23.30.155(o).

5) Is Employee entitled to penalties and interest?

Since Employer's controversion was issued in good faith, Employee is not entitled to penalties on the basis of unfair or frivolous controversion. However, an employee is entitled to penalties on compensation due if it is not timely paid. *Haile.* Employee filed his receipt for the hotel bill for SIME travel on August 4, 2021 in the amount of $384.66, and at the time of November 4, 2021 hearing this amount still had not been paid. Employee is entitled to a penalty on the $384.66, and

interest as a matter of course. AS 23.30.155(p); *Rawls*

Employee is also entitled to interest on any late paid medical benefits as discussed above.

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

Employee is requesting actual and statutory attorney fees. Where Employee has successfully prosecuted a claim or obtained a benefit, an award of attorney fees is permitted. AS 23.30.145(a). 8 AAC 45.180; *Childs*. Employee's attorney successfully obtained orders for payment of medical and transportation costs as well as PPI benefits and interest on past due benefits. This permits an award of actual attorney fees under AS 23.30.145(b). This case involves complex issues of causation and numerous medical records. *Rogers & Babler*. Employer controverted Employee's claims, which allows this decision to award actual attorney fees in addition to statutory fees. AS 23.30.145(a).

In addition to reviewing the work done, *Rusch* requires the eight factors in Alaska Rule of Professional Conduct 1.5(a) to be reviewed in determining a reasonable fee:

1. The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal services properly:

Employee's WCC seeking medical treatment for his cervical spine and left shoulder involved the complex issues of causation as well as Employer's spirited defense based on preexisting degenerative factors, age and genetics. Employee's briefs and accompanying exhibits laid Employee's case out clearly and understandably, and his attorney's arguments at hearing provided a thorough analysis of the law and facts of the case.

2. The likelihood the acceptance of the particular employment will preclude other employment by the lawyer:

To some extent, time spent working on any client's case prevents an attorney from spending time on another client's case. In her affidavit, Employee's attorney stated she is in a solo practice, and she does not employ a paralegal, so she is only able to take on a limited number of cases. She also stated any case which required depositions and hearings will necessarily limit her ability to take on other new

cases.

3. The fee customarily charged in the locality for similar services:

Employee's attorney has charged and been consistently awarded $400.00 per hour since October 26, 2016. She has requested the rate of $400 per hour through August 12, 2021, and $425 per hour thereafter. Employee's attorney provided evidence the $425 to $450 per hour rate has recently been approved in a number of cases for her peers, also highly experienced workers' compensation attorneys. *Rogers & Babler.* The increase in her hourly rate from $400 per hour to $425 per hour starting after August 12, 2021 is reasonable.

4. The amount involved and the results obtained:

Employee's attorney was successful in obtaining an order for medical treatment for Employee's cervical spine and left shoulder, as well as his PPI rating. The cost of the medical treatment, including surgeries, are substantial.

5. The time limitations imposed by the client or by the circumstances:

In her affidavit, Employee's attorney did not identify any unusual time limitation imposed by the client or the circumstances.

6. The nature and length of the professional relationship with the client.

Employee's attorney has represented him since October 14, 2019. This factor may favor either an increased fee or a decreased fee, depending on the particular case's facts. In this case Employee's attorney did not address how the length of her professional relationship with Employee would affect the fee. However, she did point out that Employer had vigorously litigated the case

7. The experience, reputation and ability of the lawyer or lawyers performing the services:

Employee's attorney has practiced law in Alaska since 1983; she is a very experienced attorney and has over 38 years' experience practicing law. Since 2005 she began to handle workers' compensation cases exclusively. She is a very skilled and experienced workers' compensation attorney.

8. Whether the fee is fixed or contingent:

Virtually all fees for employee attorneys in workers' compensation are contingent. The contingent nature of the work is considered in determining an appropriate hourly rate.

Employee's attorney is entitled to payment of reasonable actual attorney fees at $400.00 per hour up until August 12, 2021 and $425 per hour thereafter for her hours documented in her October 28, 2021 and December 6, 2021 attorney fee affidavits. However, this amount will be reduced by the duplication of the costs from September 25, 2020, which were previously denied in *Guerressi v. State of Alaska*, AWCB 20-0109 (December 4, 2020), or 3.4 hours at $400 for a total of 1,360.00. She is also entitled to payment $130.50 in costs based on her October 28, 2021 attorney fee affidavit as well as $585.50 in costs submitted on January 12, 2022. Therefore, Employee's attorney is entitled to payment of the reasonable attorney fees of $40,397.50 and $716.00 in costs for a total of $41,113.50. Considering the time expended, and the results obtained, this is a reasonable, fully compensatory amount. *Bignell*.

Employee's attorney is also entitled to statutory attorney fees for any ongoing benefits paid to Employee after November 4, 2021 hearing. *Wozniak*.

CONCLUSIONS OF LAW

1) The February 13, 2019 work injury is the substantial cause of Employee's need for medical treatment for his cervical spine and left shoulder.
2) Employee is entitled to medical and transportation benefits.
3) Employee is entitled to PPI benefits.
4) Employee is not entitled to a finding of unfair and frivolous controversion.
5) Employee is entitled to interest and penalty.
6) Employee is entitled to attorney's fees and costs.

ORDER

1) The February 13, 2019 work injury is the substantial cause of Employee's need for medical treatment for his cervical spine and left shoulder.

2) Employee is entitled to medical and transportation costs for his cervical spine and left shoulder in accord with this decision.

3) Employer shall reimburse Employee for his out-of-pocket medical costs of $1,248.57, and medical related travel costs of $191.63, plus interest in accordance with the Act.

4) Employer is ordered to reimburse Employee for his SIME travel expense of $384.66, plus interest and a penalty.

5) Employer shall pay Employee's medical providers for all the work-related medical expenses according to Alaska Workers' Compensation Medical Fee Schedule in effect for the year the medical services were provided.

6) Employer shall pay interest to Employee's own health insurances, Public Employees Local 71 Trust and Aetna AlaskaCare Retiree Plan on the amounts they paid for Employee's medical benefits pursuant to 8 AAC 45.142.

7) Employer shall pay Employee $26,550.00 for his 15 percent PPI rating and interest from the date Employee's PPI was rated.

8) Employee's claim seeking a finding of unfair and frivolous controversion is denied.

9) Employer shall pay Employee's attorney Keenan Powell attorney's fees and costs in the amount of $41,113.50.

10) Employer shall pay Employee's attorney Keenan Powell statutory fees for ongoing benefits paid to Employee subsequent to the November 4, 2021 hearing.

Dated in Anchorage, Alaska on March 23, 2022.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Judith A DeMarsh, Designated Chair

/s/
Sara Faulkner, Member

/s/
Nancy Shaw, 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 GREGORY GUERRISSI, employee / claimant v. STATE OF ALASKA, employer; STATE OF ALASKA, insurer / defendants; Case No. 201902745; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by certified US Mail on March 23, 2022.

/s/
Nenita Farmer, Office Assistant