ALASKA WORKERS' COMPENSATION BOARD

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

CHRISTINE M. JOHNSTON, Employee, Claimant, v. ANCHORAGE SCHOOL DISTRICT, Self-insured Employer, Defendant.	)	FINAL DECISION AND ORDER AWCB Case No. 202202471 AWCB Decision No. 24-0065 Filed with AWCB Anchorage, Alaska on December 3, 2024

Christine Johnston's (Employee's) amended September 17, 2024 claim was heard on November 20, 2024, in Anchorage, Alaska, a date selected on September 25, 2024. An August 16, 2024 hearing request gave rise to this hearing. Attorney Adam Franklin appeared and represented Employee who appeared and testified. Attorney Krista Schwarting appeared and represented the self-insured Anchorage School District (Employer). Stacy Ostlund appeared by telephone and testified on Employee's behalf. The record remained open until 5:00 PM on November 20, 2024, for Employee to file a supplemental fee affidavit, and until November 22, 2024, at 5:00 PM for Employer to file any objection. On November 26, 2024, the panel reopened the record to receive Franklin's supplemental fee affidavit and cost itemization, because he said he had filed and served it, but it was not found in his file. The record closed on November 26, 2024, upon receipt of Franklin's supplemental fee affidavit.

ISSUES

Employee contends her repetitive work as a food service worker for Employer caused bilateral epicondylitis; she relies on opinions from her two attending physicians. She contends her bilateral

elbow conditions therefore arose out of and in the course of her employment with Employer. Employee seeks an associated order.

Employer contends while Employee may have bilateral epicondylitis, work for Employer was not the substantial cause of that condition; it relies on opinions from its employer's medical evaluation (EME) and the second independent medical evaluation (SIME) physician. Employer seeks an order denying Employee's claim in its entirety.

1) **Did Employee's bilateral epicondylitis arise out of and in the course of her employment with Employer?**

Employee contends that since her work injury is compensable under the Alaska Workers' Compensation Act (Act), she is entitled to all reasonable and necessary past and ongoing medical benefits related to her bilateral epicondylitis.

Employer contends that since her work injury is not compensable under the Act, Employee is entitled to no medical or associated benefits related to it.

2) **Is Employee entitled to medical benefits for her bilateral epicondylitis?**

Employee contends she is entitled to attorney fees and costs if she succeeds on her claim.

Employer contends since she should fail in her claim, Employee is entitled to no associated attorney fees or costs.

3) **Is Employee entitled to attorney fees and costs?**

FINDINGS OF FACT

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

1) Employee is four feet 11 inches tall. (Wayne Weil, MD, report, September 20, 2023).

2) In May and June 2020, Employee had bilateral carpal tunnel syndrome (CTS) surgery. She had occupational therapy for several weeks thereafter and, though she had an initial improvement from

the surgeries, lesser symptoms remained. At hearing, Employee testified she never recovered fully from her CTS symptoms. (Stephanie Wettin, PA-C report, August 11, 2020; record).

3) On August 28, 2020, Alan Swenson, MD, orthopedic surgeon, saw Employee in follow up on her bilateral CTS surgeries, and ongoing hand symptoms. (Swenson report, August 28, 2020).

4) On October 9, 2020, Dr. Swenson charted Employee with left-ring-finger trigger-finger issues. (Swenson report, October 9, 2020).

5) On December 28, 2020, Dr. Swenson surgically released Employee's left-ring-finger trigger-finger. (Operative Report, December 28, 2020).

6) On January 12, 2021, Employee had a right-thumb trigger-finger diagnosis. (Wettin report, January 12, 2021).

7) On January 18, 2021, Dr. Swenson released Employee's right-thumb trigger-finger. (Operative Report, January 18, 2021).

8) On June 22, 2021, Dr. Swenson saw Employee in follow up for her trigger-finger surgeries. "She is starting to have some discomfort over the lateral aspect of her elbow which she states [has] been present for [sic] extended period. . . ." She was generally very happy with her surgical results on her hands. Employee had "pain [sic] palpation of the lateral condyle," and "pain with resisted wrist and digital extension." Dr. Swenson determined Employee "could benefit from conservative management for her lateral condyle-itis. . . ." (Swenson report, June 22, 2021).

9) On July 26, 2021, Sean Taylor, MD, saw Employee on referral from Dr. Swenson for a permanent impairment rating. He reviewed Employee's four hand-related surgeries in the past year. She was "pain-free with palpation of the fingers." Employee's hand dynamometer testing was inconsistent and there was no registered response. Dr. Taylor provided a permanent partial impairment rating for all four work-related hand injuries. (Taylor report, July 26, 2021).

10) On February 22, 2022, Dr. Swenson saw Employee for "a new injury." She was at work recently "when she was doing some heavy pushing and pulling on some very heavy shelving that is wheeled." She had acute onset of pain in both elbows, which was worsening. Any significant gripping or pulling activities increased her pain. The right elbow was worse than the left, but they were "otherwise relatively symmetric." Employee had pain with palpation directly over the lateral epicondyle but no pain over the medial epicondylar area. There is no mention of diffuse or vague pain during this examination. Dr. Swenson recommended conservative treatment including therapy; he released her to work without restrictions. (Swenson report, February 22, 2022).

11) On March 25, 2022, Dr. Swenson saw Employee for her elbow pain. He found "multiple nondermatomal complaints for her right upper extremity" but noted "overall," she was "adamant that she had focal pain over the lateral aspect of her elbow rating [sic] down along the extensor wad." He charted, "She had pain with palpation directly over the lateral epicondyle [but] no pain palpation over the medial epicondylar region." He too recommended conservative treatment. Employee's reported pain score was "1/10." (Swenson report, March 25, 2022).

12) On April 5, 2022, Daniel Jackson, OTD, saw Employee for bilateral epicondylitis, and performed three provocative tests for it (Cozen's; Maudsley's; and Mill's Tests); Employee was "positive" bilaterally on each. OTD Jackson noted Employee was "back to full work activities, which requires frequent heavy lifting overhead, gripping, pushing and pulling. She experiences weakness and pain with work activities." (Jackson report, April 5, 2022).

13) On April 7, 2022, Kenton Stephens, MD, cardiovascular surgeon, examined Employee for possible thoracic outlet syndrome. He did not make that diagnosis but explained to Employee "that the epicondylitis was certainly very real. . . ." Employee was "accompanied by her caseworker" although "her exact role is not clarified to me." Dr. Stephens did not "appreciate any subjective weakness in the intrinsic muscles of the hand or within the arm." He recommended Employee proceed with "the treatment program recommended for her epicondylitis." There was no mention in this report of diffuse pain on examination. (Stephens report, April 7, 2022).

14) Thoracic outlet syndrome and rheumatoid arthritis testing and evaluations on Employee eventually ruled these conditions out. (Employee's 2022 medical records).

15) On April 19, 2022, PA-C Wettin examined Employee for her bilateral elbow pain. Employee said her activities at work caused her symptoms to increase. She had pain over the right lateral epicondyle, medial epicondyles and olecranon. On the left, Employee had pain to palpation over the lateral epicondyle but no pain over the medial epicondyle or olecranon. There was no mention in this report of diffuse pain on examination. (Wettin report, April 19, 2022).

16) On April 26, 2022, OTD Jackson saw Employee who reported her pain as "burning, throbbing, tingling, and firecrackers." He noted she continued to present with "exquisite, hypersensitive pain" on her right elbow. However, Jackson recorded her pain "at present" as "6-Moderate Pain (4-6)," mostly in her right arm and, "at Worst, 8-Severe Pain (7-9)." (Jackson report, April 26, 2022).

17) On May 5, 2022, Kurt Mentzer, MD, saw Employee for her elbows. She was "well-adjusted, pleasant and cooperative, appropriate for clinical and encounter circumstances." He diagnosed bilateral, lateral epicondylitis. He recommended conservative treatment, but gave Employee a right-elbow steroid injection; her pain improved. There is no mention of diffuse pain or unusual reactions on this chart note and no mention of "20/10" pain reducing to "5/10" found in this report. (Mentzer report, May 5, 2022).

18) By June 13, 2022, after an ultimately unsuccessful steroid injection, Dr. Mentzer suggested Employee may need surgery to treat her elbow pain. (Mentzer report, June13, 2022).

19) On June 14, 2022, OTD Jackson charted that Employee had a "sparkling" sensation in her right elbow. (Jackson report, June 14, 2022).

20) On June 15, 2022, Jared Kirkham, MD, physiatrist, examined Employee for an EME. She reported doing paperwork and lifting food cases weighing from 10 to 50 pounds. He recorded that on her worst day, she would only need to lift six of these cases for an entire day. Employee also had to push and pull wheeled carts. Dr. Kirkham reviewed "several hundred pages" of "medical records" related to her various work-related injuries. He highlighted those he felt were notable. At one point, he cited a nurse case manager's note stating that Employee said her elbow pain was "10/10," "while calmly discussing her symptoms." (Kirkham report, June 15, 2022).

21) Many citations in Dr. Kirkham's report come from "case management" notes or "the cover letter supplied," and not from providers' medical records. For example, his report states, "According to the notes supplied, her pain had reduced from 20/10 to 5/10." He commented on a "case management note," which stated Employee had "severe" pain she rated at "10+/10," and which suggested she had "electrical and tingling sensations throughout her entire body." Here, Dr. Kirkham added editorial comments -- "exaggeration of symptoms" and "widespread pain." (Kirkham report, June 15, 2022).

22) Dr. Kirkham also quoted extensively from a May 9, 2022 "case management note":

> May 9, 2022: Case management note. "Dr. Mentzer evaluated [Employee] for a second opinion for her bilateral elbows on May 5, 2022. . . . She advised that the pain in her right elbow is 20/10. . . . When she wakes up in the morning her hands are completely numb. . . . She is having problems at work and fears losing her job. . . . She reports severe staffing issues at work and stated she feels obligated to work outside her limitations. . . . [Employee] started to cry." According to this note, Dr. Mentzer performed a right lateral epicondyle steroid injection. The note also

> indicates that her pain had reduced to 5/10 and there was recommended follow up with Dr. Mentzer on June13, 2022. (Kirkham report, June 15, 2022).

23) Dr. Kirkham found "no significant pain behavior" when he examined Employee. She denied any pain on shoulder examination. Employee had no tenderness to palpation anywhere at the cervical spine, parascapular area or bilateral shoulders. Employee did, however, have "exquisite tenderness to palpation" on her right elbow with "more moderate" tenderness on her left elbow. His provocative tests for epicondylitis were "negative." Tests that were positive on the right elbow, in his opinion, were nonspecific rather than localized to the epicondyles. Dr. Kirkham diagnosed among other things (1) no objective evidence of an injury from work-related activities on or around January 31, 2022; and (2) diffuse bilateral right greater than left elbow pain, which he opined was "out of proportion to objective findings." Nevertheless, he stated a "portion of her symptoms may be related to lateral epicondylitis or radial tunnel syndrome along with medial epicondylitis," but Dr. Kirkham felt her pain and functional impairment were even out of proportion to what he would expect with these diagnoses. Dr. Kirkham added:

> There is a significant psychosocial component to her ongoing pain symptoms and her ongoing symptoms are not substantially caused by work-related activities.
> . . . .
>
> On a more probable than not basis, there was no occupational injury from work-related activities on or around January 31, 2022. There have been no truly objective findings post injury. Her radiographs of the bilateral elbows were normal, and her physical exam is essentially normal.
> . . . .
>
> There is a significant psychosocial component to her ongoing pain symptoms, with exaggerated pain symptomatology and pain behaviors documented in post-accident records. She reports that her job is "beyond stressful." There are also non-physiologic findings on physical exam. For example, she has tenderness to very light superficial palpation. She has diffuse weakness in the right upper extremity that does not fit a myotomal distribution. She also has highly variable results on hand-held dynamometer testing.
>
> Even if [Employee] did have medial or lateral epicondylosis, the substantial cause of this is not work-related activities. According to the *AMA Guides to the Evaluation of Disease and Injury Causation*, there is insufficient evidence for highly repetitive work alone as a risk factor for medial or lateral epicondylosis. Although there is strong evidence for forceful repetitive work, based upon

> [Employee's] description of her work activities, it does not appear that she is engaging in forceful repetitive activities. . . .

In Dr. Kirkham's view, if Employee was lifting "hundreds of 50-pound boxes per day, this would be considered heavy repetitive work." He listed "all causes" of the "condition" he diagnosed and said causes of Employee's "current bilateral elbow pain" include: "age, genetics, obesity, deconditioning, work-related activities, recreational activities including gardening, and psychosocial factors." When asked to select which of all these causes is in his view "the substantial cause," Dr. Kirkham stated:

> The substantial cause of [Employee's] bilateral elbow pain is likely multifactorial and due to age, genetics, obesity, deconditioning, and especially psychosocial factors.
>
> Work activities are not the substantial cause of [Employee's] current symptoms.

Since in his opinion, there was no work injury, he recommended no further testing or medical care. Likewise, physical restrictions, "medical stability" and "permanent impairment" were irrelevant. However, while Employee was capable of performing medium duty work she was not capable of "heavy work due to deconditioning." (Kirkham report, June 15, 2022).

24) There is no "cover letter" from Employer to Dr. Kirkham in Employee's agency file. The "case management notes" to which Dr. Kirkham referred in his report, under "POST-ACCIDENT MEDICAL RECORDS," came from an unidentified nurse case manager, and are not actually Employee's medical records from a medical provider. There are no original nurse case manager notes found in Employee's agency file; some are simply cited in his report. (Experience; judgment; observations; and inferences drawn from the above).

25) On July 18, 2022, Dr. Mentzer gave Employee her second right-elbow steroid injection. He planned to do a left-elbow injection later. (Mentzer report, July 18, 2022).

26) On August 4, 2022, Dr. Mentzer gave Employee a left-elbow steroid injection. (Mentzer report, August 4, 2022).

27) On November 8, 2022, Employee testified: She has worked essentially the same job for Employer since 2011. Now, and for the last six years, she has also been a manager, which has repetitive stocking and lifting duties. She works mainly at East High School 40 hours per week and describes her work as, "Hard." East High is the largest school in the district, and she does a

lot of repetitive motion, and heavy lifting, pushing and pulling. It is a "fast-paced school" with "a lot of kids," and she prepares food for two schools, including a native culture school that meets in the upper level at East High; the kitchen is "very short-staffed." The kitchen staff went from 18 people down to about six. Employee described lifting boxes weighing up to 60 pounds "every day." She usually does not have any assistance lifting. She may lift and carry these boxes up to six times per day back and forth in and out of the cooler or from the delivery truck. (Telephonic Deposition of Christine Johnston, November 8, 2022).

28) While working for Employer in 2016, Employee had a right shoulder injury from chopping ice in the freezer and then later aggravated it from carrying heavy boxes, which caused a "snap" in her shoulder. Employee had severe CTS bilaterally around 2020, while working for Employer, which required surgery. She tried to take time off for CTS treatments during holidays and other periods when students were not attending to minimize impact on the kitchen staff. Employee also had a left-ring-finger trigger-finger and a right-thumb trigger-finger, which required surgery. (Telephonic Deposition of Christine Johnston, November 8, 2022).

29) In respect to her current injury, Employee felt "irritation" in her elbow mostly on the right but bilaterally, around the last time she saw her surgeon for her CTS. "Almost like a tingling, pounding sensation. Almost burning." Employee attributed her elbow symptoms to:

> It's the heavy lifting and pushing and pulling that we do here. It's a constant. And each thing we lift that's so heavy, they're different sizes and shapes. And then the pulling of the carts that don't go the way you want it to go. The pans that we have to pull in and out are heavy. You know, they go in light, but they come out heavy after they get done cooking.
>
> The constant picking up cases of apples and oranges to wash them. Bananas. Bananas alone are close to 60 pounds of cases that we do. And then we got the dish -- washing the dishes and putting everything up there. So it's just a lot of the heavy repetitive usage and heavy lifting that's just beating me up. . . . (Telephonic Deposition of Christine Johnston, November 8, 2022).

Employee described her January 31, 2022 injury as:

> I was lifting cases of fruit and then rearranging the storage room, and then my elbow just started to, like, hurt where, I mean, where I had shocking pain going into my elbow. And it had like a firecracker feeling, you know, like a sparkler going off. And I could feel my hands kind of getting numb a little bit, so I thought, okay, maybe I better stop. . . .

. . . .

> The right was worse than the left, but the left is starting to -- because I was trying to compensate a little bit, you know. It's very sore to the touch. And it has a heavy feeling from it being swollen.

Employee, who is right-hand dominant, said the right elbow has been swollen consistently since "a little bit like right after" January 31, 2022. When she moves her right arm a certain way, she has extremely sharp shooting pain followed by a tingling sensation. (Telephonic Deposition of Christine Johnston, November 8, 2022).

30) Employee did not work during the summer following her work injury. She used a "TENS" unit her doctor prescribed, which helped, but the effect wore off within an hour after using it. While she was off work, she noted some improvement in the tingling in her hand, but that ended as soon as she started using it. When she returned to work in the fall, the swelling got worse. Her left elbow is getting worse. She rated her right elbow on a pain scale as "8/10" and at "6/10" on the left, at the highest. Employee's favorite pastime was gardening, but she can no longer do it because it hurts too much. She still uses a topical cream her physician gave her, but when she comes home from work she may take a "shot of whiskey" even though she is "not much of a drinker" because sometimes her elbow pain is "unbearable." Employee has had one steroid injection on her left elbow and three on the right. These helped for perhaps two weeks. She did have some work restrictions, but because the kitchen was short-staffed, she tried to do her job. Pulling and planting in her garden aggravated her symptoms, as did doing dishes at home and just lifting and pulling as required at home to do things that must be done. Her elbow pain radiates up and down her arms a little every day unless she is sitting at home doing nothing. As of her deposition, Employee had not lost any time from work because she "can't afford to" and does not want to lose her job. Employee's elbow symptoms also interfere with her activities of daily living like cooking, hair care, washing, driving and grocery shopping. (Telephonic Deposition of Christine Johnston, November 8, 2022).

31) As of November 8, 2022, Employee wanted physical therapy and retraining if it was available. (Telephonic Deposition of Christine Johnston, November 8, 2022).

32) On January 16, 2023, Dr. Mentzer stated:

> This is a work-related repetitive overuse injury and is now affecting both her elbows. Unfortunately [Employee] had a previous IME that attributed her elbow

> injuries to her body habitus which is absolutely inaccurate and the opinion of a physician that this is not his medical specialty. [Employee] continues to perform medically directed home hand therapy but it [sic] is experiencing worsening symptoms in both elbows with the right side still worse than her left. We will continue to assist her with her efforts to establish her arm conditions as work-related injuries, and I have advised against further steroid injections based on very clear medical literature that demonstrates degradation of tissue quality with repetitive steroid injections. (Mentzer report, January 16, 2023).

33) On February 27, 2023, Dr. Mentzer responded to questions from Employee's attorney as follows: (1) "I am currently treating [Employee] for bilateral elbow lateral epicondylitis, and medial epicondylitis. Her lateral epicondylitis has been more symptomatic. This is a condition that affects her elbows with pain at the insertion of the common extensor tendon bilaterally." (2) "I do agree that [Employee's] presentation was entirely consistent with work-related overuse injury of both of her upper extremities." (3) "It is my opinion that [Employee's] work injury on 1/31/2022 is the substantial cause for her current bilateral elbow lateral epicondylitis." (4) "It is my opinion that [Employee's] work injury is the substantial cause for her condition and for her need for medical treatment." (5) "I have previously recommended continued occupational therapy with a focus on her bilateral elbows, common extensor tendons, and lateral epicondylar pain. At this point, [Employee] has had difficulty continuing with occupational therapy for her right arm and her symptoms have worsened significantly. She may easily progress to the point where she requires surgical intervention followed by postoperative rehabilitation supervised by Occupational Therapy." (6) "I do agree that [Employee] has incurred an impairment and will require a permanent partial impairment rating performed at the completion of her treatment. I do not personally perform these ratings and routinely refer my patients to Dr. Shawn Johnston for impairment ratings." (7) "Overall [Employee's] physical capacity will depend on her current status with both of her elbows. At the present time she has not received sufficient treatment with occupational therapy and I have recommended light duty. Given appropriate treatment I do anticipate that [Employee] will be able to return to regular work activities, but this may take many months." Dr. Mentzer also restricted Employee to lifting no more than 10 pounds occasionally. (Mentzer report, February 27, 2023).

34) On May 18, 2023, Dr. Mentzer stated he had been following Employee for almost a year for her upper extremities. He said, "I am concerned that her delay in care waiting to resolve her

workers' compensation claim may have resulted in her conditioning worsening to the point where it will not respond to physical therapy alone." (Mentzer report, May 18, 2023).

35) By June 29, 2023, Dr. Mentzer suggested Employee needed a right-elbow lateral epicondylectomy, and for her left, occupational therapy. (Mentzer report, June 29, 2023).

36) On September 20, 2023, Dr. Weil, orthopedic surgeon, saw Employee for an SIME. He reviewed approximately 663 pages of medical records and noted those he felt were most important. Many records he summarized have no observable connection to her bilateral elbow symptoms; for example, sinus, menstrual and breast issues. (Observations). Notably, many of Dr. Weil's relevant record review comments from Employee's previous records were dissimilar to Dr. Kirkham's quoted in Dr. Weil's report, even though they both presumably reviewed the same medical records. (Weil report, September 20, 2023).

37) Dr. Weil found, "Light touch sensation was normal and symmetrical throughout the bilateral upper and lower extremities." During Dr. Weil's examination of Employee's upper extremities, she did not exhibit diffuse pain behavior with light touch as she reportedly did with Dr. Kirkham. However, Dr. Weil noted "catastrophizing behavior" on elbow range-of-motion. He also found the "Cozen's testing" [for epicondylitis] was "painful bilaterally." As to her provocative epicondylitis test Dr. Weil stated, "She is extremely tender to palpation at the posterior, lateral, and medial aspects of the bilateral elbows." (Weil report, September 20, 2023).

38) Notably, Dr. Weil quoted from Dr. Kirkham's report in which the latter gleaned information from "case management notes." This included an observation from an unidentified nurse case manager and a statement attributed to Employee that her pain was rated as "10/10" while "calmly discussing her symptoms." Dr. Weil also repeated other statements attributed to Employee about rating her pain as "10+/10" and "electrical and tingling sensations throughout her entire body." His report included alleged statements from Dr. Mentzer's May 5, 2022 chart note, also gleaned from a nurse case manager, that Employee claimed her pain was "20/10" that reduced to "5/10" after her steroid injection. Dr. Weil correctly noted, "This note was not available for review." (Weil report, September 20, 2023).

39) After reviewing her records and performing a physical examination on Employee, Dr. Weil diagnosed "bilateral lateral epicondylitis -- nonindustrial based." He found Employee's symptoms and examination "out of proportion to objective findings." Dr. Weil added:

> It is opined that her ongoing symptoms are not substantially caused by work-related activities. She does have a history of treatment of bilateral carpal tunnel syndrome as well as left ring finger trigger finger and right thumb trigger finger and these are unrelated to the current claim.

When asked to list all causes of Employee's disability or need for medical treatment, he stated "The disability was caused [by] bilateral lateral epicondylitis of the elbows." In his view, there was no preexisting condition, and thus no work-related aggravation. When asked to evaluate the relative contribution of different causes of Employee's disability or need for medical treatment, Dr. Weil said, "The causes of [Employee's] current bilateral lateral epicondylitis include age, deconditioning, work-related activities, recreational activities, psychosocial factors, genetics, and obesity." In his opinion, the substantial cause of Employee's disability or need for medical treatment is "multifactorial in nature." He further opined, "Work activities were not the substantial cause for [Employee's] current symptoms." There was no work-related disability. Employee was medically stable, but Dr. Weil gave no effective date. He recommended no additional treatment for epicondylitis because in his opinion it was a "nonindustrial related condition." As to her prior treatment, he opined "no treatment was required for the diagnosis of lateral epicondylitis." She was able to work without any limitations or restrictions. With exception of disagreeing with the ultimate diagnosis, Dr. Weil's answers to the Division's questions are remarkably similar to those in Dr. Kirkham's EME report. Unlike Dr. Kirkham who said Employee had "no injury," Dr. Weil said Employee had "no disability" and needed no treatment for her bilateral epicondylitis. (Weil report, September 20, 2023; observations).

40) On October 26, 2023, Employer denied Employee's claim, based on Dr. Weil's report. (Controversion Notice, October 2, [sic] 2023).

41) On November 1, 2023, Dr. Mentzer reviewed a letter from Franklin that included Dr. Weil's SIME question responses. When asked if he agreed with Dr. Weil's opinions, Dr. Mentzer said, "I do not agree." (November 1, 2023 Post It note attached to Franklin letter, October 26, 2023).

42) On January 29, 2024, Dr. Weil testified he is a practicing orthopedic surgeon since 2005 with a specialty in hand surgery. He saw Employee as an SIME physician on September 6, 2023. He spent about an hour with Employee including reviewing her intake forms with her. Dr. Weil reviewed her medical records and examined her. Employee reported developing bilateral elbow and arm pain in repetitive-type activities at work, lifting boxes and cases of food, stacking and

pushing items and stacking trays of food and milk. He found no relevant preexisting conditions in her case. (Videoconference Deposition of Wayne Weil, MD, January 29, 2024).

43) Dr. Weil described his understanding of "the substantial cause" as the one that would be "greater than 50 percent would be the reason for someone to develop an issue." Employee demonstrated reduced motion in her elbow and shoulder, and pain not in proportion to Dr. Weil's objective findings. He found no atrophy in her arms, which means Employee was using her arms in a relatively normal fashion and had no neurological injury. Dr. Weil explained that the "Cozen's test" checked for "tennis elbow." Based on his examination, Dr. Weil diagnosed bilateral, lateral epicondylitis or "tennis elbow." When asked about "the substantial cause" of Employee's tennis elbow, Dr. Weil said, "essentially, her overall deconditioning is really the cause for that." He agreed her work for Employer "certainly, it may be a contributory factor" but "not the substantial cause." His opinions were based on his 20 years' experience as a hand and elbow surgeon and his "overall impression of the patient's current complaints and her description of job duties." Dr. Weil also agreed with Dr. Kirkham's statement that there was "no objective evidence of occupational injury" resulting from the January 31, 2022 work activities, and Employee's symptoms are out of proportion to objective findings and did not have a "clear physiologic source." (Videoconference Deposition of Wayne Weil, MD, January 29, 2024).

44) On cross-examination, Dr. Weil suggested lateral epicondylitis is "fairly controversial," and its causes are probably "multifactorial." The exact cause for it is, "truthfully . . . unknown." He noted, "Sometimes it can be due to, you know, activities that require repetitive use." Dr. Weil further explained that since Employee had a positive Cozen's test, which is one of the defining tests for epicondylitis, that is why he gave that diagnosis. In his opinion, Employee would probably have bilateral epicondylitis even if she did not work at all. However, Dr. Weil agreed it was "possible" her duties at work could cause Employee to suffer from lateral epicondylitis. The origin of epicondylitis is "somewhat unknown or poorly defined." He added:

> Q. And in terms of your ultimate opinions regarding causation, do you think that her work conditions are making her condition worse?
>
> A. You know, I think that it is part of the milieu of things that are bothering her. Again, she has, you know, kind of ill-defined pain throughout her upper extremities, so hard to know exactly -- you know, lateral epicondylitis causes the pain at the elbow, but it doesn't cause, you know, shoulder stiffness and pain with shoulder range of motion. And, you know, it doesn't cause pain that -- into the hands. . . .

Nevertheless, given that "she's also a gardener," Dr. Weil initially could not determine if her continued work for Employer was aggravating her elbow complaints. He defined "deconditioning" as "sort of loss of fitness and strength over time." Dr. Weil is unaware of any literature demonstrating that obesity is a direct cause for lateral epicondylitis. Appropriate treatment for epicondylitis could include surgery, including TENEX. (Videoconference Deposition of Wayne Weil, MD, January 29, 2024).

45) Dr. Weil's report for Employee initially had the wrong patient's name on it; he had to issue a corrected report. He uses a template and probably forgot to change the name on the header. It also appears to have retained her wrong city of residence. (Videoconference Deposition of Wayne Weil, MD, January 29, 2024; observations).

46) Dr. Weil's final comments included:

> Q. And you testified, I believe, that it was possible that [Employee's] work activities can contribute to her condition. Would you say it's probable?
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> A. I mean, I would say it's -- you know, with lateral epicondylitis, anything is sort of possible, right? So, yeah, its -- I would say it's possible.
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> Q. But is it probable?
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> A. It may be, yes. But, again, I don't think it's the substantial cause for her current condition. (Videoconference Deposition of Wayne Weil, MD, January 29, 2024).

47) On April 1, 2024, Kevin Paisley, DO, took over Employee's care on referral from Dr. Mentzer, when the latter left the area. Dr. Paisley performed a comprehensive physical examination and diagnosed Employee with recalcitrant bilateral, lateral epicondylitis. He also reviewed Dr. Mentzer's notes and agreed with his opinions including a recommendation for open tennis elbow surgery bilaterally. Dr. Paisley would recommend trying physical therapy again, first. He also diagnosed a subluxing ulnar nerve on the right. Dr. Paisley also administered bilateral elbow steroid injections. (Paisley report, April 1, 2024).

48) On April 29, 2024, Dr. Kirkham testified that he is a trained physiatrist and has practiced for 10 years post-residency. Dr. Kirkham treats "basically all painful orthopedic conditions." He reviewed Employee's medical records as well as Dr. Weil's deposition. Dr. Kirkham saw Employee approximate five months post-injury. He understands "medical stability" to mean the point at which a physician does not expect the claimant to improve to any significant degree; "it's

a plateau in their progress." Dr. Kirkham understands "the substantial cause" to mean "the most important cause contributing to the claimant's current symptoms and disability." (Deposition of Jared Kirkham, MD, April 29, 2024).

49) Dr. Kirkham found "relevant, preexisting conditions": A history of a right shoulder injury in 2016; another right shoulder injury in 2016; bilateral CTS; a left-ring-finger trigger-finger; a right-thumb trigger-finger; and de Quervain tenosynovitis. The latter is a painful condition of tendons on the radial aspect of the wrist. He did not say why these conditions were relevant. (Deposition of Jared Kirkham, MD, April 29, 2024).

50) While physically examining Employee, Dr. Kirkham found her tender to "very light, superficial pressure along most aspects of her right elbow." He found nothing specific on provocative tests. She had pain "pretty much" on all movements he did. "She also had diffuse weakness in her upper extremity, which "[he] felt was more likely to be due to pain and lack of effort rather than true musculoskeletal or neurologic weakness." Dr. Kirkham found no "concerning objective findings such as swelling, or edema, or atrophy, weakness, or loss of sensation." He would not have expected to find these in someone less than six months from an injury. Because he found no "objective" findings, Dr. Kirkham opined Employee's reported pain was inconsistent. "[He believed] at one point she reported that she was having 20 out of 10 pain." Dr. Kirkham said pain can come from "structural injury," but can also be contributed to by "psychosocial factors" which include, "stress, fear, anxiety, not liking your job, secondary gain."

> And so in my medical practice I routinely say -- see patients who are in pain, and we don't see a clear injury or structural cause to their pain. And in most cases, based on the medical literature, that's related to the psychosocial factors that I'm describing.

Dr. Kirkham found no evidence of injury because he found no objective findings. In his view, she had negative x-rays and a normal post-injury physical examination. Evidence of psychosocial factors in Employee's case included:

> In her case, the records that I reviewed document exaggerated pain symptomatology. We talked about her complaints of 20 out of 10 pain. Her description of a firecracker going off in her elbow. She also had pain behaviors documented in the records that she was withdrawing with light palpation -- also during my exam. She reported that her job is beyond stressful.

> And then we also see these nonphysiologic findings on physical examination. She had tenderness to very light touch, which is not consistent with an injury. Even if you have an injury, light touch on the skin should not cause pain.
>
> She had this diffuse weakness in her upper extremity that did not conform to any sort of distribution for any sort of neurological condition. We also checked her grip strength, and she had highly variable grip strength. At one point it was five pounds. At another point was 20 pounds, and that indicates reduced effort.

In his written report, Dr. Kirkham said Employee's symptoms "may be related to lateral epicondylitis or radial tunnel syndrome along with medial epicondylitis." Dr. Kirkham now testified he did not believe Employee has "classic medial or lateral epicondylitis." In his view, her pain is "too diffuse and widespread and nonspecific" for that diagnosis. In his experience, when a patient presents with medial or lateral epicondylitis, "it's typically focal pain along the medial or lateral epicondyles and it's provocative with either resisted wrist extension or flexion, respectively." Unlike his medical report where he included "work related activities," Dr. Kirkham now testified that possible causes of Employee's "condition" include only: age, genetics, deconditioning, and psychosocial factors. Of these, Dr. Kirkham said the substantial cause is "the psychosocial factors" that he mentioned. He based this opinion on lack of objective findings. (Deposition of Jared Kirkham, MD, April 29, 2024).

51) Since there was no injury, Dr. Kirkham did not recommend any treatment "whatsoever." He would recommend "reassurance" and advising the patient that there was no evidence of an injury and telling her to continue to use her arms normally. He would also recommend "cognitive behavioral therapy" which helps patients reframe their "pain perception." "There was no work injury." He agrees with Dr. Weil that Employee was "catastrophizing." However, he disagreed with Dr. Weil's bilateral lateral epicondylitis diagnosis, because in his view her pain was too diffuse to be explained by that diagnosis. Dr. Kirkham was read a quote from Dr. Weil's deposition in which Dr. Weil stated, referring to Employee's work injury, "Certainly it may be a contributing factor, but not the substantial cause." Dr. Kirkham responded:

> Work is not the substantial cause. And I would ultimately agree that there is a possibility that she has a mild component of lateral epicondylosis, but that does not explain her pain symptoms.

> And Dr. Weil himself said she had, quote "ill-defined pain throughout her upper extremities, extreme pain bilaterally, and essentially a non-anatomical distribution. Pain out of proportion."
>
> All of those things would be consistent with ill-defined pain, that is, cannot be explained, bilateral epicondylosis. I think he -- he was trying to provide some sort of diagnosis, because it is hard to say that the patient has pain and I don't know why they have pain, or it's related to psychosocial factors, but I have no problem saying that. (Deposition of Jared Kirkham, MD, April 29, 2024).

52) On cross-examination, Dr. Kirkham said he is a musculoskeletal medicine and pain expert. He performs "probably" two EMEs per week for Medical Evaluations of Alaska, 50 weeks per year. His EME cases involve "head to toe" issues, including concussions. Dr. Kirkham keeps up-to-date through reading medical journals. In his opinion, Employee's elbows are healthy:

> Q. So her pain is coming from her mind and not her joints?
>
> A. That's right. So her mind is interpreting what should be nonpainful signals as painful, and that can be related to a variety of factors. We talked about them; anxiety, fear, anger, stress with work.

After again stating Employee's work did not cause her pain at work, Dr. Kirkham explained his analysis with a hip arthritis analogy:

> So you could have arthritis in your hip and your walking around work and it hurts, but work didn't cause the arthritis in your hip.

Throughout his testimony, Dr. Kirkham focused no "objective evidence" of an injury. When asked if he could explain his view -- whether her mental connection he stated she has to pain was caused by "whatever mental connection she has with her work" -- Dr. Kirkham stated:

> Well that's an interesting question and a complicated question. The literature suggest that in general these personality factors that can contribute to pain, these psychosocial factors, usually predate the injury. And our personality is formed very early, so the literature is pretty clear on that, that it's the type of patient and their personality factors that lead them to have the pain, not their work. But that would also be a complicated question for, perhaps, a psychiatric IME.

He added:

> If somebody complains of pain and there's nothing objective, do we reclassify that as a work injury? If -- if we claimed that you could have pain because of psychological stress at work, that would be something that the courts would need to address. And if somebody could claim pain without anything objective, then that would be a legal situation, but not a medical situation.
>
> So in my opinion, there has to be something objective to claim an injury. But if the courts say, no, there has to be nothing objective, the patient can just claim pain, then that would be up for the courts to decide.
> . . . .
>
> There has to be something objective to say that there was an injury. And in some cases there isn't something objective. So one example of this would be a lumbar strain. Patient has pain after doing that -- in that case though, most cases, they just get better. And then I would say, yes, there was a strain or something objective. We can't see anything on imaging, x-rays, MRI, and they got better as expected, so I agree with the diagnosis of a sprain.
>
> In this case, she's not really getting better, there is nothing objective, and there's all these other psychosocial factors that are contributing.
>
> So when we talk about causation, there has to be, really, three things.
>
> So number one, the stimulus has to perceive the symptoms. So if you have -- you're claiming shoulder pain, you had pain before, then that weakens that link.
>
> Number two, it has to be biologically plausible. That's why we're talking about these boxes and lifting. And it's not biol -- biologically plausible that she would have an injury from those activities.
>
> And number three, if there can't be something else that better explains the symptoms, right? So in this case, the psychosocial factors much better explain the reason she's having pain, rather than any objective injury.
>
> And that's how I think about causation.

Lastly, when asked if Employee's work was the substantial cause of her "psychosocial factors," Dr. Kirkham opined, "No. The substantial cause [of her psychosocial factors] is preexisting personality factors." (Deposition of Jared Kirkham, MD, April 29, 2024).

53) On August 6, 2024, Dr. Paisley saw Employee for the last time, according to her medical records in her agency file. (Paisley report, August 6, 2024).

54) On September 17, 2024, Employee amended a previously filed claim and requested medical costs, transportation expenses, a penalty, interest and attorney fees and costs. (Claim for Workers' Compensation Benefits, September 17, 2024).

55) On September 26, 2024, Dr. Paisley testified: He is an orthopedic surgeon who did a shoulder and elbow surgery fellowship. Thereafter, in 2014 he moved to Alaska and joined a practice for six years and started his own practice in April 2020. His specialty is shoulder and elbow surgery. Dr. Paisley also treats hands, wrists, and knees, but he specializes in shoulders and elbows. He commonly sees patients with epicondylitis because it is "the most common elbow-related condition" and is "very, very common." Dr. Paisley estimates that he has seen around 1,000 people with epicondylitis in the last 10 years. (Deposition of Dr. Kevin Paisley Via Zoom Videoconference, September 26, 2024).

56) Dr. Paisley saw Employee four times. He also reviewed Dr. Mentzer's notes from when he was with Dr. Paisley's practice. When he first saw Employee as his patient, Dr. Paisley did his own examination and came to his own diagnoses, which he noted were "consistent with Dr. Mentzer's." He diagnosed two elbow-related issues including bilateral medial epicondylitis and lateral epicondylitis. On the right, Employee also has a subluxing ulnar nerve, which adds to the inflammation of the medial epicondyle. He added that Employee's condition was "exceptionally inflamed" and said, referring to inflammation:

> It can be, especially in the more severe and kind of stubborn or recalcitrant conditions or cases of it, which I would put [Employee] -- I mean, she's had several rounds of conservative management, and it just hasn't been able to do the trick for her.
>
> And one of the reasons why its most likely so persistent is that her nerve is subluxing, and when it subluxates -- and so as far as the anatomy, the nerve sits right behind the medial epicondyles (indicating). So I know this doesn't show up on transcription, but I'm pointing at my medial epicondyle. And posterior or towards the back of that is where that nerve travels (indicating).
>
> And so in a small subset of the population, that nerve can pop over and snaps over the medial epicondyle. It's not always painful, but if someone does develop medial epicondylitis and they just happen to have a nerve that's jumping over it as well, then the symptoms are amplified, and treatment of it is more difficult because of it being of a more recalcitrant nature.

Employee has the same subluxing nerve on the left although it does not bother her. Dr. Paisley explained that a physician can feel the nerve subluxing. This additional condition is contributing to her persistent pain at the medial epicondyles. If a person has elbow trauma or "overuse," they may develop inflammation at the origin of the muscle attachment on the epicondyles. Most people who get "golfer's elbow" or "tennis elbow" do not even play golf or tennis. Epicondylitis is usually related to overuse or activity. (Deposition of Dr. Kevin Paisley Via Zoom Videoconference, September 26, 2024).

57) In Employee's case, the basis for Dr. Paisley's epicondylitis diagnoses is her history, symptoms and physical examination. If he applied pressure on the specific site, it caused pain. There are specific, provocative tests he uses to diagnose epicondylitis. Imaging is not a requirement for a lateral epicondylitis or medial epicondylitis diagnosis. A person could have a clear elbow x-ray and still suffer from epicondylitis. Dr. Paisley agreed with Dr. Mentzer's previous diagnosis and treatment recommendations. (Deposition of Dr. Kevin Paisley Via Zoom Videoconference, September 26, 2024).

58) Dr. Paisley opined that epicondylitis is associated with repetitive activity, use and gripping. By the time Dr. Paisley took over Employee's care, she had already had conservative treatment from Dr. Mentzer. Additionally, Dr. Mentzer had already discussed the possibility that she might need surgical intervention, with which Dr. Paisley agreed. Litigation delayed that process. He found no evidence of symptom magnification or invention. "No, not at all. I mean, it seems exceptionally legitimate." Moreover, she also has the ulnar nerve subluxing, which is even more painful than the other conditions. If she were malingering, her symptoms would be more nonspecific and intense and usually diffuse. He did not find that was the case with Employee on examination. In her case, Dr. Paisley would favor the open surgical approach since the subluxing ulnar nerve also had to be addressed. (Deposition of Dr. Kevin Paisley Via Zoom Videoconference, September 26, 2024).

59) Dr. Paisley has worked in a kitchen, knows what it takes to prepare food, plates, and other items and knows that by nature it is "a repetitive business." It is the kind of work that could cause a person to have medial and lateral epicondylitis. The work Employee did loading and unloading heavy boxes, pushing carts around, putting the pans in and out of the ovens are all things that could cause her conditions. Dr. Paisley agrees completely with Dr. Mentzer's opinions set forth in their shared chart notes. In his opinion, it is "highly unlikely" that Employee would have the same

condition due to her age or genetics if she was just sitting on a couch. (Deposition of Dr. Kevin Paisley Via Zoom Videoconference, September 26, 2024).

60) Dr. Paisley's understanding of "the substantial cause" is a cause "just over 50 percent of the cause leading to the diagnosis or the condition." He has not reviewed Drs. Kirkham's or Weil's reports or depositions. Dr. Paisley agreed epicondylitis can be primarily due to genetic factors, but he would not list those as a substantial cause of lateral or medial epicondylitis. It can be nontraumatic and most cases are nontraumatic and typically tend to be more repetitive, as in this case. Dr. Paisley reviewed the tests Dr. Weil performed and said he does not ordinarily do those tests for epicondylitis because they are more nerve-related or for wrist issues. He could not explain why Employee would have told EME and SIME physicians that she had diffuse pain or why they reportedly found it on examinations. But, on the four times he had seen Employee her complaints had been very consistent and "very much localized to the respective spots that I mentioned earlier." (Deposition of Dr. Kevin Paisley Via Zoom Videoconference, September 26, 2024).

61) On October 22, 2024, Employee filed and served 39 photographs she took of her workplace with Employer. The photos show: boxes, some with size and weights visible; milk crates filled with multiple milk containers stacked up to six high; fresh fruit boxes; metal shelving in what appears to be a walk-in cooler with various sized boxes and plastic totes stacked thereon; cases of #10 cans with six cans weighing approximately six pounds apiece in each box; larger boxes containing lighter items like chips and cereal stacked on higher shelves; cases of "fruit cups" and "fruit juice"; cases of other food items like vinegar and cooking spray; cases of non-food items like cups, napkins, and lids; cases containing condiment jugs and sauces; tall, wheeled freezer carts holding up to 20 trays of frozen food such as Tater Tots; stacked cases containing frozen desserts weighing approximately 30 pounds each; cases of cooked turkey breasts weighing up to 40 pounds each; numerous cases of prepared chicken weighing up to 30 pounds each; cases of cheese weighing 20 pounds each; another room containing numerous ovens and food warmers at various heights; a mostly stainless steel kitchen with washing devices and countertops, and dozens of hanging utensils and serving trays. (Notice of Intent to Rely, October 22, 2024).

62) On October 31, 2024, Employee filed and served three articles: (1) A July 19, 2024 article entitled "Lateral Epicondylitis (Tennis Elbow)" authored by two physicians; the primary author is a clinical professor at Ohio State University (OSU) College of Medicine who is the team physician for the OSU Athletic Department. The article is taken from Emedicine.Medscape.com, is 25 pages

long and cites 86 references to various articles and medical journals. (2) Another article with the same name "Lateral Epicondylitis (Tennis Elbow)" dated August 4, 2023, taken from a National Institute of Health (NIH) website. This seven-page article has two authors whose information was provided, but the link to it is not active on the PDF. Judging from the text, the authors are probably physicians. The article cites 17 medical journal articles. (3) A third article with a similar name "Tennis Elbow (Lateral Epicondylitis)" authored by two physicians and peer-reviewed by two other physicians. The American Academy of Orthopaedic Surgeons (AAOS) sponsored this nine-page article, which was reviewed by members of American Shoulder and Elbow Surgeons (ASCS). (Notice of Intent to Rely, August 31, 2024; inferences drawn from the above).

63) Notable points summarized from the three above articles in numeral sequence include: (1) Lateral epicondylitis is the most common overuse syndrome. "Surgical intervention can be very effective for refractory cases of lateral epicondylitis. However, surgical intervention is only indicated after 6 months of conservative care has failed to relieve symptoms." There is "usually a history of repetitive activity aggravating the extensor tendons of the forearm." About 10 percent of patients with persistent symptoms at six-months require surgery. "Delayed symptoms are probably due to microscopic tears in the tendon." Moreover, "pain can vary from being mild (*e.g.*, with aggravating activities like tennis or the repeated use of a hand tool), or it can be such severe pain that simple activities like picking up and holding a coffee cup (*i.e.* "coffee cup sign") will act as a trigger for the pain." Swelling or ecchymosis seen on physical examination is "very rare." Likewise, laboratory and imaging studies are typically not useful in diagnosing lateral epicondylitis. "It is important that each case is evaluated individually, because some patients may have multiple relapses or lack progression through therapy. These patients may opt for surgery after a short trial of conservative care." (2) "It is common in . . . any activity involving repetitive wrist extension, radial deviation, and/or forearm supination." Multiple studies on surgical specimens found objective "hypertrophic or abundant fibroblasts," "collagen disorganization" and "vascular hypoplasia"; in other words, diseased tissue. On examination, pain is usually focal near the epicondyles, but "palpation of the entire tendon may have some degree and [sic] discomfort, and the connecting muscle may exhibit significant tightness." "First-line management" for lateral epicondylitis is rest from the "offending activity as guided by the level of pain." "Complications of lateral epicondylitis can include recurrence of the injury when normal activity is resumed. . . ." Lastly, (3) Several activities can cause lateral epicondylitis:

> Tennis elbow involves the degeneration (wearing down) or, in some cases, microtearing of the tendons that join the forearm muscles on the outside of the elbow. The forearm muscles and tendons become damaged from overuse -- repeating the same motions again and again, which leads to pain and tenderness on the outside of the elbow.
> . . . .
>
> Painters, plumbers, and carpenters are particularly prone to developing tennis elbow. Studies have shown that auto workers, cooks, and even butchers get tennis elbow more often than the rest of the population. It is thought that the repetition and weightlifting required in these occupations leads to injury.
> . . . .
>
> Common signs and symptoms of tennis elbow include:
> - Pain or burning on the outer part of your elbow
> - Weak grip strength
> - Sometimes, pain at night ((1) "Lateral Epicondylitis (Tennis Elbow)," July 19, 2024; (2) "Lateral Epicondylitis (Tennis Elbow)," August 4, 2023; (3) "Tennis Elbow (Lateral Epicondylitis)," undated).

64) On November 5, 2024, Dr. Mentzer testified: He is an orthopedic surgeon with an extra fellowship in the upper extremity, including shoulder, elbow and hand. He finished his fellowship training in 2003 and was a military doctor for 10 years. Dr. Mentzer has been in private practice since 2013. Approximately 80 percent of his practice is for the upper extremity. (Zoom Videoconference Deposition of: Kurt Mentzer, MD, November 5, 2024).

65) Prior to his deposition, Dr. Mentzer reviewed his chart notes for Employee beginning in May 2022; he has not communicated with Dr. Paisley about Employee. His opinions expressed in his medical records have not changed. He diagnosed Employee with bilateral elbow epicondylitis from her first visit and consistently thereafter. His diagnosis was based primarily on his physical exam, which anatomically correlated with her pain. She also had a positive "very specific" provocative epicondylitis test. Dr. Mentzer found Employee credible, nice to work with, and "very straightforward" throughout her treatment. He was never concerned about her "making something up." (Zoom Videoconference Deposition of: Kurt Mentzer, MD, November 5, 2024).

66) Dr. Mentzer understood Employee was a cook for the school district. She frequently traveled between schools and managed cooking activities and prepared meals for school district students. In his opinion her job was "absolutely" something that could cause epicondylitis, which is an overuse injury involving micro-tearing of the elbow tendon. He defined "the substantial cause" as

the work "injury" or "activity" being the substantial cause of the patient's complaint, injury or condition. In his opinion:

> So from point one, when she came in she said her work activities were causing this issue with her arms. And there was no reason to doubt that that was absolutely the substantial cause; lifting heavy items multiple times a day and -- different positions with her arms, it was -- there was no question.

When asked if in his opinion there was no question that Employee's work activity was "likely the substantial cause" of her bilateral epicondylitis, Dr. Mentzer said, "Correct. Yes." (Zoom Videoconference Deposition of: Kurt Mentzer, MD, November 5, 2024).

67) Dr. Mentzer had reviewed Dr. Kirkham's EME report "many times," but he did not review Dr. Kirkham's deposition. He did not review SIME Dr. Weil's deposition. He was not aware of "a history of upper extremity complaints" prior to Employee's work injury with Employer. Dr. Mentzer saw Employee for the epicondylitis conditions, which he treated. In his opinion, epicondylitis cannot be caused by anything other than repetitive activities. He was aware of her CTS diagnosis, as he diagnosed it on the right. Epicondylitis can "absolutely radiate." He has not seen Employee since January 29, 2024. Dr. Mentzer reviewed the three articles Franklin had sent him (factual findings #62 and #63, above) and found them consistent with his experiences treating and diagnosing epicondylitis -- "Very consistent." (Zoom Videoconference Deposition of: Kurt Mentzer, MD, November 5, 2024).

68) On November 13, 2024, Franklin filed his attorney fee affidavit and itemization of attorney fees and costs. In summary, his affidavit states:

- He is the attorney representing Employee;
- He spent the time indicated in the itemized listing on Employee's case;
- In a previous 2024 Board decision, he received $490 per hour;
- His current requested $500 per hour rate is approximately a two percent increase from his previous rate, which is less than the annual inflation rate;
- The issues in this matter were complicated and required close study of medical records, research and legal issues;
- His itemized statement state the duration and character of the work he performed;
- The time he spent on this claim was reasonable and efficient;
- His experience in general litigation and in workers' compensation allowed him to work more efficiently and bill fewer hours;
- He works independently without staff trained in these matters;
- He is responsible for all aspects in this case;

- He currently has 30 injured worker cases;
- The time he spent on Employee's case was time he could not spend on other cases for which he is paid immediately regardless of the results obtained;
- He has active cases including personal-injury, family law and criminal defense;
- He has represented clients in employment and contract matters;
- His personal injury matters are "purely contingency";
- He is paid $350 per hour for his work on family law, contracts and criminal defense matters;
- He requires retainers to represent clients in family law and criminal defense cases, which guarantee his payment;
- He turns down family and criminal defense cases regularly because he has commitments to his current workers' compensation clients;
- Workers' compensation cases generally take over a year to resolve;
- He personally funds all costs associated with these matters;
- He would not be motivated to accept workers' compensation clients unless there was a significantly higher fee award than in cases where his fees are guaranteed;
- If he does not succeed in obtaining a benefit for his client in a workers' compensation case, he loses money invested in the case in addition to time spent;
- For example, he recently spent $5,500 on an SIME deposition fee in addition to paying for the court reporter and travel;
- Settling workers' compensation cases often involves reducing fee rates and time spent;
- A relatively higher attorney fee rate is necessary to incentivize employers to avoid unnecessary litigation;
- His hourly rate is commensurate with his experience and with fees customarily charged in Anchorage by other attorneys in these matters;
- His resume is attached;
- Prior to moving to Alaska, he was licensed to practice in New York and worked in Washington, DC;
- He was a law clerk for Judge Spaan in the Alaska Superior Court in 2008;
- He has litigated criminal and civil matters in Alaska since 2009;
- He was an Assistant Public Advocate for almost seven years litigating criminal matters throughout Alaska involving all crimes;
- He has completed over 35 criminal jury trials including approximately 25 felony cases;
- He attended the National Criminal Defense College in Macon, Georgia;
- He worked for approximately 1.5 years as a private insurance defense lawyer;
- He was a senior Assistant Attorney General for the State of Alaska in its workers' compensation division;
- He independently handled dozens of workers' compensation claims throughout Alaska for approximately three years;
- He litigated workers' compensation matters before the Board in Juneau, Anchorage and Fairbanks;
- He is responsible for over 25 published workers' compensation Board decisions;
- He has litigated before the Alaska Workers' Compensation Appeals Commission;

- He was the responsible attorney representing the State of Alaska in *Alaska State Commission for Human Rights v. United Physical Therapy*, 484 P.3d 599 (Alaska 2021);
- He mediated and settled dozens of workers' compensation claims while representing the State of Alaska;
- While working for the State of Alaska, he worked in the Torts Division handling civil claims involving immunity, personal injury and property loss;
- He has been representing injured workers for approximately 18 months;
- He has mediated and resolved approximately 15 workers' compensation cases over the last year;
- His experience as a former insurance defense attorney gives him particular insight and advantages in representing injured workers;
- His experience as a public defender gives him particular skills for client communication and developing positive client relationships;
- His overall litigation experience in addition to his workers' compensation experiences allow him added efficiency in litigating and advancing claims; and
- His efficiency benefits both his client and the opponent.

Franklin's attached attorney fee itemization set forth the date and a brief description of the services performed, the time incurred and the amount billed, at $500 per hour. His attorney fees and costs totaled $21,007.14, through November 13, 2024. (Attorney Fee Affidavit of Adam R. Franklin; attached itemization, November 13, 2024).

69) On November 14, 2024, Employee added $1,200 to his litigation cost bill for Dr. Paisley's deposition expenses. (Notice of Addition to Employee Cost Demand, November 14, 2024).

70) On November 20, 2024, Employee testified consistent with her deposition; though she went into additional detail. She stopped seeing Dr. Swanson after Employee had a disagreement with an unidentified nurse case manager; she began seeing Dr. Mentzer. (Record).

71) As an assistant kitchen manager, Employee has food preparation duties plus stocking, restocking and rearranging food in the walk-in freezer and on shelves, many of which were taller than she. She lifts and carries at least 12 to 15 milk crates per day; each crate contains 50 one-half pint cartons. East High, where she works, receives food deliveries daily. Truck drivers unload food onto pallets and Employee moves it onto carts and pushes or pulls the carts into the kitchen. Sometimes the carts do not go where she wants them to go because they are old and in disrepair. She unloads the cases from the boxes and stacks them. Employee does this mostly herself each day, because other workers are either more elderly, or they are doing other prep work. When preparing food, Employee opens boxes to remove foodstuffs; they have box knives for that purpose but often they do not work, which requires her to tear the boxes open by hand. (Record).

72) Employee arrives at work at 6:30 AM five days a week, and works eight hours per day. She immediately begins obtaining, unpacking and preparing food for the breakfast meal, which may include pancakes, waffles and cereal, and "panning up" muffins and cinnamon buns that were prepared elsewhere and delivered to the school. At lunch, Employee's team has 35 minutes to feed 635 students in the first lunch wave followed by 200 more in a different shift. Each meal is placed into a "high school black tray" which is compartmentalized to separate food for each student. With exception of a 30 minute break, Employee is using her arms and hands for eight hours each work day and rotates her wrists and moves her elbows "constantly." (Record).

73) Once breakfast is over, Employee and her crew begin preparing the lunch meal, followed by the after-school meal for students who are receiving tutoring or participating in sports. For each meal, Employee and others "scoop" the food into "high school black trays." (Record).

74) Employee reviewed and explained many of the previously filed photographs she took of her kitchen area at East High. She testified in great detail about stacking, sorting and moving cases of food forward to ensure the oldest food is used first. She rearranges the freezer "constantly" for this purpose. As it is with unloading the truck pallets each day, and although there are several people on her shift, Employee does this rearranging mostly herself every day, because some of the employees are elderly while others are performing other work. (Record).

75) Employee explained how she opens #10 cans daily with an "old" type "crank" can opener. For example, the day prior to hearing, Employee opened 24 cans. To use the can opener, Employee lifts the can from the open case up to the can opener, which is affixed to a countertop. She then slams the cutting portion of the can opener onto the top of the can to make sure it gets punctured properly. Employee uses both hands to turn the handle on the can opener around to open the can. If she does not slam the cutting edge down hard enough, it may take two or three tries to properly puncture the can. Employee also explained the various carts she uses to move heavy boxes around the kitchen. They do not move easily, and the tires get "frozen" if they are in the freezer. Every day Employee moves heavy carts around six times per day. (Record).

76) Employee "fights" with carts full of food trays to make them move the right way. For example, when she prepares Tater Tots for a meal, she puts the frozen Tater Tots onto trays in a rack, pushes the carts to the cooking area, then transfers the racks from the cart into ovens; when the Tater Tots are cooked, she removes them from the ovens, places them onto another cart, moves

that cart to a counter area, and she and others manually "scoop" the Tater Tots (and other food for that meal) onto 800 trays. (Record).

77) During her shift, Employee takes turns with other workers washing all the related dishes and putting them away. (Record).

78) Employee first noted her elbow symptoms at work, shortly after her CTS surgery, a condition which also happened at work. As time went on, her elbow symptoms became worse. Employee has been working for Employer doing her same job since her work injury subject of this claim. The more active Employee is with her arms, the worse her elbow symptoms become. She does not participate in sports or go to a gym; she considers the kitchen at work "her gym." Although she loves to garden, Employee can no longer do it because her elbows hurt too much. When she gets home from work each day, her elbows are "throbbing." (Record).

79) Employee may have unpaid work-related medical bills, but she does not think she has received them yet. Employee likes her job and the people she works with. (Record).

80) Ostlund is the kitchen manager at East High, which is the largest high school in Alaska. She has worked for Employer for 20 years and with Employee for approximately five years. When Ostlund began, there were 18 workers in the kitchen; now there are 10 including her and Employee. She described Employee as a "hard worker." Ostlund corroborated Employee's testimony about stacking and moving boxes, cooking and supervising her crew. Over the past two years, she witnessed Employee appear to have pain in her elbows. Ostlund said she too has her own arm issues and implied these came from her employment. She is aware of another person in another school with similar complaints. She corroborated that Employee does heavy lifting daily, and said she sometimes feeds 1,000 kids a day. The day before hearing, Employee prepared 120 pounds of chicken. Ostlund described the pans and trays used in the kitchen as "industrial" or "commercial" size pans, which Employee often has to lift above her head. She estimated the kitchen serves 500 chocolate and 1,000 white milks each day. East High's kitchen makes three meals a day. Ostlund emphasized that the problem is not one single event, but everything together "compounded" that makes Employee's job difficult. (Record).

81) At hearing, the parties resolved two preliminary matters regarding Employer's objection to a document and Employee's response; Employer also waived any objection to photographs since Employee laid a sufficient foundation for them at hearing. Employer also agreed that Employee raised the statutory presumption; Employee agreed that Employer had rebutted it. (Record).

82) At hearing, Employer objected to only one item in Franklin's initial fee itemization. It questioned why he had billed for time related to a subpoena for Dr. Mentzer, when Employer had not received any subpoena. Franklin explained he obtained a subpoena because he felt Dr. Mentzer was overcharging for his time for giving a deposition; as it turned out, Franklin did not use the subpoena because Dr. Mentzer agreed to a lesser rate. (Record).

83) During the hearing, Franklin said he could and would file his supplemental attorney fee affidavit by 5:00 PM on November 20, 2024; the panel left the record open for that purpose and until Friday, November 22, 2024, for Employer to file any objection. (Record).

84) On November 22, 2024, Employee said he filed his supplemental attorney fee affidavit and itemization two days late. What he actually filed with the Division was a "notice" stating:

> Mr. Franklin compiled and attempted to file his amended attorney fees with the Board on Wednesday, November 20, 2024. Unbeknownst to counsel, his email was not delivered to the Board and instead was stuck in the "Outbox" of counsel's email account. A copy of a screen shot of the "outbox" is attached. Counsel for [Employee] requests the Board accept the supplemental fee filing and excuse any claim of lateness based on this technological filing issue. (Notice Regarding Supplemental Attorney Fee Filing, November 22, 2024).

With the above notice, Franklin attached a screen shot showing his attempt to email his supplemental fee affidavit to the Workers' Compensation Division (Division) and Schwarting on November 20, 2024. However, no supplemental affidavit or fee itemization was found in Employee's agency file on November 22, 2024, either. (Observations).

85) On November 22, 2024, Employer objected to Employee's "late-filed" supplemental fee affidavit that it "received" on November 22, 2024. It also objected to time Franklin spent copying hearing exhibits which it contended "is an administrative task." (Objections to Supplemental Fee Affidavit, November 22, 2024).

86) On November 26, 2024, the panel re-opened the record to ask Franklin to re-file and re-serve his supplemental fee affidavit and his supplemental costs itemization. The panel suspects the Division may have mis-filed his initial filings. (Soule email, November 26, 2024).

87) On November 26, 2024, Franklin re-filed and re-served his supplemental attorney fee affidavit and itemization. Franklin incorporated his first attorney fee affidavit and stated additional attorney fees were necessary to prepare for the November 20, 2024 hearing, including copying

costs for hearing exhibits. His additional attorney fees and costs totaled $3,314.66. (Supplemental Attorney Fee & Cost Affidavit of Adam R. Franklin, November 20, 2024).

88) "Nurse case managers" in workers' compensation are not medical providers in the assigned case. They are the employer's agents. (Experience; judgment; observations).

89) Cooks typically do not lift "hundreds" of 50 pound boxes daily on the job. (Experience; observations).

PRINCIPLES OF LAW

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

> **AS 23.30.010. Coverage**. (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability . . . or the need for medical treatment of an employee if the disability . . . or the employee's need for medical treatment arose out of and in the course of the employment. . . . When determining whether or not the . . . 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 the need for medical treatment. Compensation or benefits under this chapter are payable for the disability . . . or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability . . . or need for medical treatment. . . .

Construing AS 23.30.010(a), *Morrison v. Alaska Interstate Construction, Inc.*, 440 P.3d 224, 234-37 (Alaska 2019) said the Board must consider different causes of the "benefits sought" and the extent to which each cause contributed to the need for the benefit at issue. The Board must then identify one cause as "the substantial cause." *Morrison* clarified the statutory language:

> The statutory language does not require the Board to look at the type of injury in identifying the substantial cause of the need for medical treatment. Alaska Statute 23.30.010(a) requires the Board to "evaluate the relative contribution of different causes of the . . . the need for medical treatment." That subsection then provides, "Compensation or benefits under this chapter are payable for . . . medical treatment if, in relation to other causes, the employment is the substantial cause of the . . . need for medical treatment." When read together, these sentences do not reflect an instruction to consider the type of *injury* when evaluating compensability; instead,

> they require the Board to look at the *causes* of the injury or symptoms to determine whether "the employment" was a cause important enough to bear legal responsibility for the medical treatment needed for the injury.

In revising the applicable statute, the legislature did not remove from coverage certain injury or disease classes, "nor did it require a pathological change in a condition in order to establish compensability." *Id.* at 234. *Morrison* held the statute does not require the substantial cause to be a "51% or greater cause, or even the primary cause, of the disability or need for medical treatment." The causation test "remains flexible" and is "necessarily fact-dependent." The Board need only find which of all causes "in its judgment is the most important or material cause related to that benefit." *Id.* *Morrison* also held that preexisting conditions, which a work injury aggravates, accelerates or combines with to cause disability or need for medical treatment, can still constitute a compensable injury. *Id.* at 234, 238-39. Lastly, *Morrison* held that the legislature gave the Board discretion "to assign a cause based on the evidence before it." *Id.* at 240.

Traugott v. ARCTEC Alaska, 465 P.3d 499, 511-13 (Alaska 2020) said:

> The 2005 amendments did not change the but-for or factual part of compensability. For a disability to be compensable, work must still be a factual cause of the disability or need for medical treatment. The 2005 amendments changed the proximate or legal cause component of the compensability analysis. Now the Board must determine which among the different causes-in-fact is the most important in the current disability or need for medical care.
> . . . .
>
> Here, to show that the work at ARCTEC was a cause-in-fact of his disability and need for medical care, Traugott needed to establish that but for his work at ARCTEC he would not have suffered the disability at that time, in that way, or to that degree. No one disputes that he did so. The Board then needed to determine whether work was the most important of the identified causes of his disability and need for medical care.
> . . . .
>
> And the Board, not a medical expert, is charged with determining legal responsibility. Experts can provide opinions about the ultimate question in a case, but the Board as the fact finder has the authority to interpret an expert's opinion and decide what weight to give it.
>
> **AS 23.30.095. Medical treatments, services, and examinations**. (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse

> and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires. . . . The board may authorize continued treatment or care or both as the process of recovery may require. . . .

Nothing in the Act requires "objective evidence" to support an injury. *Rogers Electric Co. v. Kouba*, 603 P.2d 909, 911 (Alaska 1979) criticized the Board's reliance on an EME physician's opinion finding "nothing objective" that would have prevented the claimant, who had been diagnosed with "strained ligaments" from working. *Kouba* noted the Board stated it was "unusual for disability without objective signs to last for over a year," but cited no evidence or medical authority to support its statement. It further noted the Board did not state "what objective signs it expected periodically strained ligaments to present." Similarly, in *Kessick v. Alyeska Pipeline Service Co*., 617 P.2d 755, 757 (Alaska 1980) the Board relied upon among other things negative "objective testing." Citing *Kouba* and reversing the Board's decision, *Kessick* stated, "Nor does the lack of objective signs of an injury in and of itself preclude the existence of such an injury. There are many types of injuries which are not readily disclosed by objective tests."

> **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; . . . .

If parties stipulate that the presumption has been raised and rebutted, the first two prongs of the presumption analysis become irrelevant. *Jesperson v. Tri-City Air*, 547 P.3d 1042 (Alaska 2024). In the third prong an employee must prove her case by a preponderance of the evidence. She must prove that in relation to other causes, employment was "the substantial cause" of her disability or need for medical treatment. *Morrison*. This means the employee must "induce a belief" in the minds of the fact-finders that the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

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

The Board's finding of credibility "is binding for any review of the Board's factual findings." *Smith v. CSK Auto, Inc.,* 204 P.3d 1001, 1008 (Alaska 2009). "'The board has the sole power to determine the credibility of a witness' and to weigh the evidence from a witness's testimony, including medical testimony and reports." *Moore v. Afognak Native Corp.*, AWCAC Dec. No. 087 (August 25, 2008).

> **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. . . .

Cortay v. Silver Bay Logging, 787 P.2d 103 (Alaska 1990) stated attorney fees in workers' compensation cases should be fully compensatory and reasonable so injured workers can find and retain competent counsel. *Wise Mechanical Contractors v. Bignell*, 718 P.2d 971, 975 (Alaska 1986) reiterated, "As we have noted, the objective of awarding attorney's fees in compensation cases is to ensure that competent counsel are available to represent injured workers." *Rusch v. Southeast Alaska Regional Health Consortium*, 453 P.3d 784, 798-99, 803 (Alaska 2019) reviewed the Court's directives on awarding attorney fees to successful claimant lawyers:

> To clarify our holding in *Bignell*, we hold that the Board must consider all of the factors set out in Alaska Rule of Professional Conduct 1.5(a) when determining a reasonable attorney's fee. . . .

In *Israelson v. Alaska Marine Trucking, LLC*, AWCAC Dec. No. 226 (May 27, 2016) the Commission reversed a Board order denying actual attorney fees and awarding only statutory minimum fees to an attorney who filed his fee affidavit one day late. The attorney prevailed on his client's claim at hearing, but the Board denied actual fees because the attorney had failed to comply with 8 AAC 45.180 and had not shown grounds to waive or modify the filing requirement pursuant to 8 AAC 45.195. The relevant facts included:

> Following the hearing [the attorney] filed affidavits explaining that he had been unable to format his fee request and that on the morning of June 18, 2015, he contacted his transcriptionist to assist in that endeavor, but she was otherwise occupied and unable to assist him until the next morning. [The attorney] received the properly formatted fee request from his transcriptionist at 7:18 a.m. on June 19, 2015. The fee request was filed and served by email and first class mail on opposing counsel that same day.

Israelson determined, absent evidence that the employer was prejudiced by the late filing:

> 8 AAC 45.063(b) provides that the Board will, in its discretion, extend time deadlines upon a petition and for good cause. In this case, no written petition for an extension of time was filed. However, implicit in the filing of a late affidavit of attorney's fees is a request for an extension of time to file the affidavit. Moreover, [the attorney's] post-hearing response to [the employer's] objection to the late filing of the affidavit was, in effect, a written request for an extension of time, even though it referred to 8 AAC 45.195, rather than to 8 AAC 45.063(b), as the basis for the request. We conclude that [the attorney] substantially complied with the requirement in 8 AAC 45.063(b) that an extension of time be requested by petition.

Israelson concluded that the Board's failure to grant an extension of time "effectively eliminated a workers' compensation benefit" to which the employee was otherwise entitled. The Commission vacated the attorney fee award and remanded to the board for a reasonable fee award.

> **AS 23.30.395. Definition. In this chapter**,
> . . . .
>
> (24) "injury" means accidental injury or death arising out of and in the course of employment, and an occupational disease or infection that arises naturally out of the employment or that naturally or unavoidably results from an accidental injury; . . .

> **8 AAC 45.063. Computation of time**. . . .
>
> (b) Upon petition by a party and for good cause, the board will, in its discretion, extend any time period prescribed by this chapter.

> **8 AAC 45.180. Costs and attorney's fees**. . . .
>
> (b) A fee under AS 23.30.145(a) will only be awarded to an attorney licensed to practice law in this or another state. An attorney seeking a fee from an employer for services performed on behalf of an applicant must apply to the board for

> approval of the fee; the attorney may submit an application for adjustment of claim or a petition. An attorney requesting a fee in excess of the statutory minimum in AS 23.30.145(a) must (1) file an affidavit itemizing the hours expended, as well as the extent and character of the work performed, and (2) if a hearing is scheduled, file the affidavit at least three working days before the hearing on the claim for which the services were rendered; at the hearing, the attorney may supplement the affidavit by testifying about the hours expended and the extent and character of the work performed after the affidavit was filed. If the request and affidavit are not in accordance with this subsection, the board will deny the request for a fee in excess of the statutory minimum fee, and will award the minimum statutory fee.
> . . . .
>
> (f) The board will award an applicant the necessary and reasonable costs relating to the preparation and presentation of the issues upon which the applicant prevailed at the hearing on the claim. The applicant must file a statement listing each cost claimed, and must file an affidavit stating that the costs are correct and that the costs were incurred in connection with the claim. . . .

AMA Guides to the Evaluation of Disease and Injury Causation (*GEDIC*), Second Ed., p. 274-76 states: "Painful Elbow -- Lateral and Medial Epicondylitis (Tennis Elbow or Golfer's Elbow)":

> Tennis Elbow is a painful disorder of the common extensor tendon origin from the lateral humeral epicondyles. Traditionally, it has been labeled lateral epicondylitis, despite the fact that repeated studies of pathologic findings do not show inflammation of the lateral epicondyles but instead angiofibroblastic dysplasia from microtears of the tendon. . . . Similar disease in the common flexor tendon origin at the medial elbow has been labeled golfer's elbow or medial epicondylitis but similarly might be more properly termed medial epicondylopathy or common flexor tendinopathy. These are very common disorders. . . . Thus, many people have these disorders without exposure to any of the occupational risk factors.
> . . . .
>
> **Occupational Risk Factors for Painful Elbow**
> - Combination or risk factors (e.g., force and repetition, force and posture): strong evidence
> - Vibration: insufficient evidence
> - Highly repetitive work alone or in combination with other factors: insufficient evidence
> - Forceful work: low-risk evidence
> - Awkward postures: low-risk evidence
> - Keyboard activities: insufficient evidence
> - Cold environment: insufficient evidence
> - Length of employment: insufficient evidence
>
> **Non-Occupational Risk Factors for Painful Elbow**

- Age: insufficient evidence, increased risk in fourth and fifth decades
- BMI: insufficient evidence
- Sex: insufficient evidence
- Biopsychosocial factors: insufficient evidence
- Diabetes: insufficient evidence
- Dominant hand: insufficient evidence
- Genetics: insufficient evidence

. . . Table 9-19 gives the representative references and comments.
. . . .

Table 9-19 Representative References and Comments for Painful Elbow

Risk Factor	References and Comments
Combination of risk factors (e.g., force and repetition, force and posture)	Strong evidence. A case-referent study involved 267 new cases of tennis elbow and 388 referents from the background population enrolled from general practices in a county in Denmark. Manual job tasks were associated with tennis elbow (statistics omitted). The self-reported physical risk factors "posture" and "forceful work" were related to tennis elbow. Among women, work involving performing repeated movements of the arms was related to tennis elbow (statistics omitted). Among men, working with precision-demanding movements was related to tennis elbow (statistics omitted). A physical strain index was established based on posture, repetition, and force. . . . Good-quality studies consistently show a strong relationship between a combination of risk factors and tennis elbow, especially at higher exposure levels. This relationship is demonstrated in certain working populations, especially construction workers and meatpackers. There is also strong support in the sports medicine literature. The incidence of tennis elbow strongly correlates with a combination of forceful grip, position, and frequency of playing racquet sports. . . . Workers with medial epicondylitis had a significantly higher prevalence of other work-related upper-limb musculoskeletal disorders. . . .

ANALYSIS

1) Did Employee's bilateral epicondylitis arise out of and in the course of her employment with Employer?

"Causation" is the primary issue in Employee's claim. If her need to treat her bilateral elbow symptoms did not arise out of and in the course of her employment with Employer, the inquiry ends here -- Employer would be liable for no benefits. AS 23.30.010(a); AS 23.30.395(24). The parties agree Employee raised the presumption of compensability with her medical evidence and Employer rebutted the raised presumption with its evidence, which places the burden of production on Employee. Thus, the presumption analysis' first two prongs do not apply. AS 23.30.120(a)(1); *Jespersen*. The burdens of proof and persuasion fall on Employee. *Morrison*; *Saxton*.

To prevail on causation, Employee must demonstrate that her employment with Employer was the substantial cause of her need for medical treatment for bilateral elbow symptoms. *Traugott*. She must convince the fact-finders that of all the different causes of the "benefits sought," work with Employer was "the substantial cause." *Morrison*. In other words, this panel must evaluate the "relative contribution of different causes of the . . . need for medical treatment," and, if her work for Employer in relation to other causes is the substantial cause of the need for medical treatment, then Employer is liable. *Id*. The fact-finders do not consider the "type of injury" when evaluating compensability, but look at "the causes of the injury or symptoms" to determine whether employment was "a cause important enough to bear legal responsibility for the medical treatment needed for the injury." *Id*. The legislature did not require a "pathological change in condition" to establish compensability. *Id.* The "substantial cause" need not be a "51% or greater cause, or even the primary cause," of the need for medical treatment. The causation test is "flexible" and is "necessarily fact-dependent." The fact-finders use their judgment to determine which of all causes based upon the evidence before them is "the most important or material cause" related to Employee's need for medical care for her elbows. *Id*.

Employee's work with Employer must still be a factual cause of her need for medical treatment. *Traugott*. Thus, to prevail, Employee must show that "but for her work" with Employer, she would not have had elbow pain at the time, in the way or to the degree that she did. The fact-finders will then determine whether her work with Employer was the most important of the identified causes

of her elbow symptoms and need for medical care. *Id*. This panel, and "not a medical expert" determines legal responsibility. Medical experts provide opinions, but the fact-finders have the authority to "interpret an expert's opinion and decide what weight to give it." *Id*. This case presents an evidentiary battle among medical experts:

A. EME Dr. Kirkham.

Dr. Kirkham is a physiatrist, not an orthopedic surgeon and not an elbow or upper extremity expert. His opinion that Employee does not have bilateral epicondylitis is at odds with at least four orthopedic surgeons (Drs. Swenson, Mentzer, Paisley and Weil), and a cardiovascular surgeon (Dr. Stephens). Thus, his opinions are given less weight. AS 23.30.122; *Smith*; *Moore*.

More troubling, his report cited extensively from Employer's "cover letter" and from "nurse case manager" notes. The cover letter and anonymous nurse case manager's notes are not found in Employee's file. Why Dr. Kirkham would cite from these as "medical records" and evidence upon which to base his opinion is questionable. The observations he gleaned from these non-medical reports include allegations that Employee said her elbow pain was "10/10," "while calmly discussing her symptoms." The obvious inference intended to be drawn from that statement is that Employee, at least in the nurse case manager's opinion, was exaggerating. Dr. Kirkham's report says, "according to the notes supplied" her pain had reduced from "20/10 to 5/10." While commenting on these "notes" and on a statement that Employee had "electrical and tingling sensations throughout her entire body," Dr. Kirkham editorialized his report suggesting Employee had, "exaggeration of symptoms" and "widespread pain." The panel found no medical record in nearly 700 pages reviewed where a physician ever charted that Employee told him or her she ever had pain rated at "10+/10" or "20/10," or claimed she had electrical and tingling sensations "throughout her entire body." While quoting extensively from a May 9, 2022 "case management note," Dr. Kirkham accepted the case manager's report as fact and including it in his report implies the statements are from Dr. Mentzer's report, when in fact they are not. This too warrants giving Dr. Kirkham's report less weight. AS 23.30.122; *Smith*; *Moore*.

Dr. Kirkham's report is also to some degree internally inconsistent. He found "no significant pain behavior" when he examined Employee. She specifically denied any pain on shoulder

examination. She had "exquisite tenderness to palpation" on her right elbow and "more moderate" tenderness on her left elbow. Given this examination, Dr. Kirkham determined there was "no objective evidence" of a work-related injury. He found her symptoms "out of proportion to objective findings." But the medical evidence before the panel, including the three articles Employee filed, shows there are usually no objective findings in lateral or medial epicondylitis, unless one considers microscopic evidence after tissue is removed following epicondylitis surgery. Dr. Kirkham's opinion means that since he found no objective evidence of epicondylitis, Employee should have had no symptoms at all. This makes no sense. Nevertheless, Dr. Kirkham thereafter agreed a "portion of her symptoms may be related to lateral epicondylitis or radial tunnel syndrome along with medial epicondylitis," but considered her pain and functional impairment exam, where he found "no significant pain behavior," were out of proportion to what he would expect with those diagnoses. Apparently, Dr. Kirkham has never heard of "coffee cup syndrome," where a person has severe elbow pain with simply lifting a cup of coffee. "Lateral Epicondylitis (Tennis Elbow)," July 19, 2024; "Lateral Epicondylitis (Tennis Elbow)," August 4, 2023; "Tennis Elbow (Lateral Epicondylitis)," undated. Again, for these additional reasons Dr. Kirkham's opinions will be given less weight. AS 23.30.122; *Smith*; *Moore*.

To support his opinion that there is a "significant psychosocial component" to Employee's pain, Dr. Kirkham cited the *GEDIC*. He stated studies referenced in the *GEDIC* show insufficient evidence for "highly repetitive work alone" as a risk factor for epicondylitis but "strong evidence for forceful repetitive work." Dr. Kirkham then concluded Employee was not "engaging in forceful repetitive activities" while at work. It is unclear how he came to these conclusions.

First, panels are not required to use the *GEDIC* and do not use it; the Division has a copy for reference since physicians cite it, albeit rarely. On pages 274 through 276, the *GEDIC* discusses epicondylitis. The *GEDIC* does not define "force" or "forceful work." Dr. Kirkham correctly cited "insufficient evidence" for highly repetitive work alone or in combination with other factors, and "strong evidence" for a "combination of risk factors (e.g., force and repetition, force and posture") as work-related risk factor factors for epicondylitis. However, Dr. Kirkham omitted conclusions from studies of "non-occupational risk factors" for painful elbows, found in a list in the *GEDIC* directly below the list he quoted. That second list on the same page includes, age,

body mass index, sex, "biopsychosocial factors," diabetes, dominant hand and genetics. The referenced studies show "insufficient evidence" for *all non-occupational factors* listed. In other words, Dr. Kirkham's ultimate opinion that the substantial cause of Employee's elbow pain is "psychosocial" factors is belied by the *GEDIC* upon which he relies to support his opinion, because there is "insufficient evidence" to support that conclusion. While Dr. Kirkham's reliance on the *GEDIC* is not dispositive, he omitted evidence from it that weakened his opinion, and therefore he will be given less credibility and weight. AS 23.30.122; *Smith*; *Moore*.

Second, the recent 2023 and 2024 articles Employee filed from respected medical sources disagree that Dr. Kirkham's definition of "forceful work" is needed to get epicondylitis from repetitive acts. One article includes "cooks" engaged in undefined "heavy lifting" as among workers who are more likely to experience epicondylitis. Despite Dr. Kirkham's opinion to the contrary, cooks are not likely to lift "hundreds" of cases weighing 50 pounds each day at work. *Rogers & Babler*. As Employee and Ostlund stated, they use their upper extremities repeatedly all day long. Dr. Kirkham did not fully understand Employee's work as explained in her deposition and especially at hearing. This further weakens his opinions. AS 23.30.122; *Smith*; *Moore*.

Moreover, in his report Dr. Kirkham listed all possible causes for Employee's bilateral elbow "condition" as "likely multifactorial and due to age, genetics, obesity, deconditioning, *work-related activities*, recreational activities including gardening, and psychosocial factors (italics added)." When asked to select which of all these possible causes was in his view "the substantial cause" Dr. Kirkham changed the list and stated the substantial cause of Employee's bilateral elbow "pain," as opposed to her "condition," is "likely multifactorial and due to age, genetics, obesity, deconditioning, and especially psychosocial factors." For reasons he did not explain, Dr. Kirkham left out "work-related activities" altogether, essentially excluding them as a possible cause with no explanation. As stated above, age, body mass index (*i.e*., obesity) and psychosocial issues have "insufficient evidence," according to the publication upon which Dr. Kirkham relied, to support causation for epicondylitis. Furthermore, Employee's work does not need to be the substantial cause of a "condition" to be a compensable injury. It just needs to be the substantial cause of "the injury or symptoms" and "the need for medical treatment." *Morrison*; *Traugott*.

In his deposition, Dr. Kirkham demonstrated a considerable misunderstanding of the medical-legal causation standard in workers' compensation cases. He understands "the substantial cause" to mean "the most important cause contributing to the claimant's current symptoms and disability." But *Morrison* stated the substantial cause does not need to be a "51% or greater cause, or even the primary cause, of the disability or need for medical treatment." Further, Dr. Kirkham's opinion that the substantial cause of Employee's bilateral elbow pain is "multifactorial" is not helpful to the fact-finders because it includes several causes and is not in conformance with the evidentiary standard. As *Morrison* stated, physicians do not make the substantial evidence call, although they may provide medical opinions regarding the ultimate question. Rather, the fact-finders make "the substantial cause" call. This decision must identify which of all the possible causes is the one, single, substantial cause. *Morrison*. His "multifactorial" cause, which by definition includes more than one cause, gives his opinions less credibility and weight. AS 23.30.122; *Smith*; *Moore*.

Dr. Kirkham testified that he found "relevant, preexisting conditions" which included Employee's history of two right shoulder injuries in 2016, bilateral CTS, a left-ring-finger trigger-finger, a right-thumb trigger-finger and de Quervain tenosynovitis. He did not explain why he found these preexisting conditions "relevant" to her bilateral epicondylitis. However, according to Table 9-19 in the *GEDIC* upon which he relied, these preexisting conditions comport with the notion that "workers with medial epicondylitis had a significantly higher prevalence of other work-related upper-limb musculoskeletal disorders. . . ." As far as can be determined from this agency file, Employer accepted the above-referenced preexisting surgeries as work-related. If anything, their relevance is to demonstrate that Employee's work for Employer is consistent with a person incurring upper extremity repetitive use injuries from hard, repetitive work.

Dr. Kirkham further testified that Employee demonstrated pain that he thought was "hypersensitive" and inconsistent with her lack of objective findings. As already stated, there are apparently few if any objective signs for epicondylitis. Pain is subjective. But one article that Employee submitted to support her position noted the "coffee cup sign" that many patients with epicondylitis experience when they have "severe pain" from simply lifting a cup of coffee. Unfortunately, in his testimony Dr. Kirkham again referenced Employee allegedly reporting she was having "20 out of 10 pain," a statement not found in any provider's record in this file.

Perhaps most disturbing, Dr. Kirkham apparently has a predetermined disposition to finding "no injury" exists absent "objective findings." *Kouba*; *Kessick*. When that is the case, he has "no problem" attributing causation to "psychosocial factors," which include "stress, fear, anxiety, not liking your job, and secondary gain." Nevertheless, even though in his written report Dr. Kirkham said Employee's symptoms "may be related to lateral epicondylitis or radial tunnel syndrome along with medial epicondylitis," in his deposition Dr. Kirkham testified he did not believe Employee even had "classic" medial or lateral epicondylitis. Later, Dr. Kirkham flip-flopped and conceded "there is a possibility that she has a mild component of lateral epicondylosis but that does not explain her pain symptoms." Moreover, contrary to his initial inclusion of "work-related activities" as a possible cause for Employee's symptoms he testified that possible causes were only "age, genetics, deconditioning, and psychosocial factors." Of these, he testified the substantial cause is more than just one thing, and is in fact "multifactorial" things -- lumped together as "psychosocial factors." His written report and his testimony are inconsistent, and his "the substantial cause" opinion is "multifactorial" rather than singular, in opposition to *Morrison*.

Dr. Kirkham did not mince words when he explicitly said Employee's pain is coming from her mind and not her joints. Five surgeons disagree -- Drs. Swenson, Stephens, Mentzer, Paisley and Weil; they all diagnosed epicondylitis. After reiterating that Employee's work did not cause her pain at work, Dr. Kirkham explained his reasoning with a hip-arthritis analogy: A person may have arthritis in his hip and while walking around at work it begins to hurt. He pointed out that work "didn't cause the arthritis" in the worker's hip. While that may be true, Dr. Kirkham's analogy further illustrates his misunderstanding of the medical-legal causation standard. Work does not have to cause an underlying condition, nor a pathological change to such condition; it just needs to be the substantial cause of symptoms arising from that condition and the need to treat them. *Morrison*. He further stated, "If somebody complains of pain and there's nothing objective, do we classify that as a work injury?" The answer, of course, is "yes," as is often the case with sprains and strains. As if to correct himself, Dr. Kirkham thereafter acknowledged, "And in some cases there isn't something objective." *Kouba*; *Kessick*. He then used a lumbar strain as an example. Notably, he opined that if a person has a lumbar strain, for which there are generally no objective findings, and "they just get better," "as expected," then contrary to what he had previously stated Dr. Kirkham would agree that even though there were no objective findings, there was an injury,

and that "getting better" "as expected" equals "something objective." This opinion is illogical, inconsistent, and confusing and is given less weight. AS 23.30.122; *Smith*; *Moore*.

Lastly, Dr. Kirkham made it clear that if he finds no objective evidence of an injury, there was no injury, and therefore "psychosocial factors" becomes his fall-back opinion because it "much better explains the reason she's having pain, rather than any objective injury." The Court has long rejected this approach. *Kouba*; *Kessick*. Absent from his analysis is the indisputable fact that Employee continued to work for Employer after her elbow symptoms began. Thus, every work day she performs the same duties that she contends caused her symptoms. If they are the substantial cause of her symptoms, it is not surprising then that she has not recovered from those symptoms. Therefore, because Dr. Kirkham has a misconception on what medically and legally constitutes an "injury," and it permeates his opinions, his opinions will ultimately be given no weight. AS 23.30.122; *Smith*; *Moore*; *Kouba*; *Kessick*.

B. SIME Dr. Weil.

Dr. Weil is the panel's SIME physician. He is an orthopedic surgeon with a specialty in hands. Therefore, his opinion is given more weight than Dr. Kirkham's based on his qualifications and specialty. AS 23.30.122; *Smith*; *Moore*. He presumably reviewed the same medical records that Dr. Kirkham reviewed, plus Dr. Kirkham's report. Contrary to Dr. Kirkham's examination findings, Dr. Weil noted Employee had "normal and symmetrical" sensation to light touch through her bilateral upper extremities. She did not exhibit "diffuse pain behavior with light touch" as Dr. Kirkham reportedly found. Dr. Weil noted "catastrophizing behavior" on only elbow range-of-motion. His provocative testing for epicondylitis was "painful bilaterally," as one may expect with a person who has bilateral epicondylitis.

Unfortunately, Dr. Weil quoted extensively from Dr. Kirkham's report including information the latter gleaned either from Employer's "cover letter" or clearly from "case management notes" from which he quoted. These documents are not in Employee's case file. *Rogers & Babler*. Dr. Weil reiterated an unidentified nurse case manager's undisclosed notes, and he too repeated claims that Employee had reported "10+/10" pain and had "electrical and tingling sensations throughout her entire body." As stated above, these and other reports that her pain was "20/10" that reduced to

"5/10" after a steroid injection are not found in the providers' medical records in her file. In reference to that last case management note, Dr. Weil specifically noted, "This note was not available for review." That is true because "cover letters" and " nurse case manager notes" are not medical records, and would not have been included in the SIME binders that Dr. Weil reviewed. However, the panel has concerns that Dr. Weil relied on this information, as did Dr. Kirkham, and this reduces weight given to his opinions. AS 23.30.122; *Smith*; *Moore.*

In contrast to Dr. Kirkham, Dr. Weil diagnosed "nonindustrial," "bilateral lateral epicondylitis." When asked to list causes of Employee's disability or need for treatment he stated, "the disability was caused [by] bilateral lateral epicondylitis of the elbows." When asked again with slightly different wording, Dr. Weil said, "the causes of [Employee's] current bilateral lateral epicondylitis include age, deconditioning, work-related activities, recreational activities, psychosocial factors, genetics and obesity." This sounds remarkably similar to Dr. Kirkham's report. When asked to select one cause as "the substantial cause," he too said it was "multifactorial in nature." But he concluded work activities were not the substantial cause for her current symptoms. Unlike Dr. Kirkham, Dr. Weil did not say Employee had "no injury," but said she had "no disability" and needed no treatment for her diagnosed bilateral epicondylitis. It is unclear why Dr. Weil would diagnose bilateral epicondylitis and state Employee needed no treatment for it, in the past or in the future, notwithstanding causation. This questionable statement reduces his opinions' weight and credibility. AS 23.30.122; *Smith*; *Moore.*

In Dr. Weil's deposition, he testified "the substantial cause" was one "greater than 50 percent" as "the reason for someone to develop an issue." Again, this is contrary to the medical-legal standard set forth in *Morrison*. Dr. Weil's misunderstanding may have tainted his opinions. He diagnosed bilateral epicondylitis because Employee had a positive, provocative Cozen's test, which is used to help diagnose that condition. Dr. Weil found reduced motion in Employee's elbow and shoulder, and pain that he found not in proportion to his objective findings. He found no atrophy in her arms, which he took to mean Employee was using her arms in a relatively normal fashion. This is understandable, as Employee continued to work for Employer in her normal job duties. Like Dr. Kirkham, Dr. Weil failed to consider this fact, or failed to account for it adequately, which further reduces the weight and credibility given to his opinion. AS 23.30.122; *Smith*; *Moore*.

Contrary to his written report, when asked to choose one cause as "the substantial cause" of Employee's epicondylitis, Dr. Weil testified, "essentially, her overall deconditioning is really the cause for that." His report said it was "multifactorial." This is where his opinions become inconsistent and confusing. He agreed Employee's work for Employer "may be a contributory factor," but reiterated it was "not the substantial cause." Dr. Weil agreed with Dr. Kirkham's statement that there was "no objective evidence of occupational injury." Like Dr. Kirkham, Dr. Weil did not explain what objective symptoms, if any, exist for lateral epicondylitis. Based on the three articles Employee filed as evidence, there appears to be little if any objective evidence of epicondylitis, except for post-surgical specimens from elbow joints of people diagnosed with the condition, which showed micro-tearing: Laboratory tests may rule out other causes but will not diagnose epicondylitis. Diagnostic imaging is generally not useful in diagnosing epicondylitis, and swelling may or may not be present. Other than subjective but positive provocative tests for epicondylitis, which Employee repeatedly had (with Dr. Kirkham as the notable exception), subjective pain at the appropriate points appears to be the determining factor. This again diminishes weight and credibility given to Dr. Weil's opinions. AS 23.30.122; *Smith*; *Moore*.

Dr. Weil opined Employee would have developed bilateral epicondylitis even if she was not working at all. He failed to explain this conclusory statement and his opinion is questionable since he also testified that the cause of epicondylitis is "unknown." Likewise, it is unknown and unknowable what Employee's elbows would be like today "but for" her work for Employer. *Traugott*. Dr. Weil's opinions on this point is given less weight and credibility because it is speculative. AS 23.30.122; *Smith*; *Moore*.

On cross-examination, Dr. Weil retreated to his original causation determination that the substantial cause is "multifactorial," but qualified that by stating the exact cause is "truthfully . . . unknown." He acknowledged that epicondylitis could be caused by "activities that require repetitive use." Dr. Weil noted, primarily from Dr. Kirkham's report, Employee's "kind of ill-defined pain throughout her upper extremities," which he did not find on his own examination. He stated lateral epicondylitis does not cause shoulder stiffness or pain into the hands. However, Dr. Weil failed to consider that Employee contends neither her shoulder nor her hands have fully healed from her right shoulder or bilateral CTS surgeries, which could account for symptoms in

her hands and shoulder. He noted Employee is "a gardener," implying this contributed to her symptoms. But he never included gardening as a possible cause in his list of causes and the only evidence in the file regarding gardening is that Employee said she no longer does it. Her testimony on that point was credible; his was not. AS 23.30.122; *Smith*; *Moore*.

When asked if he thought Employee's continued work for Employer aggravated her elbow complaints, Dr. Weil initially could not say. However, and most notably detracting from the weight and credibility assigned to his opinions, Dr. Weil subsequently stated:

> Q. And you testified, I believe, that it was possible that [Employee's] work activities can contribute to her condition. Would you say it's probable?
>
> A. I mean, I would say it's -- you know, with lateral epicondylitis, anything is sort of possible, right? So, yeah, its -- I would say it's possible.
>
> Q. But is it probable?
>
> A. It may be, yes. But again, I don't think it's the substantial cause for her current condition.

In other words, it "may be" even "probable" that Employee's work activities contribute to her bilateral epicondylitis. Since most physicians in this case, and all three articles Employee filed as evidence in this case, agree that repetitive use may cause epicondylitis, it is not surprising that Employee's continued work for Employer causes continued elbow symptoms. One article Employee filed included "cooks" as people who develop epicondylitis more often than the general population. Nevertheless, Dr. Weil still did not believe Employee's work for Employer was "the substantial cause" for her "current condition." He did not explain this possible contradiction. It may be that this is his opinion simply because Dr. Weil misunderstands the medical-legal causation standard. As was the case with Dr. Kirkham, Dr. Weil applied an incorrect causation standard. Dr. Weil incorrectly believes Employee's work must have caused the underlying epicondylitis "condition." He erroneously focused on the "type of *injury*." *Morrison*. Employee's work did not have to cause the condition; it simply needed to be "a cause," and be "the substantial cause" for the need to treat her elbow symptoms. *Traugott*; *Morrison*. "The substantial cause" standard does not require "a pathological change in a condition in order to establish compensability."

Morrison. This misunderstanding reduces the weight and credibility accorded Dr. Weil's opinions. AS 23.30.122; *Smith*; *Moore.*

Lastly, and a minor point, Dr. Weil's report is template-based, and his initial version included a different worker's name. When this was brought to his attention, he replaced his initial report, but the replacement incorrectly states Employee lives in California. This sloppiness and lack of attention to detail detracts from the weight given to his opinions. Based on the above analyses, Dr. Weil's opinions will be given some weight, particularly on his bilateral epicondylitis diagnosis, because it comports with other orthopedic surgeons with expertise in upper extremities. On other issues, it will be given less weight for the reasons noted above. AS 23.30.122; *Smith*; *Moore*.

C. Attending physician Dr. Mentzer.

Dr. Mentzer is an orthopedic surgeon with a specialty in upper extremities; 80 percent of his patients have upper extremity problems. He saw Employee more than any other physician in this case and consistently diagnosed bilateral epicondylitis, and based on her history and provocative testing, attributed it to her work with Employer. Dr. Mentzer found Employee credible and "very straightforward." He was never concerned about her "making something up." She responded positively to "very specific" provocative epicondylitis tests. He understood her job duties with Employer and opined it was "absolutely" something that could cause epicondylitis, which he described as an overuse injury involving micro-tearing of the elbow tendon. This opinion also comports with the three articles Employee filed to support her case.

Dr. Mentzer considered Employee's work to include "lifting heavy items multiple times a day," with her arms in "different positions." Having listened to Employee's testimony and having seen the photographs she took of her workplace, the panel agrees. In Dr. Mentzer's mind, there was "no question" that Employee's work for Employer was causing not only her need for treatment, but the epicondylitis itself. *Morrison*. He unequivocally testified that Employee's work activity for Employer was "the substantial cause" of her bilateral epicondylitis. Contrary to Employer's contention, although Dr. Mentzer did not review Dr. Weil's deposition and was not aware of "a history of upper extremity complaints," this does not detract from Dr. Mentzer's causation opinion. As discussed above, Employee's "history of upper extremity complaints" was all work-related and

attributable to repetitive use and (except perhaps for her right-shoulder injuries chopping ice and then lifting a heavy box). According to the *GEDIC* upon which Dr. Kirkham relied, people with medial epicondylitis, which Employee has, have "a significantly higher prevalence of other work-related upper-limb musculoskeletal disorders." This factor also comports with Employee's history. AS 23.30.122; *Smith*; *Moore*.

Detracting minimally from Dr. Mentzer's opinion was his statement that nothing other than repetitive activities can cause epicondylitis. AS 23.30.122; *Smith*; *Moore*. However, Dr. Weil said epicondylitis is a "controversial" diagnosis and its cause is considered "unknown." Therefore, even though Dr. Mentzer's general causation statement is at odds with other medical evidence in the agency file, in context it does not significantly detract from his other opinions. He affirmed that epicondylitis symptoms can "absolutely radiate," which could explain some findings of "diffuse" symptoms in Employee's arm. One article Employee filed as evidence noted that tenderness can involve the entire associated tendon. Dr. Mentzer reviewed these three articles and found them "very consistent" with his experiences treating and diagnosing epicondylitis. Lastly, since Dr. Mentzer no longer practices in Anchorage, and will not provide any further medical services to Employee, he has no apparent pecuniary interest in this case. His opinions therefor are given significant credibility and weight. AS 23.30.122; *Smith*; *Moore.*

D. Attending physician Dr. Paisley.

Dr. Paisley is also an orthopedic surgeon who did a shoulder and elbow surgery fellowship. He now specializes in shoulder and elbow surgery. He commonly sees patients with epicondylitis and estimates he has treated 1,000 people with this condition in the last 10 years. With exception of Dr. Mentzer, Dr. Paisley has seen Employee four times more than any other relevant physician in this case. When Dr. Mentzer left the practice, Dr. Paisley took over Employee's care for her bilateral elbows. Contrary to Employer's assertions, he did his own examination and came to his own diagnoses which, he noted after reviewing the clinic file were "consistent with Dr. Mentzer's." Dr. Paisley did not simply rely on Dr. Mentzer's opinions. He too diagnosed bilateral medial and lateral epicondylitis. Dr. Paisley also diagnosed a subluxing ulnar nerve, which he opined added to Employee's symptoms. He defined Employee's symptoms as an "overuse" syndrome. Dr. Paisley based his diagnosis on her history, symptoms and physical examination. She responded

to "specific" provocative tests used to diagnose epicondylitis. Dr. Paisley opined that diagnostic imaging is not necessary to diagnose epicondylitis. This is consistent with the articles Employee filed to support her position. Dr. Paisley agreed with Dr. Mentzer's diagnoses and treatment recommendations. He opined Employee may need surgery given that conservative treatment had failed to this point. He found no symptom magnification or invention and stated Employee's symptoms seen "exceptionally legitimate." He found no evidence of nonspecific, intense and diffuse symptoms. His opinions are credible. AS 23.30.122; *Smith*; *Moore.*

Dr. Paisley testified he had worked in a kitchen and knows what it takes to prepare food, plates and other items and knows it is a "repetitive business." In his opinion, it is the kind of work that could cause a person to have medial and lateral epicondylitis. *Traugott*. He correctly understood Employee's job to include loading and unloading heavy boxes, pushing carts around, and putting pans in and out of ovens, and testified these are things that could cause epicondylitis. *Traugott*. He disagreed with Dr. Weil and in his opinion, it is "highly unlikely" Employee would have the same condition due to age or genetics if she was just at home sitting on her couch.

Dr. Paisley also misunderstands "the substantial cause." However, his misunderstanding of the medical-legal causation standard does not detract from his credibility, or the weight given to his opinion, because his understanding creates a higher bar than necessary to prove causation and compensability. *Morrison*. He opined Employee's evidence meets that higher bar, whereas Drs. Kirkham and Weil stated it did not. Given the above analysis, Dr. Paisley's opinions will be given significant credibility and weight. AS 23.30.122; *Smith*; *Moore.*

E. The other witnesses.

Employee's deposition and hearing testimony was convincing and credible. AS 23.30.122; *Smith*. Likewise, so was Ostlund's, who corroborated Employee's testimony. Employee is only four feet 11 inches tall. Her workplace photographs clearly demonstrated the heights and weights with which she deals each day while at work for Employer. Her work is repetitive and subjectively heavy, especially for a relatively diminutive person. The panel disagrees with Dr. Kirkham's opinion that it would require lifting hundreds of 50 pound boxes per day to be considered "forceful" lifting. At least one of the articles Employee filed as evidence belies Dr. Kirkham's

opinion and lists "cooks" as among those workers who perform repetitive duties that can cause epicondylitis in greater numbers than the general public.

The medical and lay evidence viewed in its totality shows that Employee's work for Employer is the "most important or material cause" of her bilateral elbow symptoms and the need to treat them. *Morrison*. Moreover, the weight of credible, non-speculative evidence shows that "but for" her work for Employer, Employee's bilateral elbow symptoms and need to treat them would not have happened at the time, in the way or to the degree that they did. *Traugott*. Employee's bilateral epicondylitis and related symptoms arose out of and in the course of her employment with Employer, and are compensable work-related injuries. AS 23.30.010(a); AS 23.30.395(24); *Moore*; *Saxton*.

2) Is Employee entitled to medical and related benefits for her bilateral epicondylitis?

As Employee's bilateral epicondylitis and related symptoms are compensable injuries, Employer must furnish medical and other attendance or treatment for the period for which the nature of the injury or the process of recovery requires. AS 23.30.095(a). Employer will be directed to pay for Employee's elbow examinations, and other reasonable and necessary elbow-related treatments including those Dr. Paisley recommended, all subject to the Act, administrative regulations and the Alaska Medical Fee Schedule. Since Employee has not filed any medical billings for past services, this decision will not address her interest claim.

3) Is Employee entitled to attorney fees and costs?

Employer controverted Employee claim. Consequently, she is entitled to an attorney fee and cost award under AS 23.30.145(a). Employee seeks attorney fees and costs for past services rendered in this successful claim. Employer did not object to Franklin's hourly rate or to the time expended on this case, with exception of time spent on Dr. Mentzer's subpoena and on copying hearing exhibits. In reviewing an attorney fee request, this decision must consider factors below in italics from Professional Rule 1.5(a). *Rusch*. Franklin's thorough initial and supplemental attorney fee affidavit provided an excellent basis to apply Rule 1.5(a) to this case. 8 AAC 45.180(b), (f). To preserve space, factual finding 68, above, is incorporated here by reference:

(1) *The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly*: Franklin demonstrated the skill requisite to perform the services properly and diligently.
(2) *The likelihood that the acceptance of the particular employment will preclude other employment by the lawyer*: The time he spent representing Employee was not available to represent Another clients, or to accept new clients.
(3) *The fee customarily charged in the locality for similar legal services*: Franklin's hourly rate is the same as customarily charged rate for similar legal services in the local community.
(4) *The amount involved, and the results obtained*: Franklin vigorously represented Employee, and obtained medical benefits for her injuries.
(5) *The time limitations imposed by the client or by the circumstances*: Franklin turned down family and criminal defense cases because he was committed to work on this case.
(6) *The nature and length of the professional relationship with the client*: This case took an average time to complete.
(7) *The experience, reputation, and ability of the lawyer performing the services*: Franklin is an experienced attorney and did an excellent job representing Employee in this case. His briefing, preparation and presentation at hearing on the primary issue helped the fact-finders make their decision. He has a good reputation.
(8) *Whether the fee is fixed or contingent*. Franklin's attorney fees in his workers' compensation cases are contingent.

Employer's objection to Franklin's "late-filed" supplemental attorney fee and cost itemization is considered but denied. Franklin provided evidence showing he attempted to file his supplemental fee affidavit on November 20, 2024, as directed. Schwarting received it, but the Division initially did not. It cannot be determined from the record whether the Division received the supplemental filing because if it did, and if Division staff inadvertently filed it in the wrong case electronically, it is virtually impossible to locate it at this point. Employer had an opportunity to object to the supplemental affidavit and did so. Thus, it was not prejudiced. Moreover, excluding Franklin's minimally late supplemental fee affidavit would deprive him of considerable attorney fees and would amount to an abuse of discretion under these facts. *Israelson*; 8 AAC 45.063(b).

Franklin's explanation for Dr. Mentzer's subpoena, which he never used, is reasonable. Obtaining a subpoena for a witness is a normal part of litigation. 8 AAC 45.180(f). Employer's objection to time incurred on this item is considered but it is also denied. Therefore, $3,314.66 will be added to Franklin's initial attorney fee and cost affidavit as well as the additional $1,200 costs for Dr. Mentzer's deposition. Considering the *Rusch* factors as required, and Employer's objections, Employee's attorney fees and costs are well-documented and reasonable. This decision will award a $25,521.80 ($21,007.14 + $3,314.66 + $1,200 = $25,521.80) in full, reasonable fees and costs. *Cortay*; *Bignell*; 8 AAC 45.180(f).

CONCLUSIONS OF LAW

1) Employee's bilateral epicondylitis arose out of and in the course of her employment with Employer.
2) Employee is entitled to medical and related benefits for her bilateral epicondylitis.
3) Employee is entitled to attorney fees and costs.

ORDER

1) Employee's September 17, 2024 amended claim is granted.
2) Employer is ordered to pay past and ongoing medical bills for Employee's bilateral epicondylitis in accordance with the Act, administrative regulations and the Alaska Fee Schedule.
3) Employer is ordered to pay Franklin $25,521.80 in full, reasonable attorney fees and costs.

Dated in Anchorage, Alaska on December 3, 2024.

ALASKA WORKERS' COMPENSATION BOARD

/s/
William Soule, Designated Chair

/s/
Bronson Frye, 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 Christine M. Johnston, employee / claimant v. Anchorage School District, self-insured employer; defendant; Case No. 202202471; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by certified US Mail on December 3, 2024.

/s/
Lisa Clemens, Office Assistant