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COURT OF APPEALS
DIVISION II

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STATE OF WASHINGTON
BY _____
DEPUTY

No. 41351-5-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

CATHY THARALDSON, Respondent,

v.

PROVIDENCE HEALTH AND SERVICES OF WASHINGTON,
Appellant.

BRIEF OF APPELLANT

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I. INTRODUCTION

This case involves an appeal from a Superior Court Judgment and Order that reversed, by way of a jury verdict, a Board of Industrial Insurance Appeals (Board) order that had affirmed a Department of Labor and Industries (Department) order that closed Ms. Tharaldson's workers' compensation claim. The issue involves whether Ms. Tharaldson's condition, caused by the industrial injury, was in need of any further proper and necessary medical treatment as of October 10, 2008.

II. ASSIGNMENT OF ERROR

A. Assignments of Error

1. The trial court erred in entering the Judgment and Order of October 8, 2010, that reversed the Board order of December 7, 2009, and remanded the claim to the Department with instructions to reopen the claim, effective October 8, 2008. CP[1] 82-84.
2. The trial court erred in awarding attorney fees ($8,700.00) and costs ($2,555.15) on October 8, 2010. CP 82-84.

[1] CP refers to Clerk's Papers, filed with the Court of Appeals.

3. The trial court erred in refusing Defendant's Proposed Jury Instruction No. 11. CP 35-53, RP[2], p.3-4.

B. Issues Pertaining to Assignments of Error

1. Did Ms. Tharaldson's condition, proximately caused by the November 8, 2006, injury to her neck and right shoulder, require further proper and necessary medical treatment, as contemplated by RCW 51.36.010, as of October 10, 2008? (Assignments of Error 1-2.)

III. STATEMENT OF THE CASE

A. Statement of Procedure

On November 29, 2006, Ms. Tharaldson filed an application for benefits, under Washington workers' compensation claim number SB78576, for an injury she sustained on November 8, 2006. CABR[3] 40. On October 10, 2008, the Department issued an order that closed this claim with time loss compensation ended as paid to January 20, 2007, and without further award for time loss or permanent partial disability. CABR 30.

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[2] RP refers to the partial Verbatim Report of Proceedings, filed on November 29, 2010.

[3] CABR refers to the Certified Appeal Board Record transmitted with the Clerk's Papers concurrently with the Certificate of Appeal Board Record. Clerk's Papers 11.

Ms. Tharaldson filed a timely appeal on October 26, 2008, from the October 10, 2008, closing order. CABR 32. The Board received this appeal on October 29, 2008, and granted the appeal on December 1, 2008. CABR 32, 36.

Following testimony and publication of perpetuation depositions, Industrial Appeals Judge Wayne B. Lucia issued a Proposed Decision and Order on October 15, 2009. CABR 20-29. Judge Lucia concluded that as of October 10, 2008, the date of the closing order, Ms. Tharaldson's condition, proximately caused by the industrial injury, did not require further proper and necessary medical treatment, as contemplated by RCW 51.36.010. CABR 28. Accordingly, he affirmed the Department closing order of October 10, 2008. *Id.*

On November 25, 2009, Ms. Tharaldson filed a Petition for Review from the October 15, 2009, Proposed Decision and Order. CABR 3-9. The Board considered the Petition for Review and the three members unanimously issued an Order Denying Petition For Review on December 7, 2009. CABR 2. This order adopted the Proposed Decision and Order as the Decision and Order of the Board. *Id.*

Ms. Tharaldson filed a timely appeal to Thurston County Superior Court on December 30, 2009. CP 4-5. Following a jury trial before The Honorable Richard D. Hicks, on September 27-28, 2010, the jury reached a unanimous verdict on September 28, 2010. RP 44-45. The six-person jury unanimously found that the Board was not correct in deciding that as of October 10, 2008, Ms. Tharaldson's condition, proximately caused by the industrial injury, did not require further proper and necessary medical treatment and had reached maximum medical improvement. *Id.,* CP 54.

The Court entered a Judgment and Order on October 8, 2010, that reflected this jury verdict and awarded Ms. Tharaldson's counsel attorney fees and costs, totaling $11,255.15. CP 82-84.

On October 27, 2010, Providence Health and Services of Washington (Providence), the self-insured employer in this matter, filed a timely appeal to the Court of Appeals, Division II. CP 85-89. The partial Verbatim Report of Proceedings was filed on November 29, 2010.

B. Statement of Facts

1. The November 8, 2006, Industrial Injury and Claimants' Testimony

Ms. Tharaldson sustained an injury while in the course of employment with Providence at St. Peter's Hospital on November 8, 2006. 08/10/09 Tr. at 6-7[4]. She injured her neck, shoulder, and upper back while cleaning, rolling and holding a 400-pound-plus patient who was incontinent of diarrhea. *Id.* at 6-7, 14-15.

Ms. Tharaldson also indicated that she has been taking Dilantin since age 12 for control of epileptic seizures. *Id.* at 15.

Mariel Plaeger-Brockway, M.D., was Ms. Tharaldson's primary doctor for this claim following the injury. *Id.* at 16-17. However, at the time she stopped treating with Dr. Plaeger-Brockway, the only treatment necessary was more physical therapy. *Id.* at 17. In Ms. Tharaldson's opinion, she had run the course of all physical therapy, massage therapy and chiropractic treatment. *Id.* at 9. The only treatment she was seeking as of October 2008, were cortisone injections from Dr. Lang for pain in her neck, and right shoulder. *Id.* 10-11.

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[4] Hearing and deposition transcripts contained in the CABR are referred to by the date of the hearing or deposition.

2. Medical Testimony

a. Robert G.R. Lang, M.D.

Of the three physicians to testify in this case before the Board, only Robert G.R. Lang, M.D., testified on Ms. Tharaldson's behalf. CABR 20-28. Dr. Lang, a board certified neurosurgeon, first examined Ms. Tharaldson on November 6, 2007, nearly one year after her November 8, 2006, injury. 08/05/09 Tr. at 5, 7. He never reviewed prior medical records for this claim from Mariel Plaeger-Brockway, M.D. *Id.* at 25-26. His initial diagnosis consisted of a right C6-7 radiculopathy, or a pinched nerve in the neck, from a disc herniation on the right side between the 6th and 7th cervical vertebra. *Id.* at 8. He estimated he examined her about 15 times from November 6, 2007, through January 21, 2009. *Id.* at 8.

Dr. Lang was aware Ms. Tharaldson had been taking Dilantin, an anticonvulsant, on a daily basis since age 12, and that she was 48 years old at the time he saw her. *Id.* at 32. When asked about any symptoms of numbness or tingling radiating down Ms. Tharaldson's neck to her arms, he only noted she was experiencing numbness and tingling in her fingers and feet at times. *Id.* at 16-17. He also felt it would be a reasonable consideration that Dilantin was a cause of her nerve problems if she was having numbness in her fingers and toes. *Id.* at 33.

Dr. Lang stated that his treatment of Ms. Tharaldson up to October 10, 2008, consisted of anti-inflammatory medication, a hard cervical collar and an EMG and nerve conduction study. *Id.* at 9-10. As of October 10, 2008, his only treatment recommendation for Ms. Tharaldson was up to three right epidural steroid injections at the C6-7 level. *Id.* at 12, 23-24.

Dr. Lang reviewed a September 2, 2007, cervical MRI of Ms. Tharaldson, and agreed that the images revealed a right disc bulge with spurring, which he described as a right posterior disc herniation, which abuts, but does not clearly compress the cord at C6-7. *Id.* at 13-14.

Dr. Lang further testified that Ms. Tharaldson had weakness of the right triceps muscle on examination that fluctuated, meaning sometimes he found it and sometimes he did not. *Id.* at 13-14. On December 16, 2007, he noted Ms. Tharaldson, who was right arm dominant, had a half "sontimeter" difference in muscle measurements, with 28 "sontimeters" for her right arm and 28.5 "sontimeters" for her left arm. *Id.* at 15. However, overall, he felt her muscle atrophy had decreased over time. *Id.* at 37.

He reviewed a January 25, 208, electrodiagnostic test on Ms. Tharaldson and noted the results did not find nerve changes to the pinched nerve in the neck, and did not assist with the diagnosis of cervical radiculopathy. *Id.* at 21, 28.

Dr. Lang reviewed a second electrodiagnostic test on Ms. Tharaldson, taken on October 1, 2008, and agreed that test showed no electrodiagnostic evidence of cervical radiculopathy in either arm. *Id.* at 33-34. Dr. Lang is not a neurologist and does not do that type of testing. *Id.* at 23.

b. Edward DeVita, M.D.

Edward DeVita, M.D., a board certified neurologist, examined Ms. Tharaldson on August 13, 2008. 08/17/09 Tr. at 5, 7 and 8-9. He noted her prior medical history, and also noted that significant to this particular evaluation, was the fact that she was taking two significant medications, Dilantin and Levothroid, that had direct and indirect consequences for peripheral neuropathy. *Id.* at 12-13. He indicated Dilantin had a toxic side effect of the nerves, causing peripheral neuropathy, and Levothroid was given for individuals with low thyroid, which is also associated with peripheral neuropathy, especially women at a high rate. *Id.* at 13.

Dr. DeVita reviewed records from Dr. Plaeger-Brockway, and noted the treatment for a year was mostly for a thoracic strain, with no suspicion of radiculopathy or anything of that nature for a period of at least a year. *Id.* at 16. He performs electrodiagnostic studies all the time, and reviewed the January 25, 2008, nerve conduction velocity study on Ms. Tharaldson. *Id.* at 18.

He felt that test showed very mild, moderate sensory carpal tunnel and no motor involvement, which was commonly found in drug effects and hypothyroid and peripheral neuropathy. *Id.* at 19. Dr. DeVita also reviewed the October 1, 2008, EMG and nerve conduction velocity test. *Id.* at 20. He opined that the nerve conduction velocity tests showed mild sensory, not motor, carpal tunnel, which again pointed to peripheral neuropathy. *Id.* at 20. The EMG testing of October 1, 2008, was entirely normal, according to Dr. DeVita, and in particular did not show any evidence of radiculopathy. *Id.* at 20, 16-17.

Dr. DeVita opined that an EMG is close to 100% in showing an abnormality if there is a problem from a nerve in the neck. *Id.* at 21. He stated that EMG findings have to be abnormal if there is atrophy or loss of reflex. *Id.* at 22.

He read cervical imaging films as well, dated June 15, 2007, and September 2, 2007, and noted there was no evidence for a herniation or nerve-root impingement. *Id.* at 17. In particular, he noted that there was no clinical correlation from the scans with her examination findings. *Id.* at 17. He indicated her MRI findings are not at all suggestive that a nerve root is being clearly pinched. There was no neuroforaminal narrowing, which he would expect if there were a nerve getting pinched, so the findings were consistent with a C6-7 degenerative disc bulge. *Id.* at 50.

On review of the records, he felt the described injury was kind of vague and not really classic for an acute herniated disk. *Id.* at 22. On examination he noted she had a "pretty darn good" range of neck motion, which he would not expect with a severe herniated disc with nerve impingement going down the right arm. *Id.* at 24. He also noted there were no specific palpable tenderness and no spasm with Ms. Tharaldson, which he would expect if there were any thing significant going on in her neck. *Id.* at 25. Her two-point discrimination test was normal as well. *Id.* at 25.

Based on vibration testing using a vibratory fork, he determined Ms. Tharaldson had significant peripheral neuropathy, bilaterally. *Id.* at 26. He noted she had no atrophy and normal tone, and indicated if there were any atrophy, there would also be decreased tone and flabbiness to the muscle. *Id.* at 27. He noted all measurements of the circumference were symmetric bilaterally. *Id.* at 27. Responding to Dr. Lang's testimony on atrophy, Dr. DeVita noted that atrophy does not come and go with radiculopathy, it comes and stays, and if it changes it's going to actually get worse. *Id.* at 35-36. With regard to circumferential measurements, Dr. DeVita indicated such a test using a tape measure is not super sensitive and that is why at least one centimeter of variability is allowed in the arms. *Id.* at 36.

With reflex testing, Dr. DeVita noted Ms. Tharaldson's reflexes were severely depressed, but symmetric bilaterally, absolutely consistent with peripheral neuropathy in an of itself, and had nothing to do with any type of radiculopathy in the upper or lower extremities. *Id.* at 28. He added that you couldn't make a diagnosis just on reflex testing. *Id.* at 44.

Dr. DeVita felt Ms. Tharaldson's cervical and right shoulder sprain were resolved, and there was no need for further curative treatment as a result of the November 8, 2006, industrial injury. *Id.* at 30. This was as of October 8, 2010, on a more probable than not basis. *Id.* at 38.

With regard to the recommended epidural steroid injections, he felt that they were contra-indicated and may be a disservice in that there are no radicular features and there are significant potential side effects. *Id.* at 35. When asked to address whether the proposed treatment would have an effect on Ms. Tharaldson's physical functioning, he indicated the only thing he could see happen, if epidurals were performed, is that she could have a side effect and they make her tremendously worse. *Id.* at 37

c. <u>Patrick Bays, D.O.</u>

Patrick Bay, D.O., is a board certified orthopedic surgeon that examined Ms. Tharaldson on May 29, 2008. 08/24/09 Tr. at 5, 7 and 9. He noted the major area of her pain at the time of his examination was in the right side of her cervical spine, and into the right trapezius. *Id.* at 15.

She also reported transient numbness and coldness affecting all digits of both the right and left hands. *Id.* at 16. Specifically, Ms. Tharaldson indicated the neck pain was localized to the cervical spine and would not radiate into the right or left upper extremities. *Id.* at 16. Dr. Bays concluded that there were no signs of any type of radicular component to the pain complaints. *Id.* at 16. He also noted she was taking Dilantin and Levothyroxine. *Id.* at 17.

Dr. Bays reviewed multiple imaging studies. A June 15, 2007, cervical spine x-ray showed some mild narrowing at the C5-6 level, with evidence of spurring or degenerative changes at multiple levels. *Id.* at 18. An MRI scan of September 2, 2007, revealed similar degenerative findings at multiple levels, and showed a right-sided posterior disc herniation at the C6-7 level that was slightly effacing, or bumping into, or touching the spinal canal. *Id.* at 19.

On examination, he noted a complete normal posture with no evidence of any visible or palpable muscle spasm, no discomfort on touching any body parts, particularly to the trapezius muscle. *Id.* at 21-22. He also noted there was no evidence of any atrophy. *Id.* at 22. She demonstrated an essentially normal range of cervical motion and all motions were accomplished without any signs of pain or discomfort. *Id.* at 22-23.

Ms. Tharaldson also had a completely normal range of shoulder motion, and normal range of motion to her elbows, forearms, wrists, and all digits of both hands. *Id.* at 24. She had normal motor strength, normal reflexes, and a symmetric absence of a triceps reflex, which he felt appeared to be something normal for her. *Id.* at 24-25. In essence, Dr. Bays indicated she had an entirely normal neurological examination as well. *Id.* at 26.

Dr. Bays diagnosed a cervical strain and sprain, and right shoulder strain, by history, because at the time of his examination Ms. Tharaldson was having no objective findings of either a shoulder strain or cervical strain. *Id.* at 28-29.

Together with Dr. Almaraz, he opined that the two electrodiagnostic studies, dated January 25, 2008, and October 1, 2008, showed only evidence for mild to moderate right-sided carpal tunnel syndrome, not related to the November 8, 2006, injury. *Id.* at 29. He concluded that on the basis of all the records he reviewed, his interview with Ms. Tharaldson, and the lack of any specific objective physical findings on examination, there was no evidence of any need for additional diagnostic or therapeutic treatment or intervention as it related to the November 8, 2006, injury. *Id.* at 30.

He added that having had an adequate opportunity to undergo conservative treatment, it would be disingenuous to think that additional conservative treatment would afford the positive benefits to alleviate any of the subjective complaints of pain. *Id.* at 31.

In addressing Dr. Lang's recommendation, Dr. Bays felt that based on objective information there was no cervical radiculopathy. *Id.* at 41. Thus, he felt Dr. Lang was basing his treatment recommendations on the fact that there was some sort of radiculopathy, however, Dr. Bays had not seen a radiculopathy objectively, nor had there been any objective tests done by other examiners that had shown a radiculopathy. *Id.* at 41.

In regard to improving functionality and curing any conditions, Dr. Bays also opined that the three epidural injections would not do anything because she did not show evidence of a radiculopathy and she has a degenerative condition of the cervical spine, for which epidural steroid injections are not indicated. *Id.* at 41.

Thus, he concluded she was at maximum medical improvement, as result of the November 8, 2006, injury, as of October 10, 2008, on a more probable than not basis. *Id.* at 43-44.

IV. ARGUMENT

A. Standard of Review

Under Washington law, the Board's decision is prima facie correct and the burden of proof is on the party attacking that decision. *Ruse v. Department of Labor & Industries,* 138 Wn.2d 1, 5 (1999); *see also* RCW 51.52.115. On review, the trier of fact, in this case a jury, may substitute its own decision only if it finds by a preponderance of the evidence that the Board's findings were incorrect. *See Ruse,* 138 Wn.2d at 5.

When reviewing a superior court decision resulting from an appeal from the Board, review is limited to an "examination of the record to see whether substantial evidence supports the findings made after the superior court's de novo review, and whether the court's conclusions of law flow from the findings." *See Ruse*, 138 Wn.2d at 5-6; *Bennet v. Department of Labor & Industries,* 95 Wn.2d 531, 534 (1981).

This court's review of whether the trial court's conclusions of law flow from the findings is also de novo. *Watson v. Department of Labor & Industries,* 133 Wn.App. 903, 909 (2006) (citing *Ruse*, 138 Wn.2d at 5). However, this court does not reweigh or rebalance the competing testimony and inferences, or apply anew the burden of persuasion, for doing that would abridge the right to a trial by jury. *Harrison Memorial Hospital v. Gagnon*, 110 Wn.App.475, 485 (2002).

Review of the evidence is made in the light most favorable to the party that prevailed before the jury. *See Bennett*, 95 Wn.2d at 534. Substantial evidence is defined as a quantum of evidence sufficient to persuade a rational fair-minded person the premise is true. *Harrison Memorial Hospital v. Gagnon*, 110 Wn.App.475, 485 (2002).

This court does not review credibility determinations on appeal. *In re Marriage of Rideout,* 150 Wn.3d 337, 350 (2003).

B. <u>Further Proper and Necessary Treatment</u>

There is but one statute that addresses the issue of treatment in worker's compensation cases. RCW 51.36.010, indicates in part, that "Upon the occurrence of any injury to a worker entitled to compensation under the provisions of this title, he or she shall receive *proper and necessary* medical and surgical services at the hands of a physician..." (Emphasis added). This statute further states, in part, "In all accepted claims, treatment shall be limited in point of duration as follows: .... That after any injured worker has returned to his or her work his or her medical or surgical treatment may be continued if, and so long as, such continuation is deemed necessary by the supervisor of industrial insurance to be necessary to his or her more complete recovery..." RCW 51.36.010.

Recently, the Court of Appeal, Division I, discussed reasonable and necessary treatment in *Rogers v. Department of Labor & Industries,* 151 Wn.App. 174 (2009). While the facts of that case are distinguishable from this case in that *Rogers* addressed unauthorized surgery that proved to be a failure, and thus involved a hindsight analysis to determine that surgery was not reasonable and necessary, the case points to other sources for addressing the problem before this court.

Specifically, the *Rogers* court looks to WAC 296-20-01002, a definitional section in the Medical Aide Rules, for the meaning of "proper and necessary." One definition of "proper and necessary" refers to health care services that are curative or rehabilitative. Care must be of a type to cure the effects of a work-related injury or illness, or it must be rehabilitative. Curative treatment produces permanent changes, which eliminate or lessen the clinical effects of the accepted condition. Rehabilitative treatment allows an injured or ill worker to regain functional activity in the presence of an interfering accepted condition. Curative and rehabilitative care produce long-term changes. WAC 296-20-01002.

This definitional section also states, "The department or self-insurer stops payment for health care services once a worker reaches a state of maximum medical improvement.

Maximum medical improvement occurs when no fundamental or marked change in an accepted condition can be expected, with or without treatment. Maximum medical improvement may be present though there may be fluctuations in levels of pain and function. A worker's condition may have reached maximum medical improvement though it might be expected to improve or deteriorate with the passage of time. Once a worker's condition has reached maximum medical improvement, treatment that results only in temporary or transient changes is not proper and necessary. "Maximum medical improvement" is equivalent to "fixed and stable."

"Fixed" is a term long familiar with the court. "Thus, the term 'fixed' does not mean 'static.' It is clear that where a claimant's condition is deteriorating or further medical treatment is contemplated, the condition is not 'fixed' and the claim remains open. However, if a claimant's condition has stabilized to the point where no further medical treatment is required, the condition is 'fixed' for purposes of closing the claim and determining the disability award." *Pybus Steel Company v. Department of Labor & Industries*, 12 Wn.App. 436, 439 (1975).

There is no question that rehabilitation was not an issue in this case. Ms. Tharaldson had resumed working full duty after only a few weeks of modified duty. 08/10/09 Tr. at 18.

Dr. Lang never indicated the epidural injections would change her ability to function. With his only treatment recommendation, consisting of three epidural steroid injections, he never clearly expressed what impact it might make other than trying to get rid of inflammation. 08/05/09 Tr. at 23.

However, there was no objective evidence for this inflammation. Further, it is clear that Dr. Lang made an initial diagnosis of cervical radiculopathy on his first examination of Ms. Tharaldson, and refused to alter that diagnosis on subsequent examinations despite insignificant circumferential measurements of her arm, an absence of radiating symptoms from the neck down through the arm, an MRI that showed no impingement on the C6-7 nerve, meaning no pinching or compression, and two sets of normal electrodiagnostic studies with regard to radiculopathy. As stated in the Proposed Decision and Order, Dr. Lang's diagnosis of radiculopathy from an impingement lacks empirical support. CABR 26. Essentially, Dr. Lang is recommending a series of epidural injections for a problem Ms. Tharaldson does not have.

In fact, even Dr. Lang admitted that if the injections did not work, he would just repeat conservative treatment. 08/05/09 Tr. at 25.

On the other hand, Dr. Bays correctly noted that having gone through all of those types of conservative treatments in the first year before seeing Dr. Lang, it would be disingenuous to think that additional conservative treatment would afford any positive benefits to alleviate any of these subjective complaints of pain. 08/24/09 Tr. at 31. Dr. Bays also indicated epidural injections would not improve functionality or cure any condition because Ms. Tharaldson does not show evidence of a radiculopathy. *Id.* at 41.

Dr. DeVita was more direct in responding to a recommendation for steroid injections, when he said that "there's no right arm stuff. There's some right shoulder symptoms, but that's not going to qualify for an ESI (epidural steroid injection), so that, in view of the EMG study being entirely normal, which as I look at the file, it has to be abnormal if there's an absent reflex for radiculopathy." 08/17/09 Tr. at 18.

Both Dr. DeVita and Dr. Bays noted on examination that there were not any true radicular features, true complaints, meaning coming from a nerve in the neck. *Id.* at 23, and 08/24/09 Tr. at 26.

Dr. DeVita even ventured to state that an epidural injection was actually contra-indicated and may be a disservice for Ms. Tharaldson in the absence of radicular features. 08/17/09 Tr. at 35.

Simply put, the substantial evidence in this record does not support the trial court's finding that Ms. Tharaldson's condition, proximately caused by the November 8, 2006, industrial injury, was in need of further reasonable and necessary treatment as of October 10, 2008. Dr. Lang holds onto his initial diagnosis of radiculopathy in the face of overwhelming evidence against it, both from his own examination and from all diagnostic tests. Both Drs. DeVita and Bays provided more thorough record reviews, more thorough examinations, and were unanimous in that the recommended treatment was for a problem Ms. Tharaldson did not have.

This is not a close call. There is substantial evidence Ms. Tharaldson did not exhibit radiculopathy symptoms and did not have objective findings of radiculopathy. Dr. Lang's efforts to recommend three epidural steroid injections lack empirical evidence and are neither likely to be curative or rehabilitative, given the overwhelming evidence that the problem the injections are meant to address does not exist.

The substantial evidence in this case just does not support the Superior Court finding, and the conclusion that Ms. Tharaldson's condition, proximately caused by the November 8, 2006, injury, was in need of further proper and necessary treatment does not flow from the facts in this case.

C. Attorney Fees

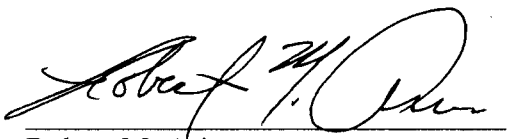
A worker is entitled to attorney fees where a court sustains his right to relief in an employer's appeal. *Young v. Department of Labor & Industries,* 81 Wn.App. 123, 132 (1996); RCW 51.52.130. Thus, upon a reversal of the superior court Judgment and Order of October 10, 2008, attorney fees are not payable.

V. CONCLUSION

Because of the foregoing reasons, Providence respectfully seeks a reversal of the Judgment and Order from superior court, a reversal of the fee and cost award, and a determination that Ms. Tharaldson's condition, proximately caused by the November 8, 2006, injury, was not in need of further proper and necessary treatment, per RCW 51.36.010, as of October 10, 2008, which would thus affirm the decision of the Board on December 7, 2009.

DATED this 11th day of January 2011.

Respectfully submitted,



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STATE OF WASHINGTON
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IN THE COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

CATHY THARALDSON, Respondent, v. PROVIDENCE HEALTH AND SERVICES OF WASHINGTON, Appellant.	))))))))))	No. 41351-5-II CERTIFICATE OF SERVICE

I certify that I caused a true and accurate copy of the foregoing BRIEF OF APPELLANT, to be served on the following parties in the manner indicated below on January 11, 2011:

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DATED this 11TH day of January, 2011.

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