ALASKA WORKERS' COMPENSATION BOARD

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

RAYMOND URREA,	)	
	)	FINAL
Employee,	)	DECISION AND ORDER
Applicant,	)	
	)	AWCB Case No. 200808100
v.	)	
	)	AWCB Decision No. 13-0145
RED ROBIN ALASKA, INC.,	)	
	)	Filed with AWCB Anchorage, Alaska
Employer,	)	on November 04, 2013
and	)	
	)	
REPUBLIC INDEMNITY CO. OF AMERICA,	)	
	)	
Insurer,	)	
Defendants.	)	
	)	

Raymond Urrea's (Employee) August 5, 2010 amended workers' compensation claim was heard on March 5, 2013, in Anchorage, Alaska, a date selected on November 29, 2012. Attorney Christopher Beltzer appeared and represented Employee, who appeared and testified. Attorney Michelle Meshke appeared and represented Red Robin Alaska, Inc. (Employer) and its workers' compensation insurer. The following witnesses testified on behalf of Employer: Ryan Faulkner, in person, and Eric Harris, M.D., telephonically; and SIME physicians Bruce McCormack, M.D., who testified both in person and by deposition; and Marvin Zwerin, M.D., who testified via deposition. The record remained open until May 15, 2013, for Employee's additional fee affidavits and Employer's objection to Employee's fee affidavits, and for the filing of Employee's treatment records up to the date of the hearing. The record closed when the panel next met on May 22, 2013.

ISSUES

Employee contends his April 8, 2008 work injury remains the substantial cause of medical care he received after the March 9, 2010 compromise and release (C&R) and Employer's September 28, 2010 controversion. This includes a January 12, 2012 right L3-L4 decompression and hardware removal surgery, and a December 18, 2012 revision L3 decompression with bilateral osteotomies L3, L3-L4 interbody fusion, bilateral L3-L4 intertransverse fusions and bilateral L3-L4 transpedicular stabilization. Employee further contends the September 28, 2010 controversion of his medical care was not based on new evidence as required by the March 9, 2010 C&R because it was based on a causation defense.

Employer contends if Employee's April 8, 2008 work injury ever was the substantial cause of Employee's need for treatment, it ceased to be the substantial cause of Employee's need for medical treatment as of the September 28, 2010 controversion. Employer contends Employee was excessively treated which is not reasonable and necessary, and, therefore, Employer should not be responsible for paying for the excessive and unsuccessful medical treatment. Employer further contends Employee suffered from a significant preexisting degenerative condition which overtook the April 8, 2008 work injury and became the substantial cause of Employee's need for further treatment overtaking the April 8, 2008 work injury.

1. *Is the April 8, 2008 work injury the substantial cause of Employee's need for medical treatment since the September 28, 2010 controversion?*
2. *Has the treatment received since the March 9, 2010 compromise and release agreement been reasonable and necessary?*

Employee contends because Employer controverted his claim for reasonable and necessary medical treatment he should prevail, and requests an order awarding attorney's fees and costs.

Employer contends it properly controverted Employee's claim and it should prevail on all issues, Employee's claim for attorney's fees and costs should be denied.

3. *Is Employee entitled to an award of attorney's fees and costs?*

FINDINGS OF FACT

Evaluation of the record as a whole establishes the following relevant facts and factual conclusions by a preponderance of the evidence:

1. Employee reported an injury on March 20, 2003, while working for the Hotel Captain Cook as a sous-chef. Employee injured his low back while repeatedly lifting boxes of meat, fish and other food. (Compromise and release in *Urrea v. Hotel Captain Cook and Commerce & Industry/Chartis*, AWCB No. 200304822, approved by the board on March 19, 2010; hereafter Hotel Captain Cook C&R).
2. Employee injured his low back on April 8, 2008, while working for Employer as a general manager, when he lifted a box of lettuce. (Report of Occupational Injury or Illness (ROI), June 18, 2008).
3. A compromise and release agreement was approved on March 19, 2010, in the Hotel Captain Cook case which waived all benefits including future medical care. (Hotel Captain Cook C&R).
4. Concurrently, a compromise and release agreement was reached on March 10, 2010, in Employer's injury case which resolved all indemnity, vocational rehabilitation, and past medical benefits. As to future medical benefits, which remained open, Employer withdrew its past controversions and agreed "any future controversion of medical and related benefits will be based on new medical evidence or opinions Dr. McCormack provided in his report and deposition." (March 10, 2010 Compromise and release Agreement in *Urrea v. Red Robin Alaska Inc. and Republic Indemnity*, AWCB No. 200808100M; hereafter Red Robin C&R).
5. After the 2003 injury at the Hotel Captain Cook, Employee treated with David Mulholland, D.C., who diagnosed an apparent facet pain generator site, a protrusion left of midline with slight left S1 nerve root displacement, a protrusion midline L4-L5 resulting in mild central spinal stenosis, annular tears posterior annulus at L4-L5 and L5 per magnetic resonance imaging (MRI) dated October 9, 2003, and altered functional status due to these diagnoses. Dr. Mulholland referred Employee to Larry Levine, M.D. (Chart note, Dr. Mulholland, November 6, 2003).
6. Dr. Levine performed bilateral L4, L5, S1 medial branch blocks on November 14, 2003. (Procedure notes, Dr. Levine, November 14, 2003).
7. Carolyn Craig, PA-C, noted significant improvement from the medial branch blocks and ordered Employee to attend physical therapy to improve his body mechanics and for trunk stabilization. (Physical therapy order and chart note, PA-C Craig, December 10, 2003).
8. On January 12, 2004, Dr. Levine performed bilateral L4, L5, and S1 medial branch rhizotomies. (Procedure note, Dr. Levine, January 12, 2004).
9. On January 26, 2004, Dr. Mulholland responded to a request from AIG Claim Services, Workers' Compensation Division, regarding Employee's work release. Dr. Mulholland

noted Employee was released to modified work "due to concern for heavy lifting/twisting" for a period of eight weeks, and his medical stability date was undetermined. (Work release, Dr. Mulholland, January 26, 2004).

10. Dr. Levine noted the rhizotomies provided 100% improvement and planned no additional treatment unless symptoms recur. Dr. Levine noted it was reasonable to anticipate the need for future treatment. (Chart note, Dr. Levine, February 5, 2004).
11. On September 16, 2004, Employee returned to PA-C Craig and reported increased back pain. (Chart note, PA-C Craig, September 16, 2004).
12. On October 1, 2004, Dr. Levine performs repeat rhizotomies bilaterally at L4, L5, and S1 medial branches. (Procedure note, Dr. Levine, October 1, 2004).
13. On October 7, 2004, Dr. Levine ordered a repeat lumbar MRI, which showed: 1) early posterior displacement of the left S1 nerve root in the canal, prior to its exit through the foramen; 2) mild to moderate central spinal stenosis at L4-L5; 3) disc dessication at L4-L5 and L5-S1, with annular tears at these levels; and 4) questionable early L5-S1 facet joint inflammation. (Order, Dr. Levine, October 7, 2004; MRI report, John McCormick, M.D., October 8, 2004).
14. Employee returned to PA-C Craig on November 8, 2004 in follow up. Employee reported significant improvement in his pain, but deferred further treatment due to his busy work schedule. (Chart note, PA-C Craig, November 8, 2004).
15. Employee was evaluated by Bruce McCormack, M.D., on September 30, 2009, for a Second Independent Medical Evaluation (SIME), prior to the Hotel Captain Cook and Red Robin C&Rs. Dr. McCormack diagnosed preexisting symptomatic painful degenerative lumbar disc disease and facet syndrome which was permanently aggravated by both the 2003 Hotel Captain Cook work injury and the 2008 Red Robin Alaska work injury. Dr. McCormack further opined the Hotel Captain Cook injury was a substantial factor in Employee's need for treatment for chiropractic care for 18 months and the three invasive procedures performed by Dr. Levine after the March 20, 2003 injury, but he was medically stable for the 2003 Hotel Captain Cook injury as of January 2005. Dr. McCormack rated Employee's permanent impairment due to the Captain Cook injury at 7% of the whole person pursuant to the American Medical Association *Guides to the Evaluation of Permanent Impairment* (5th Edition). (SIME Report, Dr. McCormack, October 25, 2009).
16. Between the date of medical stability for the 2003 Hotel Captain Cook injury and the 2008 Red Robin Alaska injury, Employee received sporadic chiropractic care with Dr. Mulholland, Tawnia Adams, D.C., and at Ireland Chiropractic through his private medical insurance. (Largely illegible chiropractic notes from Dr. Mulholland January 13 and 30, and February 1, 3, 6, 7, 13, and 20, 2006, Dr. Adams November 1, 2006, and Ireland Chiropractic October 26, 27, and 30, November 1, 3, 6, 8, 13, 16, 2006, February 12, 2007, April 30, 2007, September 20, 2007, and January 20, 2008).

17. Employee injured his low back on April 8, 2008, while lifting a box of lettuce and twisting. Employee was acting in the course and scope of his employment at Red Robin Alaska as general manager training an employee in the way to inspect produce. (Urrea).
18. Employee reported his injury to his boss, Ryan Faulkner, a few days after the injury, when Employee realized the injury was more than the ordinary aches and pains associated with working long hours. (Urrea). Employee is credible in this assertion. (AS 23.30.122).
19. Employee was terminated on April 15, 2008. (Urrea; Faulkner).
20. Employee began treating with Kurt Adams, D.C., for his low back pain on April 29, 2008, and had repeated treatments on April 30, May1, 7, 8, 9, 12, and 14, 2008. (Chiropractic notes, Dr. Adams).
21. On April 29, 2008, Dr. Adams noted "right low back pain that is now constant with right leg pain and numbness down into the right S1 dermatome…significant pain, hard to sleep, hard to walk…as well as lifting and bending….due to lifting some produce in the refrigerated section…on 04-08-08." (Chart note, Dr. Adams, April 29, 2008).
22. Dr. Adams ordered an MRI performed on May 30, 2008, which showed an L4-L5 broad posterior disc protrusion with small superimposed posterior central disc extrusions, moderate canal stenosis, left side; L5-S1 small left paracentral disc protrusion and annular tear and small right foraminal disc protrusion. (MRI report, Christopher Kottra, M.D., May 30, 2008).
23. Employee received chiropractic adjustments from Dr. Adams a minimum of biweekly through September of 2008 with minimal short term improvement. (Chiropractic notes from June through September of 2008, Dr. Adams).
24. On September 16, 2008, Grant Roderer, M.D., evaluated Employee on referral from Dr. Adams. Dr. Roderer noted Employee described his pain as being "horrible to excruciating in nature and states that his pain severely interferes with daily activities." Dr. Roderer assessed discogenic low back pain secondary to lumbar disc protrusion, lower thoracic spine pain, and paraspinous muscle spasm with lumbar strain. Dr. Roderer ordered a thoracic MRI, initiated a pain contract and pain medication, and recommended a lumbar epidural steroid injection. (Chart note, Dr. Roderer, September 16, 2008).
25. The September 16, 2008 thoracic MRI showed multiple relatively small disc protrusions throughout the mid-thoracic spin, the largest at T7-T8 and T9-T10 on the left side, with no significant canal or foramen stenosis at any level. (MRI report, Chakri Inampudi, M.D., September 16, 2008).
26. On October 16, 2008, Dr. Roderer performed a bilateral L4 transforaminal epidural steroid injection. (Procedure note, Dr. Roderer, October 16, 2008).
27. On October 24, 2008, Thomas Dietrich, M.D., evaluated Employee on Employer's behalf. Dr. Dietrich's diagnoses were degenerative disc disease at L4-L5 and L5-S1, foraminal stenosis at L5 secondary to degenerative disc disease, small extruded fragment at L4-L5 noted by radiologist centrally, and major functional interference. Dr. Dietrich

opined the 2008 injury was an aggravation of the underlying preexisting condition without evidence of a permanent change. Dr. Dietrich discounted the L4-L5 central extrusion because Employee's symptoms were more compatible with foraminal stenosis at the L5-S1 involving the L5 nerve root. Dr. Dietrich opined Employee was medically stable, had no permanent impairment from the 2008 work injury, and any treatment after ninety days would not be attributable to the work injury. (EME, Dr. Dietrich, October 24, 2008).

28. On November 5, 2008, Employee returned to Dr. Roderer, who noted Employee received a 30% improvement in his pain from an October 16, 2008 epidural steroid injection. Dr. Roderer noted the chiropractic adjustments Employee continued to receive after the last epidural steroid injection provided improved pain relief. (Chart note, Dr. Roderer, November 5, 2008).
29. Dr. Roderer performed a posterior interlaminar L5-S1 epidural steroid injection on November 13, 2008. (Procedure note, Dr. Roderer, November 13, 2008).
30. On November 17, 2008, Dr. Adams predicted Employee would incur at least one percent permanent impairment and would not have the capacity to meet his job's physical demands. (Physician Statement Regarding Retraining, Dr. Adams, November 17, 2008).
31. On December 10, 2008, Dr. Adams disagreed with Dr. Dietrich's opinions regarding the 2008 work injury being the substantial cause of Employee's need for treatment and medical stability. (Chart note, Dr. Adams, December 10, 2008).
32. Employee continued to treat concurrently with Dr. Roderer for pain management and Dr. Adams for chiropractic care, along with physical therapy. Minimal temporary improvements in his pain symptoms were noted. (SIME records 281-352).
33. On February 11, 2009, Dr. Adams referred Employee to Anchorage Neurological Associates, Inc. (Referral form, Dr. Adams, February 11, 2009).
34. Employee was initially evaluated by neurosurgeon Timothy Cohen, M.D., on February 19, 2009. Dr. Cohen made note of the significant amount of conservative treatment modalities Employee had undergone and from which received little or no benefit. He also ordered a Computed Tomography scan (CT) of the lumbar spine. (Chart note, Dr. Cohen, February 19, 2009).
35. The CT scan was conducted on March 13, 2009, and showed an L4-L5 central disc protrusion with moderate canal stenosis, and degenerative lumbar disc disease at other levels without evidence of neural impingement. (CT report, Leonard Sisk, M.D., March 13, 2009).
36. Employee returned to Dr. Kralick on March 17, 2009, who recommended surgery for the significant disc herniation with canal stenosis at L4-L5 associated with lateral recess and foraminal narrowing, and similar changes at the disc and foraminal levels at L5-S1. Dr. Kralick recommended a decompression of the stenotic areas from L4-S1 with canal and lateral recess decompression bilaterally, disc excision, and interbody and lateral mass fusion with segmental instrumentation and autgenous bone and bone morphogenic

protein. Employee decided to move forward with the recommended surgery. (Chart note, Dr. Kralick, March 17, 2009).

37. On March 27, 2009, Dr. Kralick performed an L4-L5 and L5-S1 laminectomy and decompression, with posterior interbody lateral mass fusion using autogenous bone and bone morphogenic protein and lateral mass instrumentation, and segmental fusion at L4-L5 and L5-S1, with intraoperative neural monitoring. (Operative report, Dr. Kralick, March 27, 2009).
38. On May 7, 2009, Dr. Kralick noted Employee continued to complain of backaches with pressure, but improvement in his numbness in his low back and thighs, right more than left. Employee's main complaint at the time was muscle spasms in his back. Dr. Kralick noted Employee was seeing slow resolution of his pain symptoms and referred him for physical therapy. (May 7, 2009 chart note, Dr. Kralick).
39. On August 25, 2009, after Employee completed several weeks of physical therapy, Dr. Kralick noted continued back stiffness and pressure, as well as intermittent numbness in the right leg depending on activity. Dr. Kralick characterized Employee's recovery as "slow" and noted it was unclear whether he would be able to return to his sous-chef job. (Chart note, Dr. Kralick, August 25, 2009).
40. On September 30, 2009, Employee was evaluated by Bruce McCormack, M.D., for a Second Independent Medical Evaluation (SIME). (Dr. McCormack's opinion's specific to the 2003 injury at the Hotel Captain Cook are contained in finding number fifteen.) In regards to the 2008 Red Robin injury, Dr. McCormack diagnosed preexisting painful degenerative lumbar disc disease and facet syndrome which was permanently aggravated by the April 8, 2008 work injury. Dr. McCormack apportioned the relative contribution of different causes of Employee's current disability 20% to the 2003 work injury, 30% to the preexisting condition, and 50% to the 2008 injury. Dr. McCormack weighted the 2008 injury the most because it led to surgery. Dr. McCormack further opined the 2008 work injury was the substantial cause of Employee's need for the medical treatment since the injury and he was not yet medically stable. Dr. McCormack also opined the medical treatment was medically acceptable, but further chiropractic treatment and physical therapy were no longer warranted. Dr. McCormack noted medical stability after lumbar fusion was usually obtained nine months to one year after surgery, which would be sometime between January and March of 2010. He anticipated further healing and consolidation of the fusion and improvement of Employee's myofascial pain. Dr. McCormack anticipated a 20% whole percent impairment according to the *AMA Guides to Permanent Impairment*, 5th Edition. Dr. McCormack stated periodic chiropractic treatment or physical therapy treatment may be needed in the future for minor flare ups, but not ongoing maintenance, and should conform to nationally accepted guidelines. Dr. McCormack also opined facet blocks, epidurals and rhizotomies were no longer indicated. Finally, he opined "surgery begets more surgery due to the fusion transferring stress to adjacent discs" and, long term, additional surgery may be indicated including

redo of surgery for adjacent segment disease in approximately 20 to 50 percent of cases at 10 years. Dr. McCormack disapproved the job description for sous-chef. (SIME report, Dr. McCormack, October 25, 2009).

41. Dr. McCormack was deposed on January 15, 2010, and testified consistently with his report. In addition, he said regarding the 2009 fusion, "I wouldn't have offered it myself….the patient seems to have got benefit…it falls within standard medical practice." In response to a question regarding whether Employee will need further fusions in the future, Dr. McCormack responded "Unfortunately, yes…one fusion begets others…the chance of 20 to 50 percent in 20 years…It's related to '08 injury." (Deposition of Dr. McCormack pp. 13-17, January 15, 2010).
42. In deposition, Dr. McCormack further explained Employee was initially diagnosed with a muscle strain. "It's almost what is diagnosed when an injury worker is lifting is back pain. They don't immediately jump to the conclusion that he's ruptured a disc or it's rare. As it turned out, it was a simple strain. The pain lingered and he never got better, and ultimately the true diagnosis was aggravation of degeneration of the disc condition." (*Id.* pp. 19-20).
43. On October 20, 2009, Employee was seen by Dr. Kralick, who noted Employee continued to improve, but also noted persistent backaches as well as soreness and numbness in the right hip with prolonged sitting and standing. (Chart note, Dr. Kralick, October 20, 2009).
44. On November 24, 2009, Dr. Kralick noted Employee's slow improvement after his L4-L5, L5-S1 laminectomy and decompression and continued constant achy back pain, with occasional sharp pain after prolonger standing, and occasional numbness in his right leg sometimes increased with exercise. Dr. Kralick referred Employee to Steven Johnson, M.D., for pain management, and was directed to follow up with Dr. Kralick as needed. (Chart note, Dr. Kralick, November 24, 2009).
45. Employee was evaluated by Dr. Johnson on January 18, 2010, who reviewed Employee's entire course of treatment and diagnosed lumbar post-laminectomy syndrome status posterior fusion from L4 through S1, mild right lumbar radiculopathy, and thoracic degenerative disc disease. Dr. Johnson's prescribed Duragesic and Percocet for pain, and advised Employee to use his Transcutaneous Electrical Nerve Stimulation (TENS) unit as well. Dr. Johnson also noted Employee may benefit from a spinal cord stimulator and, at some point, from further surgical intervention to include anterior fusion. (Chart note, Dr. Johnson, January 18, 2010).
46. On March 15, 2010, Employee returned to Dr. Johnson for follow up. Employee's symptoms showed no sign of improvement and Employee complained the pain medications were losing effectiveness. Dr. Johnson increased the dosage of the pain medications, scheduled an interlaminar block of the L5-S1 level with special regard to the right S1 nerve root, and discussed a spinal cord stimulator trial. (Chart note, Dr. Johnson, March 15, 2010).

47. On March 30, 2010, Dr. Johnson performed the bilateral L5-S1 interlaminar epidural steroid injection. (Procedure note, Dr. Johnson, March 30, 2010).
48. On April 12, 2010, Employee was examined by Alfred Lonser, M.D., and reported no relief from the injection performed on March 30, 2010. The decision was made to move forward with a spinal cord stimulator. (Chart note, Dr. Lonser, April 12, 2010).
49. On June 9, 2010, Dr. Johnson implanted the trial spinal cord stimulator leads. (Chart note, Dr. Johnson, June 9, 2010).
50. On June 14, 2010, Employee returned to Dr. Johnson to have the leads removed. Dr. Johnson noted Employee had an excellent spinal cord stimulator trial with very little pain and wanted to go ahead with the permanent stimulator, which was scheduled. (Chart note, Dr. Johnson, June 14, 2010).
51. On June 17, 2010, Dr. Johnson performed a bilateral spinal cord stimulator epidural lead implant with generator implant. (Procedure note, Dr. Johnson, June 17, 2010).
52. On June 19, 2010, Dr. Dietrich reevaluated Employee on Employer's behalf. Dr. Dietrich noted Employee described his pain after surgery was "different in that it shifted somewhat to the right" and there was no increase in his ability to function. Employee was examined without his spinal cord stimulator turned on. Employee characterized his pain as ninety percent in his back, and goes into his right buttock and into the lateral calf and ankle. He also characterized the low back pain as constant, but reported eighty to ninety percent relief of the back and leg symptoms from the spinal cord stimulator trial. Dr. Dietrich noted Employee's goal was to get back to work. Dr. Dietrich maintained his opinions from his previous examination and opined Employee needed no further diagnostic tests or studies in relation to the 2008 work injury, was a poor candidate for the spinal cord stimulator due to the axial nature of his back pain, and no further treatment was reasonable or necessary including rhizotomy procedures, surgery, formal physical therapy or chiropractic care as a result of the 2008 work injury. Dr. Dietrich also opined escalating use of opioids was nonproductive. (EME, Dr. Dietrich, June 19, 2010).
53. Employee returned to Dr. Johnson on July 8, 2010, for follow up to the implantation of the spinal cord stimulator. Dr. Johnson noted the spinal cord stimulator was successful in relieving Employee's back pain. Employee was complaining of pain over the right hip with some radiation down the lateral right leg described as a constant sharp pain specifically when standing. Dr. Johnson diagnosed the right hip as possible osteoarthritis and possible greater trochanteric bursitis. Dr. Johnson prescribed an injection into the right greater trochanter and possibly the right hip. (Chart note, Dr. Johnson, July 8, 2010).
54. On November 23, 2010, a CT scan of the lumbar spine showed: 1) the left L5 and S1 transpedicle screws are proud relative to the lateral margins of the corresponding vertebral bodies, the L5 transpedicle screw is adjacent to the medial margin of the left common iliac artery and the proud S1 transpedicle screw is adjacent to the medial margin

of the left common iliac vein; 2) at least moderate osseous neural foraminal narrowing on the left side at L4-L5 and L5-S1; and 3) mild retrolisthesis of L3 on L4…fairly pronounced facet arthropathy at the L3-L4 level. (CT report, Marc Beck, M.D., November 23, 2010).

55. On December 14, 2010, Dr. Johnson performed a diagnostic and therapeutic right sacroiliac joint (SI) injection. (Procedure note, Dr. Johnson, December 14, 2010).
56. Employee reported to Dr. Johnson on December 29, 2010, the SI injection provided temporary relief but afterwards the pain was worse than before. Dr. Johnson made changes to Employee's pain medications and recommended medial branch blocking and repeat rhizotomies. (Chart note, Dr. Johnson, December 29, 2010).
57. On January 4, 2011, Dr. Johnson performed a diagnostic block of the right L5, S1, S2, and S3 medial branch nerves. (Procedure note, Dr. Johnson, January 4, 2011).
58. Employee followed up with Dr. Johnson on January 26, 2011, and reported good reduction in low back, groin, and leg pain from the medial branch blocks. Pain medications were refilled and plans are made for a repeat rhizotomy. (Chart note, Dr. Johnson, January 26, 2011).
59. On February 4, 2011, Dr. Johnson performed denervation with radiofrequency lesioning of the right L5 and right lateral branch of right S1, S2, S3, and S4 nerve roots. (Procedure note, Dr. Johnson, February 4, 2011).
60. On February 24, 2011, Employee was evaluated by Jane Sonnenburg, PA-C, who noted Employee had undergone a denervation and radiofrequency procedure to the right L5 and lumbar later branch at S1, S2, S3 and S4 on February 4, 2011. Employee benefitted from this procedure for three days until his pain returned after bending and twisting in his bathroom. PA-C Sonnenburg diagnosed posterior laminectomy syndrome, lumbar radiculopathy, and right SI arthropathy. PA-C Sonnenburg renewed Employee's pain prescriptions and prescribes physical therapy to improve core conditioning. (Chart note, PA-C Sonnenburg, February 24, 2011).
61. On May 11, 2011, Employee returned to Dr. McCormack for a repeat SIME. Dr. McCormack's updated diagnoses were lumbar stenosis, lumbar disc disease, L4-L5 central disc rupture with radiculopathy, status post laminectomy and fusion, status post spinal cord stimulator, failed back syndrome, and narcotic dependence. Dr. McCormack documented Employee was not sexually active. Dr. McCormack continued to opine the 2008 work injury was the substantial cause of Employee's need for fusion surgery, injections, and spinal cord stimulator, even though the results had been modest to poor. Dr. McCormack opined fusion surgery was an "accepted but controversial treatment for discogenic low back pain" but was sometimes performed for microinstability as in this case. Dr. McCormack opined future care should include physician visits, spinal cord stimulator programming, revision and pain medication. (SIME report, Dr. McCormack, May 11, 2011).

62. On May 20, 2011, Employee was evaluated by Marvin Zwerin, D.O., for an SIME. Dr. Zwerin diagnoses were: 1) history of longstanding minor backache; 2) status post 2003 injury resulting in one year of treatment including blocks without permanent disability or loss of ability to work; 3) status post 2008 acute back injury leading inexorably to spinal decompression and fusion L4 to S1; 4) post-laminectomy syndrome without bowel or bladder involvement; 5) chronic habituation to long-acting and short-acting opiates; 6) status post spinal cord stimulator implantation with good pain relief but no reduction in opioid does; and 7) still undergoing treatment with physical therapy and pain management. Dr. Zwerin related Employee's acute lumbar strain and lumbar disc derangement L4-L5 and L5-S1 to the 2008 work injury. Dr. Zwerin opined the 2008 work injury was the substantial cause of Employee's post injury medical treatment, which has been reasonable and necessary. Dr. Zwerin further opined Employee only needed further pain management and his physical therapy should be tapered to a home exercise program. (SIME report, Dr. Zwerin, May 20, 2011).
63. Employee saw Dr. Johnson on July 18, 2011, in follow up and was doing "fairly well." Employee was progressing in physical therapy and had new pain in his left mid-buttock to left hip area. Dr. Johnson refilled Employee's pain medications and noted backing off the pain medications would begin at some point. (Chart note, Dr. Johnson, July 18, 2011).
64. On August 11, 2011, Dr. Johnson noted Employee was complaining of lower mid-lumbar and bilateral buttock/hip area pain with numbness, which is aggravated by deep tissue massage therapy. The spinal cord stimulator helped with the pain which was described as a constant dull pain to his hips and low back, which may progress to a sharp pain. (Chart note, Dr. Johnson, August 11, 2011).
65. On September 13, 2011, Employee was examined by Dr. Johnson and complained of significant pain which was not responding to medication or the spinal cord stimulator described as a constant, sharp pain to the lower spine. Dr. Johnson increased Employee's pain medications and referred him to Dr. Kralick. (Chart note, Dr. Johnson, September 13, 2011).
66. On September 13, 2011, Dr. Johnson also provided Employee with an off work slip. (Off work slip, Dr. Johnson, September 13, 2011).
67. Employee returned to Dr. Johnson on October 11, 2011, complaining of worsening pain especially in the right buttock area going into the right hip and anterolateral thigh. A right SI joint injection is planned. Dr. Johnson noted the radiofrequency lesioning conducted in February (2011) did not provide any relief, but resulted in worsening of symptoms in an eight to nine month time frame. Employee was advised to follow up with Dr. Kralick and his pain medications were adjusted. (Chart note, Dr. Johnson, October 11, 2011).
68. On October 24, 2011, Dr. Johnson performed a right SI joint injection of anesthetic and/or steroid. (Procedure note, Dr. Johnson, October 24, 2011).

69. On October 26, 2011, a CT lumbar myelogram was performed which showed: 1) stable postoperative changes from prior L4-L5 and L5-S1 discectomies with intervertebral and dorsal posterior ulna hardware fusion; 2) moderate lumbar spinal canal stenosis at the L3-L4 level, secondary to broad based disc protrusion, with likely diffuse descending instraspinal nerve root impingement and likely inferior descending lumbar spinal nerve root arachnoiditis at the L4 vertebral level; 3) moderate bilateral L3-L4 neural foraminal stenosis, secondary to intraforaminal disc protrusion; and 4) mild to moderate lumbar facet degenerative disease. (CT report, Kamran Janjua, M.D., October 26, 2011).
70. On November 11, 2011, Dr. Johnson performed a right diagnostic transforaminal epidural L3-L4 injection. (Procedure note, Dr. Johnson, November 11, 2011).
71. On November 22, 2011, Employee returned to Dr. Kralick. Employee described his pain as dull and achy with occasional sharp, radiating pain in the midline to his upper back, and a dull achiness with occasional sharp pain radiating into the right hip. Dr. Kralick noted there was likely anterior descending lumbar spinal nerve root arachnoiditis at the L4 level; moderate bilateral L3-L4 neural foraminal stenosis, secondary to intra-foraminal disc protrusion; and mild to moderate lumbar facet degenerative disease. Dr. Kralick also noted *cauda equina* compression at the L3-L4 segment. A posterior laminectomy and canal decompression were decided upon due to the "high grade stenosis." It was noted Employee did not wish to proceed with further arthrodesis with extension of his fusion to involve L3-L4 or hardware removal as part of this procedure. (Chart note, Dr. Kralick, November 22, 2011).
72. On January 12, 2012, Dr. Kralick performed an L3-L4 laminectomy and decompression of spinal stenosis, lysis of dorsal epidural adhesions, hardware removal bilaterally at L4 to S1, and fusion inspection. (Operative report, Dr. Kralick, January 12, 2012).
73. On February 2, 2012, Employee returned to Dr. Kralick in follow up to his surgery. Dr. Kralick noted Employee's pain had worsened and amplified in the same distribution since the surgery. Dr. Kralick ordered pain medications and a right L3-L4 and L5-S1 transforaminal epidural steroid injection. (Chart note, Dr. Kralick, February 2, 2012).
74. Dr. Zwerin was deposed on February 29, 2012. Dr. Zwerin testified regarding Employee's initial symptoms "pain generation can occur predominantly, given his symptoms, from the disc extrusions and the annular tears…disc extrusions are likely to be causing nerve root irritation and compression. The annular tears leak hyaluronic acid into the area of the roots and will cause a chemical irritation. So it's a combination of chemo-irritation and direct impact from the disc extrusions." (Deposition pp. 9-10, Dr. Zwerin, February 29, 2012).
75. When asked about Employee's recovery after the 2009 fusion surgery, specifically the May 7, 2009 record from Dr. Kralick, Dr. Zwerin stated "Everyone is perfect after surgery, per the surgeons." Dr. Zwerin opined the 2009 fusion had no significant effect on Employee's pain complaints. (*Id.* pp. 13-14).

76. Dr. Zwerin opined the level of narcotics prescribed to Employee in May 2010 were "reasonable and appropriate…he's chasing pain and trying to get it under control." Dr. Zwerin opined it was reasonable for Dr. Johnson to increase Employee's pain medications in an attempt to control his pain. (*Id.* p. 17).
77. Dr. Zwerin agreed with the diagnoses in Dr. McCormack's May 11, 2011 SIME report, however he disagreed with Dr. McCormack regarding discontinuing all future treatment. "[T]here's nothing in the record that suggests he's abusing….So what he was on seemed to be appropriate, and stable, and well managed…But this guy has huge amounts of pain and had a…terrible outcome from his spinal fusion, and…what are the alternatives?...Cold-turkey the guy off his meds and let the guy commit suicide because he couldn't take it or keep trying to help him?" Dr. Zwerin maintained his recommendation for future treatment of pain management and/or a functional restoration program. (*Id.* pp. 20-22, 29-34).
78. As to the 2012 surgery by Dr. Kralich, Dr. Zwerin explained it was not a miraculous cure and it would take months to know the results of the surgery due to "post-op inflammation, and swelling, and healing, and we're looking probably at four months before you have a good idea of what's happening." As to Employee's prognosis, Dr. Zwerin opined "in highly medical terms, it sucks. We now have a guy with multi-level degenerative disc disease, two back surgeries. The likelihood is he'll have a third, because the disc above L3 will fail. And he's probably consigned to the spinal cord stimulator, limited activities, likely on narcotics for life, and a very terrible future." (*Id.* pp.25-26).
79. When asked if these procedures would have been performed on Employee regardless of the 2008 work injury, Dr. Zwerin opined "probably not. Almost certainly not. If you look at the MRI, the L3, 4 level had some minor degenerative changes. The most common thing that happens after you do a fusion is the disc above fails because it is overloaded." (*Id*. p. 26).
80. On March 21, 2012, Dr. McCormack performed a records review SIME. Dr. McCormack opined Dr. Kralick's January 2, 2012 surgery, the physical therapy and injections performed since his May 2011 report were not medically necessary or indicated. Dr. McCormack agreed with Dr. Zwerin's opinions. Dr. McCormack noted Dr. Kralick stated Employee's stenosis was severe where the myelogram report findings of stenosis were mild. Dr. McCormack opined the L3-L4 laminectomy would have had to be done at some point when the stenosis became severe, but Dr. McCormack believed that point would be in the remote future. Dr. McCormack also opined any chances of success for injection therapy were practically nil. (SIME report, Dr. McCormack, March 21, 2012).
81. Dr. McCormack was deposed on March 23, 2012. Dr. McCormack opined the March 30, 2010 epidural steroid injection, the December 14, 2010 injection, the January 4, 2011 injection, the February 4, 2011 denervation, and further physical therapy were not

reasonable and necessary because "there hasn't been enough benefit to warrant these types of treatment." Dr. McCormack opined the spinal cord stimulator was reasonable and necessary. (Deposition, Dr. McCormack, March 23, 2010).

82. Dr. McCormack opined Employee's pain medications were reasonable and necessary. (*Id.* p. 20).
83. Dr. McCormack also opined the November 11, 2011 injection was reasonable "it was worth a try." (*Id.* p. 22).
84. As to the 2012 surgery, Dr. McCormack stated "[t]he myelo CT scan report indicates mild changes at 3-4. And Dr. Kralick in his report calls them severe, and you know, recommends a laminectomy because of severe stenosis. So there is a disparity in the reports….I don't feel that the surgery…would provide him a lot of benefit, but I must concede that would eventually have to be done at some point because the narrow nerve channel would just progressively worsen, and it's reasonable, to remove the hardware. I don't have a lot of faith that it's going to help his pain." (*Id.* p. 22).
85. Dr. McCormack opined the February 2, 2012 injection was not reasonable and necessary. (*Id.* p. 28).
86. Dr. McCormack further opined as to future treatment, Employee may need further surgery "he should only have additional fusion if there is mechanical instability at L3-4. And he had a laminectomy at 3-4, so the nerve channel is opened up…mechanical instability…overt spinal instability, to warrant any more invasive procedures." Dr. McCormack also opined Employee would need future pain medications. (*Id.* pp. 28-33).
87. On April 10, 2012, Employee returned to Dr. Kralick for evaluation. Dr. Kralick noted Employee's continued symptoms of constant back pain with aching and sharp, shooting pain in the right hip and right leg. X-rays taken revealed increased anterolisthesis consistent with hypermobility in flexion at the L3-L4 segment, which may require additional operative intervention for stabilization at this level. (Chart note, Dr. Kralick, April 20, 2012).
88. On April 30, 2012, Dr. Johnson referred Employee to neurosurgeon Peter Sorini, M.D., for a consultation on his unstable anterolisthesis at L3-L4 due to a new pain in the mid-lumbar area. Dr. Johnson noted a significant chance of neurologic damage without treatment. (Letter to C. Beltzer from Dr. Johnson, April 30, 2012).
89. On July 31, 2012, a repeat CT lumbar myelogram was performed, which showed: 1) a very large disc bulge/extrusion predominantly involving the right lateral recess region of the L3-L4 level…with descending nerve root impingement despite the posterior decompression given the wavy appearance of the nerve roots cranial to this L3-L4 level; 2) the dominant portion of this extrusion measures 8.3 mm in anterior posterior diameter and approximately 16 mm in craniocaudial diameter; 3) posterior aspect of L4-L5 and L5-S1 disc spaces appear fused; and 4) scattered neural foraminal narrowing throughout the lumbar spine with severe loss of perineural fat/neural foraminal stenosis on the right at L3-L4. (CT report, Marc Beck, July 31, 2012).

90. On October 15, 2012, Employee was evaluated by Dr. Sorini for the first time. Dr. Sorini noted Employee's severe low back pain and lower extremity pain, right greater than left, status post multiple low back surgeries none of which gave relief except the spinal cord stimulator. Dr. Sorini diagnosed degeneration of lumbar or lumbosacral intervertebral disc, lumbar disc herniation with myelopathy, post laminectomy syndrome of lumbar region with probable arachnoiditis, and acquired spondylolisthesis L3-L4 with vacuum disc and massive herniated nucleus pulposus L3-L4. Dr. Sorini recommended decompression and fusion of L3-L4 with possible osteotomy to correct sagittal imbalance, however Employee would be required to undergo smoking cessation for six weeks prior to surgery and evaluation to discern etiology of calcification in his chest. (Chart note, Dr. Sorini, October 15, 2012).
91. On December 14, 2012, Eric Harris, M.D., an orthopedic surgeon, evaluated Employee on Employer's behalf. Dr. Harris noted Employee's range of motion was normal by Dr. McCormack's first SIME on October 25, 2009, and on November 24, 2009, at a follow up visit with Dr. Kralick Employee had normal sensation in his lower extremities. Dr. Harris' impressions were: 1) multilevel preexisting lumbar degenerative disc disease; 2) status post L4 to S1 laminectomy with posterior interbody and lateral mass fusion; 3) status post revision of lumbar surgery for decompression at the L3-L4 level and removal of previously placed instrumentation; 4) segmental instability at L3-L4, likely secondary to number 3; 5) status post spinal cord stimulator implantation; 6) likely chronic pain syndrome; and 7) likely opiate dependence. Dr. Harris also noted Employee continued to focus on severe low back pain much worse than bilateral leg symptoms, and stated there were no cauda equina syndrome symptoms. Dr. Harris acknowledged the instability at L3-L4 was not present prior to the January 2012 surgery and may be caused by that surgery, and, for this reason, Dr. Harris acknowledged more surgery may be reasonable to prevent further progression of Employee's spondylolisthesis and sagittal imbalance. Dr. Harris opined Employee's 2008 work injury was a strain to the paraspinal musculature of his low back but the 2008 work injury was not the substantial cause of the 2009 surgery. Dr. Harris also opined Dr. Kralick's January 2012 surgery would have only been necessary if performed for significant lower extremity pain or weakness, as opposed to back pain symptoms, and although the adjacent L3-L4 segment degeneration may have been an indirect result of the 2009 fusion, the substantial cause of the need for the 2009 fusion was Employee's preexisting degenerative disc disease and not the 2008 work injury. In Dr. Harris' opinion, Employee suffered no more than a lumbar strain on April 8, 2008, which would be the substantial cause of the need for treatment for the first eight weeks after the injury any later treatment received by Employee was related to his preexisting lumbar spondylosis. Further, Dr. Harris opined all of the treatment Employee has received since 2003 have been directed at symptoms more likely than not secondary to his preexisting condition of multilevel degenerative disc disease. Finally, Dr. Harris opined no further care is reasonable and necessary in relation to the work injury, but

recommended a psychological evaluation secondary to his ongoing requirement of significant amounts of pain medication, non-organic findings suggestive of symptom magnification, and chronic pain syndrome. (EME report, Dr. Harris, December 14, 2012).

92. On December 18, 2012, Dr. Sorini performed revision decompression L3, bilateral L3 Smith-Peterson osteotomies for sagittal balance, interbody fusion and autograft, bilateral posterolateral and intertransverse fusion using autograft, allograft and Infuse, and bilateral L3-L4 transpedicular stabilization using screws and rod with crosslink. Dr. Sorini noted Employee had severe residual stenosis at L3-L4 due to a combination of facet hypertrophy at L3-L4, the spondylolisthesis at L3-L4, and the massive disc herniation at L3-L4 central and eccentric to the right. Further, the surgery was complicated by the extensive scar tissue from the previous surgeries. (Operative report, Dr. Sorini, December 18, 2012).
93. On January 3, 2013, Employee was examined by Dr. Johnson post-operatively. Employee continued to report low back pain that radiated to his right leg, but a pain level that was significantly reduced. Employee's pain medications were reduced and he was directed to return in one week for staple removal. (Chart note, Dr. Johnson, January 3, 2013).
94. Employee returned to Dr. Johnson's office on January 8, 2013, to have his staples removed. He reported a new pain which developed since surgery on his left side in the hip area and down the leg, which was similar to a bad muscle spasm. (Chart note, Dr. Johnson, January 8, 2013).
95. On January 31, 2013, Employee returned to Dr. Johnson and reported continued decrease in pain levels. Dr. Johnson decreased Employee's pain medications. (Chart note, Dr. Johnson, January 31, 2013).
96. On February 26, 2013, Employee was examined by Dr. Johnson and reported a leveling off in his back pain. Dr. Johnson ordered physical therapy to improve Employee's core strength. (Chart note, Dr. Johnson, February 26, 2013).
97. Employee testified the surgery performed by Dr. Sorini has allowed him to stand up straight, he has no more pain down his right side, less need for pain medication, and a seventy-percent reduction in his pain level. Employee also testified his pain medication use is reduced, as is his use of the spinal cord stimulator, and his functionality has improved. He was unable to pursue retraining due to his low back pain, but continues to hope he can go back to work in some capacity. (Urrea). Employee was credible in his testimony. (AS 23.30.122)
98. Ryan Faulkner was Director of Operations for Red Robin Alaska at the time Employee worked there. Mr. Faulkner stated he learned about Employee's back condition in April 2008 when he saw Employee in pain, but Employee said the pain was from an old injury at Captain Cook and refused aspirin because he was going to the doctor. Mr. Faulkner further testified Employee failed to follow company protocol for reporting his injury and

did not report any injury until after he was terminated for not upholding Red Robin's management style. Mr. Faulkner acknowledged Employee was able to work without issue from the time he was hired until April 8, 2008. (Faulkner).

99. Dr. McCormack testified after reviewing treatment records since his deposition on March 23, 2012, but having had no contact with the parties. Dr. McCormack opined the surgery performed by Dr. Sorini was a controversial procedure, but the indications for it were more standard than the two previous surgeries, *i.e.* mechanical instability at L3-L4 that was caused by Dr. Kralick's 2012 surgery at L3-L4, which occurs in 10 to 20 percent of cases. Dr. McCormack further opined Dr. Kralick's 2012 surgery was not necessary, but it was done and was the direct cause of the December 18, 2012 surgery by Dr. Sorini. Dr. McCormack confirmed his opinion the 2008 work injury was a permanent aggravation of Employee's pre-existing condition and the substantial cause of his need for medical treatment. (McCormack).

100. Under cross examination, Dr. McCormack opined without the 2008 work injury Employee would have experience occasional flare ups and remissions of his preexisting condition. Dr. McCormack acknowledged Employee's preexisting condition compromised his spine and contributed to the onset of his symptoms in 2008. But because the mechanics of the injury brought on the need for surgery in this case, the 2008 work injury was the substantial cause of Employee's need for treatment. Dr. McCormack did not disagree Employee was over-treated in this case, but he was treated within the standard of care. Dr. McCormack opined all treatment since the first surgery is related to the first surgery and, therefore, related to the 2008 work injury. Dr. McCormack opined future treatment should consist of pain management, not including injections and rhizotomies, and physical therapy and a physical capacities evaluation. (McCormack).

101. Dr. Harris testified at hearing consistently with his report. Dr. Harris opined the surgery performed by Dr. Sorini was the only surgery needed based on Employee's medical history, but he was unable to provide a positive prognosis for Employee. (Harris).

102. Employee asserted the treating physicians and both SIME physicians opined the April 8, 2008 work injury is the substantial cause of Employee's need for treatment. Employee further argued Employer's post-C&R July 8, 2010 Controversion, based on Dr. Dietrich's June 9, 2010 and October 24, 2008 EME reports, controverting all medical and related benefits except an opioid tapering program supervised by the treating physician, was not based on "new" medical evidence as required by the C&R. (Employee's brief and hearing argument).

103. Employer argued Employee's painful degenerative back condition merely became symptomatic at work which does not make the need for treatment work related. Employer further argued Employee cannot have excessive treatment and attempt to burden Employer with paying for unsuccessful treatments. At most, according to Employer, Employee suffered a temporary aggravation of his preexisting condition.

Further, Employer contended if there was a work injury for which Employer was responsible, there must be a point at which Employer's responsibility ends and the substantial cause of the need for treatment becomes the preexisting condition. (Employer's brief and hearing argument).

104. Employee claims total attorney's fees and costs for services rendered from October 7, 2010 through March 12, 2013, at an hourly rate of $275.00 per hour, in the amount of $26,702.48. (February 28, 2013 Affidavit of Attorney's Fees and Costs; March 12, 2013 Amended Affidavit of Attorney's Fees and Costs).

105. The $275 hourly rate is a reasonable rate to compensate Mr. Beltzer for legal services performed in this case, compared to fees awarded to other workers' compensation claimants' attorneys given his experience representing injured workers. (Experience, judgment, observations and inferences drawn from all the above).

106. Employee's counsel's efforts have resulted in the award of past and future medical benefits, which are significant. (Experience, judgment, observations and inferences drawn from all the above).

PRINCIPLES OF LAW

> **AS 23.30.001. Intent of the legislature and construction of chapter**. It is the intent of the legislature that
>
> (1) This chapter be interpreted . . . to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to . . . employers. . . .
>
> **AS 23.30.005. Alaska Workers' Compensation Board.**
>
> . . .
>
> (h) The department shall adopt rules . . . and shall adopt regulations to carry out the provisions of this chapter. . . . Process and procedure under this chapter shall be as summary and simple as possible. . . .
>
> **AS 23.30.010. Coverage.** (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the

> employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.

Under pre-2005 law, a preexisting disease or infirmity does not disqualify a claim under the work-connection requirement if the employment aggravated, accelerated, or combined with the disease or infirmity to produce the death or disability for which compensation is sought. *Thornton v. Alaska Workmen's Compensation Bd.*, 411 P.2d 209, 210 (Alaska 1966). In *Burgess Constr. Co. v. Smallwood*, 623 P.2d 312, 317 (Alaska 1981), the Alaska Supreme Court addressed the causation question in aggravation, acceleration or combination cases and held a claim is compensable upon a showing employment aggravated, accelerated, or combined with a preexisting condition to produce disability. *Id*, at 315 (*citing Thornton*, 411 P.2d 209, 210; *Ketchikan Gateway Borough v. Saling*, 604 P.2d 590, 595-96 (Alaska 1979); *Hawkins v. Green Associated*, 559 P.2d 118, 119 (Alaska 1977); *Beauchamp v. Employers Liability Assurance Corp.*, 477 P.2d 993, 997 (Alaska 1970); 1 A. Larson, Workmen's Compensation Law s 12.20 at 276 (1978)). Liability is imposed whenever employment is established as a causal factor in the disability and a causal factor is a legal cause if "it is a substantial factor in bringing about the harm" or disability at issue. *Smallwood*, 623 P.2d at 317. The court stated, therefore, the causation question in *Smallwood* was whether employment aggravated, accelerated or combined with an employee's preexisting condition so as to be "a substantial factor" in bringing about his disability. *Id.*

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). "An employee's preexisting condition" will not relieve an employer from liability in a proper case (*id*. at 534). In *Rogers & Babler*, the Alaska Supreme Court discussed factors considered when determining whether an aggravation, acceleration or combination is "a substantial factor" in the resulting disability. It adopted the "but for" cause-in-fact test in cases involving a preexisting condition and an aggravation, but held the test does not mean a claimant must prove "but for" the subsequent trauma the claimant would not be disabled. Instead, the claimant only must prove "but for" the

subsequent trauma the claimant would not have suffered disability at this time, or in this way, or to this degree. In other words, the claimant must prove the aggravation, acceleration or combination was "a substantial factor" in the resulting disability. *Id.* at 533. A finding disability would not have occurred "but for" employment may be supported not only by a doctor's testimony, but "inferentially from the fact" an injured worker "had been able to continue working despite pain prior to" the subject employment "but required surgery after that employment." A finding reasonable persons would find employment was a cause of the employee's disability and impose liability is, "as are all subjective determinations, the most difficult to support." However, there is also no reason to suppose Board members who so find "are either irrational or arbitrary." That "some reasonable persons may disagree with a subjective conclusion does not necessarily make that conclusion unreasonable" (*id.*).

"Thus, for an employee to establish an aggravation claim under workers' compensation law, the employment need only have been 'a substantial factor in bringing about the disability.' *Hester v. State, Public Employees' Retirement Board*, 817 P.2d 472 (Alaska 1991) suggests when a job worsens an employee's "disease" so he can is no longer "capable of working," that constitutes an 'aggravation' -- even when the job does not actually worsen the underlying "condition." "It is basic that an accident which produces injury by precipitating the development of a latent condition or by aggravating a preexisting condition is a cause of that injury." *Id.* at 475; citing 22 Am.Jur.2d *Damages* § 280 (1988); *see also*, *LaMoureaux v. Totem Ocean Trailer Express, Inc.,* 632 P.2d 539 (Alaska 1981). "We believe that increased pain or other symptoms can be as disabling as deterioration of the underlying disease itself." *Hester*, 817 P.2d at 476 n. 7.

In *DeYonge v. NANA/Marriott*, 1 P.3d 90 (Alaska 2000), the board denied an injured worker's claim for a knee injury. The Alaska Supreme Court, citing the board's analysis said:

> After weighing the three doctors' opinions, the Board concluded that Dr. Frost's report constituted affirmative evidence that DeYonge's condition was not 'aggravated or accelerated by her work.' In his report, Dr. Frost suggested that DeYonge's arthritic condition had 'probably been developing slowly for years and . . . was not specifically caused by her job.' He also suggested that 'any stressful use of her knees would have increased her symptoms.' These statements tend to demonstrate that a non-work-related factor -- DeYonge's genetic predisposition for arthritis and its natural degenerative progression -- caused

> DeYonge's underlying impairment. But we have established 'that a preexisting . . . infirmity does not disqualify a claim under the work-connection requirement if the employment aggravated, accelerated, or combined with the . . . infirmity to produce the . . . disability for which compensation is sought' (footnote omitted). Dr. Frost's explanation does not exclude DeYonge's employment as a substantial factor in the aggravation of her arthritis. On the contrary, Dr. Frost believed that DeYonge's employment with NANA/Marriott did worsen her symptoms: 'Certainly the type of duties which she performed as a housekeeper . . . would have been a substantial factor in increasing her symptoms.'
>
> In his conclusions, Dr. Frost distinguished between aggravation of DeYonge's *symptoms* and aggravation of her *underlying condition.* But in *Hester v. State, Public Employees' Retirement Board,* we explicitly declined to differentiate between the aggravation of symptoms and the aggravation of an underlying condition in the context of a claim for occupational disability benefits (citation omitted). 'We reject the distinction . . . between worsening of the underlying disease process and worsening of the symptoms of a disease' (citation omitted). . . . Although *Hester* arose under a different statutory scheme, (citation omitted) the principle that we enunciated there -- that worsened symptoms may be compensable -- is equally persuasive in the context of workers' compensation (*id.* at 96 (emphasis in original)).

DeYonge concluded: "Thus, for an employee to establish an aggravation claim under workers' compensation law, the employment need only have been "a substantial factor in bringing about the *disability.*" (*Id.*; emphasis in original).

Smallwood, Rogers & Babler, *Hester* and *DeYonge* were based on the causation standard applied in workers' compensation cases prior to the Act's 2005 amendments, which imposed liability whenever employment was "a substantial factor" in an employee's disability, death or need for medical treatment. *City of Seward v. Hansen*, AWCAC Decision No. 146 at 10 (January 21, 2011).

In 2005, the legal "causation" definition changed to "contract" the Act's coverage. For an injury occurring on or after November 7, 2005, the board must evaluate the relative contribution of all causes of disability, death or need for medical treatment and award benefits if employment is, in relation to all other causes, "the substantial cause" of the disability, death or need for medical treatment. *Hansen*, at 11-14. When all causes are compared, only one cause can be "the substantial cause." *Id.*

In *State of Alaska v. Dennis*, AWCAC Decision No. 036 at 11-13 (March 27, 2007), the commission stated the "last injurious exposure" rule provides: "The last employer: (1) whose employment aggravated, accelerated or combined with the prior injury (*i.e.* is a cause in fact), and (2) whose employment is a legal cause of the disability is liable for the whole payment of the disability compensation." *Id.* at 11 (emphasis in original). *Dennis* explained the 2005 amendments to the Act only modified the definition of "legal cause" from "a substantial factor" to "the substantial cause." The amendments did not abrogate the "last injurious exposure" rule itself, which still operates to prevent apportionment of liability of injury between or among employers. *Id.* *See, e.g.*, Senate Free Conference Committee Meeting Minutes at 1:35:19-1:39:56, S.B. 130, May 21, 2005, remarks by Kristin Knudsen, Assistant Attorney General, Department of Law:

> The board must look at the disability at the time the claim was filed or when medical treatment was occasioned by the employment. If a person had 8 years of exposure [with a prior employer], continued to be employable and did not experience any symptoms, the subsequent employer would have a difficult time establishing that the latest employment was not the substantial factor in the need for medical treatment. [Ms. Knudsen] emphasized the determination is based on the need for medical treatment at the time.

See also Rogers & Babler, 747 P.2d at 533.

In 2005, the Alaska Legislature considered and rejected proposed amendments to AS 23.30.395(17)'s "injury" definition to state:

> 18 **Sec. 42.** AS 23.30.395(17) is amended to read:
> 19 (17) 'injury' means accidental injury or death arising out of and in the
> 20 course of employment, and an occupational disease or infection **that** [WHICH] arises
> 21 naturally out of the employment or **that** [WHICH] naturally or unavoidably results
> 22 from an accidental injury; "injury" includes breakage or damage to eyeglasses, hearing
> 23 aids, dentures, or any prosthetic devices **that** [WHICH] function as part of the body
> 24 and further includes an injury caused by the willful act of a third person directed

> 25 against an employee because of the employment; 'injury' **does not include**
> 26 **aggravation, acceleration, or combination with a preexisting condition, unless the**
> 27 **employment is the major contributing cause of the disability or need for medical**
> 28 **treatment** . . . . (http://www.legis.state.ak.us/PDF/24/Bills/SB0130C.PDF).

SB 130's passed version, which amended AS 23.30.010(a) to its current "coverage" language including "the substantial cause," did not eliminate "aggravations" from the statutory "injury" definition. (http://www.legis.state.ak.us/PDF/24/Bills/SB0130L.PDF).

In *O'Hara v. Carr-Gottstein Foods Safeway, Inc.*, AWCAC Decision No. 093 (December 4, 2008), the appeals commission affirmed a board decision denying an injured worker's claim for benefits for a herniated disk. The board's decision was based primarily on its finding the employee was not credible because she had symptoms consistent with a herniated disk several months before the alleged work-related event. When she finally sought medical attention after claiming she hurt her back lifting a bucket of water at work, the injured employee never mentioned to any of several physicians anything about the alleged work injury. At hearing, the employee's only liability theory was that she herniated her disk when she picked up the water bucket at work. She did not argue she had a preexisting herniated disk; she was able to live with the condition; she would not have required surgery but for lifting the water bucket; or she would have been able to continue working but for the injury. (*Id.* at 7). Therefore, the commission concluded the board properly focused on whether lifting the bucket was the substantial factor in bringing about the herniated disk. *O'Hara* set forth the new legal standard under AS 23.30.010(a), which required the board to evaluate the relative contribution of different causes of the disability or need for medical treatment. *O'Hara* explained compensation was payable under the Act only if in relation to other causes the employment is the substantial cause of the disability or need for treatment. It further noted a work-related injury may result in temporary disability and treatment to restore the employee to pre-injury status, without necessarily being the substantial factor in bringing about the need for all future medical treatment of the underlying condition. (*Id.*).

In *City and Borough of Juneau v. Olsen*, AWCAC Dec. No. 185 (August 21, 2013), the appeals commission established the analysis for an aggravation claim under "the substantial cause" test, an

employee must show employment was a substantial factor in bringing about the need for treatment. The board must then evaluate the relative contribution of different causes of the need for medical treatment. Finally, the board must then apply the presumption of compensability analysis. (*Id. at 17-18).*

> **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, not exceeding two years from and after the date of injury to the employee. . . . It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require. . . .

AS 23.30.095(a) requires an employer to furnish an employee injured at work any medical treatment that the nature of the injury or process of recovery requires. *Philip Weidner & Associates v. Hibdon*, 989 P.2d 727, 730 (Alaska 1999). "Process of recovery" language allows the board to authorize continuing care beyond two years from the date of injury. *Municipality of Anchorage, v. Carter,* 818 P.2d 661, 665-66 (Alaska 1991).

An injured worker is entitled to a prospective determination of whether the injury is compensable, regardless of any pending claim for medical care or other benefits. *Summers v. Korobkin Construction*., 814 P.2d 1369 (Alaska 1991).

An employer shall furnish an employee injured at work any medical treatment "which the nature of the injury or process of recovery requires" within the first two years of the injury. The medical treatment must be "reasonable and necessary." *Bockness v. Brown Jug, Inc.*, 980 P.2d 462, 466 (Alaska 1999). Thus, when the board reviews an injured employee's claim for medical treatment made within two years of an injury that is indisputably work-related, "its review is limited to whether the treatment sought is reasonable and necessary." *Philip Weidner & Associates v. Hibdon*, 989 P.2d 727, 730 (Alaska 1999). Accordingly, "we hold that a claim for medical treatment is to be reviewed according to the date the treatment was sought and the claim was filed with the Board. Because Hibdon's claim was filed within two years of the date of

injury, we must determine whether the treatment she sought was reasonable and necessary." *Id.* at 731. *Hibdon* further stated:

> According to Professor Larson's treatise on workers' compensation, where a claimant receives conflicting medical advice, the claimant may choose to follow his or her own doctor's advice, so long as the choice of treatment is reasonable (footnote omitted). The question of reasonableness is 'a complex fact judgment involving a multitude of variables' (footnote omitted). However, where the claimant presents credible, competent evidence from his or her treating physician that the treatment undergone or sought is reasonably effective and necessary for the process of recovery, and the evidence is corroborated by other medical experts, and the treatment falls within the realm of medically accepted options, it is generally considered reasonable. If the employee makes this showing, the employer is faced with a heavy burden -- the employer must demonstrate to the Board that the treatment is neither reasonable and necessary, nor within the realm of acceptable medical options under the particular facts. It is not the Board's function to choose between reasonable, yet competing, medically acceptable treatments. Rather, the Board must determine whether the actual treatment sought by the injured employee is reasonable. (I*d*. at 732).

In *Hibdon*, the employer argued there was no "current" medical recommendation for surgery. The court noted though the attending physician stated he would perform additional tests before renewing his surgical recommendation, if the patient's pain persisted and testing showed her condition was the same, he would still recommend the same surgical procedure. *Id*. at 732-33. The court furthered noted some of the delay in obtaining surgery was inherent in the board's adjudication process. Administrative delay placed the injured worker in a "catch-22" where passage of time before hearing rendered "a current recommendation dated," while the board required a current surgical recommendation for the claimant to succeed at hearing. *Id*. at 733. Accordingly, even if some doctors' opined the injured worker was "unfit" for the procedure, which was rife with risks: "Choices between reasonable medical options and the risks entailed should be left to the patient and his or her physician." *Id.*

> Because Hibdon presented credible, corroborated evidence from her treating physician that the treatment she sought was reasonable and necessary for her recovery, and the treatment fell within the realm of medically accepted options, she proved her claim by a preponderance of the evidence. (I*d*.).

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

(1) the claim comes within the provisions of this chapter. . . .

Under AS 23.30.120(a)(1), benefits sought by an injured worker are presumed to be compensable. *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996). The presumption of compensability is applicable to any claim for compensation under the workers' compensation statute (*id*.; emphasis omitted). The presumption application involves a three-step analysis. To attach the presumption of compensability, an employee must first establish a "preliminary link" between his or her injury and the employment. *See, e.g., Tolbert v. Alascom, Inc*., 973 P.2d 603, 610 (Alaska 1999). For injuries occurring after the 2005 amendments to the Act, if the employee establishes the link, the presumption may be overcome at the second stage when the employer presents substantial evidence, which demonstrates a cause other than employment played a greater role in causing the disability or need for medical treatment. *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 at 7 (March 25, 2011). Because the board considers the employer's evidence by itself and does not weigh the employee's evidence against the employer's rebuttal evidence, credibility is not examined at the second stage. *See, e.g., Veco, Inc. v. Wolfer*, 693 P.2d 865, 869-70 (Alaska 1985).

If the board finds the employer's evidence is sufficient to rebut the presumption, it drops out and the 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 the disability or need for medical treatment. *Runstrom*, AWCAC Decision No. 150 at 8. This means the employee must "induce a belief" in the minds of the fact finders the facts being asserted are probably true. *See Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). In the third step, the evidence is weighed, inferences are drawn from the evidence, and credibility is considered.

A controversion notice must be filed "in good faith" to protect an employer from a penalty. *Harp v. ARCO Alaska, Inc*., 831 P.2d 352, 358 (Alaska 1992). "For a controversion notice to be filed in good faith, the employer must possess sufficient evidence in support of the controversion." *Harp* at 358; *citing Kerley v. Workmen's Comp. App. Bd.,* 481 P.2d 200, 205 (Cal. 1971). The evidence which the employer possessed "at the time of controversion" is the relevant evidence reviewed to determine its adequacy to avoid a penalty. *Harp* at 358. If none of the reasons given for a controversion is supported by sufficient evidence to warrant a Board

decision the employee is not entitled to benefits, the controversion was "made in bad faith and was therefore invalid" and a "penalty is therefore required" by AS 23.30.155. *Id.* at 359.

> **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 witness credibility, and its findings about weight are conclusive even if the evidence is conflicting. *See, e.g*., *Harnish Group, Inc. v. Moore*, 160 P.3d 146, 153 (Alaska 2007); *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249, 1253 (Alaska 2007); *Municipality of Anchorage v. Devon*, 124 P.3d 424, 431 (Alaska 2005). The board has sole discretion to determine weight accorded to medical testimony and reports. When doctors' opinions disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.*, AWCAC Decision. No. 087 at 11 (August 25, 2008). In determining whether there is substantial evidence to support a Board decision, a court "must take into account whatever in the record fairly detracts from its weight." *Delaney v. Alaska Airlines,* 693 P.2d 859, 863-64 n. 2 (Alaska 1985) *overruled on other grounds* 741 P.2d 634, 639 (Alaska 1987) (quoting *Universal Camera Corp. v. NLRB,* 340 U.S. 474 (1950)).

> **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. When the board advises that a claim has not been controverted, but further advises that bona fide legal services have been rendered in respect to the claim, then the board shall direct the payment of the fees out of the compensation awarded. In determining the amount of fees the board shall take into consideration the nature, length, and complexity of the services performed, transportation charges, and the benefits resulting from the services to the compensation beneficiaries.

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

Subsection 145(b) requires an employer to pay reasonable attorney's fees when the employer delays or "otherwise resists" payment of compensation and the employee's attorney successfully prosecutes his claim. *Harnish Group, Inc.*, 160 P.3d 149 (Alaska 2007). Attorney's fees in workers' compensation cases should be fully compensatory and reasonable so injured workers have competent counsel available to them. *Cortay v. Silver Bay Logging,* 787 P.2d 103, 108 (Alaska 1990). Fees for time spent on *de minimis* issues will not be reduced if the employee prevails on the primary issues at hearing. *Uresco Construction Materials, Inc. v. Porteleki*, AWCAC Decision No. 152 at 14-16 (May 11, 2011).

> **AS 23.30.135. Procedure before the board**. (a) In making an investigation or inquiry or conducting a hearing the board is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided in this chapter. The board may make its investigation or inquiry or conduct its hearing in the manner by which it may best ascertain the rights of the parties. . . .

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

> **8 AAC 45.065. Prehearings**. . . .
> . . .
>
> (c) After a prehearing the board or designee will issue a summary of the actions taken at the prehearing, the amendments to the pleadings, and the agreements made by the parties or their representatives. The summary will limit the issues for hearing to those that are in dispute at the end of the prehearing. Unless modified, the summary governs the issues and the course of the hearing.
> . . .

> **8 AAC 45.070. Hearings**. . . .
> . . .
>
> (g) Except when the board or its designee determines that unusual and extenuating circumstances exist, the prehearing summary, if a prehearing was conducted and if applicable, governs the issues and the course of the hearing.

ANALYSIS

Is the April 8, 2008 work injury the substantial cause of Employee's need for medical treatment since the September 28, 2010 controversion?

There is no dispute Employee had preexisting degenerative disc disease. The issue is whether the April 8, 2008 Red Robin injury was an aggravation that remains the substantial cause of Employee's need for medical treatment after the September 28, 2010 controversion.

Olsen requires the board to first determine if employment was a substantial factor in bringing about the need for treatment. The overwhelming weight of the evidence is the April 8, 2008 work injury was a substantial factor of the 2009 fusion surgery, which has been the basis for the need for nearly all medical treatment to Employee's low back and lower extremities since that surgery. Based on the opinions of treating physicians Drs. Adams, Kralick, Roderer, Johnson, and Sorini, and SIME physicians Drs. McCormack and Zwerin, Employee's work injury on April 8, 2008 was a substantial factor in bringing about the need for treatment both before and after the September 28, 2010 controversion.

The potential causes of Employee's need for treatment are his preexisting degenerative disc disease, his 2003 work injury at the Hotel Captain Cook, and the 2008 work injury at Red Robin Alaska. The history of treatment for the 2003 work injury was very limited and his symptoms were completely resolved with minimal treatment. Dr. McCormack fixed the date of medical stability for the 2003 Hotel Captain Cook injury as January 2005 and assigned 20% of Employee's current need for treatment to this injury. Between the January 2005 date of medical stability and April 8, 2008, Employee received 22 sporadic chiropractic treatments with no other significant treatment, which is an indication Employee's preexisting condition was stable and asymptomatic on April 8, 2008. Dr. McCormack assigned the preexisting degenerative disc

disease 30% of Employee's current need for treatment to his preexisting condition. The final potential cause is the April 8, 2008 work injury, which led to the 2009 fusion surgery by Dr. Kralick, and pain management treatment including a spinal cord stimulator by Dr. Johnson, prior to the September 28, 2010 controversion, and additional injections and rhizotomies by Dr. Johnson, and surgeries by Drs. Kralick and Storini, after the September 28, 2010 controversion. Dr. McCormack apportioned 50% of the need for treatment to the April 8, 2008 work injury.

The final step under *Olsen* is to apply the presumption of compensability analysis. Without weighing the evidence, Employee attaches the presumption of compensability the April 8, 2008 work injury is the substantial cause of his need for medical treatment since the September 28, 2010 controversion with his testimony, and the reports and testimony of his treating physicians Drs. Kralick, Johnson, and Sorini, and SIME physicians Drs. McCormack and Zwerin. They all opined Employee's April 8, 2008 work injury caused acute symptoms in a previously asymptomatic condition or worsened his preexisting degenerative condition, causing his need for medical treatment after the September 28, 2010 controversion. This evidence is sufficient to raise the presumption of compensability Employee's April 8, 2008 work injury is the substantial cause of his need for medical treatment since the September 28, 2010 controversion. The burden shifts to Employer, which must rebut the presumption with substantial evidence to the contrary.

Without weighing the evidence, Employer rebutted the presumption with Dr. Harris' report and testimony, which provided substantial evidence a cause other than the April 8, 2008 Red Robin injury, *i.e.*, Employee's preexisting degenerative disc disease, played a greater role in causing Employee's increased and continuing symptoms or worsened condition, and thus is the substantial cause of the need for continuing, current treatment.

The reports and testimony of the treating physicians Drs. Kralick, Johnson and Sorini, and SIME physicians Drs. McCormack and Zwerin are the most credible. AS 23.30.122. Both Dr. McCormack and Dr. Zwerin found the April 8, 2008 Red Robin injury to be the substantial cause of the 2009 fusion surgery. Dr. McCormack based his determination on the fact that the 2008 Red Robin injury led to surgery and time loss while the 2003 Hotel Captain Cook injury did not. Dr. McCormack acknowledged that while he may not have performed fusion surgery in this case,

it was within the standard of care for axial back pain which makes it reasonable, and performed in this case, therefore the natural consequences of the 2009 fusion are reasonable, and related to the April 8, 2008 work injury. "Fusions beget fusions" according to Dr. McCormack, which leads to the conclusion that if the April 8, 2008 Red Robin injury was the substantial cause of the 2009 fusion, it is the substantial cause of the two 2012 surgeries.

Has the treatment received since the March 9, 2010 compromise and release agreement been reasonable and necessary?

Employee's 2009 fusion surgery occurred within the first two years after his work injury and, as Dr. McCormack testified, was within the standard of care, therefore the 2009 fusion surgery was reasonable and necessary. Dr. Kralick's 2012 fusion surgery was brought on by the 2009 surgery and the severe stenosis and arachnoiditis which resulted from the 2009 fusion. In addition, Dr. Sorini's 2012 surgery was a direct result of the two fusions performed by Dr. Kralick, which produced mechanical instability at L3-L4. Dr. McCormack and Dr. Zwerin testified the 2012 surgeries were within the standard of care, and reasonable and necessary.

As for the pain management care since the September 28, 2010 controversion, Dr. Zwerin addressed the appropriateness of this treatment and found it to be appropriate due to Dr. Johnson "chasing pain." Dr. Zwerin found all of the injections and rhizotomies to be reasonable and necessary to treat Employee's chronic pain. Dr. Zwerin also opined the April 8, 2008 work injury was the substantial cause of Employee's need for all of the medical treatment he received since the date of injury.

Employer's argument that unsuccessful medical treatment is, by definition, unreasonable is not persuasive. This raises concerns regarding chilling medical treatment for injured workers based on providers concerns over payment for services.

Dr. McCormack testified at hearing all treatment since the 2009 fusion is related to the 2009 fusion and, therefore, related to the 2008 work injury. The 2009 fusion was reasonable and necessary, and all treatment to Employee's low back and lower extremities, including injections, rhizotomies, and medications, are reasonable and necessary.

Is Employee entitled to an award of attorney's fees and costs?

Employer vigorously resisted this case by filing the September 28, 2010 controversion, so fees and costs under AS 23.30.145(b) may be awarded. Employee retained an attorney who was successful in prosecuting this complex claim. Where an injured worker employs an attorney in the successful prosecution of the claim, the board shall make an award of reasonable attorney's fees. In making such an award, the board will consider the contingent nature of the work for an employee in workers' compensation cases, the nature, length and complexity of the services performed, the resistance of the employer or carrier, and the benefits resulting from the services performed. Counsel's efforts on Employee's behalf have resulted in the restoration of his medical benefits, a significant benefit. This decision awarding past and future medical benefits for Employee's low back is a significant benefit to Employee because it is known to be expensive.

Mr. Beltzer submitted two attorney's fees and costs affidavits totaling $26,702.48 in attorney's fees and costs. Section .145(b) requires an award of attorney's fees to be reasonable. Employer has not objected to Employee's attorney's fees and costs. The itemized hours for Employee's attorney's fees and costs are reasonable and do not reflect any misapplied time. Considering the nature, length, and complexity of the case and services performed, Employer's resistance, and the benefits resulting to Employee from the services obtained, Employee will be awarded fees and costs in accordance with this decision.

CONCLUSIONS OF LAW

1. Employee's April 8, 2008 work injury is the substantial cause of his need for medical treatment after the September 28, 2010 controversion.
2. The medical treatment Employee has received since the March 9, 2010 compromise and release has been reasonable and necessary.
3. Employee is entitled to an award of attorney's fees and costs.

ORDER

1. Employer is ordered to pay medical benefits to Employee's medical providers for past medical benefits in accordance with this decision.
2. Employer is ordered to pay for future medical treatment in accordance with this decision.
3. Employer is ordered to pay attorney's fees and costs totaling $26,702.48.

Dated at Anchorage, Alaska on November 04, 2013.

ALASKA WORKERS' COMPENSATION BOARD

____

Laura Hutto de Mander
Designated Chair

____

Patricia Vollendorf, Member

____

Robert Weel, 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 board 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 grounds 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 accordance 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 accordance 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 RAYMOND URREA, employee / applicant v. RED ROBIN ALASKA, INC., employer; REPUBLIC INDEMNITY CO. OF AMERICA, insurer / defendants; Case No. 200808100; dated and filed in the office of the Alaska Workers' Compensation Board in Anchorage, Alaska, and served upon the parties on November 04, 2013.

____

Debbie Chung, Office Assistant