ALASKA WORKERS' COMPENSATION BOARD

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

GARY D. JOHNSTON, Employee, Claimant, v. CHAZ LIMITED, Employer, and COMMERCE AND INDUSTRY INSURANCE COMPANY, Insurer, Defendants.	FINAL DECISION AND ORDER AWCB Case No. 200814397 AWCB Decision No. 17-0004 Filed with AWCB Anchorage, Alaska on January 11, 2017

Gary D. Johnston's (Employee) May 19, 2014 claim was heard on November 29, 2016, in Anchorage, Alaska, a date selected on September 21, 2016. Attorney Joe Kalamarides appeared and represented Employee who appeared and testified. Attorney Krista Schwarting appeared and represented Chaz Limited and Commerce and Industry Insurance Company (Employer). Kathleen Taylor appeared and testified for Employee. The record was left open for one week for Employee's lawyer to supplement his attorney fees and costs. Employer filed an objection to the fee affidavit on December 9, 2016, which the panel considered under 8 AAC 45.195. The record closed on December 14, 2016.

ISSUES

Employee contends his second lumbar surgery on March 26, 2015, and need for ongoing lumbar treatment, arose from his March 11, 2008 work injury with Employer, which he contends is a "continuation injury." Employee contends Employer is liable for his second lumbar surgery and should be required to pay for ongoing medical care for his lumbar spine.

The parties agree Employer paid for Employee's first lumbar surgery, which Employer concedes was necessitated by his work injury. Employer contends Employee's second lumbar surgery and any ongoing need for lumbar spine treatment are caused by natural degeneration and are not Employer's responsibility.

1) **Are Employee's March 26, 2015 lumbar surgery and any ongoing lumbar spine treatment compensable?**

Employee contends he hired an attorney to obtain additional benefits. If he prevails, Employee contends his is entitled to an attorney fee and cost award.

Employer contends Employee's March 26, 2015 surgery is not compensable. Therefore, it contends Employee's attorney fee and cost claims should be denied.

2) **Is Employee entitled to an attorney fee and cost award?**

FINDINGS OF FACT

The following facts and factual conclusions are found by a preponderance of the evidence:

1) On March 11, 2008, Employee was working for Employer on a frame machine in an auto body shop. A clamp and chain slipped off a vehicle and Employee fell about three feet trying to avoid injury. Employee landed hard on his right foot on a concrete floor and immediately noticed sharp stabbing pain, like he had been electrocuted, radiating from his knee up and down his right leg into his groin and lower back. He also injured his right shoulder. Employee began seeing a chiropractor at Ireland Chiropractic Clinic (Ireland) for his injury through early July 2008, with limited relief. Employee initially missed three days from work and returned to a lighter-duty job with Employer. (Employee.).

2) On March 13, 2008, David Parliament, DC, with Ireland saw Employee for his work injury. Employee's chief complaint was constant lumbosacral pain caused by a fall from a framework three feet up. Employee said he fell onto his foot and jammed and twisted his low back on March 11, 2008. The following day, Employee was unable to finish work secondary to pain. Employee had tingling in his right leg "to toes." Dr. Parliament removed him from work, diagnosing acute neck and low back pain "from work related injury." (Parliament Face to Face History -- Consultation; Parliament Authorization for Absence, March 13, 2008).

3) On March 14, 2008, Employee had less low back pain but it worsened with standing. He had no radicular symptoms but had an issue at L5. (Parliament report, March 14, 2008).

4) On March 17, 2008, Employee felt confident he could return to work on light duty the following day. He had right-sided lumbosacral spine pain but no radicular symptoms to his lower extremities. (Parliament report, March 17, 2008).

5) On March 18, 2008, Dr. Parliament noted sensory changes at the L4 through S1 lumbar levels, including tingling down Employee's right lower extremity to his toes. Relevant to this decision and order, he diagnosed "acute, moderate/severe, and traumatic lumbar-sacral and bilateral sacral-iliac strain/sprain associated with possible discogenic involvement." Dr. Parliament again reported L5 issues but no radicular symptoms in Employee's lower extremities early on. There is no mention of symptoms involving the L2-3 level. (Parliament chart notes, March 18, March 24, March 26, 2008; Parliament Physician's Report, March 18, 2008).

6) On May 22, 2008, Employee reported right-sided lumbosacral spine pain with associated numbness in the right anterior thigh. An L5 issue remained an objective finding. (Parliament chart note, May 22, 2008).

7) On June 11, 2008, Employee reported "constant right anterior thigh numbness" and had continued issues at L5. (Parliament chart note, June 11, 2008).

8) On July 22, 2008, Employee worked all day for Employer and went home. He had previously dug a hole in his backyard for a deck he and his wife were building. But 10 minutes after arriving home, Employee went outside and noticed a rock had fallen into the hole. Employee put his right leg into the whole with his left knee on the ground. As he picked up the rock and lifted it from the hole, Employee's right leg "went out" and felt "electrocuted." The symptoms were in the same area as his work injury. Employee was "locked up and couldn't walk," so he crawled

into the house and was lying on the ottoman when his wife arrived and took him to the emergency room, which referred him to Alaska Spine Institute (ASI). (Employee).

9) On July 22, 2008, Employee instantly developed pain in his right pelvis, which radiated into his buttocks and his low back with associated tingling on top of his right foot and thigh. Employee had abnormal sensation to light touch over his right foot between his great toe, second toe and over his right thigh. Meganne Hendricks, M.D., diagnosed low back pain with radiculopathy and right foot numbness. (Hendricks emergency room report, July 22, 2008).

10) On July 24, 2008, Robert Valentz, M.D., at ASI, diagnosed “right L4 radicular pain” and “probable displaced disc.” (Valentz chart note, July 24, 2008).

11) On July 24, 2008, on referral from Dr. Valentz, Employee had his first lumbar spine magnetic resonance imaging (MRI). His symptoms included low back and right posterior thigh pain. Radiologist Ronald Lewis, M.D., read decreased signal intensity at L1, L3 and L4 interspaces with a moderate posterior protrusion at L3-4. Dr. Lewis noted no other abnormalities at the L1-2 or L2-3 levels. There was a circumferential disc protrusion at L3-4 with severe facet joint disease much greater on the left than right, and a protruding disc into the left neural foramen but without compressing the nerve root. At L4-5, Dr. Lewis saw a circumferential disc protrusion with mild impingement on the lateral recess with facet joint hypertrophy, which caused “some definite encroachment on the exiting L4 root.” The “major abnormality is at L4-5, where a combination of facet joint disease and disc protrusion intrude into the right neural foramen with some compression of the right L4 root as it exits through this foramen.” Dr. Lewis stated, “Potentially, this may correlate with the patient’s current symptoms.” (Lewis MRI report, July 24, 2008).

12) On July 24, 2008, after reviewing the MRI results, Dr. Valentz noted Employee’s leg numbness and tingling was on the anterior right thigh and said, “It looks like he has disc protrusion at L4-L5 involving the right lateral recess. His pain is mainly at right L4 nerve root. I recommend an epidural steroid injection.” (Valentz Evaluation; chart note, July 24, 2008).

13) On July 25, 2008, Dr. Valentz performed a right L4 epidural steroid injection for right leg pain. (ASI procedure report, July 25, 2008).

14) On July 31, 2008, Employee completed an injury report stating his right shoulder, leg and hip hurt and his lumbar spine MRI “indicates L4-L5 disc injury.” (Report of Occupational Injury or Illness, July 31, 2008).

15) Employee credibly stated when he bent over to pick up the rock, "that's when the disc went out and basically paralyzed my right leg." Employee's pain after lifting the rock was in the same areas it had been all along since his work injury with Employer. Employee never returned to work thereafter until after he moved to Michigan in October 2009. By the time he left Alaska in October 2009, Employee's pain level was increasing. (Deposition of Gary Johnson, April 28, 2015, at 25, 28, 51; Employee).

16) On August 6, 2008, Larry Levine, M.D., at ASI performed electrodiagnostics on Employee's right leg. Dr. Levine diagnosed lumbar radiculopathy with axonal compromise "in all likelihood probably representing L4 based on the history of the MRI findings." Dr. Levine said this "certainly probably explains much of the situation." (Levine letter, August 6, 2008).

17) On August 6, 2008, Employee told Dr. Valentz the epidural steroid injection helped reduce some leg pain and he still had numbness and tingling "in anterior left leg and low back pain." Dr. Valentz stated Employee "has a displaced disc at L4-L5 involving the right lateral recess." After reviewing Dr. Levine's electrodiagnostic studies, Dr. Valentz recommended a repeat epidural steroid injection at the right L4 and "failing to improve with it consider surgical consultation." (Valentz chart notes, August 6, 2008).

18) On August 21, 2008, Dr. Valentz performed another right L4 epidural steroid injection. Employee reported good relief for one week. Dr. Valentz referred Employee to Dr. Wright for surgical consultation. (Valentz reports, August 21, 2008; September 3, 2008).

19) Epidural steroid injections are both diagnostic and therapeutic. (Experience).

20) On September 3, 2008, Employee had numbness in his right leg and anterior thigh down to the knee. Dr. Valentz found a positive right straight leg raise test and weakness with hip flexion. Employee had an antalgic gait and favored the left side. Dr. Valentz again recommended a surgical consult. (Valentz chart note, September 3, 2008).

21) On September 16, 2008, Employee saw Kim Wright, M.D., and provided a consistent history including the incident at home with the rock. Employee had "intractable right lower extremity pain, weakness, atrophy and numbness." He conceded a "long history of back problems" treated with chiropractic for years. Dr. Wright understood electromyography (EMG) and MRI showed likely L4 nerve root and L4-5 problems. Employee's symptoms radiated from his back through his hip into his right medial thigh where he had atrophy. His pain radiated to the foot but was mostly localized to his thigh, and Employee had weakness. Dr. Wright

reviewed the MRI without the radiologist's interpretation and thought he saw a subtle soft tissue mass in the far lateral recess at L2-3, which he thought could represent a far lateral disc herniation. He recommended Employee undergo computer assisted tomography (CT) to identify the mass at L2-3. Given Employee's right medial thigh pain, Dr. Wright was "more suspicious" he had an L2-3 level problem "even though" L4-5 "certainly appears to be quite abnormal." Further recommendations awaited CT scan results, but if a soft tissue mass was seen at L2-3 Dr. Wright proposed a far lateral L2-3 discectomy. (Wright report, September 16, 2008).

22) On September 19, 2008, Employee had a lumbar spine CT without contrast. Radiologist Christopher Kottra, M.D., found moderate L4-5 degenerative disc disease with mild degenerative disc disease present throughout the remaining lumbar levels. At L4-5, there was a small, broad, posterior disc protrusion resulting in at least mild canal stenosis and some degree of right foraminal stenosis, and moderate bilateral facet degenerative joint disease. At L3-4 there was a small, mild, broad, posterior disc protrusion accompanied by degenerative hypertrophic ligamentum flavum on both sides and pronounced left-sided facet degenerative joint disease resulting in mild canal stenosis. At L2-3 there was "very slight disc bulging as well as bilateral facet ligamentous flavum hypertrophy resulting in canal stenosis." Dr. Kottra did not mention any soft tissue mass at or near L2-3. (CT report, September 19, 2008).

23) On September 23, 2008, Dr. Wright saw Employee to review the CT results. Dr. Wright reiterated he had been suspicious Employee had a soft tissue mass at what he called L2-3 "although some might" interpret this level "as L3-4." Dr. Wright again thought he saw a mass though his report does not specify the level as the transcriptionist could not understand his dictation. Dr. Wright opined Employee's sciatica symptoms, precipitated "by his on-the-job injury," arose from the foraminal stenosis at L4-5 associated with marked facet disease. Dr. Wright surmised Employee probably "jammed" the joint when he fell, narrowing the neural foraminal and precipitating sciatica. He recommended a contrast-enhanced MRI scan to verify the suspected soft tissue mass. (Wright report, September 23, 2008).

24) On September 24, 2008, Employee had his second lumbar spine MRI scan, this time with and without contrast, which was compared to the July 24, 2008 MRI scan. The third radiologist to evaluate Employee's lumbar spine, W. Bryan Winn, M.D., found mild to moderate bilateral facet arthropathy with hypertrophic changes of the ligamentum flavum and joint capsules at L2-3; a broad far left lateral disc protrusion with associated annular fissure and moderate left neural

foraminal stenosis and bilateral facet arthropathy, left greater than right, at L3-4; a mild, broad disc bulging with associated interforaminal disc osteophyte complex on the right resulting in at least moderate neural foraminal stenosis and moderate bilateral facet arthropathy "as before" at L4-5; and a normal disc at L5-S1 with moderate bilateral facet arthropathy as in the prior study. Dr. Winn made no reference in his "impression" section to L2-3 or any related soft tissue mass. His impression included an interforaminal disc "osteophyte complex" at L4-5, which resulted in moderate to marked neural foraminal stenosis on the right, and moderate degenerative retrolisthesis at L4-5 with multilevel facet arthropathy throughout the lower lumbar spine. (Winn MRI report, September 24, 2008).

25) On September 30, 2008, following Employee's second MRI Dr. Wright reiterated Employee carried a foraminal stenosis diagnosis at L4-5, and the recent MRI again showed a disc osteophyte complex compromising the right L5 nerve root, with moderate retrolisthesis at L4-5. Employee's chief complaints were back pain, and leg pain, weakness and atrophy. Dr. Wright called Dr. Kottra and, after discussing the most recent MRI with him, stated:

> Impression: The patient, his wife and I have gone over his MRI together. Once again I am impressed with a soft tissue mass at L2-3. This led to a phone call to Dr. Kottra with Providence Radiology, and he agrees that the soft tissue mass at L2-3 most likely represents a free fragment disc herniation. Because of the patient's progress of symptoms of pain, weakness, and atrophy I have recommended a surgical exploration and decompression on the right at L2-3 as an initial means of treatment.

Risks included the "possible need for additional surgery." Employee wanted to proceed at the earliest possible date. (Wright report, September 30, 2008).

26) On September 30, 2008, at Dr. Wright's request, Dr. Kottra reviewed Dr. Winn's September 24, 2008 MRI and adopted verbatim Dr. Winn's prior reading. However, Dr. Kottra's addendum noted at L2-3 "there is a smooth oval lesion just lateral to the right lateral recess measuring approximately 6 mm by 12 mm." Dr. Kottra's differential diagnoses included a far lateral disc extrusion versus a small tumor. He favored the free fragment diagnosis given how the lesion illuminated. (Kottra MRI Addended Report, September 28, 30, 2008).

27) On October 4, 2008, Keith Holley, M.D. performed an employer's medical evaluation (EME) on Employee. Employee's chief complaints were low back and right leg pain. Dr. Holley reviewed Employee's medical records, including two MRIs and noted nothing from

those reports referencing L2-3, except Dr. Wright's reference. He also reviewed both lumbar MRIs and the lumbar CT digitally. (Deposition of Keith Holley, M.D., August 2, 2016, at 5-6). Dr. Holley said the CT "more clearly shows what appears to be a broad-based disc osteophyte complex far lateral to the right at L2-3." When asked about Employee's July 2008 MRI scan, Dr. Holley said the MRI showed facet joint arthritis. He stated, "The arthritic changes in the facet joints are certainly traumatic in nature." On examination, Employee demonstrated weakness on the right side on heel walking. Dr. Holley saw no leg atrophy but found decreased sensation on the right, anterior, medial thigh consistent with an L2 dermatome. Dr. Holley diagnosed right lower extremity radiculopathy with examination findings suggesting sensory loss in the L2 dermatome, and corresponding imaging suggesting a far right lateral disc osteophyte complex at L2-3, both related to the work injury. He also diagnosed multilevel lumbar spondylosis, degenerative disc and facet joint changes, preexisting and not caused by the work injury, but temporarily aggravated. Dr. Holley concurred with Dr. Wright's recommendation for surgery at L2-3. (Holley report, October 4, 2008).

28) On October 20, 2008, Dr. Wright performed surgery on Employee at L2-3. Employee had brief relief he attributed to surgical medications, but his symptoms returned. (Employee).

29) On October 20, 2008, Dr. Wright said during surgery he found a "focal disc protrusion//herniation at L2-3, displacing the right L2 nerve root." After a "good deal of exploration," Dr. Wright found no free fragment at this level. (Wright report, October 20, 2008).

30) On October 21, 2008, Dr. Wright discharged Employee noting he "had previously carried the diagnosis of foraminal stenosis at L4-5," but Dr. Wright had operated at L2-3, "which more likely represented the cause for his symptoms." (Wright report, October 21, 2008).

31) On December 8, 2008, Employee began physical therapy (PT). His symptoms had improved since surgery but he had intense spasms at his hip and low back pain with "significant" right lower extremity weakness. The therapist noted decreased sensation on the right leg from L2 through L4 dermatomes. (Eagle Center Physical Therapy report, December 8, 2008).

32) On January 6, 2009, Employee had back stiffness, residual right leg pain, spasms and "persistent" leg weakness. He was to return in three months. (Wright report, January 6, 2009).

33) Employee noticed his right leg became weaker post-surgery. He relied on his left leg and had right "foot drop." Walking on uneven surfaces became difficult and painful. (Employee).

34) Employee told Dr. Wright he did not believe the surgery was successful. Dr. Wright said it might take a year for the surgery's results to be fully realized. (*Id.*).

35) On March 19, 2009, Shawn Johnston, M.D., performed a permanent partial impairment (PPI) rating on Employee. Dr. Johnston said Employee had a disc herniation and surgery "at the L3-L4 level." Employee reported "ongoing back and right leg pain and also a feeling that his leg just is not as strong as the other." Employee had "slightly altered sensation in the right L4 distribution," but symmetric reflexes. Dr. Johnston provided an 11 percent PPI rating based on a disc herniation with documented, ongoing radiculopathy. (Johnston report, March 19, 2009).

36) On April 6, 2009, Employee's physical therapist updated his situation following numerous PT sessions and Employee's chief complaint continued to be burning from his back down to his anterior right thigh. (Eagle Center Physical Therapy report, April 6, 2009).

37) On April 7, 2009, Employee had continued back discomfort and residual right leg weakness. Dr. Wright told Employee to return as needed. (Wright report, April 7, 2009).

38) In late fall 2009, Employee moved to Michigan. (Employee).

39) Shortly after moving to Michigan, Employee saw family physician Terry Jackson, D.O., in December 2009, who referred him to Eugene Wang, D.O. Dr. Wang told Employee his workers' compensation insurer would require conservative treatment before allowing more aggressive care. Dr. Wang's conservative efforts, including injections and disc ablation treatments at L4-5, proved unsuccessful though Employee had some relief from the radiofrequency ablations for up to six months. He continued to take medication, which blocked the pain but left him in a "stupor." His right foot drop was progressively getting worse. (*Id.*).

40) On December 18, 2009, Employee's back was not getting better. Following his work injury, Employee's right thigh numbness never improved. His right leg weakness continued and he had difficulty sitting. Dr. Jackson diagnosed, among other things, chronic low back and right leg pain. (Jackson report, December 18, 2009).

41) On February 3, 2010, Dr. Wang reviewed the July 24, 2008 MRI and noted a broad-based disc protrusion at L4-5 causing bilateral, lateral recess stenosis and severe facet joint hypertrophy at this level. Relevant findings included right L3 and L4 radiculopathy. Dr. Wang recommended another MRI with and without contrast, and a possible lumbar epidural steroid injection followed by PT and pain medication. (Wang report, February 3, 2010).

42) On February 9, 2010, Employee had another lumbar spine MRI but the report is not found in the agency record. (Observations).

43) On March 9, 2010, Dr. Wang reviewed Employee's otherwise unidentified MRI and performed right L3 and L4 epidural steroid injections on Employee and noted he has "6 lumbar-type vertebrae." (Wang report, March 9, 2010).

44) On March 12, 2010, Employee began PT following his epidural steroid injections. He still had decreased sensation in his right lower extremity in the L2-3 distribution. (Northern Michigan Sports Medicine Center East report, March 12, 2010).

45) On March 29, 2010, Employee had 60 percent relief in his right lower extremity pain from his steroid injection but he still had back pain, worse when he sat. Employee reported increased low back pain after stair climbing. (Dr. Wang report; PT report, March 29, 2010).

46) On April 5, 2010, Employee had low back spasms on Saturday and residual soreness from them on Sunday. (PT report, April 5, 2010).

47) On April 7, 2010, Employee's right leg continued to be "tight" with minor radicular symptoms. (PT report, April 7, 2010).

48) On April 14, 2010, Employee had increased right leg pain. (PT report, April 14, 2010).

49) On April 16, 2010, Employee's right leg pain continued to be most symptomatic. (PT report, April 16, 2010).

50) On April 19, 2010, Employee had increased low back and right leg pain after having been seated in a car for a prolonged period over the weekend. (PT report, April 19, 2010).

51) On April 21, 2010, Employee's low back continued to be painful and caused right leg pain. He continued to have radicular symptoms following treatment. (PT report, April 21, 2010).

52) On April 26, 2010, Employee remained in PT but felt he had "plateaued." He continued to have burning and aching in the lateral and anterior right lower extremity. Dr. Wang diagnosed right L3, L4 radiculopathy. (Dr. Wang report, April 26, 2010).

53) By April 26, 2010, Dr. Wang suggested additional lumbar injections to address Employee's constant low back pain. (PT reports, April 26, 28, 2010).

54) On April 27, 2010, Employee had only minimal improvement in low back and radicular right leg pain. (PT report, April 27, 2010).

55) On May 18, 2010, Dr. Wang performed another epidural steroid injection on Employee at L3 and L4 on the right. (Dr. Wang report, May 18, 2010).

56) On June 17, 2010, Employee's primary complaint was right-sided spasm in his low back. Dr. Wang diagnosed right L3 and L4 radiculopathy, with right-sided muscle spasms possibly secondary to lumbar facet arthropathy. (Dr. Wang report, June 17, 2010).

57) On August 12, 2010, Employee had right-sided muscle spasms mitigated by pain pills. (Dr. Wang report, August 12, 2010).

58) On December 8, 2010, Employee still had right buttock and thigh pain. He continued using pain medication. Employee had positive straight leg raising on the right with severe right-sided low back pain. Left leg straight leg raising also caused severe pain but not as bad as on the right. Dr. Wang's impressions remained the same and he suggested another L3 and L4 epidural steroid injection and lumbar branch blocks. (Dr. Wang report, December 8, 2010).

59) On December 14, 2010, Employee received a right L3 and L4 epidural steroid injection. (Dr. Wang report, December 14, 2010).

60) On January 5, 2011, Employee said he had five day's relief from the December 14, 2010 injection. He reported the May 2010 did not help much. (Dr. Wang report, January 5, 2011).

61) On March 9, 2011, Employee's symptoms were unchanged until where sitting for prolonged periods exacerbated his low back and leg pain. (Wang report, May 9, 2011).

62) On May 9, 2011, since Employee's symptoms remained the same, Dr. Wang suggested a "left L4 medial branch and L5 dorsal remount block, possibly L3." Employee continued to take pain pills. (Dr. Wang report, May 9, 2011).

63) On May 13, 2011, Employee received a right L3 and L4 medial branch and L5 dorsal rami block. The May 9, 2011 reference to a "left" injection was a dictation or typographical error. (Dr. Wang's report, May 13, 2011; inferences drawn from the above).

64) On June 2, 2011, Employee received right L3 and L4 medial branch blocks and an L5 injection. (Dr. Wang report, June 2, 2011).

65) On June 27, 2011, Employee received a right L3 and L4 medial branch block and an L5 dorsal rami radiofrequency neurotomy. The prior two medial branch and dorsal rami injections resulted in greater than 80 percent pain reduction. The radiofrequency neurotomy was done for therapeutic purposes. (Dr. Wang report, June 27, 2011).

66) On June 30, 2011, Employee said the recent medial branch and L5 dorsal rami radiofrequency neurotomy provided 90 to 95 percent lumbar pain relief and he had significantly reduced his pain pill use as a result. (Dr. Wang report, June 30, 2011).

67) On August 24, 2011, Employee reported doing better since his radiofrequency neurotomy and was able to sit in a car for a longer period. He continued to have right-sided radicular symptoms, which were unresponsive to epidurals. Dr. Wang again diagnosed right L3 and L4 radiculopathy, "unchanged." (Dr. Wang report, August 24, 2011).

68) On November 23, 2011, Employee had restarted his pain medication. Dr. Wang continued to diagnose right L3 and L4 radiculopathy, "unchanged" and lumbar spondylosis well-controlled following radiofrequency neurotomy. (Dr. Wang report, November 23, 2011).

69) On January 18, 2012, Dr. Wang continued to diagnose right L3 and L4 radiculopathy. (Dr. Wang report, January 18, 2012).

70) On January 31, 2012, Dr. Wang responded to a letter from the adjuster and explained Employee's further treatment may include repeat radiofrequency neurotomy pending returning or worsening low back pain, chronic pain medications and possibly a spinal cord stimulator if Employee's lumbar radiculopathy worsened. Dr. Wang noted:

> As this is going to be a lifelong, chronic problem I expect he may need some or all of the above-mentioned treatments throughout his life. I believe he has reached MMI. Treatments from here on would be to maintain his current level of functioning. (Wang letter, January 31, 2012).

71) On February 15, 2012, Employee continued to have low back pain and radicular symptoms from his "work-related injuries on 3/11/2008 and 7/21/2008." Employee reported no symptom changes since his last appointment. (Wang report, February 15, 2012).

72) On April 10, 2012, Employee needed his pain medication refilled to address low back and joint pain. His radiofrequency neurotomy was "wearing off." Employee's straight leg raising was negative on both sides, though his lumbar range of motion was decreased with back pain and tenderness in the right lower lumbar spine. Dr. Wang recommended another right L3 and L4 medial branch and L5 radiofrequency neurotomy. (Dr. Wang report, April 10, 2012).

73) On April 16, 2012, Employee received another right L3 and L4 medial branch and L5 dorsal rami radiofrequency neurotomy. (Dr. Wang report, April 16, 2012).

74) On May 29, 2012, Employee told Dr. Wang the recent injections and radiofrequency neurotomy provided 90 to 100 percent pain relief. His remaining pain was localized in the right low back and groin and he described it as an aching cramping sensation radiating down his right anteromedial thigh. (Dr. Wang report, May 29, 2012).

75) By July 24, 2012, Employee reported low back pain relief but continued right anterolateral thigh pain. He used Percocet daily to control pain. (Dr. Wang report, July 24, 2012).

76) On September 18, 2012, Employee had increased low back pain from working 18 hours per week. His symptoms ached, stabbed and radiated into his right anterior lower extremity. Sitting increased his symptoms while opiate use reduced them. Dr. Wang described the 2010 MRI as "abnormal," with pertinent findings including right L4 neural foraminal stenosis. Employee increased Percocet intake to six per day. Dr. Wang recommended another MRI, EMG tests and referral to a neurosurgeon. (Wang report, September 18, 2012).

77) On October 20, 2012, Dr. Holley performed another EME. Employee told Dr. Holley when his symptoms did not improve with conservative care Dr. Wright performed an "L2-L3-L4 lateral discectomy." The surgery did not help. Employee moved to Michigan and had additional steroid injections and PT, which did not help. Employee still exhibited diminished sensation over the medial right thigh. Dr. Holley reviewed the February 9, 2010 MRI on a CD-ROM, which he interpreted to show multilevel degenerative disc disease with a broad-based posterior bulge most prominent at L4-5 creating mild, central, lateral recess narrowing but no nerve root impingement. The L2-3 and L3-4 levels were mildly degenerative with lesser bulging and there was no recurrent herniation at L2-3. Dr. Holley diagnosed a right L2-3 far lateral disc herniation with associated right lower extremity radiculopathy, status post discectomy in October 2008. He attributed this disc herniation to the March 11, 2008 work injury. He also found multilevel spondylosis, degenerative disc disease and facet arthropathy, which in his view were all preexisting but temporarily aggravated by the March 11, 2008 work injury. Dr. Holley opined the substantial cause of Employee's current disability and need for medical care was natural progression of his degenerative lumbar changes and not the March 11, 2008 work injury. Dr. Holley found no intervening factors affecting Employee's lumbar spine. In his view, Employee needed no further diagnostic studies, tests or treatment. Dr. Holley opined pain medications, Flexeril and epidural steroid injections were not reasonable or necessary going forward, though they were medically acceptable in the past. The substantial cause of the ongoing need for these modalities was, in Dr. Holley's opinion, natural progression of Employee's degenerative lumbar spine condition and not the March 2008 work injury. (Holley EME report, October 20, 2012).

78) On November 9, 2012, Employee reported back pain. He was working two eight hour days per week and lumbar pain radiated into his right anterior lower extremity and was moderate.

Sitting aggravated his symptoms while opiates helped relieve them and during his recent trip to the EME, Employee increased his Percocet intake to compensate and was typically using six pills per day. He still exhibited paresthesia on his right lower extremity. Adam Wilson, PA-C, suggested "radicular syndrome of lower limbs," and again considered electrodiagnostic testing and a lumbar MRI when he "wants to go to surgeon." (Wilson report, November 9, 2012).

79) In late 2012, Employee worked briefly in Michigan as a maintenance man about 18 to 20 hours per week cleaning and sweeping. Climbing steps and reaching proved painful and increased his right foot drop, which prompted Employee to cease this work. (Employee).

80) On January 14, 2013, PA-C Wilson renewed Employee's pain medications, repeated the prior diagnoses and agreed with Dr. Holley's opinion stating no further epidural steroid injections were needed currently but offered there could be a time when an exacerbation may require additional injections. Employee should consider a neurosurgical referral in the future as he continued to have right L4 neural foraminal stenosis. (Wilson report, January 14, 2013).

81) On March 6, 2013, Dr. Wang refilled Employee's medication and noted he had increasing right low back pain and right lower extremity radicular symptoms. Dr. Wang diagnosed radicular syndrome of lower limbs with symptomatic right L4 and lumbar spondylarthritis. (Wang report, March 6, 2013).

82) On March 11, 2013, a lumbar MRI with and without contrast revealed very slight spine dextrocurvature; no issues at L1-2; generalized disc bulging with facet hypertrophy causing mild lateral recess and foraminal encroachment at L2-3; generalized disc bulging and more severe facet hypertrophy causing mild biforaminal encroachment and left lateral recess encroachment at L3-4; generalized disc bulging with facet arthropathy causing severe right foraminal encroachment and mild right lateral recess encroachment and left foraminal encroachment at L4-5; and no significant issues at L5-S1. Radiologist Michael Angileri, M.D., opined the "most severe degree of encroachment" involved the right exit foramen at L4-5, "not significantly changed from" the February 9, 2010 MRI. (MRI report, March 11, 2013).

83) On March 13, 2013, contrary to radiologist Angileri's opinion, PA-C Wilson found increasing facet hypertrophy at L3-4 and L4-5 and severe, right, neural foraminal stenosis at L4-5 "again worse than 2010 MRI." Employee's symptoms included localized right lower back pain radiating into the right anterior and medial proximal leg. Walking and lifting aggravated the

symptoms while injections and pain medication reduced them. PA-C Wilson recommended another right, L4 epidural with radiofrequency neurotomy. (Wilson report, March 13, 2013).

84) On March 28, 2013, Dr. Wang repeated comments from PA-C Wilson's March 13, 2013 report. Employee's complaints still included localized right lower back pain radiating into his right anterior and medial proximal leg. The symptoms "began on 7/21/2008." (Wang report, March 28, 2013).

85) On April 29, 2013, Employee received another right L3 and L4 medial branch and L5 dorsal rami radiofrequency neurotomy. (Wang report, April 29, 2013).

86) On May 23, 2013, Employee reported good relief from his April 29, 2013 neurotomy. His pain was localized to the lumbar spine and did not radiate. Sitting aggravated his low back pain and it was relieved with rest and painkillers. (Wilson report, May 23, 2013).

87) On August 19, 2013, PA-C Wilson noted the three prior neurotomies had given Employee longer-lasting relief and increased his sitting tolerance. PA-C Wilson renewed his medications. (Wilson report, August 19, 2013).

88) On July 17, 2013, Employee reported his case had been controverted following the Holley EME. Dr. Wang reviewed Employee's history and noted he had no chronic, constant low back pain and radicular symptoms prior to his work injury. Post-injury he was symptomatic with constant low back pain and occasional radicular symptoms. He initially presented with difficulty walking up stairs due to weakness and pain. (Wang report, July 17, 2013).

89) On November 6, 2013, Employee had been busy preparing for winter, which caused increased pain localized in his lumbar spine and radiating down his right lower extremity. Walking and standing aggravated his symptoms and they were relieved with rest. Employee had increasing low back and "left leg spasms." PA-C Wilson noted a work accident "in 3/11/2008 and 7/21/2008," and the March 11, 2013 MRI, which revealed severe, right neural foraminal stenosis and mild lateral recess stenosis at L4-5 as well as mild, bilateral neural foraminal and mild left lateral recess stenosis at L3-4. (Wilson report, November 6, 2013).

90) On January 15, 2014, PA-C Wilson recorded similar complaints and findings as from his November 6, 2013 report. Employee again mentioned increasing low back and left leg spasms. Employee also had mild depressive symptoms. (Wilson report, January 15, 2014).

91) On March 21, 2014, Employee's right low back and buttock pain was returning and he was close to time for another radiofrequency neurotomy. The report does not mention left leg spasms or symptoms. (Wang report, March 21, 2014).

92) On April 1, 2014, Employee reported significant low back relief with radiofrequency neurotomy. He did not report back pain before his March 11, 2008 work injury. Though joint degeneration can be a normal aging process, Dr. Wang opined it was very likely Employee's work injury and resultant surgery increased the degeneration. Future radiofrequency neurotomies were needed to treat his post-work-accident back pain. (Wang letter, April 1, 2014).

93) On May 28, 2014, having apparently had another right L3 and L4 medial branch and L5 radiofrequency neurotomy (records for which are not found in the agency file), Employee reported significant pain relief. (Wang report, May 28, 2014; observations).

94) On June 16, 2014, Employer filed a notice denying Employee's right to further medical benefits, based on Dr. Holley's EME report. (Controversion Notice, June 14, 2014).

95) On August 11, 2014, Employee reported doing well until he mowed his lawn and had increased pain in his right leg and back. The pain radiated into his right lower extremity. Employee was directed to return as needed for care. (Wang report, August 11, 2014).

96) On November 18, 2014, Employee had another lumbar MRI with and without contrast, which was compared to the "March 11, 2012" MRI. Only the report's first page is found in the agency file. The unidentified radiologist's impression included progressive, broad-based disc bulging at L3-4, which in conjunction with ligamentum flavum prominence and associated facet arthropathy results in mild central canal stenosis; broad-based bulging at the L4-5 interspace with disc material extending to the right resulting in nerve root exit zone narrowing; and multilevel facet arthropathy from L2-5 bilaterally. (MRI report, November 18, 2014).

97) On December 10, 2014, neurosurgeon David Morris, M.D., evaluated Employee for low back pain with radiation into his bilateral lower legs with the right more profoundly involved than the left. Employee gave a consistent history including his work injury and related medical care. His low back and right leg symptoms waxed and waned over the years. About five years earlier, he began noticing strength loss on dorsiflexion in his right ankle. He had difficulty walking and a tendency to stumble with his right leg. Dr. Wang's radiofrequency treatments improved his back pain and radicular symptoms for up to eight months. In May 2013, Employee began noticing increased symptoms when walking on uneven ground. Employee currently had

low back pain with radiation through the anterior, medial right thigh and outside his right calf and shin to include his right foot. Employee also noted "more recent" pain involving his low back with radiation through his "left buttocks and posterior lateral thigh." These symptoms were not as dramatic as those in his right leg but seemed "variant from the pattern of symptoms which in the past predominated within his right lower extremity." Employee's surgical history included a lumbar discectomy at L2-3 in 2008. Employee currently had patchy sensation loss over the anterior right thigh. Upon reviewing the November 18, 2014 MRI, Dr. Morris noted prior surgery "potentially at L4-5 on the right," with disc space loss and significant facet spondylitic changes that could encroach on the exiting right L4 nerve root. Employee also had a central to left-sided disc protrusion at L3-4. Though he had mentioned the correct surgical level earlier in his report, Dr. Morris erroneously concluded the prior surgery had occurred at the L4-5 level, which he thought might account for some MRI findings. Employee's presentation was consistent with mechanical low back pain and residual radicular dysfunction in the L4 and L5 distributions. Dr. Morris noted Employee's radiofrequency ablations had provided good relief for back and lower extremity pain and symptoms. This further supported Dr. Morris' belief there was an issue at the L4-5 level contributing to Employee's symptoms. However, Dr. Morris opined there may be a "more acute radicular contribution" to his present complaints within his left lower extremity. Therefore, Dr. Morris recommended a lumbar myelogram with flexion and extension views to look for structural issues. (Morris report, December 10, 2014).

98) On January 7, 2015, Employee had a lumbar myelogram to evaluate a "herniated lumbar disc." The radiologist's impressions included effaced traversing nerve roots bilaterally at L1-2 and L2-3; mild canal stenosis at L2-3 and moderate canal stenosis at L3-4; a low-grade retrolisthesis of L1 on L2, L3 on L4, and L4 on L5 with improvement at L3 on L4 with flexion imaging, which suggested segmental motion instability; and exiting nerve root truncation at L3-4 secondary to canal stenosis. (Myelogram report, January 7, 2015).

99) On January 7, 2015, Employee also had a lumbar spine CT following the myelogram. The radiologist noted vertebral segment numbering was based on numbering used on the MRI. Thus, the L5 vertebra was actually a transitional segment and partially sacralized. The radiologist read disc space narrowing throughout the lumbar spine with retrolisthesis of L1 on L2, L3 on L4 and L4 on L5. L1-2 had mild disc space narrowing with slight retrolisthesis of L1 on L2 and a diffuse disc bulge eccentric to the right making an impression on the right anterior thecal sac but

with no central canal stenosis; L2-3 had disc space narrowing with a diffuse disc bulge eccentric to the right and facet joint degeneration with lateral right recess stenosis and mild central canal stenosis with mild right neural exit canal narrowing; L3-4 showed slight disc space narrowing and retrolisthesis L3 on L4 with a diffuse disc bulge, marked degenerative changes on the left facet joint and moderate central canal stenosis and bilateral neural exit canals narrowing; L4-5 demonstrated marked disc space narrowing with mild retrolisthesis of L4 on L5, marked degenerative changes in facet joints and bilateral, lateral recess stenosis without central canal stenosis but bilateral neural exit canal narrowing but especially on the right; and L5-S1 showed mild posterior disc bulge and degenerative changes in facet joints but no central canal stenosis but neural exit canal narrowing especially on the right. (CT report, January 7, 2015).

100) On January 12, 2015, given these results Dr. Morris advised bilateral medial facetectomies without fusion at L4-5. Employee wanted to proceed. (Morris report, January 12, 2015).

101) On March 26, 2015, Dr. Morris performed lumbar surgery on Employee. The surgical records are not found in the agency file. (Employee; Employer; observations).

102) On June 25, 2015, Alan Roth, M.D., saw Employee for a second independent medical evaluation (SIME). Employee had "significant degenerative spine and disc disease" prior to his work injury, which was not caused by the injury. However, he also had "some significant disc protrusion, particularly pushing against the right L4 nerve root," which Dr. Roth opined "probably was related to the -- more likely than not, was related to the work injury." Dr. Roth said it was possible the disc protrusion at L4 could have been caused by or impacted by the July 22, 2008 rock incident at home, but further stated "it's my understanding that he had some radicular complaints in the distribution of L4 and L3 levels at the time of -- subsequent to the time of his work injury, that he didn't have before his work injury, and that he continued to have and, possibly, became more significant after the home injury." (Deposition of Alan C. Roth, M.D., November 10, 2015, at 11, 12-13).

103) Dr. Roth opined epidural steroid and block injections Dr. Wang performed on Employee after he moved to Michigan were not reasonable and necessary because they did not diminish Employee's radicular or back pain. He agreed with Dr. Holley's opinion suggesting by October 20, 2012, the work injury was no longer the substantial cause of Employee's need for treatment. Dr. Roth opined Employee developed "a fairly acute episode," or possibly a "smoldering, chronic episode," of foot drop and relatively severe radiculopathy prior to his second surgery,

which "probably precipitated his surgery." Dr. Roth stated the foot drop and worsening lower extremity symptoms developed because Employee had significant spinal stenosis and degenerative changes in the lumbar spine and also had "some disc protruding or, perhaps, herniating, pushing on his -- on his nerve at that level." Dr. Roth opined Employee's degenerative changes caused his spinal stenosis to worsen. Dr. Roth agreed the second surgery performed on Employee by Dr. Morris was reasonable and necessary. (*Id*. at 14-16, 18-21).

104) Dr. Roth said Employee complained to him about, among other things, "pain to the hip and back at the left side," and a "foot drop on the left side, which was improved subsequent to his surgery." In Dr. Roth's opinion, Employee's diffuse degenerative changes throughout the lumbar spine caused his subsequent symptoms to the left lower extremity. He conceded the bulging disk was protruding more in the left side though Employee could have had symptoms on either side from the disk. Dr. Roth said within one year from Employee's 2008 lumbar surgery all additional lumbar spine treatment would be considered "nonindustrial." He based the one-year timeline on typical results from non-fusion surgery. (*Id*. at 21-22, 24, 26).

105) Other than Dr. Roth's report, the record contains no medical documentation Employee ever complained of a left foot drop. (Observations).

106) Dr. Roth noted Dr. Morris thought the first surgery had been provided at the same level on which Dr. Morris had operated, which was not correct. He stated the work injury did not aggravate or combine with Employee's preexisting lumbar condition to cause the need for the second surgery. (Deposition of Alan C. Roth, M.D., November 10, 2015, at 29, 39-40).

107) Referring to Employee's July 22, 2008 incident at home with the rock, Dr. Roth did not think the details about this event were critical because in his opinion, Employee's "problems, at that point, were substantially caused by his just prior work injury," and the rock incident "probably exacerbated his situation a little bit." Dr. Roth understood Employee, after his first low back surgery, continued to have some back pain similar to what he had prior to his surgery and he had some "chronic low back issues." He understood Employee's radicular complaints improved after the first surgery but he continued to have back pain and difficulty moving. "After another couple years, or whatever, he had some deterioration again." In his opinion, the deterioration was not affected by the injury, related surgery or Employee's treatment. (*Id*. at 33).

108) Dr. Roth thought Employee was symptomatic pre-injury in his low back because he had treated for some time with a chiropractor prior to his work injury. However, Dr. Roth agreed the only chiropractic reports he read were after his work injury with Employer. (*Id*. at 37).

109) On July 6, 2015, Dr. Morris reviewed diagnostic studies dating to February 2010, which suggested continuing disc and spondylitic contributions at L4-5 on the right, "which remained consistent with his subjective complaints." Dr. Morris noted "serial MRI studies" suggested the L4-5 condition had progressed and the MRIs showed "persistence of the disc contribution" and lateral recess compression at L4-5. On Dr. Morris' initial examination, Employee had localized low back pain with radiation through the posterior, lateral right thigh and outside right calf involving his foot. Employee noted weakness in his right foot when dorsiflexing his ankle. He had a positive right straight leg raising test, which reproduced his radicular symptoms. Dr. Morris found objective muscle weakness and subjective sensory loss consistent with L5 radicular dysfunction. In Dr. Morris' erroneous view, a November 2014 MRI showed previous surgery at L4-5 with encroachment on the L4 and L5 nerve roots and a right-sided disc protrusion at L4-5. Dr. Morris opined his March 26, 2015 surgery addressed the L4-5 segment originally defined as a symptom producer in 2008. Dr. Morris found Employee's symptoms have "been persistent and stereotypic for L5 radicular compromise" since his March 2008 work injury. He concluded since Employee's complaints began in temporal relationship to his March 2008 work injury and persisted until surgical correction in 2015, "it is likely that this accident precipitated the structural abnormality in respect to the L4-5 level that ultimately resulted in surgical therapy targeting this region." Though the degenerative process continued in the intervening years, the underlining 2008 disc injury contributed to degeneration in Employee's lumbar spine. Dr. Morris opined the March 11, 2008 work injury precipitated a focal disc herniation at L4-5. Dr. Morris said the L4-5 structural problem remained static until addressed surgically on March 26, 2015. (Morris letter, July 6, 2015; observations).

110) Dr. Morris is board-certified in neurosurgery. As had other physicians, he found Employee had an extra lumbar vertebra. He reviewed all the MRIs in this case. The July 24, 2008 MRI was "not terribly impressive in terms of obvious foraminal compromise" at the operated L2-3 level. Nonetheless, Dr. Morris was certain Dr. Wright used clinical presentation as motivation for targeting L2-3. By contrast, the L3-4 and L4-5 levels were "more dramatic" than the structural abnormality at L2-3. In Dr. Morris' opinion, the disc abnormalities at L3-4

and L4-5 "remained persistent." When Dr. Morris first examined Employee in December 2014, a myelogram showed spondylitic degenerative change "visible on the 2008 MRI." Dr. Moore said the radiologists have typically labeled the L4-5 level as L3-4 due to the anomaly in Employee's lumbar spine. Dr. Morris performed a medial facetectomy at L4-5 on both sides and found a focal disc herniation. In his view, the findings at L3-4 and L4-5 were far more impressive than at L2-3. Dr. Morris said it was easier to define these more impressive findings as continuing symptom sources "because all the diagnostic studies continued to demonstrate them, and he continued to remain symptomatic." Since the 2008 surgery did not effectively address Employee's symptom spectrum, "the implication . . . is there was another driving structural basis of his complaints." Dr. Morris noted those bases were "certainly defined" by "serial diagnostic studies that continue to demonstrate the structural abnormalities from the radiologist's perspectives at L3-4 and L4-5." The diagnostic studies in 2008 could have justified the surgery Dr. Morris ultimately performed in 2015. The areas Dr. Morris operated on in 2015 would have been consistent with Employee's clinical symptoms in 2008. While Dr. Morris would not fault Dr. Wright's opinion the L2-3 level was the more likely symptom generator, when Employee's symptoms recurred, "I would start looking for another symptom generator" and "there was a likely explanation given the known degenerative changes in 3-4 and 4-5." Dr. Morris would have thought Dr. Wright would "chase it" and was surprised he did not. Dr. Morris concluded Employee's injury was consistent with developing the structural abnormalities at L3-4 and L4-5, and is supported by his findings at surgery. (Telephonic Deposition of David Morris, M.D., September 30, 2016, at 5, 9-11, 13-14, 19, 21-23, 27-28, 30).

111) Dr. Morris explained the underlying structural abnormalities evidenced in 2008 were still evident when he operated on Employee in 2015. Since Employee did not get relief from surgery at L2-3, this level was not the "singular explanation for his symptoms." It is "not obvious" from Employee and his records that his symptoms "ever changed" in character over the intervening years and he continued to pursue treatments for the same complaints "through a six-year timeframe." As for his July 6, 2015 letter to Employee's counsel, Dr. Morris admitted he made a mistake in listing L4-5 as the operative level in 2008. This error did not play a role in his opinion on causation. Until he reviewed additional records, Dr. Morris relied on Employee's unsophisticated account of his surgical level and Dr. Morris' assumption Dr. Wright surely would have addressed the known structural abnormalities at L3-4 and L4-5 "because they've

always been there." Given the Alaska definition of "the substantial cause," Dr. Morris concluded, "The work injury is consistent with the structural abnormality ultimately defined and operated on at 3-4 and 4-5 by me." When specifically asked if, based on Employee's history and symptoms since the accident, the work injury was "the substantial cause" for the symptoms for which he provided medical treatment, Dr. Morris stated, "That would be the conclusion I would draw based on Mr. Johnston and my availability of diagnostic studies to this point." Dr. Morris admitted he did not have a complete set of Employee's records. (*Id.* at 38, 40, 43-45, 58-59).

112) Post-surgery, Employee initially had complications but eventually recovered extremely well and quickly. His back now feels like it did before his work injury with Employer. He now exercises, walks, hikes and skis downhill. Employee no longer takes narcotics. In Employee's view, Dr. Morris "performed a miracle." (Employee).

113) Employee's symptoms progressively got worse from the beginning. His right foot drop was always present, continuous and gradually got worse. Employee noticed the right foot drop before July 2008, though he is uncertain if he discussed it with his medical providers. He agreed the right foot drop got worse after the July 22, 2008 rock incident. (*Id.*).

114) In his deposition, Dr. Holley addressed the July 24, 2008 MRI. He opined the facet joint arthritic changes "are certainly traumatic in nature," while disc protrusions can be both degenerative and traumatic; but broad-based protrusions are more likely degenerative. Employer's counsel queried Dr. Holley about Employee's July 2008 incident at home and he conceded Employee's symptoms were worse following the incident. Referring to the September 24, 2008 MRI, Dr. Holley agreed its findings "were similar to what was seen on his previous MRI." After reviewing Employee's medical records, Dr. Holley opined further medications or injections were not reasonable or necessary because they did not effectively control Employee's symptoms or help him recover. However, he noted these treatments "would be considered acceptable medical options" in Employee's case though not related to his work injury. Dr. Holley does not agree with Dr. Wang's opinion the work injury increased Employee's lumbar spine degeneration. Dr. Holley initially agreed Employee's 2008 surgery was at L4-5 until Employer's counsel corrected him. He disagreed with Dr. Morris' opinion the work injury caused a structural abnormality at L4-5, stating the minor listhesis shown on the 2015 CT is "a newer finding that suggests worsening of his lumbar facet disease." When asked if he agreed with Dr. Roth's opinion the operated L4-5 disc herniation was "acute," Dr. Holley could not

make a definite comment. However, he noted Dr. Roth testified Employee in July 2008 had "some significant disc protrusion, particularly pushing against the right L4 nerve root," which Dr. Roth opined "probably was related to the -- more likely than not, was related to the work injury." In Dr. Holley's opinion, Dr. Wright's surgery at L2-3 was reasonable and necessary because it addressed an affected nerve root by decompressing it. Thereafter, ongoing treatment addressed chronic low back pain and nothing arising from the March 2008 work injury in Dr. Holley's view. Accepting the premise Employee developed a foot drop "at a later time," Dr. Holley agreed Employee's severe disc degeneration caused his increased back pain and foot drop for which he required the second low back surgery. Dr. Holley understood the first surgery was "effective in alleviating" Employee's leg symptoms. Accepting the premise that Dr. Roth testified Employee had "a fairly acute episode of foot drop and relatively severe radiculopathy," which "probably precipitated his surgery," Dr. Holley agreed this sounded "entirely reasonable. (Deposition of Keith Holley, M.D., August 2, 2016 at 9, 13, 16, 18, 19-20, 23-27).

115) As found above, Dr. Roth actually testified Employee developed either "a fairly acute episode," or possibly a "smoldering, chronic episode," of foot drop and relatively severe radiculopathy prior to his second surgery, which "probably precipitated his surgery." (Deposition of Alan C. Roth, M.D., November 10, 2015, at 14-16, 18-21).

116) Dr. Holley reviewed the July 24, 2008 MRI and agreed there was encroachment at L4-5 on the L4 nerve root. He agreed Employee's accident could have aggravated a degenerative disc at L4-5 to increase his symptoms. Dr. Holley also agreed Drs. Valentz and Levine focused on the L4-5 level. He agreed Employee may have had two pain sources at both L2-3 and L4-5. However, understanding there was a "large far lateral disc herniation at L2-3," Dr. Holley opined this was not a degenerative finding while in his view the findings at L4-5 were degenerative. Referring to physicians addressing Employee's L4-5 MRI findings, Dr. Holley opined "they were essentially chasing the less significant finding in his lumbar spine at that point." When asked why Dr. Holley's first EME report said Dr. Wright should evaluate Employee for surgical decompression at one "if not multiple levels," Dr. Holley said he leaves the surgical level up to the surgeon. He would not have had difficulty with Dr. Wright's opinion if he suggested surgery at L4-5 instead of L2-3. Dr. Holley reiterated it was not entirely clear if there were two pain generators in this case and he does not think "it's possible with any certainty to sort it out." When asked if, assuming the work injury aggravated Employee's preexisting condition at L4-5,

Dr. Morris' 2015 surgery would be reasonable and necessary, Dr. Holley said "no" because the possible aggravation at L4-5 was nerve root compression. Drs. Wang's and Morris' treatments focused on the L4-5 facet joint as "a big component in pain generator." The second surgery in his opinion was for degenerative facet disease not decompression for radiculopathy, "although there was some disc decompression done at the time." (*Id.* at 31, 33-38, 40-41, 51-52).

117) Dr. Holley did not explain why Dr. Wright's L2-3 surgery did not resolve Employee's symptoms or why he thought Dr. Wright's surgery was reasonable and necessary. He did not explain why treatments from Drs. Wang and Morris, in his view, were not reasonable and necessary even though they resolved Employee's symptoms. (Observations).

118) Kathleen Taylor, a registered nurse, is Employee's wife and has known him since 2005. She was living with Employee in Alaska in 2007 and 2008. After Employee's March 11, 2008 work injury with Employer, he had lower back pain with pain radiating inside his right leg, which he was favoring. Early on, Employee had right leg weakness but not foot drop. Dr. Valentz's injections helped but only briefly. Dr. Wright told her he saw a soft tissue mass at the L2-3 level and needed to target it with treatment. Employee felt better briefly post-surgery. Employee gradually started tripping over things. Once they moved to Michigan, Employee tripped and fell on occasion. Dr. Wang prescribed pain medication, muscle relaxants, radiofrequency ablations and therapy. Employee had good relief for about five months following each radiofrequency ablation. Dr. Morris told Taylor Employee's right leg symptoms were "classic presentation" for a disc problem at L4-5. She recalled Employee complaining about left buttock and posterior thigh symptoms, which she attributed to favoring and "sciatica." Employee is much better now and no longer takes narcotics. (Taylor).

119) Taylor could not recall Employee discussing right foot drop at Ireland, but she knows it began before they moved to Michigan. Taylor recalls Employee complaining about right foot drop symptoms, and stumbling, after the July 22, 2008 incident at home. (*Id.*).

120) Employee's and his wife's in-person testimony was helpful in deciding this case and assessing their credibility. (Judgment).

121) On November 23, 2016, Employee's lawyer and paralegal filed and served an itemized statement and affidavits documenting paralegal and attorney fees, and costs. Paralegal fees were billed at $150 to $175 per hour while attorney fees were billed at $350 to $400 per hour.

Paralegal fees totaled $5,335.25. Attorney fees totaled $18,363. Costs totaled $1,123.51. (Affidavit of Counsel; Affidavit of Douglas Johnston, November 23, 2016).

122) Employee asserts all treating physicians initially focused on his L4-5 level, but once Dr. Wright thought the operable lesion was at L2-3, the focus shifted and treatment was directed to a spinal level that did not resolve Employee's symptoms and disability arising from his work injury. In short, he contends initial conservative treatment, followed by surgery to a different spinal level, followed by Employee's relocation to another state and additional conservative care leading to his second surgery at L4-5 was continuous treatment for the same work injury, spanning some seven years. (Employee's closing argument).

123) Employer argues Employee's records from late 2013 forward demonstrate a distinct change in Employee's symptoms to include his left leg. It contends this change demonstrated a need for medical care related to preexisting and progressively degenerating lumbar spine conditions. Employer contends Dr. Morris' opinions should be given less weight because he did not have all the medical records, misunderstood the surgical level from the first surgery and did not understand causative standards under Alaska law. Employer agrees the first surgery was caused by the work injury with Employer and was necessary and reasonable. However, it contends once Employee recovered from the first surgery, his work injury no longer was the substantial cause of the need for any additional lumbar treatment. Employer asserts attorney Kalamarides is an "excellent attorney" but no fees are awardable in this case because Employee should lose. Employer had "no real objection" to Employee's requested attorney fees and costs except it noted Employee's lawyer used "block billing" and made "vague" fee itemizations. (Employer's closing argument).

124) The parties agreed no examining physician opined the July 22, 2008 incident at home was the substantial cause of the need for medical care to Employee's L4-5 spinal level. (Parties' hearing statements).

125) On December 6, 2016, Employee's lawyer and paralegal filed and served a supplemental itemized statement and affidavits documenting paralegal and attorney fees, and costs. Paralegal fees now totaled $5,387.75. Attorney fees now totaled $21,163. Costs now totaled $2,923.51. (Affidavit of Counsel; Affidavit of Douglas Johnston, December 6, 2016).

126) On December 6, 2016, Employee filed an affidavit listing expenses he and his wife incurred to participate in the November 29, 2016 hearing. These include the cost for two round-

trip economy airline tickets from Flint, Michigan to Anchorage, Alaska at $1,082.50 each; $19 for an unexplained cost; $118 for car rental in Alaska; $212.42 for two hotel nights in Flint, Michigan; and $400.57 for food. There are no receipts attached to the affidavit and statement. (Affidavit of Gary Johnston, December 6, 2016).

127) On December 9, 2016, Employer filed a limited objection to Employee's attorney fee and cost affidavits and requests. Employer noted Employee submitted an affidavit containing costs for airline tickets, meals and other travel expenses to attend the hearing. Employer objected to these requests as there were no receipts for these items attached to Employee's affidavit. Employer also objected to "any duplicative billings" where the attorney and paralegal performed the same task. Employer specifically objected to an August 27-28, 2014 entry for "reviewing discovery," for which the paralegal incurred $319.50. (Employer's Limited Objection to Fee and Cost Affidavits, December 9, 2016; Affidavit of Douglas Johnston, December 6, 2016).

PRINCIPLES OF LAW

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

> **AS 23.30.010. Coverage**. (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability . . . or the need for medical treatment of an employee if the disability . . . or the employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability . . . 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 the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the . . . 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 . . . disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability . . . or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability . . . or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability . . . or need for medical treatment. . . .

> **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. *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. *Huit v. Ashwater Burns, Inc.*, 372 P.3d 904 (Alaska 2016). Because the board does not weigh the employee's evidence against the employer's rebuttal evidence, credibility is not examined at the second stage. *Veco, Inc. v. Wolfer*, 693 P.2d 865 (Alaska 1985).

If the board finds the employer's evidence is sufficient to rebut the presumption, it drops out and the employee must prove his case by a preponderance of the evidence. He must prove that in relation to other causes, employment was "the substantial cause" of the disability or need for medical treatment. *Huit*. This means the employee must "induce a belief" in the minds of the fact finders the facts being asserted are probably true. *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. *Wolfer*.

> **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).

> **AS 23.30.145. Attorney Fees**. (a) Fees for legal services rendered in respect to a claim are not valid unless approved by the board, and the fees may not be less than 25 percent on the first $1,000 of compensation or part of the first $1,000 of compensation, and 10 percent of all sums in excess of $1,000 of compensation. When the board advises that a claim has been controverted, in whole or in part, the board may direct that the fees for legal services be paid by the employer or carrier in addition to compensation awarded; the fees may be allowed only on the amount of compensation controverted and awarded. . . . In determining the amount of fees the board shall take into consideration the nature, length, and complexity of the services performed, transportation charges, and the benefits resulting from the services to the compensation beneficiaries. . . .
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> **8 AAC 45.180. Costs and attorney's fees**. (a) This section does not apply to fees incurred in appellate proceedings.
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> (b) A fee under AS 23.30.145(a) will only be awarded to an attorney licensed to practice law in this or another state. An attorney seeking a fee from an employer for services performed on behalf of an applicant must apply to the board for approval of the fee; the attorney may submit an application for adjustment of claim or a petition. An attorney requesting a fee in excess of the statutory minimum in AS 23.30.145(a) must (1) file an affidavit itemizing the hours expended, as well as the extent and character of the work performed, and (2) if a hearing is scheduled, file the affidavit at least three working days before the hearing on the claim for which the services were rendered; at the hearing, the attorney may supplement the affidavit by testifying about the hours expended and the extent and character of the work performed after the affidavit was filed. If the request and affidavit are not in accordance with this subsection, the board will deny the request for a fee in excess of the statutory minimum fee, and will award the minimum statutory fee.
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> . . . .
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> (f) The board will award an applicant the necessary and reasonable costs relating to the preparation and presentation of the issues upon which the applicant prevailed at the hearing on the claim. The applicant must file a statement listing each cost claimed, and must file an affidavit stating that the costs are correct and that the costs were incurred in connection with the claim. The following costs will, in the board's discretion, be awarded to an applicant:
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> (1) costs incurred in making a witness available for cross-examination;
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> . . . .

> (13) reasonable travel costs incurred by an applicant to attend a hearing, if the board finds that the applicant's attendance is necessary;
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> (14) fees for the services of a paralegal or law clerk, but only if the paralegal or law clerk
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> . . . .
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> (E) does not duplicate work for which an attorney's fee was awarded;
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> . . . .
>
> (17) other costs as determined by the board.

ANALYSIS

1) Are Employee's March 26, 2015 lumbar surgery and any ongoing lumbar spine treatment compensable?

This issue raises factual questions to which the presumption analysis applies. AS 23.30.120(a); *Meek*. Without regard to credibility, Employee raises the presumption with his and his wife's lay testimony and medical opinions from Drs. Wang and Morris. *Tolbert*; *Wolfer*. Both lay witnesses and Drs. Wang and Morris linked the need for Employee's second surgery on March 26, 2015, to his March 11, 2008 work injury with Employer. Again without regard to credibility, Employer rebuts the raised presumption with medical opinions from Drs. Holley and Roth, who both concluded any medical care or treatment Employee received following one year after his October 20, 2008 surgery was no longer work-related and was caused by natural lumbar spine degeneration. *Huit*; *Wolfer*. Thus, the burden falls upon Employee to prove his claim by a preponderance of the evidence. *Saxton*.

Notwithstanding Employer's arguments to the contrary, the greatest weight is given to Dr. Morris' opinions. He correctly noted Employee's right leg symptoms never really changed but waxed and waned over the years since his work injury with Employer. Dr. Morris correctly identified "serial diagnostic studies" continually showing structural abnormalities at L3-4 and L4-5. Dr. Morris was surprised Dr. Wright failed to "chase" the true culprit after surgery at L2-3 failed to resolve Employee's ongoing right leg symptoms. Dr. Morris' opinion is squarely supported from Employee's history and the initial medical evaluations through the time he

operated on Employee on March 26, 2015. This is true regardless of whether Dr. Morris had all these medical reports in his possession.

For example, on the injury date Employee felt sharp, stabbing pain like he had been "electrocuted," radiating from his knee up and down his right leg into his groin and lower back. When he saw Dr. Parliament, Employee had tingling in his right leg down to his toes. Dr. Parliament repeatedly noted issues at L5. A week following the injury, Employee still had sensory changes from L4 through S1 including tingling into his right toes. These findings continued through June 2008. The event at home on July 22, 2008, intensified Employee's right leg symptoms. At the emergency room, Employee described tingling on the top of his right foot and on his thigh. The emergency room physician diagnosed low back pain with radiculopathy and right foot numbness. The July 24, 2008 MRI showed no abnormalities at L2-3 but significant issues at L3-4 and L4-5 including a circumferential disc protrusion with mild impingement on the lateral recess which, according to the radiologist, caused "some definite encroachment on the exiting L4 root." Radiologist Lewis said "this may correlate with the patient's current symptoms." Dr. Morris opined, and experience shows, Employee's symptoms were consistent with disc problems at lower levels in the lumbar spine and, as Dr. Morris told Taylor "classic presentation" for L4-5 disc problems. *Rogers & Babler.*

Perhaps most notably, Employee's initial medical care was *all* directed to the L4-5 level. Dr. Valentz recognized the L4-5 disc protrusion and performed an epidural steroid injection at that level. Dr. Levine performed electrodiagnostics on Employee's right leg and diagnosed lumbar radiculopathy "in all likelihood probably representing L4 based on the history of the MRI findings." Dr. Levine opined this "certainly probably explains much of the situation." Not surprisingly, the diagnostic and therapeutic epidural steroid injection provided some leg pain relief and Dr. Valentz concluded Employee "has a displaced disc at L4-L5 involving the right lateral recess." Dr. Valentz repeated the epidural steroid injection at L4 and again Employee reported good relief for approximately one week. Given this diagnostic and therapeutic evidence, Dr. Valentz understandably referred Employee to Dr. Wright for a surgical evaluation.

Dr. Wright correctly noted Employee's EMG test showed a likely L4 nerve problem and his MRI demonstrated an L4-5 level issue as well. Dr. Wright also understood Employee's pain radiated to his right foot and he had weakness. However, given Employee's anterior thigh numbness and Dr. Wright's belief he saw a soft tissue mass at L2-3, Dr. Wright suspected Employee's problem was at L2-3 even though he acknowledged L4-5 "certainly appears to be quite abnormal." Thus, upon seeing Dr. Wright, Employee's medical treatment abruptly changed from addressing the L4-5 level to treating the L2-3 area. A CT disclosed only slight bulging at L2-3 while showing a disc protrusion at L4-5 and right foraminal stenosis with moderate bilateral facet degenerative joint disease. Radiologist Kottra made no mention of any soft tissue mass at or near L2-3. Dr. Wright expressly opined Employee's symptoms were caused "by his on-the-job injury," and arose from foraminal stenosis at L4-5 and marked facet disease.

The second lumbar spine MRI was similar to the first. Radiologist Dr. Winn made no reference to any issues at L2-3, but again noted significant problems at L4-5. At a follow-up visit with Employee and his wife, Dr. Wright reviewed the MRI and called Dr. Kottra who had performed the CT. Notwithstanding the three radiologist's contrary initial impressions, Dr. Wright still thought he saw a soft tissue mass at L2-3 and Dr. Kottra eventually agreed any such mass would probably represent a free disc fragment. Dr. Kottra reviewed Dr. Winn's September 2008 MRI and said he too found a possible free fragment at L2-3. Given this supportive opinion, Dr. Wright operated on Employee at L2-3. Though he found a disc impacting the right L-2 nerve root, Dr. Wright found no free fragment at L2-3. Employee's symptoms improved temporarily but once the surgical anesthesia wore off, his right leg symptoms returned, waxed, waned and progressed. Dr. Wright believed the L2-3 finding had caused Employee's right leg symptoms.

Employer concedes the first surgery to address L2-3 was compensable and it has paid the related medical bills. But the evidence shows Dr. Wright was incorrect in his assumption L2-3 was the culprit and surgery at L2-3 was the cure. Employee and his wife testified Employee's right leg symptoms did not improve, but waxed and waned and progressively worsened. Employee and his wife agreed Employee's right foot drop developed before they left Alaska. Both Employee and his wife were credible witnesses. AS 23.30.122; *Smith*.

Even EME Dr. Holley's testimony supports Employee's position. At his first EME, Dr. Holley stated the arthritic changes in Employee's facet joints "are certainly traumatic in nature." Dr. Morris' March 26, 2015 surgery in part addressed these changes. Employee demonstrated weakness on the right foot while heel walking in October 2008 when Dr. Holley first examined him. Dr. Wright told Employee it might take a year for him to realize full recovery from the surgery at L2-3. Given Dr. Wright's advice, it is not surprising Employee patiently waited for this result, which never occurred. Employee cannot be faulted for following his doctor's advice and, upon reaching Michigan, following his new physicians' advice concerning his work injury.

Dr. Johnston performed a PPI rating on Employee and also noted a slightly altered sensation in the right L4 distribution. Thereafter, Employee continued to consistently report back discomfort and right leg weakness. Upon moving to Michigan in 2009, he saw his family physician who referred him to Dr. Wang. Based on his understanding of insurance requirements, Dr. Wang began treating Employee conservatively. Again, Dr. Wang's efforts addressed the L4-5 level which provided relief ranging from temporary to lasting up to six months or longer. Dr. Wang interpreted prior MRIs exactly as the radiologists had and noted significant issues at L4-5. He ordered another MRI, which reportedly showed results similar to the first two scans. Dr. Wang was the first physician to note Employee has six lumbar-type vertebrae. He performed epidural steroid injections at the L3 and L4 levels and again, noted Employee had brief symptomatic relief. Throughout 2010 and 2011, Employee told his physical therapist his right leg symptoms continued, waxing and waning the more he sat or the more active he became. Dr. Wang continued to treat the L4 level conservatively for years.

Employee tried returning to work in Michigan but this intensified his symptoms so he quit. By November 9, 2012, PA-C Wilson suggested another MRI when Employee decided he was ready to have lumbar surgery. Another MRI in March 2013 disclosed similar findings as previous scans with the most severe encroachment at L4-5 on the right. The last MRI on November 2014 was again similar at L4-5 to previous scans.

Eventually, Dr. Wang referred Employee to Dr. Morris for a neurosurgery evaluation. Employer criticizes Dr. Morris because he made a mistake in his written reports concerning the surgical

level at which Dr. Wright had operated. However, Dr. Morris' December 10, 2014 report initially and correctly identified Employee's lumbar discectomy at "L2-3 in 2008." Dr. Morris later explained in his deposition he had made an error based in part on the various numbering systems used by physicians and radiologists in this case given Employee's six lumbar-type vertebrae, Employee's unsophisticated explanation to Dr. Morris about where the first surgery had occurred, and Dr. Morris' assumption Dr. Wright surely would have operated on the most likely pain generator in 2008 -- L4-5. Dr. Morris ordered a myelogram and associated CT, which confirmed the problem causing Employee's symptoms still existed at L4-5, as it had since the first MRI back in 2008. The problems at L4-5 on the right never changed.

Notably, Drs. Wright, Johnston and Holley all used different vertebral levels to describe the location of Employee's first surgery. On September 23, 2008, when reviewing CT results Dr. Wright said in reference to what he called L2-3, "some might" interpret this level as "L3-4." On March 19, 2009, Dr. Johnston gave a PPI rating based on a disc herniation and surgery "at the L3-L4 level." In his second EME report on October 20, 2012, Dr. Holley noted Employee told him Dr. Wright performed an "L2-L3-L4 lateral discectomy." Given the extra lumbar vertebrae in Employee's spine, Employee's confusion, and different numbering systems used by physicians as explained by Dr. Morris, the initial error in Dr. Morris' reports will not diminish the weight or credibility given to his opinions.

Dr. Morris' March 26, 2015 surgery at L4-5 was remarkably successful. Employee no longer uses narcotics for pain control and has returned to increased activity, including downhill skiing. He deems Dr. Morris' surgery a "miracle." Dr. Morris credibly stated once the L2-3 surgery failed to resolve Employee's ongoing right leg symptoms, attention should have been directed elsewhere. Employee's attorney gave Dr. Morris the "the substantial cause" definition and Dr. Morris expressly opined the March 11, 2008 work injury with Employer was the substantial cause of the need for the March 26, 2015 surgery. The fact Dr. Morris did not have complete records does not diminish his opinion at all. The medical records in Employee's agency file corroborate Dr. Morris' opinion about serial diagnostic studies showing no significant change in the work-related lesion at L4-5 on the right. Employee's medical history further corroborates Dr. Morris' opinion and shows Employee's right leg symptoms never completely resolved, remained

present, waxed and waned and gradually worsened. The fact Employee subsequently developed left-lower extremity symptoms sometime in 2014 does not mean the March 26, 2015 surgery to address the continuing right-lower extremity symptoms is not compensable. For these reasons, Dr. Morris is given the greatest weight and credibility. AS 23.30.122; *Smith*.

With his 2008 operation on Employee at L2-3, Dr. Wright noted Employee had significant abnormalities at L4-5 directly attributable to his work injury. Dr. Wright opined surgery at L2-3 was "an initial means of treatment," implying additional surgery or other treatment may be needed later. On this point Dr. Wright was correct, and supports Dr. Morris' opinion.

Dr. Holley's initial October 4, 2008 EME report also supports Employee's case. He said the arthritic changes in Employee's facet joints "are certainly traumatic in nature." The surgery Dr. Morris performed on March 26, 2015, was a bilateral facetectomy at L4-5. Dr. Holley agreed Employee could have had two pain generators -- one at L2-3 and another at L4-5. He would not have disagreed had Dr. Wright decided to operate first at L4-5 back in 2008. Dr. Holley did not explain why he opined Dr. Wright's L2-3 surgery was reasonable and necessary, even though it never resolved Employee's symptoms, while he concurrently said Drs. Wang's and Morris' treatments were not reasonable and necessary, even though Dr. Morris' surgery ultimately resolved Employee's continuing symptoms in "miraculous" fashion.

Some opinions from Dr. Roth support Employee's case. He noted Employee in 2008 had "some significant disc protrusion, particularly pushing against the right L4 nerve root," which Dr. Roth said "probably was related to the -- more likely than not, was related to the work injury." As demonstrated through Dr. Morris' review of serial diagnostic testing, that finding never abated until Dr. Morris operated on the L4-5 level. Though Dr. Morris performed a bilateral facetectomy, he also removed disc material. Dr. Roth testified Employee had either "a fairly acute episode" or possibly a "smoldering, chronic episode" of right foot drop which "probably precipitated his surgery." Whether the foot drop episode was acute or chronic, it is clear Dr. Roth agreed the foot drop issue probably caused the need for Employee's March 26, 2015 surgery. Taylor's credible testimony the right foot drop began shortly after the July 22, 2008

incident at home, and Employee's credible testimony the right foot drop never abated until after the March 26, 2015 surgery shows the right foot drop issue was "chronic." AS 22.30.122; *Smith*.

The medical and lay evidence preponderates strongly in Employee's favor. As nearly all physicians agreed Dr. Morris performed the correct surgical procedure on March 26, 2015 to address Employee's symptoms Employee has met his burden of persuasion and the March 26, 2015 lumbar surgery will be found compensable. AS 23.30.010(a); *Saxton*. Employee also sought an order authorizing continuing medical care for his low back. Employer already accepted the L2-3 injury and this decision finds the L4-5 level injury compensable. Therefore, Employee is not prohibited from obtaining medical care to either lumbar region and Employer retains its right to object to future medical, all in accordance with the Act and this decision.

2) Is Employee entitled to an attorney fee and cost award?

In 2014, Employer controverted Employee's right to additional medical care. Therefore, as Employee has prevailed in his claim, he is entitled to attorney fees under AS 23.30.145(a) and costs under 8 AAC 45.180(f). Employer objected to any duplicate attorney fee or paralegal billings where both the attorney and his paralegal performed the same task, but only specified one instance on August 27-28, 2014, where both reviewed discovery. The paralegal in that instance incurred $319.50 in costs. Employee's lawyer provided a significant, ongoing benefit to Employee because his March 26, 2015 lumbar spine surgery has been found compensable. There being no "real objection" to the requested attorney fee and paralegal costs, Employee will be awarded $21,163 in attorney fees and $5,068.25 in paralegal costs ($5,387.75 - $319.50 for duplicative discovery review on August 28, 2014 = $5,068.25). AS 23.30.145(a).

Employer also objected to Employee's expenses incurred for him and his wife to attend the November 29, 2016 hearing because there are no receipts attached to Employee's affidavit. Employer is correct; Employee attached no receipts. But, the applicable regulation does not require receipts. It simply requires a statement and an affidavit stating the costs are correct and were incurred in connection with the claim. 8 AAC 45.180(f). Employee has complied with this requirement. Unlike travel for medical treatment, the applicable regulation does not require receipts for meals incurred when a party and a witness travel to a hearing to give testimony. *Id.*

Therefore, Employer has not stated a valid basis for objection to Employee's out-of-pocket expenses incurred in traveling to and attending the hearing. Employee's and his wife's in-person testimony was helpful in deciding this case and assessing their credibility. Employee's requested out-of-pocket costs for him and his wife to attend the hearing and give their testimony are reasonable. Therefore, Employee will be awarded an additional $2,914.99 ($1,082.50 + $1,082.50 + $19 + $118 + $212.42 + $400.57 = $2,914.99) in expenses related to travel to attend the November 29, 2016 hearing. 8 AAC 45.180(f)(1), (13), (17).

CONCLUSIONS OF LAW

1) Employee's March 26, 2015 lumbar surgery and ongoing lumbar spine care are compensable.
2) Employee is entitled to an attorney fee and cost award.

ORDER

1) Employee's March 26, 2015 lumbar surgery is compensable.
2) Employer is ordered to pay all medical expenses associated with Employee's March 26, 2015 lumbar surgery, in accordance with the Act.
3) Employee retains his right to seek additional medical care and treatment for his March 11, 2008 work injury with Employer, in accordance with the Act.
4) Employer retains its right to contest any additional medical care or treatment for Employee's March 11, 2008 work injury, in accordance with the Act.
5) Employee is awarded $21,163 in attorney fees and $5,068.25 in paralegal costs.
6) Employee is awarded $2,914.99 in out-of-pocket costs related to his and his wife's travel to attend and testify at the November 29, 2016 hearing.

Dated in Anchorage, Alaska on January 11, 2017.

ALASKA WORKERS' COMPENSATION BOARD

_____________________/s/_______________________
William Soule, Designated Chair

_____________________/s/_______________________
Dave Kester, Member

____________________/s/________________________
Mark Talbert, Member

If compensation is payable under terms of this decision, it is due on the date of issue. A penalty of 25 percent will accrue if not paid within 14 days of the due date, unless an interlocutory order staying payment is obtained in the Alaska Workers' Compensation Appeals Commission.

If compensation awarded is not paid within 30 days of this decision, the person to whom the awarded compensation is payable may, within one year after the default of payment, request from the board a supplementary order declaring the amount of the default.

APPEAL PROCEDURES

This compensation order is a final decision. It becomes effective when filed in the office of the board unless proceedings to appeal it are instituted. Effective November 7, 2005 proceedings to appeal must be instituted in the Alaska Workers' Compensation Appeals Commission within 30 days of the filing of this decision and be brought by a party in interest against the boards and all other parties to the proceedings before the board. If a request for reconsideration of this final decision is timely filed with the board, any proceedings to appeal must be instituted within 30 days after the reconsideration decision is mailed to the parties or within 30 days after the date the reconsideration request is considered denied due to the absence of any action on the reconsideration request, whichever is earlier. AS 23.30.127.

An appeal may be initiated by filing with the office of the Appeals Commission: 1) a signed notice of appeal specifying the board order appealed from and 2) a statement of the grounds upon which the appeal is taken. A cross-appeal may be initiated by filing with the office of the Appeals Commission a signed notice of cross-appeal within 30 days after the board decision is filed or within 15 days after service of a notice of appeal, whichever is later. The notice of cross-appeal shall specify the board order appealed from and the ground upon which the cross-appeal is taken. AS 23.30.128.

RECONSIDERATION

A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accord with 8 AAC 45.050. The petition requesting reconsideration must be filed with the board within 15 days after delivery or mailing of this decision.

MODIFICATION

Within one year after the rejection of a claim, or within one year after the last payment of benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, a party may ask the board to modify this decision under AS 23.30.130 by filing a petition in accord with 8 AAC 45.150 and 8 AAC 45.050.

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of Gary D. Johnston, employee / claimant v. Chaz Limited, employer; Commerce and Industry Insurance Company, insurer / defendants; Case No. 200814397; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on January 11, 2017.

/s/

Vera James, Office Assistant I