ALASKA WORKERS' COMPENSATION BOARD

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

MARIE M. EDENSHAW, Employee, Claimant, v. PENINSULA AIRWAYS, INC., Employer, and WAUSAU UNDERWRITERS INSURANCE COMPANY, Insurer, Defendants.	)	FINAL DECISION AND ORDER AWCB Case No. 201105565 AWCB Decision No. 16-0028 Filed with AWCB Anchorage, Alaska on April 6, 2016

Marie M. Edenshaw's (Employee) September 24, 2015 amended claim was heard on February 16, 2016 in Anchorage, Alaska, a date selected on December 10, 2015. Attorney Michael Patterson appeared and represented Employee, who appeared and testified. Attorney Martha Tansik appeared and represented Peninsula Airways, Inc. and Wausau Underwriters Insurance Company (Employer). As a preliminary matter, the parties stipulated they were not arguing any excessive change of physician issues prior to and including the hearing date. The parties also agreed revision surgery from T11-L3 was not in dispute, and the hearing issues were (1) the compensability of a total lumbar fusion, extending from T10 or T11 to S1; (2) the compensability of a laminectomy at L4-5; and (3) attorney's fees and costs. The parties agreed the record would be left open for them to file legal memoranda regarding attorney's fees and costs. The record closed on March 7, 2016.

ISSUES

The parties agree revision surgery from T11-L3 is a compensable medical treatment, but disagree whether additional treatment recommended by Employee's treating physician is compensable: a total lumbar fusion extending from T10 or T11 to the pelvis, and a laminectomy at L4-5. Employee contends her surgeon's proposed procedure will cure the majority of her pain symptoms for roughly ten years. She contends she does not want to undergo a less extensive procedure because, within a short time, she would experience renewed pain and need another spinal surgery; she wants to have one surgery and "be done with it."

Employer contends full lumbar surgery and an L4-5 laminectomy are not reasonable, necessary, or required for the process of recovery from the work injury. Noting it had paid Employee temporary total disability (TTD) benefits for over three years since the original recommendation for revision fusion surgery, Employer contends Employee should be ordered to proceed with only the undisputed revision procedure, or be declared medically stable, by a date certain.

1) Is a total lumbar fusion compensable?

2) Is an L4-5 laminectomy compensable?

3) Should Employee be given a specific date by which she needs to undergo surgery or be declared medically stable?

Employee contends she is entitled an attorney's fee and costs award if she prevails on her claim for medical treatment as recommended by her treating physician. Employer contends Employee billed for excessive time, given the "relatively straightforward" nature of the compensability issue. Employer also objects to a particular line item, contending it was an overhead cost that should have been included in counsel's hourly rate.

4) Should attorney's fees and costs be awarded?

FINDINGS OF FACT

The following facts and factual conclusions are either undisputed or established by a preponderance of the evidence:

1) Employee periodically sought medical treatment for low back pain since at least September 12, 2000. (Alaska Native Medical Center (ANMC) Emergency visit note, September 12, 2000.)

2) On April 13, 2011, Employee suffered a burst fracture at L1 when she fell from an airplane wing during a training exercise. On April 19, 2011, neurosurgeon William Betts, M.D., performed a T11-L3 fusion. The surgery was only partially successful and complications ensued. The parties agree revision surgery at T11-L3 is compensable. (Report of Occupational Injury or Illness, April 13, 2011; record.)

3) On April 21, 2012, Employee attended a chiropractic and orthopedic employer's medical evaluation (EME) with chiropractor Richard Rivera, D.C. and orthopedic physician Matthew Provencher, M.D., who opined Employee was not medically stable and recommended additional physical therapy for the next six to eight weeks. (EME report, April 21, 2012.)

4) On May 15, 2012, Dr. Betts recommended Employee refrain from physical therapy and undergo an XLIF (extreme lateral interbody fusion) at the L3-4 level to "correct her lumbar generated discogenic pain." Employee did not pursue this treatment. (Betts chart note, May 15, 2012.)

5) On November 7, 2012, Employee was evaluated by neurosurgeon Robert Lieberson, M.D., who opined: "Unfortunately, chronic back pain following a lumbar fusion is very common and very difficult to treat. It is unlikely that there will be anything that will completely get rid of the patient's pain." Dr. Lieberson doubted that Dr. Betts's recommended XLIF procedure would have been helpful:

> It is possible that extending the fusion might have been helpful, but then the level below that probably would have gone bad in quick order and extending it yet again until it was at least going to S1 would have eventually been required; even so, probably the pain would not have been relieved.

Dr. Lieberson concluded it might be necessary to re-explore the fusion, but on the other hand the best course of action might be a pain management clinic and no additional surgery. (Lieberson chart note, November 7, 2012.)

6) On November 12, 2012, Employee returned to Dr. Lieberson, who reviewed her recent computerized tomography (CT) scan and opined:

> At this point, I think that her best options would be either to lose weight and get in better shape, to see if her back pain improved, and remove the hardware if it does not versus removing the hardware now and losing weight and getting in better shape afterwards. I think that it is unlikely that she is ever going to have a perfect

> back. I think that if she gets in a little better shape, her back will improve. I think removing the hardware would also give her some improvement.
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> It is probable that the L2-L3 level (and even levels below) will continue to hurt. The patient tells me that she does not want the hardware removed but instead would prefer that the hardware be extended all the way to the sacrum to relieve any possible future back pain. I think that this is a bad idea. I think it would also be a bad idea to extend the fusion just 1 level crossing L3–L4. More likely than not, and in a very short period of time, the patient would develop junctional disease below the new fusion.
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> We talked for perhaps 45 minutes. I showed her the films. I explained to her husband as well. The patient is convinced that if we merely extend the fusion, she will have a complete relief of complaints and will not need to lose weight or exercise. I was unable to disabuse her of this opinion.

(Lieberson chart note, November 12, 2012.)

7) On February 7, 2013, Employee "self-referred" to orthopedic spine surgeon James Eule, M.D., who noted she had "significant incapacitating back pain" since her injury and failed fusion surgery in April 2011. Dr. Eule's diagnosis included a previous L1 burst fracture with fractured instrumentation and "almost certainly" some aspect of pseudoarthrosis and continued chronic pain; and supposed lumbar degenerative changes below her previous fusion. Dr. Eule recommended a CT myelogram extending down to her lower back and possible removal of the fusion instrumentation. (Eule chart note, February 7, 2013.)

8) On February 15, 2013, Employee returned to Dr. Eule with her thoracolumbar myelogram results. Dr. Eule noted lumbar spinal stenosis, severe at L4-5, moderate at L3-4; and severe facet arthropathy at L4-5 and L5-S1. However Dr. Eule opined it was necessary to first address Employee's more urgent, non-industrial cervical spine condition, and then "reconsider her lumbar spine." (Eule chart note, February 15, 2013.)

9) On May 6, 2013, neurosurgeon Roland Torres, M.D., performed cervical spine surgery on Employee, including a fusion at C4-6. (Torres Operative Report, May 6, 2013.)

10) On June 12, 2013, Employee's counsel sent Dr. Eule a letter stating Employer had agreed to pay for thoracolumbar spinal surgery as recommended by Dr. Eule; post-operative medications other than chronic medications for 18 months; and up to one month of outpatient physical therapy, if ordered by the surgeon. On August 27, 2013, Dr. Eule signed a statement included in the letter: "In my medical opinion, which I hold to a reasonable degree of medical certainty, the

employee will not require future medical treatment beyond what is covered by this agreement for the work related injury." On September 12, 2013, the parties submitted for board approval a Compromise and Release (C&R) settlement agreement recording these terms; the C&R was withdrawn on November 15, 2013. Neither the letter nor the C&R indicated what specific surgical procedure Dr. Eule had recommended and Employer had agreed to pay for. (Patterson letter, June 12, 2013; Eule letter, August 27, 2013; C&R, September 12, 2013; Tansik and Patterson letter, November 15, 2013; observation.)

11) On December 5, 2013, Employee returned to Dr. Eule, who diagnosed a previous L1 burst fracture with posterior instrumentation from T11-L3; probable pseudoarthrosis at T11-12 and L2-3 with fractured and loosened instrumentation; lumbar spinal stenosis most severe at L4-5 followed by L3-4 and to a lesser degree L5-S1; and significant facet arthropathy without any instability L3-S1. Dr. Eule opined:

> She has a very difficult and challenging problem from multiple aspects. I have kind of gone back and forth whether or not to take all this instrumentation out and then refuse her from T10 or T11 down to the pelvis would be the most aggressive treatment options. However, considering her age and she is getting around reasonably well with quite a bit of back pain, but some of that back pain could certainly be from loose screws and wiggling instrumentation as well as severe spinal stenosis. At her age it is probably worth trying to do the least amount possible to get the maximal benefit and hoping that would give her many years of relief and avoid an extensive fusion from her thoracic spine down to her pelvis, which I think at her age is going to be fairly disabling as well. My current thought is that we would remove her old instrumentation. If we felt like the facets were too damaged and those were pseudoarthroses then we would re-instrument her through that area and re-bone graft her and get that solidly fused or potentially we would just leave all that instrumentation out and the areas around her fracture, which is fused, then maybe we would not need to re-instrument those other levels where the screws are loose. Then we would not instrument her lower lumbar spine at all and just decompress her at L4-5 and possible [sic] L5-S1 and see if relieving her significant neurogenic claudication would give her dramatic relief, knowing that we do not have a crystal ball and sometime, hopefully not in a short period of time, but more like 10 or 15 years down the road, she may need to have a fusion from T-1 [sic] down to the pelvis. The risk/benefit ratio is better for us doing less than more at this particular time. . . .

(Eule chart note, December 5, 2013.)

12) On December 17, 2013, Employee consulted neurosurgeon Kim Wright, M.D., who noted Employee presented with complaints of chronic neck pain, and chronic back and predominantly low right lower extremity pain. Dr. Wright noted:

> She says that surgery helped her acute pain but she has been left with a great deal of chronic back pain and some right lower extremity pain. She has been seeing Dr. Eule who now believes she might benefit from hardware removal and repair of her fusion and a possible laminectomy in the lumbar spine.
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> The patient does not describe significant weakness or numbness, but does describe a good deal of pain. She says that she would like to have one operation and not have several and therefore seeks our opinion whether or not hardware removal and a decompression is the correct procedure.

Dr. Wright opined, "I certainly believe removal of the hardware is completely reasonable. If she has yet to achieve a solid fusion of L1-2, then this could certainly be done at the same time . . . Depending upon whether or not there is nerve root impingement, a lumbar laminectomy could also be performed at the same time hardware is removed." (Wright chart note, December 17, 2013.)

13) On March 20, 2014, Employee attended an EME with chiropractor Dr. Rivera and orthopedic specialist Scot A. Youngblood, M.D., who opined she was a candidate for revision lumbar fusion. (EME report, March 20, 2014; pp. 17, 19.)

14) On April 3, 2014, Dr. Betts reviewed a magnetic resonance imaging (MRI) scan of Employee's lumbar spine and noted central and lateral recess stenosis primarily at L4-5 and to a lesser extent at L3-4. Dr. Betts referred Employee to Swedish Hospital in Seattle, where her cervical spine was treated, including another surgery, from June through September, 2014. (Betts chart note, April 3, 2014; Swedish Hospital records, June 5, 2014 through September 12, 2014.)

15) On December 12, 2014, Employee returned to Dr. Eule, who concluded:

> At this point we definitely need to evaluate her thoracic spine and make sure we do not leave the T10-11 area alone if she needs something down there. It is looking like we are probably going to do a revision surgery that will probably include a T10 to pelvic fusion, decompressing her and fusing those levels. We will see her back after her thoracic MRI and make a final plan.

(Dr. Eule chart note, December 12, 2014.)

16) On December 30, 2014, Employee was reevaluated by Dr. Eule, who opined, "I think we can probably progress with her back surgery as planned." He continued:

> We are kind of still back to making a decision on what is going on. I had a long discussion with her again today about her back pain and leg pain. . . She gets low back pain. She can point to it right around the L4-5 area. She feels some crunching in her back right around the L4-5 level as well. She cannot stand very long or walk very far, but she is miserable lying down too. She is overall miserable. We had a long discussion again about possibly doing a smaller surgery; removing the instrumentation and checking on whether or not there are areas of pseudoarthrosis, and then trying to decompress her lower lumbar areas in hopes that would relieve some of her symptoms. She has long standing chronic pain and a lot of it is back pain. On her CT scan, she has a facet fracture on the left side at L4-5 and some evidence of kind of unilateral instability and gapping in the facet on that side. She has pretty significant stenosis at L4-5 as well. She has pretty significant facet arthropathy as well at L5-S1 and some mild stenosis at L3-L4. We are probably not going to be able to get by without doing a fusion. . . .
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> In brief, after going over the above and really debating this because she's young and we would have to take very seriously doing a big surgery on her, but we also do not want to do one that is not going to work and she is going to be back shortly for another surgery. After a very long discussion and debate, we decided to proceed with a T10 to pelvic fusion. We will have to decompress and fuse her lower lumbar levels and maybe decompress T10-11 area as well, particularly on the unilateral side that is tight on the right side.

(Eule chart note, December 30, 2014.)

17) On January 10, 2015, Employee attended another EME with Dr. Youngblood, who opined there were two reasonable approaches to medical treatment:

> The first would be a continuation of nonoperative care consisting of activity modification, lumbar extension exercises, aerobic conditioning, and judicious use of anti-inflammatories. This essentially was the course of treatment recommended by Dr. Lieberson in 2012. This is the most reasonable of any of the treatment choices, and would be my ultimate recommendation. As was stated by Dr. Lieberson, the examinee had an extensive injury and surgery to her back. No surgery will likely completely relieve the subjective back pain. Additional surgery is also fraught with significant risks, to include adjacent segment degeneration and symptoms to include loss of motion. Additional concerns regarding more surgery in this case are the examinee's relatively unreasonable expectations regarding surgery, the location of her pain at sites other than her pseudarthrosis, and the notable symptom magnification and pain behaviors on examination.

> The second reasonable treatment is to proceed with a revision surgery at T11-12 and L2-3 levels. This would include the removal and revision of the indwelling hardware. This recommended surgery would specifically be intended to address the nonunions at T11-12 and L2-3. It is possible that some of the examinee's pain is emanating from these levels, and this surgery would be considered reasonable and necessary. Surgery at additional levels is not recommended, in the strongest terms possible. A forlorn attempt to fuse the examinee from T10 to the pelvis would be fraught with an extremely high probability of complications, to include nonunion given the high forces involved in an attempted fusion of so many levels, hardware breakage/failure, and the rapid onset of the date of adjacent segment degeneration at T9-10. This surgery attempt would not in any means be the end of the story. [Employee] would be worse off after this proposed surgery, in my opinion, on a more-probable-than-not basis.

Dr. Youngblood also opined Employee had lower lumbar multilevel degenerative disc disease, preexisting and not substantially caused or aggravated by her work injury. (EME report, January 10, 2015, pp. 41, 44.)

18) On March 11, 2015 the parties submitted a Second Independent Medical Evaluation (SIME) form specifying medical disputes between treating physician Dr. Eule and the EME physicians Drs. Youngblood and Rivera. The form cited Dr. Eule's December 12, 2014 statement that "we are probably going to do a revision surgery that will probably include a T10 to pelvic fusion, decompressing her and fusing those levels," and Dr. Youngblood's January 10, 2015 opinion that a T10 to pelvic fusion was not advised, fraught with an extremely high probability of complications, and not reasonable or medically necessary. No mention is made of a possible L4-5 laminectomy. The parties stipulated Employee would be evaluated by SIME neurosurgeon Bruce McCormack, M.D., and orthopedic surgeon Marjorie Oda, M.D. Each physician was sent 1800 pages of medical records to review, and a letter including SIME questions and the following explanation of the "substantial cause" legal standard:

> To be considered an aggravation, acceleration, or to have combined with the pre-existing condition, employment must have been 'the substantial cause' producing the disability or need for medical treatment. 'The substantial cause' means, in relation to all different causes to which a reasonable person could assign responsibility, employment is more than any other cause, the cause of the employee's disability, death, or need for medical treatment. In determining 'the substantial cause,' the board is required to evaluate the relative contribution of different causes of an employee's death, disability, or need for medical treatment.

(SIME form, March 11, 2015; observation; physician referral letter and SIME medical records, June 29, 2015.)

19) On August 6, 2015, Employee was evaluated by SIME physician Dr. Oda, who attributed 100 percent of the causation of Employee's disability with respect to her lumbar spine to her work injury: "While there may have been some degenerative changes of the lumbar spine, these were asymptomatic and not causing any disability or need for treatment until the specific injury of 4/13/11." In her 17-page SIME report, Dr. Oda recommended exploration, hardware removal and possible refusion, but opined she saw no reason to fuse down any further than L2: "While there are degenerative changes distal to L2, there is no neurologic deficit and surgical intervention for axial pain alone in the absence of pseudoarthrosis is not advisable." She noted the surgery might not relieve Employee's chronic, debilitating pain, but it would prevent potential migration of the screws and resulting neurologic damage. Dr. Oda said the SIME question regarding aggravation or acceleration of a pre-existing condition was not applicable for the lumbar spine, and she did not discuss any possible treatment at L4-5. (Oda SIME report, August 6, 2015; pp. 12-15.)

20) On August 7, 2015, Employee was evaluated by SIME physician Dr. McCormack who, in his 35-page SIME report, opined Employee's work injury was the substantial cause of her disability or need for medical treatment for her low back. He further stated that 95 percent of Employee's low back pain was due to the T11- L3 fusion with complications of non-union and five percent from spinal stenosis at L4-5 and other degenerative changes that were a pre-existing asymptomatic condition: "Her low back had caused her pain in the past, but not in the six months prior to the 4/3/11 work injury." Dr. McCormack reported Employee believes there "is probably some surgery that could make me better." Dr. McCormack opined revision of the nonunion T11-L3 and an L4 [sic] laminectomy would likely help relieve Employee's chronic debilitating pain. Dr. McCormack was asked, "If in your opinion one cause of [Employee's] disability or need for medical treatment is a pre-existing condition, did the 4/13/11 employment injury aggravate, accelerate or combine with a pre-existing condition to cause disability or need for treatment?" He responded:

> [Employee's] burst fracture at L1 is 100% industrial. At the time of the fracture, MRI and CT showed spinal stenosis at L4-5 due to facet arthropathy. She had low back pain in the past, but no claudication or radiculopathy. The spine was instrumented from T11- L3 to obtain biomechanical advantage over the fracture site. The fusion has caused aggravation of the degenerative changes below. Discography in 5/10/12 indicates painful discs L3-L5. Spinal stenosis at L4-5 is

> now severe. At the time of the burst fracture stenosis was mild and in my opinion, accelerated stenosis is, in part, due to the fusion.

Where asked what specific additional treatment, if any, he recommended to address the work injury or its consequences, Dr. McCormack replied:

> I would recommend revision posterior fusion and hardware T11 to L3. An extreme lateral interbody approach could also be done at one or more levels of nonunion. A L4-5 laminectomy is also needed. It is reasonable to do it while you are there. The argument against the laminectomy at L4–5 is that it may potentially destabilized [sic] spine immediately below the old T11–L3 fusion. This risk of causing instability at L4–5 with laminectomy is small.
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> Dr. Eule wants to extend the fusion down to the sacrum in addition to the L4 [sic] laminectomy. Advantage is to prevent delayed spinal instability from laminectomy alone at L4–5 and perhaps more comprehensively treat her axial low back complaints. The disadvantage to this approach is that it is more extensive surgery and she didn't heal after a small fusion and this risks more potential non-healing i.e. pseudoarthrosis. Her sagittal balance is satisfactory and doesn't have to be improved upon.
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> . . . She may not heal from a larger surgery.
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> I would suggest Dr. Eule consider treating the T11–L3 nonunion and L4-5 laminectomy. Repair of the non-union may resolve the low back pain to her satisfaction without fusing the lower lumbar discs. A more extensive surgery could always be done in the future if this is unsatisfactory, but I doubt it will be necessary. At this point, I believe a T11-S1 fusion to be too much surgery for the problem.

(McCormack SIME report, August 7, 2015, pp. 4, 31-34.)

21) On September 24, 2015, Employee filed an amended claim for medical costs and attorney's fees and costs. The reason for filing the claim was: "[Employee] amends claim to request preauthorization for lumbar surgery. This claim amends and incorporates all prior claims. The Employer has refused to authorize surgery recommended by attending physician, Dr. Eule or surgery recommended by SIME physician Dr. McCormack." (Amended claim, September 24, 2015.)

22) On September 28, 2015, in response to a fill-in-the-blank letter from Employee's counsel, Dr. Eule indicated he would not proceed with Dr. McCormack's recommendation to perform revision fusion and hardware from T11-L3, and an L4-5 laminectomy. Dr. Eule opined, "Needs

fusion to pelvis. L5/S1. Has severe facet arthrosis and would not do well if left untreated." (Eule response, September 28, 2015.)

23) On September 28, 2015, Dr. McCormack responded to a letter from Employer's counsel, asking him to clarify whether he believed the substantial cause of the need for an L4 [sic] laminectomy was the April 13, 2011 injury or degenerative changes. He opined:

> If she is going to have the thoracolumbar pseudoarthrosis repaired, it is reasonable to do a laminectomy, as an add-on, while there. L4-5 stenosis preexisted the subject industrial accident.
>
> If she is going to have a laminectomy only at L4-5, then substantial cause is the preexisting degenerative changes.
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> Industrial fusion will accelerate degenerative changes and stenosis at L4-5.
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> I don't believe a fusion down to the sacrum is appropriate, and I believe Dr. Oda came to the same opinion, in reviewing Dr. Oda's report 8/28/15.

Employer's letter did not include the legal definition of "substantial cause" under the Act. At hearing on February 16, 2016, Employee's counsel contended Dr. McCormack's response was based on a wrong definition of "substantial cause," but attorney Patterson did not submit any evidence to support this contention. Dr. McCormack has been on the board's SIME physician list since 2003. (McCormack response, September 28, 2015; record; division files.)

24) On October 14, 2015, relying on Dr. Youngblood's January 10, 2015 EME report and Drs. McCormack's and Oda's SIME reports, Employer controverted a T10-S1 fusion and all sequelae as not reasonable or medically necessary for the process of recovery from the work injury. (Controversion, filed October 14, 2015.)

25) On January 12, 2016, after a conference with Employee's counsel, Dr. Eule wrote:

> Now, after extensive evaluation, my recommendation is that she has a pseudoarthrosis for sure at the T11-12 area and needs revision of T11-L3, but she has such severe degenerative changes and other problems at the L4-5 and L5-S1 levels that I recommend a fusion down to her pelvis. However, she has apparently seen three other IME's, one being Dr. McCormick [sic] in neurosurgery from California whom I am certain has not had any experience in deformity or treatment. Her complicated multilevel deformity surgery is not performed by neurosurgeons. Unfortunately this is a surgeon that does not even do this type of surgery giving a recommendation on whether or not that is the appropriate surgery. I believe the other two IME's were by foot surgeons who have no basis for making very complex decisions on revision lumbar surgery. My basis for her needing an extension of her fusion down to her pelvis is many.

> Clearly the L3-4 1evel is severely degenerative and has a problem and she had a positive discogram so she is having lots of pain in her back from there. The L4-5 level is clearly dramatically more degenerated than it was at the time comparing the CT from 2011 prior to her surgery to that now. She has developed severe left sided facet arthropathy. It looks like there is almost a facet fracture. Clearly when she is lying down there is gaping in that facet, consistent with some early instability. She has also developed possibly some mild stenosis back in 2011 to now moderate to severe stenosis. One of the neurosurgeons also said she could just be decompressed at the L4-5 level and stop her fusion about that and she would be okay, but with someone with severe facet arthropathy, early evidence of gaping and instability in her facets, decompressing the spine extensively, it would not be very long before she would have full blown instability and need to extend the fusion. She also has pretty significant facet arthropathy and foraminal stenosis at those levels, which I think is causing some of her problem as well. Rather than not do a complete surgery the first time and have to go back for another surgery in a short period of time it is overall better for the patient to just do the complete surgery at this point and be done with it.

Dr. Eule concluded by expressing concerns about the "validity" of the opinions of Drs. Youngblood, McCormack and Oda, contending they are not deformity-trained spine surgeons. (Eule note, January 12, 2016.)

26) On February 2, 2016, Dr. Eule testified by deposition. He stated he does 400-500 spinal surgeries yearly, of which he estimated 40-60 were multilevel procedures. He testified that, unlike himself, the vast majority of neurosurgeons will not do the deformity surgery Employee needs. He described her case as "exceedingly complicated." He reiterated his recommendation that Employee needs a fusion from T10 to the pelvis, plus decompression at L4-5, and opined Employee's work injury and failed T11-L3 fusion were the substantial cause of her current need for both treatments. When asked if the T11-L3 fusion accelerated degenerative disc disease, stenosis, or facet arthropathy, Dr. Eule responded, "I would think it would have for sure, yes." Based on his last meeting with Employee on December 30, 2014, he opined it would be unwise to do revision surgery and ignore the L4-5 condition. He opined if he were to do the procedure recommended by Dr. McCormack (just the L4-5 decompression without the full lumbar fusion), the substantial cause of the need for the decompression would be Employee's spinal stenosis, which has progressed rapidly as a result of her work-related fracture and surgery. He further opined decompression alone at L4-5 would be "highly likely to fail in a short period of time, which generally we say is within a couple years." He acknowledged that it was "very possible" a multilevel fusion could lead to subsequent degeneration in the SI joints, because if spine mobility

is lost, "the stress has to be transferred somewhere." On the other hand, he opined the surgery recommended by Dr. McCormack was less likely to enable Employee to return to work than his proposed surgery, because "she would be doing one surgery and then still having some pain and difficulty within a short period of time and a subsequent surgery to fix it." On cross-examination, Dr. Eule testified he did not know Drs. Youngblood or Oda, but had been told by Employee's counsel they were foot surgeons, and that he knew Dr. McCormack only through prior SIME reports, but assumed that a neurosurgeon would probably not have had any kind of formal deformity training. When asked what the "agenda" of a treating physician is, Dr. Eule responded, "I'm going to treat the whole patient's problem and not just what the work comp is going to allow us to say is connected to this versus that." He agreed there "was always a risk" that after a T11-S1 fusion, a fusion further up might be necessary, but "that would be hopefully ten-plus years" in the future. When asked whether, as the treating physician, he perceived himself as an advocate for the claimant, Dr. Eule responded, "Yes." On redirect examination, he testified that he still recommended total fusion, but prior to surgery he would need to revisit Employee's condition, symptoms and other findings. (Eule deposition, February 2, 2016; pp. 6-7; 10-11; 15-16; 23; 32; 33; 35; 37-38; 40; 57; 63-64; 69-74; 76.)

27) On February 5, 2016, Dr. Youngblood testified by deposition. He stated he did not do spine surgery, but he did treat individuals with traumatic back injuries and degenerative back conditions, and that back complaints constituted about five percent of his practice. He testified he had reviewed Employee's medical records subsequent to her January 10, 2015 EME, and none of them caused him to change the opinions in his EME report. He testified he agreed with Drs. Oda's and McCormack's opinions regarding the needed medical treatment for the work injury, though he "did not necessarily agree" with Dr. McCormack's recommendation to do a laminectomy at L4-5. Dr. Youngblood testified a full lumbar fusion was not reasonable and necessary treatment for the process of recovery from the work injury, but also opined Dr. Eule's recommended surgery, while "certainly aggressive," was not outside the standard of care. On direct examination Dr. Youngblood testified that the work injury and the fusion were not the "greatest factor" contributing to her degeneration in the lumbar spine; rather the "greatest factor" was the preexisting nature of Employee's lower lumbar spine degeneration, her age, genetics, and obesity. However later, when given the correct legal for "the substantial cause" – i.e. the cause greater than any other, as opposed to 51 percent of the total – he opined that "the arthritis

and the degeneration probably would be secondary to the injury and the surgery and the discogram and treatment, more so than any other one factor." On cross-examination, Dr. Youngblood testified he agreed with Dr. McCormack's opinion that 95 percent of Employee's low back pain is due to the T11-L3 fusion, and five percent from spinal stenosis at L4-5 and other degenerative changes that were preexisting, asymptomatic conditions: "I think her low back pain is actually coming from the pseudarthrosis levels." Dr. Youngblood stated he would not do a laminectomy at L4-5. He testified the main fields he studied were foot and ankle and also sports medicine of the knee and shoulder, and he was not a deformity-trained spine surgeon. On redirect examination, Dr. Youngblood indicated that, regardless of whether Employee's degeneration was substantially caused by the work injury and is increasing, he would not perform surgery at the lower lumbar levels. On recross examination, Dr. Youngblood testified he "certainly would value" Dr. Eule's opinion regarding spinal surgery, and would "defer" to Dr. McCormack's opinion, "if it sounded reasonable." In its hearing brief, Employer admitted that Dr. Youngblood's opinion regarding causation of the need for treatment at L4-5 is "at best, a wash." (Youngblood deposition, February 5, 2016, pp. 6-7; 16; 20; 28; 29-30; 32; 33; 56-58; 73; 75-76, 78-80; Employer's hearing brief, February 9, 2016.)

28) At hearing on February 16, 2016, Employee testified she was aware of all the risk factors related to a total lumbar fusion, but she wanted it anyway. She believed Dr. Eule's recommended procedure would cure a majority of her pain, though not all, and she wanted to have one surgery and "be done with it," rather than have one surgery now and another within a few years, when it will be harder to deal with because she will be older. She stated she was in chronic pain. She said her quality of life had been getting worse since the work injury, and it could be a lot better. She testified she wanted to return to work. (Employee.)

29) On February 18, 2016, Employer filed a Notice of Intent to Rely on Employee's deposition dated August 28, 2014. Because the document was not entered into evidence 20 days prior to hearing, as required under 8 AAC 45.120(f), and because the record was left open solely for the purposes of filing legal memoranda regarding attorney's fees and costs, on due process grounds the deposition was not considered in rendering this decision. (Notice of Intent to Rely, February 18, 2016; judgment, observation, unique or peculiar facts of the case.)

30) On February 19, 2016, the parties filed a written stipulation that they are not seeking medical records exclusions based on changes of physician prior to February 16, 2016. Employee

stipulated her attending physician for her thoracolumbar spine is Dr. Eule, and Employer stipulated its physician is Dr. Youngblood. Because the written stipulation clarifies and memorializes an oral stipulation made at hearing, it is included here, even though the record was left open solely for the purposes of filing legal memoranda regarding attorney's fees and costs. (Stipulation, February 19, 2016; judgment, observation, unique or peculiar facts of the case.)

31) On February 19, 2016, attorney Patterson filed an affidavit requesting an award of $35,880.83 in attorney's fees and $4,764.26 in costs, for a total of $40,645.09. (Affidavit of Attorney's Fees and Costs, February 19, 2016.)

32) On February 29, 2016, Employer filed a limited opposition to attorney Patterson's fee affidavit, contending he billed for excessive time, considering the "relatively straightforward" nature of the compensability issue. Employer also objected to a $50 line item for paper, binders and file folders, contending these were general overhead costs not allowed by 8 AAC 45.180(f). (Limited Opposition to Employee's Petition for Attorney's Fees and Costs, February 29, 2016.)

33) On March 8, 2016, Employee filed a reply to Employee's limited opposition to her petition for attorney fees and costs. Because at hearing the parties agreed the record would close on March 7, 2016, this document was not considered in rendering this decision. (Reply to Employer's Limited Opposition to Employee's Petition for Attorney Fees and Costs, March 8, 2016; judgment, observation, unique or peculiar facts of the case.)

PRINCIPLES OF LAW

> **AS 23.30.001. Intent of the legislature and construction of chapter.**
> It is the intent of the legislature that
>
> (1) this chapter be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter;

The board may base its decisions not only on direct testimony and other tangible evidence, but also on the board's "experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-534 (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 death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.

For an injury occurring on or after November 7, 2005, the board must evaluate the relative contribution of all causes of disability, death or need for medical treatment and award benefits if employment is, in relation to all other causes, "the substantial cause" of the disability, death or need for medical treatment. *City of Seward v. Hansen*, AWCAC Decision No. 146 at 11-14 (January 21, 2011). When all causes are compared, only one cause can be "the substantial cause." *Id*.

> **AS 23.30.095. Medical treatments, services, and examinations.**
> (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. . . . It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require. . . .
> . . .
>
> (d) If at any time during the period the employee unreasonably refuses to submit to medical or surgical treatment, the board may by order suspend the payment of further compensation while the refusal continues, and no compensation may be paid at any time during the period of suspension, unless the circumstances justified the refusal.

Under the Alaska Workers' Compensation Act (Act), an employer must pay for medical treatment that "the nature of injury or process of recovery requires" within the first two years of the injury. AS 23.30.095(a); *Phillip Weidner & Associates v. Hibdon*, 989 P.2d 727, 731 (Alaska 1999). When the board reviews an injured worker's claim for medical treatment within two years of injury, its review is limited to whether the treatment sought is reasonable and necessary. *Bockness v. Brown Jug, Inc.*, 980 P.2d 462, 465 (Alaska 1999). An employee "may choose to follow his or her own doctor's advice, so long as the choice of treatment is reasonable." *Hibdon* at 731-32.

> Where the claimant presents credible, competent evidence from his or her treating physician that the treatment undergone or sought is reasonably effective for the process of recovery, and the evidence is corroborated by other medical experts, and the treatment falls within the realm of medically acceptable options, it is generally considered reasonable. If the employee makes this showing, the employer is faced with a heavy burden -- the employer must demonstrate to the board that the treatment is neither reasonable and necessary, nor within the realm of acceptable medical options under the particular facts. It is not the board's function to choose between reasonable, yet competing, medically acceptable treatments. Rather the board must determine whether the actual treatment sought by the injured employee is reasonable. *Id.* at 732.

However, when the board examines a claim for continued treatment beyond two years from the date of injury, it has discretion to authorize "indicated" medical treatment "as the process of recovery may require." *Id.* at 731, quoting *Municipality of Anchorage v. Carter*, 818 P.2d 661, 664 (Alaska 1991). Given this discretion, the board is not limited to reviewing the reasonableness and necessity of the particular treatment sought, but has some latitude to choose among reasonable alternatives. *Hibdon* at 731, citing *Carter* at 665. Referring to treatment provided more than two years after a work injury, the Commission noted "the board's inquiry should not have been limited to whether the treatment sought is reasonable and necessary, but should have been expanded, as it had the discretion to choose among reasonably effective medical treatment alternatives, as the process of recovery requires." *Voorhees Concrete Cutting v. Kenneth Monzulla,* AWCAC Decision No. 68 (February 4, 2008) at fn.36, citing *Hibdon* at 731; *Jones v. Frontier Flying Serv., Inc.*, AWCAC Dec. No. 018, 23 (Sept. 7, 2006).

Injured workers must weigh many variables before deciding whether to pursue a certain course of medical or related treatment. An important treatment consideration for claimants in many

cases is whether a physician's recommended treatment is compensable under the Act. *Summers v. Korobkin*, 814 P.2d 1369, 1372 (Alaska 1991). An employee need not have unpaid medical bills to bring a claim for medical services. *Id.* at 1372. An injured worker is entitled to a prospective determination of whether the treatment sought is compensable. *Id.* at 1373-74.

> **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 is applicable to any claim for compensation under the workers' compensation statute, including medical benefits. *Id.* An employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski v. Best Western Golden Lion*, 813 P.2d 286, 292 (Alaska 1991).

Application of the presumption 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). Medical evidence may be needed to attach the presumption of compensability in a complex medical case. *Burgess Constr. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). In less complex cases, lay evidence may be sufficiently probative to establish the link. *Veco, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). The employee need only adduce "some relevant evidence establishing a preliminary link" between the claim and the employment. *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987). "In making the preliminary link determination, the Board may not concern itself with the witnesses' credibility." *Excursion Inlet Packing Co. v. Ugale*, 92 P.3d 413, 417 (Alaska 2004).

If the employee establishes the preliminary link, then the employer can rebut the presumption by presenting substantial evidence demonstrating that a cause other than employment played a greater role in causing the disability or need for medical treatment, or by substantial evidence that employment was not the substantial cause. *Runstrom v. Alaska Native Medical Center,*

AWCAC Decision No. 150 (Mar. 25, 2011). "Substantial evidence" is the amount of relevant evidence a reasonable mind might accept as adequate to support a conclusion. *Miller v. ITT Arctic Services*, 577 P.2d 1044, 1046 (Alaska 1978). Because the employer's evidence is considered by itself and not weighed at this step, credibility is not examined at this point. *Veco v. Wolfer* at 869-70.

If the presumption is raised and not rebutted, the Employee need produce no further evidence and the Employee prevails solely on the raised but un-rebutted presumption. *Williams v. State*, 938 P.2d 1065 (Alaska 1997). "If the employer rebuts the presumption, it drops out, and the employee must prove, by a preponderance of the evidence, that in relation to other causes, employment was the substantial cause of the disability, need for medical treatment, etc. Should the employee meet this burden, compensation or benefits are payable." *Runstrom* at 8. This means the employee must "induce a belief" in the minds of the factfinders the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). At the third step, evidence is weighed, inferences are drawn from the evidence, and credibility is considered.

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

The board's finding of credibility "is binding for any review of the Board's factual findings." *Smith v. CSK Auto, Inc.*, 204 P.3d 1001, 1008 (Alaska 2009). The board has the sole power to determine witness credibility, and its findings about weight are conclusive even if the evidence is conflicting. *Harnish Group, Inc. v. Moore*, 160 P.3d 146, 153 (Alaska 2007). The board has the sole discretion to determine the weight of the medical testimony and reports. When doctors' opinions disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.*, AWCAC Decision No. 087 (August 25, 2008) at 11.

The Alaska Supreme Court held it is not necessary that doctors use particular phrasing or terminology in workers' compensation cases:

> The compensation process is not a game of "say the magic word," in which the rights of injured workers should depend on whether a witness happens to choose a form of words prescribed by a court or legislature. What counts is the real substance of what the witness intended to convey, and for this purpose there are more realistic approaches than a mere appeal to the dictionary. . . .

Smith v. Univ. of Alaska, Fairbanks, 172 P.3d 782 at 791(Alaska 2007), citing 8 Arthur Larson & Lex K. Larson, *Larson's Workers' Compensation Law* §130.06[2][e] (2006). The Supreme Court held "we have previously refused to adopt a general rule in workers' compensation cases that a treating physician's opinion is entitled to greater weight than the opinion of an employer's expert. The board alone is charged with determining the weight it will give to medical reports." *Id.* at 793, citing *Safeway, Inc. v. Mackey*, 965 P. 2d 22, 29 (Alaska 1998).

In *Sarmiento-Mendoza v. State of Alaska*, AWCB Decision No. 14-0122 at 18 (September 2, 2014), an SIME physician's opinion was given less weight because, among other reasons, he either contradicted himself as to the causation of Employee's disability and need for medical treatment or misunderstood the nature of an aggravation of a preexisting condition. When asked to address the relative contribution of the different causes of an injured worker's "complaints and symptoms," the physician attributed 90 percent of the complaints and symptoms to her preexisting condition. The board held:

> While doctors are not required to use 'magic words,' the cause of 'complaints and symptoms' is not necessarily the same as the substantial cause of disability or need for medical treatment. A preexisting condition may indeed cause 90 percent of a person's complaints and symptoms yet not cause the inability to work or need for medical treatment. Where the disability and need for medical treatment are due to the remaining 10 percent of 'complaints and symptoms,' the cause of the 10 percent would be the substantial cause.

Less weight may be given to a physician who appears to be advocating for a party. In *Hanson v. Municipality of Anchorage*, AWCB Decision No. 10-0175 (October 29, 2010), an EME physician was found to have appeared to advocate for a particular position favorable to the employer, when she offered an opinion about a medical condition that was clearly outside her area of expertise, and minimized the effect lifting heavy fire hoses could have on an abnormal lumbar disc, while maximizing the effect lifting a pencil could have on a similar disc.

> **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 . . . When the board advises that a claim has not been controverted, but further advises that bona fide legal services have been rendered in respect to the claim, then the board shall direct the payment of the fees out of the compensation awarded. In determining the amount of fees the board shall take into consideration the nature, length, and complexity of the services performed, transportation charges, and the benefits resulting from the services to the compensation beneficiaries.
>
> (b) If an employer fails to file timely notice of controversy or fails to pay compensation or medical and related benefits within 15 days after it becomes due or otherwise resists the payment of compensation or medical and related benefits and if the claimant has employed an attorney in the successful prosecution of the claim, the board shall make an award to reimburse the claimant for the costs in the proceedings, including reasonable attorney fees. The award is in addition to the compensation or medical and related benefits ordered.

In *Harnish Group, Inc. v. Moore*, 160 P.3d 146 (Alaska 2007), the Alaska Supreme Court discussed how and under which statute attorney's fees may be awarded in workers' compensation cases. A controversion (actual or in fact) is required for the board to award fees under AS 23.30.145(a). "In order for an employer to be liable for attorney's fees under AS 23.30.145(a), it must take some action in opposition to the employee's claim after the claim is filed." *Id*. at 152. Reasonable fees may be awarded under AS 23.30.145(b) when an employer "resists" payment of compensation and an attorney is successful in the prosecution of the employee's claims. *Id*. at 152-153. The nature, length, and complexity of services performed, the resistance of the employer, and the benefits resulting from the services obtained are also considerations when determining reasonable attorney's fees for the successful prosecution of a claim. *Wise Mechanical Contractors v. Bignell*, 718 P.2d 971, at 973, 975 (Alaska 1986).

ANALYSIS

1) Is a total lumbar fusion compensable?

2) Is an L4-5 laminectomy compensable?

Employee was injured on April 13, 2011, and six days later underwent surgery that proved unsuccessful. The parties agree revision surgery from T11-L3 is compensable, but disagree as to the compensability of any proposed treatment below L3. The voluminous medical evidence in this case includes post-surgical opinions about Employee's thoracolumbar spine from treating

physicians Drs. Betts, Lieberson, Wright and Eule; EME physicians Drs. Rivera, Provencher and Youngblood; and SIME physicians Drs. Oda and McCormack. To facilitate analysis, their most salient treatment recommendations are summarized in the table below:

Physician(s)	Role	Date	Spinal Treatment Recommendation Summary
Rivera & Provencher	EME	4/2012	Physical therapy
Betts	Treating	5/2012	Refrain from physical therapy; XLIF at L3-4
Lieberson	Treating	11/2012	Lose weight + get in better shape; remove hardware if pain does not improve; bad idea to extend fusion below L3
Eule	Treating	2/2013	Possible instrumentation removal, after non-work injury to cervical spine is treated
Eule	Treating	12/2013	Remove instrumentation; possible re-instrumentation and revision fusion; decompress at L4-5 and possibly L5-S1
Wright	Treating	12/2013	Remove hardware; possible refusion of L1-2; lumbar laminectomy if nerve roots impinged
Rivera & Youngblood	EME	3/2014	Revision fusion for work-related lumbar injury
Eule	Treating	12/2014	T10 to pelvic fusion; decompress lower lumbar levels and maybe also T10-11
Youngblood	EME	1/2015	Nonoperative care, as recommended by Lieberson, or revision fusion; surgery at other levels strongly opposed
Oda	SIME	8/2015	Hardware removal and possible revision fusion, not to extend below L2
McCormack	SIME	8/2015	Revision fusion; L4-5 laminectomy; no T11-S1 fusion
Eule	Treating	2/2016	T10 to pelvic fusion; decompression at L4-5
Youngblood	EME	2/2016	Revision fusion; no L4-5 laminectomy; no T11-S1 fusion

An injured worker is entitled to a prospective determination of whether the treatment sought is compensable under the Act. *Summers.* At dispute here are two treatments recommended by current treating physician, Dr. Eule: a total lumbar fusion extending from T10 or T11 to S1, and a laminectomy at L4-5. The compensability of each is a factual issue subject to the presumption analysis. *Sokolowski.* There is no evidence the medical treatments sought were recommended within the first two years after Employee's April 2011 injury; the L4-5 laminectomy was first recommended in December 2013, and the full lumbar fusion in December 2014. Therefore, for either treatment to be compensable, two conditions must be met: (1) the work injury must be the substantial cause of the need for the recommended treatment; and (2) the indicated procedure must be a reasonably effective medical treatment "as the process of recovery may require." *Hibdon;*

Carter; Monzulla; Jones. Dr. Eule's proposed fusion and laminectomy procedures are analyzed separately below.

Full lumbar fusion

Employee attached the presumption of compensability with Dr. Eule's opinion, first articulated in December 2014, that Employee requires a T10 to pelvic fusion. At deposition Dr. Eule specifically opined Employee's work injury and failed T11-L3 fusion were the substantial cause of her need for this treatment.

At the second step of the analysis, Employer rebutted the presumption with Drs. Youngblood's, Oda's and McCormack's shared recommendation against full lumbar fusion. Viewed in isolation, and without regard to credibility, these EME and SIME opinions provide substantial evidence to rebut the presumption, cause it to drop out, and require Employee to prove compensability by a preponderance of the evidence. *Saxton; Runstrom.*

At the third step of the presumption analysis, evidence is weighed and credibility determinations made. The factfinders have sole discretion to determine the weight given to medical testimony and reports. When doctors' opinions disagree, the factfinders determine which have greater credibility. *Harnish; Moore v. Afognak.* Hypothetically, if Employee were seeking treatment recommended within two years after her injury, the factfinders' review of her claim would be limited to whether the treatment sought is reasonable and necessary. *Hibdon.* However, because Employee is seeking treatment recommended more than two years after the injury, the factfinders have discretion to choose among reasonable alternatives, as the process of recovery may require. *Hibdon; Carter; Monzulla; Jones.* Here medical opinions issued prior to 2013 are accorded less weight than those after, due to several interrelated factors: (1) Employee first was evaluated by her current treating physician in February 2013; (2) Employee has not yet been found medically stable; (3) Employee testified her quality of life has been getting worse since the accident; and (4) the changing nature of her condition and symptoms renders recent opinions more relevant than earlier ones.

Since February 2013, six physicians articulated thoracolumbar treatment recommendations for Employee: treating physicians Drs. Eule and Wright; EME physicians Drs. Rivera and Youngblood; and SIME physicians Drs. Oda and McCormack. Dr. Wright's opinion is given less weight than Dr. Eule's, because Employee only consulted once with Dr. Wright before deciding she preferred to treat with Dr. Eule, whom she saw at least five times in 2013 and 2014. Chiropractor Rivera is of minimal significance in the credibility determination analysis because, after he and Dr. Youngblood issued their joint EME report in March 2014, Dr. Rivera had no further contact with Employee; the most recent EME, in January 2015, was conducted by Dr. Youngblood alone because there was no evidence of ongoing chiropractic care. Consequently, the four physicians whose opinions are most significant to this analysis are Drs. Eule, Youngblood, Oda and McCormack. The medical disputes between the first two led the parties to stipulate to SIMEs conducted by the latter.

A treating physician's opinion is not automatically accorded greater weight than that of an employer's expert. *Smith v. UAF; Mackey.* However Employer's arguments as to why Dr. Eule is not credible are unpersuasive. First, the fact Dr. Eule, unlike the EME and SIME physicians, has not done an extensive records review does not in itself render his opinions less credible; it merely reflects Dr. Eule's role as a treating physician, as opposed to Employer's or the board's medical evaluators. Dr. Eule performs 400-500 spinal surgeries a year, and at this point Employee is no more than a potential patient whom he has not seen for well over a year. It would be unrealistic to expect Dr. Eule to exhaustively research the medical history of every person who seeks his surgical opinion; he would have to dramatically reduce his volume of business if he were to do so. Instead, Dr. Eule articulated the reasonable business and medical approach that, prior to any future surgery he performed on Employee, he would revisit her condition, symptoms and other findings.

Second, Dr. Eule's credibility is not diminished by the fact his treatment recommendations changed between his first evaluation of Employee, in February 2013, and his last, in December 2014. Dr. Eule did not arrive at his treatment recommendations lightly. In December 2013, he noted he had "kind of gone back and forth" about whether he should take out Employee's instrumentation and then perform a total lumbar fusion, which he termed the "most aggressive treatment options"; he decided against the more extensive procedure, but noted "we do not have a crystal ball" and even if he did the smaller procedure now, Employee might need the full fusion later. In December 2014,

when he recommended the full lumbar fusion, Dr. Eule was still weighing the pros and cons of his treatment options: "We are kind of still back to making a decision on what is going on." However at that point, after a "very long discussion and debate," Dr. Eule decided against the smaller surgery, because he did "not want to do one that is not going to work and she is going to be back shortly for another surgery." The fact Dr. Eule changed his treatment recommendation between December 2013 and December 2014 does not reflect negatively on his credibility; rather it represents a thoughtful analysis of what he termed an "exceedingly complicated" case, and a willingness to change his medical opinion as the patient's condition and symptoms changed. Altered treatment recommendations are to be expected in dealing with a patient whose health continues to deteriorate. This is particularly true where, as here, there is no consensus as to a single, definitive, cure-all treatment; throughout the medical evidence in this case, numerous doctors expressed their recommendations in terms of possibility, probability and likelihood, rather than certainty.

Third, Dr. Eule's credibility is not lessened by the fact that when asked if he perceived himself as an advocate for the claimant, he responded, "Yes." This self-perception correlates with his opinion that his "agenda" is "to treat the whole patient's problem and not just what the work comp is going to allow us to say is connected to this versus that." The circumstances here are distinguishable from those in *Hanson*, where an EME physician's opinions were given less weight because she appeared to be advocating for her employer by opining about a medical condition that was clearly outside her area of expertise, and by minimizing certain objective findings in order to come to a specific conclusion. In the instant case, under cross-examination Dr. Eule simply responded as a person who has taken the Hippocratic Oath, not one who has a litigant's awareness that identifying himself as a party's advocate may, under certain circumstances, render him not credible. In fact a reasonable person would hope that his treating physician would act as his advocate, as opposed to his enemy or antagonist. In summary, Dr. Eule's current recommendation that full lumbar fusion is a reasonable and necessary treatment for the process of recovery from Employee's work injury is found credible. AS 23.30.122; *Smith v. CSK*.

Employee in turn contends the opinions of Drs. Youngblood, Oda and McCormack should be given less weight because they lack Dr. Eule's training and experience as deformity-trained spine surgeons. Employee's contentions are less than persuasive. For example, Dr. Youngblood is

upfront about his relative lack of spinal surgery experience compared to Dr. Eule. However both physicians appear to have arrived at their treatment recommendations after thoughtful analyses, and Dr. Youngblood does not dismiss Dr. Eule's treatment opinions out-of-hand. On the contrary, while Dr. Youngblood concluded he did not believe a full lumbar fusion was reasonable and necessary treatment for the process of recovery from the work injury, he also opined Dr. Eule's recommended surgery, while "certainly aggressive," was not outside the standard of care. Dr. Youngblood additionally testified he "certainly would value" Dr. Eule's opinion regarding spinal surgery.

Neither do Employee's criticisms concerning the "validity" of the opinions of Drs. Oda and McCormack convincingly detract from their credibility. If Employee had reservations about either Drs. Oda's or McCormack's credentials or ability to evaluate her, she should not have stipulated that those physicians would perform her SIMEs. Instead, Employee waited until after receiving Drs. Oda's and McCormack's treatment recommendations, and then attacked opinions she did not like on the basis their authors lacked Dr. Eule's specialized knowledge and experience. Moreover, Employee failed to present convincing evidence to support Dr. Eule's opinions about Drs. Oda's and McCormack's allegedly inadequate qualifications.

In conclusion, the treatment recommendations of Drs. Eule, Youngblood, Oda and McCormack are all found credible with regard to the proposed full lumbar fusion. AS 23.30.122; *Smith v. CSK.* The decisive factor in deciding whether that procedure is compensable therefore lies not in a credibility determination, but in weighing the evidence as a whole. Dr. Eule's belief the procedure is compensable is vastly outweighed by the equally credible, shared opinions of EME physician Dr. Youngblood and SIME physicians Drs. Oda and McCormack, all of whom strongly recommend against it. Acting as the board's independent physician, Dr. McCormack's articulation of this view is particularly cogent and persuasive. After carefully considering the advantages and disadvantages of a total lumbar fusion, Dr. McCormack concluded that revision fusion alone might resolve Employee's low back pain to her satisfaction, she might not heal from a larger surgery, and at this point a T11-S1 fusion would be "too much surgery for the problem." Dr. McCormack reasonably and logically noted that a "more extensive surgery could always be done in the future if this is unsatisfactory, but I doubt it will be necessary." Employee has experienced chronic pain for five years, and her desire to have one surgery "and be done with it" is understandable. However

Employee failed to prove the compensability of the total lumbar fusion by the preponderance of the evidence. Her September 24, 2015 amended claim for total lumbar fusion surgery will be denied.

L4-5 laminectomy

Employee attached the presumption of compensability to this procedure with Dr. Eule's opinion that Employee's work injury and failed T11-L3 fusion constitute the substantial cause of her need for decompression at L4-5. Employer then rebutted the presumption with Dr. Youngblood's opinions that no surgery was indicated below L3, and Employee's lower lumbar multilevel degenerative disc disease was preexisting and not substantially caused or aggravated by her work injury. At the third step of the presumption analysis, Employee needs to prove the compensability of the proposed L4-5 laminectomy by a preponderance of the evidence.

As set out above, the most pertinent medical opinions are those of treating physician Dr. Eule, EME physician Dr. Youngblood, and SIME physicians Drs. Oda and McCormack. However here, unlike in the discussion of the full lumbar fusion, Dr. Youngblood's credibility is diminished to the point where Employer admitted his opinions regarding the proposed L4-5 laminectomy are "at best, a wash." Specifically, Dr. Youngblood's views about the decompression are given less weight due to inconsistencies between his opinions from January 2015 and February 2016. Most notably, at deposition Dr. Youngblood contradicted his earlier opinion on causation by opining Employee's low back pain "is actually coming" from the pseudoarthrosis levels, *i.e.* the failed fusion: "the arthritis and the degeneration probably would be secondary to the injury and the surgery and the discogram and treatment, more so than any other one factor."

Employee's assertion that Dr. McCormack's opinion regarding causation also lacks credibility is unpersuasive. Dr. McCormack advised against extending the fusion down to the sacrum, but recommended that Dr. Eule perform an L4-5 laminectomy as an "add-on" to the revision fusion, because it "is reasonable to do it while you are there." Dr. McCormack opined Employee's failed surgery caused aggravation of the degenerative changes below. Though he stated "the accelerated stenosis is, in part, due to the fusion," he did not specify whether that "part" constituted a cause greater than any other. However, when Employer's counsel asked him to clarify whether he

believed the substantial cause for the need for the laminectomy was the work injury or degenerative changes, Dr. McCormack specified, "If she is going to have a laminectomy only at L4-5, then substantial cause is the preexisting degenerative changes." This is in direct contrast to Dr. Eule's opinion that, if her were to perform just the L4-5 laminectomy, without the full lumbar fusion, the substantial cause for the need for the laminectomy would be Employee's spinal stenosis, which has progressed rapidly as a result of her work-related fracture and surgery.

Employee's argument that this opinion was based on a misunderstanding of the substantial cause legal standard, and therefore should be given less weight, is unconvincing for several reasons. First, Dr. McCormack was provided the definition of "the substantial cause" in the SIME physician referral letter accompanying the SIME medical records. Second, Dr. McCormack is an experienced SIME physician, having served for 12 years before evaluating Employee, and, in the absence of persuasive evidence to the contrary, it is reasonable to assume he understands the relevant causation standard. Third, and most important, Employee failed to follow up with interrogatories or deposition questions to gather evidence to support her argument Dr. McCormack's opinion was based on confusion or miscomprehension, or to demonstrate the instant case is comparable to *Sarmiento-Mendoza.*

Hence, at the third step of the presumption analysis regarding the proposed laminectomy, Dr. Youngblood's opinions are discounted, while those of Drs. Eule, Oda and McCormack are found credible. AS 23.30.122; *Smith v. CSK.* Of these three, only Dr. Eule met both prongs of the compensability test, by opining the work injury and failed surgery were the substantial cause of the need for an L4-5 laminectomy, and by identifying the procedure as a reasonably effective treatment required for the process of recovery. Dr. Oda did not even mention L4-5 surgery and therefore, by omission, effectively opined it was not a treatment required for recovery from the work injury. Dr. McCormack agreed with Dr. Eule that Employee needs an L4-5 laminectomy but, significantly, Dr. McCormack also specified that if only a laminectomy (and not a fusion) was going to be performed at those levels, the substantial cause of the need for treatment was not work-related, but rather preexisting, degenerative changes. As was the case with the total lumbar fusion, the decisive factor in deciding whether an L4-5 laminectomy is compensable lies not in a credibility determination, but in weighing the evidence as a whole. Dr. Eule's opinion is not enough to outweigh those of Drs.

Oda and McCormack. Consequently, Employee failed to prove the compensability of the desired decompression by the preponderance of the evidence. Her September 24, 2015 amended claim for an L4-5 laminectomy will be denied.

3) Should Employee be given a specific date by which she needs to undergo surgery or be declared medically stable?

Employer asks the board to order Employee to proceed with a revision fusion by a specific date or be found medically stable. While acknowledging the legislative intent for quick, efficient and fair delivery of benefits at reasonable cost to employers, this decision declines to issue such an order. AS 23.30.001(1). In September 2015, Dr. Eule indicated he would not proceed with Dr. McCormack's recommendation to perform only revision fusion and hardware, plus an L-4 laminectomy; in other words, without also performing the full lumbar fusion. It is unknown whether Dr. Eule still holds this opinion. Even if Dr. Eule has changed his mind and is now willing to perform the lesser surgery authorized by this Decision and Order, the record includes no evidence as to his surgical schedule or availability to perform the procedure.

Employee has been in chronic pain for years and her condition continues to deteriorate. She seeks maximum relief in the shortest time possible, and wants to return to work. She therefore has little, if any, incentive to postpone revision surgery any longer than necessary. Employee will be ordered to undergo the undisputedly compensable surgical treatment as soon as is reasonably possible. If she unreasonably refuses to submit to medical or surgical treatment, Employer may petition the board to suspend payment of further compensation, as provided in AS 23.30.095(d).

4) Should attorney's fees and costs be awarded?

Under AS 23.30.145(a), attorney fees may be awarded based on the amount of compensation awarded. Under AS 23.30.145(b), fees may be awarded when a claimant successfully prosecutes a claim. Here, Employee was not awarded any additional compensation, nor did she prevail on her September 24, 2015 amended claim. Consequently there is no basis upon which attorney fees may be awarded. *Harnish; Bignell.*

CONCLUSIONS OF LAW

1) A total lumbar fusion is not compensable.

2) An L4-5 laminectomy is not compensable.

3) Employee will not be given a specific date by which she need to undergo surgery or be declared medically stable.

4) Employee will not be awarded attorney's fees and costs.

ORDER

1) Employee's September 24, 2015 amended claim for medical costs associated with full lumbar fusion is denied.

2) Employee's September 24, 2015 amended claim for medical costs associated with an L4-5 laminectomy is denied.

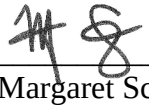
3) Employee's September 24, 2015 amended claim for attorney's fees and costs is denied.

4) Employer's request that Employee be given a date certain by which she need to undergo surgery or be declared medically stable is denied.

5) Employee is ordered to proceed with the undisputedly compensable revision surgery as soon as is reasonably possible.

Dated in Anchorage, Alaska on April 6, 2016.

ALASKA WORKERS' COMPENSATION BOARD



Margaret Scott, Designated Chair

Michael O'Connor, Member

Rick Traini, 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 MARIE M. EDENSHAW, employee / claimant; v. PENINSULA AIRWAYS, INC., employer; WAUSAU UNDERWRITERS INSURANCE CO., insurer / defendants; Case No. 201105565; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on April 6, 2016.

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Elizabeth Pleitez, Office Assistant