ALASKA WORKERS' COMPENSATION BOARD

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

STEPHAN C. MITCHELL, Employee, Claimant, v. UNITED PARCEL SERVICE, Employer, and LIBERTY MUTUAL FIRE INSURANCE COMPANY, Insurer, Defendants.	FINAL DECISION AND ORDER AWCB Case No. 199523875 AWCB Decision No. 18-0042 Filed with AWCB Anchorage, Alaska on May 1, 2018

Advanced Pain Center's (Advanced) March 3, 2016, Pioneer Peak Surgery's (Pioneer) March 16, 2016, Stephan Mitchell's (Employee) March 3, 2017 claims for benefits and United Parcel Service's (Employer) November 23, 2016 petition for a Social Security offset, its March 30, 2017 petition to bar Employee's wife from acting as his representative and its October 3, 2017 petition to strike Employee's hearing Exhibit 3 were heard on October 4, and on November 21, 2017, in Anchorage, Alaska, dates selected on May 18, 2017 and October 4, 2017, respectively. Attorney Richard Harren and non-attorney representative Jeanne Mitchell appeared and represented Employee who appeared and testified. Attorney Nora Barlow appeared and represented Employer. Michelle Murrills appeared, represented Advanced and testified. There was no appearance for Pioneer. Witnesses included Daniel LaBrosse and Kelly Smith who

appeared by telephone, and Paul Smith and Jeanne Mitchell who appeared in person, all on Employee's behalf.

As preliminary issues, an oral order denied Employer's request for Employee to be physically present at the first hearing day. An oral order granted Employer's request to strike Employee's hearing brief Exhibit 3 and its request to restrict Employee's wife's advocacy at hearing. An oral order granted Employee's petition for more time to file support for his attorney fee and cost request. On the second hearing day, the parties disagreed about whether the panel could consider medical reports from two EME physicians, reports an earlier decision had stricken from the record. The panel reserved ruling on this issue. This decision examines the oral orders, decides the EME report issue and decides the parties' claims and petitions on their merits.

Labor panel member Stacy Allen resigned her position prior to final deliberations, which continued with a two-member panel. The two-member panel deadlocked and the designated chair selected Labor Member Nancy Shaw and permitted her to review the written record, evidence and hearing recording and to deliberate with the panel to make a decision. The panel reopened the hearing record on April 27, 2018, to receive a document clarifying Employee's Social Security disability payments. The record closed on April 30, 2018, when Employee filed the requested document and the panel members completed deliberating.

ISSUES

Employer contended Employee must be physically present for credibility determinations, based on his contention he cannot work even in a sedentary position. Employer contended since Employee's physical abilities were at issue, his personal attendance was mandatory.

Employee contended he would be present later in the hearing for his testimony and the fact-finders could observe and judge his capabilities and demeanor then. Employee contended he was not physically able to sustain a full day of hearing attendance.

1) Was the oral order denying Employer's request for an order requiring Employee to be physically present at hearing correct?

Employer next contended Employee's hearing brief Exhibit 3 should be stricken from the record. Employer contended Employee's wife, his non-attorney representative, prepared Exhibit 3 and included her irrelevant opinions on records and prior proceedings. Employer contended this document is not "evidence" and Employee's wife can testify about relevant points.

Employee contended *Mitchell IX* admitted an abbreviated, seven page version of the document to which Employer objected. He contended his hearing brief Exhibit 3, or the up-to-date 33 page version, should substitute for the seven page version admitted in *Mitchell IX*.

2) Was the oral order to not consider Employee's hearing brief Exhibit 3 correct?

Employer contended an order should prohibit Employee's non-attorney representative from advocating for Employee, because an attorney represents him. Employer contended *Mitchell XIII* prohibited Employee's wife from participating as an advocate.

Employee agreed his counsel would make all arguments and examine witnesses, and Employee's wife would not advocate. Therefore, in Employee's view, this issue was moot.

3) Was the oral order granting Employer's request to prohibit Employee's non-attorney representative from advocating at hearing correct?

Employee's September 29, 2017 and October 3, 2017 petitions sought an order accepting his late-filed attorney fee and cost evidence. He contended though Harren made a diligent effort, he was unable to obtain adequate information to document attorney fees and costs and, even when he did, his office inadvertently failed to file appropriate documentation due to a communication error.

At the first hearing day, Employer contended though it received Harren's affidavit, it never received an itemized accounting of Employee's attorney fees. Employer objected to late-filed fee affidavits and to a lack of fee affidavits from Harren's paralegals.

4) Was the oral order giving Employee additional time to file attorney fee and cost documentation, and giving Employer time to object, correct?

Employer contends it filed previously stricken medical records from two EME physicians because Employee "opened the door" by referencing these reports in a subsequent EME physician's deposition. Employer contends the panel should consider the previously stricken EME reports.

Employee contends he referenced the stricken EME reports in the deposition to show the EME physician copied the stricken reports in his current EME record. Employee implies the current EME record is also inadmissible because it copies verbatim from the stricken record.

5) Are the medical records stricken in *Mitchell X* admissible for this hearing?

Employee contends he is entitled to continuing medical care from December 20, 2005 forward. He contends medical care he received since that date has been work-related, necessary and reasonable. Employee seeks reimbursement, payment and continuing medical care.

Employer contends Employee is not entitled to additional medical care other than conservative treatment. It contends there have been no significant changes in his symptoms or condition since *Mitchell VI* and no evidence Employee needs anything other than conservative care.

6) Is Employee entitled to additional past or future medical care?

Employee contends he was never medically stable as determined in *Mitchell VI*. Consequently, he contends he is entitled to temporary total disability (TTD) from August 1, 2003 to March 30, 2004, and from April 1, 2004 and continuing.

Employer contends *Mitchell VI* found Employee medically stable. It contends Employee is, therefore, not entitled to additional TTD benefits at any time thereafter.

7) Is Employee entitled to TTD benefits?

Alternately, Employee contends he met requirements for PTD benefits since at least April 1, 2004. If he is not entitled to TTD benefits, he seeks a PTD award from April 1, 2004 and continuing.

Employer contends Employee is not permanently and totally disabled. Employer contends it retrained Employee to return to work in sedentary positions and is capable of working.

8) Is Employee entitled to PTD benefits?

Employee contends Employer engaged in activities resulting in unfair and frivolous controversions. Employee contends he is entitled to one or more penalties.

Employer contends medical evidence or the law support its controversion notices. It contends Employee is not entitled to a finding Employer made an unfair or frivolous controversion, and he is not entitled to any late-payment penalties.

9) Is Employee entitled to an order finding Employer made an unfair or frivolous controversion, and is he entitled to any penalties?

Employee contends he is entitled to considerable past and ongoing benefits resulting from his attorney's efforts. Consequently, he seeks interest and attorney fees and costs.

Employer contends Employee is not entitled to additional benefits. Therefore, it contends there is no basis for interest, attorney fees or costs.

10) Is Employee entitled to interest, attorney fees or costs?

Advanced and Pioneer contend Employer should pay for their services to Employee. They seek benefits pursuant to their March 3, 2016, and March 16, 2016 claims.

Employee expressed no opinion on Advanced's or Pioneer's claims.

Employer contends Advanced's and Pioneer's services were not work-related or were not reasonable or necessary. It contends Advanced's claim is barred because it failed to timely request a hearing and Pioneer no longer exists. Employer seeks an order denying these claims.

11) Are Advanced and Pioneer entitled to medical benefits from Employer?

Employer contends if Employee obtains additional benefits it is entitled to an offset for Social Security benefits Employee received. It seeks an order awarding the offset.

Employee did not directly address this issue at hearing. However, his answer disputed Employer's calculations and reserved his right to object.

12) Is Employer entitled to a Social Security offset?

Employer contends Employee's benefits must be suspended or forfeited for his failure to return discovery releases. It seeks an order defining the time for which his benefits are affected.

Employee did not address this issue at hearing or in his briefing. This decision presumes Employee opposes this request.

13) Is Employer entitled to an order declaring Employee's benefits suspended or forfeited?

FINDINGS OF FACT

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

1) On October 31, 1995, Employee's supervisor said Employee claimed a back injury from driving a tractor-trailer on the job. (Report of Occupational Injury or Illness, October 31, 1995).

2) On October 31, 1995, Employer began paying TTD benefits. His weekly TTD rate is $570.84. (Compensation Report, March 16, 2004).

3) On November 10, 1995, Byron Perkins, D.O., released Employee to resume modified work effective November 14, 1995. He restricted Employee to no lifting, pulling or pushing over 25 pounds. Employee had to take "posture breaks" hourly and should not drive longer than one hour without a break. (Perkins Work Status Form, November 10, 1995).

4) On January 27, 1996, Michael McNamara, M.D., saw Employee for an employer's medical evaluation (EME). He directly related Employee's then-current problems to his work injury arising from sitting in his work truck. Dr. McNamara further stated when Employee stepped out of his vehicle at home off the job this was "just an exacerbation of the existing problem from work." Dr. McNamara said:

> Mr. Mitchell should probably indefinitely not be lifting heavy weights, doing heavy construction work or doing prolonged sitting, whether he is being treated conservatively or surgically. (McNamara report, January 27, 1996).

5) On February 27, 1996, Lawrence Dempsey, M.D., performed a laminectomy and discectomy at L5-S1 on the right, Employee's first back surgery. (Operative Note, February 27, 1996).

6) On July 10, 1996, Dr. Perkins stated:

> It is my opinion that the patient would benefit from vocational rehab. counseling in anticipation of return to work later this fall. I believe the patient may be more suited to sedentary work that does not require significant lifting or prolonged sitting. . . . (Perkins letter, July 10, 1996).

7) On August 7, 1996, Larry Levine, M.D., saw Employee for an EME. He opined Employee could not lift, lower, push, pull or carry 70 pounds. Employee should not be stooping with any weight, but should be able to squat or crouch. He was not able to return to work. Employee's lifting capacity was 50 pounds. He should avoid stooping and twisting but could use his upper and lower limbs for repetitive motion. Dr. Levine expected Employee to have full recovery between six and 12 months after his recent lumbar surgery. He anticipated medical stability nine months post-surgery. (Levine report, August 7, 1996).

8) On September 7, 1996, Dr. Perkins agreed with Dr. Levine's August 7, 1996 EME report. (Perkins letter, September 7, 1996).

9) On September 12, 1996, Employee told Dr. Perkins that about two weeks earlier he had been on a caribou hunt but after unloading his boat felt low back tightening and did not hunt. He subsequently developed bilateral paresthesia in his heels and in the right great toe. Employee reported minimal pain unless he "does something wrong." (Perkins report, September 12, 1996).

10) On November 21, 1996, Employee said he went caribou hunting just off the road with friends who did all the work for him. He had difficulty driving. (Perkins report, November 21, 1996).

11) On December 31, 1996, Susan Klimow, M.D., examined Employee and provided a 10 percent whole-person permanent partial impairment (PPI) rating for his work injury with Employer. (Klimow report, December 31, 1996).

12) On April 24, 1997, Dr. Perkins approved Motor Vehicle Dispatcher, Traffic Rate Clerk and Administrative Clerk job descriptions for Employee. (Job Descriptions, April 24, 1997).

13) On May 16, 1997, Northern Rehabilitation Services (NRS) performed a labor market survey for Administrative Clerk, finding numerous jobs in the Anchorage area and a viable labor market with over 11,000 Administrative Clerks in Alaska and over 2,000 in Anchorage. (Labor Market Survey, May 16, 1997).

14) On May 21, 1997, the parties jointly signed a vocational rehabilitation service plan to retrain Employee to be a Motor Vehicle Dispatcher, Traffic Rate Clerk and Administrative Clerk. (Reemployment Plan, May 21, 1997).

15) On January 7, 1998, Employee reported low back pain while snow machining on a hunting trip to Yentna, Alaska the prior weekend. Employee told his doctor:

> He actually did quite well, he took it easy, was able to bag a moose with his friend and get back to town with minimal difficulty. He did not take any of his medications on the trip and in hindsight wished he had due to the episodic spasm particularly at night laying down. Overall he's pleased with the results of the hunt, he was able to go and do what he likes to do with minimal problems. . . . (Perkins report, January 7, 1998).

16) Snow machining in Alaska can be physically demanding and strenuous. (Experience).

17) On February 23, 1998, Employee had low back pain on the right side "after working with some disabled children on an ice fishery." Employee had done significant bending and squatting and was not able to loosen up. (Perkins report, February 23, 1998).

18) On July 21, 1998, Employee had lower back pain for three weeks since going to Yakutat, Alaska on a survey job. Employee used up all his medication and was planning to go back out the following week. (Perkins report, July 21, 1998).

19) On September 10, 1998, Employee reported he was moose hunting over the weekend and had lower back and shoulder pain and miserable sleep. He again had run out of his pain medications, which he used more when he was physically active. He was planning to return to Yakutat for a week and a half. (Perkins report, September 10, 1998).

20) On September 18, 1998, Employee reported recurrent low back pain while working on a road project at Lake Otis and Tudor. (Perkins report, September 18, 1998).

21) By November 2, 1998, Employee reported daily low back pain since returning to land surveying work. He was using narcotic pain relievers daily to control his pain. Employee insisted this work was tolerable, he enjoyed doing it and it gave him something physical to do. However, he said it aggravated his chronic back pain. Employee told his doctor he never

completed the retraining process through workers' compensation. (Perkins report, November 2, 1998).

22) On December 4, 1998, Employee had acute right hip and low back pain after hunting on Thanksgiving weekend. He used up his pain medication and was traveling to Eek, Alaska to survey their airport over the next two weeks. (Perkins report, December 4, 1998).

23) On December 29, 1998, Employee reported severe, recurrent low back pain over the weekend after cleaning ice rinks for the school district. (Perkins report, December 29, 1998).

24) On January 28, 1999, NRS performed another labor market survey for Motor Vehicle Dispatcher and Rate Clerk. NRS concluded a labor market for these jobs exists in Alaska with recent and anticipated openings. (Labor Market Survey, January 28, 1999).

25) On March 5, 1999, Employee was sore after butchering a moose in his garage. (Perkins report, March 5, 1999).

26) On May 14, 1999, Employee had recurrent low back pain while attending classes at Charter College. His back tightened up from sitting. Back pain prevented him from playing with his daughter and from getting a good night's sleep. He had depression. Dr. Perkins did not think Employee had a surgical issue but referred him nonetheless to Davis Peterson, M.D., for another opinion at the adjuster's request. (Perkins report, May 14, 1999).

27) On June 16, 1999, Employee said he had gone fishing the prior weekend at Deep Creek and could not land a fish. Dr. Perkins was going to schedule an appointment with William Dempsey, M.D., for another opinion. (Perkins report, June 16, 1999).

28) On June 29, 1999, Dr. Perkins referred Employee to Dr. Peterson, as Dr. Dempsey was unavailable. Employee remained active, was currently attending Charter College for retraining and had worked for the school district during the school year. (Perkins report, June 29, 1999).

29) On July 20, 1999, Dr. Klimow saw Employee for another EME. She opined he did not need further osteopathic manipulation with Dr. Perkins. A sacroiliac belt and home exercises would be better suited to treat his symptoms in her view. Employee's continuation of Flexeril, Vicoprofen and Effexor was appropriate and Dr. Klimow opined Employee might try a "new" anti-inflammatory such as Celebrex or Vioxx. She suggested an orthopedic evaluation to address Employee's limited spinal motion and tingling in his heels. Until then, Employee was not medically stable in Dr. Klimow's opinion. (Klimow report, July 20, 1999).

30) On July 27, 1999, Dr. Peterson found chronic low back pain bilaterally, right greater than left. He recommended an MRI with gadolinium to ferret out the reason for Employee's pain. If further testing showed the pain originated from a discogenic source, Dr. Peterson opined Employee could be a candidate for an interbody fusion. (Peterson report, July 27, 1999).

31) An August 2, 1999 MRI revealed a broad-based posterior disc bulge at L5-S1 with loss of disc height and associated osteophytes and facet joint hypertrophy. These findings resulted in narrowing of the lateral recess and possible mass effect on the exiting nerve root on the right. In all other respects, the MRI was normal. (MRI report, August 2, 1999).

32) On August 11, 1999, Edward Tang, M.D., found Employee had no radicular symptoms or criteria for either facet or SI joint pain. Dr. Tang recommended a right L5 nerve root block and a discogram. (Tang report, August 11, 1989).

33) On August 16, 1999, Dr. Tang performed an L5 followed by an S-1 nerve root block, with no results. Dr. Tang concluded, "It does not appear that either of these nerve roots explain his pain very well." (Tang report, August 16, 1999).

34) An August 25, 1999 computer tomography (CT) demonstrated only degenerative disc disease at L5-S1 with vacuum disc phenomena and mild facet arthritis. (CT, August 25, 1999).

35) A September 3, 1999 discogram disclosed concordant pain at the L5-S1 disc level. (Discogram, September 3, 1999).

36) On September 21, 1999, Dr. Peterson concluded Employee had a discogenic issue in his lumbar spine and would benefit from an anterior interbody fusion if he could quit smoking, or if he could not quit smoking, a 360 degree instrumented posterior lateral fusion. Dr. Peterson was concerned about the latter procedure, because of "transition syndrome risks" to higher lumbar levels. (Peterson report, September 21, 1999).

37) On October 14, 1999, Dr. Klimow reviewed the case with Employee, his wife and Tracy Conrad, a nurse case manager for Employer. Conrad noted Dr. Perkins' reports from 1995 indicated Employee had been hunting. The adjuster was concerned this activity may have contributed to Employee's low back problem and need for additional surgery. Dr. Klimow said:

> Mr. Mitchell indicates that he attempted to go hunting and did go out, but had to return home the next day since this seemed to lead to an aggravation of his lower back discomfort. He states that he did not kill any animals, butcher or transport any meat.

Dr. Klimow connected Employee's ongoing lower back pain directly to his October 31, 1995 work injury with Employer. She opined Employee's work injury necessitated the scheduled October 27, 1999 surgery. (Klimow report, October 14, 1999).

38) Employee's account to Dr. Klimow about not hunting, killing and butchering wild game is not consistent with his prior reports to Dr. Perkins on January 7, 1998 and March 5, 1999. (Observations and inferences drawn from the above).

39) On October 27, 1999, Dr. Peterson performed an anterior interbody fusion at L5-S1 for a herniated disc, Employee's second surgery. (Operative report, October 27, 1999).

40) On December 17, 1999, Dr. Peterson said he expected Employee to return to his externship program to finalize his retraining by January 30, 2000, and anticipated medical stability by February 28, 2000. (Peterson letter, December 17, 1999).

41) On February 15, 2000, Dr. Peterson said Employee was not physically capable of completing his externship but should be able to begin by April 1, 2000. (Peterson letter, February 15, 2000).

42) On February 29, 2000, Dr. Peterson suggested Employee could return to his externship with accommodations including no prolonged sitting, no lifting objects weighing over five pounds, frequent position changes, no stooping, bending or crawling and no more than four hours a day in the program with Employee advancing as tolerated. (Peterson letter, February 29, 2000).

43) By March 28, 2000, Dr. Peterson suspected Employee's fusion was not solid. He suggested a right facet block and x-rays. If pseudoarthrosis was present, Dr. Peterson recommended an un-instrumented posterior lateral fusion. (Peterson report, March 28, 2000).

44) On March 30, 2000, Dr. Klimow referred Employee to Douglas Smith, M.D., for a "Referral EME." (Klimow note, March 30, 2000).

45) From April 3 through April 14, 2000, Employee participated in an externship at and through Alaska Computer Essentials (ACE) as part of his reemployment plan. Employee participated for 10 days during this period and spent anywhere from four to six and one-half hours each day at his externship. (ACE Semi-Monthly Timesheet, April 15, 2000).

46) From April 17 through April 28, 2000, Employee participated in his externship for six hours each day. (ACI Semi-Monthly Timesheet, April 29, 2000).

47) ACE's timesheets are inconsistent with Employee's hearing testimony, where he said he was only able to work at ACE for a few hours and then had to lay down for an hour. (Observations).

48) On April 20, 2000, Dr. Peterson reviewed Employee's situation, found him medically stable and provided a 20 percent PPI rating. He opined Employee would finish his retraining course by the end of April and "should be employable at that time." He suggested Employee would need ongoing pain management assistance and referred him to Shawn Hadley, M.D. or Rehabilitation Medicine Associates. (Peterson report, April 20, 2000).

49) On April 29, 2000, ACE's Bea Campbell said Employee had successfully completed his externship and "did an excellent job." (Campbell letter, April 29, 2000).

50) On April 29, 2000, Employee said he had received his promised training and could use the skills gained through ACE in future employment. (ACE Exit Interview, April 29, 2000).

51) Employee earned a 3.9 grade point average for software training at ACE, on all 1998 Microsoft office products. (ACE student transcript, April 28, 2000).

52) On May 9, 2000, EME Dr. Smith reported Employee completed his computer school in September 1999 and became medically stable April 20, 2000. Dr. Smith reviewed the training program from NRS and found it proposed general office duties five days a week, eight hours a day with lifting in the 20-pound range. Dr. Smith concluded this was "light," not sedentary work. He could not opine on Employee's actual physical capacities. However, Dr. Smith agreed with

Dr. Peterson's opinion Employee could be employable effective April 30, 2000, as an Administrative Assistant. Employee should continue a fitness program and antidepressant medication and may need something for pain control. (Smith report, May 9, 2000).

53) On May 12, 2000, Dr. Peterson referred Employee to Lawrence Stinson, M.D., at a pain clinic but reiterated Employee was still medically stable. (Peterson report, May 12, 2000).

54) On July 12, 2000, Dr. Stinson said Employee might benefit from an intradiscal electrothermal therapy (IDET) procedure for discogenic pain. (Stinson report, July 12, 2000).

55) On August 17, 2000, Dr. Stinson instead gave Employee a right L5-S1 transforaminal, epidural steroid injection. Dr. Stinson charted:

> Mr. Mitchell returned again to the Advanced Pain Centers of Alaska with acutely exacerbated epidural inflammation following a boating trip where he went

> hunting. . . . Unfortunately his hunting trip has greatly exacerbated his symptoms and he requests another injection. (Stinson report, August 17, 2000).

56) On October 2, 2000, Dr. Stinson prescribed OxyContin for Employee's lumbar pain and referred him to pain psychologist Robert Trombley, PhD, for possible cognitive, behavioral training or a functional restoration program. (Stinson report, October 2, 2000).

57) On October 16-18, 2000, Dr. Trombley evaluated Employee who was cooperative "until asked to complete psychological testing." Employee said he had to tend to child-care issues. Dr. Trombley rescheduled psychological testing for October 18, 2000, and advised Employee how long the interview and testing would last. However, on October 17, 2000, Employee called and said he would not perform the testing, refused to say why and would only tell Dr. Trombley "to his face" why he would not see him for psychological tests. (Trombley report, October 16, 2000).

58) On October 26, 2000, Dr. Stinson said, "The patient will continue to follow up with conservative therapy with Robert Trombley, M.D., our pain psychologist. . . ." His report does not say if he knew Employee had never completed his psychological testing with Dr. Trombley. (Stinson report, October 26, 2000).

59) On March 22, 2001, Employee stated he had completed retraining and had returned to work. (Prehearing Conference Summary, March 22, 2001).

60) On April 7. 2001, Employee objected to the March 22, 2001 prehearing conference summary, clarifying that he attempted a return to work part-time but was not currently working. (Mitchell letter, April 7, 2001).

61) On April 17, 2001, Dr. Stinson maneuvered Employee's lumbar spine under fluoroscopic guidance and found a "subtle" two to three millimeter slip of L5 on S1, which recreated Employee's symptoms. Dr. Stinson referred Employee back to Dr. Peterson for evaluation of his lumbar-sacral instability and possible surgical options. (Stinson report, April 17, 2001).

62) On April 18, 2001, x-rays showed a solid fusion at L5-S1 and no evidence of vertebral misalignment or splaying of the spinous processes on flexion and extension views. (X-ray reports, April 18, 2001).

63) An April 20, 2001 CT showed an incomplete fusion at L5-S1. (CT report, April 20, 2001).

64) On May 4, 2001, Dr. Peterson reviewed the CT results and concluded Employee needed a posterior lateral instrumented fusion, which he scheduled for June. (Peterson report, May 4, 2001).

65) On June 12, 2001, Dr. Peterson wrote:

> Mr. Mitchell has a known failure of fusion or pseudoarthrosis at L5-S1 from an interbody approach. He has failed all conservative measures so far. He does have notable motion on flexion and extension fluoroscopy views. I think his current status regarding pain and disability warrants a posterior lateral fusion with instrumentation to assure a solid union and to improve his long-term outcome. From a legal or medicolegal standpoint, I now think he does not warrant a medically stable status. I think he should be considered medically unstable. (Peterson letter, June 12, 2001).

66) On July 12, 2001, EME Dr. Levine agreed Employee had a pseudoarthrosis at L5-S1 and the work injury was a substantial factor in his then-current back pain, disability and need for additional surgery. Dr. Levine agreed Employee needed a second fusion to provide stability. In his view, Employee would be medically stable approximately six months post-fusion. Employee's narcotic use was appropriate as it increased his functional status and allowed him to homeschool his child. If additional fusion provided good results, Dr. Levine would consider weaning his medications. Dr. Levine did not think Employee was malingering. (Levine report, July 12, 2001).

67) On August 20, 2001, Dr. Peterson performed Employee's third lumbar surgery, a posterolateral, un-instrumented revision fusion at L5-S1. (Operative report, August 20, 2001).

68) On April 11, and April 25, 2002, Dr. Stinson performed radiofrequency rhizotomies at L4 and L5 on the right and at L3, L4 and L5 on the left. (Stinson report, April 11, 2002).

69) On June 5, 2002, Employee said he had bent over to tie his shoe and felt a pop in his lumbar region. Since then, Employee had recurrent pain in the lumbar area extending into the right posterior hip and leg. Dr. Stinson diagnosed probable L4-5 instability and recommended a lumbar support brace. (Stinson report, June 5, 2002).

70) On June 19, 2002, Dr. Stinson diagnosed probable L4-5 discogenic pain representing a transitional disc phenomenon. He recommended a discogram to pinpoint the pain's source, and possibly an annuloplasty. (Stinson report June 19, 2002).

71) A July 18, 2002 discogram disclosed no symptoms arising from L3-4 disc but concordant results at L4-5. (Discogram, July 18, 2002).

72) On July 18, 2002, a post-discogram CT showed a "rather degenerated L4-5" and "a relatively well-preserved L3-4" disc. (CT, July 18, 2002).

73) On July 31, 2002, Dr. Stinson diagnosed a third-degree, lateral annular tear at L4-5 and said:

> Different treatment options were discussed in detail with the patient because of his fusion at L5/S1 level, his L4-5 disc is at increased risk as a 'transitional disc' to undergo degenerative changes. Heating annuloplasty should significantly palliate the symptoms and provide for longer-term viability of this disc. If not treated, it is likely he will develop further degenerative changes more cephalad in the lumbar spine. Another possibility would be to perform heating annuloplasty to palliate the current symptoms and with the development of prosthetic lumbar discs, he may be a candidate for disc replacement in the future. (Stinson report, July 31, 2002).

74) On August 10, 2002, Dr. Stinson performed another IDET at the L4-5 level. (Operative Note, August 10, 2002).

75) On September 6, 2002, Dr. Peterson opined Employee had not fully recovered strength in the back and lower extremities and was not sufficiently pain-free for subsistence hunting. However, he met the state criteria for proxy hunting. (Peterson letter, September 6, 2002).

76) On September 12, 2002, *Mitchell v. UPS*, AWCB Decision No. 02-0182 (September 12, 2002) (*Mitchell I*) granted Employer's request to bifurcate hearing issues. (*Mitchell I*).

77) On September 27, 2002, *Mitchell v. UPS*, AWCB Decision No. 02-0195 (September 27, 2002) (*Mitchell II*) found Dr. Klimow's referral to Dr. Smith was not an excessive physician change. *Mitchell II* also ordered a second independent medical evaluation (SIME). (*Mitchell II*).

78) On October 24, 2002, Dr. Stinson performed diagnostic bilateral L3-4 and L4-5 intrafacetal joint injections to identify Employee's lumbar pain generator. (Operative Note, October 24, 2002).

79) On November 7, and November 26, 2002, respectively, Dr. Stinson performed right and left L3, L4 and L5 medial branch radiofrequency rhizotomies. (Operative Note, November 7, 2002).

80) After each procedure to this point, Employee's symptoms improved briefly, and then returned or he developed new symptoms. (Observations and inferences drawn from the above).

81) On November 21, 2002, *Mitchell v. UPS*, AWCB Decision No. 02-0239 (November 21, 2002) (*Mitchell III*) granted most of Employee's interest and penalty claims but denied his request for unpaid externship fees. (*Mitchell III*).

82) A March 3, 2003 MRI disclosed no disc protrusions or herniations. (MRI, March 3, 2003).

83) On March 18, 2003, *Mitchell v. UPS*, AWCB Decision No. 03-0060 (March 18, 2003) (*Mitchell IV*) granted the parties' petitions to clarify *Mitchell III*'s interest award. (*Mitchell IV*).

84) On June 2, 2003, Joella Beard, M.D., performed electromyography tests and found an "abnormal study" with evidence of reinnervation in the L-4 distribution bilaterally. Dr. Beard recommended flexion-extension x-rays to check for instability. (Beard report, June 2, 2003).

85) On June 23, 2003, radiologist David Moeller, M.D., interpreted Employee's flexion-extension x-rays to show a solid L5-S1 fusion, normal vertebral body alignment, narrowing and widening of the L4-5 disc space and no significant subluxation of the vertebral bodies identified on flexion or extension views. (Moeller report, June 23, 2003).

86) On June 23, 2003, notwithstanding the radiologist's report, Dr. Stinson opined Employee's flexion-extension x-rays showed posterior spondylolisthesis of L4 on L5 with extension. (Stinson report, June 23, 2003).

87) On July 15, 2003, at EME Dr. Smith's referral, Alan Blizzard, PT, evaluated Employee's physical capacities. Blizzard concluded:

> Based on Mr. Mitchell's current physical capacity evaluation, if he were to be returned to the workforce, it would be at a strength demand level of sedentary position. The following accommodations would be necessary for him to perform on a daily basis. These would include a workstation that allows him to go from sit-to-stand as necessary. For increased low back pain, only occasional activities involving lifting from floor-to-waist and waist-to-shoulder and frequent lifting would be contraindicated secondary to increased low back pain. Only very infrequent bouts of walking would seem tolerable for Mr. Mitchell. Also, no activities that involve a stooping posture. These would be performed in kneeling if necessary. (Blizzard report, July 15, 2003).

88) Blizzard's physical capacities evaluation (PCE) does not expressly say it relates to an eight-hour day. The only reference to duration in this PCE relates to accommodations needed for Employee to perform "on a daily basis." However, a PCE based on durations less than an eight-hour day would be useless. (*Id.*; experience and inferences drawn from the above).

89) On July 31, 2003, Dr. Peterson assessed improving L4 and L5 radiculopathy as noted by recent electromyography, and chronic low back pain probably related to transitional changes at the L4-5 facets. Since Employee had no obvious forward listhesis, dynamic stenosis, claudication pain or pathological hypermobility at L4-5, Dr. Peterson recommended conservative treatment "to avoid any surgical intervention at this point." (Peterson report, July 31, 2003).

90) On August 13, 2003, Dr. Smith concluded Employee became medically stable on July 31, 2003, had a 20 percent PPI rating, had no surgery or other invasive treatments indicated "at this point" but would need narcotics such as methadone indefinitely. He could return to work at sedentary duties like Motor Vehicle Dispatcher and Traffic-Rate Clerk, with appropriate accommodations outlined in Blizzard's PCE. Dr. Smith opined Employee probably could not work as an Administrative Clerk. (Smith EME report, August 13, 2003).

91) Sedentary jobs requiring entry-level ability to use standard computer software exist regularly and continually throughout Alaska. (Experience, judgment, observations).

92) On September 16, 2003, Dr. Peterson reiterated Employee had no surgical indications. He suggested managing Employee's pain conservatively "as long as possible and avoid consideration of arthrodesis at the L4-5 level" because given Employee's age this could lead to transitional disc problems at higher lumbar levels. (Peterson report, September 16, 2003).

93) On October 13, 2003, Employee was going to California for further medical evaluation. Dr. Stinson opined, "His ongoing symptomatology is undoubtedly related to his original Workmen's Compensation injury and the subsequent sequelae from ongoing degeneration as well as surgical intervention to repair the original injury." He said, "Conservative therapy should be maintained until his symptoms worsen to the point that surgical intervention is necessary, as per Dr. Peterson's previous report." (Stinson report, October 13, 2003).

94) On October 24, 2003, Alan Roth, M.D., performed an SIME. He made his diagnoses and opined Employee became medically stable by December 16, 2002. He assessed a 20 percent whole person PPI rating. (Roth SIME report, December 10, 2003).

95) On February 4, 2004, Dr. Stinson said Employer incorrectly described Dr. Peterson's opinion to say no surgery should ever be attempted. By contrast, Dr. Stinson understood it to say no surgery was currently indicated but this did not mean surgery may not be needed in the future. Employee was trying to avoid surgery to escape ascending, transitional disc syndrome. Dr.

Stinson diagnosed transitional disc syndrome with instability at L4-5 given the previous L5-S1 fusion. (Stinson report, February 4, 2004).

96) Effective March 5, 2004, in response to manufacturer Zimmer's request for authorization to market a medical device called the Dynesys System, the Food & Drug Administration (FDA) approved the device for marketing but stated:

> The office of device evaluation has determined that there is a reasonable likelihood that this device will be used for intended use not identified in the proposed labeling and that such use could cause harm. Therefore, . . . the following limitation must appear in the warnings section of the device's labeling:
>
> The safety and effectiveness of this device for the indication of spinal stabilization without fusion have not been established.

Zimmer intended Dynesys to provide spinal immobilization and stabilization "as an adjunct to fusion." The FDA did not approve Dynesys for any use prior to March 5, 2004. (FDA literature, Employer's Affidavit of Service of Hearing Evidence, August 29, 2005).

97) On March 11, 2004, Employee had negative discogram results at L3-4 but concordant results at L4-5, which reproduced Employee's symptoms. A post-discogram CT demonstrated third-degree disc degeneration, a small, third-degree left anterior lateral annular tear and a right paracentral third-degree annular tear at L4-5. (Stinson report, March 11, 2004).

98) On June 2, 2004, Employee reported he could only walk a block without stopping and resting due to back and leg pain. Activity pain interfered with all aspects of his life. Dr. Stinson assessed L4-5 instability with post-laminotomy syndrome. (Stinson report, June 2, 2004).

99) On June 16, 2004, Dr. Peterson said Employee eventually might be a clinical candidate for disc replacement surgery. He did not want to suggest an additional fusion given Employee's age. He stated, "I suspect the disc replacement option will be available to us within the next year to two years. It would certainly offer him a better long-term outlook." (Peterson report, June 16, 2004).

100) On August 23, 2004, Dr. Stinson permanently excused Employee from jury duty for "multiple permanent med. conditions." (Stinson prescription, August 23, 2004).

101) On October 6, 2004, Employee told Dr. Stinson he was becoming frustrated and, because his symptoms were so severe, he did not think he could wait for artificial disc replacement approval before he opted for lumbar fusion. (Stinson report, October 6, 2004).

102) On October 29, 2004, a physician whose signature is illegible signed a form for the Alaska Department of Fish & Game stating Employee was at least 70 percent, permanently physically disabled and qualified for a proxy fishing and hunting permit. (Physician's Affidavit of Physical Disability for Proxy Fishing and Hunting, October 29, 2004).

103) By December 13, 2004, Employee said he could not walk more than one-half block because of his worsening lumbar and lower extremity symptoms. (Stinson report, August 23, 2004).

104) On December 30, 2004, a radiologist performed a lumbar MRI and compared this to Employee's 2003 MRI. The radiologist discerned Employee's lumbar spine was unchanged from the prior MRI. (MRI, December 30, 2004).

105) On January 5, 2005, Dr. Peterson referred Employee to Rick Delamarter, M.D., in California for his opinion on a disc replacement at L4-5. (Peterson letter, January 5, 2005).

106) On April 19, 2005, Dr. Peterson noted Employee had failed all conservative measures. Since Employee had a positive discogram at L4-5 and a negative discogram at L3-4, Dr. Peterson recommended disc replacement at L4-5 to preserve lumbar mobility and to minimize progression to higher levels. Dr. Peterson said Dr. Delamarter agreed Employee was a reasonable candidate to consider disc replacement. Since fusion typically causes transitional symptoms at the level above the fused disc, it can accelerate degenerative changes. Therefore, Dr. Peterson preferred not to extend the fusion into the L4-5 level. (Peterson letter, April 19, 2005).

107) It is unclear why Dr. Peterson thought Dr. Delamarter said Employee was a good candidate for disc replacement surgery. The earliest medical record from Dr. Delamarter's office in Employee's agency file is dated July 13, 2005, nearly three months after Dr. Peterson's April 19, 2005 letter. (Observations and inferences from the above).

108) On April 19, 2005, Dr. Peterson also wrote to the adjuster:

> It is not uncommon after an interbody fusion particularly at L5-S1 to have transitional symptoms at the level above due to increased stresses at this level. It can also accelerate degenerative changes which is why we prefer not to extend a fusion up into the L4-5 level. Apparently, Mr. Mitchell has not been authorized to pursue further evaluation and management in this regard. I would request that his case be reviewed by workers' compensation in this regard as I would consider the L4-5 exacerbation still indirectly related to his L5-S1 pathology. (Peterson letter, April 19, 2005).

109) On April 22, 2005, Employee claimed unspecified TTD benefits, $600 in pending medical costs plus continuing medical benefits, transportation expenses, a penalty, interest, an unfair or frivolous controversion finding and claimed he had undergone an "unfair SIME." (Workers' Compensation Claim, April 22, 2005).

110) On May 22, 2005, Employer denied this claim. (Controversion Notice, May 18, 2005).

111) On July 13, 2005, Jason Huffman, M.D., at Dr. Delamarter's office examined Employee and recommended an artificial disc replacement at L4-5 or alternatively, fusion at the same level, both subject to a CT to determine if Employee had degenerative arthritis in his facet joints. (Huffman report, July 13, 2005; Delamarter report, July 13, 2005).

112) A July 13, 2005 CT demonstrated an L5-S1 anterior fusion in good alignment and some areas of foraminal stenosis. (CT, July 13, 2005).

113) Following the CT, though the record is unclear, either Dr. Hoffman, Dr. Delamarter or possibly both stated:

> ADDENDUM: The patient comes back. We have got a CAT scan, which shows severe facet arthritis, even a cystic type erosion in the L4-L5 facet on the left side and moderately so on the right side. Thus, I think with this amount of severe facet arthritis, he is not a candidate for the artificial disc replacement, but is a candidate for the Dynesys non-fusion technology, decompression of this level, and then Dynesys implant at L4-L5 has a good chance of helping him. I would not recommend a fusion due to the adjacent level disease process, which he clearly has propensity for. . . . His L4-L5 level and appropriate surgery is directly related to his L5-S1 fusion, which has put increased stress on the L4-L5 level precipitating in this degeneration. . . .
>
> ADDENDUM: Clearly, the L4-L5 problem is related to his L5-S1 surgery and subsequent adjacent level degeneration. Thus, it should be covered appropriately with the Worker's Compensation carrier. (Huffman report, Delamarter report, July 13, 2005).

114) On August 3, 2005, SIME Dr. Roth reviewed additional medical records and opined Employee reached medical stability by December 16, 2002, and warranted a 20 percent PPI rating. (Roth Supplemental SIME report, August 3, 2005).

115) As of August 19, 2005, Dynesys as a stand-alone non-fusion device for spinal stabilization was in clinical trials. "The system is designed to stabilize the spine without fusing." (FDA literature, Employer's Affidavit of Service of Hearing Evidence, August 29, 2005).

116) On September 1, 2005, Dr. Roth opined Employee needed no surgical procedures, was not a candidate for an artificial disc replacement and should not undergo the Dynesys implant. He again selected December 16, 2002, as the date Employee was medically stable. In Dr. Roth's opinion, when he saw Employee in October 2003, Employee's entire lumbar spine met the legal definition of "medical stability." (Deposition of Alan Roth, M.D., September 1, 2005).

117) On September 1, 2005, *Mitchell v. UPS*, AWCB Decision No. 05-0224 (*Mitchell V*) denied Employee's petition for a "do-over" SIME. (*Mitchell V*).

118) On December 20, 2005, *Mitchell v. UPS*, AWCB Decision No. 05-0333 (*Mitchell VI*) decided Employee's claim for TTD benefits from December 16, 2002 forward, additional medical benefits, penalty and interest and his claim for an unfair or frivolous controversion. Employee based his claim on the recommended treatment for his L4-5 spinal condition, contending his L5-S1 fusion caused, aggravated or accelerated his instability and symptoms at L4-5. *Mitchell VI* found "the need for medical treatment associated with instability at L4-L5 bears a causal relationship to the treatment at L5-S1." *Mitchell VI* based its finding on opinions from Drs. Stinson, Peterson and Delamarter who agreed on the relationship between the L5-S1 fusion and the need to treat the L4-5 level. *Mitchell VI* also found:

> . . . Dr. Peterson developed a conservative treatment plan to avoid surgery at L4-L5 since he believed that surgery at L4-L5 could lead to negative impact on higher lumbar levels (footnote omitted). We find it reasonable for Dr. Peterson to develop a treatment plan consisting of conservative treatment first and then, if necessary, more aggressive treatment.

Mitchell VI credited Dr. Roth's SIME opinion that objective testing did not show a noticeable change in L4-L5. *Mitchell VI* specifically found Employee's back pain at L4-L5 is "a consequence of the prior treatment for the work-related injury" and compensable. Given Dr. Delamarter's opinion, it further found Employee was not a candidate for "disc replacement surgery" and said:

> We further find that the only reasonable and necessary treatment presented in the record at this time is for conservative care. Therefore, we retain jurisdiction to resolve any future disputes regarding whether future treatments are reasonable, necessary and within the realm of accepted medical practice.

As for his TTD claim from December 16, 2002 and continuing, *Mitchell VI* found Employee medically stable effective January 30, 2003, 45 days after December 16, 2002, when records showed Employee's lumbar symptoms had resolved. It also erroneously found Employee "underwent a fusion in March 2003." It found nothing in the file suggested a physician removed Employee from the workforce due to this surgery. *Mitchell VI* ordered:

> The employee is entitled to medical benefits for reasonable and necessary conservative medical treatment associated with his low back through the date of this decision and order.

Mitchell VI awarded Employee TTD benefits from December 16, 2002, through January 30, 2003, but denied his request for a finding Employer frivolously and unfairly controverted his benefits. *Mitchell VI* called itself a "Final Decision and Order." The decision did not mention Dynesys by name. (*Mitchell VI*; observations).

119) There was no 2003 fusion. The parties did not appeal *Mitchell VI*. (Observations).

120) On January 9, 2006, Dr. Stinson prescribed a custom sacral arthrosis to stabilize Employee's lumbosacral spine. (Stinson prescription, January 9, 2006).

121) On January 20, 2006, attorney Chancy Croft entered his appearance on Employee's behalf. (Entry of Appearance, January 19, 2006).

122) On January 23, 2006, Dr. Stinson opined Employee's activity level had progressively diminished and he was not medically stable. (Stinson report, January 23, 2006).

123) On January 30, 2006, *Mitchell v. UPS*, AWCB Decision No. 06-0024 (*Mitchell VII*) completed its factual findings on medical expenses, interest and penalties from *Mitchell VI*. *Mitchell VII* reviewed Employee's itemized summary of unpaid medical expenses and Employer's response. On these issues, *Mitchell VII* said in another "Final" decision:

> We hereby reaffirm our holding in *Mitchell VI* that disc replacement surgery for this employee is neither reasonable nor necessary under the facts presented. We further affirm our finding that the only reasonable and necessary treatment presented in the record at this time is for conservative care, which under the facts presented, we find can include limited diagnostic testing.

In accordance with this finding, *Mitchell VII* granted Employee's request for unpaid medical benefits in part, and interest, but denied his request for a penalty. The decision did not mention Dynesys by name. (*Mitchell VII*).

124) Employee did not appeal *Mitchell VII*. (Observations).

125) On February 17, 2006, Dr. Stinson renewed Employee's proxy hunting and fishing recommendation and stated he was permanently disabled at least 70 percent. (Physician's Affidavit of Physical Disability for Proxy Fishing and Hunting, February 17, 2006).

126) On February 27, 2006, *Mitchell v. UPS*, AWCB Decision No. 06-0045 (*Mitchell VIII*) denied Employer's February 4, 2006 petition to reconsider *Mitchell VII*, as untimely. (*Mitchell VIII*).

127) On March 6, 2006, Employee through Croft timely filed a petition seeking modification of *Mitchell VI*. Employee alleged *Mitchell VI* did not address the Dynesys procedure because the decision did not mention it by name. Employee alleged that, following *Mitchell VI*, he filed a claim specifically requesting an order allowing him to obtain the Dynesys procedure. However, he noted Employer answered the claim alleging *Mitchell VI* heard and decided Employee's prior claim for the Dynesys surgery and found it not medically reasonable or necessary. Alternately, Employee contended if *Mitchell VI* intended to deny Dynesys, it should modify its decision finding that there was no "reasonable and necessary treatment presented in the record at this time" other than "conservative care," and order Employer to pay for the Dynesys surgery, which several physicians had recommended. Alternately, Employee requested reconsideration. (Petition for Modification If There Has Been a Mistake of Fact, March 3, 2006).

128) Employee's March 3, 2006 modification petition lay dormant for years. (Observations).

129) On May 1, 2006, Dr. Stinson opined:

> The work injury has directly led to his current clinical situation. He has failed more conservative therapy to this point. Surgical intervention by Dr. Delamarter has been proposed. This may lead to increased stability and decreased symptoms. . . . Unfortunately, in Mr. Mitchell's case, without some kind of stabilization, he will likely be permanently disabled. His clinical condition has been progressive in nature and is quite limiting to him. (Stinson report, May 1, 2006).

130) On May 3, 2006, Employee and his wife wrote to Dr. Delamarter seeking additional opinions. Employee asked the following questions, and hand-written to the right of each question are the following responses:

> 1. Is Dynesys experimental or has it been approved for general use? *FDA approved*

> 2. Is Craig's work injury a substantial factor in his need for the recommended Dynesys procedure? *Yes*
> 3. Is it likely to improve Craig's condition so that he might return to gainful/full-time employment? *Yes*
> 4. Even if Dynesys is only palliative, will it still permanently reduce or moderate intensity of pain? *Yes*
> 5. Is there any alternative treatment that is likely to be as effective as Dynesys? *Fusion*
> 6. Without surgical intervention to stabilize, is Craig presently permanently and totally disabled? *Yes*
> 7. And finally for us, any comments regarding the risks of delayed surgical stabilization. *Condition will worsen* (Employee letter, May 3, 2006; hand-written responses, undated).

Facsimile numbers and identifying information from Employee and from Dr. Delamarter's office are visible on the document. However, it cannot be determined solely from the document who wrote the answers to Employee's questions. (*Id.*; judgment and inferences drawn from the above).

131) On May 3, 2006, Employee said he was in computer training but unable to work because he could not sit or stand long enough. Rafael Prieto, M.D., recommended a current functional capacity evaluation. (Prieto report, May 3, 2006).

132) On June 28, 2006, Dr. Delamarter and his associate Erik Spayde, M.D., wrote:

> The patient with his wife comes down from Alaska. He has had a pretty rough year with progressive back, buttock and radiating leg pain. It appears that the insurance company in Alaska has not really handled this in good faith. They have not allowed him to have appropriate surgery, and thus, he is progressing with his disability and actually radiographically now on CAT scan he is progressing with further degeneration at the L3-L4 level.
>
> He has had the fusion at L5-S1, has adjacent level disease subsequent to this at L4-L5 and now even up to L3-L4 level. We as of a year ago had recommended a non-fusion procedure, which in his case would be the Dynesys stabilization and decompression. . . . Unfortunately, the insurance company did not allow this saying that it is experimental. Clearly, it is not experimental. It has been FDA approved even as a fusion device. There are dynamic stabilization protocols and clinical trials ongoing as well.
>
> At this point, the patient's options are either to undergo an additional two-level fusion L3-L4 and L4-L5 which really would not be the medically indicated procedure since he has clearly shown a propensity to develop adjacent-level disease. The appropriate surgical procedure would be a dynamic stabilization

> non-fusion with the Dynesys system and this could help alleviate future adjacent-level issues as well. . . . [I]t is medically necessary and medically appropriate. (Delamarter note, June 28, 2006).
> . . . .
>
> . . . He has evidence of some degeneration from his previous visit now at the L3-4 level as well as L4-L5. He has severe degeneration at L4-L5. The patient will be a great candidate for Dynesys type procedure from L3 to L5 as he does have a propensity for adjacent level degeneration. This would be his best option. . . . (Spayde note, June 28, 2006).

133) On July 19, 2006, Croft withdrew from representing Employee and filed a lien for $12,500 for attorney and paralegal fees for services rendered on Employee's behalf. (Withdrawal of Attorney and Claim of Lien, July 18, 2006).

134) On July 20, 2006, Employee sent the adjuster a letter, itemized statement and supporting receipts documenting $5,278.92 in medical expenses and related transportation, lodging and per diem for services Dr. Delamarter rendered in June 2006. (Employee letter, July 20, 2006).

135) On July 25, 2006, Dr. Stinson said:

> He is not medically stable and is not released to work. In his present condition, he needs stabilization surgery. I am recommending that he follow through with Dr. Delamarter to . . . achieve internal stabilization so that his ongoing progressive symptomatology can come under control. (Stinson report, July 25, 2006).

136) On July 25, 2006, Employee called Dr. Delamarter's office to report worsening symptoms, including leg spasms and cramping in the medial thigh and calves bilaterally. Employee had pain in the hip area with his legs giving out occasionally, and progressive numbness. (Delamarter Phone Conversation, July 25, 2006).

137) On July 27, 2006, attorney Constance Livsey told Employee her client would not be reinstating TTD benefits. Livsey noted the board adjudicated Employee's medical stability date effective January 30, 2003, and Employer had paid all time loss benefits through that date. While Employer would pay for Employee's custom back brace, it declined to pay for any medical charges associated with Dr. Delamarter's consultation in June 2006. (Livsey letter, July 27, 2006).

138) On July 28, 2006, Employee claimed TTD benefits from July 31, 2003 and continuing, medical costs totaling $5,278.92 and continuing and $12,000 in attorney fees and costs and continuing. (Workers' Compensation Claim, July 28, 2006).

139) On July 31, 2006, Celeste Turner with Med-Net Billing told Employee the estimated surgery fees for Dr. Delamarter and his assistant for "L3-L5 posterior spinal fusion with Dynesys (instrumentation and stabilization)" were $39,312.50. However, Dr. Delamarter gave Employee a discount to $19,000. Turner said the surgical fees changed since Employee's first written request "due to the additional level of L3-L4 and the addition of the spinal fusion at each level." Employee paid Dr. Delamarter $19,000 on August 9, 2006. (Turner letter, July 31, 2006; attached receipt).

140) On August 10, 2006, Jim Burrows, M.D., evaluated Employee for surgery. He described Employee's upcoming surgery as, "L3-5 posterior spinal fusion with Dynesys under general anesthesia by Dr. Delamarter." (Burrows chart note, August 10, 2006).

141) On August 10, 2006, Dr. Delamarter proceeded with Dynesys surgery and described the procedure in detail. Dr. Delamarter's report says nothing of a conventional fusion performed in association with this surgery. (Operative Report, August 10, 2006).

142) On August 12, 2006, Aaron Perlmutter, M.D., examined Employee for post-surgical issues. Dr. Perlmutter described Employee's August 10, 2006 surgery as an "L3 to L5 posterior spinal fusion with _____ for spinal stabilization which occurred without complications." The missing word, which the transcriptionist could not understand, is probably "Dynesys." (Perlmutter report, August 12, 2006; experience, judgment and inferences from the above).

143) On August 14, 2006, Dr. Delamarter summarized his August 10, 2006 Dynesys procedure. The report again does not mention "fusion." (Delamarter report, August 14, 2006).

144) On August 25, 2006, Employer denied Employee's July 28, 2006 claim. (Controversion Notice, August 25, 2006).

145) On September 11, 2006, Employee said he felt "progressive improvement" since the August 2006 surgery with a "significant change in his overall symptomatology." Employee's sleep improved, with less pain. Dr. Stinson recommended physical therapy and weaning from medications on approval from Drs. Peterson or Delamarter. (Stinson report, September 11, 2006).

146) On September 21, 2006, Employee reported his calf pain and spasms on the right had resolved. He could stand and extend his back without severe pain, had no radicular pain, no new numbness and no bowel or bladder symptoms. (Peterson report, September 21, 2006).

147) On September 21, 2006, Dr. Peterson clarified his July 31, 2003 opinion, which stated Employee should remain with conservative treatment "given the limited surgical options available at that time." He noted disc replacement or "neutralization devices" were not available in 2003. Dr. Peterson further stated in 2003 Employee was still symptomatic with ongoing back pain and was not medically stable. In his opinion, Employee had limited treatment options available in 2003, which subsequently became available to him. (Peterson report, September 21, 2006).

148) On October 23, 2006, Dr. Stinson assessed Employee as, "Status post multilevel fusion with the Dynesys System by Dr. Delamarter." Employee reported lumbosacral discomfort possibly related to overexertion at physical therapy. Dr. Stinson recommended a "TENS" unit. (Stinson report, October 23, 2006).

149) Employee's pain diagrams show less symptoms immediately post-Dynesys-surgery than pre-Dynesys. (Pain drawing, October 23, 2006; experience, judgment).

150) Employee continued taking Percocet, methadone and Zanaflex, post-Dynesys-surgery. (Prescriptions, October 30, 2006).

151) On November 8, 2006, Dr. Delamarter stated:

> Craig is basically three months out from his L3 to L5 decompression and Dynesys type stabilization. He is actually doing marvelously well, much improved from his preoperative status. He still has some issues, but he is doing pool walking and he is cutting down on his medications, which I am pleased with. X-rays look good, good alignment and position of the Dynesys system. . . . (Delamarter report, November 8, 2006).

152) Notwithstanding the above report, Employee continued to take Methadone and Percocet at the same dosages well into 2007, though he was no longer taking Zanaflex. (Stinson prescriptions, November 29, 2006 through March 27, 2007).

153) On March 26, 2007, Employee reported he had undergone no physical therapy since his August 2006 surgery and he still had bilateral thoracic or lumbar muscle spasms extending to his bilateral thigh regions. Dr. Stinson incorrectly understood Employee had undergone "artificial disc replacement" surgery. (Stinson report, March 26, 2007).

154) On April 5, 2007, at Dr. Stinson's referral Employee began physical therapy. The therapist was under the mistaken impression Employee had a "two level disc replacement surgery." (Physical therapy report, April 5, 2007).

155) There was confusion among medical providers about the nature of Dr. Delamarter's surgical procedure. He did not perform a disc replacement or fusion on Employee's spine in conjunction with his August 10, 2006 Dynesys surgery. (Inferences drawn from the above).

156) On April 18, 2007, Dr. Delamarter stated:

> He is now seven months out from the Dynesys L3 to L5. He actually has made quite a bit of improvement. He still has some lower back issues where he had the fusion at L5-S1, but is quite pleased with his progress. Just started a couple of days of therapy. We need to continue the therapy and he is coming down off the medication as well. . . . (Delamarter report, April 18, 2007).

157) Notwithstanding Dr. Delamarter's understanding, Employee continued to take the same dosages of Percocet and Methadone. (Stinson prescription, April 20, 2007).

158) On April 23, 2007, Dr. Stinson prescribed a TENS unit for Employee. (Stinson prescription, April 23, 2007).

159) On May 14, 2007, Dr. Delamarter completed a physical capacity assessment form for the Social Security Administration. He opined Employee, in an eight-hour day, could continuously sit, stand and walk without changing position for 15 to 20 minutes. He did not expect Employee to work more than "0" straight days at a time. Employee could lift up to five pounds occasionally and should never lift anything over five pounds. He could use his hands for simple grasping and fine manipulation occasionally, but should never push or pull anything. The medical conditions producing Employee's symptoms and limitations included spinal stenosis and lumbar surgery. Emotional factors did not play a role. In Dr. Delamarter's opinion, Employee's symptoms would interfere with his attention and concentration "often." When asked to what degree Employee could tolerate work stress, Dr. Delamarter said this question was "not applicable." However, with then-current and ongoing treatments, Employee's condition was "improving." In his view, Employee's disability became effective "October 13, 1995," and continued. (Physical Residual Functional Capacity Assessment Form, May 14, 2007).

160) On June 18, 2007, Employee was still having difficulties with low back pain. He was weaning from his lumbar brace but still had problems sleeping and with some daily living

activities. Employee wanted to begin tapering off his medications. Dr. Stinson gave Employee samples of Rozerem to help with sleep issues. (Stinson report, June 18, 2007).

161) On July 23, 2007, Employee reported increasing depression. Dr. Stinson referred him to a psychiatric nurse practitioner for evaluation and treatment. Dr. Stinson expected to taper Employee's Methadone on his next prescription. (Stinson report, July 23, 2007).

162) Notwithstanding the above goal, Employee's medications continued to include Zanaflex, Rozerem, Percocet, and Methadone. (Deborah Kiley, ANP, report, December 13, 2007).

163) On January 7, 2008, Employee said he was no longer having back pain and his pain was primarily in the gluteal and pelvic areas. Sitting for more than 15 minutes provoked these symptoms. He was still wearing his back brace and still had paresthesia extending to his bilateral heels. Dr. Stinson again prescribed Percocet and Methadone. (Stinson report, January 7, 2008).

164) On January 19, 2008, Employee said as part of his evaluation for depression:

> He . . . tried obtaining vocational rehab after that [his work injury] and attempted to work but that he was physically incapable of doing same. . . . He tried doing computer work for 6 months and he said he could not do it because he could not sit in the same position. He tried reeducation. He tried driving a school bus, he was unable to do same and working at an ice rink. . . .
> . . . .
>
> He volunteers with the community patrol and will ride around for a few hours of time, he said. . . .
> . . . .
>
> He is beginning to have increasing thoracic pain and two months ago started having headaches. . . . (Catherine Barrett, ANP, report, January 19, 2008).

165) By March 3, 2008, Employee reported his low, midline back pain near L5-S1 was "quite significant" and interfered with his daily living activities. (Stinson report, March 3, 2008).

166) On March 31, 2008, Employee said his Percocet and Methadone took the edge off his pain but did not cover acute spasms, which caused him to "shudder." (Stinson report, March 31, 2008).

167) On June 23, 2008, Employee still had lumbosacral symptoms. He asked for and received a refill of Percocet, Methadone, Rozerem and Lidoderm patches. (Stinson report, June 23, 2008).

168) On July 28, 2008, Employee filed a hearing request on his July 28, 2006 claim, which included current "and continuing" medical costs. (Affidavit of Readiness for Hearing, July 28, 2008; Workers' Compensation Claim, July 28, 2006).

169) On July 29, 2008, Employee submitted a reimbursement request and 46 pages itemizing $76,202.72 in expenses for medical care and related travel, food and lodging, which he attributed to his work injury. The service dates ranged from August 1, 2006 through April 19, 2007, for medical care with Dr. Delamarter. Employee served this letter and attachments by certified mail on Liberty Northwest. (Mitchell letter, July 29, 2008; Cash Package Agreement, undated).

170) On July 31, 2008, Employee claimed TTD benefits from July 13, 2003 through continuing, medical costs in excess of $81,481.64, related transportation expenses, penalty, interest, attorney fees, costs and a finding Employer made an unfair or frivolous controversion. (Workers' Compensation Claim, July 30, 2008).

171) On August 22, 2008, Employer denied Employee's July 31, 2008 claim and contended *Mitchell VI* addressed all these same issues raised in Employee's similar September 28, 2005 claim. (Controversion Notice August 22, 2008).

172) On September 8, 2008, Employee reported he could walk only two blocks before he had to stop and take a break. In his view, this problem affected his daily living activities greater than any other issue. According to Employee, "He has never had symptoms like this before." Dr. Stinson recommended an MRI. (Stinson report, September 8, 2008).

173) A November 3, 2008 MRI disclosed bilateral, lateral recess narrowing most prominent at L4-5 on the right but no nerve root impingement and no spinal stenosis. (MRI, November 3, 2008).

174) On December 8, 2008, Dr. Stinson suggested the foraminal stenosis found on MRI might account for his increased symptomatology and activity intolerance. Employee reported no change in his symptoms while tapering his narcotics. (Stinson report, December 8, 2008).

175) On January 26, 2009, Employee reported significant lumbar pain and he was not even able to do his usual walking. He described being uncomfortable almost all the time and his medications had become less effective. Employee requested referral to Dr. Peterson for a PPI evaluation.

Dr. Stinson recommended a lumbar epidural injection. (Stinson report, January 26, 2009).

176) On March 17, 2009, an administrative law judge found Employee disabled under the Social Security Act from April 1, 2004 through March 17, 2009. The judge relied on Blizzard's 2003 PCE, which she found showed Employee was limited to sitting for 10 to 15 minutes, walking about five minutes and standing for about 20 minutes at a time. The judge found Blizzard opined Employee was unable to fulfill the full range of sedentary work and gave his opinion greater weight than a medical consultant's assessment because she found it was more consistent with the record as a whole and with Employee's subjective complaints. The decision found Employee credible. The decision does not explain what evidence was in the record and does not mention Employee's successful vocational retraining plan. LaBrosse testified at the Social Security disability hearing but the decision does not summarize his opinions. (Decision, March 17, 2009).

177) The judge's finding that Blizzard's PCE said Employee was unable to fulfill the full range of sedentary work is not consistent with this panel's reading of Blizzard's July 15, 2003 PCE. (Observations, judgment).

178) Effective April 1, 2009, Employee began receiving Social Security disability benefits at a $2,093.10 per month entitlement. (Social Security Administration letter, May 20, 2009).

179) The parties presented no other evidence showing a different, initial monthly Social Security disability entitlement amount. (Agency file).

180) On September 14, 2009, Employee saw Dr. Stinson for the first time in several months. Employee said two to three months earlier his pain escalated and was now "severe." His brace and medications were no longer sufficient. (Stinson report, September 14, 2009).

181) On September 16, 2009, Dr. Stinson performed bilateral facet injections. (Procedure Note, September 16, 2009).

182) On October 19, 2009, Employee said the facet joint injections made his back feel much better for about two weeks but his symptoms recurred. (Stinson report, October 19, 2009).

183) Employee subsequently underwent additional facet joint injections and radiofrequency rhizotomies. (Procedure Notes, November 4, 2009; December 8, 2009).

184) On November 4, 2009, the FDA held a hearing on Zimmer's request for approval to use its Dynesys system as a stand-alone spinal stabilization implant without a concurrent fusion. The chief Zimmer advocate supporting the request, James Maxwell, M.D., spoke concerning the Dynesys system's proposed use:

> The concept then is stabilization without fusion. . . . Can the spine just be neutralized, not necessarily as a motion preserving device or a motion restorative device, but just a way to neutralize the spine in a safe position? . . . . (Notice of Filing, June 9, 2016; United States of America, Department of Health & Human Services, Food & Drug Administration, Center for Devices & Radiological Health, Medical Devices Advisory Committee, Orthopedic & Rehabilitation Devices Panel transcript, November 4, 2009, at 23).
> . . . .
>
> I would also like to point out the Dynesys is not intended to be an articulating system. It's a stabilization system. . . . (*Id*. at 31).

Another sponsor spokesperson addressing the FDA panel said:

> Dr. Welch: I would just say . . . I did show the results based on Medical Metrics of the flexion and extension and that the Dynesys system does reduce movement in the functional spinal unit . . . almost to the point of fusion. So it certainly does reduce movement. (*Id*. at 186).

FDA panel members added:

> Dr. Kirkpatrick: . . . [T]hey have made the comment that all of these [patients] should be decompressed, and so what they're really using the Dynesys for is to reestablish spinal stability following decompression. And it's my understanding that they want to do that without a fusion. Is that an appropriate understanding of the device? I see a lot of nodding. So I appreciate that. (*Id*. at 207-08)
> . . . .
>
> [Chairman Dr. Kelly]: So it is by a majority vote the recommendation from this Panel that this PMA [pre-marketing approval] be deemed not approvable. (*Id*. at 250-51).

185) As of November 4, 2009, the FDA had still not approved Dynesys for use as a spinal implant without a concurrent fusion. (Inferences drawn from the above).

186) On December 28, 2009, Employee reported his symptoms continued. Dr. Stinson recommended spinal cord stimulation. (Stinson report, December 28, 2009).

187) On March 3, 2010, Dr. Stinson implanted leads for a trial, spinal cord stimulator. (Procedure Note, March 3, 2010).

188) On March 5, 2010, Employee reported he felt "great." He had approximately 80 percent pain relief and he was sleeping better. He opted for permanent, spinal cord stimulator placement. (Stinson report, March 5, 2010).

189) On April 9, 2010, Dr. Stinson implanted a permanent, spinal cord stimulator. (Procedure Note, April 9, 2010).

190) On April 27, 2010, Employee said he was doing well and improving. Employee was optimistic he would be able to "do more" moving forward. (Stinson report, April 27, 2010).

191) On May 17, 2010, Employee reported he loved his new stimulator, his walking and activities had improved and he "feels great!" (Stinson report, May 17, 2010).

192) On June 14, 2010, Employee claimed TTD benefits from July 31, 2003 through March 31, 2004, PTD benefits from April 1, 2004 and continuing, medical costs and a finding Employer made an unfair or frivolous controversion. (Workers' Compensation Claim, June 11, 2010).

193) On January 14, 2010, Leticia Jensen on Advanced's behalf claimed "undetermined," but unpaid medical costs. (Workers' Compensation Claim, January 12, 2010).

194) On July 9, 2010, Employer denied Employee's June 11, 2010 claim based on *Mitchell VI*, which it contended barred his TTD claim, and based its PTD denial on a lack of evidence showing Employee was permanently disabled. Employer also contended AS 23.30.105 barred his PTD claim. (Controversion Notice, July 9, 2010).

195) On August 2, 2010, Jensen claimed $28,645 for Advanced for unspecified medical services. (Workers' Compensation Claim, July 29, 2010).

196) On August 26, 2010, Employer denied Advanced's claim to medical costs other than conservative care, based on *Mitchell VI*. (Controversion Notice, August 24, 2010).

197) On October 10, 2010, Employee said he was still doing well with his new stimulator, had tapered off his Methadone and was only taking Percocet on an as-needed basis for breakthrough pain. (Stinson report, October 10, 2010).

198) On March 10, 2011, Employee reported his stimulator was not working in three of its four programs. A simple adjustment cured this issue. (Stinson report, March 10, 2011).

199) By April 18, 2011, Employee said he had been "walking great distances again." However, he was starting to be limited with this and with sitting. Employee had pain in the right perisacral and thigh area, sometimes extending toward his knee. (Stinson report, April 18, 2011).

200) On August 15, 2011, Employee reported he lost his stimulator effectiveness after flying on an airplane. (Stinson report, August 15, 2011).

201) On August 29, 2011, Employee had been out-of-state for three months for family issues, his stimulator coverage changed and he needed reprograming. (Stinson report, August 29, 2011).

202) By February 27, 2012, Employee developed increasing right lower sacral pain aggravated by prolonged walking or sitting. Dr. Stinson recommended physical therapy and a sacroiliac stabilization belt. (Stinson report, February 27, 2012).

203) On or about June 7, 2012, Tina Paul for Advanced requested a hearing on an unspecified claim. (Affidavit of Readiness for Hearing, undated but notarized June 7, 2012).

204) On June 11, 2012, Employer's counsel received Advanced's hearing request and objected on grounds the request was not substantially complete, lacked the claim date for which the hearing was requested, was notarized in the wrong year and lacked other information. (Affidavit of Opposition to Defective Affidavit of Readiness, June 18, 2012).

205) On June 18, 2012, Employer filed as an attachment to its hearing opposition, Advanced's hearing request. Employer also attached an envelope showing Advanced served its hearing request and an attached itemization for services from March 3, 2010 through April 27, 2010 totaling $45,846, on Employer on June 8, 2012. (*Id*.).

206) On August 21, 2012, Charlotte Kost, for Advanced and Pioneer, requested a hearing on unspecified claims. Kost checked the box stating she had completed necessary discovery, had obtained necessary evidence and was fully prepared for a hearing. Attached to Advanced's hearing request was an itemized bill from Advanced for services from March 3, 2010 through April 27, 2010, (including April 9, 2010) relating to a spinal cord stimulator. Charges totaled $45,846 with a balance due of $33,741.80. Attached to Pioneer's hearing request was an itemized statement from Pioneer for services on April 9, 2010, relating to a spinal cord stimulator. Charges totaled $45,724. Both requests show service only on the board. (Affidavits of Readiness for Hearing, one for Advanced and one for Pioneer, August 20, 2012).

207) On August 30, 2012, Employer objected to Pioneer's hearing request on grounds its affidavit was not substantially complete, including the claim date for the requested hearing, and on grounds Employer was not ready for a hearing. (Affidavit of Opposition to Pioneer Peak Surgery Center's Affidavit of Readiness for Hearing, August 30, 2012).

208) On December 5, 2012, Employee reported he had reduced his pain medication to a minimal amount and his spinal cord stimulator had allowed him to be much more functional.

However, Employee noted his stimulation intensity was lessening with time. Dr. Stinson opined Employee had probably developed epidural fibrosis, which interfered with the stimulator coverage. After unsuccessfully reprogramming the device, Dr. Stinson suggested moving the leads. (Stinson report, December 5, 2012).

209) On January 9, 2013, Employee's non-attorney representative Jeanne Mitchell stated:

> Mitchell, via attorney Chancy Croft, filed a PETITION FOR MODIFICATION IF THERE HAS BEEN A MISTAKE OF FACT on 03-03-2006. The request for reconsideration and the merits of this petition have never been heard. The mistaken fact deals directly with the incorrect board opinion; 'We further find that the only reasonable and necessary treatment presented in the record at this time is for conservative care.' That opinion was incorrect in 2005 and it is still incorrect today. . . . (Mitchell letter, January 9, 2013; emphasis in original).

210) By February 1, 2013, Employee's spinal cord stimulator no longer would communicate with the battery charger. (Stinson report, February 1, 2013).

211) By February 4, 2013, the battery charger was working but his stimulator required maximum stimulation output to provide appropriate paresthesia coverage. (Stinson report, February 4, 2013).

212) On February 5, 2013, the board's designee confirmed that Advanced's and Pioneer's claims for medical costs are included with Employee's medical cost claims. (Prehearing Conference Summary, February 5, 2013).

213) On May 22, 2013, Employee again reported problems charging his spinal cord stimulator. (Stinson report, May 22, 2013).

214) On October 7, 2013, *Mitchell v. UPS*, AWCB Decision No. 13-0123 (*Mitchell IX*) in an interlocutory decision held Employee's March 6, 2016 modification petition and his July 28, 2006 claim as amended were viable and ripe for hearing. It also denied in part and granted in part Employee's appeal of the designee's denial of a petition to compel discovery. *Mitchell IX* directed the parties to attend a prehearing conference to frame issues and set a hearing on Employee's March 6, 2006 modification petition and his amended July 30, 2006 claim. (*Mitchell IX*).

215) On November 20, 2013, Employee said "increasing, bilateral, lumbosacral pain interferes with his functioning." Employee had been using his spinal cord stimulator on maximum setting, constantly with some benefit. (Stinson report, November 20, 2013).

216) On February 6, 2014, EME Dr. Chong reviewed Employee's medical records and examined him. His resultant report is not considered as discussed below. (Chong report, February 6, 2014).

217) On February 8, 2014, EME Dr. Holley also prepared a report, which is not considered for reasons discussed below. (Holley report, February 8, 2014).

218) On March 5, 2014, Employee sent Drs. Chong's and Holley's 2014 reports to Dr. Stinson and asked him to comment on their conclusions. Dr. Stinson stated:

> They both gloss over the original disc displacement and W/C authorized subsequent surgeries that lead to the pseudo fusion/instability/↑ scar w/nerve damage that made all the rest of the care necessary. They also said there is no SI joint problem w/o examining Craig or seeing the x-rays. Specific SI joint x-rays show obvious problems. (Stinson note, undated).

219) On March 12, 2014, Employer sought a Social Security offset under AS 23.30.225(b), if Employee obtained any workers' compensation benefits after April 1, 2004. Employer attached no calculations with its request. (Petition, March 14, 2014).

220) No answer from Employee to the March 12, 2014 Social Security offset petition is found in the agency file. (Agency file).

221) On April 7, 2014, *Mitchell v. UPS*, AWCB Decision No. 14-0049 (*Mitchell X*) in an interlocutory decision granted in part and denied in part Employer's petition to exclude handwritten annotations in Employee's exhibits but allowed his wife's seven page summary. Most notably, *Mitchell X* granted Employee's petition to exclude EME reports from Drs. Chong and Holley because they resulted from Employer's unlawful physician change. (*Mitchell X*).

222) By May 5, 2014, Employee was using Cymbalta and still using Lidoderm patches, Methadone, Percocet and re-started Zanaflex. (Stinson report, May 5, 2014).

223) On August 7, 2014, Drs. Chong and Holley performed a record-review EME, which is not considered for reasons discussed below. (Drs. Chong's and Holley's reports, August 7, 2014).

224) Drs. Chong's and Holley's reports are noted in this decision to make a record and provide context for the reader. (Experience, judgment).

225) On September 18, 2014, Employee said he was unable to walk for more than an hour and probably more than a mile without needing to stop. (Stinson report, September 18, 2014).

226) On December 12, 2014, *Mitchell v. UPS*, AWCB Decision No. 14-0161 (*Mitchell XI*) in an interlocutory decision denied Employee's petition for a protective order, granted Employer's petition for an SIME and modified *Mitchell X* because it found Dr. Levine, Employer's last lawful EME physician, was no longer available. *Mitchell XI* permitted Employer to change its medical evaluator to an EME of its choice including Drs. Chong and Holley. (*Mitchell XI*).

227) On March 9, 2015, Employee reported low back pain even though he was using his spinal cord stimulator on maximum. His pain was "progressive in nature." Employee continued to use Cymbalta, Lidoderm patches, Methadone, Percocet and Zanaflex. Dr. Stinson said:

> He responded in the past very well to medial branch blocks and radiofrequency rhizotomy treatment for similar symptoms. This provided long-term relief. He would like to seek that again but is blocked by his ongoing Worker's Compensation litigation. It is extremely unusual in my experience to have this type of litigation ongoing for a decade or more. While these proceedings continue indefinitely Craig continues to suffer with significant symptomatology. He has always responded to appropriate treatment in a very expected manner. This prolonged impediment to his treatment is mystifying at best and the delay is certainly harmful to his well-being. I'm not sure of the technical reasons for the delay but on a medical basis it borders on malicious. . . . I would expect, following the appropriate treatment, that he would be symptomatically stable again for a prolonged period of time in conjunction with the use of his stimulator. (Stinson report, March 9, 2015).

228) On April 9, 2015, *Mitchell v. UPS*, AWCB Decision No. 15-0040 (*Mitchell XII*) in an interlocutory decision addressed parameters for an SIME. *Mitchell XII* ordered that previously stricken EME medical records would not be included in the SIME binders. (*Mitchell XII*).

229) On May 11, 2015, Alan Brown, M.D., reviewed Employee's records and said if Employee sustained a work injury on October 31, 1995, his subsequent disability was causally related to that injury and a "failed back syndrome." He disagreed Employee had a sacroiliac disorder. Dr. Brown found no material deterioration in Employee's low back condition since 1996, other than attributed to time, genetics and normal aging. In his view, Dr. Delamarter's surgery was not unreasonable but was not causally related to Employee's work injury. Dr. Brown agreed with *Mitchell VI*'s assessment that only conservative care was reasonable and necessary and said Dr. Delamarter's surgery was ill-advised but not below the standard of care. In Dr. Brown's view, the spinal cord stimulator was not required as a result of the 1995 work injury and had a low likelihood of success. Dr. Brown said the only treatment since December 2005 that was

reasonable and necessary for the work injury was a home-based physical therapy program. He agreed Employee became medically stable effective, or before, January 30, 2003. In Dr. Brown's opinion, Employee could perform sedentary or possibly light level work limited only by his pain perception. In his view, Employee's inability to perform higher exertion work was not because of his 1995 injury, but due to subsequent procedures and degeneration above the accepted L5-S1 level. (Brown report, May 11, 2015).

230) On May 14, 2015, Employer's newly re-selected EME Dr. Chong reviewed Employee's medical records from October 30, 1995 through March 9, 2015, and examined him. Employee was still taking Methadone, Oxycodone and Lidoderm patches. His spinal cord stimulator reduced some symptoms but did not result in functional improvement, except that the "relief of pain" from this and from other procedures "permitted him to go around and do things and not be housebound." Employee reported constant low back pain since 1995. He wore a lumbar corset during the day for the past three years. Employee said that after sitting for approximately 10 minutes, he developed bilateral, global leg numbness, since 1995. Movement generally increased his back pain but walking may increase or reduce his symptoms. Dr. Chong noted Employee sat for more than 30 minutes during his interview with "no evidence of distress." He opined that nearly 20 years after the 1995 soft tissue injury, the work injury was not a substantial factor "in the conditions diagnosed." Dr. Chong disagreed Employee had a sacroiliac joint disorder and found no anatomical or physiological basis for one arising from a 1995 soft tissue injury. He opined "non-work causes" of Employee's "current condition" include the "invasive and extensive lumbar spine surgery from 2006, which have now resulted in extensive fibrosis and scarring." Additional alternative causes included Employee's chronic overweightness, tobacco and opioid habituation and questionable diabetes control. In Dr. Chong's opinion, all these contribute to "perpetuate the perception of chronic low back pain" but none are related to the work injury. Dr. Chong said the August 10, 2006 Dynesys surgery was not required for recovering from the work injury. He noted Employee has never been off opioids. In Dr. Chong's view, Employee's pain has never decreased and he has never had any functional improvement from medical care received since *Mitchell VI*. Dr. Chong conceded none of the treatments was outside the realm of accepted medical practice but in his view none was reasonable or necessary because they did not assist in recovery. In his opinion, Employee remained medically stable effective January 30, 2003. Dr. Chong opined Employee needs no

additional medical treatment, including medication. Given what Employee does around the house, Dr. Chong said he is performing at a sedentary, physical demand exertional level. Depending upon his activities, Employee may be operating at a light physical demand level, according to Dr. Chong. In his opinion, the work injury is not a substantial factor in Employee's inability to work in any previously approved job. Dr. Chong opined only subjective pain complaints prevent him from working. He found no material worsening in Employee's physical condition since 2003 attributable to the 1995 work injury. His ongoing pain, in Dr. Chong's opinion, is attributable to chronic degenerative changes in his musculoskeletal system. (Chong report, May 14, 2015).

231) On July 13, 2015, SIME Thomas Gritzka, M.D., said Employee did not respond well to the Dynesys procedure and consequently, "implantation of a spinal cord stimulator was the most reasonable approach to the examinee's complaint of chronic back pain." Dr. Gritzka found a "direct link" between the 1995 work injury and the spinal cord stimulator. Dr. Delamarter's treatment was not unreasonable or unnecessary in his view. Dr. Gritzka ultimately opined Employee had not reached medical stability and had an aging spinal cord stimulator that might need replacement. He further said Employee's physical examination was compatible with him working at least at a sedentary level job. Dr. Gritzka opined a physical capacity evaluation might demonstrate he is capable of sedentary work even without revising his spinal cord stimulator. (Gritzka report, July 13, 2015).

232) On July 22, 2015, *Mitchell v. UPS*, AWCB Decision No. 15-0085 (*Mitchell XIII*) in a final decision denied Employee's March 3, 2006 petition to modify *Mitchell VI*, but said:

> . . . [O]n or about August 10, 2006, Employee underwent Dynesys surgery and paid for it himself. *Mitchell VI* expressly retained jurisdiction to 'resolve any future dispute regarding whether future treatments are reasonable, necessary and within the realm of acceptable medical practice.'. . . . Thus, there remains a question . . . whether or not Employee has a valid, pending claim for reimbursement for his subsequently obtained Dynesys procedure, and any related benefits, or if this medical procedure is barred for any reason. (*Mitchell XIII*).

233) No party appealed *Mitchell XIII*. (Observations).

234) On August 20, 2015, *Mitchell v. UPS*, AWCB Decision No. 15-0102 (*Mitchell XIV*) set forth additional parameters to resolve disputes over the SIME ordered in *Mitchell VII*. (*Mitchell XIV*).

235) On March 3, 2016, Courtney Lingnofski claimed $28,625 for Advanced for services from March 3, 2010 through April 9, 2010. Also included in an attached statement were "insurance pending" charges totaling $586 for services from January 13 and January 14, 2016. (Workers' Compensation Claim, March 3, 2016, and attachments).

236) Around March 7, 2016, Employee began complaining about his spinal cord stimulator "zapping" him in his back and down his leg. (Stinson report, March 7, 2016).

237) On March 15, 2016, Employer wrote Dr. Stinson to inquire about Employee's ability to travel. (Barlow letter, March 15, 2016, with attached questionnaire).

238) On March 16, 2016, Dr. Stinson stated he did not concur with the travel recommendations in Barlow's March 15, 2016 letter. Dr. Stinson said Employee:

> Needs to have the shocking sensations from the IPG site resolved which limits activities and transfers. At this time this is the major impediment to travel. (Stinson replied, March 16, 2016).

239) On March 16, 2016, Lingnofski claimed $45,724 for Pioneer for April 9, 2010 services. The attached itemized statement refers to Employee's spinal cord stimulator implantation. (Workers' Compensation Claim, March 16, 2016, and attachments).

240) On March 29, 2016, Employer opposed Pioneer's March 16, 2016 claim on grounds Pioneer no longer existed. Employer further denied the request based on *Mitchell VI*, which stated Employee was only entitled to conservative care. Employer denied the claim based on a time bar under AS 23.30.110(c), alleging the March 16, 2016 claim is for the same spinal cord stimulator as the July 29, 2010 claim Advanced filed and Employer controverted. Employer said Advanced failed to timely ask for a hearing. (Employer's Answer to Workers' Compensation Claim Filed by Pioneer Peak Surgery Center Dated 03/16/16 and Board-Served on 3/21/16, March 29, 2016).

241) On April 12, 2016, Employer opposed Advanced's March 3, 2016 claim on the same grounds as it opposed Pioneer's. (Employer's Answer to Workers' Compensation Claim Filed by APS Health Solutions Center Dated 03/03/16 and Board-Served on 3/04/16, April 12, 2016).

242) On June 28, 2016, *Mitchell v. UPS*, AWCB Decision No. 16-0051 (*Mitchell XV*) addressed preliminary issues and resolved disputes over a proposed SIME physician's ability to perform the evaluation ordered in *Mitchell VII*. (*Mitchell XV*).

243) On October 10, 2016, Dr. Stinson opined Employee may have adjacent segment disease at L2-3, left greater than right. He recommended additional lumbar imaging for Employee's work injury. There is no referral for cervical spine x-rays. (Stinson report, October 10, 2016).

244) On October 11, 2016, Employee obtained the lumbar x-rays but also got five-view cervical x-rays. (X-ray reports, October 11, 2016).

245) Dr. Stinson is board-certified in pain medicine and anesthesiology. He has been treating Employee since 2000. Dr. Stinson is familiar with spinal cord stimulators, which "reshuffle" pain impulses as they go up the posterior spinal cord to eliminate or reduce pain sensations. He has training in using these devices and has trained other physicians how to use and manage them. (Video Deposition of Lawrence Stinson, M.D., October 12, 2016, at 6-10). He implanted Employee's spinal cord stimulator in March 2010. Since then, there have been "very significant improvements" in spinal cord stimulators. They are more programmable, batteries last longer and stimulators have better battery connections. Dr. Stinson's recent patient had a newer model installed and is already back to work. (*Id*. at 12-14). However, sometimes leads work loose on stimulators and cause "shocking or zapping," which can be very uncomfortable. Dr. Stinson believes Employee has this situation and needs to have his stimulator revised. (*Id*. at 15-16). Dr. Stinson said he has not revised the stimulator due to payment and coverage issues. (*Id*. at 17). Since Employee has a 10-year battery in his stimulator, if Dr. Stinson were to revise his unit he would probably insert a modern battery since the useful life of the current battery is almost over. (*Id*. at 18-19). Current batteries also have improved programmability built in, so it is unnecessary to change the actual stimulator or the leads. Dr. Stinson does not agree with physicians who say Employee is self-limited by his own pain perceptions unsupported by objective evidence. He has seen Employee's muscle spasms, localized pain in his back, diagnostic imaging showing specific structural abnormalities in Employee's spine and Employee has never failed any tests Dr. Stinson performed to detect malingering. (*Id*. at 20-22). Through the Dynesys system and lower lumbar fusions, Employee is now "essentially fused" from L3 through S1 and is having difficulties at L2-3 due to adjacent disc syndrome. (*Id*. at 23-25). Dr. Stinson said other physicians selected the Dynesys system because Employee was not a candidate for disc replacement surgery and fusing his lower back again would simply increase the risk of adjacent disc syndrome. (*Id*. at 24-27).

246) Dr. Stinson was aware Employee refused his referral for a psychiatric evaluation with Dr. Trombley. (*Id*. at 46-47). Dr. Stinson was uncertain if he spoke with Employee about being a Medicare patient, but Medicare does cover spinal cord stimulators. (*Id*. at 50). As for Employee's benefit from the Dynesys system, Dr. Stinson said initially Employee did better but it "did not sustain." (*Id*. at 74). Even though Dynesys did not do what was hoped, it essentially turned into a "fusion procedure" from L3 to L5. (*Id*. at 76). Dr. Stinson agreed the Dynesys procedure is only FDA approved as an adjunct to a "real fusion." (*Id*.). He agreed that if the FDA approved Dynesys for use only with a concurrent fusion, "then that was probably not that difficult to predict it wasn't going to be that effective" in Employee's case. (*Id*. at 77). He placed a spinal cord stimulator in Employee to control intractable pain and allow for more function. (*Id*. at 80). A patient will be medically stable from an implanted spinal cord stimulator "within a few weeks." (*Id*. at 81). In Dr. Stinson's opinion, the spinal cord stimulator was successful and is the only modality over the years to significantly help Employee. (*Id*.). Dr. Stinson's current plan is to revise Employee's stimulator battery, and if the leads need replacement, revise them as well. However, Dr. Stinson opined Employee's current issues with symptoms arising from L2-3 overshadow his battery issues. (*Id*. at 96). He implied issues at L2-3 arose from Employee's work injury because it is the adjacent level above the surgically treated segments. (*Id*. at 96-97). Dr. Stinson stated Employee now has an osteophyte growing at L2-3, which often forms because there is excessive movement. It is "nature's way" of stabilizing the spine. (*Id*. at 98).

247) On October 24, 2016, Dr. Peterson recommended a lumbar CT and myelogram for diagnosing Employee's ongoing, work-related symptoms. (Peterson, October 24, 2016).

248) Occasional lumbar imaging for Employee's work injury is reasonable and necessary to monitor his injury's progression. (Experience, judgment and inferences drawn from the above).

249) On October 31, 2016, a CT myelogram revealed no stenosis at L1-2 through L4-5 but showed mild, bilateral foraminal stenosis at L5-S1. (CT Myelogram report, October 31, 2016).

250) On November 15, 2016, Employer requested an order compelling Employee to sign a release purportedly sent to his attorney on September 8, 2016. (Petition, November 15, 2016).

251) There is no evidence Employee filed a petition for a protective order concerning the above-mentioned release. (Agency file).

252) On November 18, 2016, Dr. Chong reviewed eight volumes of more recent chart notes and examined Employee. Employee said movement relieved his symptoms so Employee moved around the house all day. Dr. Chong's diagnoses and opinions remained unchanged from his previously expressed opinions from his excluded May 2014 EME. (Chong report, November 18, 2016). Employer asked Dr. Chong to address the Dynesys system between the date *Mitchell VI* issued and August 2006, when Dr. Delamarter performed Dynesys surgery on Employee. He said there was no evidence the FDA had approved Dynesys for any purpose other than as an adjunct to a spinal fusion and no evidence Dynesys was efficacious and safe for other purposes. Dr. Chong concluded Dynesys was not reasonable or necessary as it was not FDA approved. In his view, any off-label use should have occurred within a clinical trial setting, and Employee's did not. Notwithstanding those opinions, Dr. Chong stated Employee should have been medically stable within four to six months post-Dynesys surgery. In respect to all other invasive procedures, he opined Employee reached medical stability within 45 days after each procedure. In Dr. Chong's opinion, there is no medical evidence Employee has instability at L2-3. (*Id*.).

253) In his deposition, Dr. Chong shared Dr. Gritzka's concern about Employee possibly having Munchausen syndrome and agreed with Dr. Robinson that Employee should have a thorough psychiatric evaluation before any spinal cord stimulator revision. He disagreed with LaBrosse's assessment concerning Employee's ability to return to work, agreed with Blizzard's opinion Employee could return to work at a sedentary level and opined Blizzard was actually conservative in his opinion. Dr. Chong opined Employee could probably function at a medium physical demand capacity based on his ability to lift up to 50 pounds. He also questioned the PCE's validity at the upper exertional level given Employee's inconsistent results on three PCE tests. In Dr. Chong's view, LaBrosse improperly "dismissed" Blizzard's PCE. Dr. Chong said a vocational reemployment specialist would exceed his qualifications were he to give an opinion about an injured worker's disability. Dr. Chong opined LaBrosse's report "has crossed the line and he is now practicing medicine." (Chong deposition, November 13, 2017).

254) On November 23, 2016, Employer amended its March 12, 2014 request for a Social Security offset and provided calculations based on Employee's supposed initial entitlement, $2,093.10 per month. It requested a $379.94 offset against any benefits and an order allowing recoupment of any overpayment since April 2009 by withholding 20 percent from future

payments. (Employer's Amended Petition for Social Security Disability Offset, November 23, 2016).

255) Employer properly calculated the Social Security disability offset based on the information available. (Experience, judgment).

256) On December 5, 2016, Employee was having significant pain and spasms in the mid-lumbar area. Dr. Stinson opined Employee's previous imaging demonstrated an eight millimeter dynamic retrolisthesis at L2-3. (Stinson report, December 5, 2016).

257) On December 6, 2016, Employee answered Employer's petition to compel him to sign a release and contended the motion was frivolous and moot because Employee had signed a similar release on October 12, 2015, which was still effective for one year or "or until the conclusion of this claim, whichever occurs later." Employee, to insure mootness, said he would also sign a new release within 48 hours. (Employee's Opposition to Employer's Petition to Compel Execution of a Medical Records Release as Unnecessary and Moot, December 6, 2016).

258) It is unclear from the agency record whether or not Employee signed a release within 48 hours. (Observations, judgment).

259) On December 13, 2016, Employee disputed Employer's Social Security offset calculations and reserved his right to raise any defenses, contending the offset petition was not ripe. Employee presented no alternative calculations. (Employee's Answer to Employer's Amend a Petition for Social Security Disability Offset, December 13, 2016).

260) On December 28, 2016, Employee underwent bilateral selective nerve root blocks at L2. (Procedure report, December 28, 2016).

261) On January 23, 2017, Employee said he had an 80 percent decrease in right-sided back and thigh pain from the December 28, 2016 injections. He still had left-sided pain. Dr. Peterson recommended conservative treatment but noted if Employee had neurogenic claudication secondary to stenosis or instability in his low back, a fusion from T10 to the lower lumbar segments would be necessary. (Peterson report, January 23, 2017).

262) On January 28, 2017, Employee told SIME James Robinson, M.D., he had been taking Oxycodone and Methadone for several years. Employee said his wife had to occasionally assist him with daily living activities such as putting a sock on his left leg and showering. Employee reported spending hours in his recliner and getting up for short walks. He frequently sits in the car when his wife shops. Standing and sitting aggravate his symptoms. Back pain interferes

with his sleep, which was limited to two to three hours per night. Employee said his functional limitations had gotten worse over the past few years. Dr. Robinson noted Employee frequently shifted in his chair and winced during his evaluation. He stood up, and rocked back and forth frequently. Employee's pain behaviors and reactions were "dramatic." (Robinson report, January 28, 2017).

263) Dr. Robinson commented on whether the October 31, 1995 work injury can be viewed "as the substantial factor in the symptoms he later had." Dr. Robinson stated:

> In reality, Mr. Mitchell's current symptoms and limitations reflect a complex combination of his original injury, adverse consequences of the treatments he received, new injuries, aging, suboptimal health habits on his part, such as smoking, medical conditions unrelated to his injury -- diabetes mellitus, and perhaps genetic susceptibility to degenerative disk disease. . . .
> . . . .
>
> . . . My perspective is that Mr. Mitchell's original injury set in motion a series of events that have played a substantial role in the disability that he now has. . . .
>
> It should be noted, in this regard, that there is an established literature indicating that when a spinal fusion is performed, there is a substantial probability of a transfer lesion because of the stress imposed on segments adjacent to the fused one. . . .
> . . . .
>
> . . . Several questions deal with the appropriateness of the medical and surgical care that Mr. Mitchell has received. By my count, he has undergone four lumbar spine surgeries, 15 injection procedures (epidurals, facet rhizotomies, IDET) designed to influence his clinical condition, and 12 or 13 invasive diagnostic procedures (facet joint injections, nerve root blocks, discograms, myelogram/CT scans). It should be noted that all of the above procedures are based on a conceptual model of spine symptoms. Specifically, they posit that a specific pain generator can be identified and treated so that patients demonstrate significant clinical improvement. Some of the treatments that Mr. Mitchell underwent could be questioned because of lack of compelling evidence for their efficacy. Questions in this line have been raised regarding the Dynesys instrumentation performed by Dr. Delamarter.
>
> My concern is somewhat different, however. The entire conceptual model that there is a definite [sic] a pain generator underlying a patient's symptoms should be seriously questioned when the patient goes through one unsuccessful procedure after another, and when he has had years of disabling pain.

> As far as I can see, neither Dr. Stinson, Dr. Peterson, nor Dr. Delamarter ever questioned the appropriateness of their conceptual model. They have continued to look for, and treat, pain generators with stunning lack of success. After a few failed procedures, these physicians should have seriously questioned their conceptual model and should have done detailed psychosocial evaluations of Mr. Mitchell to see whether he had slipped into a chronic pain syndrome that was not closely associated with any definable structural abnormality in the spine. As far as I can see, this type of analysis was never undertaken.
> . . . .
>
> When I evaluated Mr. Mitchell on January 28, 2017, he had clear evidence of a chronic pain syndrome that would make it very unlikely that he would benefit from interventions to address structural lesions in his spine. (*Id*. at 39-41).
>
> . . . Several questions address the issue of work disability for Mr. Mitchell. Work disability is never an easy thing to assess since it involves complex interplays among medical issues, psychological issues, work skills, and an individual's age. Some independent medical examiners have expressed the view that Mr. Mitchell could function in a work environment except for his perception of pain. This type of assessment glosses over the fact that pain is the problem that disables individuals with back conditions. That is, they do not become disabled because of some kind of mechanical failure of their bodies; instead, they are unable to function because of the symptoms that they experience when they attempt to be active. (Citation omitted).
> In Mr. Mitchell's situation, I believe that he has been subjected to so many interventions and has appeared to be severely impaired for so many years, that I believe that the likelihood that he could successfully reintegrate into the workforce is virtually zero. Thus, I predict that he will not return to competitive employment. The question then becomes one of whether he **should be** able to work, and therefore should be denied benefits, as opposed to concluding that his pain is so intrusive that it makes it impossible for him to sustain gainful employment. I favor this latter interpretation of his situation (emphasis in original).

Dr. Robinson concluded Employee had a low back condition predating his October 31, 1995 work injury, and the work injury aggravated, accelerated or combined with this condition to cause disability and need for treatment. In his view, the injury created a permanent change. This change "is also at least partially the result of the treatment that Mr. Mitchell received for his condition." Dr. Robinson could not rule out the October 31, 1995 injury as a substantial factor in causing Employee's disability or need for treatment and Dr. Robinson had no alternative cause for the disability or need for treatment that excluded the October 31, 1995 injury as a cause. Furthermore, in response to Employer's question, Dr. Robinson also opined the 1995 work injury

was a substantial factor in the lumbar spine "condition" he diagnosed. Dr. Robinson said the work-related disability continues and Employee remains disabled from the work injury. In his opinion, Employee became medically stable effective approximately December 2002. As for Employee's need for further medical care, Dr. Robinson opined:

> I do not believe that Mr. Mitchell can benefit from any interventional treatment that attempts to address a structural lesion in his spine. Also, he has had very extensive physical therapy and bracing, so I do not believe that further treatments in these domains will be helpful for him. He is on long-term, low-dose opioid therapy, and I believe that it is reasonable for him to continue with this treatment as long as he does not engage in any aberrant behaviors.
>
> Also, I would distinguish sharply between interventions to treat structural abnormalities in his spine and spinal cord stimulation. Spinal cord stimulation essentially tries to override pain signals and can, in principle, be helpful regardless of whether or not there are identifiable structural lesions in an individual's spine that are causing pain.
>
> Thus, I believe that continued access to spinal cord stimulation is a reasonable option for Mr. Mitchell. Moreover, based on recent notes from Dr. Stinson, it appears that Mr. Mitchell's current spinal cord stimulation system may be failing and that he may need a new system placed. However, there is a caveat. . . . I believe Mr. Mitchell should undergo his psychological evaluation before any modification of his spinal cord stimulator is undertaken. The psychologist should address Mr. Mitchell's spectacular treatment failures over the past 21 years, analyze the causes of these failures, and, if he or she concludes Mr. Mitchell is a good candidate for spinal cord stimulator revision, provide credible justification for this conclusion.

In Dr. Robinson's opinion, continued medications and possibly spinal cord stimulation will relieve Employee's chronic debilitating pain "to some extent." However, ongoing treatment will not limit or reduce permanent impairment and will not enable Employee to return to work. Dr. Robinson stated in reference to Employee's ability to work as an Administrative Clerk without any limitations or restrictions, "I do not believe that he can work on a sustained basis at this type of job." After reviewing Blizzard's PCE and Dr. Smith's report concluding the PCE was a valid test, Dr. Robinson opined Employee's physical capacities at this time "are more likely to be less than they were as of the summer of 2003." Addressing causation, Dr. Robinson said:

> . . . However, I do believe that the injury of October 31, 1995 set in motion a chain of events that has led him to his current condition. Thus, I believe the

> injury of October 31, 1995 has been a substantial factor in the surgeries that he has undergone.

Dr. Robinson opined Employee does not have a "sacroiliac joint disorder" caused by the 1995 work injury and attempts to implicate this joint is another effort to find a specific structural lesion for an individual who has a chronic pain syndrome not closely associated with any pathology. He could not identify any new, non-work-related substantial factors that created a need for surgery. Dr. Robinson deferred to other physicians more familiar with Dynesys' efficacy because he had not studied the FDA's evaluation. However, he expressly stated the August 10, 2006 Dynesys surgery was not reasonable or necessary because the surgeon undertook "inadequate" preoperative evaluations. In his view, Dr. Delamarter should have required Employee to go through a psychological evaluation first. As for Dr. Stinson's treatments, Dr. Robinson said procedures he performed on April 11, 2002, April 25, 2002, August 16, 2002, November 7, 2002, November 26, 2002, January 28, 2009, November 4, 2009, December 8, 2009 and December 26, 2016, were "ill-advised." However, he agreed placement of a spinal cord stimulator was justifiable in principle even though Dr. Stinson failed to have Employee undergo a psychological evaluation before placing the stimulator. Dr. Robinson agreed July 31, 2003 was an appropriate date for medical stability. Nonetheless, he conceded Employee could be medically stable, deteriorate over time and require more medical treatment that would render him not medically stable. The use of Methadone and Percocet as palliative pain treatments do not, in Dr. Robinson's opinion, bear on medical stability. He could not comment on whether Employee was permanently totally disabled on July 31, 2003, or on April 1, 2004, because he did not examine Employee until 2017. In his view, Employee "is not capable of competitive employment at this time." Lastly, he stated:

> I believe that Mr. Mitchell is currently disabled from competitive employment, even at a sedentary level, and that his 1995 work injury set in motion a series of events leading to this disability, so that it does represent the substantial factor in his present disability. (*Id*.).

264) On March 3, 2017, Employee's non-attorney representative claimed additional medical benefits including $4,621 to Alaska Spine Institute for services related to an October 31, 2016 myelogram and $248 to Imaging Associates for an October 11, 2016 x-ray of "neck spine." (Workers' Compensation Claim, March 3, 2017, and attachments).

265) On May 17, 2017, Employer sent Employee's lawyer a letter with an attached medical release for Employee's signature and return within 14 days. (Barlow letter, May 17, 2017).

266) On June 21, 2017, Employer requested an order compelling Employee to sign the medical release attached to Employer's May 17, 2017 letter. (Petition, June 21, 2017).

267) There is no evidence Employee filed a petition for protective order on the above-referenced release. (Agency file).

268) On September 12, 2017, the division sent a hearing notice to Employee, his non-attorney representative, his attorney and Employer's attorney for the October 4, 2017 hearing. The division did not serve notice on Advanced or Pioneer. (Hearing Notice, September 12, 2017).

269) On September 29, 2017, Employee set forth the facts upon which he relied, attached documents and contended he has been totally disabled since July 31, 2003. As for treatment, Employee said he opted for the Dynesys procedure as the best alternative, superior to a spinal fusion. He concedes that if doctors had fused his spine in 2005 or 2006, "it most likely would have been compensable." However, Employee contends he should not be punished for seeking a "better alternative" for him and for the insurer. He also contends the spinal cord stimulator was reasonable and necessary treatment. In a footnote, Employee said to date, he had paid or owes around $150,000 in medical care including $45,000 to Dr. Stinson and the surgery center for his spinal cord stimulator treatment. Employee presented no additional argument and reserved its right to do so at hearing. (Employee's Hearing Brief, September 28, 2017).

270) On September 29, 2017, Employee sought an order extending the time for filing his attorney fee and cost materials. He later argued for an order accepting his late-filed evidence of attorney fees and costs. Employee contended his attorney had four legal assistants over three and one-half years and two retired, one suddenly. This made it difficult to compile cost information. Harren said he had recently taken his childhood friend on a 10-day moose hunt and when they returned, Harren was overwhelmed with hearing preparation. Consequently, Employee contended although Harren made a "diligent effort," he was unable to obtain adequate information to document attorney fees and costs and, even when he was able, his office inadvertently failed to file appropriate documentation due to a communication error. (Petition, September 29, 2017; Employee's arguments at hearing, October 4, 2017).

271) On October 3, 2017, Employee requested an order accepting his late-filed attorney fees and costs affidavits. (Petition, October 3, 2017).

272) On October 3, 2017, Harren filed an affidavit stating he works on a contingent basis, bills at $350 per hour and charges $180 per hour for paralegal services. He has over 30 years' experience representing injured Alaskans and has presented cases before the board and the Alaska Supreme Court. In his opinion, all services rendered were reasonable and necessary to assist Employee in this case. There were no attachments to Harren's affidavit. (Affidavit of Attorney Fees and Costs, October 2, 2017).

273) On October 3, 2017, Harren also filed an affidavit stating he has represented Employee for approximately three and one-half years and employed Anuhea Reimann-Giegerl, Roxy Miller and Colleen Ouzts as paralegals or legal assistants. Miller retired in February 2017, followed by Reimann-Giegerl in July 2017. Harren stated the time identified in summaries attached to his affidavit for these paralegals and legal assistants was incurred in advancing Employee's claims. Harren claims he advanced $4,684.10 in costs to Employee. In his view, all these costs were reasonably and necessarily incurred representing Employee. A chart attached to his affidavit states Harren incurred 277.55 hours representing Employee from March 2014 through September 2017, totaling $97,142.50. Paralegal Olson incurred 16.8 hours between February 2014 and March 2014 totaling $3,024. Paralegal Ouzts incurred 18.4 hours at $150 per hour between March 2017 and September 2017 totaling $2,760. Legal assistant Miller incurred 70.17 hours from March 2014 through February 2017, at $150 per hour totaling $10,525.50. Legal assistant Reimann-Giegerl incurred 64.23 hours at $150 per hour from March 2014 through June 2017 totaling $9,634.50. Employee claimed total attorney fees and costs for all professionals totaled $123,086.50. (Affidavit of Costs, Including Paralegal Costs; Summary of Time for Steven "Craig" Mitchell, October 3, 2017).

274) On October 3, 2017, Ouzts filed an affidavit stating Harren is the attorney for Employee and she is one of Harren's legal assistants. Ouzts said she performed her services under Harren's direct supervision and the statement of her time and notes attached to her affidavit accurately describes the work she performed pursuing Employee's benefits. She identified 18.40 hours legal assistant time working on this case. (Affidavit of Colleen T. Ouzts; timesheet, October 2, 2017).

275) On October 3, 2017, Employee filed documents showing "legal costs" expended in pursuing his claim. He documented $223.50 for Dr. Stinson's deposition, $1,338.01 in out-of-pocket expenses such as postage and "supplies" and $1,941.04 for mileage for an unspecified

person at various rates per mile. (Legal Costs/Expense Reimbursement Request, September 29, 2017).

276) At hearing on October 4, 2017, as a preliminary matter, Employer sought an order requiring Employee to be physically present during the hearing so the panel could observe his condition and demeanor and judge his credibility. Employee, attending by phone, objected, noting he could not comfortably participate at an all-day hearing, but would appear later to testify in person. An oral order denied Employer's request. (Record).

277) Employer also sought an order striking Employee's hearing brief Exhibit 3 contending the 33 page document was irrelevant as it contained Employee's wife's editorialized comments about medical records and board proceedings. Employee objected, contending the 33 page document was a chronological history Employee's wife would use to refresh her memory. An oral order granted Employer's request; the panel will not consider the 33 page document. (*Id.*).

278) Employer also wanted an order limiting Employee's non-attorney-representative from advocating on his behalf at hearing. Employee conceded his attorney would be his advocate at hearing and his wife would just be a witness. Though the issue appeared moot, given the case's contentious history, an oral order limited Employee's wife's participation at hearing to being a witness, although she was free to otherwise assist Harren. (*Id.*).

279) At hearing, Employee addressed his September 29, 2017 petition to accept his late-filed attorney fee and cost pleadings. Employee requested additional time to file supporting documentation. Employer objected. An oral order gave Employee until Friday, October 6, 2017, to file missing documentation from his initial filings regarding attorney fees and costs. The order gave Employer until Friday, October 13, 2017, to object to the attorney fees and costs. (*Id.*).

280) Daniel LaBrosse is a certified vocational rehabilitation counselor in private practice since 1991. He performs vocational rehabilitation evaluations for Social Security and does evaluations as a private consultant. He reviewed various medical records for Employee, and the Social Security Administration's determination finding him disabled. He asked Employee's attending physicians to complete a physical capacity form he uses in his evaluations. Employee's attorney asked LaBrosse to give an opinion about whether or not Employee was permanently totally disabled. Many PCE forms do not measure durational capabilities, while his Residual Functional Capacity form does. As a rehabilitation specialist, he is interested in a person's ability to

perform at a certain level over an eight-hour day. LaBrosse reviewed the reemployment plan Employee completed, including job objectives as Motor Vehicle Dispatcher, Traffic Clerk and Administrative Clerk. For workers' compensation purposes, LaBrosse considers a person must be able to perform a job eight hours a day to be considered employable in a position. He did not see any job analyses to determine if Employee was approved for a full, eight hour day. However, LaBrosse saw Blizzard's 2003 PCE. When asked if he applied the physical capacities of the three jobs for which Employee was retrained to Employee's physical capabilities from the2003 PCE, LaBrosse said the PCE required 50 percent "downtime" during the day, which in his mind is not considered full-time employment in the three fields for which Employee was retrained. LaBrosse relies on medical records and what they say about a person's physical capacities to determine whether a person is able to do a particular job that exists in the labor market. In LaBrosse's opinion, sedentary, full-time work requires six hours of sitting and two hours of standing or walking in an eight hour day. Consequently, if a person is not able to sit for six hours in an eight hour period, it is unlikely there is any full-time sedentary work for that person to perform. The specific vocational preparation (SVP) code for jobs for which Employee was retrained include two sedentary positions at SVP 5, which is six months to one year training or experience and one light duty position at SVP 4, which requires three to six months training or work experience, regardless of the physical requirements. (LaBrosse).

281) When asked about his 50 percent downtime statement, LaBrosse referred to the 2003 PCE, conceded it did not appear there and mused he may have gotten it from Dr. Robinson's report. LaBrosse opined there was no durational limits listed in the PCE but other limitations therein do not support Employee working an eight hour day, in his view. Physicians and physical therapists do not have knowledge of physical requirements for every job for which an injured worker may be qualified. LaBrosse agreed the only opinion that matters to the board is the medical physicians' opinions as to whether or not a person can "perform a plan." In making his opinions, LaBrosse relied on the 2003 Blizzard PCE, Dr. Delamarter's May 14, 2007 evaluation, the 2009 Social Security disability determination letter and Drs. Gritzka's and Robinson's SIME reports. LaBrosse agreed Dr. Gritzka said Employee is capable of sedentary work. LaBrosse does not look at ADA accommodations when writing a rehabilitation plan for workers' compensation purposes. (*Id.*).

282) A Residual Functional Capacity Assessment form is not a PCE. It is a form a physician uses to estimate a patient's physical capacities based largely upon the patient's self-reporting. (Experience, judgment and observations).

283) Employee's last employment was in 1996. He participated in a reemployment plan to gain computer ability beginning in 1997. Before his training, he knew nil about computers. "Some people" thought he was retrained by 2000. However, in Employee's opinion after completing his training there were no jobs available for him as he was not trained for any specific position. Employee went to an externship but he had no on-the-the-job training. He was a "volunteer or employee" for ACE computer training, where he taught people how to use the Microsoft Word program on a computer. Employee said he worked three to four hours per day depending upon how many students he had. He has not used Microsoft Word since the 1995 version. Employee said he could only work on the computers for three or four hours and then go in the back and lay down on the couch for about an hour. In July 2003, Employee honestly told Dr. Smith what he thought his physical capacities were and he did his best on Blizzard's 2003 PCE. Employee liked Dr. Peterson's suggestion to try conservative measures, because he did not want to "jump into another surgery." However, things changed and Employee began thinking surgery might be a better option. He began to tire of the pain and wanted it gone. Dr. Peterson initially recommended a disc replacement surgery and Dr. Stinson concurred. Employee did not want disc replacement surgery, but he was willing to see Dr. Delamarter if surgery would make him better. However, Dr. Delamarter told Employee too much time had passed and he was no longer a candidate for disc replacement surgery. Dr. Delamarter recommended Dynesys as an alternative, and in Employee's mind, as the only alternative. In his May 3, 2006 letter to Dr. Delamarter, Employee asked if Dynesys was experimental or approved for general use. According to Employee, Dr. Delamarter replied that Dynesys was FDA approved and this statement factored into Employee's decision to obtain the Dynesys procedure. Employer and its insurer did not authorize the Dynesys procedure though it was his understanding they would have approved the artificial disc replacement. Employee's mother-in-law paid for the Dynesys procedure because the compensation carrier said it would not pay for it, stating the procedure was not FDA approved. Following the Dynesys procedure, Employee "felt good" for about a year. In Employee's opinion, Dr. Stinson "saved my life." Employee also likes Dr. Peterson and has never had any difficulty following his recommendations. He also likes Dr. Delamarter and

researched him extensively before going to California for surgery. Employee eventually applied for Social Security disability for his back because he did not think he could ever return to work. Social Security found Employee disabled and paid him disability benefits retroactive for several years. Employee's spinal cord stimulator battery is still zapping him and this has not been changed since Dr. Stinson's October 12, 2016 deposition. He uses the stimulator 24 hours per day and has it turned on as high as it can go. Employee thinks the stimulator reduces the narcotics he takes. Employee does not think any of his medical treatment in this case has been excessive. He does not think he could compete with the general public for any job in the labor market. (Employee).

284) Employee disputed a report from ACE stating he had helped with grant applications and inventoried furniture during his externship and said he never did these things and never received any training specific to the three jobs identified as his vocational goal. Employee never applied for any job following his training because, in his view, the plan trained him to do nothing. Employee's daughter is 21 years old and was born about one year after his work injury. Employee's wife worked, and Employee stayed home as the primary caretaker for his daughter and did housekeeping when he could. Employee last went moose hunting in 2016 at Point MacKenzie and shot a moose 15 feet from the roadway. He has assistance with this from his neighbor's sons. Prior to that hunt, Employee maintained he probably went moose hunting once a year or two earlier and at other times obtained moose proxies. He has gone four-wheeling and snow-machining since his injury. Employee initially said he has not ridden his snow machine in eight or nine years. About six to seven years ago, he rode a snow machine as far as 15 miles, which took a couple of hours. Notwithstanding the above testimony, Employee said he will ride his snow machine once or twice a year on the river. Two years ago, Employee went fishing for salmon two or three times at Ship Creek in downtown Anchorage. Employee conceded while all his medical care provided some relief, his symptoms returned and he concluded "pain is as pain does." He feels the same today as he felt at age 48 when he had his PCE and concluded perhaps his medical care prevented him from getting far worse over the years. Employee agreed he sat in the hearing for 41 minutes and did not have to get up. Employee was under the impression the FDA had approved the Dynesys system according to his research and to Dr. Delamarter's information. (*Id.*).

285) Following Employee's testimony, the panel continued the hearing until November 21, 2017, when it reconvened. (Record).

286) On October 6, 2017, Employee filed affidavits from Randi Olson, Anuhea Reimann-Giegerl, Colleen Ouzts and Ouzts for Roxie Miller. These affidavits itemize and request the following, with reasonable and necessary amounts awarded in this decision also shown as discussed further in the appropriate analyses, below:

Table I

Affiant	**Hours billed**	**Hours awarded**	**Amount Awarded**
Olson	16.8	16.8	$3,024
Reimann-Giegerl	64.23	52.7	$11,561.40
Ouzts for Miller	70.17	0	$0
Ouzts	31.45	26.65	$4,797
		Total	$19,382.40
		Total Awarded	$3,876.48

(Affidavit of Randi Olson, March 17, 2014; Affidavit of Anuhea Reimann-Giegerl, October 6, 2017; Affidavit of Colleen Ouzts, October 6, 2017; experience, judgment).

287) On October 6, 2017, Employee filed an affidavit from Harren itemizing litigation costs with reasonable and necessary amounts awarded in this decision also shown as discussed further in the appropriate analyses, below:

Table II

Date Paid	**Description**	**Cost Claimed**	**Awarded**
3/10/14	Holley video	$150	$0
3/13/14	Chong video	$172.50	$0
3/21/14	DAL rehab report	$625	$625
3/26/14	DOL CD 3/19/14 hearing	$20	$20
9/3/14	USPS postage	$5.80	$5.80
6/25/15	Attorney's Process Service	$80	$0
6/25/15	Attorney's Process Service	$80	$0
10/10/16	Stinson meeting and deposition	$1275	$1,275
11/22/16	Stinson meeting and deposition	$1,100	$1,100
12/19/16	Alaska Legal video	$320	$320
1/9/17	Transcripts Only, Stinson Deposition	$530	$530

10/6/17	LaBrosse preparation and testimony	$2,512	$2,512
	Mileage for unknown person	$321	$0
	12,813 copies at .15 each	$1,921.96	$1,281.30
	Exhibit copies	$63	$0
		Total	$7,669.10
		Total Awarded	$1,533.82

(Affidavit of Costs, Including Paralegal Costs, October 6, 2017; experience, judgment).

288) On October 13, 2017, Employer objected to Employee's attorney fees and to his paralegal and legal assistants' costs. Employer's objections are set forth in a 13 page chart. Objections to Harren's attorney fees generally involve charges for activities on which Employee lost in whole or in part at hearing, work Employer contends was administrative, or legal services Employer contends took too long. It objects to Reimann-Giegerl's legal assistant or paralegal costs generally claiming her work was administrative or charged on issues on which Employee lost before the board. Employer objects to Miller's legal assistant or paralegal time because she failed to provide an affidavit, and objects to all services for matters on which Employee lost before the board in whole or in part and contends Miller should not be compensated for administrative work. Employer seeks to reduce Employee's attorney fees by 88.1 hours, Reimann-Giegerl's costs by 42.04 hours and Miller's costs in total for lacking an affidavit or by at least 33.1 hours. (Employer's Objection Affidavit of Attorney's Fees and Costs, October 13, 2017).

289) On October 23, 2017, the division sent notice of the November 21, 2017 hearing to Employee, his non-attorney representative, his attorney and Employer's attorney. The division did not send notice to Advanced or Pioneer. (Hearing Notice, October 23, 2017).

290) On November 21, 2017, the hearing reconvened. As a preliminary matter on the second hearing day, Employer said it had filed Drs. Chong's and Holley's 2014 EME reports, stricken from the record in *Mitchell X*, because Employee insisted on referencing them in Dr. Chong's recent deposition. Employer contends the previously excluded reports are now available for consideration. Employee contends he only discussed the excluded reports during Dr. Chong's deposition to show Dr. Chong had copied verbatim approximately 90 percent of the excluded

report, thus tainting the current report. The panel reserved this issue for its written decision. (Parties' arguments at hearing; record).

291) Kelly Smith has known Employee for over 30 years and lived across the street for about 10 years. They are friends and have gone hunting, fishing, boating and snow machining together. The last time Kelly and Employee went moose hunting was more than five but perhaps as many as seven to eight years ago. Employee participated in dressing an animal in the field. Kelly first started noting limitations in Employee's ability to participate in hunting 15 to 18 years ago. Employee's ability to ride a snow machine more than a quarter of a mile got worse and he had to stop and rest after about 15 minutes. Kelly last observed this about three to four years ago, though this started early and progressed. Beginning in 1997, over the next five to 10 years Employee's inability to participate gradually progressed and then accelerated more recently. The "dramatic change" occurred over the last 10 to 12 years. Two years ago, Employee shot a moose and called Kelly asking for his help dressing the animal. When Kelly arrived the next morning, he found Employee had shot a moose, which was lying on the ground unprocessed. "Depending upon what you call a road," the moose was about 30 yards from the trail on which Kelly had ridden on his four-wheeler one-quarter-mile to get to the site. On this occasion, Employee was able to move around all day "with difficulty." Employee had driven out the night before this hunt and slept in his trailer. In Kelly's experience, moose are gutted immediately to preserve the meat. "There was quite a lot of spoilage" on the moose due to delay in processing. The last time Kelly went snow-machining with Employee was seven to eight years ago. Going back to the early 90s, Kelly said Employee would break trail, but in the last few years, Employee never left the trail. Over the last 10 years, Employee went hunting and fishing less often. Employee had snow-machined to Yentna Station, which was an all day trip. It has been more than six to seven years since the last time he and Employee had Employee's boat in the water. Kelly was aware Employee went to California for surgery a few years ago and noticed some "short-lived" improvement following the surgery. Employee did not get the result for which he hoped. Employee does not frequently talk about his pain and is "pretty stoic." Employee occasionally mows the lawn. He tries to fix his vehicles. Kelly and his sons on occasion have assisted Employee with automotive repairs. (Kelly Smith).

292) Paul Smith is Kelly Smith's son and also knows Employee. Paul moved away from Employee as a neighbor when Paul was about eight years old, but has seen Employee regularly

at least once a month since high school. This includes stopping by to say hello or going out on hunting or fishing trips. He would go hunting, snow-machining and walking around with Kelly Smith and Employee at least once per year. Employee was more active when Paul was young, but as time went by Employee's ability has declined over the years and went from "bad to worse." Paul recalled going to Employee's house after one operation and it looked like he "hurt like hell." In years past, Employee could only wade out to knee-deep water in hip-waders because he was not strong enough to fight the current. As time passed, Employee stopped fishing altogether. When he did go out with Employee, it was a "different outing" and they would have to take frequent breaks including every 15 minutes on a four-wheeler. On these occasions, Employee would lie down and stretch sometimes. Employee tried to tune up his pickup truck and was unable to do it physically, so Paul went over and did it for him. To Paul's remembrance, Employee had shot three moose and the last time Paul assisted Employee in dressing his kill. Employee's moose lay in the field all night without dressing. There was considerable spoilage on the meat. Employee's wife drove her vehicle right up to the dead moose, which was on flat ground in a clearing. Over the last 10 years, Employee has spoken about wanting to work and was interested in finding a job. Over the last five to 10 years, Paul observed Employee cannot be ready to go by 6 AM for a hunting trip, but typically takes until 10 AM to be ready. "More than five years ago" was the last time Paul and Employee went snow-machining for an entire day, possibly to the Yentna River. It is a two-hour road drive from Anchorage to get to the snow machine starting point. The snow-machine trip itself was approximately 300 miles round trip, and with Employee, speeds are limited to 15 to 30 mph on snow machines. When asked about "work" in a broader sense, Paul said Employee "does what he can." Kelly Smith did Neighborhood Watch with Employee, which involved "driving around." Paul did not see Employee between 2002 through 2005. (Paul Smith).

293) Automobile seats are typically not as comfortable as ergonomically designed office chairs. (Experience, judgment and inferences from the above).

294) Michelle Murrills is supervisor and records custodian at Advanced, which filed its own claim. Advanced sent Employee's lawyer all medical bills and medical records related to Employee. Advanced has given Employee medical records on individual visits. It also provided every bill to Employer's workers' compensation insurance company. (Murrills).

295) Jeanne Mitchell is Employee's wife for 42 years. Their only child was born April 29, 1996. Jeanne accompanied Employee to California when he had the Dynesys procedure in 2006. Employee was "not in good shape" and needed assistance traveling and recalling dates and details from his medical history. They borrowed money from her mother to pay for the Dynesys surgery. In respect to the letter Employee and his wife faxed to Dr. Delamarter's office on May 3, 2006, with hand-written notations to the right of the typed questions, Jeanne clarified that the May 8, 2006 "received" stamp is hers. She does not recognize the hand-written initial followed by what appears to be the word "Ok." The hand-written responses to the right of each of the seven questions is not in Jeanne's handwriting. In her opinion, the hand-written responses are Dr. Delamarter's. Employee was "not in good shape" on July 31, 2003, and had difficulty engaging in activities; his pain patterns come and go. It is rare for Employee to have a low pain level, in her view. She does not think Employee was medically stable effective July 31, 2003. At that time, Employee would rock, shift, jiggle his legs and was generally uncomfortable at doctors' offices. She agreed with the July 15, 2003 PCE, including Dr. Smith's recommended limitations and accommodations; Employee needed many accommodations at that time in her opinion. Within 15 days of the July 15, 2003 PCE, she observed no physical differences in Employee's condition. Employee went to see Dr. Delamarter on Dr. Peterson's referral, because Employee's symptoms were getting worse. In Jeanne's opinion, Employee has been honest and forthright with his reports to his physicians. His accounts to physicians are consistent with her daily observations of Employee over the years since his work injury. In 2000, when Dr. Peterson said Employee was medically stable he attempted to return to work with three companies and could perform none of them. His attempts included Jeanne's firm, which she said provided "special accommodations" but Employee still could not perform the job duties. Another job was with the school district plowing snow. In Jeanne's opinion, Employee has always wanted to work but his physical limitations are what keep him back. She describes Employee's computer abilities as "dismal." He has difficulty navigating software programs, has problems concentrating and paces when in pain. Employee's sleep is unrestful; sometimes he moves while sleeping and "hollers in pain." She doubts he has had six hours of sleep a night since 2001. Jeanne contends Employer engaged in unfair or frivolous activity by having a private meeting with EME Dr. Smith without notifying Employee. She understood *Mitchell VI* to say that at the time the decision was issued, Employee had not presented evidence supporting the Dynesys

surgery. In her view, the Dynesys system is "doing its job" to prevent vertebral collapse, so said Dr. Peterson. (Jeanne Mitchell).

296) Employee contends his disability continues. He contends Livsey improperly met with EME Dr. Smith to manipulate his opinion about Dynesys. Employee relies on Dr. Gritzka's SIME report as the "best evidence." However, he notes Dr. Gritzka never saw Dr. Robinson's SIME report. He contends prior attorney Croft asked Dr. Delamarter if the Dynesys system was FDA approved. He says Dr. Delamarter told him it was and Employee relied upon this information to go forward with Dynesys surgery. Therefore, Employee contends, if "common sense" does not otherwise prevail, if he was injured through "medical malpractice," damages are recoverable to Employee as part of his work injury and the insurer can seek relief from his physicians who recommended an inappropriate procedure. However, Employee clarified that in his view, there was no malpractice and Dr. Delamarter did a "great job." Employee relies on the 2003 Blizzard PCE, which he contends shows he can perform only sedentary work with breaks every 15 minutes from standing and sitting. Employee contends he cannot walk a significant distance. In reviewing evidence, Employee contends it is "risky" to cherry-pick evidence from various medical reports "in the search for truth." Employee contends he became medically unstable as evidenced by Dr. Peterson's 2005 opinion, making his 2003 medical stability opinion no longer valid. (Employee's opening statement).

297) Employee further contends he was not given enough time to present his case. As an example, Employee contends Employer did not turn over all discovery, including *sub rosa* videotapes, which he says would have shown Employee behaving consistent with his physical limitations rather than exceeding them. (Employee's hearing comments).

298) Employer contends Employee had a minor injury and "a cascade" of medical treatment thereafter including dozens of invasive injections and tests. He went through the reemployment process and agreed to a plan to return him to sedentary, clerical work. He completed his retraining in 2000. Employer contends the 2003 Blizzard PCE determined Employee could return to work in a sedentary position. Employer relies on *Mitchell VI*, which found him medically stable in December 2003 and found he was entitled to conservative care only. Further, Employer contends a mistaken finding in *Mitchell VI* regarding a 2003 fusion, which all parties agree never occurred, cannot form the basis for medical instability, disability or further invasive

care. As for the Dynesys procedure, Employer contends the FDA warned against the specific use for which Dr. Delamarter used this device on Employee in August 2006. Employer contends there is no evidence showing anything changed medically for Employee between December 20, 2005 and August 10, 2006, to warrant the Dynesys procedure. Therefore, it contends Employee cannot prevail on his claim for this surgery. Employer contends it paid for all conservative medical care to date. In its opinion, Employee cannot rebut the presumption he has been medically stable since December 2005, and therefore he cannot receive TTD benefits. At best, Employer concedes Employee could be medically unstable for 45 days following injections and for two months following spinal cord stimulation implantation, though it disagrees any of these procedures were reasonable or necessary. Employer relies on Dr. Gritzka's opinion that Employee can do sedentary work. As for Employee's PTD claim, Employer relies on the 2003 Blizzard PCE and on Drs. Brown and Chong, who say Employee can return to sedentary work consistent with his retraining. Employer concedes Dr. Robinson says Employee is permanently disabled effective the date Dr. Robinson's examined him. It contends since *Mitchell VI* found the Dynesys system not reasonable or necessary and Employee was only entitled to conservative care, and Employee did not appeal *Mitchell VI*, the relevant evidence must show something changed between December 20, 2005, the date *Mitchell IV* issued, and the date Employee had the Dynesys surgery, August 10, 2006. It contends Employee failed to meet this burden. (Employer's opening statement).

299) When the November 21, 2017 hearing concluded, the chair left the record open until December 5, 2017, so Employee could file an updated attorney fee affidavit, Employer could respond and the parties could file 25 page closing arguments to remedy Employee's objection that he had inadequate time to present his case. (Record).

300) On December 5, 2017, Employer contended Employee simply chose not to return to work utilizing his computer skills though he was physically capable. It contends Employee never questioned his retraining plan until recently. Employer contends LaBrosse's opinion is inadequate to support a PTD finding as he is not a physician and is not qualified to render opinions on physical capacities. Employer suggests the Social Security FCE form is entitled to little weight, as it restricts Employee's use of his hands and other extremities, even though there is no evidence his work injury affected these extremities. Lastly, Employer contends it is

entitled to a Social Security disability offset from any benefits awarded. (Employer's Closing Argument, December 5, 2017).

301) On December 6, 2017, Employee filed a one-page list of claimed medical and other expenses. This decision did not consider this filing because it was untimely. (Closing Brief, December 5, 2017; judgment).

302) On December 6, 2017, Employee also filed a 39 page exhibit called an "audit trail." This decision did not consider this filing because it was untimely. (History Chronological, December 2, 2017; judgment).

303) On December 6, 2017, Employee filed another affidavit from Harren itemizing his additional attorney fees between October 2, 2017, and December 5, 2017, as follows, with amounts awarded in this decision also shown as discussed more fully in the analyses, below:

Table III

Date	General Description	Requested Hours	Awarded Hours
10/2/17	Prepare fee/cost affidavit	5	5
10/3/17	Hearing preparation	6.5	6.5
10/4/17	Travel to/from/to 10 hearing	10.8	10.8
10/11/17	Letter to client	.2	.2
10/23/17	Teleconference with the board	.1	.1
10/23/17	Teleconference regarding Chong deposition	.2	.2
10/25/17	Teleconference with client	.5	.5
10/25/17	Review Chong deposition	.2	.2
10/27/17	Interview witness	1.2	1.2
10/30/17	Teleconference with colleague and witness	.8	.8
11/8/17	Memo to assistant	.8	.8
11/18/17	Hearing prep	1.2	1.2
11/18/17	Note to file	.1	.1
11/18/17	New medical report	.4	.4
11/20/17	Prepare for/travel to/from/to 10 hearing	8.5	8.5
12/1/17	Teleconference with client	.3	.3
12/2/17	Work on closing	4	0

	argument		
12/3/17	Work on closing argument	5.5	0
12/4/17	Edit closing argument	9.0	0
12/5/17	Work on closing arguments	9.5	0
		Total	70.9
		Total Awarded	14.18

Employee also sought additional paralegal costs from October 2, 2017, through December 5, 2017, for Ouzts, as follows, with amounts awarded in this decision also shown as discussed more fully in the analyses, below:

Table IV

Date	Description	Requested Hours	Awarded Hours
10/2/17	Prepare timesheet	.3	.3
10/3/17	Prepare affidavits	5.0	5.0
10/4/17	Travel to/from/to 10 hearing	8.3	8.3
10/31/17	Teleconference with Jeanne Mitchell	.3	.3
11/8/17	Draft subpoenas	.7	.7
11/14/17	Teleconference with Jeanne Mitchell	.2	.2
11/15/17	Prepare hearing exhibits	1.2	1.2
11/15/17	Meet with attorney	.4	.4
11/21/17	Travel to/from/attend hearing	10.25	10.25
12/5/17	Closing argument	4.8	0
		Total	26.65
		Total Awarded	5.33
	Airfare for Chong deposition	$748.50	$748.50
	Mileage	$150	$0
		Total	$748.50
		Total Awarded	$149.70

(Affidavit of Costs, Including Paralegal Costs, December 5, 2017).

304) On December 11, 2017, Employer objected to the December 5, 2017 attorney fee affidavit, possibly believing it had been filed timely. Employer did not object on grounds the affidavit was untimely. Employer contended some attorney fee entries are duplicative and Harren spent too much time on some pleadings. It also contended Employee did not need Ouzts to attend the

hearing since Harren already had co-representative Jeanne Mitchell assisting him. (Employer's Objection to Affidavit of Employee's Attorney's Fees and Costs Filed on 12/5/17, December 11, 2017).

305) On January 2, 2018, Employee's non-attorney representative filed his first closing argument. This decision did not consider this document because it was untimely. (Closing Argument of Employee by Non-Attorney Representative Jeanne Mitchell, January 2, 2018; judgment).

306) On January 2, 2018, Harren filed Employee's second closing argument. This decision did not consider this filing because it was untimely. (Closing Argument of Employee Attorney Representative Richard Harren (Pages 1-14), January 2, 2018; judgment).

307) On January 3, 2018, Employee filed an affidavit claiming additional costs received while Harren was on vacation. The additional costs are referenced but not reflected in the document. (Affidavit of Additional Costs, January 2, 2018).

308) Employer presented no evidence or argument supporting its November 15, 2016 or June 21, 2017 petitions to compel Employee to sign a release. The basis for Employer's request for an order suspending or forfeiting Employee's benefits is not adequately set forth in the hearing record. (Record; judgment).

309) Employee's lawyer's briefing and arguments provided little assistance to the panel in deciding this case. (Experience, judgment and inferences drawn from the above).

310) Employee's attorney has a history of filing documents late in this case. (Experience, judgment and inferences drawn from the above).

311) While the Dynesys surgery was not reasonable or necessary, Employee reasonably relied on recommendations from Drs. Peterson, Stinson, Delamarter, and Spayde to undergo it, and on Dr. Delamarter's assurances it was FDA approved for the use to which he put it on Employee's spine. (Experience, judgment and inferences drawn from the medical evidence above).

312) Employee seeks past TTD or PTD benefits from August 1, 2003, through this decision's date. This period equates to approximately 768.57 weeks. Any benefits payable after Employee began receiving Social Security Disability benefits are subject to an offset. If Employee prevails on his entire claim for past disability benefits, at his current disability rate, taking into account a possible Social Security offset, he would be entitled to past disability benefits totaling $146,720.02 (768.57 weeks x $190.90 after Social Security offset = $146,720.02). Pursuant to

an Excel spreadsheet, and using the statutory interest rates for each year and the proposed $190.90 offset rate, interest on disability benefits from August 1, 2003 through May 1, 2018, had Employee prevailed, would be approximately $92,212. According to his hearing brief, Employee also seeks approximately $150,000 in past medical bills. Therefore, if he were to prevail on all identifiable benefits Employee sought in his claim, it would total approximately $388,932.02 ($146,720.02 + $92,212 + $150,000 = $388,932.02). (Observations).

313) The applicable interest rates for this claim are: 2006 -- 8.25 percent; 2007 -- 9.25 percent; 2010 -- 3.5 percent; 2017 -- 4.25 percent. (Alaska Court System website).

314) On April 27, 2018, the panel reopened the hearing record to receive a requested document clarifying Employee's past Social Security disability payments. (Soule email, April 27, 2018).

315) On April 30, 2018, Employee filed a Social Security form showing Employee, in 2009, received retroactive Social Security disability payments beginning December 2005, and continuing. (Form SSA-1099 – Social Security Benefits Statement, undated)

316) This is a particularly contentious case and has been in litigation for an unusually long time. (Experience, judgment, observations and inferences drawn from all the above).

PRINCIPLES OF LAW

This case comes under substantive law in effect in 1995. This decision cites statutes and case law applicable to Employee's 1995 injury date. The board may base its decision not only on direct testimony and other tangible evidence, but also on the board's "experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987).

> **AS 23.30.010. Coverage.** Compensation is payable under this chapter in respect of disability or death of an employee.
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> **AS 23.30.045. Employer's liability for compensation**. . . .
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> (b) Compensation is payable irrespective of fault as a cause for the injury.
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> **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. . . .
> . . . .

> (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 in a time during the period of suspension, unless the circumstances justified the refusal.
>
> (e) The employee shall, after an injury, at reasonable times during the continuance of the disability, if requested by the employer or when ordered by the board, submit to an examination by a physician or surgeon of the employer's choice. . . . If the employee refuses to submit to examination provided for in this section, the employee's rights to compensation shall be suspended until the obstruction or refusal ceases, and the employee's compensation during the period of suspension may . . . be forfeited. . . .

An employer must provide reasonable and necessary medical care for a work injury. *Bockness v. Brown Jug, Inc*., 980 P.2d 462 (Alaska 1999).

> **AS 23.30.110. Procedure on claims**. . . .
> . . . .
>
> (c) Before a hearing is scheduled, the party seeking a hearing shall file a request for a hearing together with an affidavit stating that the party has completed necessary discovery, obtained necessary evidence, and is prepared for the hearing. . . . If the employer controverts a claim on a board-prescribed controversion notice and the employee does not request a hearing within two years following the filing of the controversion notice, the claim is denied.

In *Kim v. Alyeska Seafoods, Inc*., 197 P.3d 193, 198 (Alaska 2008) the Alaska Supreme Court held that the two-year deadline in AS 23.30.110(c) could be met if the moving party substantially complied with the requirement to request a hearing. The court defined substantial compliance as filing a clear, written request for hearing.

> **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.*). The presumption application involves a three-step analysis. To attach the presumption of

compensability, an employee must first establish a "preliminary link" between his injury and the employment. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 610 (Alaska 1999). Credibility is not examined at the first step. *Veco, Inc. v. Wolfer*, 693 P.2d 865, 869-70 (Alaska 1985).

If the employee's evidence raises the presumption, it attaches to the claim and in the presumption analysis' second step the burden of production then shifts to the employer. Credibility is not examined at the second step either (*id.*). If the employer's evidence is sufficient to rebut the presumption, it drops out and in the analysis' third step the employee must prove his case by a preponderance of the evidence. 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 presumption analysis' third step, the evidence is weighed, inferences are drawn from the evidence, and credibility is considered. *Steffey v. Municipality of Anchorage*, 1 P.3d 685, 691 (Alaska 2000).

> **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 credibility findings and weight accorded evidence are "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. *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249, 1253 (Alaska 2007). When doctors' opinions disagree, the board determines credibility. *Moore v. Afognak Native Corp.*, AWCAC Decision. No. 087 at 11 (August 25, 2008).

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

> **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. . . .

Attorney fees in workers' compensation cases should be fully compensatory and reasonable so injured workers have competent counsel available to them. *Cortay v. Silver Bay Logging,* 787 P.2d 103, 108 (Alaska 1990). Fees for time spent on minor issues will not be reduced if the employee prevails on the primary issues at hearing. *Uresco Construction Materials, Inc. v. Porteleki*, AWCAC Decision No. 152 at 14-16 (May 11, 2011).

The commission in *Israelson v. Alaska Marine Trucking, LLC*, AWCAC Decision No. 226 (May 27, 2016), reversed a decision denying substantial actual fees to a successful claimant's lawyer because he filed his fee affidavit and supporting information one day late due to computer issues.

In 1995, before the Act expressly provided for interest, the seminal case *Land & Marine Rental Co. v. Rawls*, 686 P.2d 1187 (Alaska 1984), provided for the universal application of interest in Alaska workers' compensation cases.

> **AS 23.30.180. Permanent total disability**. (a) In case of total disability adjudged to be permanent 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the total disability. . . . In all other cases permanent total disability is determined in accordance with the facts. In making this determination the market for the employee's services shall be
>
> (1) area of residence;
> (2) area of last employment;
> (3) the state of residence; and
> (4) the State of Alaska.
>
> (b) Failure to achieve remunerative employability as defined in AS 23.30.041(p) does not, by itself, constitute permanent total disability.

In *J.B. Warrack Company v. Roan*, 418 P.2d 986, 988 (Alaska 1966), the Alaska Supreme Court described PTD and stated:

> For workmen's compensation purposes total disability does not necessarily mean a state of abject helplessness. It means the inability because of injuries to perform services other than those which are so limited in quality, dependability or quantity that a reasonably stable market for them does not exist. . . . As the Supreme Court of Nebraska has pointed out, the 'odd job' man is a nondescript in the labor market, with whom industry has little patience and rarely hires. Work, if appellee could find any that he could do, would most likely be casual and intermittent. . . . (footnotes omitted).

In *Meek v. Unocal Corp*., 914 P.2d 1276, 1278 (Alaska 1996), a PTD case, the court explained:

> The concept of total disability includes an education component (citations omitted). 'Factors to be considered in making [a finding that a person's earning capacity was decreased due to a work-related injury] include not only the extent of the injury, but also age, education, employment available in the area for persons with the capabilities in question, and intentions as to employment in the future.' Thus, a person's lack of education, as much as his physical injury, may be the 'handicap' preventing him from obtaining all but 'odd-lot' jobs. (Citation omitted).
> . . . .
>
> If a lack of education can be overcome through vocational rehabilitation, then a disability that was once 'total' may no longer be so. This is precisely what section .041 aims to do; its goal is to retrain and educate permanently impaired employees (footnote omitted) so that they can attain 'remunerative employability' (footnote omitted).

In *Carlson v. Doyon Universal Ogden Services*, 995 P.2d 224 (Alaska 2000), the injured worker appealed denial of her PTD benefit claim. On appeal, the employer argued she failed to provide medical evidence she was PTD. *Carlson* stated this argument "oversimplifies" the total disability concept because Alaska adopted the "odd lot doctrine" in defining what constitutes permanent total disability. Under the odd lot analysis, a vocational reemployment expert's testimony demonstrated evidence of disability despite overwhelming medical evidence Carlson could perform "light duty" work. A competing vocational expert said a regular, stable labor market existed for people with Carlson's skills and capabilities. *Carlson* explained:

> To avoid paying PTD benefits, an employer must show that 'there is regularly and continuously available work in the area suited to the [employee's] capabilities,

> *i.e*., that [she] is not an 'odd lot' worker' (footnote omitted). The Board concluded that the three doctors' unanimous view that Carlson was not PTD and Jacobsen's testimony identifying continuous and suitable work sufficed to overcome the presumption. This evidence satisfies the 'comprehensive and reliable' requirement propounded in *Stephens* (footnote omitted). The Board considered Carlson's medical limitations and her competitiveness in the job market, specifically referring to the testimony of rehabilitation expert Jacobsen and her Anchorage area labor market survey. (*Id*. at 229).

Carlson also affirmed the board's reliance on testimony from a vocational reemployment expert who reviewed Carlson's claim file and a labor market survey. The expert identified job classifications suitable to the employee given her physical and educational limitations. (*Id*.).

> **AS 23.30.185. Compensation for temporary total disability.** In case of disability total in character but temporary in quality, 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the disability. Temporary total disability benefits may not be paid for any period of disability occurring after the date of medical stability.

In *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249, 1250 (Alaska 2007), the board heard the injured worker's claim in 2002. It found the worker's knee was initially medically stable on October 9, 2000. The board also held that once a physician recommended additional surgery on January 25, 2001, the "knee was no longer medically stable" but also held the worker was not entitled to TTD benefits between the initial medical stability determination on October 9, 2000 and the January 25, 2001 surgery recommendation. The board based its medical stability finding on a November 2, 2000 physician's report stating he did not expect any change for 45 days and on another doctor's December 2000 report stating the knee would improve with a home exercise program. The employee appealed, arguing her knee was not medically stable and had worsened. The employer on appeal offered no argument supporting a medical stability finding between November 2, 2000 and January 25, 2001.

The court noted by the time the board made its medical stability finding in 2002, it already knew the two doctors' 2000 predictions had proven incorrect and that a doctor had recommended surgery in 2001. The court concluded that medical predictions that proved to be incorrect were not substantial evidence upon which the board could reasonably conclude a worker had achieved medical stability. The court reversed the board's determination that the injured worker had

reached medical stability from November 2, 2000 to January 25, 2001. While the court's decision did not expressly discuss TTD benefit entitlement related to this issue, assuming the surgery was work-related and the surgery caused disability, the court's medical stability finding and analysis would result in TTD payable for the period during which the employee was not medically stable.

In *Vetter v. Alaska Workmen's Compensation Board*, 524 P.2d 264 (Alaska 1974) the board found Vetter was not working because she does "not want to work and that her husband, who did not want her to work before the injury, probably keeps her from working now." The board further found the fact she had "a previous earning history of minimal employment during the three years previous to injury is indicative of this." (*Id*. at 265). *Vetter* concluded:

> If a claimant, through voluntary conduct unconnected with his injury, takes himself out of the labor market, there is no compensable disability. . . . Total disability benefits have been denied when a partially disabled claimant has made no bona fide effort to obtain suitable work when such work is available (footnote omitted). And, a claimant has been held not entitled to temporary total disability benefits even though she had a compensable injury when she had terminated her employment because of pregnancy and thereafter underwent surgery for the injury. Since the compensable injury was not the reason she was no longer working, temporary disability benefits for current wage losses were denied (*id*. at 266-67).

The Alaska Supreme Court in *Thurston v. Guys With Tools, Ltd*., 217 P.3d 824, 828-29 (Alaska 2009), clarified the rules applicable to preexisting conditions versus injuries involving two or more independent causes. *Thurston* stated:

> Whether a work injury is a substantial factor in a resulting disability is evaluated differently in the context of a preexisting condition than in the context of two independent conditions.
>
> In the context of a preexisting condition . . . the employee must show that the work injury 'aggravated, accelerated, or combined with the disease or infirmity to produce the . . . disability for which compensation is sought' (footnote omitted). To prove that a work injury combined with a preexisting condition to produce a disability, the employee must show that '(1) the disability would not have happened 'but-for' an injury sustained in the course and scope of employment; and (2) reasonable persons would regard the injury as a cause of the disability and attach responsibility to it' (footnote omitted). . . .

> In the different context of a subsequent independent condition . . . the employee must show that the work-related condition is a substantial factor in the overall disability. . . . Thurston does not need to show that but for her work injury she would not be disabled. To be eligible for TTD or PTD benefits Thurston needs to show that her work-related disability is a substantial factor in her total disability, without regard to whether her cancer could independently have caused the total disability (footnote omitted). . . .

In *Croft v. Pan Alaska Trucking, Inc*., 820 P.2d 1064, 1066-67 (Alaska 1991), a statute stated an employer could recover a benefit overpayment only by withholding a percentage from future benefits payable. The board said it lacked authority to order full repayment and the superior court reversed, ordering full repayment. The Alaska Supreme Court reversed and stated:

> In reaching this conclusion, we employ the principle of statutory construction *expression unius est exclusio alterius.* 'The maxim establishes the inference that, where certain things are designated in a statute, 'all omissions should be understood as exclusions.' The maxim is one of longstanding application, and it is essentially an application of common sense and logic.' (Citations omitted).
> . . . .
>
> The case for application of *expression unius est exclusio alterius* is particularly compelling where, as here, the scheme is purely statutory and without a basis in the common law. Where a statutory scheme provides comprehensive and specific remedies, it "implies that the legislature did not intend to allow further unenumerated remedies." (Citations omitted).

In *Baeza v. Remington Arms Co*., 224 P.2d 223 (Colo. 1950), a worker hurt his ankle in a state where the law allowed the employer to select a treating physician and authorize care. A hearing decided medical only issues and two years later, without giving advance notice to the employer or labor commission, the worker found his own physician who performed surgery, causing temporary and permanent "disability." The Colorado Supreme Court held that by not giving advance notice to the employer and commission, the injured worker nullified the statute allowing the employer to have the worker examined and treated by the employer's physician. Consequently, the employer did not have to pay disability related to the surgery.

In *Janvari v. Peter Schweitzer Co*., 80 A.2d 367, 368 (N.J. Super. 1951), an injured worker had a hearing and the deputy director found, "There has been some indirect allusion to surgery. The greater weight of the credibility testified [sic] in this case preponderates against that." Several

months later, the employee on his own accord had surgery for his work injury. A little over a year after the initial hearing, the worker filed a petition seeking additional benefits stating his work-related disability had increased. The deputy director dismissed the worker's petition on grounds there had been a finding that surgical intervention was not reasonably indicated, *res judicata* barred the claim and the employee should have given advance notice to the employer so it could investigate before the employee underwent surgery. On appeal, the court reversed the *res judicata* decision and, citing from an earlier case, said:

> Where injured employee used reasonable care in the selection of physicians and submitted to surgical operation which was unsuccessful and aggravated the original injury; held, employee is entitled to recover compensation for increased permanent disability resulting therefrom.

The court commented on the reasonableness of the employee's actions in obtaining the surgery.

> The petitioner is not a lawyer nor a surgeon nor an X-ray specialist and he did what any ordinary person would naturally do under the circumstances. He knew what the attitude of respondent's doctors was from what they had said at the first hearing. To require a workman to give notice that he intends to seek treatment would be introducing conditions and refinements into the Compensation Act which are entirely out of place as a general rule, and the facts do not justify such a requirement in this particular case. . . .
> . . . .
>
> I find that at the first hearing surgery was not reasonably indicated but that thereafter petitioner returned to work and his condition became worse and that because of his worsened condition he sought the services of Dr. Weigel, who performed an operation as part of his treatment for the man's worsened condition, and that the operation was necessary for his worsened condition in which Dr. Weigel found him at the time; that petitioner was fully justified in following the advice of Dr. Weigel and submitting to the operation, and that petitioner used reasonable care in the selection of a physician and surgeon. (*Id*. at 293).

In *Pacific Employer's Insurance Co. v. Industrial Commission*, 652 P.2d 147, 150 (Arizona App. 1982), an injured worker followed his physician's advice and underwent surgery designed to improve his condition. The employer's examiner had opined the worker was not a candidate for surgery because there were no objective findings, and recommended a course of conservative care. The carrier refused authorization for surgery. The employee's back condition worsened as a result of the surgery. On an appeal from a disability award, the court held "increased disability

is thus compensable if respondent's decision to undergo surgery was reasonable under all the circumstances and not 'intentionally reckless conduct.'"

> **AS 23.30.187. Effect of unemployment benefits**. Compensation is not payable to an employee under AS 23.30.180 or 23.30.185 for a week in which the employee receives unemployment benefits.
>
> **AS 23.30.225. Social security . . . offsets**. (a) When periodic retirement or survivors' benefits are payable under 42 U.S.C. 401-433 (Title II, Social Security Act), the weekly compensation provided for in this chapter shall be reduced by an amount equal as nearly as practicable to one-half of the federal periodic benefits for a given week.
>
> (b) When . . . in accordance with 42 USC 401-433, periodic disability benefits are payable to an employee . . . for an injury for which a claim has been filed under this chapter, weekly disability benefits payable under this chapter shall be offset by an amount by which the sum of (1) weekly benefits to which the employee is entitled under 42 USC 401-433, and (2) weekly disability benefits to which the employee would otherwise be entitled under this chapter, exceeds 80 percent of the employee's average weekly wages at the time of injury. . . .
>
> **AS 23.30.230. Persons not covered**. (a) The following persons are not covered by this chapter:
>
> (1) part-time baby-sitters;
>
> (2) cleaning persons;
>
> (3) harvest help and similar part-time or transient help;
>
> (4) persons employed as sports officials on a contractual basis and who officiate only at sports events in which the players are not compensated; in this paragraph, 'sports official' includes an umpire, referee, judge, scorekeeper, timekeeper, organizer, or other person who is a neutral participant in a sports event;
>
> (5) persons employed as entertainers on a contractual basis;
>
> (6) commercial fishermen, as defined in AS 16.05.940; and
>
> (7) individuals who drive taxicabs whose compensation and written contractual arrangements are as described in AS 23.10.055 (13), unless the hours worked by the individual or the areas in which the individual may work are restricted except to comply with local ordinances.

> (b) The exclusion of certain persons under (a) of this section may not be construed to require inclusion of other persons as employees for purposes of compensation under this chapter.
>
> **AS 23.30 235. Cases in which no compensation is payable**. Compensation under this chapter may not be allowed for an injury
>
> (1) proximately caused by the employee's willful intent to injure or kill any person.
>
> (2) proximately caused by intoxication of the injured employee or proximally caused by the employee being under the influence of drugs unless the drugs were taken as prescribed by the employee's physician.

In *Walt's Sheet Metal v. Debler*, 826 P.2d 333, 335 (Alaska 1992), a worker with a work-related lumbar fusion reinjured his back when a police officer placed his knee on the employee's spine while the employee was resisting arrest. His employer denied benefits contending the employee's reckless behavior was an intervening cause barring a compensation award. Rejecting this argument, the Alaska Supreme Court said:

> We affirm the Board's decision because the record contains insufficient evidence to overcome the statutory presumption that Debler did not wilfully intend to injure himself. An act is wilful if it is done intentionally and purposefully, rather than accidentally or inadvertently. (Citations omitted). Mere recklessness does not constitute wilful conduct. Debler may have acted recklessly when he resisted arrest and fought with the arresting officer, but he clearly did not act with the intent to reinjure his back. Alaska Statute 23.30.235 therefore does not apply to this case. (Citations omitted).
>
> The employer argues that the application of AS 23.30.235 should not be limited to those situations in which an employee specifically intends to injure himself, for such a standard would allow a convalescing employee to engage in risky activities with the assurance that his employer will be required to pay for any aggravation of the employee's injury. This argument ignores the statute's unequivocal language. If AS 23.30.235 is to be modified to provide a defense based on the misconduct or reckless behavior of employees, the legislature should make that modification.
>
> **AS 23.30.265. Definitions**. In this chapter,
> . . . .
>
> (2) 'arising out of and in the course of employment' includes employer-required or supplied travel to and from a remote job site; activities performed at the

> direction or under the control of the employer; and employer-sanctioned activities at employer-provided facilities; but excludes recreational league activities sponsored by the employer, unless participation is required as a condition of employment, and activities of a personal nature away from employer-provided facilities;
> . . . .
>
> (10) 'disability' means incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment. . . . .
>
> (17) 'injury' means accidental injury or death arising out of and in the course of employment. . . .
> . . . .
>
> (21) 'medical stability' means the date after which further objectively measurable improvement from the effects of the compensable injury is not reasonably expected to result from additional medical care or treatment, notwithstanding the possible need for additional medical care or the possibility of improvement or deterioration resulting from the passage of time; medical stability shall be presumed in the absence of objectively measurable improvement for a period of 45 days; this presumption may be rebutted by clear and convincing evidence;

The Alaska Supreme Court applies the *res judicata* doctrine to workers' compensation cases. In *Robertson v. American Mechanical, Inc.*, 54 P.3d 777, 780 (Alaska 2002), the court said:

> When applicable, *res judicata* precludes a subsequent suit 'between the same parties asserting the same claim for relief when the matter raised was or could have been decided in the first suit' (citation omitted). It requires that '(1) the prior judgment was a final judgment on the merits, (2) a court of competent jurisdiction rendered the prior judgment, and (3) the same cause of action and same parties or their privies were involved in both suits.'

> **8 AAC 45.050. Pleadings**. . . .
> . . . .
>
> (e) **Amendments**. A pleading may be amended at any time before award upon such terms as the board or its designee directs. If the amendment arose out of the conduct, transaction, or occurrence set out or attempted to be set out in the original pleading, the amendment relates back to the date of the original pleading.
> . . .

> **8 AAC 45.082. Medical treatment**. . . .
> . . . .

(c) If, after a hearing, the board finds a party made an unlawful change of physician in violation of AS 23.30.095(a) or (e) or this section, the board will not consider the reports, opinions, or testimony of the physician in any form, in any proceeding, or for any purpose. . . .

8 AAC 45.120. Evidence. . . .

. . . .

(e) . . . Irrelevant or unduly repetitious evidence may be excluded on those grounds.

. . . .

(m) The board will not consider evidence or legal memoranda filed after the board closes the hearing record, unless the board, upon its motion, determines that the hearing was not completed and reopens the hearing record for additional evidence or legal memoranda. The board will give the parties written notice of reopening the hearing record, will specify what additional documents are to be filed, and the deadline for filing the documents.

8 AAC 45.180. Costs and attorney's fees.

. . . .

(b) A fee under AS 23.30.145(a) will only be awarded to an attorney licensed to practice law in this or another state. . . . An attorney requesting a fee in excess of the statutory minimum in AS 23.30.145(a) must (1) file an affidavit itemizing the hours expended, as well as the extent and character of the work performed, and (2) if a hearing is scheduled, file the affidavit at least three working days before the hearing on the claim for which the services were rendered; at the hearing, the attorney may supplement the affidavit by testifying about the hours expended and the extent and character of the work performed after the affidavit was filed. If the request and affidavit are not in accordance with this subsection, the board will deny the request for a fee in excess of the statutory minimum fee, and will award the minimum statutory fee. . . .

. . . .

(f) The board will award an applicant the necessary and reasonable costs relating to the preparation and presentation of the issues upon which the applicant prevailed at the hearing on the claim. The applicant must file a statement listing each cost claimed, and must file an affidavit stating that the costs are correct and that the costs were incurred in connection with the claim. The following costs will, in the board's discretion, be awarded to an applicant:

(1) costs incurred in making a witness available for cross-examination;
(2) court reporter fees and costs of obtaining deposition transcripts;
(3) costs of obtaining medical reports;

(4) costs of taking the deposition of a medical expert, provided all parties to the deposition have the opportunity to obtain and review the medical records before scheduling the deposition;
(5) travel costs incurred by an employee in attending a deposition prompted by a Smallwood objection;
(6) costs for telephonic participation in a hearing;
(7) costs incurred in securing the services and testimony, if necessary, of vocational rehabilitation experts;
(8) costs incurred in obtaining the in-person testimony of physicians at a scheduled hearing;
(9) expert witness fees, if the board finds the expert's testimony to be relevant to the claim;
(10) long-distance telephone calls, if the board finds the call to be relevant to the claim;
(11) the costs of a licensed investigator, if the board finds the investigator's services to be relevant and necessary;
(12) reasonable costs incurred in serving subpoenas issued by the board, if the board finds the subpoenas to be necessary;
(13) reasonable travel costs incurred by an applicant to attend a hearing, if the board finds that the applicant's attendance is necessary;
(14) fees for the services of a paralegal or law clerk, but only if the paralegal or law clerk

(A) is employed by an attorney licensed in this or another state;
(B) performed the work under the supervision of a licensed attorney;
(C) performed work that is not clerical in nature;
(D) files an affidavit itemizing the services performed and the time spent in performing each service; and
(E) does not duplicate work for which an attorney's fee was awarded;

(15) duplication fees at 10 cents per page, unless justification warranting awarding a higher fee is presented;
(16) government sales taxes on legal services;
(17) other costs as determined by the board.

ANALYSIS

1) Was the oral order denying Employer's request for an order requiring Employee to be physically present at hearing correct?

An oral order denied Employer's request for Employee's physical presence at hearing so the fact-finders could observe his appearance and judge his demeanor and credibility. Employee, attending by telephone, said he had difficulty sitting for long periods but would appear later for his testimony. Employee subsequently appeared and testified in person. Consequently, the panel

observed his appearance and demeanor and drew some conclusions from this and from his testimony. The oral order declining Employer's request was correct. AS 23.30.135.

2) Was the oral order to not consider Employee's hearing brief Exhibit 3 correct?

Employer successfully objected to Exhibit 3 to Employee's hearing brief. This is a multi-page document Employee's non-attorney representative Jeanne Mitchell created years ago and to which she adds as new information becomes available. Exhibit 3 is a chronological list of events, which contains Jeanne's editorial comments on medical records, prehearing conferences and other proceedings. It is not "evidence" and is irrelevant. Since it attempts to re-create statements from records already in the agency file, it is also unduly repetitious. 8 AAC 45.120(e). While Exhibit 3 could form the basis for Employee's argument, the panel did not consider his untimely closing arguments. Therefore, the oral order was correct. Employee's Exhibit 3 will remain in the record but the panel will not be consider the exhibit.

3) Was the oral order granting Employer's request to prohibit Employee's non-attorney representative from advocating at hearing correct?

Employer also obtained an order restricting Employee's non-attorney representative's role at hearing, even though Employee agreed his attorney would be the only person advocating on his behalf. This has been a long, contentious case with 15 previous decisions. *Rogers & Babler*. An experienced attorney represents Employee. Various colloquies over the years in depositions and on the record at hearings as well as in prehearing conferences show Employee's non-attorney representative and Employer's attorneys have not gotten along. Employee has reportedly sued Employer's previous attorney Livsey for damages in civil court. To avoid unpleasant colloquy between Employee's non-attorney representative and Employer's current counsel, and to conduct the hearing in the manner best suited to ascertain the parties' rights, the oral order restricting Employee's non-attorney representative to her role as a witness, was correct. AS 23.30.135.

4) Was the oral order giving Employee additional time to file attorney fee and cost documentation, and giving Employer time to object, correct?

Employer unsuccessfully sought an order striking Employee's untimely and incomplete attorney fee and cost request. Harren conceded his fee documents were late and lacking but explained he

had been on a hunting trip prior to hearing and had difficulty obtaining information from paralegals he no longer employed. Even then, once Employee obtained the information, a miscommunication between Harren and his current paralegal resulted in additional delays. Since the hearing was continued to late November, because Employer was given an opportunity to object to Employee's attorney fee submission and because limiting Employee's attorney fees to statutory minimum fees should he prevail would result in considerable revenue loss for his attorney, the oral order giving Employee more time to file appropriate documentation for his attorney fees and costs and giving Employer a chance to respond was correct. *Israelson*.

5) Are the medical records stricken in *Mitchell X* admissible for this hearing?

Mitchell X struck 2014 EME reports from Drs. Chong and Holley finding these doctors were unlawful physician changes. 8 AAC 45.082(c). Employer did not seek review of *Mitchell X*. Thereafter, *Mitchell XI* found Employer's last "lawful" physician, Dr. Levine, was no longer available to serve as an EME. Consequently, *Mitchell XI* modified *Mitchell X* and permitted Employer another physician change, including its right to re-select Drs. Chong and Holley. Employee did not seek review of *Mitchell XI*. Employer re-selected Dr. Chong as its EME. Not surprisingly, Dr. Chong relied on his knowledge from having examined Employee and having written his 2014 reports to prepare a new report and give his deposition testimony.

Unhappy with this process, Employee asked Dr. Chong deposition questions concerning his prior reports in an effort to demonstrate he had simply "cut and pasted" his old report into his new one. In Employee's view, Dr. Chong's use of his old report, which *Mitchell X* had stricken, tainted his new report making it also inadmissible. By contrast, in Employer's view, Employee's deposition questioning of Dr. Chong concerning his stricken report "opened the door" to its admission at hearing, notwithstanding *Mitchell X*.

No higher authority has overruled either *Mitchell X* or *Mitchell XI*. Consequently, both are the law of the case on this issue. Regulation 8 AAC 45.082(c) is clear and applicable. *Mitchell X* found Employer made an unlawful change of physician. The panel cannot consider Drs. Chong's and Holley's 2014 reports. Employee presented no legal authority preventing Dr. Chong's subsequent, lawful EME reports and deposition following *Mitchell XI*, also the law of

the case on this issue, from being admissible for consideration in this case. Nothing in the Act prevents Dr. Chong, as opposed to the panel, from gleaning information from his previous examination and reports. Therefore, the panel will consider Dr. Chong's records and testimony subsequent to *Mitchell XI*.

6) Is Employee entitled to additional past or future medical care?

Employee seeks past and future medical care. AS 23.30.095(a). This issue raises factual disputes to which the compensability presumption applies. AS 23.30.120; *Meek*. As to both past and future medical care, Employee raises the presumption with medical opinions from Drs. Peterson, Stinson, Delamarter, Gritzka and Robinson. *Tolbert*. Drs. Peterson, Stinson and Delamarter recommended the past medical care Employee received for his work injury. Drs. Stinson, Gritzka and Robinson recommend additional care. Employer rebuts the raised presumption as to both past and future medical care with medical opinions from Drs. Roth, Brown and Chong. *Wolfer*. Dr. Roth said Employee needed no further care. Drs. Brown and Chong said Employee needed only conservative care or no ongoing care at all. This shifts the burden of proof back to Employee who must prove his medical benefits claims by a preponderance of the evidence. *Steffey*; *Saxton*.

There are no credible medical opinions suggesting the 1995 work injury was or is not a substantial factor in the need for Employee's disputed medical care. No physician has offered a credible opinion suggesting an alternate cause that excludes work as a substantial factor. AS 23.30.122; *Smith*. Therefore, the 1995 work injury has been and remains a substantial factor in Employee's need for medical care. The remaining issue is whether the care was or is reasonable and necessary.

A) Past medical care:

Mitchell VI heard Employee's claim for past medical care through December 20, 2005. Because the record was unclear, *Mitchell VI* ordered him to provide evidence showing unpaid medical bills. *Mitchell VII* resolved the remaining, then-current past medical expenses. Employee did not appeal either *Mitchell VI* or *Mitchell VII* and both are "final" decisions. Since Employee appealed neither decision, the *res judicata* doctrine bars Employee from re-litigating any medical

expenses already incurred but previously denied in *Mitchell VI* or *VII*. *Robertson*. Therefore, for this decision's purposes, "past" medical care refers to care after January 30, 2006, when *Mitchell VII* reviewed Employee's itemized unpaid medical expenses, awarded some and denied others.

Employee timely filed a March 3, 2006 petition requesting modification of *Mitchell VI*. Nine years later, *Mitchell XIII* addressed it and found *Mitchell VI* had considered and denied the Dynesys procedure, without mentioning it by name. Since the parties stipulated to limit the evidence for the modification hearing to the "record as it stood in December 2005," Employee could not prove *Mitchell VI* erred in denying the Dynesys surgery. Since *Mitchell VI* was a final decision, *Mitchell XIII* was a final decision denying modification. Employee did not appeal *Mitchell XIII* either. However, because *Mitchell VI* expressly retained jurisdiction to "resolve any future dispute regarding whether future treatments are reasonable, necessary and within the realm of acceptable medical practice," *Mitchell XIII* determined Employee could still pursue a claim for medical care obtained after *Mitchell VI*. Employee's medical claims are divided into separate categories:

i) The Dynesys procedure.

The main, past medical care in contention is the August 10, 2006 Dynesys surgery, which Employee obtained and paid for. Employer is correct that evidence showing what occurred between *Mitchell VI* and the date Employee had the Dynesys procedure is most relevant in determining whether something changed between December 20, 2005, when *Mitchell VI* issued, and the date Employee obtained the Dynesys procedure. It is possible something may have changed to make a procedure, not reasonable and necessary on December 20, 2005, reasonable and necessary on August 10, 2006. The analysis now turns to this evidence.

On December 20, 2005, *Mitchell VI* found Dr. Peterson had a treatment plan for conservative care to avoid surgery and its resultant adjacent disc disease. Based on Dr. Peterson's opinion, *Mitchell VI* found conservative care "reasonable." There is no medical record authored between December 20, 2005, and August 10, 2006, showing Dr. Peterson changed his view on Employee's then-current situation. Nothing changed in this regard. Dr. Peterson's retrospective

September 21, 2006 letter, referring to and clarifying his July 31, 2003 opinion recommending conservative care, does not affect his September 16, 2003 opinion upon which *Mitchell VI* relied.

Mitchell VI denied "disc replacement surgery." The parties agree Employee was not a candidate for disc replacement surgery in 2005 or in 2006. Nothing changed here either.

Mitchell VI expressly found "the only reasonable and necessary" treatment presented in the record at that time was for conservative care. Employee takes especial umbrage with this finding because Drs. Hoffman and Delamarter were recommending Dynesys surgery as early as July 13, 2005, and Employee's request for this recommended procedure was the impetus for *Mitchell VI*. Employee reasons, since this medical evidence was "in the record," there was an alternative treatment recommendation pending, proving *Mitchell VI* was wrong. But Employee misses the point. *Mitchell VI* did not say the only treatment presented in the record was for conservative care. It said, ". . . the only reasonable and necessary treatment presented in the record at this time is for conservative care." Therefore, while the Dynesys treatment recommendation was "in the record," *Mitchell VI* decided it was not reasonable and necessary in reliance primarily on Dr. Peterson's call for conservative care. Employee's belated effort to modify *Mitchell VI* failed in *Mitchell XIII*. Employee is simply wrong on this contention.

In January 2006, Dr. Stinson noted Employee's activity level had diminished, said he was not medically stable and prescribed a custom sacral arthrosis to stabilize his spine. There was nothing new here, as Employee's activity level waxed and waned since his injury, Dr. Stinson had prescribed a back brace in 2002 and Dr. Stinson agreed with Dr. Delamarter's 2005 Dynesys surgery recommendation, which by definition meant Dr. Stinson did not think Employee was medically stable. Employee may conflate the legal term "medical stability" with the purely medical term referring to spinal "instability" where one vertebra slips over another. A person with a medically "unstable" spine may or may not be legally "medically stable." Employee's confusion on these terms may account for his frustration and misunderstanding.

Dr. Stinson wrote Employee's proxy hunting and fishing request in February 2006. There was nothing different here, as Employee's physicians had provided proxy forms in 2002 and 2004.

In May 2006, Dr. Stinson reiterated Dr. Delamarter's proposal for Dynesys surgery. This is not new, as Employee's physicians had offered the Dynesys treatment in July 2005 and Dr. Stinson had concurred then too. In May 2006, Dr. Delamarter responded to Employee's letter addressing the Dynesys procedure, stating nothing new in his answers other than his understanding that the Dynesys system was "FDA approved." In reality, Dynesys was not FDA approved for "general use" as Dr. Delamarter incorrectly thought, but was only approved for use as an adjunct to a concurrent fusion, as stated in FDA documents. As of August 19, 2005, the FDA required a warning label on Dynesys packaging stating the exact use for which Dr. Delamarter put this device on Employee's spine was not established as safe or effective. Thus, nothing changed about the FDA's lack of approval for Dr. Delamarter's off-label Dynesys use.

Employee takes exception to this FDA finding as well. He reasons that since he had a spinal fusion at L5-S1 in 1999 and again in 2001, Dr. Delamarter correctly used the Dynesys system as an "adjunct" to his old fusions. Employee further contends Dynesys could never have been intended for use with a concurrent fusion, arguing its intent was to retain spinal mobility, a principal diametrically opposed to a spinal fusion, which limits spinal movement. However, a November 2009 FDA hearing proves Employee's opinion is incorrect. Speaking as Zimmer's advocate in its attempt to get FDA approval for the off-label use operant in this case, Dr. Maxwell described Dynesys as "stabilization" without fusion. Had Dynesys already been approved for use without a concurrent fusion, Dr. Maxwell would not have been seeking FDA approval stating the concept was stabilization "without fusion." *Rogers & Babler*. According to its medical advocates, Zimmer sought FDA approval for Dynesys "not necessarily as a motion preserving device or a motion restorative device, but just as a way to neutralize the spine in a safe position." Dynesys is not intended "to be an articulating system." In fact, Zimmer advocate Dr. Welch said Dynesys reduced movement "almost to the point of fusion." FDA panel member Dr. Kirkpatrick pointed out Zimmer was really seeking approval to use the Dynesys system off-label to reestablish spinal stability following decompression "without a fusion." This is exactly how Dr. Delamarter used Dynesys off-label in this case.

Based on FDA records, Employee misunderstands Dynesys in all respects. Zimmer's medical experts' understanding of Dynesys' intended purpose is given more weight than Employee's or

his doctors' understanding. AS 23.30.122; *Smith*. On November 4, 2009, the FDA's expert medical panel deemed Zimmer's proposed use, *i.e.*, Dr. Delamarter's use in this case, "not approvable." There is no evidence in Employee's agency file showing the FDA ever approved Dynesys as Dr. Delamarter used it in Employee's spine.

In May 2006, Employee told Dr. Prieto he was in computer training but could not sit or stand adequately. Nothing changed here, as Employee previously reported problems with sitting and standing before *Mitchell VI*. In June 2006, Employee returned to Dr. Delamarter's office and reported progressive back, buttock and radiating pain. The record shows this is not new or changed, as these symptoms have continued off and on since Employee's injury. Dr. Delamarter implied the lack of Dynesys surgery lead to progressive disability and further degeneration at L3-4. He offered Employee an additional two-level fusion at L3-4 and L4-5 but downplayed this procedure because Employee has a propensity for adjacent disc disease, which would cause issues at the next level up, L2-3. Dr. Spayde echoed this opinion. The only things new here were the opinions that Employee's spinal degeneration had progressed from July 13, 2005, when Dr. Delamarter first recommended Dynesys. Employee's degeneration was not unexpected given his well-documented, post-injury, progressive degenerative history. *Rogers & Babler*.

In July 2006, Employee reported worsening symptoms including leg spasms, cramping and numbness and said his legs occasionally "give out." Dr. Stinson reiterated his opinions stating Employee was not medically stable and needed the Dynesys procedure. Nothing was new here as Employee had reported similar symptoms on June 5, 2002, September 6, 2002, June 2, 2004, October 6, 2004 and December 13, 2004, and Employee's physicians had previously said he was not medically stable and needed the Dynesys procedure in July 2005. Lastly, Dr. Delamarter did not perform a fusion in conjunction with his August 10, 2006 Dynesys surgery, though many providers mistakenly charted he did.

The above summarizes the most relevant evidence between *Mitchell VI*'s December 20, 2005 issue date and the date Employee obtained Dynesys surgery, August 10, 2006. In short, nothing changed significantly. Employee has not met his burden to show that something changed in the interim, making the Dynesys procedure, which *Mitchell VI* found not reasonable and necessary

in December 2005, reasonable and necessary in August 2006. Dr. Delamarter's off-label Dynesys use was not reasonable or necessary in July 2005 as *Mitchell VI* found in December 2005, and it was still not reasonable or necessary in August 2006. *Rogers & Babler*.

Additionally, Dr. Delamarter using Dynesys contrary to an FDA warning is cause for concern. Contrary to Employee's contentions, Dynesys did not "do its job." Like all other short-lived improvement from procedures Employee has had to date for his work injury, he initially felt better following Dynesys surgery for about a year but as Dr. Stinson stated this symptomatic improvement "did not sustain." Dr. Gritzka agreed. Throughout the records, Employee says he was reducing his medication, yet he continued taking opioids at the same dosages as before the Dynesys surgery. While he may have briefly reduced his medications from time to time, overall Employee continues to use the same medications, post-Dynesys. Dr. Stinson said Dynesys did not do what was hoped and said, conceding Dr. Delamarter used it contrary to FDA approval and warning, it "was probably not that difficult to predict it wasn't going to be that effective."

By April 2007, less than a year post-Dynesys, Dr. Stinson prescribed a TENS unit for Employee and in May 2007, Dr. Delamarter told the Social Security Administration Employee could not work. By January 2008, he still had paresthesia extending to his bilateral heels. Opioids continued. Employee became depressed. By March 2008, narcotics no longer controlled Employee's pain, which now caused him to "shudder." Within two years following Dynesys surgery, Employee was as limited as before, and reported, "He has never had symptoms like this before." His symptoms were actually worse than before Dynesys surgery. The record shows there was no long-term benefit. *Rogers & Babler*. Ironically, but not surprisingly, in 2016 Dr. Stinson noted Employee is now having difficulties at L2-3 due to adjacent disc syndrome.

The law requires Employer to pay for reasonable and necessary medical care and treatment for Employee's work injury. AS 23.30.095(a); *Bockness*. Given the above analysis, Dr. Delamarter's Dynesys procedure was neither reasonable nor necessary. Therefore, Employer will not have to pay for it. Employee insisted on obtaining this procedure and Dr. Delamarter insisted on providing it, no matter what. On the positive side for Employee, even though Employer need not reimburse Employee for services related to Dr. Delamarter's Dynesys

procedure incurred after *Mitchell VII*, Employee got the treatment he wanted and got the benefit of his bargain with Dr. Delamarter.

> *ii) TENS unit, IDET, injections, radiofrequency rhizotomies and similar invasive treatments.*

Dr. Stinson provided other invasive treatments to address Employee's pain. Predictably, Employee experienced short-term relief only to have his symptoms return, move or worsen. SIME Dr. Robinson summarized these numerous treatments designed to influence Employee's clinical condition. He noted Drs. Stinson, Peterson and Delamarter never questioned the appropriateness of their "conceptual spine model," which hopes to find the pain generators' locations and eliminate the issues. In Dr. Robinson's opinion, once it became apparent these various modalities did not produce a long-lasting effect, these physicians should have questioned their conceptual model and referred Employee for a mental health evaluation. His opinion Employee has evidence of a chronic pain syndrome making it unlikely he would benefit from care intended to address structural lesions, is persuasive and worth considerable weight. AS 23.30.122; *Smith*.

Dr. Stinson referred Employee to psychologist Dr. Trombley for an evaluation but Employee refused to participate in mental health testing and refused to say why. Though the record is unclear when he became aware no one had evaluated Employee's mental health, Dr. Stinson said he knew Employee had never undergone a psychiatric or psychological evaluation yet he continued to provide interventional medical care.

The record shows these invasive procedures provided Employee with no long-term relief. They exemplify the old adage, "To a hammer, everything is a nail." In this instance, invasive medical treatment was the hammer, and Employee's symptoms were the nails. It was unreasonable for Dr. Stinson to continually provide invasive medical treatment to Employee without requiring him to undergo a psychiatric or psychological evaluation under these facts. Therefore, Employer will not have to pay for this medical care including hip treatment. AS 23.30.095(a); *Bockness*.

iii) Spinal cord stimulators.

The analysis for the spinal cord stimulator is different. SIME Dr. Robinson distinguished "sharply" between interventions to treat structural abnormalities in the spine and spinal cord stimulation. Spinal cord stimulation works regardless of whether or not there are identifiable structural lesions in Employee's spine that are causing pain. Further, Dr. Robinson opined spinal cord stimulation will relieve Employee's chronic debilitating pain "to some extent." Moreover, though he recommends a psychological evaluation before Employee's current stimulator is revised, Dr. Robinson agrees the initial spinal cord stimulator placement was justifiable even though Dr. Stinson failed to have Employee undergo a pre-placement mental evaluation.

Similarly, Dr. Stinson is an expert in spinal cord stimulators having used them and trained others on these devices for years. He agrees the spinal cord stimulator was reasonable and necessary. SIME Dr. Gritzka agrees it was the most reasonable approach to Employee's chronic back pain. These opinions are credible and gain great weight. AS 23.30.122; *Smith*. The spinal cord stimulation care to date has been reasonable and necessary, and Employer shall pay for it.

iv) Medication.

Most treating and the most recent SIME physicians agree long-term narcotic painkillers are reasonable and necessary to address Employee's ongoing symptoms from his work injury. This decision does not rely on Drs. Holley's or Chong's 2014 reports excluded in *Mitchell X*. Dr. Chong in his admissible May 14, 2015 report, unlike most physicians in this case, disagrees medication was necessary or reasonable, finding no medical care in this case has been reasonable or necessary because it did not assist in Employee's recovery. He focuses on Employee's subjective "pain perceptions." Experience teaches pain is a perception, and as Dr. Robinson states, the perception is what causes the need for care. *Rogers & Babler*. Dr. Chong glosses over this self-evident truth. His opinion gets less weight because it stands alone. AS 23.30.122; *Smith*. Dr. Robinson's opinion makes more sense than Dr. Chong's, and comports with the panel's experience. It gets more weight. AS 23.30.122; *Smith*. Therefore, Employer shall pay for Employee's past, work-related prescription medications if it has not already done so. Employee is also responsible for Dr. Stinson's office visits to monitor and prescribe prescription medication. AS 23.30.095(a).

v) Physical therapy.

Occasional physical therapy is the last significant treatment Employee received since *Mitchell VI*. The medical and lay evidence does not show Employee gained any particular benefit from formal physical therapy. Drs. Brown and Robinson agreed Employee could do home-based physical therapy for general toning and strengthening. Consequently, past physical therapy has not been reasonable or necessary under these facts and Employer need not pay for it. AS 23.30.095(a).

vi) October 2016 imaging.

On October 10, 2016, Dr. Stinson recommended lumbosacral imaging to review Employee's work-related condition. Employee obtained lumbar x-rays, which are reasonable and necessary to evaluate Employee's lower back. Employer will pay for those. However, he also got five cervical spine x-rays with no explanation in the records relating the neck to his work injury. Employer will not pay for those. On October 24, 2016, Dr. Peterson recommended a CT and myelogram for further diagnosing and reviewing Employee's ongoing, work-related lumbar issues. Employee obtained these images. These are reasonable and necessary and Employer will pay for them and for the related office visits. *Rogers & Babler*. All payments will be made pursuant to the Alaska medical fee schedule.

B) Future medical care:

i) Medication.

Most physicians agree Employee's long-term medication regimen has been relatively effective in attenuating his symptoms. Dr. Stinson has provided medication to Employee for approximately 18 years and Employee has never failed any malingering test or given Dr. Stinson reason to doubt he was taking his medications as prescribed. SIME Dr. Robinson agreed Employee's medications were appropriate so long as he exhibited no "aberrant behavior." To date, the record discloses none. Employer shall continue to pay for work-related medications Dr. Stinson prescribes, and related office visits subject to its right to controvert on new grounds. AS 23.30.095(a).

ii) Spinal cord stimulator revision.

The only other currently recommended medical care is revising Employee's spinal cord stimulator. Most medical providers agree it is reasonable and necessary for Employee to continue using his spinal cord stimulator. Dr. Stinson said on occasion, stimulator leads disconnect partially causing an unpleasant jolt or "zapping" sensation to the patient. Employee credibly testified he has this sensation, Dr. Stinson agrees and says he can resolve this by revising the spinal cord stimulator battery and possibly the leads. SIME Drs. Gritzka and Robinson both agree continuing to use the spinal cord stimulator is reasonable. Their impartial opinions are credible and achieve significant weight. AS 23.30.122; *Smith*.

Dr. Robinson offered a caveat that Employee undergo a psychological evaluation before any attempts to revise his spinal cord stimulator. However, Employee's mental health is irrelevant when it comes to repairing a malfunctioning spinal cord stimulator. Since Employer is responsible to pay costs associated with the spinal cord stimulator, it necessarily must pay for costs associated with the stimulator when it needs repair. In other words, Employee may hypothetically have a myriad of mental health issues but he would still need the spinal cord stimulator to stop zapping him. Employer will pay for the costs to revise Employee's spinal cord stimulator and he need not attend a psychiatric or psychological evaluation as a precondition.

Nevertheless, given that most prior treatment failed to provide Employee with any significant, long-lasting relief, Dr. Robinson's recommendation that Employee undergo a psychological or psychiatric evaluation before any other invasive medical treatment is sound and his recommendation is creditable. AS 23.30.122; *Smith*. Any and all future invasive treatment is preconditioned on Employee attending a psychological or psychiatric evaluation pursuant to Dr. Robinson's report. To be clear, this decision is not ordering Employee to attend a psychological or psychiatric evaluation. However, if he wants Employer to pay for any additional invasive treatment, other than his spinal cord stimulator revision, he must first attend an evaluation as outlined in Dr. Robinson's report. Employee's attending physician may refer him to an appropriate evaluator. Employer shall pay for the evaluation. AS 23.30.095(a).

7) Is Employee entitled to TTD benefits?

Employee's TTD claim is hard to pin down and is confusing. According to the September 11, 2017 prehearing conference summary, Employee seeks TTD benefits from August 1, 2003, to March 30, 2004, and in the alternative TTD or PTD from April 1, 2004, and continuing. AS 23.30.180; AS 23.30.185. *Mitchell VI* found Employee reached medical stability effective January 30, 2003, and awarded TTD benefits from December 16, 2002 through January 30, 2003. *Mitchell IX* found Employee's subsequent efforts to re-litigate TTD prior to "Employee's fusion surgery in March, 2003" barred by *res judicata*. *Robertson*. At that time, Employee claimed TTD benefits from July 31, 2003, and continuing, which *Mitchell IX* found was not barred by *res judicata*. Employee subsequently amended his TTD claim to begin April 1, 2004. This decision defers to the September 11, 2017 prehearing conference summary for the issues.

There was no "March 2003 fusion," which would have made Employee not medically stable and disabled him at least temporarily. Thus, he cannot receive TTD benefits arising from a nonexistent event. However, Employee had medical treatment that conceivably could have made him not medically stable, and disabled, which could entitle him to TTD benefits. Employer disagrees. This disagreement raises factual disputes to which the compensability presumption applies. AS 23.30.120; *Meek*. Employee raises the presumption with Drs. Stinson's, Gritzka's and Robinson's opinions. *Tolbert*. Dr. Stinson repeatedly said Employee was never medically stable after *Mitchell VI*. SIME Drs. Gritzka's and Robinson's respectively opined he was either not medically stable at some point after Employee's spinal cord stimulator began zapping him or was medically stable in 2003 but deteriorated and required more medical treatment that made him not medically stable. Employer rebuts the raised presumption with Drs. Roth's and Brown's opinions and with Dr. Chong's 2015 and 2016 opinions. *Wolfer*. They opined Employee was medically stable in 2002 or 2003. Employee must show he was not medically stable and his 1995 work injury was a substantial factor in any disability from April 1, 2004, and continuing. *Steffey*; *Saxton*.

This decision found the Dynesys surgery was not reasonable and not necessary. It also found the spinal cord stimulator was reasonable and necessary treatment. Recommended surgery may render a previously medically stable worker medically unstable and potentially disabled until he

recovers from the procedure. However, some TTD benefits Employee claims arise from "non-compensable" Dynesys surgery and other invasive treatments, while some result from a compensable spinal cord stimulator surgery. Employee claims continuing TTD benefits including periods before and between these two surgical procedures. Therefore, this decision analyses these various TTD benefit claim periods separately.

A) TTD from August 1, 2003 to March 30, 2004.

Employee's basis for this TTD claim is not clear. On July 31, 2003, the day before Employee's TTD claim begins, Employee's radiculopathy was improving. Dr. Peterson recommended conservative treatment "to avoid any surgical intervention at this point." On August 13, 2003, EME Dr. Smith found medical stability effective July 31, 2003. He also said Employee needed no surgery or other invasive treatments "at this point" but would need life-long medication and could return to work at sedentary duty on jobs for which he had been retrained, with accommodations. On September 16, 2003, Dr. Peterson reiterated Employee had no surgical indications. On October 13, 2003, Dr. Stinson agreed, "Conservative therapy should be maintained until his symptoms worsen to the point that surgical intervention was necessary, as per Dr. Peterson's previous report." On October 24, 2003, SIME Dr. Roth said Employee was medically stable by December 16, 2002, and gave him a PPI rating. On February 4, 2004, Dr. Stinson reviewed a controversion notice and Dr. Peterson's July 31, 2003 opinion and disagreed with Employer's interpretation. He referred Employee back to Dr. Peterson for reevaluation to see if Employee needed surgery. On February 13, 2004, Dr. Stinson signed a disability parking permit form, stating Employee had severe limitations in his ability to walk. On March 11, 2004, Employee had a discogram and a CT. This summarizes the significant medical evidence between August 1, 2003 and March 30, 2004.

TTD benefits are not payable after the date of medical stability. AS 23.30.185. The above summary shows Dr. Smith found Employee medically stable on July 31, 2003. *Mitchell VI* found Employee medically stable effective January 30, 2003. Employee did not provide adequate argument to show, by clear and convincing evidence that something made him medically unstable after January 30, 2003, or after July 31, 2003. AS 23.30.265(21). The medical evidence between the subject dates do not support a change in medical stability status.

Rogers & Babler. Further, TTD benefits are not payable unless Employee was disabled. AS 23.30.265(10). Blizzard's July 15, 2003 PCE concluded Employee could work at sedentary employment on a daily basis. Dr. Smith released Employee to work effective July 31, 2003. Again, Employee did not provide adequate evidence or argument showing temporary total disability from August 1, 2003 to March 30, 2004. *Steffey*; *Saxton*. Employee will not receive TTD benefits for this period.

B) TTD benefits related to the Dynesys procedure.

This period for which Employee claims TTD benefits raises a legal question: Is an injured worker who obtained "non-compensable" treatment entitled to TTD benefits associated with the treatment? To put a finer point on this, in August 2006, Employee obtained a procedure that in December 2005, *Mitchell VI* found was not reasonable and necessary. To hone it even further, *Mitchell VI* left the possibility open that additional treatment including Dynesys could be compensable in the future, and Employee obtained Dynesys before the instant decision found it was still not reasonable and necessary. Alaska law does not address this situation directly and it appears to be one of first impression.

Substantive statutes in effect in 1995 control this issue. Some general concepts apply here: Under 1995 law, compensation is payable "in respect to" an Employee's disability. AS 23.30.010. Compensation is payable "irrespective of fault" as a cause for the injury. AS 23.30.045(b). The Act defines "disability" as incapacity "because of injury" to earn the wages Employee was earning at the time of injury in the same or any other employment. AS 23.30.265(10). Lastly, "injury" is an accidental one arising out of and in the course of employment. AS 23.30.265(17).

The legislature knows how to suspend or restrict an injured worker's right to benefits. No 1995 Act provision expressly or implicitly states that an injured worker who obtains unauthorized, unreasonable or unnecessary surgical treatment forfeits his right to receive disability benefits resulting from the surgery. Had it wanted, the legislature could have excluded or limited an injured worker's right to receive TTD benefits under such circumstances. It did not. The statutory construction axiom *expression unius est exclusio alterius* applies here. This principle

suggests where certain things are designated in a statute, all omissions are understood as exclusions. Where the Act gives comprehensive and specific remedies, it implies the legislature did not intend to allow unenumerated ones. *Croft*. Such is the case with TTD benefits.

For example, AS 23.30.095(d) suspends "the payment of further compensation" during a worker's unreasonable refusal to undergo medical treatment. An injured worker's compensation may be suspended or forfeited if he unreasonably refuses to see the employer's doctor. AS 23.30.095(e). Injured workers are not entitled to TTD benefits after the date of medical stability. AS 23.30.185. TTD benefits are not payable for a week in which an injured worker also receives unemployment. AS 23.30.187. Benefits are reduced when an injured worker receives Social Security benefits. AS 23.30.225. Some injured workers are not "covered" because they are not considered "employees." AS 23.30.230. Some covered workers are not entitled to compensation if their injuries are caused by their willful intent to injure someone or where drug or alcohol intoxication causes their injury. AS 23.30.235. "Arising out of and in the course of employment" includes some things but excludes others. AS 23.30.265(2). Clearly, the legislature could have, but did not, restrict TTD benefits to disability caused by compensable medical treatment only.

Further, there is a clear legal distinction between medical and disability benefits. The Alaska Supreme Court stated an injured worker is not entitled to any and all medical care he seeks. Apart from being "necessitated by an injury," medical and related benefits must be reasonable and necessary to invoke the employer's obligation to pay. AS 23.30.265(20); *Bockness*. By contrast, no provision in the Act and no decisional law allows factfinders to determine whether disability, once found, is "reasonable." In other words, unless other statutes exclude him from coverage or payment, if the facts show the work was a substantial factor in Employee's total disability, and he is not medically stable, he is entitled to TTD benefits. In such case, compensation is simply "payable" in respect to his disability. AS 23.30.010; AS 23.30.265(10). Nothing in the law authorizes factfinders to decide surgery-related disability somehow becomes not reasonable and necessary disability even if the surgery causing the disability was unreasonable and unnecessary.

Lastly, apart from the lack of any statutory or decisional law supporting this concept, denying Employee TTD benefits if he is otherwise entitled to them because he had non-compensable medical treatment for his work injury injects "fault" into a no-fault system and inappropriately blames Employee for work-related disability. AS 23.30.045(b).

While no Alaska case is on point, decisions from other jurisdictions are instructive. One court, in a state where the employer selects a treating physician and authorizes care, held the injured worker's failure to give advance notice to the employer before obtaining surgery nullified the statute allowing the employer to have the worker examined and treated by the employer's doctor. In that instance, the employer did not have to pay disability related to the surgery. *Baeza*. Alaska does not have a similar provision and injured workers select their own physicians.

In a case factually similar to the case at bar, a New Jersey worker had a hearing and the Deputy Director found he was not a surgical candidate. Nonetheless, several months later, the employee had back surgery for his work injury. He later filed a claim for increased work-related disability following the surgery. On appeal, the court held he used reasonable care in selecting physicians and could recover compensation for increased disability resulting from the unsuccessful surgery that aggravated his original injury. The court concluded as a layman, the worker did what an ordinary person would do under the circumstances. It found the employee fully justified in following his physicians' opinions and submitting to the operation. *Janvari*.

Here, post-*Mitchell VI*, Drs. Stinson, Delamarter and Spayde all agreed Employee needed invasive treatment and encouraged him to obtain the Dynesys procedure. Dr. Delamarter told Employee the FDA had approved the Dynesys system for his intended use. Even though *Mitchell VI* had, eight months earlier found Employee needed only conservative care, Employee reasonably believed his subjective symptoms worsened in the subsequent eight months justifying, in his mind, more invasive treatment. His decision to go forward was reasonable under these circumstances.

In Arizona, another worker followed his physician's advice and had surgery intended to improve his condition. Other doctors, including the employer's examiner, had stated the worker was not a

surgical candidate. Subsequent back surgery worsened the worker's condition. The court held increased disability was compensable if the worker's decision to undergo surgery was reasonable under the circumstances and not "intentionally reckless" conduct. *Pacific Employer's.* The instant decision concluded Employee's choice to rely on three physicians and undergo Dynesys was reasonable. There is no evidence Employee's choice was intentionally reckless.

The Alaska Supreme Court, in a similarly strange situation, rejected an argument that an injured worker with a back fusion should be denied further benefits because he resisted arrest resulting in added spinal injuries. In that case, the employer argued a convalescing worker who engages in risky activities is excluded from coverage under AS 23.30.235. The court reasoned the worker, while possibly behaving recklessly, did not intend to re-injure himself by resisting arrest. The court concluded if there were to be any modification to the statute based on misconduct or reckless behavior, "the legislature should make that modification." *Debler*. This concept applies to this unusual TTD benefits issue equally well.

In some instances, disability benefits may be denied if a claimant through voluntary conduct "unconnected with his injury" takes himself out of the labor market. *Vetter*. There can be no question that Employee underwent the Dynesys surgery in an effort to reduce his symptoms arising from his work injury, at his physicians' recommendation and urging. On the other hand, Employee voluntarily underwent the Dynesys surgery. However, the surgery was still "connected" to his work injury and *Vetter* does not apply here. Thus, if Employee otherwise qualifies for TTD benefits following the Dynesys surgery, benefits are payable. AS 23.30.010.

The other relevant facts on this issue are not difficult to analyze. *Mitchell VI* in December 2005 expressly found "that the need for medical treatment at L4-L5 is related to the employee's L5-S1 fusion. . . ." Employer never disputed the L5-S1 injury. *Mitchell VI* also found "the employee continues to suffer from chronic low back pain." It said "the employee's back pain at L4-L5 is a consequence of the prior treatment for the work-related injury." It found "the need for medical treatment at L4-L5 is work-related, and . . . compensable." Employer did not appeal *Mitchell VI*.

The medical records between *Mitchell VI's* December 2005 issuance and August 10, 2006, when Employee underwent Dynesys surgery resulting in disability discloses no evidence of any intervening or superseding injury affecting Employee's low back. To the contrary, Dr. Peterson suggested a conservative approach in 2003 but conceded in 2004 that advancing technology would be available in the next "year to two years" and such treatment would "certainly offer him a better long-term outlook." On May 1, 2006, Dr. Stinson said "the work injury" directly led to Employee's then-current situation and said he needed Dr. Delamarter's recommended spinal stabilization. On May 3, 2006, Dr. Delamarter stated Employee's work injury was a substantial factor in his need for the Dynesys procedure and it was expected to improve his condition, and on June 28, 2006, reiterated that Employee needed spinal stabilization to mitigate his symptoms and prevent further degeneration. On July 25, 2006, Dr. Stinson said Employee was not medically stable, not released to work and needed spinal stabilization surgery.

On January 28, 2017, SIME Dr. Robinson unequivocally stated the 1995 work injury remained a substantial factor in Employee's ongoing low back symptoms. He could not provide an alternative cause for Employee's disability or need for treatment excluding the 1995 work injury as a cause and could not rule the injury out as a substantial factor in his disability. In addition, Dr. Robinson opined the 1995 work injury was a substantial factor in the actual lumbar spine "condition" he diagnosed. He further recognized that although Employee was initially medically stable in 2002, additional surgery could render him medically unstable again. On July 13, 2015, Dr. Gritzka said Dr. Delamarter's treatment was not unreasonable or unnecessary. While this decision does not credit Dr. Gritzka's "reasonable and necessary" opinion, his view supports the notion that Employee had a reasonable basis to obtain medical care in reliance on Drs. Delamarter's and Stinson's opinions, which Dr. Gritzka supports in retrospect. Dr. Delamarter also opined Dynesys surgery would provide Employee with spinal stability and improve or prevent slippage. As Dr. Stinson noted, vertebral slippage or the lack thereof, is objectively measurable through radiographs. These causation opinions are credible and are entitled to significant weight. AS 23.30.122; *Smith*; *Rogers & Babler*.

By contrast, Dr. Roth opined before *Mitchell VI* that Employee should not undergo Dynesys and needed no further surgery. On May 11, 2015, Dr. Brown said Dr. Delamarter's surgery was ill-

advised but not unreasonable or below the standard of care. He said it was just not related to Employee's work injury. Their causation opinions receive less weight because they offer no alternative explanation for Dr. Delamarter's surgery that rules out the work injury as a substantial factor in this treatment. Similarly, Dr. Chong's May 14, 2015 opinion gets less weight because he addressed whether the work injury was a substantial factor "in the conditions diagnosed," which is not the applicable test. AS 23.30.122; *Smith*. No physician offered a causation opinion contrary to Drs. Stinson's, Delamarter's and Spayde's opinions between *Mitchell VI*'s December 20, 2005 issuance date and the August 10, 2006 Dynesys surgery.

The record is clear that in June 2006 Employee again sought Dr. Delamarter's Dynesys procedure and in August 2006, Dr. Delamarter performed it solely to address Employee's work injury. As *Mitchell VI* found, Employee's continuing low back symptoms, which Dr. Delamarter attempted to treat with his August 10, 2006 surgery, were the direct consequence of the 1995 work injury. In other words, the work injury remained a substantial factor in Dr. Delamarter's need to treat Employee's symptoms through the Dynesys procedure. There is no question Dr. Delamarter expected some objectively measurable improvement in Employee's spinal stability through this procedure. In short, absent a statute or decisional law on point requiring a different result, though the Dynesys surgery is not compensable, the resulting disability is. Thus, given the above analysis, disability resulting from this procedure arose out of and in the course of Employee's work injury. AS 23.30.265(2), (10), (17). Compensation is payable in respect to Employee's disability from the Dynesys surgery. AS 23.30.010; *Janvari*; *Pacific Employer's*.

The next question is: For what dates are TTD benefits payable for the Dynesys surgery? *Thoeni* implies that where there is a predicted medical stability date that turns out to be wrong, TTD benefit entitlement goes back to the medical stability date the factfinders found, if the employer offers no evidence or argument proving a different date for medical stability. *Thoeni* is difficult to follow because it never discusses TTD benefits in relationship to the medical stability dispute. One must infer from reading *Thoeni*, that the injured worker was entitled to disability benefits back to the previously determined medical stability date.

Here, on December 20, 2005, *Mitchell VI* found Employee medically stable effective January 30, 2003. Only eight months after *Mitchell VI*, on August 10, 2006, Employee underwent Dynesys surgery. Employee pursued TTD benefits in his July 28, 2006 claim. In 2013, *Mitchell IX*, an interlocutory decision, found Employee's July 28, 2006 claim seeking TTD benefits from July 31, 2003, forward, was not barred by *res judicata*. It is unclear why it took seven years to decide only that the July 28, 2006 claim was still viable. It is equally unclear why it took 12 years to hear Employee's amended disability claims on their merits. Long delays between hearings in this case make the legal analysis on this issue complex and difficult. *Thoeni* is informative.

Under *Thoeni* Employee's TTD claim could reach as far back as August 1, 2003, as Employee claimed at the September 11, 2017 prehearing conference. However, unlike the employer in *Thoeni*, Employer contends Employee has been medically stable since January 30, 2003, based on *Mitchell VI*'s findings, and contends rebutting the presumption Employee remains medically stable requires "clear and convincing" evidence, which it contends Employee does not have. In this regard, Employee's case is distinguishable from *Thoeni* where the employer offered "no evidence or argument" showing medical stability during the period in question.

Mitchell VI already found, as of December 20, 2005, that nothing before that date rendered Employee medically unstable after January 30, 2003. Post-*Mitchell VI*, on January 23, 2006, Dr. Stinson said Employee was not medically stable. On February 17, 2006, he said Employee was at least 70 percent disabled. On May 1, 2006, Dr. Stinson suggested Dr. Delamarter's Dynesys surgery "may lead to increased stability" and decreased symptoms. Thus, by May 1, 2006, Dr. Stinson had said Employee was not medically stable, was disabled and needed surgery that he expected to make an objectively measurable improvement in Employee's spine stability.

Accordingly, Employee is entitled to TTD benefits from the date Dr. Stinson reexamined him and recommended surgery, May 1, 2006, until he became medically stable following the August 10, 2006 Dynesys procedure. *Thoeni*. The only physician expressly addressing medical stability post-Dynesys is Dr. Chong who on November 18, 2016, said Employee should have been medically stable within four to six months following the Dynesys surgery. Three months post-surgery on November 8, 2006, Dr. Delamarter stated Employee was much improved but still had

"some issues." Then there is a gap in the medical records. On March 26, 2007, Employee said he had undergone no physical therapy since his surgery and still had some symptoms. Based on the upper limit of Dr. Chong's medical stability opinion, the lack of significant medical treatment between November 8, 2006 and March 26, 2007, and Employee's March 26, 2007 report, he became medically stable from the Dynesys surgery effective March 26, 2007. AS. 23.30.265(21); *Rogers & Babler*. Therefore, Employee is entitled to TTD benefits from May 1, 2006, through March 26, 2007. This totals 47 weeks. Employee's TTD rate is $570.84. Therefore, Employee's gross TTD benefits for this period equal $26,829.48 (329 days / 7 = 47 weeks x $570.48 = $26,829.48). However, these benefits are subject to a Social Security disability offset, determined below, because they came after the Social Security disability award, which paid Employee benefits retroactive to 2005. AS 23.30.225(b). Employer will pay Employee net TTD benefits totaling $8,972.30 (47 weeks x $190.90 = $8,972.30) for this period.

C) TTD benefits related to spinal cord stimulator surgery.

On March 3, 2010, after Employee's symptoms continued, Dr. Stinson implanted leads for a trial, spinal cord stimulator. Employee said he felt "great," had pain relief and enjoyed better sleep. Given the positive trial results, Dr. Stinson on April 9, 2010, implanted a permanent, spinal cord stimulator. Employee's reports regarding the stimulator thereafter are also generally positive. However, by March 10, 2011, he began having difficulties with the stimulator, often corrected by a simple adjustment or reprogramming. Notwithstanding occasional problems with his stimulator throughout 2012 and 2013, Employee enjoyed symptomatic relief from the stimulator. His reports of improved symptoms are credible. AS 23.30.122; *Smith*. Dr. Stinson related the spinal cord stimulator to Employee's 1995 work injury and offered that a patient would be medically stable from a spinal cord stimulator operation "within a few weeks." Since Dr. Stinson is an expert in spinal cord stimulators and trained other physicians on their use, his opinion receives considerable weight. AS 23.30.122; *Smith*.

SIME Dr. Gritzka said the spinal cord stimulation was the most reasonable approach to Employee's chronic back pain. He found a "direct link" between the 1995 work injury and the stimulator. Dr. Gritzka specifically opined Employee was not medically stable because he had an aging spinal cord stimulator needing replacement. SIME Dr. Robinson stated Employee's

work-related disability continues and, though Employee initially became medically stable in December 2002, his spinal cord stimulator was failing and additional surgery would render him not medically stable. Dr. Robinson specifically opined the work injury remained a substantial factor and he could think of no alternative factor causing the need for his medical care and resulting disability. SIME Drs. Gritzka's and Robinson's opinions earn significant weight given their impartiality, experience and consistency with the record as a whole. AS 23.30.122; *Smith*.

Dr. Brown opined the 1995 work injury did not necessitate the stimulator, which he opined had a low likelihood of success. His opinion gets less weight because he offers no alternative explanation for the need for the spinal cord stimulator and overlooks reduced symptoms Employee had following its use. AS 23.30.122; *Smith*. Dr. Chong did not opine about causation for the spinal cord stimulator but noted it gave Employee "relief of pain" and permitted him to be more active. He did, however, state Employee reached medical stability within 45 days after each "invasive procedure." His opinion gets some weight. AS 23.30.122; *Smith*.

The evidence in totality shows Employee's physicians and SIME experts expected objectively measurable improvement from the spinal cord stimulator and all related it directly to his 1995 work injury, which remains a substantial factor in the need for this treatment. Once Dr. Stinson recommended the spinal cord stimulator trial, Employee became medically unstable again. *Thoeni*. Most examiners expected medical instability upon the procedure and from a "few weeks" up to 45 days post-surgery. Therefore, Employee is entitled to TTD benefits from the date

Dr. Stinson first recommended and implanted his trial stimulator on March 3, 2010, until 45 days following the April 9, 2010 permanent implantation, or May 24, 2010. This totals 11.71 weeks equaling $6,684.54 in gross TTD benefits (82 days / 7 = 11.71 weeks x $570.84 = $6,684.54). However, these benefits are also subject to a Social Security offset in accordance with this decision. Employee's net TTD entitlement for this period after the Social Security disability offset is $2,235.44 (11.71 weeks x $190.90 = $2,235.44).

D) TTD benefits for other periods from April 1, 2004 to the present.

Apart from the above TTD award periods, Employee claims TTD benefits from April 1, 2004 through the present, a period now exceeding 18 years. To obtain TTD for the balance of this lengthy time, Employee must show he was both disabled and not medically stable. If Employee's evidence fails on either evidentiary branch, his TTD benefit claim fails. *Mitchell VI* found Employee medically stable effective January 30, 2003. The instant decision found him medically unstable from May 1, 2006 through March 26, 2007, for the Dynesys surgery and from March 3, 2010 through May 24, 2010, for the spinal cord stimulator surgery. To obtain additional TTD benefits, Employee must show through "clear and convincing evidence" that he was no longer medically stable at times other than between these dates. AS 23.30.265(21).

With the exception of the above-referenced physician's opinions concerning the Dynesys and spinal cord stimulator surgeries, only Dr. Stinson and to a limited degree Dr. Delamarter opined Employee has never been medically stable. Their opinions on medical stability receive lesser weight given the entire record, which shows a stunning lack of objectively measurable, or even subjective improvement from other treatments during this time. AS 23.30.122; *Smith*. All the other physicians opined Employee was medically stable. Employee's medical records demonstrate that, with the two just-referenced surgical exceptions, since *Mitchell VI*, Employee's various other medical treatments were not likely to result in objectively measurable improvement from the effects of the 1995 work injury, and indeed did not. In fact, SIME Dr. Robinson noted Employee underwent "one unsuccessful procedure after another," with "stunning lack of success." Therefore, given the whole record, Employee failed to show he was medically unstable for the entire period from April 1, 2004, through the present, with clear and convincing evidence. TTD benefits are not payable after the date of medical stability. AS 23.30.185. Employee does not receive TTD benefits during these remaining periods.

8) Is Employee entitled to PTD benefits?

In the alternative, Employee claims he is entitled to PTD benefits since April 1, 2004, and continuing. AS 23.30.180. Employer claims it retrained Employee and he was and is employable but simply chose not to return to work preferring to stay home and raise his child. Both parties rely on relatively old evidence to support their PTD claim and defenses.

This issue raises factual disputes to which the compensability presumption applies. AS 23.30.120; *Meek*. Employee raises the presumption with his own testimony, Drs. Stinson's, Delamarter's and Robinson's opinions and lay evidence from Jeanne Mitchell, Kelly and Paul Smith and Daniel LaBrosse. *Tolbert*. Employee said he cannot work eight hours a day because he cannot sit or stand long enough. Jeanne Mitchell said Employee got worse following the July 2003 PCE and could not perform the three different jobs he tried post-retraining. She thought Employee's computer abilities were "dismal." Dr. Stinson repeatedly said Employee remains disabled and on May 3, 2006, said he was permanently totally disabled without surgical intervention to stabilize his spine. In 2006, Dr. Delamarter said Employee was permanently totally disabled without spine stabilization. Dr. Robinson opined Employee was likely permanently totally disabled from at least the date he examined him in early 2017. Kelly and Paul Smith both said Employee's functional capacities have diminished gradually but dramatically since 1995. Lastly, rehabilitation specialist LaBrosse said Employee could not work full time at any recognized sedentary employment within his vocational abilities.

Employer rebuts the raised presumption with Blizzard's PCE, and with Drs. Brown's, Chong's and Gritzka's and Northern Rehabilitation Services' opinions. *Wolfer*. Blizzard said Employee was capable of working at sedentary employment. Drs. Brown, Chong's and Gritzka all opined he could work at least at sedentary and possibly at light duty work based on his physical examinations. NRS said there were thousands of jobs within the Anchorage labor market for which Employee's retraining qualified him. Thus, Employee must prove his claim for PTD benefits by a preponderance of the evidence. *Steffey*; *Saxton*. This analysis considers two distinct periods:

A) PTD benefits prior to Dr. Robinson's SIME.

Employee's PTD benefits claim spans approximately 14 years from 2004 through 2018. Employee's accounts of his physical abilities prior to the period for which he seeks PTD benefits lack credibility in several respects and call into question his reliability in reporting future activates during the relevant periods. In September 1998 and March 1999, Employee told Dr. Perkins he had pain after hunting in 1998 and after butchering a moose in 1999. In October 1999, Employee told Dr. Klimow he had been hunting but had returned home because his back

hurt and he had not killed any animals, or butchered or transported any meat. Either Employee went on more than one moose hunt in 1999, or he was not completely forthright reporting his then-recent activities to Dr. Klimow. If Employee was reporting a different 1999 hunt to Dr. Klimow, his hunting activities were inconsistent with his professed limitations, which he claims have continued since his 1995 injury. If he was not forthright with Dr. Klimow, then he is simply not credible. Either way, Employee's variations raise concerns. AS 23.30.122; *Smith*.

While Employee claims he cannot sit for long, he nonetheless told a physician post-injury he volunteered for the Neighborhood Watch, riding around in automobiles for several hours at a time. Paul Smith said Employee did this activity with Smith's father Kelly though the dates were not clear. Experience teaches that automobile seats are typically not as comfortable as ergonomically designed office chairs. This Neighborhood Watch activity is inconsistent with a significant sitting limitation. *Rogers & Babler*.

Though he seeks disability benefits back to April 1, 2004, and says he could not compete with the general public for any job in the labor market, Employee admitted to occasionally hunting, fishing, boating and riding his snow machine during much of the period for which he seeks disability benefits. Though his testimony on his recreational activities was internally inconsistent, uncertain and vague, it is clear Employee said, in his own words, he rode a snow machine and went fishing in 2014, went moose hunting sometime in 2013 or 2014 and killed a moose in 2016. While Employee minimizes these activities, this behavior belies Employee's claim he cannot sit, stand, walk or function well overall. While he does not need to be in a state of "abject helplessness" to qualify for PTD benefits, Employee's activities over the years consistently demonstrate a selective ability to be active when Employee so chooses. *Roan*.

Following his spinal cord stimulator implant in 2010, Employee told his physician he "felt great" and said Dr. Stinson "saved his life." Employee said his pain improved 80 percent. Yet, Employee admitted he never applied for any job following his vocational retraining, even in 2010 after the spinal cord stimulator success because in his view he was not properly retrained. However, when he successfully finished his vocational retraining plan, including an externship, Employee completed an exit survey expressly stating he had been retrained, gained much from

his retraining and felt he could use this training and experience in his future employment. Employee's testimony again lacks credibility and gets minimal weight. AS 23.30.122; *Smith*.

Kelly and Paul Smith's testimony gets some weight. However, their testimony was understandably somewhat vague as well, since the events about which they testified occurred over a span of nearly 20 years. Kelly Smith went moose hunting with Employee anywhere from as little as five to as many as eight years ago. Kelly said Employee could dress an animal in the field. Within the past two years, Kelly assisted Employee with a moose he shot but was unable to dress until the following day. On this most recent occasion, Employee was able to move around all day but "with difficulty." Spending the night in the field, even sleeping in a pickup truck or camper, after shooting a moose and moving around all the following day is inconsistent with inability to work at a sedentary job. *Rogers & Babler*. Paul Smith knew Employee had shot at least three moose over the past few years and he too assisted in the most recent kill. While Kelly and Paul Smith are Employee's friends, their testimony did not assist his case.

Blizzard's 2003 PCE, while it does not expressly so state, necessarily refers to Employee's limitations and ability to work in an eight hour day. Experience shows many PCE reports specifically state an eight-hour duration for the patient's working ability. Blizzard's does not. However, experience also teaches it would be virtually worthless for a physical therapist to perform a PCE premised on something other than a full work day since that is the standard in reviewing disability claims. *Rogers & Babler*. Therefore, the 2003 PCE states Employee had ability to work in at least a sedentary occupation for an eight-hour day subsequent to December 2003, unless and until something changed. It receives some weight. AS 23.30.120; *Smith*.

LaBrosse is the only certified vocational rehabilitation counselor to provide current vocational evidence in this case. However, LaBrosse based his opinions primarily on Blizzard's 2003 PCE, which he said lacked a durational component. As discussed above, Blizzard's PCE contemplates an eight-hour day, contrary to LaBrosse's understanding. Furthermore, LaBrosse did not adequately explain his 50 percent "downtime" comment, which also forms the basis for his opinion that Employee could not work full-time in any recognized job within his physical and vocational limitations. LaBrosse said this downtime understanding came from Blizzard's PCE.

Blizzard's PCE does not provide for 50 percent downtime. LaBrosse later attributed this statement to SIME Dr. Robinson. Dr. Robinson's SIME report does not state Employee has 50 percent downtime, but more importantly, Dr. Robinson expressly stated he could not comment on whether Employee was permanently totally disabled in 2003 or 2004, because he did not examine him until 2017. Consequently, to the extent LaBrosse relied on Dr. Robinson's opinion to support permanent total disability for Employee since 2004, his opinion receives little weight. AS 23.30.122; *Smith*.

By contrast, in 1997 as part of Employee's retraining plan, to which he agreed, vocational rehabilitation specialists from NRS identified a viable, active labor market for sedentary to light positions as Motor Vehicle Dispatcher, Traffic Rate Clerk and Administrative Clerk. Employee's assigned specialist identified thousands of jobs in Anchorage and in Alaska generally within these fields. Dr. Perkins approved these job descriptions as something within Employee's predicted physical capabilities. Employee earned a nearly perfect grade point average in his retraining. Post-retraining, Employee returned to work briefly at three jobs. Two were at a higher exertional level than sedentary, performing surveying on road projects and cleaning ice rinks for the city. It is unclear what he did at his wife's office for the third job. Employee did not succeed at these positions but conceded he never applied for a sedentary job consistent with his retraining. While this evidence is relatively old, it is not much older than the 2003 PCE upon which Employee relies. Experience shows sedentary jobs requiring entry-level ability to use standard computer software have existed and do exist regularly and continually throughout Alaska. *Rogers & Babler*.

Medical evidence addressing Employee's ability to work during this period is all over the map. EME Dr. Smith said Employee would be employable effective April 30 2000, in conformance with a general office job with sedentary requirements. Blizzard's 2003 PCE showed Employee capable of sedentary work on a full-time "daily basis." In August 2003, Dr. Smith concluded Employee could return to sedentary duties "like" a Motor Vehicle Dispatcher or Traffic Rate Clerk with accommodations, but could not return to work as an Administrative Clerk.

Drs. Stinson and Delamarter thereafter repeatedly said Employee was not released to return to work because he was not medically stable. However, as discussed in the TTD section above, this decision discounted their medical stability opinions and set parameters for Employee's TTD benefit entitlement. While Employee could receive PTD benefits during times he was medically stable and disabled, he obtained no additional PCEs demonstrating his actual physical capacities after 2003. The May 14, 2007 Dr. Delamarter document LaBrosse referred to as a Residual Functional Capacity Assessment is not a PCE. It is a form a physician uses to estimate a patient's physical capacities based largely upon the patient's self-reporting. *Rogers & Babler*. Where Employee's physicians relied upon his self-reported limitations, their opinions concerning his disability get lesser weight because Employee lacks credibility. AS 23.30.122; *Smith*.

In 2015, Dr. Brown opined Employee could perform sedentary or possibly even light level work. Also in 2015, EME Dr. Chong noted Employee, after more than 30 minutes during his interview, had "no evidence of distress." He sat through his hearing for at least 41 minutes without getting up. Dr. Chong agreed, based on what Employee said he did around the house, Employee could work at least at a sedentary and possibly up to a light demand level. In July 2015, SIME Dr. Gritzka found Employee's physical examination compatible with working at least at a sedentary job level. SIME Dr. Robinson declined to opine on Employee's ability to work prior to his January 2017 evaluation.

In 2009, an administrative law judge found Employee disabled under the Social Security Act beginning April 1, 2004, and continuing. The judge relied on Blizzard's 2003 PCE and Employee's subjective complaints. The judge found Employee credible; the instant decision does not. The Social Security decision states it is based on the "entire record," but does not state what medical or other evidence was in the "record." The decision states Employee's "acquired job skills" do not transfer to jobs consistent with his residual functional capacity. Nowhere does the Social Security decision discuss Employee's successful vocational retraining plan. It is unknown whether the judge even knew about this plan. Lastly, the instant decision views Blizzard's July 15, 2003 PCE differently than the 2009 administrative law judge. She found it said Employee could not perform the entire range of sedentary work. But in his summary and recommendations, Blizzard said Employee could return to work at a sedentary "strength demand

level." Employee's "nonmaterial handling physical demand levels" had some limitations, but nowhere in Blizzard's 2003 PCE does he say this disqualifies Employee from the full range of sedentary work. LaBrosse testified at Employee's Social Security hearing though his testimony is not available for review. For these reasons, the Social Security decision receives little weight. AS 23.30.122; *Smith*.

Permanent total disability determinations are not based solely on medical opinions, and contrary to Dr. Chong's assertions, LaBrosse did not "practice medicine" by asserting his opinion that Employee could not work full time even in sedentary employment, and therefore was permanently totally disabled. Physicians are experts in medical conditions and procedures. They are not job experts. Physicians can estimate an injured worker's physical capacities, but a physical or occupational therapist has tests to quantify actual residual physical capabilities. But physical therapists are not job experts either. A vocational rehabilitation specialist is a job expert, but is not a physician or a physical therapist. An injured worker makes a *prima facie* PTD claim by presenting medical evidence of a work-related condition or symptom that reasonably could cause the worker's reported disability, a PCE demonstrating actual physical capacities and vocational expertise showing no jobs existing in the area for which the injured worker qualifies taking into account his medical condition, symptoms, demonstrated physical capacities and his age, education, training and work experience. *Meek*; *Carlson*.

Employer does not have to pay PTD benefits if it demonstrates "there is regularly and continuously available work in the area" suited to Employee's capabilities. *Carlson*. Accordingly, on balance the combination of Employee's credibility issues and Employer's evidence of regularly and continuously available work in the Anchorage area suitable to Employee's capabilities, demonstrated through Blizzard's 2003 PCE and Employee's subsequent activity over the years, along with the weight of medical opinion, Employee has not convincingly proven he was permanently and totally disabled from April 1, 2004, at least until Dr. Robinson's SIME evaluation. He will not receive PTD benefits for this period. *Moore*; *Steffey*; *Saxton*.

C) PTD benefits after Dr. Robinson's SIME report.

SIME Dr. Robinson saw Employee on January 28, 2017. There is a distinction between Employee's PTD claim before he saw Dr. Robinson and after. The distinction arises from Employee's medical records, his and other lay witnesses' testimony and Dr. Robinson's opinions. Employee was occasionally, but actively hunting, fishing and riding snow machines up until approximately 2016, according to his testimony, Kelly and Paul Smith's accounts, and Employee's medical records. While Employee may contend this evidence does not mean he was doing these activities regularly, a reasonable inference from the vague, inconsistent and confusing hearing testimony from Employee and the lack of specificity from his lay witnesses support this finding. *Rogers & Babler*. As analyzed in detail, above, Employee's activities at home and his recreational pursuits belie his claim for totally disabling limitations, until recently.

Dr. Robinson expressly and convincingly stated, based on his review of all the medical records and after examining him that Employee's physical capacities as of January 28, 2017, are "more likely to be less than they were as of the summer of 2003." He specifically and forcefully opined Employee "is not capable of competitive employment at this time" even at a sedentary level. His logical, well-supported opinions get significant weight. AS 23.30.122; *Smith*; *Moore*.

Other medical evidence supports Dr. Robinson's opinion. On October 10, 2016, Dr. Stinson opined Employee was having adjacent segment disease at L2-3 with increased radiculitis. In other words, Employee's adjacent segment disease is moving up his spine, as predicted by numerous physicians. On December 5, 2016, he reported increasing pain and spasms in the mid-lumbar area. Dr. Stinson opined Employee's imaging showed an eight millimeter dynamic retrolisthesis at L2-3. This is a new finding. On January 23, 2017, just days before Dr. Robinson evaluated Employee, Dr. Peterson recommended conservative treatment but noted if he has neurogenic claudication secondary to stenosis or instability, he might need a fusion from T10 to the lower lumbar segments. In short, in the last year or so, Employee's physical condition is objectively worse. These medical facts and opinions also receive substantial weight. AS 23.30.122; *Smith*.

As for causation, Dr. Robinson could find no substantial factor not related to the 1995 work injury causing Employee's current, permanent total disability. While Dr. Chong opined any ongoing disability is not related to the 1995 work injury, he focused on Employee's "perception of pain" as a cause of his disability and dismissed it as unimportant. He related degenerative changes to health habits and aging. Dr. Chong's opinions receive less weight because they stand in stark contrast to the bulk of medical opinions in this case. AS 23.30.122; *Smith*.

By contrast, Dr. Robinson convincingly explained that pain perception is precisely what disables Employee. His causation opinion that the work injury was "the substantial factor" in his current disability goes beyond the legal standard, which requires only "a substantial factor." There can be no doubt that the 1995 injury and subsequent surgeries to address it remain a substantial factor in Employee's current, permanent disability. The record is devoid of any medical opinion indicating a superseding intervening cause that eliminates the 1995 work injury as a substantial factor in Employee's disability. To the extent Employee had a preexisting spinal condition, the evidence shows the 1995 work injury aggravated, accelerated and combined with that preexisting condition to cause Employee's temporary and permanent disability. *Thurston*. But for the 1995 injury, Employee would not have become disabled at the same time, to the same degree, or to the same extent that he ultimately did. Therefore, Employee has demonstrated through substantial evidence that his 1995 work injury as a new event or as an aggravation of a preexisting condition, caused him to become permanently totally disabled effective January 28, 2017, and continuing until his situation changes. *Saxton*.

This results in Employer owing Employee past PTD benefits beginning January 28, 2017, through this decision's date, and continuing PTD benefits at the same rate so long as Employee remains in PTD status under the law. Both past and ongoing PTD benefits are subject to a Social Security offset, in accordance with this decision. Therefore, Employee's net past PTD totals $12,490.58 (458 days / 7 = 65.43 weeks PTD through May 1, 2018 x $190.90 = $12,490.58).

9) Is Employee entitled to an order finding Employer made an unfair or frivolous controversion, and is he entitled to any penalties?

Employee provided no evidence and offered no admissible argument that Employer made an unfair or frivolous controversion. He failed to provide a proper basis for this claim. The record discloses medical evidence supporting Employer's controversions. Employee has, in numerous pleadings, complained about a meeting between attorney Livsey and EME Dr. Smith. To the extent Employee contends Employer's *ex parte* visit with Dr. Smith somehow raises an actionable claim for penalties or an unfair or frivolous controversion, he provided no factual basis or legal authority for this contention. In short, Employee made no credible argument addressing his penalty and unfair or frivolous controversion issues and he has no right to relief.

10) Is Employee entitled to interest, attorney fees or costs?

A) Interest.

Employee receives statutory interest on past TTD and PTD benefits awarded in this decision. *Rawls*. Pursuant to an Excel spreadsheet, he is entitled to interest as follows:

Table V

From	To	Weeks	Midpoint	End	Comp. rate	Int. Rate	Interest
5/1/06	12/31/06	34.86	8/31/06	5/1/18	$190.90	8.25%	$6,408.71
1/1/07	3/26/07	12	2/12/07	5/1/18	$190.90	9.25%	$2,377.91
3/3/10	5/24/10	11.71	4/13/10	5/1/18	$190.90	3.5%	$630.44
1/28/17	5/1/18	65.43	9/14/17	5/1/18	$190.90	4.25%	$333.05
						Total Awarded	$9,750.11

Employer shall pay Employee interest in accordance with this decision. It shall also pay interest to medical providers whose bills this decision orders paid.

B) Attorney fees.

Employee seeks attorney fees for his lawyer's assistance in prosecuting this claim. He does not specify which subsection of the attorney fee statute applies. Employer controverted Employee's claims on numerous occasions. Therefore, this decision may award fees under AS 23.30.145(a). Attorney fees in these cases should be fully compensatory and reasonable so injured workers

have competent counsel to represent them. *Cortay*. Fees for time spent on minor issues are typically not reduced if Employee prevails on the primary issues. *Porteleki*.

Attorney fee awards must consider the nature, length and complexity of services performed and the benefits resulting from those services to Employee. AS 23.30.145(a). This was a particularly contentious case with much of the contention occurring before Harren entered his appearance on March 6, 2014. Nevertheless, the strife continued and eventually resulted in Employee through Harren suing Livsey in civil court. Most litigation began in 2002, 12 years before Harren began representing Employee. There are 15 prior decisions in this case. Harren appeared in the previous five. It is unusual for a workers' compensation case to continue in litigation for over 10 years. *Rogers & Babler*. This case was particularly lengthy. Legal services were not particularly complex though one issue is a first impression issue in Alaska. However, Harren's briefing, and for the most part his questioning and arguments, were not particularly helpful in resolving this case. *Rogers & Babler*. Some pleadings were late and consequently not considered.

As for benefits to Employee resulting from Harren's services, the result is decidedly mixed. Through May 1, 2018, Employee sought over 768 weeks in past disability benefits and, using the estimate stated in his hearing brief, $150,000 for medical care, including $80,000 for the Dynesys surgery. Had he prevailed on his entire claim, he would be entitled to approximately $388,932.02 ($146,720.02 in disability benefits + $150,000 plus for medical care + $92,212 in interest = $388,932.02). This sum takes into account $190.90 as a Social Security disability offset-reduced rate. One could argue the claimed amount would be even higher, since Employee opposed the Social Security offset but offered no contrary legal argument or numbers to counter Employer's calculations. However, for purposes of gaging "benefits" to Employee for awarding attorney fees, his Social Security opposition is a minor issue. *Porteleki*.

By contrast, out of 768 weeks requested, Employee only prevailed on 123.14 weeks of TTD and PTD benefits, worth $23,698.32, plus $9,750.11 in interest, totaling $33,448.43. Employee also sought over $80,000 in past medical benefits related to his Dynesys procedure. This decision awards him nothing for that claim. Employee prevailed on his claim for the past spinal cord

stimulator but lost on other procedures not awarded in this decision. It is difficult to determine what past spinal-cord-stimulator-related care cost. Assuming the awarded past costs for the spinal cord stimulator are roughly $45,000, Employee won approximately $78,448.23 in past benefits ($33,448.43 + $45,000 = $78,448.43) but lost on approximately $310,483.59 in past claims ($388,932.02 - $78,448.43 = $310.483.59). Employee prevailed on approximately 20 percent of his past claims, not a particularly good result. *Rogers & Babler*.

On the other hand, this decision awards Employee continuing PTD benefits so long as he remains in PTD status under the law, worth $9,926.80 per year, after the Social Security disability offset, a rate subject to revision once Employee begins to receive Social Security retirement. This is a considerable benefit to Employee. *Rogers & Babler*. He also prevails on the stimulator revision.

Given the above findings and conclusions, and all factors required in awarding a fully compensatory and reasonable attorney fee, Employer shall pay Employee 20 percent of his actual attorney fees, and shall pay him ongoing statutory minimum attorney fees on PTD benefits paid after May 1, 2018, and on the value of the stimulator revision. AS 23.30.145(a); *Cortay*.

On October 6, 2017, Harren submitted a fee affidavit reflecting 299.85 hours in attorney time at $350 per hour. Post hearing, on December 6, 2017, Harren filed another fee affidavit adding 99.3 hours in attorney time at the same rate. Employee filed the second affidavit one day late, though Employer did not object on that ground. As Employer said, 22.3 hours in the second affidavit were included in the first. This reduces the second affidavit to 77 attorney hours. Harren also recorded 28 attorney hours related to closing arguments the panel did not consider because they were filed late. Since work on the closing arguments was to no avail, 28 hours are deducted from the 77 hours leaving 49 hours. This results in 348.85 attorney hours (299.85+49 = 348.85). At Harren's $350 hourly rate, which is reasonable for an attorney with his experience, his total attorney fees equal $122,097.50 (348.85 x $350 = $122,097.50). Given the above analysis, Employer will pay Harren 20 percent of his fees, or $24,419.50, which represents fully compensatory and reasonable fees incurred through this decision's date and takes into account Employer's other objections to certain fees, as fees are reduced proportionally. *Cortay*.

C) Costs.

On October 6, 2017, Employee filed affidavits from his lawyer's paralegals. Olson's and Reimann-Giegerl's hours reflect typical paralegal duties with exception of Reimann-Giegerl's efforts transcribing a June 13, 2013 hearing, presumably *Mitchell IX*. She spent 11.53 hours on this task, which at her $180 per hour rate would cost $2,075.40. Employee did not explain how a transcript of this hearing helped his case. A transcriptionist would charge less for transcribing this hearing. *Rogers & Babler*. This is not an awardable cost. Ouzts affied for Miller, but Miller did not provide an affidavit. 8 AAC 45.180(f)(14)(D). While Ouzts explained why Miller could not provide an affidavit on short notice, there is no explanation why Miller could not have provided an affidavit if given adequate notice. Miller's costs are not awardable.

On October 6, 2017, Employee also filed an affidavit from his attorney listing various costs. Employee successfully petitioned in *Mitchell X* to strike Drs. Chong's and Holley's 2014 EME reports and opinions. Video of these doctors could not be used in any event and Employer will not pay for these related costs. Employee did not explain why Attorney's Process Service incurred $160 in costs on June 25, 2015. The undated "mileage" entry does not show for whom the mileage refers or why it is a compensable cost. These process server and mileage costs are not compensable.

Lastly, on December 6, 2017, Employee sought additional litigation costs, including Ouzts' paralegal fees from October 2, 2017, through December 5, 2017 (26.65 hours x $180 per hour = $4,797), and expenses for Harren to fly to Dr. Chong's deposition and unidentified mileage charges. Most of Ouzts' costs were reasonably incurred in assisting Harren. Unidentified mileage is not awardable. Harren's cross-examination of Dr. Chong was helpful, and this cost ($748.50) is awarded. Ouzts provided valuable assistance to Harren at hearing in a case with voluminous records. However, since Employee filed his closing arguments late, and the panel did not consider them, Employer will not pay for Ouzts' closing argument efforts.

In conformance with Tables I, II and IV, above, Employee identifies $32,597 in compensable litigation costs, including paralegal costs ($19,382.40 + $7,669.10 + $4,797 + $748.50 = $32,597). However, he did not prevail on all issues. The analysis applied to his attorney fee

claim applies to his cost claim, since most costs are paralegal fees. Therefore, Employer will pay Employee 20 percent of his total, compensable legal costs, or $6,519.40. 8 AAC 45.180.

11) Are Advanced and Pioneer entitled to medical benefits from Employer?

Advanced's and Pioneer's claims and Employer's defenses to them are confusing at best. The record shows Dr. Stinson is affiliated with Advanced. On January 14, 2010, Leticia Jensen on Advanced's behalf claimed "undetermined," but unpaid medical costs. On August 2, 2010, Jensen claimed $28,645 for Advanced for unspecified medical services. On August 26, 2010, Employer controverted a claim to medical costs other than for "conservative care," based on *Mitchell VI*. It is difficult to determine from the Controversion Notice what claim Employer was controverting. The notice does not specify a particular claim. The only clues are that the controversion followed Advanced's claim chronologically and Employer served this notice on Advanced and on Dr. Stinson, at least implying it was controverting Jensen's August 2, 2010 claim. On or about June 7, 2012, Tina Paul for Advanced requested a hearing on an unspecified claim by filing an undated Affidavit of Readiness for Hearing, notarized June 7, 2012. Advanced also filed a March 3, 2016 claim and Pioneer filed a March 16, 2016 claim as a third-party medical provider, both requesting payment for medical services rendered to Employee.

On June 18, 2012, Employer filed, as an attachment to its hearing opposition, Advanced's affidavit of Readiness for Hearing. Employer also attached an envelope showing Advanced served its hearing request and an attached itemization for services from March 3, 2010 through April 27, 2010, totaling $45,846, on Employer on June 8, 2012. This shows Employer received the hearing request and itemization for services rendered. Employer also eventually received medical records related to Advanced's services, if by no other way, through the SIME records. On August 21, 2012, Charlotte Kost, acting for both Advanced and Pioneer, requested a hearing on unspecified claims. Attached to Advanced's hearing request was an itemized bill for its services rendered to Employee from March 3, 2010, through April 27, 2010, (including a separate April 9, 2010 entry) relating to a spinal cord stimulator. Charges totaled $45,846 with $33,741.80 due. Attached to Pioneer's hearing request was an itemized statement for its services to Employee on April 9, 2010, relating to a spinal cord stimulator. Charges totaled $45,724. Both hearing requests show service only on the division. It is not clear from the record what, if

any, relationship there is or was between Advanced and Pioneer. It is equally unclear from the record if Pioneer's bill is included in Advanced's bill, or if they are separate and why Advanced's bills vary in amount.

The file does not contain an opposition from Employer to Advanced's August 21, 2012 hearing request. On August 30, 2012, Employer objected to Pioneer's hearing request on grounds its affidavit was not substantially complete, including the claim date for the requested hearing, and on grounds Employer was not ready for a hearing. Obviously, Employer received Pioneer's hearing request or it would have not needed to respond.

On March 3, 2016, Courtney Lingnofski claimed $28,625 for Advanced for services to Employee from March 3, 2010, through April 9, 2010. Again, it is unclear from the record if these are additional charges distinct from those in the 2010 claim. Also included in the attached statement were "insurance pending" charges totaling $586 for services from January 13, 2016, and January 14, 2016. On March 29, 2016, Employer denied Pioneer's March 16, 2016 claim on grounds Pioneer no longer existed. Employer further denied the request based on *Mitchell VI*, which stated Employee was only entitled to conservative care. Employer also denied it based on a time bar under AS 23.30.110(c), alleging the March 16, 2016 claim is for the same spinal cord stimulator as the July 29, 2010 claim Advanced filed and Employer controverted. Employer alleged Advanced failed to timely request a hearing.

On April 12, 2016, Employer opposed Advanced's March 3, 2016 claim in reliance on *Mitchell VI*, which limited Employee to conservative care. Employer also defended on grounds Advanced filed a July 29, 2010 claim for the same services, which Employer controverted and for which Advanced allegedly did not request a hearing within two years. Thus, Employer asserted a time bar under AS 23.30.110(c). The parties did not address this issue at hearing.

Michelle Murrills is Advanced's supervisor and a records custodian. Advanced sent Employee's lawyer all Employee's medical bills and records. It gave Employee medical records on individual visits. Advanced also provided every bill to the insurance company for Employer. Murrills is credible. AS 23.30.122; *Smith*. However, Murrills did not explain any relationship

between Advanced and Pioneer and did not purport to represent Pioneer or provide any additional information about Pioneer's claim. To make this matter more confusing, on February 5, 2013, a prehearing conference summary confirmed that Advanced's and Pioneer's claims for medical costs are included with Employee's medical cost claims.

As for the 110(c) time bar issue, the record shows Advanced's and Pioneer's representative timely requested a hearing within two years of Employer controverting their claims. Although the representative did not fully complete the form, the substantially completed hearing request satisfied the Supreme Court's requirements to request a hearing. *Kim*. Therefore, Advanced's and Pioneer's claims are not barred for failure to timely request a hearing. The division failed to give notice of the October 4 and November 21, 2017 hearings to either Advanced or Pioneer.

This decision found the past spinal cord stimulator and related expenses were reasonable, necessary and compensable and ordered Employer to pay for them. That analysis is incorporated here by reference. To the extent Advanced's claims seek benefits related to the spinal cord stimulator, Employer shall pay these benefits pursuant to the Alaska medical fee schedule. To the extent they seek other benefits this decision found unreasonable and unnecessary, Employer shall not pay those medical expenses. Since Pioneer did not receive notice of the merits hearings, and its relationship if any to Advanced cannot be determined from the existing record, this decision will not reach Pioneer's pending claim. AS 23.30.135.

12) Is Employer entitled to a Social Security offset?

Employer first petitioned for a Social Security offset on March 12, 2014. The petition was insufficient because it lacked required calculations. There is no answer from Employee in the agency file. Employer amended its March 12, 2014 petition on November 23, 2016, and provided required calculations. The amendment relates back to the original petition. 8 AAC 45.050(e). On December 13, 2016, Employee answered the petition but provided no alternative calculations all the while disputing Employer's. He reserved any defenses to the petition and contended it was not yet ripe. Nevertheless, on September 11, 2017, the parties agreed the Social Security offset petition was an issue for hearing. Employee provided no admissible briefing or argument on this issue.

It is undisputed Employee's Social Security disability benefits relate to his work injury. It is also undisputed Employee's Social Security disability benefits began April 1, 2009; they presumably continue. As Employer's calculations are correct, and Employee provided no contrary facts or arguments, Employer's November 23, 2016 petition shall be granted. Employer is entitled to a $379.94 Social Security offset. AS 23.30.225(b).

This decision awards Employee past TTD benefits from May 1, 2006 through March 26, 2007, and from March 3, 2010 through May 24, 2010. Since Employee's Social Security disability benefits began in December 2005, Employer gets an offset on TTD and PTD benefits payable in this decision. The offset also applies to PTD benefits beginning January 28, 2017, and continuing so long as Employee remains permanently totally disabled. Effective December 2005, Employee's time loss shall be paid at $190.90 per week ($570.84 weekly rate - $379.94 Social Security offset = $190.90), subject to revision upon his retirement. AS 23.30.225(a).

13) Is Employer entitled to an order declaring Employee's benefits suspended or forfeited?

Employer did not present evidence or adequate argument on this issue. While it filed two petitions to compel Employee to sign releases, one on November 15, 2016, and another on June 21, 2017, it cannot be determined from the agency file whether the request applies to these or to some other petition. Assuming the request applies to the above-mentioned petitions, the petitions are not "evidence" proving the matter asserted. Thus, Employer abandoned this issue.

CONCLUSIONS OF LAW

1) The oral order denying Employer's request for an order requiring Employee to be physically present at hearing was correct.
2) The oral order to not consider Employee's hearing brief Exhibit 3 was correct.
3) The oral order granting Employer's request to prohibit Employee's non-attorney representative from advocating at hearing was correct.
4) The oral order giving Employee additional time to file attorney fee and cost documentation, and giving Employer time to object, was correct.
5) The medical records stricken in *Mitchell X* are not admissible for this hearing.

6) Employee is entitled to additional medical care.

7) Employee is entitled to TTD benefits.

8) Employee is entitled to PTD benefits.

9) Employee is not entitled to an order finding Employer made an unfair or frivolous controversion, and he is not entitled to any penalties.

10) Employee is entitled to interest, attorney fees or costs.

11) Advanced is entitled to medical benefits from Employer.

12) Employer is entitled to a Social Security offset.

13) Employer is not entitled to an order declaring Employee's benefits suspended or forfeited.

ORDER

1) Employee's request for medical benefits related to the Dynesys surgery is denied.

2) Employee's request for past TENS units, IDET procedures, injections, radiofrequency rhizotomies and similar invasive treatments and past physical therapy is denied.

3) Employee's request for past medical benefits for his spinal cord stimulator is granted.

4) Employer shall pay for revision of Employee's spinal cord stimulator revision.

5) Employee's right to any other further invasive treatment is preconditioned on his evaluation by a psychologist or psychiatrist to whom his attending physician may refer him.

6) Employer retains all defenses in respect to future claims for invasive medical care.

7) Employee's claim for TTD benefits is granted in part and denied in part.

8) Employer shall pay Employee past TTD benefits from May 1, 2006, through March 26, 2007, totaling $8,972.30 and from March 3, 2010, through May 24, 2010, totaling $2,235.44. Employee's claim for all other past TTD benefits is denied.

9) Employer shall pay Employee past PTD benefits from January 28, 2017 through May 1, 2018, totaling $12,490.58. Employee's claim for all other past PTD benefits is denied.

10) Employer shall pay Employee ongoing PTD benefits beginning May 2, 2018 and continuing so long as Employee remains permanently totally disabled.

11) Employee's request for an order finding Employer made an unfair or frivolous controversion and his claim for penalties are denied.

12) Employee's request for interest is granted. Employer shall pay Employee $9,750.11 in interest set forth in Table V and interest to medical providers whose services this decision awards.

13) Employee's request for attorney fees and costs is granted in part and denied in part. Employer shall pay Employee's attorney $24,419.50 in attorney fees and $6,519.40 in litigation costs, including paralegal fees. Harren's other past attorney fees and costs are denied.

14) This decision does not affect any right attorney Croft may have to claim attorney fees and costs pursuant to his lien, as he was not noticed or a party to the hearing.

15) Employer shall also pay Harren statutory minimum fees on all PTD benefits paid to Employee beginning May 2, 2018.

16) Employer shall pay Advanced's past medical bills related to the spinal cord stimulator, regular examinations for prescription medication refills and diagnostic imaging for Employee's low back. Any past claims for diagnostic imaging of Employee's neck are denied.

17) Employer shall pay for diagnostic imaging for Employee's October 2016 lumbar spine imaging including a CT myelogram.

18) Pioneer's claim is held in abeyance as the division did not serve Pioneer with a hearing notice.

19) Employer's request for a Social Security disability offset is granted. The past and ongoing benefits awarded in this decision shall be paid at a $190.90 weekly rate. Employee's ongoing PTD rate is subject to revision upon Employee's entitlement to Social Security retirement benefits.

20) Employer's request for an order suspending Employee's benefits is denied.

Dated in Anchorage, Alaska on May 1, 2018.

ALASKA WORKERS' COMPENSATION BOARD

/s/
William Soule, Designated Chair

BRADLEY EVANS, MEMBER, CONCURRING IN PART AND DISSENTING IN PART

Member Evans concurs with the chair on issues 1 through 6 and 8 through 13, creating a majority opinion on these issues. However, with due respect he dissents from the chair's and Member Shaw's opinion on issue 7, regarding Employee's right to receive TTD benefits during disability periods arising from non-compensable medical treatment, as follows:

7) Is Employee entitled to TTD benefits?

After *Mitchell VI* found the Dynesys procedure was neither reasonable nor necessary, Employee eight months later undertook that procedure at his own risk. Several physicians and *Mitchell VI* specifically found Employee should not undergo this procedure because it was not FDA approved. *Mitchell VI* based its decision to limit Employee to conservative care on credible and persuasive expert medical opinions from several doctors who recommended against having this surgery. Nevertheless, Employee insisted on obtaining the Dynesys System and went forward with an unproven procedure that the record shows did not provide significant, long-term benefit. The Designated Chair and Member Evans agree Employer does not have to pay for this procedure. However, contrary to the Designated Chair's and Member Shaw's opinions, there is no applicable statute or regulation providing for disability benefits in this circumstance and Employer should not have to pay for disability related to this procedure. Employee's claim for TTD benefits from May 1, 2006, through March 26, 2007, should be denied.

/s/
Bradley Evans, Member

NANCY SHAW, MEMBER, CONCURRING IN PART AND DISSENTING IN PART

Member Shaw concurs with the chair on issues 1 through 5 and 7 through 13, creating a majority opinion on these issues. In respect to Employee's PTD benefit claim for periods during which he was medically stable and not entiled to TTD benefits, this concurrence concludes Employee may

have prevailed on his PTD benefits claim on an earlier date had he properly prepared and presented his claim for these benefits. Nevertheless, given the evidence and arguments presented, this concurrence agrees with the majority's PTD benefit claim result.

However, with due respect Member Shaw does not concur in the finding that Employee lacks credibility and does not concur that the evidence supports a description of the Employee as actively engaged in hunting, fishing and riding snow machines since his injury date. These observations do not change the outcomes outlined in the sections of the majority opinion with which she concurs. Further, she dissents from the chair's and Member Evans' opinion on issue 6, with respect to Employee's right to receive past medical benefits as follows:

(6) Is Employee entitled to additional past or future medical care?

Member Shaw's dissent would award Employee all requested past medical treatments in accordance with the Alaska medical fee schedule. Employee's physicians were doing the best they could to alleviate Employee's chronic pain. Dr. Stinson regularly tested Employee for malingering and determined he was not a charlatan. Their treatments were successful for short periods and, were within the realm of medically accepted options according to several physicians. Furthermore, Employee's attending physicians followed the conservative-treatment-first model, consistent with the goal to reduce Employer's costs. They only pursued the Dynesys surgery as a last resort when Employee's symptoms did not improve and to prevent further deterioration. Neither Employee nor his attending physicians should be penalized for trying conservative care first. This decision should include requiring Employer to reimburse Employee for the Dynesys procedure, which is compensable because Drs. Peterson, Stinson and Delamarter recommended this care. The majority found Employee reasonably relied on their advice when he obtained the treatment. It also found Dr. Delamarter performed this surgery solely in relation to Employee's work injury and there were no superseding intervening causes necessitating this treatment. This is substantial evidence supporting Employee's claim for this medical care.

Other reasonable attempts to reduce Employee's pain include the TENS unit, IDET procedures, numerous injections, radiofrequency rhizotomies and similar invasive treatments. The majority denies these treatments. Several physicians opined these were all within the realm of medically

acceptable options to treat Employee's symptoms from his work injury. Physical therapy is a common adjunct to enhance core strengthening and past therapy should also be compensable in this case. This dissent would award all these benefits to Employee and to his providers in accordance with the Alaska medical fee schedule. AS 23.30.095(a).

/s/
Nancy Shaw, 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 Stephan C. Mitchell, employee / claimant v. United Parcel Service, employer; Liberty Mutual Fire Insurance Company, insurer / defendants; Case No. 199523875; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on May 1, 2018.

/s/
Nenita Farmer, Office Asst.