ALASKA WORKERS' COMPENSATION BOARD

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

JASON GUYLL, Employee, Claimant, v. THE ODOM COMPANY, Employer, and HARTFORD FIRE INSURANCE COMPANY, Insurer, Defendants.	FINAL DECISION AND ORDER AWCB Case No. 201914494 AWCB Decision No. 21-0118 Filed with AWCB Anchorage, Alaska on December 14, 2021.

Jason Guyll's April 15, 2021 workers' compensation claim (WCC) was heard in Anchorage, Alaska on November 4, 2021, a date selected on September 9, 2021. A June 16, 2021 hearing request gave rise to this hearing. Attorney Robert Bredesen appeared and represented Jason Guyll (Employee). Attorney Aaron Sandone appeared and represented The Odom Company and Hartford Fire Insurance Company (Employer). Employee appeared and testified. Janet Osorno Guyll, Employee's wife, also appeared and testified. The record was held open until November 12, 2021 for Employee's attorney's supplemental attorney fee affidavit and Employer's objections to that affidavit.

ISSUES

Employee contends the work injury is the cause of his current right lower extremity pain and the substantial cause of his disability and need for medical treatment. He contends a spinal cord

stimulator (SCS) recommended by his treating physician is reasonable and necessary medical treatment. He further contends there is an undisputed opinion a SCS is treatment which falls within the realm of medically accepted options and is thus reasonable.

Employer contends the work injury is not the substantial cause of Employee's current lower extremity pain and disability. It contends although the work injury remains one factor, it is Employee's psychosocial factors that are the substantial cause.

1. **Is Employee entitled to a SCS?**

Employee contends he is entitled to attorney fees and costs

Employer did not express an opinion on Employee's attorney fees and costs. It is assumed it is opposed to the award of attorney's fees and costs.

2. **Is Employee entitled to attorney fees and costs?**

FINDINGS OF FACT

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

1) On October 14, 2019, Employee was seen at the emergency room for low back pain and pain radiating down his right leg. He reported having developed low back pain one month prior while working as a truck driver, a job in which he was required to lift heavy items frequently. He was lifting a package and twisting to the right when the injury occurred. This low back pain had been constant ever since. The morning of October 14, 2019, he felt his back "pop" and then had sharp pains down his right leg. (ER physician Kevin Del Duca, M.D.'s note, October 14, 2019).

2) On October 14, 2019, on referral from Dr. Del Duca, a magnetic resonance imaging (MRI) study was performed to assess Employee's back pain. At L5-S1, there was a large right paracentral disc protrusion with likely extruded fragment measuring 9.5mm causing significant compression and posterior deviation of the traversing right S1 and S2 roots. (MRI report, October 14, 2019).

3) On October 17, 2019, orthopedic surgeon Samuel Adams, M.D., of Pioneer Peak Orthopedics noted Employee was using a cane and was in considerable pain, rated as 9/10 or 10/10 and

constant. Dr. Adams diagnosed Employee with intervertebral disc disorder with right S1 radiculopathy and explained disc herniations typically go away on their own. He ordered an L4-5 interlaminar epidural steroid injection and prescribed Gabapentin. (Adams' clinic note, October 27, 2019).

4) On November 1, 2019, Dr. Adams performed a right S1 nerve root block. (Adams' clinic note, November 1, 2019).

5) On November 4, 2019, Employee followed up with Dr. Adams and reported his pain was substantially decreased, down to a 1 out of 10. Dr. Adams arranged for Employee to participate in physical therapy for lumbar, core strengthening and hyperextension exercises for disc herniation. (Adams' clinic note, November 4, 2019).

6) On December 16, 2019, Employee's ongoing symptoms included numbness in the lateral aspect of his right foot as well as pain with certain activities. He also complained lower back and right butt cheek pain. Dr. Adams decided Employee had attempted multiple conservative measures but was unable to go back to full duty work. The decision was made to proceed with surgery. (Adams' clinic note, December 16, 2019).

7) On December 19, 2019, Dr. Adams performed a right L5-S1 microdisectomy. (Operative report, December 19, 2019).

8) On January 21, 2020, Employee's lumbar spine MRI showed status post right laminotomy at L5 with postoperative scar and inflammation with no changes suggesting arachnoiditis. There was an early recurrent protrusion slightly to the right at L5-S1 with mild posterior displacement of the right S1 nerve without high-grade mass effect. (MRI report, January 21, 2020).

9) On March 17, 2020, on referral from Dr. Adams, orthopedic surgeon Curtis Mina, M.D., of Orthopedic Physicians Alaska, evaluated Employee for a second opinion. Dr. Mina reviewed Employee's medical records and imaging studies and noted inflammatory changes surrounding the S1 nerve root. He recommended a transforaminal epidural injection at L5-S1 and conservative measures. Dr. Mina referred Employee to Algone, an interventional pain clinic. (Mina's clinic note, March 17, 2020).

10) On April 13, 2020, on referral from Dr. Mina, anesthesiologist Mathew Peterson, M.D., of Algone Interventional Pain Clinic, evaluated Employee. He planned a lumbar transforaminal epidural steroid injection (ESI) to treat Employee's lumbar radiculopathy. He noted this

procedure was urgent and medically necessary as there is only a window of time to properly treat the affected nerve. (Peterson's clinic note, April 13, 2020).

11) On April 20, 2020, Dr. Peterson performed the right L5-S1 transforaminal ESI. (Peterson's clinic note, April 20, 2020).

12) On May 5, 2020, Employee reported no pain relief from the ESI. Dr. Peterson ordered an electromyography (EMG) test and a caudal epidural ESI. (Peterson's clinic note, May 5, 2020).

13) On May 29, 2020, physiatrist Jared Kirkham, M.D., examined Employee in an Employer's Medical Evaluation (EME). He reviewed the medical records and performed a physical examination. Dr. Kirkham diagnosed Employee with right S1 radiculopathy, manifesting as right leg pain, reduced sensation in an S1 distribution, and absent right Achilles reflex, due to a disc herniation at L5-S1, caused by the September 11, 2019 work injury. He also diagnosed Employee with a history of anxiety and depression and post-traumatic stress disorder (PTSD), tobacco use, and obesity. Dr. Kirkham suggested an electromyography (EMG) of the right lower extremity would be helpful to determine whether there was active radiculopathy. He opined the substantial cause of Employee's current disability and need for treatment remained the September 11, 2019 work injury. He agreed with Dr. Peterson a trial of caudal epidural steroid injection would be reasonable. Dr. Kirkham opined Employee had not reached medical stability but would in two to four weeks as long as the EMG did not reveal any active nerve root injury that would require further surgical intervention. (EME report, May 29, 2020).

14) On June 9, 2020, Shawn Johnston, M.D., who is board certified in pain medicine, physical medicine, and rehabilitation and electrodiagnostic medicine, performed Employee's bilateral lower extremities EMG study, which revealed a chronic right S1 radiculopathy. Dr. Johnston suggested Employee might benefit from a caudal epidural injection. (Johnston EMG report, June 9, 2020).

15) On June 29, 2020, Dr. Peterson performed a caudal ESI for Employee's right lower extremity radiculopathy. (Peterson's clinic note, June 29, 2020).

16) On July 13, 2020, Employee followed up with physician assistant Jane Sonnenburg, PA-C, of Algone Pain Management. PA Sonnenburg noted Employee had experienced no relief from the June 29, 2020 caudal ESI. She recommended a repeat caudal ESI with catheter to direct the injection to the adhesions around the nerve. She opined if this did not provide relief, Employee might need a SCS. (Sonnenburg's clinic note, July 13, 2020).

17) On July 22, 2020, Dr. Peterson recommended a psychology evaluation in anticipation of a SCS in the event a second caudal ESI with catheter targeting was not successful. (Peterson's clinic note, July 22, 2020).

18) On July 27, 2020, Employee received a caudal ESI for his right S1 radiculopathy. (Peterson's clinic note, July 27, 2020).

19) On August 5, 2020, Dr. Kirkham evaluated patient for a second time. He reviewed the updated medical records and performed a physician examination. He opined Employee's September 11, 2019 injury had reached medical stability. He opined Employee's case was significantly confounded by psychosocial factors, including anxiety and depression and negative pain beliefs, which were contributing to his degree of pain and disability out of proportion to the objective findings. He further opined these psychological factors were unrelated to the work injury. Dr. Kirkham stated the intervention which had the highest likelihood of success was a multidisciplinary pain management program. He opined neither the spinal cord stimulator recommended by Dr. Peterson or the L5-S1 fusion mentioned by Dr. Adams were likely to result in any long-term improvement in Employee's pain and function. He maintained, according to the medical literature, lumbar fusion and spinal cord stimulation had low success rates for failed back surgery syndrome, with a 35% success rate for lumbar fusion after 15 months and a 37% success rate (defined as 50% leg pain relief) at two years for failed back surgery syndrome. Dr. Kirkham stated one study published in 2010 showed a lower success rate (10%) for the spinal cord stimulator in the workers' compensation population. He opined a spinal cord stimulator would be an acceptable medical option under the particular facts of this case, as there is fair evidence for spinal cord stimulation in managing patients with failed back surgery syndrome. An L5-S1 fusion would also be an acceptable medical option if all other efforts, including a spinal cord stimulation failed. However, he opined both options would be unlikely to be successful in Employee due to the recalcitrant nature of his symptoms and the superimposed psychosocial facts influencing his pain and degree of disability. Dr. Kirkham opined the September 11, 2021 work injury substantially caused the disc herniation with radiculopathy and Employee still had a residual radiculopathy. However, he also opined Employee's persistent symptoms were overwhelmingly influenced by psychosocial factors, which were unrelated to the work injury. He stated although the work injury was a contributing cause to Employee's current presentation, the substantial cause was psychosocial factors. Dr. Kirkham rated Employee's

permanent partial impairment (PPI) as a result of his work injury at 11% whole person impairment according to the AMA *Guides to the Evaluation of Permanent Impairment*, Sixth Edition. (EME report, August 5, 2020).

20) On August 12, 2020, Employee reported having received no pain relief from the July 27, 2020 caudal ESI. PA-C Sonnenburg recommended a spinal cord stimulator. (Sonnenburg clinic note, August 12, 2020).

21) On September 2, 2020, psychiatrist Ellen Halverson, M.D., on referral from Dr. Peterson, evaluated Employee in an outpatient psychiatric diagnostic interview secondary to pursuing a spinal cord stimulator. Dr. Halverson reviewed Employee's medical history, including work injury, chronic pain, current mild episode of major depressive disorder, anxiety, and chronic post-traumatic stress disorder (PTSD). Dr. Halverson noted Employee was symptomatic with his depression, trauma issues and anxiety issues, but those were longstanding. She concluded Employee was an appropriate candidate for the proposed spinal cord stimulator from a mental health standpoint. She concluded he did not have unreasonable expectations or mental health issues that would interfere. (Halverson report, September, 2, 2020).

22) On October 5, 2020, Dr. Adams noted Employee had no back pain, but did have leg pain which caused him to have a hard time driving long distances, bending over, or twisting repeatedly. Dr. Adams opined Employee should continue to pursue a SCS trial. (Adams' clinic note, October 5, 2020).

23) On February 15, 2021, Dr. Peterson noted despite lumbar surgery Employee continued to have right leg pain and was looking for further treatment options. Employee's January 21, 2020 MRI showed degenerative disc disease, most severe at L5/S1 with impingement of the L5 and S1 nerve roots. In addition, the June 9, 2020 EMG was consistent with S1 radiculopathy. Employee reported his pain was constant with intermittent flare ups. The pain was characterized as hot, burning, shooting, numbness and tingling and included right foot and leg numbness and tingling. These symptoms were aggravated by many activities of daily living, including climbing stairs, sneezing/coughing, driving, rising from a seated position, sitting, standing, walking, lying flat on his back, and putting on socks and shoes. Dr. Peterson also reviewed the treatment Employee had received to date for his right leg pain, which included the nonsteroidal anti-inflammatory (NSAID) Ibuprofen, which was not effective, and the opiate Hydrocodone, which was only effective after his December 2019 surgery. Employee had participated in

physical therapy for two months prior to surgery and four months after surgery, but the physical therapy was not successful in reducing his right leg S1 radiculopathy pain. Employee had used a transcutaneous electrical nerve stimulation (TENS) unit, heat, and ice, none of which reduced his right leg radiculopathy pain and disability. Employee had had one transforaminal lumbar ESI and two caudal ESI's, none of which reduced his reported right leg symptoms. Employee was currently taking the nerve pain medication Lyrica. Based on Employee's previously tried and failed interventions, Dr. Peterson again recommended a SCS trial. (Peterson's clinic note, February 15, 2021).

24) On March 25, 2021, Employer controverted a SCS medical treatment. (Controversion, March 25, 2021).

25) On April 15, 2021, Employee filed his workers' compensation claim (WCC) for temporary total disability, medical and transportation costs, and attorney fees. (WCC, April 15, 2021).

26) On May 6. 2021, Employer controverted SCS medical treatment. (Controversion, May 6, 2021).

27) On July 26, 2021, Dr. Peterson noted Employee had tried both Cymbalta and Amitriptyline for his depression, but the Cymbalta caused insomnia and the Amitriptyline was not effective. Dr. Peterson treated Employee with a right sciatic nerve block. (Peterson's clinic note, July 26, 2021).

28) On August 2, 2021, Dr. Kirkham again examined Employee. He reviewed his updated medical records and conducted a physical examination. He noted PA-C Sonnenburg's recommendation for a SCS, and Dr. Halverson's opinion Employee was an appropriate candidate from a mental health standpoint. Employee reported to Dr. Kirkham there had been no change in his symptoms since August 5, 2021, the date of the last EME. Employee reported sharp pain on the lateral aspect of his right thigh and occasional numbness along his lateral right foot. Employee also reported he is only able to drive about one hour before his pain became too severe. He felt his leg was like driving around a dead weight. Dr. Kirkham diagnosed right S1 radiculopathy due to the work injury but opined he did not have any radicular symptoms in an S1 distribution. Although he did have an absent right Achilles reflex and altered sensation along the right lateral foot, which were consistent with a prior history of right S1 radiculopathy, the vast majority of his radiculopathy had resolved and reached medical stability. The diagnosis of chronic right lateral thigh pain was unclear, as it did not clearly fit an S1 distribution. Dr.

Kirkham opined his right lateral thigh pain was not substantially caused by the work injury, but a combination of non-injury factors including age, genetics, obesity, deconditioning, tobacco use, and psychosocial factors. He could not clearly relate the right lateral thigh pain to the S1 radiculopathy as the pain did not seem to follow an S1 distribution. Dr. Kirkham suggested because Employee's tenderness to superficial palpation along the right lateral thigh, without other corresponding neurological deficits on exam to suggest a neurologic source to his symptoms, his current symptoms were not substantially caused by the work injury. However, Dr. Kirkham could not completely rule out the work injury as the substantial cause of Employee's current need for treatment. (EME report, August 2, 2021).

29) On August 17, 2021, in response to a letter from Employee's attorney, Dr. Adams noted after Employee's December 19, 2019 surgery he continued to have pain in his right lateral thigh and numbness in an S1 distribution in his right foot. He had tried medications, therapy and injections with no significant relief and had been offered a spinal cord stimulator and fusion. However, Dr. Adams opined he did not believe either a spinal cord stimulator or fusion were likely to give him significant benefit. Dr. Adams agreed with EME physician Dr. Kirkham's recommendation for a referral to a multidisciplinary pain management program and support of Employee's psychological factors that contribute to his ongoing pain. (Adams' letter, August 17, 2021).

30) On October 15, 2021, Dr. Kirkham testified in a deposition. His August 5, 2020 opinion was Employee's dysfunction and symptoms related to his work injury had plateaued and reached medical stability and his ongoing pain was highly influenced by psychosocial factors so that the substantial cause of his ongoing pain and disability was the psychosocial factors, although the work injury remained a contributing factor. In his August 2, 2021 EME, Employee's symptoms seemed to be different than the 2020 evaluation. Employee had more lateral thigh pain, which was not entirely consistent with an S1 radiculopathy. It is possible Employee's lateral thigh pain could be a manifestation of S1 nerve root irritation in the lumbar spine. This is because the dermatomes, which are the distributions of pain from the nerve root injury or irritation of the lumbar spine are not completely specific. They overlap. It is possible S1 nerve root pain could be manifesting along the side of the leg. Dr. Kirkham could not rule out the work injury as a substantial factor in the right lateral thigh pain, but he thought it was unlikely it was a substantial factor. He thought an alternative cause for the right lateral thigh pain was nervous system

hypersensitivity, which was substantially caused by a variety of psychosocial factors, such as anxiety and depression, thoughts about pain and disability, et cetera. Dr. Kirkham admitted the work injury may have aggravated psychosocial factors in the first place. The psychological factors would be the anxiety, depression, PTSD, suicide attempt, et cetera. The psychosocial factors are the social context in which this occurs, the workers' compensation environment, the work environment, relationship with coworkers, and the fact it is a litigated case. All those factors can influence pain and sometimes those factors are so prominent they are the primary pain drivers. It is possible the work injury affected the psychosocial factors. However, psychosocial issues generally precede a chronic pain complaint, rather than vice versa. On average, considering all the literature regarding SCS, Dr. Kirkham said it would be something to consider for somebody with persistent radicular type pain. His concern in Employee's case is his current pain is not entirely consistent with ongoing nerve root irritation in the lumbar spine, and if it's not consistent with that, then he is less likely to get benefit from a SCS. Dr. Kirkham testified it is not completely unreasonable for a trial SCS, but the substantial cause of the need for the SCS was not the work injury, but instead is primarily psychosocial factors. He also testified spinal cord stimulators are not used to treat psychosocial conditions. (Kirkham deposition, October 15, 2021).

31) On November 4, 2021, Employee testified at hearing. He was born in Alaska. He joined the Army reserves and was deployed to Iraq. He was diagnosed with anxiety and PTSD in 2017. Before 2017 he had been diagnosed with minor depression, and he struggled with depression most of his life. He has been in counseling since 2017 for depression and PTSD through the Veterans Administration (VA). He is currently not taking any medication for depression. He received his commercial drivers' license (CDL) in April 2015. His work injury occurred when he was on the back of his truck getting a product that was behind some pallets. He climbed over the pallets, bent down, retrieved the product, then straightened up and turned to the right. When he turned, he felt a pop in his back and pain that went all the way down his right leg. He went for treatment to the VA but was told the pain would probably resolve without treatment, so he continued to work. About a month later, when he was in bed, he moved his leg and suddenly felt a bigger pop in his back than he had felt in the incident at work a month prior. He felt major pain and lost all the strength in his leg. About an hour later the pain was no better, so his ex-wife took him to the emergency room. Employee testified he had participated in the physical therapy

prescribed by Dr. Adams, which helped with getting his strength back, but did nothing to alleviate the pain in his lower back and on the side of his thigh. The injections prescribed by Dr. Adams did not alleviate the pain. After his December 19, 2019 microdiscectomy Employee said his back pain improved, but the pain on the side of his thigh persisted. Dr. Adams then referred Employee to Dr. Mina, who gave him three options, exploratory surgery, fusion, or a pain clinic. Both Dr. Mina and Employee felt the pain clinic would be the best bet and he started treating with Dr. Peterson at the Algone pain clinic. The injections administered by Dr. Peterson did not provide any relief from his pain, expect for one injection which was delivered directly to the nerve in the leg instead of the back, which provided relief for one day. Then the pain came back. Anti-inflammatory medication did not help with his pain, and pain medications are not an option for him as he does not like the way they make him feel. Employee testified his symptoms as described in Dr. Peterson's February 15, 2021 clinic note as a hot, burning, shooting, numbness, and tingling of the right leg and foot was accurate and had been present since the December 19, 2019 surgery. He also testified his pain continued to be aggravated by climbing stairs, sneezing/coughing, driving, rising from a seated position, sitting, standing, walking, laying flat on his back, and putting on socks and shoes. When asked about Dr. Peterson's February 15, 2021 clinic note describing Employee putting decreased weight on his right leg and having a slow, cautious, antalgic gait, Employee testified he does walk with a slight limp due to the numbness in his right foot and leg and the pain in his right thigh, which continues. Employee had discussed Dr. Kirkham's opinions with Dr. Peterson and in particular the possibility his mental condition might be playing a role. This did not affect Dr. Peterson's treatment recommendations. Employee testified he receives counseling at the VA every two weeks. He has been evaluated by Dr. Kirkham three times. Employee disputed Dr. Kirkham's statement in his deposition that in his most recent EME on August 2, 2021, Employee no longer had posterior leg pain consistent with radiculopathy. Employee stated he had had the burning, pain, and numbness in the side of his right thigh since his work injury and even before the surgery. Employee's condition had plateaued about one month after the surgery. He had not improved since that time. Employee testified he had been willing to go to one of the multidisciplinary pain clinics in the lower 48 recommended by Dr. Kirkham. The adjustor for Employer gave him three clinic names, but when his wife contacted the clinics, she learned none of them accepted workers' compensation insurance. Employee understands the SCS procedure's risks and benefits

and despite the risks and the potential for lack of benefit, he wants to proceed as he had a duty to his family to be the best he can be. This is the reason he pursues counseling and back treatment. (Hearing record, November 4, 2021).

32) Employee is credible. (Observation, experience).

33) On November 4, 2021, Janet Osnoros Guyll, Employee's wife, credibly testified at hearing she and Employee had known each other for five to six years and they have been married for two years. She testified Employee could no longer do any outdoor activities such as hiking, camping or outdoor activities. He cannot ride his motorcycle or drive a car for long periods. She now does most of the driving. Their marriage has been affected tremendously, and their love life has also been affected due to the injury. He has been more depressed since the injury and his inability to return to work, as he is a hard worker. Employee lost his CDL because he could not pass the physical due to his leg pain. She felt Employee should have the SCS despite the risk involved. She disagreed with Dr. Kirkham's statement in his August 5, 2020 EME report that Employee had reduced motivation and a negative sense of self advocacy. She testified if Employee was not motivated, they would not be there today trying to advocate for a spinal cord stimulator. She stated Employee had been cooperating with any treatment recommendations and was very motivated to get better. (Hearing record, November 4, 2021; observation, experience).

34) On October 28, 2021, Employee's attorney submitted his affidavit documenting over 20 years' experience as a lawyer, overwhelmingly involving workers' compensation cases arising under Alaska law. Employee's attorney is a solo practitioner and does not employ a paralegal, so he is only able to take on a limited number of clients. Any case that requires depositions and hearings limits his ability to take on new clients' cases. He also submitted his attorney fee affidavit itemizing the hours devoted to Employee's case starting on August 12, 2020 through August 28, 2021, for a total of $17,865.00 as well as costs of $151.70, for a total of $18,016.70. (Attorney fee affidavit, October 28, 2021).

35) On November 9, 2021, Employee's attorney submitted his supplemental fee affidavit totaling 8.7 hours for a total of $3,915.00. (Attorney fee affidavit, November 9, 2021).

36) Employer made no objection to attorney fees or costs at hearing or while the record remained open. (Record.)

PRINCIPLES OF LAW

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

> **AS 23.30.095. Medical treatments, services, and examinations**. (a) The employer shall furnish medical . . . treatment . . . medicine . . . for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. It shall be additionally provided that, if continued treatment or care or both beyond the two year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require.
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> (o) Notwithstanding (a) of this section, an employer is not liable for palliative care after the date of medical stability unless the palliative care is reasonable and necessary (1) to enable the employee to continue in the employee's employment at the time of treatment, (2) to enable the employee to continue to participate in an approved reemployment plan, or (3) to relieve chronic debilitating pain. A claim for palliative care is not valid and enforceable unless it is accompanied by a certification of the attending physician that the palliative care meets the requirements of this subsection . . . .

When the board reviews a claim for medical treatment made within two years of an undisputed work-related injury, its review is limited to whether the treatment sought is reasonable and necessary. *Philip Weidner & Associates, Inc. v. Hibdon*, 989 P.2d 727 (Alaska 1999). *Hibdon* addressed reasonable medical treatment:

> The question of reasonableness is 'a complex fact judgment involving a multitude of variables.' However, where the claimant presents credible, competent evidence from his or her treating physician that the treatment undergone or sought is reasonably effective and necessary for the process of recovery, and the evidence is corroborated by other medical experts, and the treatment falls within the realm of medically accepted options, it is generally considered reasonable. (Citations omitted.) *Id.* at 732.

When reviewing a claim for continued treatment beyond two years from the injury date, the Board has discretion to authorize "indicated" medical treatment "as the process of recovery may require." *Id.* With this discretion, the Board has latitude to choose from reasonable alternatives

rather than limited review of the treatment sought. *Id.*

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

Under AS 23.30.120(a), benefits sought by an injured worker are presumed to be compensable, and the burden of producing evidence it is not is placed on the employer. *Sokolowski v. Best Western Golden Lion Hotel*, 813 P.2d 286, 292 (Alaska 1991). The presumption of compensability applies to any claim for compensation under the Act. *Meek v. Unocal Corp.*, 914 P.2d 1276, 1279 (Alaska 1996). An employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski* at 292.

A three-step analysis is used to determine the compensability of a worker's claim. At the first step, the claimant need only adduce "some" "minimal" relevant evidence establishing a "preliminary link" between the injury claimed and employment. *McGahuey v. Whitestone Logging, Inc.*, 262 P.3d 613, 620 (Alaska 2011). The evidence necessary to attach the presumption of compensability varies depending on the claim. In claims based on highly technical medical considerations, medical evidence is often necessary to make that connection. *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). In less complex cases, lay evidence may be sufficiently probative to establish causation. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Witness credibility is not weighed at this step in the analysis. *Resler v. Universal Services Inc.*, 778 P.2d 1146, 1148-49 (Alaska 1989).

At the second step, once the preliminary link is established, the employer has the burden to overcome the presumption with substantial evidence. *Smallwood* at 316. To rebut the presumption, an employer must present substantial evidence that either (1) something other than work was the substantial cause of the disability or need for medical treatment or (2) work could not have caused the disability or need for medical treatment. *Huit v. Ashwater Burns, Inc.*, 372 P.3d 904 (Alaska 2016). "Substantial evidence" is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 611-

12 (Alaska 1999). At the second step of the analysis, the employer's evidence is viewed in isolation, without regard to the claimant's evidence. Issues of credibility and evidentiary weight are deferred until after a determination whether the employer has produced a sufficient quantum of evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051, 1054 (Alaska 1994); *Wolfer* at 869-870.

If the employer successfully rebuts the presumption, it drops out, and the employee must prove all elements of his case by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381. At this last step of the analysis, evidence is weighed, and credibility considered. To prevail, the claimant 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 *Morrison v. Alaska Interstate Construction Inc.*, 440 P.3d 224 (Alaska 2019), the court said the board must consider the different causes of the "benefits sought" and the extent to which each cause contributed to the need for the specific benefit at issue. The board then must identify one cause as "the substantial cause." Morrison held the statute does not require the substantial cause to be a "51% or greater cause, or even the primary cause, of the disability or need for medical treatment." The board need only find which of all causes, "in its judgment is the most important or material cause related to that benefit." (*Id*.). Morrison further held that preexisting conditions, which a work injury aggravates, accelerates, or combines with to cause disability or the need for medical treatment, can still constitute a compensable injury. (*Id.* At 234, 238-39).

> **AS 23.30.122. Credibility of witnesses**.
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> 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). When doctors' opinions disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.*, AWCAC Decision No. 087 (August 25, 2008).

> **AS 23.30.145. Attorney fees.**
> (a) Fees for legal services rendered in respect to a claim are not valid unless approved by the board, and the fees may not be less than 25 percent on the first $1,000 of compensation or part of the first $1,000 of compensation, and 10 percent of all sums in excess of $1,000 of compensation. When the board advises that a claim has been controverted, in whole or in part, the board may direct that the fees for legal services be paid by the employer or carrier in addition to compensation awarded; the fees may be allowed only on the amount of compensation controverted and awarded. When the board advises that a claim has not been controverted, but further advises that bona fide legal services have been rendered in respect to the claim, then the board shall direct the payment of the fees out of the compensation awarded. In determining the amount of fees the board shall take into consideration the nature, length, and complexity of the services performed, transportation charges, and the benefits resulting from the services to the compensation beneficiaries.
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> (b) If an employer fails to file timely notice of controversy or fails to pay compensation or medical and related benefits within 15 days after it becomes due or otherwise resists the payment of compensation or medical and related benefits and if the claimant has employed an attorney in the successful prosecution of the claim, the board shall make an award to reimburse the claimant for the costs in the proceedings, including reasonable attorney fees. The award is in addition to the compensation or medical and related benefits ordered.

Wise Mechanical Contractors v. Bignell, 718 P.2d 971, 974-75 (Alaska 1986), held attorney fees should be reasonable and fully compensatory, considering the contingency nature of representing injured workers, in order to ensure adequate representation. *Bignell* required consideration of a "contingency factor" in awarding fees to employees' attorneys in workers' compensation cases, recognizing attorneys only receive fee awards when they prevail on a claim. *Id*. at 973. *Bignell* instructed the board to consider the nature, length, and complexity of services performed, the resistance of the employer, and the benefits resulting from the services obtained, when determining reasonable attorney fees for the successful prosecution of a claim. *Id*. at 973, 975. *Rusch v. Southeast Alaska Regional Health Consortium*, 453 P.3d 784 (Alaska 2019), stated the AS 23.30.120 presumption does not apply to attorney fee amounts or reasonableness. It held the board must consider all factors set out in Alaska Rule of Professional Conduct 1.5(a) when determining a reasonable attorney fee and either make findings related to each factor or explain why that factor is not relevant. *Rusch* held when attorneys perform their own paralegal work,

they must be paid at the rate of an attorney. *Rusch* also held attorney fee reasonableness is not a factual finding but is a discretionary exercise.

> **AS 23.30.395. Definitions**. In this chapter,
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> (28) "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;
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> **8 AAC 45.180. Costs and attorney's fees**.
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> (b) . . . An attorney seeking a fee from an employer for services performed on behalf of an applicant must apply to the board for approval of the fee; the attorney may submit an application for adjustment of claim or a petition. An attorney requesting a fee in excess of the statutory minimum in AS 23.30.145(a) must (1) file an affidavit itemizing the hours expended, as well as the extent and character of the work performed, and (2) if a hearing is scheduled, file the affidavit at least three working days before the hearing on the claim for which the services were rendered; at the hearing, the attorney may supplement the affidavit by testifying about the hours expended and the extent and character of the work performed after the affidavit was filed. If the request and affidavit are not in accordance with this subsection, the board will deny the request for a fee in excess of the statutory minimum fee, and will award the minimum statutory fee.
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> (d) The board will award a fee under AS 23.30.145(b) . . . .
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> > (1) A request for a fee under AS 23.30.145(b) must be verified by an affidavit itemizing the hours expended as well as the extent and character of the work performed, and, if a hearing is scheduled, must be filed at least three working days before the hearing on the claim for which the services were rendered; at hearing the attorney may supplement the affidavit by testifying about the hours expended and the extent and character of the work performed after the filing of the affidavit. Failure by the attorney to file the request and affidavit in accordance with this paragraph is considered a waiver of the attorney's right to recover a reasonable fee in excess of the statutory minimum fee under AS 23.30.145(a), if AS 23.30.145(a) is applicable to the claim, unless the board determines that good cause exists to excuse the failure to comply with

this section.
. . . .

ANALYSIS

1) Is Employee entitled to medical treatment in the form of a spinal cord stimulator?

Employer initially accepted Employee's September 11, 2019 work injury as compensable and paid indemnity and medical benefits. Employee requests a SCS medical benefit for pain and disability caused by his S1 radiculopathy. AS 23.30.095(a). Employee's treating physician PA Sonnenburg recommended a SCS on July 13, 2020, in the event Employee did not receive pain relief from the planned July 27, 2021 catheter directed caudal ESI. Employee's treating physician Dr. Peterson also recommended a SCS on July 22, 2020, if the caudal ESI was unsuccessful. A psychiatric examination determined Employee was an appropriate SCS candidate. Employee's claim for a SCS was made on April 15, 2021, within two years of the injury date. Therefore, Employee sought and filed a claim for a SCS well within two years of his September 11, 2019 injury. Consequently, it must be determined whether the SCS is reasonable and necessary for the process of recovery. *Hibdon*. Employee has presented credible evidence from his treating physicians, PA Sonnenburg and Dr. Peterson that the SCS is reasonable and necessary. AS 23.30.122. Neither Dr. Kirkham nor Dr. Adams opined a SCS was outside the realm of medically accepted options. Thus, Employee has met the *Hibdon* requirement to show SCS medical treatment is reasonable and necessary. This places a heavy burden on Employer to demonstrate a SCS is neither reasonable and necessary, nor within the realm of acceptable medical options, which it has failed to do. Although he later changed his mind, on October 5, 2020, Dr. Adams believed a SCS was an acceptable medical option and directed Employee to pursue a SCS. Dr. Kirkham said the dermatome pain distribution of a lumbar spine nerve root injury or irritation is not completely specific and spinal dermatome pain distributions may overlap. He acknowledged Employee's S1 nerve root pain could be manifesting along the side of the leg despite his opinion Employee's pain was related to psychosocial factors because it did not follow the S1 dermatome. Thus, following *Hibdon*, there is no reason to second guess the consensus reached between Employee and his treating physicians Peterson and Sonnenberg regarding his reasonable and necessary treatment options. Dr. Peterson confirmed, even if Employee has psychosocial issues, he has evidence of S1 nerve root pain and, having failed all

other treatments, a SCS is reasonable and necessary for Employee's recovery process.

In the alternative, if these facts do not meet the *Hibdon* criteria, a strict presumption analysis will be applied to Employee's request for SCS medical treatment. AS 23.30.120; *Meek; Sokolowski*. .

Without regard to credibility, Employee raises the presumption of compensability for SCS treatment through his own testimony regarding his pain and disability and with treating physicians PA Sonnenburg's and Dr. Peterson's opinions a SCS is medically necessary to treat Employee's pain and disability resulting from his chronic S1 radiculopathy caused by the September 11, 2019 work injury. *Resler*; *Wolfer*; *McGahuey*; *Smallwood*.

Because Employee raised the presumption, Employer must rebut it and may do so with substantial evidence that either: (1) provides an alternative explanation excluding work-related factors as a substantial cause of the disability; or (2) directly eliminates any reasonable possibility employment was a factor in the disability. *Huit*. Substantial evidence is the amount of relevant evidence a reasonable mind might accept as adequate to support a conclusion. *Miller*. Without regard to credibility, Employer does rebut the presumption for the SCS with Dr. Kirkham's opinion Employee's current pain and disability is not substantially caused by the work injury, but rather due to psychosocial factors which preceded the work injury. *Huit*; *Smallwood*; *Tolbert*; *Norcon*. Dr. Adams' opinion agreeing with Dr. Kirkham's assessment also rebuts the presumption. *Id.*

Because Employer rebutted the presumption, the analysis proceeds to the third step, where Employee must prove by a preponderance of the evidence his work injury is the substantial cause of his need for SCS medical treatment. *Koons*. At this stage, evidence is weighed, inferences are drawn from the evidence and credibility is determined. *Saxton*.

PA Sonnenburg's and Dr. Peterson's opinions are given more weight than Dr. Kirkham's and Dr. Adams' opinions. AS 23.30.122. Both have expertise in pain management. Dr. Peterson is an anesthesiologist who specializes in interventional pain management. He has treated Employee

over many months since April 2020, when he was referred by Dr. Mina for pain management after his surgery. Dr. Peterson referred Employee for an EMG, which was performed on June 6, 2020 and demonstrated a chronic S1 radiculopathy. PA Sonnenburg is also a pain management specialist. When conservative measures including physical therapy, medications, a TENS unit, heat, and ice, and multiple ESIs, all failed to lessen or adequately manage Employee's pain and disability due to his S1 radiculopathy, PA Sonnenburg recommended a SCS. Dr. Peterson concurred and recommended a SCS when all conservative measures had failed. Employee's treating physicians recommended a SCS to treat Employee's chronic S1 radiculopathy, which had been verified by EMG.

Dr. Kirkham could not rule out the work injury as a substantial factor in causing Employee's ongoing right leg pain and disability. However, in his opinion, it was a contributing factor and the substantial cause is psychosocial factors such as Employee's preexisting depression, anxiety and PTSD. However, Dr. Kirkham also acknowledged the work injury may have aggravated these psychosocial factors. Dr. Kirkham conceded he could not rule out the work injury as a substantial factor in Employee's right lateral thigh pain as it was not "entirely" consistent with an S1 radiculopathy. He stated it was possible Employee's lateral thigh pain could be a manifestation of S1 nerve root irritation as the distributions of pain from the nerve root injury or irritation are not completely specific. Dr. Kirkham identified an alternative cause for Employee's right lateral thigh pain; specifically, nervous system hypersensitivity caused by psychosocial factors, which he believes are the substantial cause of Employee's disability and need for medical treatment. Treating physician Dr. Adams' opinion neither a SCS nor fusion were likely to give Employee significant benefit because his pain and disability are significantly confounded by psychosocial factors also rebuts the presumption.

When determining whether work is the substantial cause of the need for medical treatment, the relative contributions of different causes must be evaluated. Employee's age, genetics, and preexisting anxiety, depression, and PTSD are likely factors in increasing his right leg pain and disability and his need for SCS medical treatment. However, based on: 1) treating physicians PA Sonnenburg's and Dr. Peterson's opinions a SCS is reasonable and necessary to treat Employee's S1 radiculopathy; 2) Dr. Kirkham's admissions S1 radiculopathy may manifest in the lateral

thigh; 3) Employee's credible testimony his S1 radiculopathy had manifested in his right lateral thigh since even before the surgery; and 4) the board's knowledge and experience, Employee has demonstrated by a preponderance of the evidence the substantial cause of his disability and need for SCS medical treatment to treat his chronic S1 radiculopathy is the September 11, 2019 work injury with Employer. *Morrison*; *Moore*; *Rogers & Babler*.

2) Is Employee entitled to attorney fees and costs?

Employee is requesting attorney fees. Where Employee has successfully prosecuted a claim or obtained a benefit, an award of attorney fees is permitted. AS 23.30.145(a). 8 AAC 45.180. Employee's attorney successfully obtained an order for medical treatment. This case involves complex issues of causation and numerous medical records. *Rogers & Babler*. Employee prevailed on his claim for SCS medical treatment. Employer controverted Employee's claim, which allows this decision to award actual attorney fees. AS 23.30.145(a). Employee submitted two itemized fee affidavits totaling $21,780 in attorney fees and $151.70 in costs for a grant total of $21,931.70. 8 AAC 45.180(b).

In addition to reviewing the work done, *Rusch* requires the eight factors in Alaska Rule of Professional Conduct 1.5(a) to be reviewed in determining a reasonable fee:

1. The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal services properly:

Employee's WCC for a spinal cord stimulator involved the complex issue of causation involving Employer's defense that psychosocial factors, not the work injury, was the substantial cause of Employee's pain. Employee's brief provided a thorough analysis of *Hibdon*'s application and the basis for giving Dr. Kirkham's opinion's less weight in the presumption analysis.

2. The likelihood the acceptance of the particular employment will preclude other employment by the lawyer:

To some extent, time spent working on any client's case prevents an attorney from spending time on another client's case. In his affidavit, Employee's attorney stated his is a solo practice and he does not employ a paralegal, so he is only able to take on a limited number of cases. He also stated any case which required depositions and hearings will necessarily limit his ability to take on other new cases.

3. The fee customarily charged in the locality for similar services:

Employee's attorney charges $450.00 per hour as of January 2020. Employee's attorney provided evidence the $450 per hour rate has recently been approved in one case for a highly experienced attorney in *Barbaza v. State*, AWCB Decision No. 20-0058 (July 15, 2020). *Rogers & Babler.*

4. The amount involved and the results obtained:

Employee's attorney was successful in obtaining an order for SCS medical treatment. There was no evidence presented regarding the medical costs for a SCS.

5. The time limitations imposed by the client or by the circumstances:

In his affidavit, Employee's attorney did not identify any unusual time limitation imposed by the client or the circumstances.

6. The nature and length of the professional relationship with the client.

Employee's attorney has represented him since August 12, 2020 but did not file his entry of appearance until February 17, 2021. This factor may favor either an increased fee or a decreased fee, depending on the particular case's facts. In this case Employee's attorney did not address how the length of his professional relationship with Employee would affect the fee.

7. The experience, reputation and ability of the lawyer or lawyers performing the services:

Employee's attorney has practiced law for over 20 years, and his practice has overwhelmingly involved workers' compensation cases arising under Alaska law. He is an an experienced workers' compensation attorney.

8. Whether the fee is fixed or contingent:

Virtually all fees for employee attorneys in workers' compensation are contingent. The contingent nature of the work is considered in determining an appropriate hourly rate.

Employee is entitled to payment of reasonable attorney fees for 39.7 hours at $450 per hour, or $17,865, plus costs of $151.70, for a total of $18, 016.70 based on his October 28, 2021 attorney fee affidavit and invoice. He is also entitled to payment of the reasonable attorney fees of $450 per hour for 8.7 hours totaling $3,915.00 based on the November 9, 2021 supplemental attorney fee affidavit and invoice. Employee is entitled to a total of $21,931.70 in attorney fees and costs. Considering the time expended, and the results obtained, this is a reasonable, fully compensatory amount. *Bignell*.

CONCLUSIONS OF LAW

1) Employee is entitled to a SCS.
2) Employee is entitled to attorney fees and costs.

ORDER

1) Employee's April 15, 2021 WCC for SCS medical treatment is granted.
2) Employer shall pay for all medical expenses preliminary to and associated with a spinal cord stimulator trial. Upon Employee's satisfactory completion of all his prerequisites to a spinal cord stimulator trial, and if the trial is successful, Employer shall pay all medical expenses attendant with a permanent spinal cord stimulator pursuant to the fee schedule.
3) Employee is entitled to an award of attorney fees and costs in the amount of $21,931.70.

Dated in Anchorage, Alaska on December 14, 2021.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Judith DeMarsh, Designated Chair

/s/
Sara Faulkner, Member

/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 JASON GUYLL, employee / claimant v. THE ODOM COMPANY, employer; HARTFORD FIRE INSURANCE COMPANY, insurer / defendants; Case No. 201914494; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by certified US Mail on December 14, 2021.

/s/
Kimberly Weaver, Office Assistant II