Alaska Workers' Compensation Appeals Commission

Stephan C. Mitchell, Appellant/Cross-Appellee, vs. United Parcel Service and Liberty Mutual Fire Insurance Company, Appellees/Cross-Appellants.	Final Decision Decision No. 272 December 6, 2019 AWCAC Appeal No. 18-009 AWCB Decision No. 18-0042 AWCB Case No. 199523875

Final decision on appeal from Alaska Workers' Compensation Board Final Decision and Order No. 18-0042, issued at Anchorage, Alaska, on May 1, 2018, by southcentral panel members William Soule, Chair, Nancy Shaw, Member for Labor, and Bradley Evans, Member for Industry.

Appearances: Richard L. Harren, Law Offices of Richard L. Harren, PC, for appellant, Stephan C. Mitchell; Nora G. Barlow, Barlow Anderson, LLC, for appellees, United Parcel Service and Liberty Mutual Fire Insurance Company.

Commission proceedings: Appeal filed June 25, 2018; cross-appeal filed July 10, 2018; briefing completed June 25, 2019; oral argument held August 28, 2019.

Commissioners: James N. Rhodes, Amy M. Steele, Andrew M. Hemenway, Chair *pro tempore*.

By: Andrew M. Hemenway, Chair *pro tempore*.

1. Introduction.

This case is on appeal from the most recent of sixteen decisions by the Alaska Workers' Compensation Board (Board) relating to a back injury incurred by Stephan C. Mitchell in 1995 while he was employed by United Parcel Service (UPS).[1] Through its

[1] *See Mitchell v. United Parcel Serv.*, Alaska Workers' Comp. Bd. Dec. No. 02-0182 (Sept. 12, 2002) (*Mitchell I*); *Mitchell v. United Parcel Serv.*, Alaska Workers' Comp. Bd. Dec. No. 02-0195 (Sept. 27, 2002) (*Mitchell II*); *Mitchell v. United Parcel Serv.*, Alaska Workers' Comp. Bd. Dec. No. 02-0239 (Nov. 21, 2002) (*Mitchell III*); *Mitchell v. United Parcel Serv.*, Alaska Worker's Comp. Bd. Dec. No. 03-0060 (Mar. 18, 2003) (*Mitchell IV*);

insurer, Liberty Mutual Fire Insurance Company, UPS accepted liability for the injury. In *Mitchell VI*, the Board found that Mr. Mitchell was medically stable as of January 30, 2003, and that on the evidence before it only conservative medical care was appropriate. The Board retained jurisdiction to resolve any future disputes regarding medical care.

On January 20, 2006, Mr. Mitchell filed a claim asking the Board to authorize implantation of a Dynesys spinal stabilization device, and on March 3, 2006, he filed a petition for modification of *Mitchell VI*, asserting that the Board had mistakenly failed to authorize that treatment. Before either petition was heard, Mr. Mitchell obtained the Dynesys surgery at his own expense on August 10, 2006. In *Mitchell XIII*, on the basis of the record considered by the Board in *Mitchell VI*, the Board denied Mr. Mitchell's petition to modify *Mitchell VI*, leaving his claim for authorization of the Dynesys treatment for decision in a subsequent hearing.

Mr. Mitchell filed additional claims for temporary total disability (TTD) and permanent total disability (PTD) benefits, as well as for payment for the Dynesys surgery he had obtained in 2006.[2] Following a hearing, the Board issued *Mitchell XVI*. In that

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Mitchell v. United Parcel Serv., Alaska Workers' Comp. Bd. Dec. No. 05-0224 (Sept. 1, 2005) (*Mitchell V*); *Mitchell v. United Parcel Serv.*, Alaska Workers' Comp. Bd. Dec. No. 05-0333 (Dec. 20, 2005) (*Mitchell VI*); *Mitchell v. United Parcel Serv.*, Alaska Workers' Comp. Bd. Dec. No. 06-0024 (Jan. 30, 2006) (*Mitchell VII*); *Mitchell v. United Parcel Serv.*, Alaska Workers' Comp. Bd. Dec. No. 06-0045 (Feb. 27, 2006) (*Mitchell VIII*); *Mitchell v. United Parcel Serv.*, Alaska Workers' Comp. Bd. Dec. No. 13-0123 (Oct. 7, 2013) (*Mitchell IX*); *Mitchell v. United Parcel Serv.*, Alaska Workers' Comp. Bd. Dec. No. 14-0049 (Apr. 7, 2014) (*Mitchell X*); *Mitchell v. United Parcel Serv.*, Alaska Workers' Comp. Bd. Dec. No. 14-0161 (Dec. 12, 2014) (*Mitchell XI*); *Mitchell v. United Parcel Serv.*, Alaska Workers' Comp. Bd. Dec. No. 15-0040 (Apr. 9, 2015) (*Mitchell XII*); *Mitchell v. United Parcel Serv.*, Alaska Workers' Comp. Bd. Dec. 15-0085 (July 22, 2015) (*Mitchell XIII*); *Mitchell v. United Parcel Serv.*, Alaska Workers' Comp. Bd. Dec. No. 15-0102 (Aug. 20, 2015) (*Mitchell XIV*); *Mitchell v. United Parcel Serv.*, Alaska Workers' Comp. Bd. Dec. No. 16-0051 (June 28, 2016) (*Mitchell XV*); *Mitchell v. United Parcel Serv.*, Alaska Workers' Comp. Bd. Dec. No. 18-0042 (May 1, 2018) (*Mitchell XVI*).

[2] Mr. Mitchell filed claims for TTD benefits on July 28, 2006 (beginning July 31, 2003) and July 31, 2008 (beginning July 13, 2003). *Mitchell XVI* at 26, No. 138; at 30, No. 170; R. 998-999, 1018-1019. On June 14, 2010, Mr. Mitchell filed an amended claim for TTD benefits (beginning July 31, 2003, through March 31, 2004) and for PTD benefits (beginning April 1, 2004). *Mitchell XVI* at 33, No. 192; R. 1040-1041. In *Mitchell*

decision the Board found that the Dynesys treatment was not reasonable and necessary. However, it awarded TTD benefits from the time the Dynesys treatment was recommended by Mr. Mitchell's treating physician through the date of his recovery from the surgery. The Board awarded PTD benefits effective January 28, 2017.

Mr. Mitchell appeals, asserting that the Board erred in finding that the Dynesys surgery was not reasonable and necessary, and in not finding that his permanent disability began at an earlier date. UPS filed a cross-appeal, arguing that the Board erred in awarding TTD payments.

We conclude that there is substantial evidence to support the Board's findings regarding permanent disability. We also conclude that there is substantial evidence to support the Board's decision to deny payment for the Dynesys treatment, and we deny UPS's cross-appeal. Accordingly, we affirm the Board's decision.

2. Factual background and proceedings.[3]

Stephan C. Mitchell incurred a back injury in 1995 while employed by UPS.[4] UPS paid TTD benefits beginning October 31, 1995.[5] On February 27, 1996, Dr. Lawrence Dempsey performed a laminectomy and discectomy at the L5-S1 level of Mr. Mitchell's spine.[6]

In 1997, Mr. Mitchell began a vocational rehabilitation program.[7] He was found physically capable of working as an administrative clerk, motor vehicle dispatcher, and

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IX, the Board ruled that all three claims were timely and were not barred by *res judicata*. *Id.* at 32-42.

[3] We make no factual findings. We state the facts as found by the Board in its various decisions, adding context and detail by citation to the record.

[4] *See Mitchell XVI* at 6, No. 1.

[5] *Mitchell XVI* at 6, No. 2.

[6] *Mitchell XVI* at 7, No. 5.

[7] *Mitchell XVI* at 8, No. 14.

traffic rate clerk.[8] Labor market surveys in 1997 and 1999 confirmed that there were jobs available in these categories within the Anchorage labor market.[9]

On October 27, 1999, Dr. Davis Peterson performed a fusion at L5-S1.[10] Both Dr. Peterson and an employer's medical examiner deemed Mr. Mitchell medically stable and employable in some capacity in April 2000.[11] Dr. Peterson referred Mr. Mitchell to Dr. Lawrence W. Stinson for pain management.[12] After recovering from his fusion surgery, Mr. Mitchell resumed his vocational rehabilitation program and successfully completed an externship in computer skills in April 2000.[13] He has not applied for or obtained employment since then.[14]

After a CT test in April 2001 showed an incomplete fusion, Dr. Peterson and an employer's medical examiner recommended a second spinal fusion and deemed Mr. Mitchell to be no longer medically stable.[15] On August 20, 2001, Dr. Peterson performed a revision fusion at the L5-S1 level.[16] Dr. Stinson performed rhizotomies at the L3, L4, and L5 levels in April 2002.[17] At a visit to Dr. Stinson on June 5, 2002, Mr. Mitchell reported that he had bent over to tie his shoe when he felt a "pop" in his lumbar region.[18] Dr. Stinson initially diagnosed instability and transitional disc syndrome

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8 *Mitchell XVI* at 7, No. 12.

9 *Mitchell XVI* at 8, No. 13; at 9, No. 24.

10 *Mitchell XVI* at 11, No. 39.

11 *Mitchell XVI* at 12, Nos. 48, 52.

12 *Mitchell XVI* at 12, No. 53.

13 *Mitchell XVI* at 11, Nos. 40-42, 45-46; at 12, Nos. 49-51.

14 *Mitchell XVI* at 53-54, Nos. 283, 284.

15 *Mitchell XVI* at 14, Nos. 65, 66.

16 *Mitchell XVI* at 14, No. 67.

17 *Mitchell XVI* at 14, No. 68. The record includes evidence that Dr. Stinson also performed facet joint injections at L4-L5 in March 2002. R. 13445.

18 *Mitchell XVI* at 14, No. 69; R. 9050, R. 6544 (June 15, 2002). Mr. Mitchell reported to his physical therapist that the incident had occurred at the end of their May 23, 2002, therapy session. R. 3373.

at the L4-L5 level.[19] After diagnosing a lateral annular tear at the L4-L5 level on July 31, 2002,[20] Dr. Stinson performed an intra-distal electrothermal treatment at the L4-L5 level in August 2002 and rhizotomies at the L3, L4, and L5 levels in November 2002.[21] Following the latter treatment, Dr. Stinson reported on December 16, 2002, that "[h]is lumbar symptoms are essentially asymptomatic now."[22] Dr. Stinson's treatments provided brief improvement in Mr. Mitchell's symptoms, but no lasting relief or improvement.[23]

On June 2, 2003, Dr. Joella Beard performed electromyography tests and noted reinnervation in the L4-L5 distribution;[24] she recommended flexion-extension x-rays to check for instability.[25] The x-rays were taken on June 23, 2003; the radiologist found no "significant sublaxation," but Dr. Stinson was of the opinion that the x-rays showed posterior spondylolisthesis.[26] On July 31, 2003, Dr. Peterson assessed improving L4-L5 radiculopathy, and chronic low back pain likely related to transitional changes at the L4-L5 level.[27] In the absence of "obvious forward listhesis, dynamic stenosis, claudication

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[19] *Mitchell XVI* at 14, Nos. 69, 70.

[20] *Mitchell XVI* at 15, No. 73; R. 6597.

[21] *Mitchell XVI* at 15, Nos. 74, 79. Dr. Stinson also provided diagnostic joint injections at the L3-L4 and L4-L5 levels in October 2002. *Id.*, No. 78.

[22] R. 539 (December 16, 2002).

[23] *Mitchell XVI* at 15, No. 80.

[24] The Board's medical examiner, Dr. Alan C. Roth, testified this "is a positive sign sometimes suggesting healing of the nerves." Alan Roth, M.D., Dep., Sept. 1, 2005, at 19:10-13.

[25] *Mitchell XVI* at 16, No. 84. According to his physical therapist's note dated May 23, 2002, "[f]unctional X rays were taken in flexion and extension with significant translation noted at L4 5 indicating instability at this level." R. 3373. *See also* R. 3375 (June 5, 2002). We have not identified a record of functional x-rays prior to June 23, 2002.

[26] *Mitchell XVI* at 16, Nos. 85, 86 (June 23, 2003). Dr. Peterson characterized the radiologist's report as showing "motion at L4-5" and "slight retrolisthesis of about 2 mm." R. 3423. The radiologist's report in the record does not include that language. R. 3419. *See* n. 25, *supra*.

[27] *Mitchell XVI* at 17, No. 89 (July 31, 2003); R. 3424.

pain or pathological hypermobility at L4-5," he recommended conservative (non-surgical) treatment "at this point."[28] Dr. Douglas G. Smith examined Mr. Mitchell on July 11, 2003, on behalf of UPS. In his August 13, 2003, report he concurred with Dr. Peterson's opinion that "there are not surgical interventions indicated at this point." He stated, based on Dr. Peterson's July 31, 2003 note, "The instability which was felt important by Dr. Stinson on [the] most recent x-rays has not led to a need for further surgery." He concluded that Mr. Mitchell was medically stable as of July 31, 2003, when he was seen by Dr. Peterson.[29] Dr. Smith concluded, based on a report from the physical therapist, Alan Blizzard, to whom he had referred Mr. Mitchell, that Mr. Mitchell was capable (with accommodations) of sedentary work as a traffic rate clerk or motor vehicle dispatcher, but not light work as an administrative clerk.[30]

On September 16, 2003, Dr. Peterson reported that Mr. Mitchell had "no clear surgical indications from a neurological standpoint" and suggested that he "try to manage his pain conservatively as long as possible and avoid consideration of [fusion] at the L4-5 level since . . . this could certainly lead to transitioning to higher lumbar levels."[31] Dr. Stinson's treatment plan called for continuing conservative therapy, including pain medication, "until his symptoms worsen to the point that surgical intervention [is] necessary, as per Dr. Peterson's [September 16, 2003,] report."[32]

In substance, Mr. Mitchell's physicians' view in the first half of 2004 was that there was an instability at his L4-L5 level, but that fusion at the L4-L5 level was not indicated

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[28] *Mitchell XVI* at 17, No. 89 (July 31, 2003); R. 3424.

[29] *Id.* at 90; R. 12196. Dr. Roth examined Mr. Mitchell on behalf of the Board on October 23, 2003. He concluded that Mr. Mitchell had reached medical stability on December 16, 2002. *Mitchell VI* at 17; *Mitchell XVI* at 17, No. 94; R. 3322, 11673. That is the date on which Dr. Stinson, assessing Mr. Mitchell after his most recent rhizotomy, reported that Mr. Mitchell's "lumbar symptoms are essentially asymptomatic now." R. 539. *See also* Roth Dep. at 16:7 – 17:2.

[30] *Mitchell XVI* at 16, No. 87 (July 15, 2003); R. 12174-12176; at 17, No. 90; R. 12198.

[31] *Mitchell XVI* at 17, No. 92; R. 3480 (Sept. 13, 2003).

[32] *Mitchell XVI* at 17, No. 93; R. 3429 (Oct. 13, 2003).

at that time (but could be in the future), because (a) the instability at the L4-L5 level was not pronounced and (b) fusion at the L4-L5 level could lead to transitional syndrome at the adjacent L3-L4 level.[33] Responding to Mr. Mitchell's report of a high degree of pain and his request for additional treatment options,[34] Dr. Peterson suggested that one possible treatment would be disc replacement surgery, but that this would not likely be available for another year or two.[35]

After further discussing the possibility of disc replacement surgery with his patient, and with the disc replacement surgery having been approved by the FDA,[36] on January 5, 2005, Dr. Peterson noted that Mr. Mitchell had "failed all conservative measures to date" and referred him to Dr. Rick Delamarter in California for evaluation for possible disc replacement surgery at L4-L5.[37] UPS declined to authorize payment for the proposed

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[33] *See Mitchell XVI* at 16, No. 86 (Stinson, June 23, 2003) ("posterior spondylolisthesis of L4 on 5 with any kind of extension"); at 17, Nos. 89, 92, 95; R. 3423-3424, 3480) (Peterson, July 31, 2003, Sept. 16, 2003; Stinson, Feb. 2, 2004) ("motion at L4-5 . . . slight retrolisthesis . . . absence of . . . pathological hypermobility L4-5," "arthrodesis at the L4-5 level . . . could lead to transitioning to higher lumbar levels," "transitional disk with instability at the L4-L5 level); at 18, Nos. 97, 98 (Stinson, Mar. 11, 2004, June 2, 2004) (annular tears at L4-L5, "L4-L5 instability with post laminotomy syndrome"); at 19, No. 106 (Peterson, Apr. 19, 2005) ("[fusion] can . . . accelerate degenerative changes which is why we prefer not to extend a fusion up into the L4-5 level"). *See also* R. 3425 (July 31, 2003, chart note) ("6/23/05 L4-5 movement").

[34] *See Mitchell XVI* at 18, Nos. 97, 98, 101 (Stinson Mar. 11, 2204, June 2, 2004, Oct. 6, 2004); R. 3407 (Stinson, Sept. 24, 2003) ("[he] would like either more pain medication or some other treatment option."). Dr. Roth testified that rhizotomies "can be extremely helpful" but that any improvement in symptoms is "never permanent" and might last for nine months to a year. Roth Dep. at 19:18 – 20:1. Mr. Mitchell's reported symptoms in June, September, and October 2004, from seven to ten months after his November 2003 rhizotomy, are consistent with Dr. Roth's testimony.

[35] *Mitchell XVI* at 18, No. 99 (Peterson, June 16, 2004).

[36] *See Jones v. Frontier Flying Serv., Inc.*, Alaska Workers' Comp. App. Comm'n Dec. No. 18 at 24, n. 122 (Sept. 7, 2006) (hereinafter, *Jones*) (approval by the federal Food and Drug Administration [FDA] granted in 2004).

[37] *Mitchell XVI* at 18, No. 101 (Stinson, Oct. 6, 2004) ("He is going to . . . discuss with Dr. Peterson again the pros and cons of waiting for approval of disk replacement versus progressing to disk fusion") R. 3442; at 19, No. 105; R. 3448. *See also* R. 3444 (Stinson, Dec. 13, 2004) ("Both he and his wife are aware that the artificial

evaluation in California and, on April 22, 2005, Mr. Mitchell filed a claim for the cost of transportation and the evaluation by Dr. Delamarter.[38] UPS controverted the claim, and prior to a hearing Mr. Mitchell, at his own expense, flew to California and was evaluated on July 13, 2005.[39] Dr. Delamarter concluded that Mr. Mitchell was not a candidate for disc replacement surgery because of severe facet arthritis. In lieu of fusion, Dr. Delamarter suggested that Mr. Mitchell consider "the Dynesys non-fusion technology, decompression of [the L4-L5] level, and then Dynesys implant at L4-L5 level."[40]

Mr. Mitchell's claim for medical benefits came before the Board for hearing on September 28, 2005. At that time, the Dynesys implant was being used in a number of countries to provide spinal stability absent fusion,[41] had been approved by the FDA for use in conjunction with fusion at the same level,[42] and was undergoing clinical trials for FDA approval for use absent fusion.[43] Dr. Delamarter was one of the physicians conducting the clinical trials.[44] In addition to Dr. Delamarter's suggestion for Dynesys surgery, the record before the Board included the deposition testimony of Dr. Roth, the Board's medical examiner, that Mr. Mitchell was not a good candidate for the Dynesys clinical trial based on his view that no surgery of any type was indicated, although "the people running the clinical trial would have to determine whether or not he was an appropriate candidate."[45]

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disk has been approved by the FDA. . . . He will follow up with Dr. Peterson for re-evaluation and likely referral for artificial disk replacement."). According to Dr. Stinson, Mr. Mitchell had been planning on travelling to California for evaluation much earlier, in October 2003. *Mitchell XVI* at 17, No. 93 (Stinson, Oct. 13, 2003); R. 3429.

38 *Mitchell XVI* at 20, No. 109; *Mitchell VI* at 9; R. 261-262.

39 *Mitchell XVI* at 20, Nos. 110, 111; *Mitchell VII* at 7.

40 *Mitchell XVI* at 20, No. 113; R. 7240.

41 *See* R. 4250-4251.

42 *See* R. 3224-3225.

43 *Mitchell XVI* at 20, No. 115; at 24, No. 132; R. 3214. *See* Roth Dep. at 21:22-25.

44 *See* R. 3215.

45 Roth Dep. at 22:1-12. *See Mitchell XVI* at 21, No. 116.

In *Mitchell VI*, the Board found that the date of medical stability was January 30, 2003, based on an absence of symptoms after December 16, 2002, for 45 days.[46] The Board found, based on Dr. Delamarter's July 2005 evaluation, that "disc replacement surgery is contraindicated."[47] It found that "the only reasonable and necessary treatment presented in the record at this time is for conservative care."[48] The Board retained jurisdiction to resolve any future disputes "regarding whether future treatments are reasonable, necessary and within the realm of acceptable medical practice."[49] Shortly thereafter, in *Mitchell VII*, the Board authorized payment for Mr. Mitchell's July 2005 travel to California and the evaluation by Dr. Delamarter, noting that on January 5, 2005, Dr. Peterson had rescinded his 2003 opinion "regarding a conservative care treatment" and that when he referred Mr. Mitchell to Dr. Delamarter, Dr. Peterson "had a reasonable belief that conservative measures had failed and it was appropriate to consider more aggressive options."[50] At the same time, the Board reaffirmed its decision in *Mitchell VI* that "the only reasonable and necessary treatment presented in the record at this time is for conservative care, which . . . can include limited diagnostic testing."[51]

Neither *Mitchell VI* nor *Mitchell VII* referenced the Dynesys treatment, and Mr. Mitchell filed a petition to modify *Mitchell VI* on the ground that the Board had made a mistake of fact by not approving the Dynesys surgery[52] as well as a new claim for

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46 *Mitchell VI* at 18. *See* AS 23.30.395(28). In *Mitchell VI*, the Board stated, "By December 16, 2002, [Mr. Mitchell's] lumbar symptomatology had resolved." *Id.* at 18, citing Dec. 16, 2002, Stinson chart; R. 539. The Board also stated that Mr. Mitchell obtained a fusion at L5-S1 in March 2003. *Id.* at 5 and 18, citing Mar. 3, 2003, Stinson chart note. The latter statement, as the Board subsequently recognized, was clearly erroneous. *See* R. 3410; *Mitchell XIII* at 10, No. 24; *Mitchell XVI* at 22, No. 119.

47 *Mitchell VI* at 15.

48 *Mitchell VI* at 15.

49 *Mitchell VI* at 21.

50 *Mitchell VII* at 6-7.

51 *Mitchell VII* at 6.

52 *Mitchell XVI* at 23, No. 127 (Mar. 6, 2006); R. 992-993.

medical benefits specifying the Dynesys treatment.[53] While these matters were pending, Mr. Mitchell returned to California and on August 10, 2006, at his own expense, obtained the Dynesys implant surgery. The surgery involved implanting the Dynesys stabilization system at the L3-L4-L5 levels, without fusion at those levels.[54]

Following the Dynesys surgery, for about a year, Mr. Mitchell reported improvement in his symptoms, with reduced pain.[55] He initially relied on conservative measures, such as medication and a lumbar brace, to alleviate pain.[56] In November 2006, he filed an application for disability benefits from the Social Security Administration, and following a hearing in February 2009, he was found to be disabled for purposes of the Social Security Act as of April 1, 2004.[57]

In 2009, following a hearing, the FDA declined to approve the Dynesys treatment as a stand-alone spinal stabilization treatment absent fusion at the same level.[58] From 2009 to 2016, Mr. Mitchell, at various times, engaged in recreational and other activities that the Board considered indicative of functional employability.[59] Beginning in 2009, Mr. Mitchell was provided a series of invasive treatments,[60] including facet joint injections in September 2009,[61] a rhizotomy in November 2009,[62] a spinal cord stimulator implant

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[53] *Mitchell XVI* at 26, No. 138 (July 28, 2006); R. 998-999.

[54] *Mitchell XVI* at 26, Nos. 140-143; at 28, No. 155.

[55] *Mitchell XVI* at 26, No 145; at 27, Nos. 146, 149; at 53-54, No. 283; at p. 86 ("he initially felt better following the Dynesys surgery for about a year.").

[56] *Mitchell XVI* at 27, Nos. 150, 152; at 28, No. 157; at 29, Nos. 162, 166, 167. *See* R. 7310-7311.

[57] *Mitchell XVI* at 31, No. 176; R. 12832-12836.

[58] *Mitchell XVI* at 31-32, Nos. 184-185. *See* R. 4183-4434.

[59] *See Mitchell XVI* at 103-104.

[60] In addition, Dr. Stinson provided a lumbar epidural injection in January 2009. *See Mitchell XVI* at 30, No. 175; R. 7466-7467 (Jan. 28, 2009).

[61] *Mitchell* XVI at 31, Nos. 181-183; R. 9066 (Sept. 16, 2009).

[62] *Mitchell XVI* at 31, No. 183; R. 9071 (Nov. 4, 2009).

in April 2010,[63] and nerve root blocks at the L2 level in December 2016.[64] As with prior invasive treatments, these provided some temporary relief, but no permanent change in his condition.[65]

The Board conducted a hearing on Mr. Mitchell's pending claims on October 4 and November 21, 2017. Mr. Mitchell and his wife testified on his behalf, as did two family friends. In addition to Mr. Mitchell's physicians' medical records, expert opinions and written reports were submitted from the medical examiners of the Board (Dr. Roth, Dr. Gritzka, and Dr. Robinson) and UPS (Dr. Smith, Dr. Chong, and Dr. Brown).[66] Expert testimony was provided by rehabilitation counselor Paul LaBrosse, and expert deposition testimony was provided by Dr. Stinson and Dr. Chong.

3. Discussion: Mitchell appeal.

The Board issued *Mitchell XVI* on May 1, 2018. After disposing of subsidiary issues not pertinent to this appeal, the Board first addressed Mr. Mitchell's request for past medical benefits relating to his 2006 Dynesys surgery[67] and other non-conservative treatments since then.[68] The Board denied compensation for the 2006 Dynesys surgery and all of the non-conservative treatments since then, other than the spinal cord stimulator.[69] Next, the Board considered Mr. Mitchell's claim for TTD benefits. It granted TTD benefits for the timeframes surrounding the Dynesys surgery and the spinal cord

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[63] *Mitchell XVI* at 32, No. 187; R. 9056 (Mar. 3, 2010); at 33, No. 189; R. 9059 (Apr. 9, 2010).

[64] *Mitchell XVI* at 44, No. 260.

[65] *See*, *e.g.*, R. 7476.

[66] Also in the record, but not germane to this appeal, are reports from the employer's medical examiners, Dr. McNamara (1996), Dr. Larry A. Levine (1996, 2001), and Dr. Susan S. Klimow (1999). R. 6870-6876, 6925-6931, 3110-3115, 3104-3105, 16135-16139.

[67] *Mitchell XVI* at 82-87.

[68] *Mitchell XVI* at 87-88.

[69] *Mitchell XVI* at 82-87. The Board also addressed past conservative care and future medical benefits, neither of which is at issue in this appeal. *See id.* at 88-90.

stimulator implant.[70] Lastly, the Board determined that Mr. Mitchell was permanently totally disabled beginning January 28, 2017, and not before then.[71]

Mr. Mitchell's brief raises two issues for our consideration: (1) whether the Board erred by not finding that he was permanently totally disabled prior to January 28, 2017,[72] and (2) whether the Board erred in finding that the Dynesys surgery was not reasonable and necessary in 2006.[73]

a. Permanent total disability.

At issue in this case is not the existence of a permanent total disability, but the date on which that disability began. The Board found that the disability began on January 28, 2017, the date Mr. Mitchell was examined and found to be permanently disabled by the Board's medical examiner, Dr. James Robinson. Mr. Mitchell argues that the Board erred by not selecting a date prior to then, because he presented evidence sufficient to create a presumption of permanent disability beginning in 2003, and UPS failed to present sufficient evidence to overcome that presumption. In particular, Mr. Mitchell argues, UPS failed to present evidence that Mr. Mitchell was capable of sedentary work at any time during 2003-2014.[74] It "defies common sense," Mr. Mitchell contends, for the Board not to extend the date of the disability to prior to Mr. Mitchell's visit with Dr. Robinson.[75] Mr. Mitchell argues that the Board erred by basing its decision on testimony regarding his recreational activities rather than on his ability to perform sustained reliable work.[76] Lastly, Mr. Mitchell argues that he did not successfully complete

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70 *Mitchell XVI* at 93-101.

71 *Mitchell XVI* at 103-110.

72 Mitchell Brief at 34-40.

73 Mitchell Brief at 41-48.

74 Mitchell Brief at 35.

75 Mitchell Brief at 36.

76 Mitchell Brief at 37.

a rehabilitation plan and that it has not been shown that there are jobs available in the market for which he is trained that he is physically capable of performing.[77]

We turn first to Mr. Mitchell's assertion that UPS failed to present substantial evidence that he was capable of sedentary work at any time in 2003-2014. The parties agree, as do we, that Mr. Mitchell presented substantial evidence that he was permanently and totally disabled in 2003.[78] The Board concluded that UPS had presented substantial evidence to the contrary.[79] The Board cited opinions finding no permanent total disability, and an ability to perform at least sedentary work, expressed in 2015 by

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[77] Mitchell Brief at 37-40.

[78] *Mitchell XVI* at 103, citing the testimony of Mr. Mitchell and opinions provided by Dr. Stinson, Dr. Delamarter, and Dr. Robinson, and Mr. Daniel LaBrosse, a rehabilitation counselor. The opinions of Dr. Stinson and Dr. Delamarter, submitted in support of Mr. Mitchell's initial claim for payment for the Dynesys surgery, appear to be predictions of future disability absent spinal stabilization, and they arguably were rendered inapplicable by the subsequent Dynesys surgery. *See, e.g.*, R. 7236 (Stinson, May 1, 2006) ("[W]ithout some kind of stabilization, he will likely be permanently disabled."); R. 12292 (Delamarter, May 3, 2006) ("Without surgical intervention to stabilize, [Mr. Mitchell] is . . . presently permanently and totally disabled"). Regardless of whether those opinions are sufficient, other medical and lay evidence, not all of which was cited by the Board, supports a finding of an existing permanent total disability beginning long prior to 2017. *See, e.g.,* R. 16010 (LaBrosse, Sept. 14, 2017) ("currently and has been at a less than sedentary R[esidual] F[unctional] C[apacity] since July of 2003"); R. 12294 (Dr. Rafael Pietro, May 3, 2006) ("[I]t is doubtful that he will be able to obtain and maintain employment even at a sedentary level.").

[79] *Mitchell XVI* at 103.

UPS's medical examiners, Dr. Alan Brown[80] and Dr. Dennis Chong,[81] and the Board's medical examiner, Dr. Thomas Gritzka,[82] as well as in 2003 (with accommodations) by Alan Blizzard, a physical therapist.[83] The Board also referenced Northern Rehabilitation Services' 1997 report, which found that there were thousands of light duty jobs as an administrative clerk in the Anchorage labor market for which Mr. Mitchell was qualified.[84]

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[80] *See Mitchell XVI* at 37-38, No. 229. Dr. Brown, an orthopedic surgeon, reviewed Mr. Mitchell's medical records on behalf of the employer on May 11, 2015. He concluded that Mr. Mitchell was at that time capable of sedentary work and was not permanently totally disabled. R. 14073-14075. Contrary to UPS's assertion, Dr. Brown did not offer an opinion as to whether Mr. Mitchell was disabled in 2003, or at any time prior to 2015. *Compare* UPS Brief at 11, n. 20, *with* R. 14074-14075. Dr. Brown's opinion was that Mr. Mitchell's work injury was not "the substantial factor in [Mr. Mitchell's] inability to participate in the positions offered him since 1993." [emphasis added] R. 14074. This is an opinion regarding causation, not regarding the existence of a disability.

[81] *See Mitchell XVI* at 38-39, No. 230. Dr. Chong, a physiatrist, examined Mr. Mitchell on behalf of the employer on May 14, 2015. He concluded that at the time of his examination Mr. Mitchell was capable of sedentary work and was not permanently disabled. R. 14100-14102. Contrary to UPS's assertion, Dr. Chong, in his report, did not offer an opinion whether Mr. Mitchell was disabled in 2003, or at any time prior to 2015. *Compare* UPS Brief at 11, n. 20, *with* R. 14101. Dr. Chong's report opines that "[t]he 1995 work injury is not a substantial factor in the inability of Mr. Mitchell to work in the approved positions for which he completed the training in 2000" and that "there is no material worsening in Mr. Mitchell's physical condition since 2003 that is attributable to the 1995 work injury." R. 14101. These are opinions regarding causation, not the existence of a disability. However, in his deposition, Dr. Chong indicated that he agreed with Mr. Blizzard's opinion concerning Mr. Mitchell's functional capacities in 2003. *See* Dennis Chong, M.D., Dep., Mar. 3, 2014, at 46:11 – 52:23.

[82] *See Mitchell XVI* at 39, No. 231. Dr. Gritzka, an orthopedic surgeon, examined Mr. Mitchell on behalf of the Board on July 13, 2015. He concluded that Mr. Mitchell was capable of sedentary work at that time. R. 14175. He concurred with Mr. Blizzard's 2003 evaluation, but also stated, somewhat ambiguously, "whether he could work at either sedentary or light duty jobs since 2003 is indeterminate[.]" R. 14174.

[83] *See Mitchell XVI* at 16, No. 87. R. 12176 (Blizzard, July 15, 2003). Mr. Blizzard saw Mr. Mitchell on referral from Dr. Smith, an orthopedic consultant, who examined Mr. Mitchell on behalf of UPS on July 11, 2003. Dr. Smith concurred that Mr. Mitchell was capable of sedentary work (but not work as an administrative clerk) at that time. R. 12198 (Aug. 13, 2003).

[84] *Mitchell XVI* at 103. *See id.* at 7-8, Nos. 12, 13.

The Board also had before it another labor market survey performed by Northern Rehabilitation Services in 1999, after Mr. Mitchell had participated in the first portion of his vocational retraining program, which found that there was a labor market in Anchorage for the specific sedentary jobs he had been retrained for, motor vehicle dispatcher and rate clerk.[85] In addition, as the Board found, Mr. Mitchell had successfully completed an externship to develop his computer skills.[86]

Mr. Mitchell's argument that the evidence cited by the Board is insufficient to rebut a presumption of disability has two primary components.[87] First, he argues that the 1997 and 1999 labor market surveys are irrelevant because Mr. Mitchell did not successfully complete a retraining program, and the labor market surveys are stale and outdated.[88] Second, he argues that the Board should have extended a presumption of disability forward from 2003, based on a report by Dr. Peterson,[89] or backward from 2017, when

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[85] *Mitchell XVI* at 9, No. 24.

[86] *See supra*, n. 13.

[87] Mr. Mitchell also argues, briefly, that the Board erred by considering the lay witnesses' testimony regarding his recreational or other non-work related activities, because the existence of a disability depends on inability to work, rather than an ability to engage in other kinds of activities. Mitchell Brief at 37. This argument is irrelevant to whether there is substantial evidence to rebut a presumption of disability because the Board cited the lay witnesses' testimony, without assessing its credibility or weight, in support of establishing a presumption. *Mitchell XVI* at 103. Subsequently, the Board weighed the strength of the lay witnesses' testimony in determining whether Mr. Mitchell had established a permanent disability prior to 2017 by a preponderance of the evidence, and deemed it not helpful to him. *Mitchell XVI* at 105. It is well established that evidence of an employee's recreational and other non-work related activities is relevant, in conjunction with the medical evidence, to the Board's ultimate determination that a disability does or does not exist. *See*, *e.g.*, *Sulkosky v. Morrison-Knudsen*, 919 P.2d 158, 168 (Alaska 1996).

[88] Mitchell Brief at 37-40.

[89] Mr. Mitchell's brief refers to a report of July 30, 2003. Mitchell Brief at 35. We have not identified a report from Dr. Peterson on that date. The record does include a report dated July 31, 2003, and we presume that is the report Mr. Mitchell intended to refer to. *See* R. 542-543.

the Board's examining physician, Dr. Robinson, found that he was permanently disabled.[90]

Turning to the latter argument, we reject Mr. Mitchell's suggestion that there is an unrebutted presumption of permanent total disability that extends forward from 2003, or backward from 2017. First, in 2017, Dr. Robinson specifically declined to offer an opinion as to whether Mr. Mitchell was permanently totally disabled at any time prior to his examination.[91] Similarly, Dr. Peterson's July 31, 2003, report did not state an opinion regarding permanent total disability.[92] Hence, neither report provides specific support for the existence of a permanent total disability at any particular time prior to the date of Dr. Robinson's examination. Second, to the extent that evidence of the existence of a disability creates a presumption that extends back or forward, so, too, does substantially contemporaneous evidence that rebuts that presumption. In this case, the 2003 evidence Mr. Mitchell relies on to create a presumption of disability was rebutted in 2003,[93] and the 2017 evidence that he relies on was rebutted in 2017 and in 2015.[94]

Mr. Mitchell's objection to the Board's reliance on the evidence relating to vocational rehabilitation is also unpersuasive. He asserts that there was no "competent" vocational rehabilitation plan and that the plan was not completed, or that in any event it was not successfully completed.[95] The allegation that there was no "competent" plan may reflect dissatisfaction Mr. Mitchell expressed with his plan at the time it was

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90 Mitchell Brief at 34-37.

91 R. 14668-14669.

92 R. 542-543.

93 *See* R. 12176 (Blizzard, July 15, 2003), R. 12198 (Smith, Aug. 13, 2003). There is also substantial evidence dating from 2015 and 2017 to rebut the presumption that Mr. Mitchell was permanently totally disabled in 2003. *See* Chong Dep. at 46:11 – 52:23; R. 14175 (Gritzka, July 13, 2015).

94 *See* n. 80, 81, 82, *supra*.

95 Mitchell Brief at 37.

created,[96] but any objection Mr. Mitchell had to the content of the plan should have been raised at the time the plan was developed and implemented, and cannot be heard now.[97]

As for his assertion that he did not successfully complete the plan, there is substantial evidence in the record that Mr. Mitchell completed the externship that was the final component of his rehabilitation plan, and that he did so successfully.[98] Mr. Mitchell's argument that the labor market surveys are stale disregards that they were not unduly stale in 2003, when Mr. Mitchell was deemed to be capable of sedentary work. Moreover, his objection goes to the weight of the evidence, not its existence.[99] The Board did not abuse its discretion in using its own judgment and experience to form its

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[96] *See* R. 16104.

[97] *See* AS 23.30.041(j). Mr. Mitchell objects that he did not receive the job application training or job placement services anticipated in the plan. Mitchell Brief at 40. The plan itself, however, mentions only academic training, and the concerns Mr. Mitchell expressed at the time revolved around the lack of adequate skills training, not job application or placement services. *See* R. 16062-16063, 16092.

[98] *Mitchell XVI* at 12, Nos. 49-51. The initial plan, in May 1997, called for retraining to work as a motor vehicle dispatcher, traffic rate clerk, or administrative clerk. R. 16062-16071. An amendment in August 1997 called for training as an administrative clerk through a computer skills program at the University of Alaska Anchorage. R. 16079-16082. Mr. Mitchell completed that course, but felt that it did not adequately prepare him for alternative employment. R. 16104. The externship plan was developed in response to his concerns. R. 16106-16111. The externship was extended due to Mr. Mitchell's physical limitations. R. 16254-16255. After his October 1999 surgery, Mr. Mitchell completed the externship in April 2000. *See* R. 16281-16282; Exc. 990-991. He continues to assert that the program was inadequate, and for that reason, he testified, he never attempted to obtain employment. *See Mitchell XVI* at 54, No. 284.

[99] The Alaska Supreme Court has "not held that a failure to offer evidence of surveys of the statutorily specified employment markets necessarily results in a failure to rebut the presumption of compensability." *Leigh v. Seekins Ford*, 136 P.3d 214, 220 (Alaska 2006). On the other hand, it has also indicated that the capability to perform light work (much less sedentary work) does not give rise to a presumption that light work is available. *Id.* at 221, n. 24, *citing* 4 Larson's Workers' Compensation Law §84.01[3] (2000).

conclusion, based in part on the labor surveys and other evidence in the record, that there is substantial evidence to rebut the presumption of disability.[100]

Given that UPS provided sufficient evidence to rebut a presumption of disability, the question remains whether there is substantial evidence, in light of the record as a whole, to support the Board's finding that the disability began in 2017, and not at a time prior to then. It is to that issue, we think, that Mr. Mitchell's argument the Board's decision "defies common sense" is directed. In Mr. Mitchell's view, common sense dictates that his permanent total disability, which the Board viewed as the product of a progressively worsening condition,[101] did not suddenly spring into existence on the date he was examined by Dr. Robinson. But, that the Board might have selected an earlier date for the onset of disability does not mean that the date it chose lacks substantial evidence in light of the record as a whole. Because the presumption of permanent total disability had been rebutted, Mr. Mitchell had the burden of proof to establish the date of onset of permanent total disability. The Board's decision indicates that it was not until Dr. Robinson provided his opinion of an existing permanent total disability that Mr. Mitchell met his burden of proof. The Board's decision conforms with Dr. Robinson's pointed refusal to offer an opinion as to Mr. Mitchell's condition prior to the date of his examination. We conclude that there is substantial evidence, in light of the record as a whole, to support the Board's decision on this issue.

b. Dynesys surgery.

Mitchell XVI determined that the 2006 Dynesys surgery was not reasonable and necessary based on the record presented to the Board in 2017. Mr. Mitchell contends

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[100] *See* AS 23.30.122; *Fairbanks North Star Borough v. Rogers and Babler*, 747 P.2d 528, 533-534 (Alaska 1987).

[101] *See Mitchell XVI* at 85.

that the Board erred in deeming the surgery not reasonable and necessary. In our view, the Board's analysis is questionable, but its decision to deny medical benefits is not.

The Board characterized the issue before it as whether "something changed,"[102] such that the Dynesys surgery, which the Board had deemed not to be reasonable and necessary when it issued *Mitchell VI* in December 2005, was nonetheless reasonable and necessary some eight months later, in August 2006, when Mr. Mitchell obtained that surgery at his own expense. Arguably, this characterization misstated the Board's task. *Mitchell VI* was a final decision with respect to authorization for the Dynesys surgery in 2005. But, having decided in *Mitchell IX* that *Mitchell VI* was not a final decision with respect to surgery performed some eight months later, and having reopened the record to include evidence dating for another ten years after the surgery was obtained, arguably the Board ought to have approached the issue of medical benefits anew, rather than limiting itself to considering whether "something changed" during the eight-month period between the date of the decision and the date of the surgery. Had it approached the matter anew on the basis of the expanded record, the Board might have decided that the surgery was reasonable and necessary in 2006, even if nothing had changed in the eight months between *Mitchell VI* and the date of the surgery. In particular, the Board had

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102 *Mitchell XVI* at 82.

substantially more information regarding the Dynesys surgery in 2017 than it had in 2005.[103]

Moreover, it is not clear that the Board gave sufficient weight to the consensus of Mr. Mitchell's physicians at the time he obtained the Dynesys surgery. The Alaska Supreme Court stated in *Hibdon*:[104]

> The question of reasonableness is "a complex fact judgment involving a multitude of variables." However, where the claimant presents credible,

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[103] As noted above, at the time of the *Mitchell VI* hearing, the only opinion testimony, apart from Mr. Mitchell's physicians, regarding the Dynesys surgery was Dr. Roth's somewhat ambiguous deposition testimony. *See* n. 45, *supra*. By the time of the *Mitchell XVI* hearing, several other medical examiners had weighed in. *See* R. 14167 (Gritzka, July 13, 2015) ("The treatment done by Dr. Delamarter was not unreasonable [or] unnecessary"); R. 14068 (Brown, May 11, 2015) ("procedure was ill advised, but not below the standard of care"); R. 14578 (Chong, Nov. 18, 2016) ("The Dynesys procedure was absolutely not reasonable or necessary. It was not FDA approved. If such a procedure was attempted, it should have been in the setting of a clinical trial.") (emphasis in original); R. 14665 (Robinson Jan. 28, 2017) ("I believe it was undertaken without an adequate preoperative evaluation. . . . Thus I do not believe that the surgery was reasonable and necessary.").

Dr. Gritzka was the Board's medical examiner. The Board did not mention his opinion in its discussion of the Dynesys issue. *Mitchell XVI* at 82-87. However, in its discussion of temporary disability benefits, the Board stated it did "not credit" his opinion on the Dynesys issue, without any explanation. *Mitchell XVI* at 97. Dr. Chong's opinion, it appears, was based on two premises: that no surgery at all was indicated, and that because the surgery was not FDA approved it should not have been provided outside of a clinical trial. *See* R. 14578, 5510 (Dennis Chong, M.D., Dep., Nov. 13, 2017, at 149:6-22). Dr. Robinson's opinion was based on the premise that an evaluation for chronic pain syndrome should have been conducted prior to any surgery. R. 14653.

In addition to new opinion testimony, the Board, in 2017, had before it evidence that in 2009 the FDA had declined to approve the surgery for use absent a concurrent fusion at the same level. *See Mitchell XVI* at 31-32, Nos. 184-185. That a particular treatment is not approved by the FDA does not in itself necessarily mean that it is below the standard of care. *See Odom v. State, Division of Corporations, Business and Professional Licensing*, 421 P.3d 1, 10-11 (Alaska 2018); R. 14068, 14073. However, it is a factor that may be considered in determining whether the treatment is reasonable and necessary for purposes of a compensation claim. *See Bockness v. Brown Jug, Inc.*, 980 P.2d 462, 466-467 (Alaska 1999).

[104] *Phillip Weidner & Assocs., Inc. v. Hibdon*, 989 P.2d 727, 732 (Alaska 1999) (hereinafter, *Hibdon*).

> 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 opinions, it is generally considered reasonable.

The Board seems to have recognized this principle in its discussion of temporary disability benefits, when it stated that Mr. Mitchell "had a reasonable basis to obtain [the Dynesys treatment] in reliance on Drs. Delamarter's and Stinson's opinions."[105] Similarly, the dissenting opinion highlights, as grounds for approving the surgery, the fact that it had been recommended by Mr. Mitchell's physicians.[106] That the Board's 2017 examining physician, Dr. Gritzka, deemed the surgery not unreasonable or unnecessary highlights the possibility that the Board did not provide sufficient weight to Mr. Mitchell's physicians' consensus with their patient and, hence, failed to apply the correct legal standard to the determination of whether the surgery was reasonable and necessary.

These concerns, however, do not affect our conclusion that the Board did not err in denying payment for the Dynesys surgery. Because the surgery was requested far more than two years after the injury, the Board "had some latitude to choose among reasonable alternatives."[107] In this case, there was ample evidence that conservative treatment was a reasonable alternative to surgical intervention in 2006. Indeed, that is why the Board approved payment for the conservative measures that were undertaken before and after the intermittent surgical treatments that Mr. Mitchell obtained. In that light, and given the Board's conclusion in its discussion of temporary disability benefits that Mr. Mitchell's decision to undertake the Dynesys surgery was reasonable, it is clear that the Board rejected Mr. Mitchell's physicians' recommendations for the Dynesys surgery and chose instead a reasonable alternative treatment, namely, conservative care. The Board did not abuse its discretion in making that choice.

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105 *Mitchell XVI* at 97.

106 *Mitchell XVI* at 122.

107 *Hibdon*, 989 P.2d at 731. *See also Municipality of Anchorage v. Carter*, 818 P.2d 661, 665 (Alaska 1991); *Jones*, App. Comm'n Dec. No. 18 at 9 (Sept. 7, 2006).

4. Discussion: UPS appeal.

The Board awarded TTD payments from May 1, 2006, when Dr. Stinson noted Mr. Mitchell had failed conservative treatment and supported the Dynesys surgery, through March 26, 2007, the date on which the Board deemed Mr. Mitchell "became medically stable from the Dynesys surgery."[108] Having decided that the Dynesys surgery on August 10, 2006, was not reasonable and necessary, the Board wrestled with its authority to provide TTD related to that surgery.[109] It characterized the issue before it as whether a claimant who obtains medical treatment that the Board subsequently deems not to be compensable may be awarded TTD benefits "associated with the treatment."[110] Because UPS does not challenge the Board's conclusion that such benefits may be payable in an appropriate case, we limit our discussion to the issue raised by UPS, which is whether the Board erred in finding sufficient evidence of medical instability to rebut the presumption that Mr. Mitchell remained medically stable after January 30, 2003, the date the Board found that he was presumed to be medically stable pursuant AS 23.30.395(28).[111]

In order to rebut the presumption of medical stability pursuant to AS 23.30.395(28), Mr. Mitchell needed to present clear and convincing evidence that he was not medically stable at some point between January 30, 2003, and May 2, 2006. He could do this by presenting clear and convincing evidence of either of two factual

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108 *Mitchell XVI* at 100.

109 *Mitchell XVI* at 93-100.

110 *Mitchell XVI* at 93.

111 AS 23.30.395(28) reads:

> "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.

propositions: that there was an objectively measurable improvement during that period of time, or a reasonable expectation of objectively measurable improvement beyond it.[112] Clear and convincing evidence sufficient to rebut the counter-presumption of medical stability is "evidence that could induce in a reasonable mind the belief that it is highly probable the asserted fact is probably true."[113] In determining whether the evidence is sufficient to rebut the counter-presumption, the Commission will "examine the evidence tending to rebut the presumption by itself."[114]

With these standards in mind, we turn to the evidence. The Board acknowledged UPS's position that Mr. Mitchell needed to present clear and convincing evidence to overcome the presumption of medical stability,[115] but did not expressly identify the evidence it relied on to do so. In discussing causation, the Board mentioned Dr. Delamarter's expectation that the Dynesys surgery would stabilize the spine, which, as Dr. Stinson noted, is objectively measurable.[116] Thus, the Board concluded, "There is no question Dr. Delamarter expected some objectively measurable improvement" as a result of the Dynesys procedure.[117] In discussing the presumption, the Board pointed to Dr. Stinson's opinion of January 23, 2006, that Mr. Mitchell was not medically stable and his May 1, 2006, opinion that the Dynesys surgery "'may lead to increased [spinal] stability' and decreased symptoms."[118] The Board characterized the latter opinion as Dr. Stinson "expected [the Dynesys surgery] to make an objectively measurable improvement in [Mr. Mitchell's] spine stability."[119]

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112 *See Lowe's HIW, Inc. v. Anderson*, Alaska Workers' Comp. App. Comm'n Dec. No. 130 at 16 (Mar. 17, 2010) (hereinafter, *Lowe's*).

113 *Lowe's* at 18, n. 57.

114 *See Wollaston v. Schroeder Cutting, Inc.*, 42 P.3d 1065, 1066, n. 1 (Alaska 2002).

115 *Mitchell XVI* at 99.

116 *Mitchell XVI* at 99.

117 *Mitchell XVI* at 98.

118 *Mitchell XVI* at 99.

119 *Mitchell XVI* at 99.

UPS argues that the opinions of Dr. Stinson and Dr. Delamarter are insufficient to rebut the presumption for two reasons. First, the Board rejected the opinions of both Dr. Stinson and Dr. Delamarter that the Dynesys procedure was reasonable and necessary, and declined to accept their opinions on medical stability for any other periods.[120] Second, because it turned out that the Dynesys procedure did not result in measurable objective improvement, the Board was obliged, under *Lowe's*, to reject their opinions.[121]

As to the first argument, the Board's findings "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."[122] The Board may reasonably provide more weight to a physician's opinion on one issue than on another, in view of the record as a whole, and that the Board did so in this particular case is not reversible error.

UPS's second argument rests on our statement in *Lowe's* that "a general hope for improvement that turns out to be incorrect cannot provide clear and convincing evidence that the employee is not medically stable."[123] We added, "when examining past predictions that objectively measurable improvement is reasonably expected with medical treatment, the board must determine if the objectively measurable improvement occurred with the treatment."[124]

As to the first point, the opinions relied upon to rebut the presumption in this case, unlike *Lowe's*, do not consist of a "general hope for improvement." In *Lowe's*, we pointed out that one treating physician had stated only that he was "hopeful" that continued treatment would lead to improvement, and had not provided "a prediction of future

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120 UPS Brief at 19-20. *See Mitchell XVI* at 102.

121 UPS Brief at 20-21.

122 AS 23.30.122.

123 *Lowe's* at 15.

124 *Id.*

objectively measurable improvement."[125] We deemed his testimony insufficient to rebut the presumption of medical stability based on *Municipality of Anchorage v. Leigh*[126] and *Thoeni v. Consumer Electronic Services*.[127] In the former case, we found the presumption of medical stability set forth in AS 23.30.395(28) to be constitutional, in part based upon the argument that evidence to rebut it is readily available:

> This evidence is easily obtained by examining the treating physician. That is, the treating physician should have no difficulty offering an opinion on whether or not further objectively measurable improvement is expected. The 45 day provision merely signals when that proof is necessary. The alleged difficulty in proving the nonexistence of medical stability, simply fades when viewed in light of the proof actually required.[128]

In *Lowe's*, we deemed the treating physician's testimony insufficient to meet even this relatively low standard.[129] We also deemed insufficient another treating physician's testimony because it was "equivocal."[130] However, we deemed the latter treating physician's testimony sufficient with respect to a different condition, even though that physician did not use the precise statutory language, because that testimony "demonstrated his attention to objective measures of improvement and an affirmative statement that [the claimant] should be treated."[131] In the case at bar, as it did with

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[125] *Lowe's* at 16-18. The claimant sought benefits for a complex of conditions, including her cervical and lumbar spine, chronic pain syndrome, and anxiety and depression. *See Anderson v. Lowe's Co., Inc.*, Alaska Workers' Comp. Bd. Dec. No. 09-0097 (May 19, 2009) at 60-61 (hereinafter, *Anderson*). This particular physician was a psychiatrist who was treating the claimant for anxiety and depression. *See Anderson* at 31, 55-57.

[126] *Lowe's* at 18, n. 58, citing *Municipality of Anchorage v. Leigh*, 823 P.2d 1241, 1246 (Alaska 1992) (hereinafter, *Leigh*).

[127] *Lowe's* at 18, n. 59, citing *Thoeni v. Consumer Electronic Serv.*, 151 P.3d 1249, 1256 (Alaska 2007).

[128] *Leigh*, 823 P.2d at 1246.

[129] *Lowe's* at 18.

[130] *Lowe's* at 18-19. This testimony was offered in connection with the claimant's lumbar spine. *Id*. The treatment involved pain management. *See Anderson* at 24-25, 34-35, 52-55.

[131] *Lowe's* at 20.

respect to the testimony we deemed sufficient in *Lowe's*, the Board focused on the expectations of both Dr. Stinson and Dr. Delamarter that the proposed Dynesys surgery would result in measurable objective improvement. We conclude that the evidence of a reasonable expectation of measurable objective improvement as of May 2, 2006, was sufficient, viewed in itself,[132] to rebut the presumption of medical stability.

We next turn to UPS's argument that the evidence is insufficient to rebut the presumption because the Dynesys surgery did not, in fact, result in objectively measureable improvement. UPS relies on our observation in *Lowe's* that "when examining past predictions that objectively measurable improvement is reasonably expected with medical treatment, the board must determine if the objectively measurable improvement occurred with the treatment."[133]

Here, we believe it is important to note two important distinctions. First, we distinguish between our review of the Board's determination that the presumption has been overcome, and our review of the Board's factual determination that the claimant is, or is not, medically stable. In determining whether there is substantial evidence to rebut the presumption, we look only to the evidence tending to rebut the presumption, whereas in determining whether there is substantial evidence to support the Board's factual determinations, we consider the record as a whole. Second, we distinguish between medical stability prior to medical treatment, and medical stability after treatment. A prediction that surgery will not result in measurable objective improvement in a claimant's pre-surgical condition does not preclude the possibility that the surgery will require a period of recuperation during which the patient will show measurable objective improvement. With those distinctions in mind, we turn to the evidence.

Initially, we consider the period from the date of the Dynesys surgery, August 10, 2006, through March 27, 2007. UPS's argument, insofar as it rests on the alleged lack of objective improvement resulting from the surgery, is that after Mr. Mitchell recovered

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[132] *See* n. 114, *supra*.

[133] *Lowe's* at 15, citing *Burke v. Houston NANA, L.L.C.*, 222 P.3d 851, 862 (Alaska 2010).

from the surgery, he did not demonstrate any objective improvement from his condition prior to the surgery, and that, therefore, the presumption of medical stability was not overcome for the period of time prior to the surgery. But this has nothing to do with why the Board awarded disability benefits relating to the Dynesys surgery. The Board awarded temporary disability benefits for the post-surgery period because Mr. Mitchell was recuperating from surgery, not because the surgery resulted in measurable objective improvement from his condition prior to the surgery.[134] With that understanding, we reject UPS's argument that the Board erred in awarding temporary disability payments for August 10, 2006, through March 27, 2007.

Lastly, we consider the period from May 2, 2006, through August 10, 2006. In considering whether there is substantial evidence to rebut the presumption that Mr. Mitchell was medically stable during that time, we look only to the evidence tending to rebut the presumption. We have already decided that the evidence before the Board, viewed in itself, was sufficient to rebut the presumption.[135] Although evidence that the predicted improvement did not occur must be considered in determining whether a claimant is medically stable, it may not be considered in determining whether the presumption of stability is rebutted. Accordingly, we do not disturb the Board's determination that the presumption of medical stability was overcome.

5. Conclusion.

There is substantial evidence, in light of the record as a whole, to support the Board's denial of medical benefits for the Dynesys treatment and for permanent total disability benefits prior to January 28, 2017. The evidence tending to rebut the presumption of medical stability is sufficient, viewed in itself, to rebut that presumption. The Board's decision is, therefore, AFFIRMED.

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134 *See Mitchell XVI* at 99-100.

135 *Supra*, at 25-26.

Date: *December 6, 2019* Alaska Workers' Compensation Appeals Commission

Signed
James N. Rhodes, Appeals Commissioner

Signed
Amy M. Steele, Appeals Commissioner

Signed
Andrew M. Hemenway, Chair *pro tempore*

APPEAL PROCEDURES

This is a final decision. AS 23.30.128(e). It may be appealed to the Alaska Supreme Court. AS 23.30.129(a). If a party seeks review of this decision by the Alaska Supreme Court, a notice of appeal to the Alaska Supreme Court must be filed no later than 30 days after the date shown in the Commission's notice of distribution (the box below).

If you wish to appeal to the Alaska Supreme Court, you should contact the Alaska Appellate Courts *immediately*:

Clerk of the Appellate Courts
303 K Street
Anchorage, AK 99501-2084
Telephone: 907-264-0612

RECONSIDERATION

A party may ask the Commission to reconsider this decision by filing a motion for reconsideration in accordance with AS 23.30.128(f) and 8 AAC 57.230. The motion for reconsideration must be filed with the Commission no later than 30 days after the date shown in the Commission's notice of distribution (the box below). If a request for reconsideration of this final decision is filed on time with the Commission, any proceedings to appeal must be instituted no later than 30 days after the reconsideration decision is distributed to the parties, or, no later than 60 days after the date this final decision was distributed in the absence of any action on the reconsideration request, whichever date is earlier. AS 23.30.128(f)

I certify that, with the exception of changes made in formatting for publication, this is a full and correct copy of Final Decision No. 272, issued in the matter of *Stephan C. Mitchell vs. United Parcel Service and Liberty Mutual Fire Insurance Company*, AWCAC Appeal No. 18-009, and distributed by the office of the Alaska Workers' Compensation Appeals Commission in Anchorage, Alaska, on December 6, 2019.

Date: *December 10, 2019*

Signed
K. Morrison, Appeals Commission Clerk