Alaska Workers' Compensation Appeals Commission

Assets, Inc., Commerce & Industry Insurance Co., Chartis, and Northern Adjusters, Inc., Appellants/Cross-Appellees, vs. Derrick F. Taylor, Appellee/Cross-Appellant.	Final Decision Decision No. 195 April 22, 2014 AWCAC Appeal No. 13-017 AWCB Decision No. 13-0081 AWCB Case Nos. 200512941M and 200506253

Final decision on appeal from Alaska Workers' Compensation Board Final Decision and Order No. 13-0081, issued at Anchorage, Alaska, on July 17, 2013, by southcentral panel members William Soule, Chair, Pam Cline, Member for Labor, and Linda Hutchings, Member for Industry.

Appearances: Colby J. Smith, Griffin & Smith, for appellants/cross-appellees, Assets, Inc., Commerce & Industry Insurance Co., Chartis, and Northern Adjusters, Inc.; Steven Constantino, for appellee/cross-appellant, Derrick F. Taylor.

Commission proceedings: Appeal filed July 30, 2013; cross-appeal filed August 19, 2013; briefing completed February 18, 2014; oral argument held April 16, 2014.

Commissioners: James N. Rhodes, Philip E. Ulmer, Laurence Keyes, Chair.

By: Laurence Keyes, Chair.

1. Introduction.

Derrick F. Taylor (Taylor) had a history of back problems which predated his employment with Assets, Inc. (Assets). In 2007 and 2008, he filed back-related

workers' compensation claims against the company.[1] Those claims are at issue in this appeal. On April 16, 2013, the Alaska Workers' Compensation Board (board) held a hearing on Taylor's claims.[2] A few days after the hearing, James M. Eule, M.D., performed low-back surgery on Taylor.[3] Assets appealed to the Workers' Compensation Appeals Commission (commission) that portion of the board's decision awarding Taylor temporary total disability (TTD) benefits from August 21, 2008, through January 17, 2013.[4] Taylor subsequently cross-appealed the board's denial of TTD benefits over a different time span, from November 28, 2007, through August 21, 2008.[5] Consequently, the focus of this appeal is whether Taylor was entitled to TTD benefits between November 28, 2007, and January 17, 2013. Pursuant to the provisions of AS 23.30.128(d),[6] the commission remands this matter to the board, with instructions, as more fully set forth below.

---

[1] Taylor filed a claim on December 28, 2007, relating to an injury date of August 19, 2005; the Alaska Workers' Compensation Board Case Number assigned to that claim was 200512941. R. 014-15. Counsel for Taylor filed a claim on November 17, 2008, under Board Case No. 200506253, indicating an injury date of March 15, 2005. R. 0050-51. That same day, Taylor's counsel filed another claim that was identical in all respects to the first one he filed, except it indicated an injury date of August 19, 2005, and a different case number, Board Case No. 200512941. R. 0052-53.

[2] *See Derrick F. Taylor v. Assets, Inc.*, Alaska Workers' Comp. Bd. Dec. No. 13-0081 at 1 (July 17, 2013). The board had already issued an Interlocutory Decision & Order (ID&O) with respect to Taylor's claims. *See Derrick F. Taylor v. Assets, Inc., Boys & Girls Clubs of Greater Anchorage, and Alternatives Community Mental Health*, Alaska Workers' Comp. Bd. Dec. No. 09-0062 (March 31, 2009). A Decision and Order Errata was also issued. *See Derrick F. Taylor v. Assets, Inc.*, Bd. Dec. No. 13-0081 (July 30, 2013).

[3] R. 3623.

[4] *See* Notice of Appeal at 1. Assets also appealed the board's award of attorney fees. *See id*.

[5] *See* Notice of Cross-Appeal at 1.

[6] AS 23.30.128(d) is quoted in Part 4(a), *infra*.

2. Factual background and proceedings.

Taylor did not recall any significant mid- or low-back problems before graduating from high school or while he attended college.[7] On July 24, 1996, while employed with Boys & Girls Clubs of Greater Anchorage (Boys & Girls Clubs), Taylor bruised his back while involved in a basketball tournament.[8] According to medical records in that case, on or about August 15, 1996, Taylor treated with Jay Chapnik, D.C. Dr. Chapnik found decreased range of motion in the lumbar area and diagnosed subluxation complex.[9] Taylor reportedly had no pain, numbness, or tingling in his lower extremities following this injury.[10]

Taylor had a minor motor vehicle accident in November 1997. He saw a chiropractor who treated him briefly for low back and neck symptoms, which resolved by April 20, 1998.[11]

On March 24, 1999, while employed with Alternatives Community Mental Health (Alternatives) as a youth and family counselor, Taylor injured his lower back while playing basketball.[12] After icing his back for 45 minutes, he was still not able to stand or walk. Staff members called paramedics who transported Taylor to Alaska Regional Hospital's emergency room for evaluation.[13] On March 25, 1999, Dr. Chapnik released him to work

---

[7] *See Taylor*, Bd. Dec. No. 13-0081 at 4. The board's factual findings in this matter are extensive. We will narrow our recitation of the facts to those having a bearing on the TTD issues in this appeal.

[8] Report of Occupational Injury or Illness dated August 18, 1996, Board Case No. 199616903.

[9] *See Taylor*, Bd. Dec. No. 13-0081 at 5. Subluxation is "[a] partial or incomplete dislocation." Taber's Cyclopedic Medical Dictionary (2009).

[10] *See id.* at 5. The file for Board Case No. 199616903 contains no additional information until after Taylor's 1999 injury. *See id*. and n.11, *infra*.

[11] *See Taylor*, Bd. Dec. No. 13-0081 at 5.

[12] Report of Occupational Injury or Illness dated March 26, 1999, Board Case No. 199905547.

[13] *See Taylor*, Bd. Dec. No. 13-0081 at 5.

effective March 29, 1999.[14] Taylor treated with Dr. Chapnik on several subsequent occasions. In September 1999, he began treating with Matthew Huettl, D.C.[15] Taylor reported no lower extremity pain, numbness, or tingling from this injury.[16]

In approximately 2001, Taylor started working for Assets.[17] At no time prior to 2005, with the exception of the above-referenced incidents, did Taylor experience any difficulty participating in sports, and had no lower extremity pain, numbness, or tingling.[18]

When Taylor saw Gary Child, D.O., on July 1, 2004, he reported chronic low-back and left rotator cuff pain. Taylor could not recall any trauma causing the low-back pain. Dr. Child diagnosed a lumbosacral strain; an x-ray showed slight L5-S1 disc space narrowing, but otherwise revealed a normal radiographic examination.[19]

On March 15, 2005, while employed as a project supervisor for Assets,[20] Taylor was cleaning a courtroom when he reportedly felt a pop in his right knee, felt shooting pain and numbness in his low back, and his right leg began to feel numb.[21] Later that month, on March 23, 2005, Taylor saw Richard Taylor, M.D. (Dr. Taylor). He told the doctor that his right leg went numb from the knee down and he experienced tingling in his left leg. Taylor also reported some gait disturbance in his right leg. Dr. Taylor assessed questionable neuropathy and requested electrodiagnostic testing.[22] Nerve conduction

---

[14] *See Taylor*, Bd. Dec. No. 13-0081 at 5.

[15] *See id*.

[16] *See id*. at 6.

[17] *See id*.

[18] *See id*.

[19] *See id*.

[20] Taylor was also working for the Anchorage School District as a teacher's aide in this timeframe. Hr'g Tr. 81:25–82:10.

[21] Report of Occupational Injury or Illness dated April 25, 2005. R. 0001. This injury was ultimately assigned Board Case No. 200506253. *See* n.1, *supra*.

[22] *See Taylor*, Bd. Dec. No. 13-0081 at 7.

studies were consistent with a moderate, right L5 radiculopathy and did not meet minimum nerve conduction criteria for polyneuropathy.[23]

A few days later, on March 26, 2005, Taylor had a magnetic resonance imaging (MRI) scan. He reported losing feeling and touch in his right leg and knee and involved the left foot as well. The radiologist, Harold F. Cable, M.D., found a central, focal protrusion at L5-S1, which extended to the left. According to his report, this was an obvious herniation which displaced and compressed the nerve root in the left lateral recess.[24]

On April 18, 2005, Dr. Taylor reviewed the diagnostic test results and concluded the nerve conduction studies and MRI did not correlate well with Taylor's symptoms, which consisted of continued right leg numbness and a limp. Taylor was restricted to light duty. His physicians never removed this restriction until he ceased working for Assets in 2007.[25]

The earliest medical record in the file for Alaska Workers' Compensation Board Case No. 200506253 is a follow-up report from Dr. Taylor dated May 5, 2005. Taylor reported his left foot was feeling better, he still had some numbness in his right knee and toe, and he had no pain in his legs. However, he was experiencing some low-back pain. Taylor continued to limp and his right leg felt weak when he was walking. He requested a referral to an orthopedic specialist. Dr. Taylor found Taylor's back examination unremarkable and assessed degenerative disk disease with radiculopathy and/or a peripheral neuropathy. He recommended continued physical therapy and a consult with an orthopedic surgeon.[26]

On May 19, 2005, Taylor saw Edward Voke, M.D., an orthopedic surgeon. He reported no pain in his legs, however, he had numbness involving his right leg from the knee to the foot and some numbness in the left foot on the lateral aspect. Dr. Voke

---

[23] *See Taylor*, Bd. Dec. No. 13-0081 at 7.

[24] Exc. 205.

[25] *See Taylor*, Bd. Dec. No. 13-0081 at 7.

[26] *See id*.

reviewed the March 26, 2005, MRI of the lumbar spine and said it showed a herniated disk central and to the left at L5-S1 with desiccation. Dr. Voke's diagnoses included a herniated nucleus pulposus L5-S1 on the left and degenerative disk disease L5-S1.[27] Dr. Voke did not think surgery was necessary. However, he believed that if Taylor's quality of life deteriorated, a laminectomy might be helpful and appropriate.[28]

When he saw Dr. Taylor on June 10, 2005, Taylor reported his legs were particularly numb in the morning, especially on the right, but also on the left, and physical therapy and traction were not helping him. Dr. Taylor recommended an epidural injection.[29] As of July 6, 2005, Dr. Taylor thought Taylor might be a surgical candidate.[30]

On June 16, 2005, Taylor saw Dr. Voke complaining of back pain, pain in the arch of his right foot, particularly with walking, and mild numbness in the tips of his left toes. Dr. Voke noted the MRI report and observed Taylor's symptoms were more on the right than the left at this visit compared with his May 19, 2005, complaints.[31] On July 12, 2005, Dr. Voke's office provided work restrictions including no lifting over 15 pounds, no bending, stooping, squatting, or crawling. Taylor was released to perform sedentary work only.[32]

According to the board, before he was injured in August 2005, Taylor experienced mostly low-back pain, occasional tingling and numbness in both legs and feet, and he had minor difficulty walking. The symptoms were somewhat stable over the preceding few months.[33] On August 5, 2005, he saw Dr. Taylor and reportedly felt

---

27 *See Taylor*, Bd. Dec. No. 13-0081 at 7-8.

28 *See id*. at 8.

29 *See id*. Taylor did have epidural steroid injections, with mixed results. *See id*. at 9.

30 *See id*. at 8.

31 *See id*.

32 *See id*.

33 *See id*. at 9.

better since his last epidural injection, however, Taylor still had paresthesias, weakness, and pain, particularly in his right leg.[34]

On August 19, 2005, Taylor reported another injury while working for Assets. At the hearing before the board, he provided the details. While supervising others who were cleaning the courthouse, he was informed that one individual with mental health issues refused to work and later ran off. Taylor located the individual and accompanied him out of the courthouse to send him home. A struggle ensued during which the individual head butted Taylor and slammed him backwards into a doorframe. His head, mid- and low-back hit against the metal doorframe. Taylor felt pain, tingling, and numbness in his mid-back, and his low-back symptoms increased. The shooting pain he had in his right leg after the March 15, 2005, injury came back.[35] Shortly after the incident, coworker Brian Blunt told Taylor he had blood on the back of his shirt. The blood was in the mid-back area between the shoulder blades.[36] Taylor does not recall receiving any treatment for the cut on his back.[37]

When Taylor saw Dr. Voke again on August 25, 2005, he told Dr. Voke that he reinjured his back on the job. He reported constant pain in the right lower extremity to the knee and intermittent pain in the lower extremity to the foot. The right leg was worse than the left. Dr. Voke recommended continued physical therapy and a new MRI. He also stated that Taylor was partially disabled but could perform light-duty work for one month.[38]

---

[34] *See Taylor*, Bd. Dec. No. 13-0081 at 9.

[35] *See id*.

[36] *See id*. at 10. A syrinx was later found in that approximate location. *See id*. at 10. A syrinx is: 1) a tube or pipe; 2) a pathological cavity (cyst) in the spinal cord or brain; 3) a fistula. Taber's Cyclopedic Medical Dictionary (2009).

[37] *See Taylor*, Bd. Dec. No. 13-0081 at 10. Taylor thought he told Dr. Voke and Dr. Eule about the details of the August 19, 2005, incident, however, he is not sure why none of the medical records reference him hitting his thoracic spine on the doorjamb during that incident. *See id*. at 9.

[38] *See id*. at 10.

On August 26, 2005, Taylor participated in an employer's medical evaluation (EME) performed by Thad C. Stanford, M.D. His report contains a brief history of the two injuries that are the subject of Taylor's claims against Assets. Dr. Stanford thought Taylor's claims presented a conundrum. His examination showed what might be hyperreflexia[39] and he suspected a possible cord lesion, which he thought would probably be unrelated to Taylor's work, although he declined to comment any further without more evaluation. Dr. Stanford said Taylor was not medically stable.[40]

Taylor had a second lumbosacral MRI on August 29, 2005. John McCormick, M.D., compared the films to the March 26, 2005, MRI. Dr. McCormick's impression was a protrusion slightly to the left of midline at L5-S1. In his opinion the protrusion was smaller than it was previously and now caused only mild mass effect on the left S-1 nerve root at the recess. He found no new abnormalities.[41] On September 7, 2005, Taylor underwent a lower extremity nerve conduction study. Dr. Taylor interpreted the study as abnormal and consistent with a mild, right L5 radiculopathy.[42]

Taylor returned to see Dr. Voke on September 15, 2005, complaining of continuing low-back pain and burning and tingling in his right foot. Dr. Voke referred him to Dr. Eule,[43] whom Taylor saw on October 11, 2005. Taylor provided Dr. Eule with a medical history including the two incidents when he hurt his back working for Assets. On Dr. Eule's physical examination, Taylor complained of buttock and lateral back pain, mainly on the right side, but with a little pain on the left side. His reflexes were active in his lower extremities. Dr. Eule reviewed the radiographs and concluded Taylor had a herniated disc at the L5-S1 level causing pressure on the right side, and had very degenerative disks at the L5-S1 level. His diagnoses were degenerative disc disease at L5-S1, herniated disc at L5-S1, with some right-sided symptoms, and unclear etiology of

---

[39] Hyperreflexia is "[a]n increased action of the reflexes." Taber's Cyclopedic Medical Dictionary (2009).

[40] *See Taylor*, Bd. Dec. No. 13-0081 at 10.

[41] *See id*. at 10-11.

[42] *See id*. at 11.

[43] *See id*.

hyperreflexia and clonus[44] in Taylor's bilateral lower extremities. Dr. Eule noted the hyperreflexia and clonus could be normal for him, but in conjunction with recent weight loss, might indicate a tumor. Dr. Eule also reviewed the MRIs and found no obvious large disk herniation or spinal cord compression in the cervical, thoracic, or lumbar spine. Nevertheless, Dr. Eule was concerned about Taylor's symptoms, including the weight loss, and thought a brain MRI would be useful to rule out a tumor. Notably, Dr. Eule doubted that Taylor had a tumor or other spinal cord lesion in his cervical or thoracic spine because he had what appeared to be a normal scout film on his MRI. Dr. Eule referred Taylor to Kenneth Pervier, M.D., a neurologist, for an evaluation.[45]

On November 18, 2005, Dr. Eule reexamined Taylor and again stated his thoracic spine showed no lesions, making a brain MRI desirable. On December 1, 2005, Taylor saw Dr. Pervier, who determined that he had a degree of hyperreflexivity in all four extremities. According to Dr. Pervier, Taylor's antalgic gait and low-back pain would be consistent with his low-back problems, however, they would not explain his hyperreflexivity. Dr. Pervier recommended that he have a cervical and thoracic MRI.[46]

Taylor began having numbness and tingling in his groin area. He never had these symptoms prior to the August 2005 injury. He also began to have vision problems and difficulty with migraines; his arms started to become weak, and he had difficulty writing.[47]

A cervical and thoracic MRI performed on December 7, 2005, revealed an extensive cord abnormality extending from T1 through T6. According to the radiological report, differential diagnostic considerations included traumatic, inflammatory, and neoplastic

---

[44] Clonus is "[s]pasmodic alternation of muscular contractions between antagonistic muscle groups caused by a hyperactive stretch reflex from an upper motor neuron lesion. Usually, sustained pressure or stretch of one of the muscles inhibits the reflex." Taber's Cyclopedic Medical Dictionary (2009). Dr. Eule's report is the first clonus finding in Taylor's records. *See Taylor*, Bd. Dec. No. 13-0081 at 12.

[45] *See Taylor*, Bd. Dec. No. 13-0081 at 11-12.

[46] *See id*. at 12.

[47] *See id*.

etiologies. The likelihood of neoplasm was deemed somewhat low. Post-traumatic cord syrinx would also be a consideration.[48]

On or about December 13, 2005, Dr. Eule completed a form for Assets' human resource department. It indicated that Taylor was not medically stable, confirmed Dr. Eule's prior work restrictions, and in response to an inquiry when he expected Taylor to be released to full-duty work, Dr. Eule said "No!"[49] On January 20, 2006, another thoracic MRI revealed the same abnormality at T1 through T6. The radiologist noted no changes from the prior MRI but conceded the interval between images was probably too short, however, the lack of change indicated a sub-acute or chronic condition.[50] On February 14, 2006, Taylor returned to Dr. Taylor for follow up. Dr. Taylor noted a recent MRI showed a central canal dilation and possible syrinx. Dr. Taylor suggested Taylor might need a referral to a tertiary center for his spinal cord lesion.[51]

Taylor saw Estrada J. Bernard, Jr., M.D., on March 6, 2006, for evaluation. Dr. Bernard reviewed the previous MRI studies. He noted Taylor had spasticity involving the lower extremities and some sensory changes. He recommended a CT myelogram. Dr. Bernard also suggested surgical intervention if there were no unexpected findings seen on the CT myelogram. Specifically, he suggested a thoracic hemilaminectomy and syringostomy.[52] In Dr. Bernard's opinion, Taylor could not be released to return to work for an unknown period.[53]

On March 16, 2006, a thoracic CT myelogram revealed mild cord expansion consistent with a thoracic cord syrinx. There was mild, diffuse, degenerative thoracic disk disease without evidence of a herniated disk or any neural impingement.[54] Shortly

---

48 Exc. 222-23.

49 Exc. 224.

50 *See Taylor*, Bd. Dec. No. 13-0081 at 13.

51 *See id*.

52 *See id*.

53 *See id*.

54 *See id*. at 13-14.

thereafter, on March 20, 2006, Dr. Bernard recommended thoracic exploratory surgery with a T3 through T6 laminotomy with shunt placement.[55]

Assets controverted medical and surgical care for Taylor's back in a notice dated March 31, 2006. The bases for the controversion were that Assets understood Dr. Taylor and Dr. Stanford as having concluded that Taylor's condition was not work-related.[56]

A year passed during which Taylor continued to seek treatment regarding his syrinx.[57] On March 22, 2007, Taylor saw Dr. Taylor again. His syrinx-related symptoms were getting worse; his arms and hands were tingling and getting numb; he had difficulty writing, and his lower extremity symptoms were worse. Dr. Taylor agreed with Dr. Bernard's recommendation and assessed a probable post-traumatic cord syrinx, and degenerative disk disease at L5-S1, with impingement and a herniated disk.[58] Taylor saw Dr. Taylor again on April 26, 2007. Dr. Taylor recorded that he complained of a new symptom, buttocks numbness.[59] On May 16, 2007, Taylor reported rectal bleeding associated with constipation, which Dr. Taylor thought might be a neurological problem related to his syrinx.[60]

On July 6, 2007, Dr. Eule reported that Taylor might have some pain from his herniated disk at the L5-S1 level. In Dr. Eule's opinion, his leg symptoms and numbness were most likely related to his syrinx and the disk injury was a secondary issue. He also recommended surgical treatment for the syrinx. Dr. Eule remarked that it was difficult to say whether or not this was a work-related injury. He deferred to the neurosurgeons. However, Dr. Eule thought if Taylor had an injury in that area it might be a post-traumatic syrinx.[61]

---

55 *See Taylor*, Bd. Dec. No. 13-0081 at 14.

56 Exc. 204.

57 *See Taylor*, Bd. Dec. No. 13-0081 at 14.

58 *See id*.

59 *See id.*

60 *See id*. at 15.

61 Exc. 226-27.

On seeing Dr. Bernard on August 13, 2007, immediate surgery was recommended for Taylor because his symptoms were worsening.[62] Three days later, on August 16, 2007, Dr. Bernard performed a T4 through T6 laminotomy to decompress the syrinx. The operative report makes no reference to the color of the cerebrospinal fluid in the syrinx and does not say the surgeon found a syrinx filled with clear fluid.[63] Taylor's other medical records from Alaska Regional Hospital for his 2007 syrinx surgery make no reference to syrinx cerebrospinal fluid color at the time of surgery.[64]

Following surgery, Dr. Bernard removed Taylor from work.[65] He also recommended physical therapy, which Taylor attended.[66] On October 15, 2007, Dr. Bernard said the syrinx surgery was intended only to prevent progression and not to cure his symptoms, which might be permanent. In Dr. Bernard's opinion, it might take six months to a year to gauge the results. He further found no evidence of S1 radiculopathy, did not believe Taylor's residual symptoms arose from an L5-S1 herniation, and did not recommend an L5-S1 discectomy.[67]

On October 30, 2007, Dr. Eule found that Taylor still had hyperreflexivity consistent with his previous spinal cord problems, yet not consistent with his disk herniation. Dr. Eule reviewed a 2005 MRI film and found Taylor had a small, broad-based disk bulge at the L5-S1 level that was unlikely to be causing his current symptoms. He recommended a new lumbar MRI.[68] On October 31, 2007, a lumbar MRI showed a small-to-moderate sized protrusion left of midline at the L5-S1 level with resultant posterior displacement of the left S-1 nerve root.[69]

---

62 *See Taylor*, Bd. Dec. No. 13-0081 at 15.

63 *See id*.

64 *See id*.

65 *See id.* at 16.

66 Exc. 230, 232, 234-37, 245, 251-52.

67 *See Taylor*, Bd. Dec. No. 13-0081 at 16.

68 *See id*.

69 *See id*.

In a record dated November 26, 2007, Dr. Eule suggested an epidural injection at the L5-S1 level, which could be diagnostic as well as therapeutic. He hoped this might address Taylor's left leg symptoms; it might also determine whether or not the disk should be removed.[70]

Dr. Bernard reported that Taylor had reached the point of maximum medical improvement on November 28, 2007. He had residual sensory changes that might be related to permanent changes resulting from the syrinx. Taylor also had residual hyperreflexivity resulting from the syrinx. That same day, Dr. Bernard recommended a functional capacity evaluation to assess whether Taylor could return to work and thought he might need vocational rehabilitation for work not involving exertion.[71] A physical capacities evaluation was performed on December 3, 2007. As a result, the therapist concluded that Taylor could not return to his prior job with Assets due to his physical limitations.[72]

On December 27, 2007, Dr. Eule commented that lumbar surgery at L5-S1 was not warranted because Taylor's symptoms were not coming from the L5-S1 lesion. They were residuals from his syrinx.[73] The following day, December 28, 2007, Taylor filed a workers' compensation claim requesting unspecified TTD benefits, temporary partial disability (TPD) benefits from August 19, 2005, and continuing, permanent total disability (PTD) benefits from August 19, 2005, and continuing, medical costs, transportation costs, vocational reemployment benefits, a finding of unfair or frivolous controversion, and attorney fees and costs.[74]

On referral from Dr. Eule, Taylor came under the primary care of Larry A. Levine, M.D. On January 16, 2008, under Dr. Levine's direction, he had a physical capacities evaluation. The evaluator rated Taylor's exertional strength level at light-to-medium

---

70 Exc. 231.

71 *See Taylor*, Bd. Dec. No. 13-0081 at 16.

72 Exc. 238.

73 *See Taylor*, Bd. Dec. No. 13-0081 at 18.

74 R. 014-16.

capacity with the ability to lift 20 pounds occasionally and 10 pounds frequently. He stated that these limitations did not allow Taylor to meet the overall strength demands for his other job as a teaching assistant at the Anchorage School District (ASD). Consequently, the evaluator concluded Taylor could not be released to full duty as a teaching assistant.[75] Taylor expressed to Dr. Levine his interest in having L5-S1 surgery to address his low back symptoms. Dr. Levine recommended discography, electromyography, and general conservative care; he suspected Taylor's symptoms were coming from L5-S1.[76]

On January 23, 2008, Assets filed an answer to the December 28, 2007, claim. It denied that Taylor was entitled to the benefits, etc., that he referenced in his claim, generally for lack of supporting medical opinion.[77]

Dr. Levine performed electrodiagnostic studies on March 5, 2008, and found them indeterminate. He commented that he was unsure what to make of the information obtained from the studies. Dr. Levine concluded that Taylor had an apparent disk protrusion at L5-S1 with an annular tear and some left-sided neural foraminal narrowing. He stated that most of Taylor's symptoms could be correlated to the residual thoracic syrinx, but there could be a new issue to explain his current presentation. He suggested a provocative discography.[78]

By spring 2008, Taylor's upper extremity symptoms had largely resolved. He had no difficulty writing or picking things up and had no numbness or tingling in his arms, hands, or fingers. Following the syrinx surgery, Taylor had no more migraines or vision problems. However, his low-back symptoms did not change following the syrinx surgery.[79]

---

[75] Exc. 238. Taylor had been working for ASD as well. *See* n.20, *supra*.

[76] Exc. 239-43. Both Dr. Eule and Dr. Levine continued to treat Taylor's low back to address his ongoing symptoms in his lower extremities. *See Taylor*, Bd. Dec. No. 13-0081 at 16.

[77] *See Taylor*, Bd. Dec. No. 13-0081 at 19.

[78] *See id*. at 20.

[79] *See id*.

On May 7, 2008, James Glenn, Dr. Levine's physician's assistant (PA-C), reported that Taylor would not be able to return to work in the immediate future and that his ability to do so would be determined on a month-to-month basis. Because Taylor was undergoing physical therapy and Dr. Levine had changed his medication, it was hoped that Taylor could return to work in the near future.[80] Four weeks later, on June 4, 2008, PA-C Glenn saw Taylor again and suggested that if he did not improve with medication and physical therapy, Dr. Levine might consider epidural steroid injections, discography, and referring Taylor back to Dr. Eule for a surgical consultation.[81] Another thoracic MRI performed on June 25, 2008, showed a slight decrease in the size of the previous abnormality within the thoracic cord.[82]

On July 23, 2008, Dr. Bernard submitted a physician's report listing the two injury dates that relate to Taylor's employment with Assets. In section 3, Dr. Bernard diagnosed a thoracic syrinx from T1 to T6 and syringomyelia.[83] In block 26, he indicated that the condition was medically stable, although he did not provide a medical stability date. In block 30, with respect to a permanent partial impairment (PPI) rating, Dr. Bernard stated that it would need to be performed by another provider.[84]

Taylor underwent an L3 through S1 discogram followed by an MRI on August 8, 2008. These revealed a large posterior annular tear centrally and to the left of midline at L5-S1 and a possible anterior tear at L3-4.[85] The following week, on August 13, 2008, Dr. Levine advised Taylor that the discogram confirmed some symptoms were coming from the L5-S1 disk, but he would not advocate for aggressive treatment at that level

---

80 Exc. 246.

81 *See Taylor*, Bd. Dec. No. 13-0081 at 20.

82 *See id*.

83 Syringomyelia is "[a] disease of the spinal cord characterized by the development of a cyst or cavities with the cord. It usually begins at the site of a congenital malformation of the cerebellum, but sometimes results from spinal cord trauma, tumors, or after spinal cord infection. Taber's Cyclopedic Medical Dictionary (2009).

84 *See Taylor*, Bd. Dec. No. 13-0081 at 20.

85 Exc. 247-48.

only.[86] On August 21, 2008, Taylor saw nurse practitioner Brandy Moates in Dr. Levine's office to review his recent discogram. Disk replacement surgery was recommended, as it was thought that it might help with some of his chronic pain complaints.[87]

On September 3, 2008, Taylor saw John W. Swanson, M.D., for another EME. According to Dr. Swanson's report, Taylor provided a history covering his 1996 basketball injury, and the work-related incidents occurring on March 15, 2005, and August 19, 2005. Dr. Swanson reviewed medical records and imaging studies. His impressions included: Pre-existing spondylosis in the lumbar spine consisting of arthritis in the facet joints and degenerative disk disease; a lumbar strain on March 15, 2005, which was stable; a lumbar strain on August 19, 2005, which was stable; idiopathic syringomyelia from T1 to T6, which was stable; symptom magnification with probable secondary gain; physical dependence and possible psychological addiction to narcotic pain medications; and pre-existing thoracic spondylosis consisting of arthritis in the facet joints and degenerative disk disease.[88]

In support of his findings, Dr. Swanson pointed to a positive Waddell rotation test, distraction test, superficial tenderness test, markedly exaggerated knee reflex response, inconsistent seated and supine straight leg raising test results, inconsistent hip flexion and forward lumbar spine flexion results, and Taylor's refusal to attempt lumbar extension or right and left thoracic rotation, as evidence of symptom magnification. Whether the March 15, 2005, or August 18, 2005, incidents were a substantial factor in causing any condition he diagnosed, Dr. Swanson concluded that those incidents were a substantial factor in causing lumbar strains on those two occasions. However, as far as Dr. Swanson was concerned, none of the other diagnoses he offered had the work incidents on those two dates as their etiology. Dr. Swanson said all the other conditions failed the "but-for" and "reasonable physician" tests to have the work incident on March 15, 2005, as a substantial cause. However, until Dr. Swanson could personally review the March 26,

---

86 *See Taylor*, Bd. Dec. No. 13-0081 at 21.

87 Exc. 249-50.

88 Exc. 008-37.

2005, MRI films, he could not offer an opinion whether or not the March 15, 2005, incident was a substantial factor aggravating Taylor's pre-existing lumbar spondylosis. He offered to prepare an addendum to his report following film review. Dr. Swanson thought that if the scan demonstrated extruded or free disk fragments indicating a herniated disk, Taylor might have had an aggravation of his pre-existing spondylosis attributable to the March 15, 2005, incident.[89]

Nevertheless, in Dr. Swanson's opinion, based upon the radiologist's description, the findings at L5-S1 on the left were attributable to disk protrusion caused by pre-existing degenerative spondylosis in the lumbar spine. Thus, the medical probability was that Taylor did not suffer a pathological worsening of his underlying pre-existing spondylosis on March 15, 2005, or August 19, 2005. Dr. Swanson also found there was no indication Taylor suffered a pathological worsening of the underlying idiopathic syringomyelia because of his work injuries. He thought Taylor had typical syringomyelia symptoms in 2001.[90]

In connection with the EME, Taylor reportedly told Dr. Swanson that when he was thrown against the door frame on August 19, 2005, he not only injured his low back, but also his thoracic spine. Dr. Swanson said this history differed from that set forth in the medical records. However, in Dr. Swanson's opinion, even if Taylor did contuse his thoracic spine during the August 19, 2005, incident, there was no medical evidence he suffered a pathological worsening of the pre-existing syringomyelia.

It was noted by Dr. Swanson that the March 15, 2005, injury did not involve Taylor's thoracic spine according to the records and Taylor's representations. Therefore, he concluded it was physiologically impossible that incident was a substantial factor in causing Taylor's need for thoracic spine surgery. He observed that the records did not indicate the August 19, 2005, injury involved the thoracic spine. Even if Taylor's history provided on September 3, 2008, was correct, Taylor had clinical evidence of syringomyelia

---

89 Exc. 030-31.

90 Exc. 030-31.

as noted in 2001. Therefore, according to Dr. Swanson, the syringomyelia was a pre-existing condition not pathologically worsened by the August 19, 2005, incident.

Dr. Swanson concluded that the August 19, 2005, work incident was not a substantial factor in Taylor's need for thoracic surgery.[91] Moreover, he thought that Taylor was medically stable from the March 15, 2005, incident by November 15, 2005, at the latest, however, he was probably medically stable by August 19, 2005, because he had returned to work when he was reinjured. In Dr. Swanson's opinion, Taylor was medically stable from the August 19, 2005, incident by April 19, 2006.[92]

According to Dr. Swanson, the March 15, 2005, and August 19, 2005, incidents did not cause any ratable PPI. However, with respect to the syringomyelia condition, in Dr. Swanson's view, Taylor had a 37% whole-person PPI that was entirely due to his pre-existing idiopathic syringomyelia and was not attributable to either the March 15, 2005, or August 19, 2005, work incidents.[93]

Dr. Swanson thought that Taylor did not have the physical capacities to perform his prior job as Project Supervisor II. Dr. Swanson would limit him to light-duty work with no lifting over 20 pounds occasionally or 10 pounds repetitively. However, in Dr. Swanson's opinion, these work restrictions stemmed from Taylor's pre-existing conditions and were not the result of the March 15, 2005, or August 19, 2005, work-related incidents.[94] As far as Dr. Swanson was concerned, Taylor had no physical restrictions resulting from the March 15, 2005, or August 19, 2005, work-related injuries, he needed no further evaluation or treatment for those injuries, and no surgical procedure was currently indicated, even if Taylor had a herniated disk at L5-S1 on the left. Dr. Swanson stated any necessary medical care would address only pre-existing, non-work-related conditions.[95]

---

91 Exc. 032.

92 Exc. 032.

93 Exc. 034.

94 Exc. 035.

95 Exc. 035-36.

On September 29, 2008, at Assets' request, Dr. Swanson reviewed imaging studies. Included in his review were the December 7, 2005, thoracic spine MRI, the December 7, 2005, cervical spine MRI, the January 20, 2006, thoracic spine MRI, and the August 7, 2007, thoracic spine MRI. Dr. Swanson also reviewed his recent EME report. Based on these reviews, Dr. Swanson concluded:

> There is no indication of pathological worsening of the pre-existing thoracic spondylosis since there was no evidence of extruded or free disk fragments to indicate a herniated disk and there were no fractures of the vertebral bodies or facet joints to indicate pathological worsening.
>
> Reviewing the MRIs of the cervical and thoracic spine from 12/07/05 demonstrates longstanding pre-existing syringomyelia in addition to longstanding pre-existing spondylosis of the cervical spine and thoracic spines.
>
> Therefore, reviewing the additional imaging studies above adds one impression, #8, of pre-existing spondylosis of the cervical spine. Otherwise, reviewing these imaging studies confirms the impressions and opinions expressed on 09/03/08.[96]

On October 14, 2008, PA-C Glenn removed Taylor from work pending a surgical consult and said he was unable to return to his ASD job because lumbar spine pain limited his abilities. Taylor indicated he wanted to explore surgical options available to him. In response, PA-C Glenn and Dr. Levine referred him to Dr. Bernard for a second opinion and consultation.[97]

Assets filed controversions of all benefits on October 21, and October 23, 2008, based on Dr. Swanson's September 3, 2008, and September 29, 2008, EME reports.[98] Assets also denied medical and indemnity benefits under AS 23.30.095 and AS 23.30.105, respectively.[99]

---

96 *Taylor*, Bd. Dec. No. 13-0081 at 23-24.

97 *See id*. at 24.

98 *See id*.

99 *See id*.

On October 28, 2008, Dr. Levine responded to a questionnaire provided by Taylor's attorney. Dr. Levine also wrote a supplemental letter to explain his responses. Dr. Levine stated in his letter:

> We are asked multiple questions in relation to overall situation. This gentleman did have two separate work injuries on March 1[5], 2005, and August 19, 2005.
>
> We were told by Derrick Taylor he had not had any back problems before.
>
> If that is indeed the case, then we have little to offer in relation to further cause of his overall situation, and thus we would think it was related.
>
> However, we have been given an independent medical exam, which were (sic) reviewed, previous notes. Apparently, there were complaints of erectile dysfunction quite some time before, and this would certainly be related to the syrinx as one of the early signs that this may have been contributing to his situation. In addition, there were apparently some intermittent complaints of some lumbar spine pain going back to about 1999. Again, this may lead one to believe there are some preexisting issues.
>
> I believe he probably had some fairly asymptomatic back issues that then were made worse by the injury as noted.
>
> I think it would be best addressed by one of the neurosurgeons or someone who deals with the posttraumatic syrinx to comment whether they believe this is posttraumatic related to the particular mechanism of injury he describes or were (sic) preexisting and iatrogenic as the independent medical examiner opines.
>
> Again, he notes to us that there are no other causes, and we have filled out the paperwork with his history given to us. If there is additional information to be shown to us that would include your evidence of no prior injury or evidence of a prior injury, then certainly this would help us be more direct in our responses.[100]

In his responses to Taylor's attorney's questions, using a check-the-box method, Dr. Levine indicated his lumbar spine had a large, annular tear left of midline L5-S1 and a small annular tear at L3-4. He also had a left herniated disk at L5-S1. On a more probable than not basis, Dr. Levine thought the March 15, 2005, bending and twisting incident and/or the August 19, 2005, incident in which Taylor struck his back on a door frame was a substantial factor in causing the condition Dr. Levine diagnosed. Dr. Levine

---

[100] *Taylor*, Bd. Dec. No. 13-0081 at 24-25.

noted that Taylor denied any history of low-back pain prior to March 15, 2005. As for additional care for the lumbar spine, Dr. Levine referred Taylor to Dr. Bernard for a surgical consult. Dr. Levine stated that Taylor's lumbar spine medical care was reasonable and expected to result in objective improvement in his condition. He also said that Taylor's current symptoms and medical condition prevented him from returning to his job held at the time of his injury. He predicted a ratable PPI as a result of the March 15, 2005, or August 19, 2005, incidents. Dr. Levine held the opinion that the two injuries might permanently prevent Taylor from returning to the job he held at the time of injury. With respect to the thoracic spine, Dr. Levine diagnosed that he was post-surgery for a thoracic spine syrinx. He deferred to the surgeon as to causation related to any trauma in this case. However, Dr. Levine thought the March 15, 2005, and August 19, 2005, incidents aggravated, accelerated, or combined with an identifiable pre-existing condition to bring about the need for medical treatment and any disability. Dr. Levine suggested continued monitoring by Dr. Bernard. He said the August 19, 2005, injury seemed to cause a thoracic spine injury or pain but deferred to Dr. Bernard on whether trauma caused the syrinx. In Dr. Levine's opinion, it was reasonable to expect the medical treatment he recommended to result in objective improvement in Taylor's thoracic condition and noted he was seeing some small improvements in his thoracic spine pain. As he did with respect to the lumbar spine, in Dr. Levine's opinion, the thoracic symptoms and condition currently prevented Taylor from returning to his job at the time of injury, might permanently prevent him from doing so, and would probably result in a ratable PPI.[101] Dr. Levine's lumbar spine opinions were based on his understanding that Taylor had no pre-injury low-back problems.[102]

---

101 *See Taylor*, Bd. Dec. No. 13-0081 at 25-26.

102 *See id*.

On November 12, 2008, Dr. Levine and PA-C Glenn stated they wanted to look at the actual MRI films before trying to decide if the syrinx was traumatically caused. They also suggested an IDET[103] procedure might help relieve Taylor's lumbar symptoms.[104]

On November 17, 2008, Taylor's counsel filed an amended claim seeking TTD from August 16, 2007, and continuing, PPI when rated, medical and related transportation costs, vocational reemployment eligibility, penalty, interest, attorney fees, costs, and a second independent medical evaluation (SIME).[105] On November 26, 2008, a petition was filed on Taylor's behalf seeking to join the Boys & Girls Clubs and Alternatives as parties to his claim against Assets.[106]

On December 5, 2008, in reliance on Dr. Swanson's EME report, Assets again controverted Taylor's right to all benefits.[107] On February 9, 2009, Assets opposed Taylor's petitions for joinder and for an SIME.[108]

On March 1, 2009, Dr. Swanson responded to Assets' request for additional information. He clarified that his previous reports did not intend to indicate either the 1996 Boys & Girls Club injury or the 1999 Alternatives injury were substantial factors causing Taylor's syringomyelia or the pre-existing lumbar spondylosis. He said they were not. It was also his opinion that the IDET procedure Dr. Levine recommended was not necessary.[109]

---

103 "Intradiscal Electrothermal Therapy (IDET) is a relatively new minimally invasive treatment for spinal disc-related chronic low back pain." WebMD.

104 Exc. 044-45.

105 *See Taylor*, Bd. Dec. No. 13-0081 at 26.

106 *See id.* at 27.

107 *See id*.

108 *See id*.

109 *See id.*

The board issued an ID&O on March 31, 2009.[110] The decision granted Taylor's request for an order joining the Boys & Girls Clubs and Alternatives as parties to his claim against Assets and granted his request for an SIME.[111]

On August 11, 2009, Walter Ling, M.D., saw Taylor as part of an SIME. Dr. Ling is a neurologist and psychiatrist.[112] The following day, Taylor saw Fred Blackwell, M.D., an orthopedic surgeon, in connection with his SIME.

On February 1, 2010, Taylor saw PA-C Glenn, who reviewed his records. PA-C Glenn thought that he should pursue full course physical therapy, obtain a physical capacity evaluation, and begin vocational rehabilitation. Speaking for himself and Dr. Levine, PA-C Glenn said they would not want to consider more invasive measures or treatment protocol given Taylor's chronic symptoms. He had seen numerous surgeons and was not considered a surgical candidate.[113] On February 8, 2010, Taylor began physical therapy, which he attended regularly through March 30, 2010.[114]

On April 5, 2010, Taylor reported his upper extremity symptoms dramatically improved with physical therapy. He wanted to return to Dr. Eule for further surgical consultation regarding his low back and leg symptoms. Another MRI and additional physical therapy were ordered.[115] On April 9, 2010, Taylor had another lumbar spine MRI, which revealed a moderate-sized protrusion slightly to the left of midline and projecting below the disk space at L5-S1. This caused early mass effect on the left S-1 nerve root.[116] On April 12, 2010, PA-C Glenn referred Taylor back to Dr. Eule for surgical evaluation, given the MRI results.[117]

---

110 *See* n.2, *supra*.

111 *See Taylor*, Bd. Dec. No. 13-0081 at 27.

112 *See id*.

113 *See id.* at 31.

114 *See id*.

115 *See id*. at 31-32.

116 *See id*. at 32.

117 *See id*.

When Dr. Eule saw Taylor again on November 23, 2010, his symptoms related to syringomyelia had resolved, although he was still having radicular-type pain in his legs. Before considering surgical intervention, Dr. Eule wanted another discogram and possibly electromyography (EMG).[118] On February 16, 2011, on Dr. Eule's referral, Taylor saw Dr. Levine for an EMG. This resulted in an abnormal study, however Dr. Levine could not determine whether the findings were related to a central process with the syrinx or related to a peripheral nerve root.[119] Dr. Eule saw Taylor again on March 8, 2011. He reviewed the EMG results and discogram and determined his only treatment option for Taylor's low-back symptoms was disk replacement surgery. In his opinion, Taylor's back-related symptoms resulted from a combination of his thoracic syringomyelia and his low-back condition. Dr. Eule believed the conditions he was seeing Taylor for in 2012 were the same problems he saw him for in 2005.[120]

On July 27, 2012, Assets paid Taylor 8% PPI in a lump sum based on Dr. Blackwell's medical opinions. On August 13, 2012, the board, acting on the parties' stipulation, approved an order awarding Taylor statutory minimum attorney fees of $1,566.00 on the value of the voluntarily-paid PPI.[121]

At a prehearing conference (PHC) on November 7, 2012, a hearing on Taylor's claim was set for April 16, 2013. A follow-up PHC was scheduled for February 21, 2013, to narrow the issues for the hearing.[122]

When Taylor saw Dr. Eule on November 29, 2012, Dr. Eule stated that if he was going to consider whether or not low-back surgery was necessary, he needed to re-image and reevaluate Taylor. Dr. Eule ordered a new MRI and possibly another discogram and post-discogram imaging to determine whether or not Taylor would be a candidate for

---

118 *See Taylor*, Bd. Dec. No. 13-0081 at 32.

119 *See id*.

120 *See id.*

121 *See id*. at 33.

122 *See id*.

fusion versus disk arthroplasty.[123] On December 3, 2012, Taylor had another lumbar spine MRI. The radiologist found a central disc protrusion with extension to the left at L5-S1. This was typical of an annular tear with disk herniation, which contacted the left S1 nerve root, but not the right S1 nerve root.[124]

On January 4, 2013, at Dr. Eule's request, Taylor underwent another discography. Dr. Levine found slight fissuring at L3-4 and a low-pressure, low-volume, chemically sensitive disk with significant pain response at L5-S1. Dr. Levine concluded L5-S1 was the primary pain generator. On a post-discography CT scan, the radiologist found an annular tear at L3-4 and extravasation of contrast material posteriorly, left laterally at L5-S1. He was uncertain if there was an associated protrusion.[125] On January 18, 2013, Taylor saw Dr. Eule, who gave him options to treat his low-back issues. Taylor chose to proceed with an L5-S1 disc arthroplasty and Dr. Eule said he would schedule it in the near future.[126]

On February 21, 2013, the parties, through counsel, attended a PHC at which they listed the following issues for hearing: (1) TTD from August 16, 2007, through continuing, (2) medical costs in an amount to be proven, (3) transportation costs, (4) penalty on TTD and medical bills after the date Assets accepted the low-back claim, (5) PTD, (6) interest, (7) attorney fees and costs, and (8) reemployment benefits after Assets accepted the low-back injury.[127]

On March 26, 2013, the parties, through counsel, again appeared at a PHC to further refine the issues for the April 16, 2013, hearing. At this PHC, Taylor withdrew his PTD claim without prejudice. Assets stipulated to a reemployment eligibility evaluation on Taylor's low back only and agreed he had unusual and extenuating circumstances to justify the evaluation. The designee noted Taylor's low-back surgery had been deferred until shortly after the hearing. The parties' issues were stated as: (1) TTD based on the

---

123 *See Taylor*, Bd. Dec. No. 13-0081 at 33.

124 *See id*. at 34.

125 *See id*.

126 *See id*.

127 R. 3614.

syrinx and low back from August 16, 2007, and continuing, although this date might change, (2) medical costs in an amount to be proven for the syrinx and low back, although Assets agreed to pay unpaid low-back bills, (3) transportation costs, (4) medical bills after the date Assets accepted Taylor's low-back claim, (5) interest, and (6) attorney fees and costs. The PHC summary did not list the compensability of Taylor's low-back injury as an issue for the April 16, 2013, hearing. The PHC summary was never modified.[128]

In connection with the April 16, 2013, hearing, the board was presented with and/or relied on the following evidence. In his report dated August 13, 2009, Dr. Blackwell indicated that the March 15, 2005, injury accounted for the herniated disk at L5-S1, and the August 19, 2005, injury resulted in the need for medical treatment for Taylor's low back, however, it did not cause the need for surgical intervention for the syringomyelia. He stated the syringomyelia was probably congenital, developmental, and pre-existed the two incidents that are the subject of Taylor's claims against Assets. Dr. Blackwell did not believe the syringomyelia was caused by trauma and was unrelated to Taylor's two work injuries with Assets. As for the low back, Dr. Blackwell stated that Taylor had no history of back pain or symptoms for over five years pre-incident, the March 15, 2005, incident herniated his L5-S1 disk, the August 19, 2005, injury aggravated the process, and these account for the L5-S1 lesion. He initially did not believe either work injury aggravated the syringomyelia or was a substantial factor in causing the need for thoracic surgery to treat the syringomyelia condition.[129]

Dr. Blackwell was deposed on May 1, 2012. He conceded that Taylor had an increase in syringomyelia symptoms after his 2005 injury while working for Assets. Before his 2005 work injuries, Taylor did not have a syringomyelia needing medical treatment. After his 2005 work injuries, he did. Dr. Blackwell thought that being head-butted, having one's neck snapped back in whiplash fashion, and having one's mid-back slammed against a doorframe could increase intra-abdominal pressure, increase spinal fluid pressure, and

---

128 R. 3623.

129 *See Taylor*, Bd. Dec. No. 13-0081 at 29-30.

force cerebral spinal fluid into a syrinx, enlarging it. The enlarged syrinx is what results in syringomyelia. Dr. Blackwell could think of no other factor causing increased cerebrospinal fluid pressure after March 2005 other than the two work incidents.[130]

Dr. Blackwell noted that as early as March 23, 2005, Taylor began having new symptoms consistent with syringomyelia, including some gait disturbance. After the August 2005 work incident, he thought Taylor had enhanced syringomyelia symptoms including weakness with walking, tingling in his leg, and numbness in the right leg from the knee down but not including the thigh.[131]

On cross-examination, Dr. Blackwell explained that when he originally wrote his SIME report, he did not think the March 2005 or August 2005 work injuries were a substantial factor aggravating or increasing the need for treatment of Taylor's syringomyelia. However, given the more precise historical background provided in Taylor's deposition, Dr. Blackwell thought the blow to the thoracic spine could actually have contributed to the acceleration of the process that had already begun. The cut Taylor alleged he had on his thoracic spine from hitting a doorframe was not the important point, in Dr. Blackwell's view. The fact that Taylor had testified he had a direct blow to the thoracic area where the syrinx was located caused Dr. Blackwell to change his opinion. The cut would have healed in 10 days, so many examining physicians would never have seen it, or if they saw it, would not have felt it was significant.[132]

In Dr. Blackwell's opinion, Taylor's March 15, 2005, injury became medically stable by August 5, 2005.[133] Although Dr. Blackwell thought Taylor was medically stable from his August 19, 2005, injury on August 13, 2007, based upon Dr. Bernard's opinion, he would not argue with Dr. Eule's statement that medical stability occurred on July 6, 2007.[134] According to Dr. Blackwell, on a more probable than not basis, the August 19,

---

130 *See Taylor*, Bd. Dec. No. 13-0081 at 30.

131 *See id*.

132 *See id.* at 30-31.

133 *See id*. at 31.

134 *See id*.

2005, work injury was a substantial factor accelerating the development of the syrinx to an operable syringomyelia.[135]

Dr. Ling's deposition was taken the following day, May 2, 2012. He asserted that neurologists and neurosurgeons would not necessarily have a better sense of what causes syringomyelia than the other physicians involved with Taylor's treatment or evaluation.[136] Dr. Ling testified that clonus and hyperreflexia are indicators of a spinal cord disease. These signs indicate an upper spinal cord problem, rather than a problem with the lower spinal circuitry normally seen with lumbar spine injuries. According to Dr. Ling, there were some reports before August 2005 suggesting that Taylor had something approaching hyperreflexia.[137] In Dr. Ling's view, Taylor had an aberrantly organized spinal cord before the March 2005 incident and must have had some preexisting condition predisposing a syrinx because they are uncommon. His manifestations of syringomyelia became more pronounced after the August 2005 work incident, and included penis and groin numbness with upper extremity coordination issues, which are all symptoms of an expanded syringomyelia.[138] However, in Dr. Ling's opinion, it was not likely the August 2005 injury would worsen Taylor's syringomyelia because there was no literature or evidence to support such a progressive development of that disease.[139]

Although Dr. Ling conceded that he does not know a lot about syringomyelia, he thought Taylor's two work incidents separately or in conjunction with one another probably did not aggravate, accelerate, or combine with the pre-existing condition to cause symptoms requiring treatment for syringomyelia at a different time, or to a different degree, than Taylor would otherwise have required. However, Dr. Ling would yield to the treating neurosurgeon's causation opinions regarding syringomyelia.[140]

---

135 *See Taylor*, Bd. Dec. No. 13-0081 at 31.

136 *See id*. at 27.

137 *See id*. at 28.

138 *See id.*

139 *See id*.

140 *See id*.

During his deposition, Dr. Ling reiterated what he had said in his written report, in which he stated: "[Taylor's] injuries of 3/05 and 8/05 would be considered factors that aggravate or combine with the preexisting syringomyelia that have resulted in both temporary changes requiring treatment and also permanent changes that will impact his rehabilitation."[141] However, Dr. Ling did not believe either 2005 work incident with Assets was a substantial factor in causing the need for syrinx treatment.[142]

On cross examination, Dr. Ling said he agreed with Edward Eyster, M.D.,[143] and did not believe the March 15, 2005, and August 19, 2005, incidents were a substantial factor in aggravating or accelerating Taylor's preexisting syrinx condition. Dr. Ling also agreed that the two work injuries did not cause the need for or accelerate the need for syringomyelia surgery.[144] His testimony also indicated that he agreed with Dr. Blackwell, who thought Taylor was medically stable for his low-back condition by July 6, 2007;[145] he also agreed with Dr. Bernard's opinion that Taylor was medically stable for his syringomyelia by November 28, 2007.[146]

Dr. Eule was deposed on July 17, 2012. Notably, he agreed with Drs. Ling and Blackwell that Taylor's low-back condition could have been medically stable as of July 6, 2007.[147]

Dr. Bernard's deposition was taken on October 15, 2012. At that deposition, when asked whether the August 2005 incident was probably a substantial factor in bringing about what Dr. Bernard described as myelopathic symptoms, he responded affirmatively.[148] Dr. Bernard was also of the opinion that Taylor's medical signs following

---

141 *Taylor*, Bd. Dec. No. 13-0081 at 29.

142 *See id*.

143 Dr. Eyster's testimony is summarized *infra*.

144 *See Taylor*, Bd. Dec. No. 13-0081 at 29.

145 *See id*.

146 *See id*.

147 Eule Dep. 57:3–59:3, July 17, 2012.

148 *See Taylor*, Bd. Dec. No. 13-0081 at 17.

the August 2005 work incident prompted him to conclude that surgery was appropriate for Taylor's syringomyelia.[149] On cross-examination, in response to a question whether or not Taylor's injuries while working for Assets caused a permanent symptom aggravation, Dr. Bernard indicated the August 2005 incident was compelling evidence of that symptom aggravation.[150] By way of explanation, Dr. Bernard testified that sometimes people with syringomyelia can have an asymptomatic condition until an incident "tips it over into a symptomatic state that never subsides."[151] He candidly acknowledged that he did not know whether the syringomyelia surgery would still have been necessary if Taylor never sustained either injury while working for Assets.[152] In summation, Dr. Bernard thought that Taylor had a developing, asymptomatic syrinx at the time of his March 15, 2005, work incident. The August 19, 2005, work incident aggravated, accelerated, and combined with the pre-existing syrinx and was a substantial factor causing it to become symptomatic, requiring medical intervention for the syringomyelia and resulting disability.[153]

Dr. Levine was deposed on April 3, 2013, shortly before the hearing on April 16, 2013. In his testimony, Dr. Levine characterized this as an odd case with respect to Taylor's low-back condition because the syrinx complicated the diagnosis. In his opinion, Taylor was not medically stable before Dr. Eule's January 18, 2013, surgery recommendation.[154] Dr. Levine recognized that all the physicians in this case had difficulty determining what treatment could make Taylor better.[155] According to Dr. Levine, Taylor was not medically stable concerning his low-back injury from the date he

---

149 *See Taylor*, Bd. Dec. No. 13-0081 at 17.

150 *See id*.

151 *Id*.

152 *See id*. at 18.

153 *See id*.

154 *See id*. at 26.

155 *See id*.

first saw him up to the present.[156] Dr. Levine agreed with Dr. Blackwell's opinion that the March 15, 2005, work incident was the probable cause of the L5-S1 disc symptoms, complicated by the August 19, 2005, work incident.[157]

On April 5, 2013, Assets paid Taylor TTD from January 18, 2013, and continuing. The decision to make this payment was based on Dr. Eule's January 18, 2013, report stating Taylor was being scheduled for lumbar surgery and was therefore no longer medically stable in terms of his low-back injury as of January 18, 2013.[158]

The board reviewed the hearing testimony of Dr. Eyster at length in its decision.[159] Dr. Eyster primarily treats any issue regarding the brain and spinal cord. In his opinion a syrinx does not always require surgical intervention. He noted surgeons do not see it very often and when they do, it is usually in conjunction with a brain problem.[160]

Dr. Eyster diagnosed Taylor's main issue as residuals from his syrinx surgery, which included bowel, bladder, and paraplegic-like symptoms. However, he noted that the earlier medical records pertained primarily to Taylor's low-back symptoms. Dr. Eyster remarked that findings such as hyperreflexia are a red flag for a spinal condition, which prompted him to conclude that the syrinx pre-existed the August 2005 work incident.[161]

As distinguished from Dr. Bernard's opinion, Dr. Eyster did not think the August 2005 work incident aggravated a pre-existing syrinx condition. However, he agreed there can be post-traumatic syrinxes. However, in Dr. Eyster's opinion, the surgical findings did not demonstrate evidence of trauma because there still would have been some discoloration in the spinal fluid released from the syrinx at surgery.[162]

---

156 *See Taylor*, Bd. Dec. No. 13-0081 at 26.

157 *See id*.

158 *See id*. at 35.

159 *See id*. at 35-38.

160 *See id*. at 35.

161 *See id*.

162 *See id*. at 35-36.

Dr. Eyster explained that a syrinx is essentially a pressurized bubble in the spinal cord. The syrinx's lining secretes cerebral spinal fluid and if it does not communicate with the adjoining spinal cord, there is no place for the fluid to go and pressure rises. When a syrinx becomes pressurized with cerebral spinal fluid, it presses on the spinal cord and causes symptoms, which is what happened in Taylor's case. In Dr. Eyster's opinion, early signs of impotency could be a sign of the expanding syrinx. It could not, however, be caused by a disk problem.[163]

Dr. Eyster agreed with Dr. Ling that trauma does not increase spinal fluid pressure. However, it does not mean a trauma would not aggravate the syrinx because it would cause bleeding, blood vessel disruption, and catastrophic results. According to Dr. Eyster, the physicians who treated Taylor early on were diagnosing and treating the low back, thinking it was causing symptoms that actually were arising from the syrinx. Dr. Eyster stated the March and August 2005 incidents were not substantial factors in aggravating or accelerating the syrinx. He based this opinion on his belief that Taylor was clearly demonstrating symptoms related to a syrinx before these injuries. In Dr. Eyster's view, frequently people with a syrinx will present with back pain only in the paraspinal muscles and physicians will think it emanates from a spinal cord or nerve issue.[164]

A syrinx can exist in the spinal cord from birth or it can form at a later date, according to Dr. Eyster. The spinal cord has a fixed diameter. As a syrinx pressurizes and expands, there is no place for the syrinx to go other than to push on adjacent nerves within the spinal cord. This creates a pressure phenomenon on the nerves and surgery is performed to shunt the fluid from the syrinx to the spinal cord to relieve the pressure. The central canal is a very small tube within the spinal cord. It, too, contains spinal fluid. Certain physical activity can cause an increase in cerebral spinal fluid pressure. Coughing, bearing down, and anything increasing cranial pressure will increase spinal fluid pressure.[165]

---

163 *See Taylor*, Bd. Dec. No. 13-0081 at 36.

164 *See id*.

165 *See id*.

In Dr. Eyster's opinion, the syrinx pre-existed Taylor's two incidents occurring while he worked for Assets and Taylor was probably born with it. Neither the March 2005 nor the August 2005 injury was a substantial factor accelerating, aggravating, or causing a need for Taylor's August 2007 syrinx surgery, as far as Dr. Eyster was concerned. In his opinion, neither work injury was a substantial factor in causing the need for any lumbar spine surgery based upon Taylor's pre-existing conditions and contraindications for surgery including degenerative spine disease. According to Dr. Eyster, Taylor is 100% disabled due to residuals from syrinx surgery.[166]

Dr. Eyster believed the medicals records, in particular Dr. Voke's May 19, 2005, report, showed that Taylor had clonus before August 2005, although he conceded that the report does not specifically say clonus. Clonus is a finding on physical examination that can be indicative of a syrinx. In Dr. Eyster's opinion, Dr. Voke would have discovered the clonus had he had tested for that. Dr. Eyster stated that Dr. Child's 2001 record was evidence that Taylor had erectile dysfunction, which could be an early indicator of a neurological problem.[167]

The syrinx process develops over time and takes years if not decades. The symptoms can arise rather quickly, but the pathological process develops over time. In Dr. Eyster's opinion, a sudden increase in cerebrospinal fluid pressure does not affect a syrinx because there is no fluid communication between the two areas. Dr. Eyster agreed, theoretically, increased spinal fluid pressure pushing on the outside of the syrinx would increase pressure within the syrinx. When the syrinx presents the pressure phenomenon on the spinal cord, it also stretches the spinal cord nerve paths. However, Dr. Eyster believes spinal cord pressure is the more significant factor causing symptoms.[168]

Dr. Eyster conceded that Taylor's neurological symptoms were accelerating after the work incidents with Assets, however, he was not sure if they were increasing more rapidly after those incidents. In Dr. Eyster's opinion, neither work injury had any bearing

---

166 *See Taylor*, Bd. Dec. No. 13-0081 at 37.

167 *See id*.

168 *See id*.

on or relationship to the need for syrinx surgery or resulting disability.[169] Specifically, Dr. Eyster stated it was his opinion to a reasonable degree of medical probability that neither incident with Assets was a substantial factor in causing the need for that surgery. Dr. Eyster believed there was no evidence that the work incidents with Assets caused the syrinx to become more symptomatic or to require surgery. According to Dr. Eyster, a normal syrinx, one that is communicating fluid back and forth with the spinal cord, could not be blocked by a blow to the back directly over the area where the syrinx is located. However, if one had a blocked syrinx and had a blow to the back directly over the area where the syrinx is located, it could cause the syrinx to get bigger.[170] Dr. Eyster also concluded that Taylor's proposed lumbosacral surgery is contraindicated because Taylor's remaining symptoms, including back pain and lower extremity symptoms, are residuals from damage done to the spinal cord resulting from the syrinx.[171] When asked whether the onset of neurological symptoms following Taylor's work incidents with Assets was a coincidence, Dr. Eyster responded that there was significant medical evidence of syrinx-related neurological symptoms prior to the August 2005 incident, including the May 2005 spasticity, as well as hyperreflexia and gait problems.[172]

After issuing its decision, the board issued a Decision and Order Errata (Errata).[173] It found that, based on Dr. Bernard's and Dr. Ling's opinions, Taylor had reached maximum medical improvement and was medically stable with respect to his syrinx and syringomyelia on November 28, 2007, not November 20, 2007.[174] The board observed:

> Dr. Bernard performed syrinx surgery on August 16, 2007, and said [Taylor's] syrinx became medically stable on November 28, 2007[.] . . . Dr. Bernard said [Taylor's] syrinx had reached "maximum medical

---

169 *See Taylor*, Bd. Dec. No. 13-0081 at 38.

170 *See id*.

171 *See id*.

172 *See id*.

173 *See* n.2, *supra*.

174 *See* Errata at 2.

> improvement" by November 28, 2007. . . . This comports with SIME Ling's November 28, 2007[,] opinion. . . . Therefore, the weight of medical evidence on the syrinx's medical stability date supports November 28, 2007. As no medical care was directed to the syrinx thereafter, there was no reasonable expectation of an objectively measureable improvement. [Taylor's] syrinx and syringomyelia were medically stable on November 28, 2007, based on Drs. Bernard's and Ling's opinions. . . . [Taylor] is entitled to TTD for his syrinx and syringomyelia from August 16, 2007[,] through November 28, 2007[.] This determination leaves the period from November 29, 2007[,] to the present and continuing in [dispute]. The burden shifts to [Taylor] who must prove he was disabled from November 29, 2007[,] to the present because of his now [Assets]-accepted low-back injury[.] . . . The record lacks sufficient evidence to find [Taylor] was disabled and thus entitled to TTD from November 29, 2007[,] until January 16, 2008, because of his lumbar spine[.] . . . Therefore, the weight of the credible medical evidence shows although [Taylor's] low-back injury was not medically stable, there was no medical evidence stating he was disabled by it or that any medical care or treatment was reasonably expected to make an objective improvement from the lumbar injur[y's] effects from November 29, 2007[,] through August 20, 2008[.] . . . Because there was no medical evidence stating he was disabled from his lumbar spine injury and no evidence objectively measurable improvement was likely to result from additional medical care, [Taylor] was not entitled to TTD from November 29, 2007[,] through August 20, 2008[.][175]

3. Standard of review.

The commission is to uphold the board's findings of fact if they are supported by substantial evidence in light of the whole record. Substantial evidence is such relevant evidence which a reasonable mind might accept as adequate to support a conclusion.[176] The question whether the quantum of evidence is substantial enough to support a conclusion in the contemplation of a reasonable mind is a question of law.[177] We exercise our independent judgment when reviewing questions of law and procedure.[178]

---

[175] Errata at 3-5.

[176] *See, e.g., Norcon, Inc. v. Alaska Workers' Compensation Bd.*, 880 P.2d 1051, 1054 (Alaska 1994).

[177] *See Wasser & Winters Co., Inc. v. Linke*, Alaska Workers' Comp. App. Comm'n Dec. No. 138, 5 (Sept. 7, 2010).

[178] *See* AS 23.30.128(b).

4. Applicable law.

a. Statutes.

AS 23.30.128. Commission proceedings.

. . .

(d) The commission may affirm, reverse, or modify a decision or order upon review and issue other orders as appropriate. The commission may remand matters it determines were improperly, incompletely, or otherwise insufficiently developed. The commission may remand for further proceedings and appropriate action with or without relinquishing the commission's jurisdiction of the appeal. The administrative adjudication procedures of AS 44.62 (Administrative Procedure Act) do not apply to the proceedings of the commission.

. . .

AS 23.30.122. Credibility of witnesses.

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

AS 23.30.185. Compensation for temporary total disability.

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

AS 23.30.395. Definitions. In this chapter,

. . .

(16) "disability" means incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment;

. . .

(27) "medical stability" means the date after which further objectively measurable improvements 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[.]

b. The presumption of compensability.

The incidents on March 15, and August 19, 2005, while Taylor was employed by Assets, predate the effective date of the 2005 amendments to the Alaska Workers' Compensation Act (Act), November 7, 2005.[179] Therefore, the pre-amendment version of the Act applies to Taylor's 2007 and 2008 claims which relate to those incidents.

In *Runstrom v. Alaska Native Medical Center*,[180] the commission had the opportunity to discuss the presumption of compensability, as it was formulated both before and after the 2005 amendments to the Alaska Workers' Compensation Act.

> As the commission has observed, prior to the 2005 amendments to the Act, case law required that employment be "a substantial factor" in causing the employee's disability, need for medical treatment, etc. . . . Under AS 23.30.010(a), as has always been required of the employee under the presumption of compensability analysis, to attach the presumption, the employee must first establish "a causal link" between employment and his or her disability, need for medical treatment, etc. . . .
>
> . . .
>
> As for the second step of the analysis, to rebut the presumption under former law, the employer's substantial evidence had to either (1) provide an alternative explanation which, if accepted, would exclude work-related factors as a substantial cause of the injury, etc.; or (2) directly eliminate any reasonable possibility that employment was a factor in causing the injury, etc. . . .
>
> . . .
>
> If the employer successfully rebuts the presumption, under former law, the supreme court consistently held that in the third step of the analysis, 1) the presumption dropped out, and 2) the employee was required to prove all elements of his or her claim by a preponderance of the evidence. . . .[181]

---

[179] *See Rivera v. Wal-Mart Stores, Inc.*, 247 P.3d 957, 959, n.2 (Alaska 2011).

[180] Alaska Workers' Comp. App. Comm'n Dec. No. 150 (Mar. 25, 2011); the Alaska Supreme Court (supreme court) affirmed, 280 P.3d 567 (Alaska 2012).

[181] *Runstrom*, App. Comm'n Dec. No. 150 at 5-7 (footnotes omitted).

c. Disability, medical stability, entitlement to TTD benefits.

Under Alaska workers' compensation law, "[o]nce an employee is disabled, the law presumes that the employee's disability continues until the employer produces substantial evidence to the contrary."[182] "If the employer produces substantial evidence, the presumption drops out and the claimant must prove the claim by a preponderance of the evidence."[183] Ordinarily, medical stability signals an end to temporary total disability and any entitlement to TTD benefits.[184]

> Medical stability is reached at 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.[185]

5. Discussion.

a. Compensability is not an issue.

At the board level, the compensability of Taylor's injuries was in dispute.[186] However, in this proceeding, only Taylor's TTD benefits are at issue. Assets appealed the board's award of TTD benefits to Taylor from August 21, 2008, through January 17, 2013. Taylor cross-appealed the board's denial of TTD benefits over an earlier time span, from November 28, 2007, through August 21, 2008. Accordingly, their arguments to the commission focused on Taylor's entitlement to TTD benefits, not the

---

[182] *Grove v. Alaska Constr. & Erectors*, 948 P.2d 454, 458 (Alaska 1997); *Bailey v. Litwin Corp.,* 713 P.2d 249, 254 (Alaska 1986).

[183] *Id*.

[184] AS 23.30.185 provides in part: "Temporary total disability benefits may not be paid for any period of disability occurring after the date of medical stability."

[185] *Alyeska Pipeline Service Co. v. DeShong*, 77 P.3d 1227, 1232 (Alaska 2003)(*DeShong*).

[186] *See Taylor*, Bd. Dec. No. 13-0081 at 52-66. The board declined to enter an order that Taylor's low-back injury was compensable because the issue was not listed on the March 26, 2013, PHC summary. *See id*. at 52. It held that Taylor's syrinx and syringomyelia were compensable. *See id*. at 66.

compensability of Taylor's claims against Assets arising out of the March 15, 2005, and August 19, 2005, incidents. Therefore, we conclude that the only issues before us, other than attorney fees and costs, are: 1) whether Taylor was disabled as a result of either incident; and 2) if he was disabled, on what dates was he totally disabled and entitled to TTD benefits.

b. The TTD issues are complex.

Preliminarily, with respect to the TTD issues, our recitation of the factual background of this claim demonstrates that there were numerous physicians who offered varying opinions on the subject of Taylor's medical stability. As the board did, it now falls to us to evaluate this evidence. Beginning that process, the commission notes that in the past, the supreme court has held that, for complex medical questions, medical evidence is needed to resolve them. "We find this case involves highly technical medical considerations, and that a determination of causation requires the production of a greater weight of medical evidence."[187] Analogously, given the facts of this case, we think it involves highly technical medical considerations and a determination of medical stability requires the production of a greater weight of medical evidence.

c. Is Taylor entitled to TTD benefits from November 29, 2007, through August 21, 2008?

We continue our analysis of the TTD issues with consideration of the board's denial of benefits from November 29, 2007, through August 21, 2008, which is the subject of Taylor's cross-appeal.[188] The board found that there was substantial evidence that Taylor had reached maximum medical improvement, that is, he had reached medical stability, in terms of the syrinx and syringomyelia. Dr. Bernard, who performed the syrinx surgery on August 16, 2007, stated that Taylor had reached

---

[187] *Smith v. University of Alaska, Fairbanks*, 172 P.3d 782, 789 (Alaska 2007).

[188] Even though Taylor cross-appealed the denial of TTD benefits from November **28**, 2007, through August 21, 2008, *see* Notice of Cross-Appeal at 1, the board awarded him TTD benefits through the date of medical stability, November 28, 2007. *See* Errata at 4. Thus, November **29**, 2007, was the first day the board's decision operated to preclude Taylor from receiving TTD benefits.

maximum medical improvement on November 28, 2007, following that surgery.[189] Dr. Ling also considered Taylor to be medically stable as of that date.[190] Moreover, we are not aware of any medical evidence being introduced that Taylor was not medically stable as of November 28, 2007, or that he was medically stable at a later date, in terms of his syrinx and syringomyelia.

Having discussed whether the syrinx and syringomyelia was potentially disabling after November 28, 2007, we move to the next question, which is whether Taylor's low-back condition was medically stable at any time between November 28, 2007, and August 21, 2008. If his low back was medically stable, he would not be entitled to TTD benefits in that timeframe. There were two physicians who were the most involved in Taylor's care for his low back at the time, and presumably in the best position to comment on medical stability. Dr. Eule, who had treated Taylor since October 2005, did not think he was medically stable in December 2005. However, he later testified that Taylor could have been medically stable in terms of his low back as of July 6, 2007, which is consistent with the opinions of SIME doctors Blackwell and Ling.[191] It was not until January 2008, on referral from Dr. Eule, that Dr. Levine took over Taylor's primary care. After ordering a number of diagnostic tests, on August 21, 2008, Dr. Levine concluded that Taylor needed disc replacement surgery, an indication he was not medically stable. However, based on the foregoing, the board found that the greater weight of the medical evidence was that no medical care or treatment was reasonably expected to make an objective improvement in Taylor's lumbar spine in the relevant time period, November 29, 2007, to August 21, 2008.[192]

We are remanding the other issues in this matter to the board. That remand includes reopening the record to receive more medical evidence, should the board

---

[189] "As no medical care was directed to the syrinx thereafter, there was no reasonable expectation of any objectively measureable improvement." Errata at 4.

[190] *See* Errata at 3-5.

[191] *See* n.146, *supra*.

[192] *See* Errata at 5. The board's weight finding is conclusive. *See* AS 23.30.122.

decide that is necessary. Therefore, in the interest of completeness,[193] the commission concludes that a remand of the board's denial of TTD in the post-November 28, 2007, timeframe is also appropriate.

d. Is Taylor entitled to TTD benefits from August 21, 2008, through January 17, 2013?

Similarly, for the subsequent timeframe that TTD benefits were in dispute, between August 21, 2008, and January 17, 2013, the issue is whether Taylor proved that he was temporarily, totally disabled over that entire time or any portion thereof. Like the board, our focus will be on the evidence whether Taylor's low-back injury rendered him totally disabled over the approximately four-and-a-half years between August 2008 and January 2013.

The board continued its analysis by noting that Taylor's "TTD entitlement turns in part on factual issues to which the presumption of compensability applies. The factual issues include the date [Taylor] became 'medically stable,' and whether he was totally disabled during periods for which he seeks TTD before the medical stability date . . . "[194] was reached for his low back. The board proceeded with a presumption of compensability analysis, concluding that Taylor had attached the presumption and Assets rebutted it.[195] We agree with the board. It then declared that Taylor had to prove he was *not* medically stable through January 17, 2013, by a preponderance of the evidence. In this third phase of its presumption analysis, the board weighed the evidence concerning medical stability.[196]

Conveniently, the board, in its decision, included a table which summarized the evidence having a bearing on the medical stability issue.[197] We reproduce that table here, although it has been edited to focus on the opinions of the various physicians who treated or evaluated Taylor for his low-back injury.

---

193 *See* AS 23.30.128(d).

194 *Taylor*, Bd. Dec. No. 13-0081 at 66.

195 *See id*. at 66-67.

196 *See id*. at 67.

197 *See id.* at 67-68.

Date	Provider	Lumbar Treatment	Medically Stable	Disabled
May 19, 2005	Voke	Surgery not recommended unless Taylor's quality of life deteriorated at which time a laminectomy might be appropriate.		
July 6, 2005	Taylor	Taylor might be a surgical candidate.		
August 26, 2005	Stanford		No, for low back as of August 26, 2005.	
December 13, 2005	Eule		No, for low back as of December 13, 2005.	Yes.
July 6, 2007	Eule		Low back stable.	
October 15, 2007	Bernard	Did not recommend an L5-S1 discectomy.		
December 27, 2007	Eule	Surgery at L5-S1 is "certainly not warranted."		
August 21, 2008	Levine	Recommended disc replacement surgery.		
September 3, 2008	Swanson	No surgical procedure currently indicated.	March 15, 2005 injury by August 19, 2005.	Yes.
October 28, 2008	Levine	Referred to Dr. Bernard for surgical consult.	No for low back. In retrospect, should have had surgery in 2005; was not stable from at least January 16, 2008, through April 3, 2013.	Yes.
August 11, 2009	Ling		Yes for low back by July .6, 2007	
August 12, 2009	Blackwell		Yes, for low back by August 5, 2005.	
March 8, 2011	Eule	Taylor is a reasonable candidate for low back surgery.	Low back was medically stable as of July 6, 2007.	
January 18, 2013	Eule	Dr. Eule offered a disc arthroplasty or a lumbar fusion.		

The board made the following credibility and weight findings with respect to this evidence.

> [Taylor] relies on Dr. Levine's opinion his low back injury was not medically stable from 2005 forward and should have been surgically repaired years ago. Dr. Levine's medical stability opinion is given considerable weight because it comports with Dr. Swanson's initial opinion [Taylor's] low back was not medically stable effective August 26, 2005, Dr. Eule's view it was not stable as of December 13, 2005, and MRI evidence [Taylor] had a herniated L5-S1 disk. No other physician offered a medical stability opinion for the low back injury until September 8, 2008, when EME Dr. Swanson said [Taylor] was medically stable for his March 15, 2005[,] and August 19, 2005[,] injuries by August 19, 2005[,] and April 19, 2006, respectively. Dr. Swanson's conflicting medical stability opinions are unexplained, confusing and given little weight. Dr. Ling, and later Dr. Eule, offered a July 6, 2007[,] stability date for the low back. Their opinions are somewhat conclusory and are given less weight.[198]

---

198 *See Taylor*, Bd. Dec. No. 13-0081 at 68 (statutory citation omitted).

By statute, the commission must defer to the board's credibility and weight findings,[199] which we willingly do. Otherwise, the board's factual findings are reviewable under the substantial evidence standard; substantial evidence is such relevant evidence which a reasonable mind might accept as adequate to support a conclusion.[200] With these principles in mind, we now undertake to review whether the board's medical stability findings for Taylor's low back are supported by substantial evidence.

The medical evidence that was available to the board on the issue of Taylor's entitlement to TTD benefits from August 21, 2008, through January 17, 2013, can be summarized as follows. In 2005, Dr. Voke, an orthopedic surgeon who was treating Taylor at that time, thought that he would *not* need low-back surgery unless his quality of life deteriorated. Dr. Eule, also an orthopedic surgeon, took over Taylor's care from Dr. Voke in October 2005. On December 13, 2005, Dr. Eule proclaimed that Taylor was not medically stable and was disabled in terms of his low back. However, as of July 6, 2007, he declared Taylor to be medically stable with respect to his low back. Later in 2007, both Dr. Eule and Dr. Bernard, who had by then performed the syrinx surgery, were of the opinion that Taylor did not need low-back surgery. When he saw Taylor on August 21, 2008, Dr. Levine, who is not an orthopedic surgeon, recommended disc replacement surgery. This is some evidence that Taylor was not medically stable for his low back. On September 3, 2008, Dr. Swanson evaluated Taylor and added his opinion to those of Drs. Bernard and Eule that Taylor was not a surgical candidate. After performing some diagnostic testing, in October 2008, Dr. Levine concluded 1) that Taylor should have had lumbar spine surgery back in 2005 and 2) that his low back was not medically stable from at least January 16, 2008, when Dr. Levine first saw Taylor, through April 3, 2013, when Dr. Levine was deposed.

Continuing our review of the low-back medical evidence, Dr. Eule began treating Taylor on October 11, 2005, and was still treating him in December 2007, when he remarked that low-back surgery was "certainly not warranted." Yet the board

---

[199] *See* AS 23.30.122.

[200] *See* Part 3, *supra*.

dismissed as "conclusory" Dr. Eule's statement that Taylor was medically stable with respect to his low back as of July 6, 2007. In contrast, Dr. Levine began treating Taylor in January 2008. By October 2008, he had expressed the views referenced at the end of the preceding paragraph. We note that, of the numerous medical opinions of the various providers and evaluators, only Dr. Levine thought that Taylor was not medically stable, on account of his low back, after July 6, 2007, the date Taylor was medically stable according to Dr. Eule and others. Moreover, Dr. Levine's remark that Taylor should have had back surgery in 2005 could be understood as an opinion that Taylor had not been medically stable since 2005, but in any event, he was not medically stable from at least January 16, 2008, when Dr. Levine first saw Taylor.

In order to have awarded Taylor TTD benefits between August 21, 2008, and January 17, 2013, the board necessarily had to find that Taylor's low back was *not* medically stable in that time frame, based on Dr. Levine's opinion that Taylor should have had back surgery in 2005 and should have had disc replacement surgery in 2008. We note that Dr. Eule is an orthopedic surgeon; Dr. Levine is not. Dr. Eule was treating Taylor in 2005; Dr. Levine was not. Dr. Eule was still treating Taylor, and Dr. Levine was not, when in December 2007, Dr. Eule declared low-back surgery for Taylor was not warranted. Until Taylor started seeing Dr. Levine in January 2008, Dr. Eule was in a superior position to comment on Taylor's low back. As late as March 8, 2011, Dr. Eule, who continued to see Taylor,[201] expressed his opinion that, although Taylor was a candidate for low-back surgery, he would adhere to his long-standing opinion that Taylor was medically stable for his low back as of July 6, 2007. Lastly, certain medical evaluators, Drs. Swanson, Ling, and Blackwell, all agreed that Taylor's low back was medically stable no later than July 6, 2007, which is consistent with Dr. Eule's opinion.

Notwithstanding this evidence, the board concluded that Taylor had proven by a preponderance of the evidence that he was not medically stable for his lumbar spine

---

[201] *See Taylor*, Bd. Dec. No. 13-0081 at 16.

after May 19, 2005.[202] Again, the board assigned more weight to Dr. Levine's opinion, which finding is conclusive. However, it remains to be seen whether the board's finding that Taylor was TTD in this timeframe is supported by substantial evidence. Prior to August 21, 2008, none of the physicians who had treated or evaluated Taylor said he needed surgery, and the medical consensus was that his low back was medically stable as of July 6, 2007. In contrast to this evidence, on August 21, 2008, Dr. Levine provided his opinion that Taylor needed back surgery. On remand, the board would be in position to shed more light on its evaluation of this and any other evidence it admits.

e. What is the proper standard of proof if Taylor was medically stable for a period of 45 days at any time from November 28, 2007, through January 17, 2013?

Finally, Assets argued in its briefing that the board applied the wrong legal standard in terms of Taylor's evidentiary burden when it came to whether he was medically stable.[203] According to Assets, in the relevant timeframe, Taylor had gone more than 45 days without showing any prospect for objective medical improvement. In the circumstances, under AS 23.30.395(27) and the supreme court's decision in *DeShong*, Taylor had to prove he was not medically stable, and thus entitled to TTD benefits, by clear and convincing evidence, not by a preponderance of the evidence.

The board found that Taylor had proven by a preponderance of the evidence that he was not medically stable for his lumbar spine after May 19, 2005. However, if, on remand, the evidence demonstrates that Taylor was medically stable for 45 days for his low back at any time between May 19, 2005, and January 17, 2013, Taylor would have to prove by clear and convincing evidence that he was not medically stable and therefore entitled to TTD benefits.

f. Is Taylor entitled to an award of attorney fees?

Assets has requested that the commission remand the attorney fees award if it reverses the board's award of TTD benefits for Taylor's low back.[204] It points out that

---

202 *See Taylor*, Bd. Dec. No. 13-0081 at 69.

203 *See* Assets' Reply Br. at 4-5.

204 *See* Assets' Br. at 31.

the board awarded fees under AS 23.30.145(a), which provides for fees on the amount of compensation controverted and awarded.[205] Taylor maintains that entitlement to TTD benefits was not the primary issue between the parties, compensability was, and he prevailed in terms of compensability.[206] As we are remanding the TTD issues to the board, under the circumstances the commission concludes that a remand of the attorney fees award is also appropriate.

6. Conclusion.

We REMAND this matter to the board, subject to the following instructions: 1) the issue whether Taylor is entitled to TTD from November 28, 2007, to August 21, 2008, is to be revisited and decided, based on all available evidence at the time of the hearing on remand, including evidence relative to Taylor's low-back surgery in April 2013 and recovery therefrom, should the board conclude that this evidence ought to be admitted; 2) the issue whether Taylor is entitled to TTD from August 21, 2008, to January 17, 2013, is to be revisited and decided, based on all available evidence at the time of the hearing on remand, including evidence relative to Taylor's low-back surgery in April 2013 and recovery therefrom, should the board conclude that this evidence

---

[205] **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.

[206] *See* Taylor's Br. at 37-38.

ought to be admitted; and 3) the board should revisit and decide whether Taylor is entitled to an award of attorney fees and costs, based on its disposition of the matter on remand.

Date: *22 April 2014* ALASKA WORKERS' COMPENSATION APPEALS COMMISSION

Signed
James N. Rhodes, Appeals Commissioner

Signed
Philip E. Ulmer, Appeals Commissioner

Signed
Laurence Keyes, Chair

APPEAL PROCEDURES

This is a final decision on the merits of this appeal. The appeals commission remands the matter to the board, as more fully set forth above. The commission's decision becomes effective when distributed (mailed) unless proceedings to reconsider it or to appeal to the Alaska Supreme Court are instituted (started).[207] For the date of distribution, see the box below.

Effective, November 7, 2005, proceedings to appeal this decision must be instituted (started) in the Alaska Supreme Court no later than 30 days after the date this final decision is distributed[208] and be brought by a party-in-interest against all other parties to the proceedings before the commission, as provided by the Alaska Rules of Appellate Procedure. *See* AS 23.30.129(a). The appeals commission is not a party.

---

[207] A party has 30 days after the distribution of a final decision of the commission to file an appeal to the supreme court. If the commission's decision was distributed by mail only to a party, then three days are added to the 30 days, pursuant to Rule of Appellate Procedure 502(c), which states:

> **Additional Time After Service or Distribution by Mail.** Whenever a party has the right or is required to act within a prescribed number of days after the service or distribution of a document, and the document is served or distributed by mail, three calendar days shall be added to the prescribed period. However, no additional time shall be added if a court order specifies a particular calendar date by which an act must occur.

[208] *See id*.

You may wish to consider consulting with legal counsel before filing an appeal. 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

More information is available on the Alaska Court System's website:
http://www.courts.alaska.gov/

RECONSIDERATION

This is a decision issued under AS 23.30.128(e). A party may ask the commission to reconsider this final decision by filing a motion for reconsideration in accordance with 8 AAC 57.230. The motion for reconsideration must be filed with the commission no later than 30 days after the day this decision is distributed to the parties. 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 this is a full and correct copy of Final Decision No. 195 issued in the matter of *Assets, Inc., Commerce & Industry Insurance Company, Chartis, and Northern Adjusters, Inc. vs. Derrick F. Taylor*, AWCAC Appeal No. 13-017, and distributed by the office of the Alaska Workers' Compensation Appeals Commission in Anchorage, Alaska, on April 22, 2014.

Date: *April 23, 2014*

Signed

K. Morrison, Appeals Commission Clerk