State of Wisconsin
Labor and Industry Review Commission

Danyl Albright Applicant **Deckert W L Co., Inc.** Employer **Acuity Ins. Co.** Insurer Claim No. 2017-013593	**Worker's Compensation Decision and Remand Order**[1] **Dated and Mailed:** June 28, 2019

Interlocutory Order

The commission **modifies** and **affirms** the decision of the administrative law judge as to causation, extent of disability, and reasonableness of treatment; the commission **sets aside** and **remands** the decision regarding the amounts the respondent must pay for the medical treatment expenses that were incurred to treat the applicant's work injury. Accordingly, the respondent shall pay:

1. To the applicant, the sum of seventy-three thousand, one hundred sixteen dollars and eighty-five cents ($73,116.85), for temporary total disability and permanent partial disability benefits; and the sum of thirty dollars and no cents ($30.00) for medical expense reimbursement.

2. To the applicant's attorney, the sum of eighteen thousand, two hundred seventy-nine dollars and twenty-one cents ($18,279.21), for attorney fees.

Respondent is entitled to take a credit against the amount to which the applicant is otherwise entitled for any correspondent payments of worker's compensation benefits that have already been paid, including short-term disability, long-term disability, or Social Security offset. Jurisdiction is reserved for such further findings and orders as may be necessary consistent with this order.

By the Commission:

/s/_____ _____
Michael H. Gillick, Chairperson

/s/_____
David B. Falstad, Commissioner

[1] **Appeal Rights**: See the yellow enclosure for the time limit and procedures for obtaining judicial review of this decision. If you seek judicial review, you **must** name the following as defendants in the summons and the complaint: the Labor and Industry Review Commission, and all other parties in the caption of this decision or order (the boxed section above). Appeal rights and answers to frequently asked questions about appealing a worker's compensation decision to circuit court are also available on the commission's website, http://lirc.wisconsin.gov.

/s/_____
Georgia E. Maxwell, Commissioner

Procedural Posture

In June of 2017, the applicant filed a hearing application, alleging an occupational back injury with a date of injury of March 20, 2015. The employer and its insurer (collectively, the respondent) conceded jurisdictional facts and an average weekly wage of $860.00. An administrative law judge for the Department of Administration, Division of Hearings and Appeals, Office of Worker's Compensation Hearings, heard the matter on May 8, 2018, and issued a decision on September 17, 2018, finding that the applicant sustained an occupational back injury, and awarding benefits. The respondent filed a timely petition for review.

The commission has considered the petition and the positions of the parties and has independently reviewed the evidence. Based on its review, the commission modifies (rewrites) and affirms the decision of the administrative law judge as to causation, extent of disability, and reasonableness of treatment, and sets aside and remands the decision for a determination of the amount of the medical expenses that were incurred to treat the applicant's work injury.

Findings of Fact and Conclusions of Law

1. The applicant, who was born in 1966, worked for about ten years for the respondent, a fabricator and distributor of rubber and plastic conveyor belts and related products,[2] first as an intern and then as a tool and die maker.

2. The applicant started working for the respondent in 2005 in an internship while he was going to school for mechanical engineering.[3] As an intern, the applicant worked for two summers, about 15 to 20 hours per week, working on design projects.[4] The applicant described this work as "only very occasionally" physical in nature.[5] In 2009, the applicant was hired full-time and did a variety of jobs, including working in an office role, a maintenance role, a production role, and a role in the machine shop.[6] He spent occasional time on the production floor:

> The only time I worked on production was when they were behind, and usually when they were behind, they were pretty far behind, so I would get called out there to catch them up. And the jobs that I did, sometimes it was running that radiofrequency welding machine and making those grain belts. Other times it was running things through the splitter and

[2] Transcript of Proceedings dated May 8, 2018 (Tr.), p. 148.
[3] Tr., p. 88.
[4] Tr., p. 89.
[5] Tr., p. 90.
[6] Tr., pp. 100-101.

> punching some slots in them and rolling them up and then tying them together and stacking them on a skid to get those out. And, I mean, there was all different types and stuff, and I didn't do it all the time. I'd be the first to admit I was doing different work there, but when production was slow…[7]

3. The applicant indicated that the heaviest weights he lifted would have been not more than 100-120 pounds.[8] Some of the bigger belts the respondent made were 60 feet long that would need to be cut and rolled up, and then fed into a machine.[9] Most of the time he lifted things himself, but sometimes the applicant used a fork lift or had others help. When he worked in production, the applicant would spend anywhere from a few hours to up to three days there, depending on the type of material or the type of belt being built or the number of people missing that he had to fill in for.[10]

4. The applicant also did maintenance on production machines,[11] and he also ran a milling machine and various lathes.[12] The applicant is 6'4" tall and indicated that the controls on a milling machine were fairly low to the ground and he had to bend over to run those.[13] The applicant used software to make design sketches, and he estimated that in a typical day he spent about one out of nine hours at his desk; the rest of the time he was in the machine shop making a tool or fixture, or doing some kind of maintenance work, or helping out in production.[14] He enjoyed his work because it was not the same thing every day.[15] The applicant also filled in as needed in the shipping and receiving area.[16]

5. The applicant thought that on days he was working in the shop, his back would be sore at the end of the day, but he "never thought nothing of it other than that [he] worked hard all day, and that's to be expected."[17] While he worked at the respondent between 2014 and 2015, the applicant indicated that he had to take a pain pill in the morning and in the afternoon, and then he would take Vicodin in the evening.[18]

6. Stephen Maas, the employer's president and owner, confirmed the applicant's description of his work duties.[19] Regarding whether the applicant's work was

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[7] Tr., pp. 93-94.
[8] Tr., p. 94.
[9] Tr., p. 128.
[10] Tr., p. 124.
[11] Tr., p. 94.
[12] Tr., p. 96.
[13] Tr. pp. 96-97.
[14] Tr., pp. 99-100, 125.
[15] Tr., p. 122.
[16] Tr., pp. 127-128.
[17] Tr., p. 146.
[18] Tr., p. 131.
[19] Tr., p. 150.

strenuous, Mr. Maas indicated that it would depend on the function and how heavy an object you are lifting or how much cranking you are doing; since Mr. Maas only did the work part-time, he could not say: "It's just one of those things that, you know, an operator does, and, you know, if you're having problems, you stop and rest. It's up to the individual."[20] He agreed that there were times the applicant had to lift large poles occasionally, and that his work involved awkward positions, bending over fixing machines, and maintenance.[21]

7. The applicant's medical history shows a history of prior treatment for low back pain before the applicant's alleged date of injury of March 20, 2015. The applicant indicated that his back started to bother him in 2011, and he sought treatment in 2012 because it was getting harder to deal with it. "It got to a point where all of a sudden it stopped getting better and it just kept getting worse, and then that's when I sought treatment for it because it was affecting my ability to do my job."[22]

8. The applicant treated with his primary care doctor, Dr. Wieslaw I. Frankowski, M.D., for an annual physical exam on March 6, 2013. Dr. Frankowski noted the applicant had lumbar radiculopathy.[23] The note indicates that the applicant had chronic back pain. The applicant treated with Dr. Frankowski on March 20, 2013, for low back pain at 8/10 with pain radiating to the right leg at the knee level and was diagnosed with lumbar radiculopathy.[24] The applicant again treated for low back pain on April 17, 2013, with pain at 5/10.[25] The applicant had an x-ray of his lumbar spine on October 2, 2013, which showed mild degenerative changes, but was otherwise negative.[26] Dr. Frankowski noted that the applicant was there for evaluation of tail bone pain, low back pain, and shoulder pain; the applicant denied injury or heavy lifting.[27] The applicant again treated with Dr. Frankowski for back pain of 5/10 on January 17, 2014.[28] Dr. Frankowski noted the applicant was seen for chronic back joint pain and lumbar radiculopathy.

9. On March 8, 2014, the applicant first treated with Dr. Douglas Milosavljevic, M.D., on referral from Dr. Frankowski, and planned for follow-up care for severe lumbar pain with radiculopathy. The medical note indicated that the applicant needed a lumbar MRI, then epidural steroid injections, and refill on medications.[29] On March 13, 2014, Dr. Milosavljevic diagnosed chronic low

[20] Tt., p. 154.
[21] Tr., p. 155.
[22] Tr., p. 102.
[23] Ex. 4.
[24] Ex. 4.
[25] Ex. 4.
[26] Ex. 4.
[27] Ex. 4.
[28] Ex. 4.
[29] Ex. 1.

back pain and lumbar radiculitis.[30] The applicant had his first epidural steroid injection on March 27, 2014, which provided 95% relief from pain.[31]

10. The applicant continued to see Dr. Frankowski for low back pain on April 15, 2014, September 9, 2014, and October 8, 2014. In October, the medical note indicates that the applicant had chronic back pain under the care of a pain clinic. On December 4, 2014, Dr. Frankowski noted the applicant had lumbar radiculopathy and that the applicant was under the care of the pain clinic; his pain was 6/10.[32]

11. During 2014, Dr. Milosavljevic performed epidural steroid injections on April 28, 2014, and May 27, 2014, which provided 95% and 90% pain relief, respectively. On June 23, 2014, the applicant had bilateral medial branch blocks at L4-L5 and S1, and reported 100% relief from pain. On July 21, 2014, the applicant again had bilateral medial branch blocks and reported 95% relief from pain. On August 18, 2014, Dr. Milosavljevic noted that the 100% relief from pain with increased range of motion was now fading; he planned to do a radiofrequency ablation. Dr. Milosavljevic continued to monitor and follow up with the applicant throughout 2014. On January 26, 2015, the applicant was reporting a new location of pain and underwent another epidural steroid injection. The applicant continued to follow up with Dr. Milosavljevic, and on March 13, 2015, he reported increasing pain. Dr. Milosavljevic dispensed a lumbar brace.[33]

12. The date of the alleged injury is March 20, 2015. On that date, the applicant indicated it was a day like any other day. He had been working on taking a die apart and making adjustments, and had to put the die back together.[34] He left work at 3:40 p.m. and went to his lawyer's office to get something notarized and described what happened:

> And I sat down, he read the one paragraph that said Dan Albright has no dependent children. I just had to sign it in front of him. So I was there all of 3 minutes, you know, and he says, okay, just sign right here. And I just leaned forward about this far in the chair, and I wrote the D and the A in my name, and this liquid hot fire erupted above my knee and all up my leg, and I just went flying out of the chair and rolling around on the floor screaming in pain. And it was horrible pain, and I don't ever want to go through that again, and I did – Yeah, that's what happened.[35]

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[30] Ex. 1.
[31] Ex. 3.
[32] Ex. 4.
[33] Ex. 3; the applicant indicated that he had used a brace since 2013 when he had picked one up at a rummage sale. Tr., pp. 140-141.
[34] Tr., p. 107.
[35] Tr., p. 108.

13. The applicant continued to seek medical treatment for his back but did not report this as a work injury. The applicant indicated that he did not report it as a work injury until March of 2016 because he did not know it was work-related until then.[36] He thought he had a blood clot in his leg and did not know what was going on. "I had no idea what was making me hurt, so I did not claim it was work related."[37] It was not until the applicant subsequently had a nerve conduction study that he realized that it was work-related.[38]

14. The day after the incident at his lawyer's office, on March 21, 2015, the applicant was seen in the emergency room for low back pain. The nurse note indicates:

> Pt reports right leg pain, onset yesterday. Pt locates pain to top of right leg. Describes as "burning, hot and numb" to right upper leg. Took Percocet at 1900 yesterday with no relief. Hx sciatica, states this pain is much different.[39]

15. The applicant was seen in the emergency department by Dr. Richard S. Kowalczyk, M.D., who noted the chief complaint as leg pain. Dr. Kowalczyk described the complaint:

> Danyl P Albright is a 48 year old male w/ a h/o sciatica presents to the ED c/o sudden onset R upper leg pain since 4 PM yesterday. Pt states that he leaned forward in a chair when the pain onset and states that his leg felt like it was on "fire." He describes the pain as localized to the anterior aspect of the R leg just above the knee. He reports that he started wearing a "belt"[40] 3 days ago that compresses and aligns his spine. Pt states that he took Percocet at 7 PM last night with no relief of sx. He reports that he had another episode of severe pain while he was driving to the ED today. He reports a tingling sensation to the R upper leg, but denies other associated sx at this time. Pt states that he placed ice on the R leg, but does not report any other modifying factors at this time. Pt has a past medical history significant for sciatica.[41]

Dr. Kowalczyk diagnosed low back pain with right-sided sciatica.

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[36] Tr., pp. 133-134.
[37] Tr., p. 134.
[38] Tr., p. 135.
[39] Ex. 4.
[40] The applicant indicated that this was the belt that went through his pant loops, and not the brace. Tr., p. 139.
[41] Ex. 4.

16. By March 25, 2015, Dr. Milosavljevic noted that the applicant was experiencing increased pain radiating down his legs to the knees.[42] On March 27, 2015, Dr. Frankowski noted the applicant was seen for an annual physical and had severe right leg back pain 10/10, noting the applicant was seen in the emergency room a week ago. According to the applicant, Dr. Frankowski put him in the hospital because he could not walk, and they did tests.[43] On March 28, 2015, the applicant had an MRI of his lumbar spine. The impressions were that L4-L5 demonstrated a broad-based central disk protrusion; there was mild bilateral neural foraminal narrowing at L3-L4 and moderate bilateral at L4-L5; and L2-L3 and L3-L4 mild disk bulges.[44]

17. On April 7, 2015, Dr. Milosavljevic noted that the applicant had a right lateral femoral cutaneous nerve block injection that provided 100% relief from pain.[45] On April 24, 2015, Dr. Frankowski noted the applicant was seen for low back pain of 8/10, and that he had received 3-4 epidural steroid injections and walked with a cane.[46]

18. The applicant continued to treat with both Dr. Milosavljevic and Dr. Frankowski. Dr. Milosavljevic noted the applicant was experiencing pain radiating down his legs, and on May 14, 2015, had bilateral branch blocks at L4-L5 and S1 that provided 100% pain relief.[47] On May 14, 2015, Dr. Milosavljevic also imposed work restrictions, limiting the applicant to sedentary work; 4 hours per day with breaks; standing/walking 1-4 hours; sitting 1-3 hours; driving 1-3 hours in an 8-hour day; and no squatting, climbing, twisting, or reaching.

19. On June 22, 2015, the applicant was experiencing increasing pain and underwent another lateral femoral cutaneous nerve block injection that provided 100% pain relief.[48] Dr. Frankowski noted on July 29, 2015, that the applicant had low back pain at 5/10 and leg pain at 6/10, with the pain radiating to the right leg. The applicant's right leg was numb between the thigh and knee, with a tingling sensation in the right hip area. The note indicated that the applicant had not worked since March 20, 2015.[49]

20. The applicant saw Dr. Frankowski for chronic back pain at 9/10 on August 21, 2015.[50] By August 24, 2015, the applicant was again experiencing increasing pain symptoms, and Dr. Milosavljevic performed a lumbar

[42] Ex. 3.
[43] Tr., p. 114.
[44] Ex. C.
[45] Ex. 3.
[46] Ex. 4.
[47] Ex. 3.
[48] Ex. 3.
[49] Ex. 4.
[50] Ex. 4.

epidural steroid injection that provided 100% pain relief.[51] On September 2, 2015, the applicant again saw Dr. Frankowski for chronic back pain at 6/10.[52]

21. On September 18, 2015, Dr. Milosavljevic noted that the applicant gets about 3-4 weeks of almost 100% pain relief of lumbar radiculopathy before his pain starts to return. His pain was listed as a 10/10, and Dr. Milosavljevic performed a lumbar epidural steroid injection.[53] On September 28, 2015, Dr. Frankowski noted that the applicant saw a new pain doctor who wanted an MRI on the applicant's right leg.[54] The listed diagnoses included osteoarthritis of spine with radiculopathy, lumbar region, right meralgia paresthetica, and lumbar degenerative disk disease.

22. On October 1, 2015, Dr. Milosavljevic noted the applicant continued to suffer from lateral femoral cutaneous nerve pain and performed another lateral femoral cutaneous nerve block, which provided 100% pain relief. Dr. Milosavljevic noted that he would get an MRI for the applicant's right and left hip pain. The applicant had another epidural steroid injection on October 29, 2015, and then again on January 19, 2016.[55] The applicant saw Dr. Frankowski during this time period on October 2, 2015, October 28, 2015, November 25, 2015, December 14, 2015, and February 24, 2016.[56] The applicant had an MRI of his right hip on November 24, 2015.

23. On March 4, 2016, the applicant reported that he had been released from physical therapy after 11 of 12 visits. The applicant reported pain increasing all over. Dr. Milosavljevic performed a medial branch block that provided 100% pain relief.[57] On March 14, 2016, the applicant saw Dr. Frankowski for upper back and neck pain.[58] The applicant had a nerve conduction study done on April 1, 2016, for his low back and leg pain, which showed evidence of radiculopathy affecting the right L5 nerve root; the applicant's history and description of symptoms was consistent with right meralgia paresthetica or lateral femoral cutaneous neuropathy.[59] On April 4, 2016, Dr. Frankowski reviewed the nerve conduction study and saw the applicant for low back pain.

24. The applicant had about a month of pain relief and received another medial branch block on April 14, 2016.[60] On May 12, 2016, the applicant reported increased pain and again received a bilateral medial branch radiofrequency ablation at L4-L5 and S1.

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[51] Ex. 3.
[52] Ex. 4; note that the applicant qualified for Social Security Disability Insurance benefits as of September 1, 2015. Tr., p. 141.
[53] Ex. 3.
[54] Ex. 4.
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[56] Ex. 4.
[57] Ex. 3.
[58] Ex. 4.
[59] Ex. 4.
[60] Ex. 3.

25. The applicant had several treatments for his cervical spine and knee in 2016, but did not have another lumbar steroid injection until December of 2016. On December 30, 2016, the applicant was reporting that the radiofrequency ablation was starting to wear off, and Dr. Milosavljevic performed a lumbar epidural steroid injection at L4-L5. On January 30, 2017, when the applicant was experiencing increased pain, Dr. Milosavljevic performed bilateral medial branch blocks at L4-L5 and S1 that provided 90% relief. On February 17, 2017, Dr. Milosavljevic again performed bilateral lumbar medial branch radiofrequency ablation at L4-L5 and S1. On April 28, 2017, the applicant had a lumbar trigger point injection.[61] The applicant again had increasing pain, and on May 25, 2017, had another lumbar epidural steroid injection at L4-L5; and at L3-L4 on June 22, 2017.[62] He had another lumbar epidural steroid injection on L4-L5 on July 13, 2017, and lumbar trigger point injections on August 17, 2017. Dr. Milosavljevic performed right selective nerve root blocks at L3, L4, and L5 on September 14, 2017.[63]

26. On May 3, 2017, Dr. Milosavljevic wrote a letter, to whom it may concern, indicating that at this point in the applicant's career, the applicant was no longer able to work due to the severe changes in his lumbar spine and radicular component pain. Dr. Milosavljevic stated, "Patient's disc disease is aggravated by the constant sitting and standing required by such job."[64] Dr. Milosavljevic listed the applicant's permanent restrictions:

> At this point his permanent restrictions are: No sitting, squatting, twisting, reaching above head or bending, and bending at the waist only as tolerated. He can carry a maximum of 10 lbs occasionally. Stand or walk anywhere from 1 to 4 hours daily, also sitting 1 to 4 hours daily. He can use his hands for single grasping fine manipulation but he should not push or pull any large carts.[65]

In the letter, Dr. Milosavljevic stated that the applicant was 100% disabled.

27. On October 12, 2017, Dr. Milosavljevic noted that the applicant was using very little of his pain medication because he had to pay for it out-of-pocket and had limited resources.[66] By November 7, 2017, Dr. Milosavljevic noted the applicant had been weaned off all of his oral narcotics and pain medications.[67]

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[61] Ex. 3.
[62] Ex. C.
[63] Ex. C.
[64] Ex. C.
[65] Ex. C.
[66] Ex. C.
[67] Ex. C.

28. As of the date of the hearing, the applicant indicated that he always has to shift positions. He cannot sit for very long and has to stand up, then he can only stand for so long and has to lay down, and then has to sit again.[68] He does not even carry his laundry upstairs.

29. The applicant submitted the WKC-16-B of Dr. Milosavljevic.[69] Dr. Milosavljevic described the work incident as "sitting in a chair, reached forward, developed intense painful right inguinal pain, lumbar pain with radiculopathy."[70] He described the applicant's disability as "severe lumbar pain with radiculopathy, facet arthropathy, right inguinal neuropathy."[71] He checked "Yes" in box 11 that it was probable that the work incident directly caused the applicant's disability. He assessed 15% permanent partial disability due to severe lumbar pain with radiculopathy and inguinal neuropathy. Dr. Milosavljevic noted the applicant's prognosis was fair and that he would need further treatment.

30. Dr. Milosavljevic also testified at length at the hearing. In his testimony, Dr. Milosavljevic was familiar with the applicant's work:

> My understanding is he works in a factory, and he does a lot of heavy twisting, lifting of conveyor belt parts. I kind of caught the idea that he was also involved with CNC working, but he's a tool and die maker. So he has to do a lot of lifting and bending and stretching, and these materials that he's talking about are huge pieces of rubber which are very heavy, you know, it hurts.[72]

31. Dr. Milosavljevic also recognized that the applicant was not doing factory work all the time, and that he did other things at the company, but he could not recall what they were.[73] According to Dr. Milosavljevic, the job activities that contributed to the applicant's spine injury over time were:

> The heavy lifting and twisting of materials, you know, and with or without help over time is going to make a huge difference in the way somebody's back works. And this starts – Everybody's spine degenerates over time; you can't doubt that. But you can accelerate a process that's going on by, you know, stretching,

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[68] Tr., p. 116.

[69] Ex. A. Dr. Milosavljevic's curriculum vitae was included in a separate exhibit, Ex. E. His experience included a chronic pain management fellowship at the Medical College of Wisconsin, work as an instructor in anesthesiology and assistant professor of anesthesiology at the Medical College of Wisconsin for several years, many years of work as a staff anesthesiologist in a chronic pain management clinic. Since 2010, he has had his own practice as a chronic pain management provider and anesthesiologist.

[70] Ex. A; Tr., p. 29.

[71] Ex. A; Tr., p. 30.

[72] Tr., p. 14.

[73] Tr., p. 14.

> putting a lot of compression on it, axial compression, squeeze those discs that are drying out anyway as you age; and you're going to accelerate a degenerating process, and you're going to end up like he does. And then you could be as if you were walking down the street and then all of a sudden feel a pop in your back and that's it.[74]

32. Dr. Milosavljevic further stated that his understanding was that the applicant:

> …works in a factory that makes large conveyor belts of heavy rubber, and at times he's lifting these things, he's also assembling the cut-outs or something for the machines, and that he sometimes will work in the front office or I don't know what its' called, you know, the lesser strenuous job. That's all I know.[75]

33. Dr. Milosavljevic agreed that 5 years of occupational exposure from the applicant's job tasks would be an adequate time to cause additional acceleration of the applicant's degenerative condition: "The longer he's working and doing that kind of work the more accelerated the process is going to be."[76] Dr. Milosavljevic continued, "If this guy didn't have this job doing what he did, he probably wouldn't be sitting here today."[77] Dr. Milosavljevic responded in the affirmative when asked if he could state to a medical degree of certainty whether or not the applicant's work activity was a material contributing factor to the dysfunction and ongoing processes.[78]

34. According to Dr. Milosavljevic, the applicant's work activities predisposed him to having the acute exacerbation when he leaned forward,[79] and the leaning was an exacerbation of a problem that was caused previously.[80] While acknowledging that everyone has degenerative changes in their spines, Dr. Milosavljevic indicated that the applicant has an accelerated process that would not be just the natural progression of a disease process because they do not wear that fast.[81] "He has advanced changes with degenerative changes in his spine in the sense that his disc spaces are markedly narrowed, and he has evidence of bone remodeling or remodeling if you want to call it where it's thicker a little bit here, that kind of thing, but that's it."[82]

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[74] Tr., pp. 17-18.
[75] Tr., p. 79.
[76] Tr., p. 18.
[77] Tr., p. 21.
[78] Tr., p. 22.
[79] Tr., pp. 35-36.
[80] Tr., p. 60.
[81] Tr., p. 61.
[82] Tr., p. 80.

35. Regarding the nature of his treatment, Dr. Milosavljevic testified that when he did injections, the applicant would get better, but the pain relief would subside, which was quite common. Then he would do another one, and he would get a little better and more active, then it would subside and return to the baseline.[83] Dr. Milosavljevic indicated that he had considered other treatment modalities, and had been thinking about referrals to neurosurgery: "We've gone through physical therapy, and we were using medications, but he was just in decline because he had less and less function over time."[84]

36. At the respondent's request, Dr. Richard K. Karr, M.D., S.C., performed an independent medical evaluation and provided a report dated August 28, 2017.[85] Dr. Karr examined the applicant and reviewed the medical records. He reviewed the lumbar MRI from January 10, 2014. Dr. Karr opined that the applicant had multilevel degenerative lumbar spondylosis (disc disease involving 80% of the lumbar anatomy), with variable degrees of foraminal stenosis, that was a personal health condition aggravated by habitual cigarette smoking and chronic narcotic dependence, and that predated the alleged March 20, 2015, injury by years. He also diagnosed chronic low back pain and sciatica complaints necessitating multiple spinal injections and oral medications that predated the alleged March 20, 2015, injury by years. Dr. Karr attributed the applicant's conditions to a combination of the normal progression of his preexisting degenerative lumbar spondylosis plus the aggravating effects of multiple personal comorbidities (smoking, chronic narcotic dependence, and psychological illness). According to Dr. Karr, the objective MRI findings are diagnostic of a longstanding personal attritional condition and not proof of occupational disease. Further, Dr. Karr noted that the applicant's pain and limitations are disproportionate to the 2014 MRI findings.

37. Dr. Karr opined that the applicant's work exposure on or about March 20, 2015, did not cause any structural spinal or neurological damage, did not aggravate his preexisting degenerative lumbar spondylosis or chronic lumbar symptoms beyond their normal progression, did not necessitate spinal treatments, and did not result in any disability. He opined that the applicant's work was not a material contributory causative factor in the applicant's spinal condition, and that it was merely a manifestation of a preexisting nonwork-related personal health condition. Regardless of causation, Dr. Karr opined that appropriate treatment would include diagnostic x-rays and MRIs, self-directed exercise, smoking cessation, cessation of narcotics, use of nonnarcotic medications, avoidance of unprotected heights, optimize mental healthcare, and possibly other treatment indicated by spinal imaging. He opined that the applicant should

[83] Tr., p. 17.
[84] Tr., p. 17.
[85] Ex. 3.

avoid surgeries unless warranted by neoplastic disease or progressive neurological impairment.

38. The applicant submitted the vocational evaluation of Michael J. Ewens, M.A., dated March 29, 2017. Mr. Ewens found that based on the medical reports from Dr. Milosavljevic, the applicant is incapable of employment, and he would sustain a permanent and total loss of earning capacity.[86] It does not appear that Mr. Ewens reviewed Dr. Karr's report.

39. The respondent submitted the Vocational Expert Report of Timothy J. Riley, M.S., L.P.C., C.R.C. dated October 13, 2017.[87] Based on Dr. Milosavljevic's opinion, Mr. Riley opined that the applicant sustained a total loss of earning capacity. He noted that if Dr. Milosavljevic would provide for work restrictions allowing for full-time sedentary work, then the applicant would be fully employable and could restore his earning capacity. Based on Dr. Karr's opinions, the applicant has sustained no future loss of earning capacity as a result of a work incident on March 20, 2015.

40. The commission credits Dr. Milosavljevic, who opined to a reasonable degree of medical certainty that the applicant's work exposure was a material contributory causative factor in the applicant's back dysfunction and ongoing processes, and finds that the applicant sustained an occupational back injury with an injury date of March 20, 2015.

41. The commission finds that the applicant is entitled to temporary total disability benefits from March 20, 3015, to August 29, 2016, (75 weeks and 1 day x $573.34) in the amount of $43,096.06.

42. The commission credits Dr. Milosavljevic that the applicant sustained a 15% permanent partial disability as a result of the work injury, which results in an award of $48,300.00 (150 weeks x $322.00).

43. The applicant's attorney is entitled to a fee of 20% of the benefits awarded, or $18,279.21, leaving a total of $73,116.85 due to the applicant.

44. The commission finds that Dr. Milo's treatment of the applicant for the work injury was reasonable and necessary. The respondent is liable for and shall pay the applicant's reasonable medical treatment expenses for the work injury. Some of the claimed medical treatment expenses were for treatment unrelated to the work injury, however. The commission sets aside the decision of the administrative law judge regarding the amounts the respondent must pay for medical treatment expenses, and remands the issue to the division for a new decision on this issue.

[86] Ex. B.
[87] Ex. 2.

45. The commission finds that it is premature to address any further disability or loss of earning capacity at this time until there is further diagnostic testing, evaluation, and consideration of the applicant's narcotic use and explanation of what further treatment may be necessary.

46. Respondent is entitled to take a credit against the amount to which the applicant is otherwise entitled for any correspondent payments of worker's compensation benefits that have already been paid, including short-term disability, long-term disability, or Social Security offset.

Memorandum Opinion

The issues are whether the applicant sustained an occupational back injury, and, if so, the nature and extent of his disability, and the respondent's liability for medical expenses. The applicant has the burden of proving beyond a legitimate doubt all the facts necessary to establish a claim for compensation.[88] The commission must deny compensation if it has a legitimate doubt regarding the facts necessary to establish a claim, but not every doubt is automatically legitimate or sufficient to deny compensation.[89] Legitimate doubt must arise from contradictions and inconsistencies in the evidence, not simply from intuition.[90]

The respondent argues that there is no credible medical evidence to support a finding that the applicant sustained an occupational injury, and it asserts that Dr. Milosavljevic's opinions are not credible. It asserts that Dr. Milosavljevic's medical opinion was not made to a reasonable degree of medical certainty, and that it was self-serving and not credible because he wanted to get paid.[91] According to the respondent, Dr. Milosavljevic never offered a medical opinion that the applicant's condition was caused by an appreciable period of workplace exposure which was at least a contributory causative factor in the condition's onset or progression.

The respondent also questions the reasonableness of the treatment Dr. Milosavljevic performed, and it points out that he injected steroids into the applicant's spine numerous times[92] but never conducted testing to determine whether demineralization was occurring in the applicant's vertebrae; Dr. Milosavljevic never obtained an MRI to determine whether the applicant had experienced progression of his degenerative condition after the initial MRI in 2014; and Dr. Milosavljevic did not follow medical protocols regarding prescription of opioid medications. According to the respondent, Dr. Milosavljevic admitted that he did not keep up-to-date on the Center for Disease Control or American Medical Association for the treatment of chronic pain, and Dr. Milosavljevic's conduct was

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[88] *Leist v. LIRC,* 183 Wis. 2d 450, 457, 515 N.W.2d 268 (1994); *Erickson v. DILHR*, 49 Wis. 2d 114, 118, 181 N.W.2d 495 (1970).

[89] *Erickson, supra, at 119*; *Leist, supra*, at 457.

[90] *Erickson, supra; Richardson v. Indus. Comm'n,* 1 Wis. 2d 393, 396-97, 84 N.W.2d 98 (1957).

[91] Dr. Milosavljevic testified that he has a billing company that handles his bills and he was not aware of what his bills to the applicant were. Tr., p. 32.

[92] *See* Ex. 5, Injection History, almost all of which correlates with the medical records.

contrary to all reasonable medical protocols and the treatment expenses should not be compensable.

In support of its argument that the treatment Dr. Milosavljevic provided was not reasonable, the respondent submitted abstracts of two articles that came out in January and March of 2018 (a few months before the hearing on May 8, 2018) that summarized studies that found that epidural steroid injections may be associated with decreased bone mineral density and increased risk for vertebral fracture; and that they should be used with caution, especially in patients at risk for osteoporotic fractures such as postmenopausal aged women.[93] The respondent also submitted an abstract of an article from March of 2018 that discussed the outcome of a study comparing opioid versus nonopioid medications for pain-related function, pain intensity, and adverse effects, and that found that treatment with opioids was not superior to treatment with nonopioid medications for improving pain-related function over 12 months. The respondent also submitted the March 18, 2016, Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain.[94]

In its summary of the findings for clinical questions, the CDC stated that "evidence on long-term opioid therapy for chronic pain outside of end-of-life care remains limited, with insufficient evidence to determine long-term benefits versus no opioid therapy, though evidence suggests risk for serious harms that appears to be dose-dependent."[95] The report reviews other nonopioid treatments and states that "Interventional approaches such as epidural steroid injection for certain conditions (e.g., lumbar radiculopathy) can provide short-term improvement in pain. Epidural injection has been associated with rare but serious adverse events, including loss of vision, stroke, paralysis, and death."[96] The CDC lists several recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care. The report does not prohibit the use of opioids, but urges caution and the need to assess risks before starting opioid therapy. The report notes, for instance, that "Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate."[97] The report noted that efforts would be made to disseminate the information, and noted that further research was necessary:

> This guideline provides recommendations that are based on the best available evidence that was interpreted and informed by expert opinion. The clinical scientific evidence informing the recommendations is low in quality. To inform future guideline development, more research is necessary to fill in critical evidence

[93] Exs. 6 and 7.
[94] Ex. 9.
[95] Ex. 9, p. 15.
[96] Ex. 9, p. 18.
[97] Ex. 9, p. 23.

> gaps. The evidence reviews forming the basis of this guideline clearly illustrate that there is much yet to be learned about the effectiveness, safety, and economic efficiency of long-term opioid therapy. …The National Institutes of Health panel recommended that research is needed to improve our understanding of which types of pain, specific diseases, and patients are most likely to be associated with benefit and harm from opioid pain medications; evaluate multidisciplinary pain interventions; estimate cost-benefit; develop and validate tools for identification of patient risk and outcomes; assess the effectiveness and harms of opioid pain medications with alternative study designs; and investigate risk identification and mitigation strategies and their effects on patient and public health outcomes.[98]

Though the respondent questions Dr. Milosavljevic's treatment, Dr. Milosavljevic stated that he believes that epidural steroid injections are a good means to treat lumbar dysfunction acutely.[99] He understood that two medial branch blocks and three radiofrequency ablations in a 12-month period would be reasonable.[100] He indicated that his clinic is "kind of like the clinic of last resort" and that he has the patients that nobody wants because they are "in a chronic pain state, and they're on medications before they come in the door usually."[101] He felt that the applicant was at the point where opioids were necessary because other mechanisms to treat had already been utilized.[102] The respondent also questions Dr. Milosavljevic as to whether he had had a mineral bone density test done on the applicant to see whether the applicant had mineral bone density loss, and Dr. Milosavljevic indicated he had not, and that he had never done that on anyone.[103] Dr. Milosavljevic sees about 300 patients per month, and about 70 percent of his caseload is treating back pain.[104]

The respondent also questions Dr. Milosavljevic's opinions based on his understanding of the applicant's work duties. According to the respondent, Dr. Milosavljevic thought the applicant worked in factory, whereas the applicant only worked on the factory floor on an occasional basis. The respondent also argues that Dr. Milosavljevic is not credible because he opined in his WKC-16-B that the applicant's condition was caused by a specific, nonwork-related traumatic event that did not happen at work, but his testimony was inconsistent. The respondent points out that Dr. Milosavljevic is an anesthesiologist and holds no board certification and has no hospital privileges, and argues that his opinions do not support the applicant's claim that he suffers from an occupational disease.

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[98] Ex. 9, p. 40.
[99] Tr., p. 37.
[100] Tr., p. 44.
[101] Tr., p. 80.
[102] Tr., p. 82.
[103] Tr., p. 56.
[104] Tr., p. 12.

According to the respondent, the only credible medical evidence comes from Dr. Karr who consistently and without contradiction stated the applicant's condition was not caused by an appreciable period of workplace exposure or a specific traumatic work event. Dr. Karr opined that the applicant's degenerative spinal condition was solely personal to him and was not caused by any work injury.

The applicant responds and argues that the objective medical evidence and the extensive testimony of Dr. Milosavljevic provide credible and substantial evidence to support the applicant's claim. The applicant describes Dr. Milosavljevic as an "interventional pain management specialist" with extensive experience in interventional pain management and anesthesiology. He states, "It is hard to imagine a more credible and substantial medical support than the very doctor who provided care for an injured worker for over three years coming to testify for several hours to ensure that the correct decision is reached."[105] He objects to the respondent's allegation that Dr. Milosavljevic is motivated solely to get paid and points out that "he is doing fine seeing over 3,600 patients per year."[106] The applicant argues that Dr. Milosavljevic's opinion was based on hours of treatment spent with the applicant discussing his job, analyzing the objective medical evidence, and an intimate understanding of the conditions that aggravated the applicant's spine. Dr. Milosavljevic supported his conclusion that the applicant's workplace exposure over a decade was at least a material contributory causative factor in the condition's onset or progression by discussing the MRI findings which showed advanced degenerative changes that would not be expected in a 49-year old male. According to the applicant, Dr. Milosavljevic had an accurate understanding of his work duties and detailed the work he did as a tool and die maker where he was required to twist, bend, and lift conveyor belt parts, which was confirmed by the owner of the company.

Regarding the reasonableness of the applicant's treatment, the applicant points out that an MRI was done in 2015. The steroid injections helped to alleviate the applicant's pain, and the applicant asserts that even partial temporary relief is desirable when someone is experiencing constant excruciating pain. Finally, the applicant argues that Dr. Milosavljevic did, in fact, provide his opinion to a degree of medical certainty that the applicant's workplace exposure was a material contributory causative factor in the condition's onset or progression. He specifically opined, to a reasonable degree of medical certainty, that if the applicant had not performed the work he did for nearly a decade, he would not have suffered the same lumbar dysfunction and ongoing processes.

The commission has carefully reviewed the evidence in the case, and credits the opinion of Dr. Milosavljevic, who opined to a reasonable degree of medical certainty that the applicant's work exposure was a material contributory causative factor in the applicant's back dysfunction and ongoing processes. Dr. Milosavljevic came to the hearing and testified at length, showing a sound understanding of the

[105] Applicant's Brief, p. 8.
[106] Applicant's Brief, p. 8.

applicant's work activities and treatment history. Though the respondent attempted to challenge his expertise, Dr. Milosavljevic's clinic focuses on pain management and he sees 300 patients per month. He has worked with both pain management and anesthesiology since 1996, and he has substantial experience and expertise to provide a medical opinion as to pain causation and treatment. The commission is also not persuaded that Dr. Milosavljevic's treatment was unreasonable. He treats people in chronic excruciating pain situations in a "last resort" context, and seeks to provide relief from pain through a variety of modalities, including steroid injections, nerve blocks, physical therapy, and opioid and nonopioid pain relievers. He was consistently able to provide the applicant with pain relief.

The respondent asserted that Dr. Milosavljevic was not up-do-date on his understanding of opioid treatment or potential bone demineralization with steroid injections, but those articles came out only a couple of months before the hearing, and they basically concluded that the risks have to be weighed against the benefits. The medical records note that the risks were discussed with the applicant before each procedure. It is not unreasonable that someone in excruciating pain would prefer to have pain relief and risk a potential fracture. For the opioid article and the CDC report, the guidelines are basically to be careful with opioid use, and to use nonopioid treatment options as well. In this case, Dr. Milosavljevic used the combination of epidural steroid injections, nerve root ablations, opioids, and physical therapy. The treatment he provided did not clearly violate the CDC guidelines. Though the respondent attempts to make it sound like Dr. Milosavljevic is out of touch with current pain treatment recommendations, the articles and report it provided did not provide rigid requirements against which Dr. Milosavljevic's treatment could be measured and shown to fall short. Also, during the time that the applicant treated with Dr. Milosavljevic, the applicant also treated with Dr. Frankowski, and Dr. Frankowski expressed no concerns in his treatment notes with the pain relieving efforts of Dr. Milosavljevic.

The respondent also asserts that Dr. Milosavljevic did not have an accurate understanding of the applicant's work duties. However, Dr. Milosavljevic explained that he knew the applicant worked both in the factory and doing other things, and he still opined that the work activity that included heavy lifting aggravated his lumbar degeneration. The commission finds that Dr. Milosavljevic had a sufficient understanding of the applicant's work duties. The applicant did not exaggerate his work duties in his testimony, and the employer's owner confirmed that the applicant described his duties accurately. Given this, there is no reason to think that the applicant did not accurately describe his work duties to Dr. Milosavljevic.

Though the respondent also asserts that the applicant's "injury" occurred outside of work when he was at his lawyer's office, that is a red herring. The applicant is claiming that his activities at work were a material factor in the progression of his degenerative lumbar condition. As Dr. Milosavljevic testified, if he had not had the job, he would not have been in his medical situation. Dr. Milosavljevic also testified that the applicant's work activities predisposed him to having the acute exacerbation when he leaned forward in the lawyer's office, though the problem was

caused previously. A subsequent injury is compensable where an initial injury at work predisposes a body part to the subsequent injury.

In *Burton v. DILHR,*[107] a firefighter's back had been weakened when he fell while sliding down a pole in the firehouse, but he then suffered a disc protrusion nine months later when he sneezed at home. The applicant's treating physician testified that the pole incident so weakened the applicant's back that the sneeze caused the disc to protrude; the injury was found to be compensable. In *Shelby Mut. Ins. Co. v. DILHR,*[108] the applicant, who had a history of work-related trauma to his lower back, was at home on vacation when he sneezed and felt a sharp pain across his back and sustained a herniated disc. The court of appeals agreed the injury was compensable. Similarly, in *Lange v. LIRC,*[109] the court of appeals held that a work-related injury that plays any part in a second, non-work-related injury is properly considered a substantial factor in the re-injury, but will not be a substantial factor where the second injury alone would have caused damages. In this case, the applicant's leaning over to sign a document alone would not have caused spinal damage but for the alleged previous work injury to his back.

Finally, the commission does not credit Dr. Karr because he did not have an accurate understanding of the applicant's work duties and he was focused on the March 20, 2015, date as a date of a traumatic injury. Dr. Karr repeatedly noted that the applicant's back complaints predated this injury date. However, since the applicant is claiming an occupational injury, the prior treatment is consistent with the applicant's theory of causation.

Accordingly, the commission affirms the decision of the administrative law judge. The commission has rewritten the decision to reflect the factual and legal bases for the commission's decision.

cc: Atty. Paul R. Riegel
Atty. Alex E. Eichhorn

[107] *Burton v. DILHR,* 43 Wis. 2d 218, 168 N.W.2d 196 (1969).
[108] *Shelby Mut. Ins. Co. v. DILHR,* 109 Wis. 2d 655, 327 N.W.2d 178 (Ct. App. 1982).
[109] *Lange v. LIRC*, 215 Wis. 2d 561, 573 N.W.2d 856 (Ct. App. 1997).