COURT OF APPEALS
DECISION
DATED AND FILED

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Diane M. Fremgen
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Appeal No. 2016AP2355 **Cir. Ct. No. 2016CV1206**

STATE OF WISCONSIN **IN COURT OF APPEALS**
DISTRICT II

MATTHEW O'BRIEN,

PLAINTIFF-RESPONDENT,

V.

LABOR & INDUSTRY REVIEW COMMISSION, DEPARTMENT OF CORRECTIONS AND DEPARTMENT OF ADMINISTRATION,

DEFENDANTS-APPELLANTS.

APPEAL from an order of the circuit court for Racine County: EUGENE A. GASIORKIEWICZ, Judge. *Reversed*.

Before Neubauer, C.J., Gundrum and Hagedorn, JJ.

¶1 GUNDRUM, J. The Labor & Industry Review Commission (Commission), Department of Corrections (DOC) and Department of Administration appeal from the circuit court's reversal of the Commission's

decision denying Matthew O'Brien's worker's compensation claim. Because we conclude the circuit court erred in reversing the Commission's decision, we now reverse.

Background

¶2 O'Brien filed a workers compensation claim related to a September 6, 2013 work incident. A hearing on the claim was held before an administrative law judge (ALJ). The record presented at the hearing includes the following relevant evidence.

¶3 O'Brien began work as a correctional officer for DOC in 2004. In 2007, he sustained a neck injury while on military duty. For several years thereafter, he was treated by medical professionals for his cervical neck pain.

¶4 On April 13, 2013, O'Brien complained of "neck pain, swelling and heat with pain radiating into the shoulder blade," "increasing pain and numbness down his arm to his fingers," and that he was "shaking with pain." On April 25, 2013, O'Brien was examined by Dr. Yashdip Pannu, who noted that O'Brien had "experienced progressively worsening neck pain as well as upper extremity weakness and numbness and tingling" since his 2007 military injury, but had reported experiencing a "significant increase in his neck pain" over the prior two weeks. O'Brien went to the emergency room because the pain had become "extreme." He described the pain as being in the "posterior aspect of his cervical spine radiating into his right upper extremity," and complained of "weakness, numbness, and tingling" in that extremity. "He admits dropping objects as well as having difficulty in terms of fine finger movements and manual dexterities…. [S]itting, lying flat, and lifting anything greater than 10 [pounds] aggravates his pain." O'Brien described his pain as "miserable." On May 8, 2013, O'Brien

underwent a C5 through C7 anterior and posterior cervical decompression and fusion surgery performed by Pannu.

¶5 Medical records show that at a May 23, 2013 appointment with Pannu, O'Brien reported that he "continue[d] to experience some neck pain," which could be "as high as 6.5/10." He also continued to experience "numbness and tingling in his fingers in the right hand," but overall was "very pleased with the progress" he had made since the surgery. O'Brien reported that he had quit smoking that same month, but before that "had smoked half [of a] pack of cigarettes daily as well as chewed tobacco approximately one tin daily." Pannu counseled O'Brien "on the importance [of] remaining currently [sic] with his smoking cessation," and provided him a prescription for nicotine transdermal patches.

¶6 O'Brien next saw Pannu on June 27, 2013. O'Brien was "doing extremely well postoperatively" and was "pleased with his progress," but he continued to experience neck pain, which he rated as a 4/10 at the time of this appointment. He expressed that "exertional activity aggravates his pain while rest and his prescriptive medications help alleviate" it. O'Brien had "experienced a fall out of bed" and "hit his head on the box spring," which caused him "elevated pain," but he indicated that his pain from that fall was improving. O'Brien acknowledged smoking approximately four cigarettes per day. Pannu counseled him on "the importance of smoking cessation" and issued him another prescription for nicotine transdermal patches. Pannu planned to fit O'Brien with an "external cervical bone stimulator," which Pannu indicated O'Brien "require[d]" "due [to] being a multilevel cervical fusion/obesity/smoker or diabetes." Pannu recommended O'Brien begin physical therapy to evaluate and treat his "worsening neck pain."

¶7 At the time of O'Brien's July 1, 2013 physical therapy appointment, O'Brien reported that his pain was a 3/10 and would "[burn] at times." He indicated he "[g]ets dizzy spells daily since surgery and has slipped or tripped on stairs [a] 'few times.'" His joint mobility was not assessed at this appointment "due to pain." O'Brien's "Neck Disability Index" at the time was "46% disability." The report indicates: "Patient will benefit from skilled PT services to improve overall [upper extremity] functioning and manage pain."

¶8 At a July 29, 2013 physical therapy appointment, O'Brien reported that his pain was a 3/10. The therapist found that his "Neck Disability Index" was "30% disability." After seven physical therapy sessions, O'Brien "continue[d] to demonstrate significant weakness with deep neck flexor activation and limited upper cervical spine mobility."

¶9 At an August 1, 2013 appointment with Pannu, O'Brien felt his neck pain had improved and he was pleased with the progress he had made since surgery, but he stated he has "good and bad days." He continued experiencing pain, numbness, and tingling in his right upper extremity, and expressed that "neck extension and sudden movements aggravate his pains." O'Brien indicated his pain as being 4/10 at the time of this appointment. Pannu reported O'Brien was doing "extremely well" since his surgery, but recommended he continue with physical therapy to treat his neck pain. O'Brien continued to smoke "less than 10 cigarettes per day," and he was again counseled "on the importance of smoking cessation."

¶10 During an August 29, 2013 appointment with Pannu, O'Brien rated his neck pain at that time as a 4-5/10. He described "a 'burning' sensation" and complained of "bilateral trapezius pain." He continued to experience "numbness and tingling in his bilateral upper extremities in the C6 distribution," which he

rated at a 2/10. O'Brien continued "to have some difficulty with fine finger movements." He had returned to work, but indicated that "occasionally he is required to work a mandatory 16 hour shift which is increasing his neck pain." He indicated "rest and his prescriptive medications help alleviate his pains." Continued physical therapy was recommended to treat his "postoperative cervical neck pain." O'Brien continued to smoke "approximately 3 cigarettes per day," he was again counseled "on the importance of smoking cessation," and a prescription was again provided for nicotine transdermal patches. At this appointment, O'Brien was also fitted for and provided a cervical external bone stimulator. The external bone stimulator was noted again as "require[d]" "for one or more of the following reasons: history of multilevel lumbar fusion, obesity, smoker or diabetes."

¶11 On September 6, 2013, O'Brien was sitting at work when the back rest of his chair broke off, causing him to begin falling backward. At the hearing before the ALJ, O'Brien explained that in order to keep himself from hitting his head on the wall behind him, he put his "head at a downward angle" and experienced a "sudden jerking motion," which immediately caused him severe pain in his neck. He went to the emergency room later that day.

¶12 Records from O'Brien's emergency room visit indicate he presented with neck and back pain, which he described as "aching." It was noted he had "[n]o weakness or numbness" but did have "some mild upper thoracic pain." O'Brien's pain was reported as moderate but also noted as 7/10. His symptoms were "aggravated by bending and twisting," but he had no numbness, headaches, dizziness, tingling or weakness. An x-ray of the surgery site showed: "No evidence for fracture or dislocation of the cervical spine." O'Brien's surgical site was reported as "intact," and it was determined he could go back to work the

following day, but with a restriction of no lifting for two days. He was to schedule an appointment with Pannu as soon as possible. O'Brien's history from this emergency room visit indicated he was a "current everyday smoker," smoking "0.2 packs/day for 22 years."

¶13 At a physical therapy appointment ten days later, O'Brien reported that he had experienced increased pain since the September 6 work incident, rating his pain as a 5/10. Regarding therapy targets, the report states: "Patient will improve score on Neck Disability Index [NDI] from 46% disability at initial evaluation to less than or equal to 38% disability to meet criteria for clinically significant functional improvement in ADL's." The report notes that on July 29, 2013, O'Brien had "MET" the target NDI with 30% disability but that on August 28, 2013, his NDI was back up to 46%.

¶14 The report of O'Brien's September 23, 2013, physical therapy appointment indicates his pain was a 3/10 at the start of his appointment and a 5/10 at the end. An assessment of O'Brien's condition indicates:

> Patient with continued strength deficits which are likely related to neck pain and altered posture due to nature of surgical intervention. Pain levels seem to fluctuate with activity and stress levels. Patient's Neck Disability Index significant for improved overall functional ability since initiating PT treatment. All goals have been MET as of today's treatment.

Notes also identify that O'Brien "MET" the target of improving his NDI score "from 46% disability at initial evaluation to less than or equal to 38% disability," and thus met the criteria "for clinically significant functional improvement in ADL's."

¶15 O'Brien saw Pannu on October 3, 2013. The report of the visit indicates that "since [the September work incident] [patient] has been experiencing significant increase in pain. He currently rates his neck pain as a 6/10, but states it has been as high as a 10/10." O'Brien denied pain radiating into his bilateral shoulders, left trapezius muscle, or arm, and "any weakness or cervical radicular pain in his upper extremities," however, he indicated he did "continue to experience numbness and tingling in his hands." O'Brien indicated that "sitting for extended periods of time aggravate[s] his pains while rest and his prescriptive medications help alleviate his pains." The report indicates that O'Brien had been "doing relatively well postoperatively" until the September work incident, but since then O'Brien had "experienced progressively worsening neck pain." Pannu recommended that O'Brien undergo x-rays and a CT scan of the cervical spine. It was noted that O'Brien was back at his job as a correctional officer, he "continues to smoke approximately 5 cigarettes per day," and Pannu again counseled him "on the importance of smoking cessation."

¶16 Per Pannu's directive, an x-ray and CT scan were done on October 3, 2013, and October 25, 2013, respectively. The x-ray showed that there were "[n]o fractures, dislocations or other acute bone or joint pathology" and "[n]o hardware failure or loosening," and the CT scan showed no alignment or stenotic abnormalities.

¶17 At a November 14, 2013 appointment with Pannu, O'Brien indicated he had been in increased pain since his September work incident, rating his neck pain as a 4-5/10, and further stated the pain would travel into his "left upper extremity, predominantly in his scapula." He rated this pain as a 2/10. O'Brien denied "any subjective weakness or cervical radicular pain in his upper extremities," but stated he "intermittently experiences numbness and tingling."

O'Brien expressed that "exertional activity and sitting for extended periods of time aggravate his pains while rest and his prescriptive medications help alleviate his pains." He indicated he had been working two days per week on light duty since the September work incident. An assessment stated that following his surgery, O'Brien had been "doing relatively well" until the September work incident, and that he had experienced "progressively worsening neck pain" since then. Pannu recommended that he "undergo a hardware block at the C6-C7 level … for further evaluation in hopes to alleviate his neck pain." O'Brien acknowledged smoking approximately five cigarettes per day, and was again counseled on the importance of smoking cessation.

¶18 O'Brien underwent the hardware block with Dr. Cyril Philip on December 2, 2013. The report from this appointment indicates O'Brien experienced "back pain and pain radiating to the shoulders and causing headaches," the pain "can sometimes be as bad as a 10 out of 10," and any type of head movement or stretching aggravated the pain. Philip performed the hardware block procedure hoping that it would "be diagnostic in terms of whether the hardware is potentially compromised." As part of the procedure, Philip injected an anesthetic near the screws, which afforded O'Brien increased lateral rotation of his head and approximately five hours of pain relief.

¶19 O'Brien saw Pannu again on January 2, 2014. The report of the visit indicates O'Brien rated his neck pain as 4-5/10, continued to experience "whole hand numbness and tingling as well as intermittent numbness and tingling in the C6 distribution bilaterally," but denied having difficulty with fine finger movements or manual dexterity. He described the pain as being "fairly constant," and "radiating in between his bilateral trapezius muscles." It was noted that O'Brien continued to smoke "approximately 6 cigarettes per day," he was

counseled on the importance of smoking cessation, and he was "encouraged to follow up in approximately 4-6 weeks."

¶20 O'Brien testified at the hearing before the ALJ that "[i]f" he "recall[ed] correctly," at some point after the December 2, 2013 hardware block, Pannu indicated to him that the block "showed … that the pain was actually in the hardware," i.e., the screws, and recommended further surgery. O'Brien testified at the hearing that he went to the emergency room on February 8, 2014, because he "couldn't take the pain anymore" and could "feel the screws moving in [his] neck."

¶21 A CT scan performed on February 8, 2014, showed:

> There is apparent pseudarthrosis development with bone graft material at the posterior margin of the facet at C5-6 bilaterally. This replacement hardware is stable. The surgical hardware itself appears intact without evidence of hardware malfunction…. No hardware fracture area and there is no evidence of an acute cervical spine fracture.

The impression of the scan was: "[p]ostsurgical changes are stable from the prior study. No acute fracture." A February 10, 2014 report of Pannu's indicates that the February 8, 2014 CT scan showed "a pseudoarthrosis at C5-C6 bilaterally. The concern at this point is the patient was having increasing pain." Pannu determined O'Brien "would benefit from a posterior cervical decompression and fusion revision."

¶22 Pannu performed the surgery on February 10, and "evaluat[ing] strength and mass of the fusion[,] … found the bone to be eggshell thin, particularly at C5-C6 where the pseudoarthrosis had been previously diagnosed." Pannu "removed the screws at C5, C6, and C7," noting they were "loose

consistent with the patient's increasing posterior cervical neck pain." Pannu replaced the screws with larger ones.

¶23 O'Brien returned to work on May 1, 2014. In the year following the February 2014 surgery, O'Brien saw Pannu and participated in physical therapy on numerous occasions. During that time, he rated his neck pain at varying levels from a 3/10 to a 9/10. During appointments with Pannu on December 4, 2014, and January 15, 2015, he respectively rated his neck pain at the time of his visits as a 4-5/10 and a 7-8/10. At each visit, O'Brien expressed that "exertional activity aggravates his pains."

¶24 In lieu of testimony at the hearing before the ALJ, Pannu filled out a state form WKC-16-B, dated March 4, 2014, and a WKC-16-B, dated December 13, 2014. On the March 2014 form, Pannu stated that the February 2014 "re-fusion surgery" was "necessitat[ed]" by "[p]seudoarthrosis." In response to the question: "Describe the accidental event or work exposure to which the patient attributes his/her condition," Pannu responded: "The patient describes a fall from a chair that broke at work on September 6, 2013. He is now in need of surgical intervention. (See attached report of 2-19-14.)" In a February 19, 2014 letter from Pannu to O'Brien's counsel—presumably the "attached report of 2-19-14"—Pannu stated that "Mr. O'Brien has developed a pseudoarthrosis at C5-6 necessitating a revision from C5-C7." In the letter, Pannu also stated: "Mr. O'Brien, due to the work injury of 9/6/2013, developed increasing posterior cervical neck pain due to the pseudoarthrosis at C5-6" and "[i]n order to alleviate his posterior cervical neck pain due to the pseudoarthrosis, I would recommend a C5-C7 revision posterior cervical decompression and fusion."

¶25 In his December 2014 WKC-16-B, Pannu was asked: "Describe the accidental event or work exposure to which the patient attributes his/her condition." Pannu responded: "The patient fell from a chair at work on 9-6-13 resulting in the need for cervical re-fusion surgery." On both WKC-16-B forms, Pannu was asked: "If not directly, is it probable that the [September work incident] caused the disability by precipitation, aggravation and acceleration of a pre-existing progressively deteriorating or degenerative condition beyond normal progression?" On both forms, Pannu checked the box for "Yes."

¶26 Also at the hearing, DOC submitted a report authored by neurological surgeon Dr. Tibor Boco. For his report, Boco reviewed O'Brien's medical records from February 5, 2008, through May 1, 2014. In the report, Boco summarized various medical visits O'Brien had during that time period and noted that O'Brien's history of neck injury began with a 2007 incident while on military duty.

¶27 In discussing his impressions, Boco noted that "[i]t is documented that [O'Brien's] neck pain never really abated since" his 2007 military injury. O'Brien's "symptoms changed on 4/13/2013 at which time he presented with worsened neck pain, increasing pain and numbness down his right arm, all the way to his fingers. Indeed, he reported that he was dropping objects as well as having difficulty in terms of manual dexterity."

¶28 Regarding O'Brien's May 8, 2013 surgery, Boco stated that

> [p]ostoperatively, the arm pain improved but his neck pain could still be as high as a 6.5 out of 10. This suggests that at this point there was no real improvement with regards to his neck pain from his preoperative, chronic state.… Postoperatively, he also did not stop smoking and continued to smoke anywhere between five to [ten cigarettes] to half a pack of cigarettes a day.

Boco added:

> Mr. O'Brien continued to have significant neck pain in the postoperative period. He also continued smoking. Even as his neck pain seemed to ever so slightly improve to a 4-5 out of 10, he was diagnosed radiographically with pseudoarthrosis at C5-C6. Typically, the fusion rate in the two-level anterior cervical discectomy and fusion is between 90-95 percent. Given the fact that the construct had been augmented by a posterior instrumentation I would judge that there was a 95 percent likelihood to fuse. However, Mr. O'Brien being a smoker increased the rate of pseudoarthrosis to 30 percent or more. Neither the fall from his bed, nor the 9/6/2013 work incident described should be ultimately held responsible for the pseudoarthrosis. Indeed, bony fusion is a process that can take up to a year. Short instances of stress on the hardware could theoretically temporarily disrupt bony bridging but subsequent healing would allow the fusion process to continue unless one chronically exposes oneself to repeat insult, such as smoking.

¶29 In response to "specific interrogatives," Boco stated that O'Brien "did not sustain an injury" during the September work incident and the incident "did not directly cause Mr. O'Brien's medical condition." He added that "[t]here is no objective evidence to suggest that anything changed on or after" the work incident. He noted that

> subsequent imagining of the cervical spine did not show any changes with regard to hardware. Any subjective increase in neck pain that Mr. O'Brien related to the 9/6/2013 incident should not be interpreted as being causative of the pseudoarthrosis. The pseudoarthrosis is directly correlated with Mr. O'Brien's continuation of cigarette smoking after his initial fusion surgery. Indeed, his continuation to smoke puts him at further risk for pseudoarthrosis even after re-surgery.

When asked "[t]o a reasonable degree of medical probability, what is the cause of the current condition," Boco responded: "Mr. O'Brien has a diagnosis of neck pain or cervicalgia … and cervical spondylosis…. After a detailed review of the

data and the records, he had these symptoms and diagnoses since his original neck injury in 2007. Therefore, this is a chronic pre-existing problem."

¶30 Boco further stated that O'Brien's "acute cervical radiculopathy related to his pseudoarthrosis responded very well to re-surgery and he is at maximal medical improvement with regard to that procedure. As the neck pain is chronic it might not respond even if a bony fusion is obtained at the surgical site." In response to an interrogatory asking if the treatment rendered to O'Brien was "medically necessary as it relates to the work injury," Boco stated:

> None of the treatment rendered was related to the alleged work injury. The worsening of Mr. O'Brien's neck pain is related to the pseudoarthrosis which is related to his continuation to smoke. Therefore, the 9/6/2013 work incident cannot be considered a work injury. Regardless of cause, it is appropriate to treat flare ups of neck pain with over-the-counter analgesia as well as two to four weeks of physical therapy if needed. The revision surgery was appropriate with regard to addressing radiographic pseudoarthrosis even if it is unlikely to cure his chronic neck pain.

In response to a final interrogatory inquiring as to "the necessity for surgery and its relation to the work injury," Boco stated: "Given the fact that he had pseudoarthrosis associated with his continuation to smoke, he eventually underwent reexploration of fusion. The revision surgery of 2/10/2014 is not related to the 9/6/2013 alleged work injury."

¶31 Embracing the opinions and findings of Pannu over those of Boco, the ALJ concluded that O'Brien sustained an injury arising out of his employment with DOC, and awarded employment compensation, medical expenses, and attorney fees and costs. Giving more weight to Boco's opinions and findings than Pannu's, the Commission reversed the decision of the ALJ. In its decision, the Commission found that O'Brien's neck problems began with his 2007 military

injury and that O'Brien sought medical care for several years thereafter for his neck pain. The Commission further found that following his May 2013 surgery, O'Brien repeatedly complained of neck pain during appointments with Pannu and physical therapy. His pain postsurgery ranged from a 3/10 to a 6.5/10 and was aggravated by "neck extension and sudden movements."

¶32 The Commission noted that Pannu opined that O'Brien "suffered a traumatic injury" with the September work incident "that precipitated, aggravated or accelerated a pre-existing progressively deteriorating or degenerative condition." "In [Pannu's] opinion, the condition linked causatively to the injury was pseudoarthrosis, commonly called a failed fusion. The pseudoarthrosis was at C5-6, and required revision surgery from C5-C7."

¶33 The Commission also considered the "contrary" medical opinion of Boco. The Commission noted that Boco opined that O'Brien did not sustain an injury in the September work incident, "recounted the history of [O'Brien's] surgery and ongoing neck pain up until the time of the work incident, and stated that there was no objective evidence to suggest anything had changed in the applicant's condition after the incident." "Dr. Boco accepted that the applicant developed pseudoarthrosis, and that the hardware from the prior surgery had become loose, but did not interpret the work incident and the applicant's subsequent modest increase in neck pain as causative, as opposed to the applicant's continued cigarette smoking." The Commission noted that following the May 2013 surgery, O'Brien "continued to smoke about 3 to 10 cigarettes per day." The Commission recognized that Boco denied that the September work incident "was causative of [O'Brien's] pseudoarthrosis in any way," but acknowledged that "the revision surgery was appropriate to address his pseudoarthrosis."

¶34 As to Pannu, the Commission stated that his opinion "asserts causation without describing the mechanism of the injury or how it contributed to a loosening of the screws or to pseudoarthrosis." The Commission noted that O'Brien "points to his increasing pain after the September incident and to x-ray evidence before and after the incident in order to support Dr. Pannu's causation opinion," but it pointed out that Boco's

> general point, that the increase in pain resulting from the incident was modest, is accurate. The applicant's pain level varied from about 4 to 6 in the months between the May 2013 surgery and the September 2013 work incident, and varied from 4 to 7 in the months after the work incident, although at one time[1] he reported a spike up to 10/10. In his last examination before the September incident, August 29, 2013, he reported his pain at 4-5/10; and in his last examination before the revision surgery, January 2, 2014, he reported the same level of pain, 4-5/10. Based upon the applicant's measurement of pain, there does not appear to be a great effect from the incident in September 2013.

¶35 The Commission also found unpersuasive O'Brien's reliance on imaging studies, noting that imaging from between the May 2013 surgery and the September work incident and between the September work incident and the February 2014 surgery all indicated no problems with the hardware. The Commission recognized

> [i]t is undeniable that the hardware from the first surgery was loose by February 2014, and may have been loose by the time of the hardware block study in December 2013, but imaging studies in the weeks before and after the work incident do not isolate the September incident as the cause.

[1] While the Commission's statements regarding O'Brien's pain are generally supported by the record, we note that O'Brien reported on *two* occasions after the September 2013 work incident that his pain had "spiked" to a 10/10.

¶36 Considering Boco's opinions and findings, the Commission stated:

> In contrast to Dr. Pannu, Dr. Boco opined that the applicant's continued smoking probably caused the failure of his May 2013 fusion surgery. It is undisputed in the record that the applicant continued to smoke after the surgery. It is also undisputed that his treating physician advised him against smoking. In fact, Dr. Pannu fitted the applicant for an external bone stimulator, and the only reason apparent in the evidence for doing so was his concern about the effect of smoking on the healing process. This concern arose before, and therefore independent of, the September work incident. Dr. Boco's opinion about the effect of smoking on the success rate of fusion surgery was uncontested, and Dr. Pannu's plan to provide the applicant with an external bone stimulator was a recognition of the negative effect of smoking. Also uncontested was Dr. Boco's opinion of the substantial degree (30%) to which smoking negatively affected the likelihood of success of the kind of fusion surgery the applicant had.

¶37 The Commission noted that the case came down "to a conflict between medical experts regarding the cause of the disabling condition." The Commission concluded:

> Given [Dr. Pannu's] lack of an explanation supporting his opinion, the weakness of the subjective and objective evidence tying the September incident causatively to the disabling condition discovered several months later, and the uncontested medical opinion of an alternative, non-work-related cause of the applicant's pseudoarthrosis, … there is legitimate doubt that the applicant's condition was caused by the September 2013 incident at work.

The Commission denied O'Brien's worker's compensation claim, O'Brien appealed the Commission's decision to the circuit court, and the court reversed. The Commission, DOC, and the Department of Administration now appeal.

Discussion

¶38 On appeal, we review the decision of the Commission and not that of the circuit court. ***Cargill Feed Div./Cargill Malt & AIG Cas. Co. v. LIRC***, 2010 WI App 115, ¶13, 329 Wis. 2d 206, 789 N.W.2d 326. O'Brien bore the burden before the Commission "of proving the elements of his … claim," and on appeal, he also bears the burden of showing that the Commission's decision should be overturned. *See* ***Kowalchuk v. LIRC***, 2000 WI App 85, ¶8, 234 Wis. 2d 203, 610 N.W.2d 122.

¶39 WISCONSIN STAT. § 102.23(1)(a)1. (2015-16)[2] provides that with judicial review of a decision by the Commission "[t]he findings of fact made by the commission acting within its powers shall, in the absence of fraud, be conclusive." Subsection (6) provides that

> [i]f the commission's order or award depends on any fact found by the commission, the court shall not substitute its judgment for that of the commission as to the weight or credibility of the evidence on any finding of fact. The court may, however, set aside the commission's order or award and remand the case to the commission if the commission's order or award depends on any material and controverted finding of fact that is not supported by credible and substantial evidence.

Sec. 102.23(6). Whether or not the incident of September 6, 2013, caused O'Brien's claimed injury is a question of fact. *See* ***Bumpas v. DILHR***, 95 Wis. 2d 334, 342, 290 N.W.2d 504 (1980); *see also* ***Kowalchuk***, 234 Wis. 2d 203, ¶7.

[2] All references to the Wisconsin Statutes are to the 2015-16 version unless otherwise noted.

¶40 In an appeal from the Commission's findings, our review "is limited to a determination of whether there is sufficient credible evidence in the record to support [those] findings." ***Bumpas***, 95 Wis. 2d at 343.

> The evidence in support of the [Commission's] finding need not meet the increased burden of proof to that of a preponderance or the great weight of the evidence but need only be sufficient to exclude speculation or conjecture. If there is credible evidence to support the findings of the [Commission], such findings will not be upset on appeal.

Id. at 343-44. The question for us on appeal is "whether there was sufficient evidence to raise in the mind of the [Commission] a legitimate doubt regarding [O'Brien's] claim of injury." *See* ***id.*** at 344. We conclude there was such evidence.

¶41 "A legitimate doubt comprises 'some inherent inconsistency … or conflict in the testimony.'" ***Kowalchuk***, 234 Wis. 2d 203, ¶8. "Conflicts in testimony of medical witnesses are to be resolved by [the Commission], and a determination of the [Commission] that the testimony of one qualified medical witness rather than the testimony of another is to be believed is conclusive." ***E. F. Brewer Co. v. DILHR***, 82 Wis. 2d 634, 637, 264 N.W.2d 222 (1978). As the Commission recognized in the case now before us, "[t]his case comes down to a conflict between medical experts regarding the cause of the disabling condition."

¶42 The parties agree that the need for O'Brien's second surgery, on February 10, 2014, was caused by the pseudoarthrosis that had developed after his first surgery on May 8, 2013.[3] Pseudoarthrosis is defined in a common dictionary

[3] On this point, O'Brien states: "It is clear that the surgery of February 2014 which is the subject of this claim was necessitated by a pseudoarthrosis." The Commission states: "The key question in this worker's compensation case is whether the September 6, 2013, work incident caused O'Brien's pseudoarthrosis."

as: "[T]he formation of a false joint (as by fibrous tissue between the ends of a fractured bone which has not perfectly united); *also*: a false joint or abnormal union between parts of bone." *Pseudoarthrosis*, WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY (1993). The disagreement comes over what caused the pseudoarthrosis. O'Brien insists the September 6, 2013 incident was a cause of the pseudoarthrosis. The Commission contends it has legitimate doubt as to whether that is the case.

¶43 O'Brien relies on Boco's statement in his report that "[s]hort instances of stress on the hardware could theoretically temporarily disrupt bony bridging but subsequent healing would allow the fusion process to continue unless one chronically exposes oneself to repeat insult, such as smoking." From this, O'Brien argues:

> Dr. Boco's opinions recognize the prospect of two causal factors producing the pseudoarthrosis that necessitated the second surgery: an injury *and* a smoking habit. Dr. Boco's report theorizes that the injury produced the loosening of the screws and the smoking habit prevented a re-fusion. While the smoking habit, upon which the Commission entirely relies, may have produced a delay in the fusion from the surgery of May 8, 2013 or a delay in the re-fusion subsequent to the injury, it could not represent a "short instance of stress" (injury) "disrupting" the fusion by traumatically loosening the screws.

¶44 O'Brien stretches Boco's statements beyond what they actually say. To begin, Boco is unabashedly clear as to his opinion that the September work incident did not cause the injury to O'Brien. Second, Boco's statement that "[s]hort instances of stress on the hardware *could theoretically* temporarily disrupt bony bridging" in no way implies that Boco was of the opinion that the September work incident *was* a short instance of stress on the hardware that in fact *did* disrupt bony bridging. (Emphasis added.) Furthermore, in the same sentence of his report

in which he referenced the September work incident as a potential short instance of stress that "could theoretically" temporarily disrupt bony bridging, Boco also referenced O'Brien's "fall from his bed"—in which he "hit his head on the box spring"—as another potential instance. Ultimately, however, Boco concluded neither instance was responsible for the pseudoarthrosis. It is Boco's unambiguous opinion that O'Brien's "smoking habit" "produced a delay in the fusion from the surgery of May 8, 2013," resulting in the pseudoarthrosis. *See supra* ¶¶28-30.

¶45 O'Brien claims it is "clear that the pseudoarthrosis which necessitated the surgery had two points of origin.… [T]he *failure* to fuse due to smoking and the *breakage* due to the injury." The Commission on the other hand concluded, and maintains, that it had "legitimate doubt" that the September 6, 2013 incident caused the pseudoarthrosis "discovered several months later." It had such doubt because of Pannu's "lack of an explanation supporting his opinion, the weakness of the subjective and objective evidence tying the September incident causatively to the disabling condition …, and the uncontested medical opinion of an alternative, non-work-related cause" of O'Brien's pseudoarthrosis, i.e., his continued smoking. The Commission was more persuaded by Boco's opinion that "[t]he pseudoarthrosis is directly correlated with Mr. O'Brien's continuation of cigarette smoking after his initial fusion surgery. Indeed, his continuation to smoke puts him at further risk for pseudoarthrosis even after re-surgery."

¶46 The Commission found Pannu's causation opinion unconvincing in large part because it was so conclusory. We must defer to the Commission's credibility determination as we conclude it was reasonable. In his February 14, 2014 letter to O'Brien's counsel, which letter is presumed to be the

"report" "attached" to Pannu's WKC-16-B form dated March 4, 2014, *see supra* ¶24, Pannu states O'Brien's "neck pain" was "due to the pseudoarthrosis." In the letter, Pannu responds to the inquiry: "[F]rom a structural [perspective], how does the injury of 9/6/2013 anatomically act upon the condition which survived the surgery in May of 2013 so as to necessitate the recommended surgery?" Despite this request for an explanation, Pannu provided the very conclusory statement: "[D]ue to the work injury of 9/6/2013, [O'Brien] developed increasing posterior cervical neck pain due to the pseudoarthrosis at C5-6." This one sentence is the most direct causation statement made by Pannu that we can find in the record with regard to the September work incident and the February 2014 surgery. Even that sentence is not clear: Did O'Brien's neck pain increase "due to the work injury of 9/6/2013" or "due to the pseudoarthrosis at C5-6"? Though it appears somewhat implied, the statement does not provide clear indication that Pannu was of the opinion that the September work incident caused the pseudoarthrosis, which Pannu opined was the cause of O'Brien's increasing neck pain, and the statement certainly does nothing to explain how this might be so.

¶47 In response to the December 2014 WKC-16-B form inquiry: "Describe the accidental event or work exposure to which *the patient* attributes his/her condition," Pannu states: "The patient fell from a chair at work on 9-6-13 resulting in the need for cervical re-fusion surgery." (Emphasis added.) Besides being conclusory, this statement also is unclear as to whether this is Pannu's own causation opinion or merely Pannu relating O'Brien's causation opinion. In his notes related to O'Brien's February 2014 surgery, Pannu indicates the screws in O'Brien's neck were "loose consistent with the patient's increasing posterior cervical neck pain." But this told the Commission nothing about how or when the screws became loose, how Pannu could make a determination with confidence as

to how or when they became loose, or how Pannu could conclude the loose screws might be the cause of O'Brien's pain, as opposed to the pseudoarthrosis that Pannu identified in the February 2014 letter as the cause of O'Brien's pain.

¶48 Particularly when competing expert opinions are presented, fact finders need to be given convincing reasons to choose one opinion over another. The Commission reasonably concluded that Pannu provided none. Pannu's failure to explain "from a structural [perspective], how" the September work incident "anatomically acted upon" the condition of O'Brien's neck following his May 2013 surgery, gave the Commission significant reason to reject what O'Brien represents as Pannu's causation conclusion and to instead embrace Boco's explanation as to the cause of O'Brien's pseudoarthrosis that caused O'Brien's pain and the need for the February 2014 surgery.

¶49 We note that the medical records from the months following O'Brien's May 2013 surgery are replete with statements by O'Brien that the pain in his neck would be aggravated by his "exertional activity," "neck extension," and "sudden movements." Further, just a month and a half after surgery, O'Brien reported he had fallen out of bed and struck his head on the box spring. Even if we assume the loose screws Pannu observed during the February 2014 surgery were a cause of O'Brien's pseudoarthrosis, Pannu makes no attempt to explain why O'Brien's "sudden movement" of the September work incident is more likely the cause of the loosening of the screws than O'Brien striking his head in this fall out of bed or other "exertional activity," "neck extension," or "sudden movements" of O'Brien's. Moreover, O'Brien does not identify for us, and we are unable to locate, any evidence in the record indicating the loosening of the screws could only have been caused by an incident resulting in a short instance of stress. Furthermore, Boco made the following uncontested statement:

> Typically, the fusion rate in the two-level anterior cervical discectomy and fusion is between 90-95 percent. Given the fact that the construct had been augmented by a posterior instrumentation I would judge that there was a 95 percent likelihood to fuse. However, O'Brien being a smoker increased the rate of pseudoarthrosis to 30 percent or more.

This statement can only be interpreted as indicating that pseudoarthrosis can develop following a fusion surgery, such as O'Brien's May 2013 surgery, without a short instance of stress or traumatic event. Indeed, this is precisely what Boco opined happened in this case, as he stated that O'Brien's "worsening … neck pain is related to the pseudoarthrosis which is related to his continuation to smoke" and concluded the September work incident did not contribute to O'Brien's need for the February 2014 surgery. Nowhere does Pannu address the likelihood or lack thereof that O'Brien's continued smoking could have been the sole cause of his pseudoarthrosis, as Boco opined.

¶50 As noted, both O'Brien and the Commission agree the surgery was necessitated by the pseudoarthrosis that was discovered by the CT scan taken on February 8, 2014. Attempting to reconcile Pannu's opinion and Boco's, O'Brien insists on appeal that the pseudoarthrosis resulted both because of his smoking *and* because the screws were loose. Even if we assume it to be true that the September work incident did in fact cause the screws to loosen—or perhaps loosen more—Pannu does not explain how the loosening of the screws may have caused the pseudoarthrosis. The Commission reasonably concluded that Boco did a better job of explaining that as a "smoker" O'Brien had approximately a thirty percent or more chance of developing pseudoarthrosis and that the pseudoarthrosis observed on February 8, leading to the surgery on February 10, was likely caused by O'Brien's continued smoking. The Commission also noted:

> At the examination on August 29, 2013, [O'Brien] was fitted for an external bone stimulator. The doctor noted:

> "The patient requires the use of an adjunct external bone stimulator for one or more of the following reasons: history of multilevel lumbar fusion, obesity, smoker or diabetes." There is no evidence of the applicant[] having had lumbar fusion surgery or diabetes, and his weight hovered around 150 pounds. He was, however, a long-time smoker. During the approximately four months following his May 2013 surgery the applicant reported several times that he continued to smoke; the number of cigarettes he reported smoking per day varied from about 3 to about 10.

The Commission found that "the only reason apparent in the evidence for [fitting O'Brien for an external bone stimulator] was [Pannu's] concern [before the September work incident] about the effect of smoking on the healing process." The Commission's finding that Pannu required that O'Brien use an external bone stimulator because Pannu was concerned about the effect O'Brien's continued smoking would have "on the healing process" following the May 2013 surgery is supported by the record.

¶51 For the foregoing reasons, we conclude there is sufficient credible evidence supporting the Commission's decision that it had legitimate doubt as to whether the September work incident caused the pseudoarthrosis and increased pain necessitating the February 2014 surgery. As a result, the order of the circuit court must be reversed.

By the Court.—Order reversed.

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