ALASKA WORKERS' COMPENSATION BOARD

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

JIM HAMILTON, Employee, Claimant, v. CHUGACH ELECTRIC ASSOCIATION, INC., Employer, and LIBERTY INSURANCE CORPORATION, Insurer, Defendants.	)	FINAL DECISION AND ORDER AWCB Case Nos. 200712999, 200916499 & 201407529 AWCB Decision No. 15-0007 Filed with AWCB Anchorage, Alaska on January 13, 2015

Jim Hamilton's (Employee) May 1, 2013 claim was heard on the written record on January 6, 2015, in Anchorage, Alaska, a date selected on December 30, 2014. Attorney Thomas Melaney represented Employee. Attorney Rebecca Holdiman-Miller represented Chugach Electric Assn., Inc., and Liberty Insurance Corporation (Employer). The parties stipulated to a written record hearing limited to compensability of injuries to Employee's knees and his right hip. There were no witnesses. The record closed at the hearing's conclusion on January 6, 2015.

ISSUE

Employee contends he injured his left knee in 2007, his right hip and right knee in 2009 and his left knee in 2014, all while working for Employer as a lineman. Consequently, he seeks an order

holding Employer liable under the Alaska Workers' Compensation Act (Act) for all workers' compensation benefits to which he might be entitled for both knees and for his right hip.

Employer contends if Employee injured his knees and right hip while employed with Employer, any such injuries were temporary aggravations of preexisting degenerative conditions and have long ago resolved. Therefore, it contends Employee is not entitled to any further benefits for his knees or right hip. Employer seeks an order declaring any requested benefits for these injuries are not compensable under the Act.

Does Employee have compensable work injuries to his knees and right hip?

FINDINGS OF FACT

The following facts and factual conclusions are established by a preponderance of the evidence:

1) There is no medical report in either the 2007, 2009 or 2014 case showing any medical care for Employee's left knee prior to his left or right knee injuries discussed below (observations).

2) On August 10, 2007, Employee asserts he was doing a "reconnect," and a piece of wood on which he was standing rolled out from underneath him, injuring his left knee (Report of Occupational Injury or Illness, August 14, 2007).

3) On August 16, 2007, Employer stated it first knew about the left knee injury on August 13, 2007. Employer did not doubt the injury (*id*., August 16, 2007).

4) There is no record of any medical care or treatment for Employee's left knee through October 17, 2009 (observations).

5) On October 17, 2009, Employee saw Dale Trombley, M.D., and stated two days earlier he was working on the hillside and as he was walking through the grass he stepped into a hole with his right foot, throwing himself forward. Employee caught himself and did not recall twisting but had an acute spasm of his right thigh and hip area. Since then Employee had been having pain and discomfort in the right hip and knee area and his right knee would occasionally click. It had been slightly more swollen and he had never had clicking before. Dr. Trombley's impression was: acute strain of the right hip muscles and possible strain of the knee as well as tearing of the cartilage or ligament. He wanted to take x-rays. Dr. Trombley released Employee

to return to work effective October 19, 2009 with a "no climbing" limitation (Trombley report, October 17, 2009).

6) On October 19, 2009, Employee saw John Lapkass, M.D., with a new problem and chief complaint of right knee and right hip pain. Employee said he hurt himself on October 14, 2009, at work as a lineman. He was walking through a grassy field when he stepped into a hole. His upper body "kept going" and he had a hyperextension type injury to his right knee and some sort of right hip injury. He had some early right knee swelling and pain. He was seen in an urgent care center and a magnetic resonance imaging (MRI) scan was ordered but not yet obtained. His knee pain had improved over the past five days. However, he has an ongoing "click" or "pop" in the knee associated with some discomfort. There had been no locking or giving way. Right hip and right knee x-rays showed some mild to moderate medial compartment joint space narrowing and some early arthritic changes. There was no acute pathology. Right hip x-rays also showed mild, early degenerative arthritis. Dr. Lapkass' assessment was: right knee pain possibly secondary to internal derangement with a meniscal tear, and right hip pain most likely secondary to a nonspecific strain or sprain. He too ordered an MRI (Lapkass report, October 19, 2009).

7) On October 19, 2009, Employee underwent a right knee MRI without contrast. He told the radiologist he had right knee pain following a twisting injury on October 14, 2009. There was nothing with which to compare this MRI. The radiologist's impression was: complex tear of the medial and lateral menisci; mucoid cystic degeneration versus a remote partial sprain of the anterior cruciate ligament without any discontinuity; remote medial collateral ligament sprain; lateral patellar translation and lateral patellar tilt; tricompartmental osteoarthritis with grade III articular cartilage loss in all three compartments; moderate effusion (MRI, October 19, 2009).

8) On October 20, 2009, Dr. Lapkass called Employee to report on the right knee MRI. Dr. Lapkass explained the MRI is "really quite impressive." There was a complex tear in the posterior horn and body of the medial meniscus, which was three centimeters in length, and there was a complex tear essentially along the entire lateral meniscus. There was also evidence of some "chronic injury or some degeneration of the anterior crucial ligament," but it looked intact. There were some arthritic changes as well. Dr. Lapkass left this as a voicemail message for Employee stating if he should become significantly symptomatic there was plenty reason for it and explained arthroscopic surgery was an option (Lapkass report, October 20, 2009).

9) On October 20, 2009, Employee completed another injury report with Employer. He stated that on October 14, 2009, he was working on a trouble call with another individual named "Hacking" and fell in a hole and hurt his right knee and hip. He went to Health Works and Anchorage Fracture & Orthopedic Clinic for medical care (Report of Occupational Injury or Illness, October 20, 2009).

10) On October 22, 2009, Employer completed its portion of the injury report and said it first knew of this injury on October 19, 2009. The report says Employee stepped into a low depression that was covered by tall grass. Employer did not dispute the injury (*id*.).

11) On October 30, 2009, an initial chart note from Dr. Lapkass said Employee was an established patient and was complaining about his left knee. Employee stated he was on a "meter base" and went to reach for something and his knee twisted. He was complaining of aching and popping (Lapkass report, October 30, 2009).

12) This is the first medical report in the agency record, in the three above-referenced case numbers, in which Employee complained of left knee symptoms (observations).

13) On October 30, 2009, Employee saw Dr. Lapkass with both left knee and right hip pain. His "main problem" was his "left knee." Dr. Lapkass had recently seen him for his right knee. According to this report, on the previous occasion, Employee had told Dr. Lapkass about his left knee "briefly" and Dr. Lapkass asked him to return for a formal evaluation for the left knee. Employee stated his left knee problems started roughly two years ago. He was putting up a meter box and he was standing on a block of wood. The wood rolled and he fell, torqueing and twisting his left knee. He had immediate pain in the knee at that time and for "a while" but did not seek immediate medical attention. The knee improved. However, last winter the injury was significantly aggravated. He was doing some work out in the snow, but Dr. Lapkass is not sure he understood this history correctly. Employee said he broke through the snow while walking forward and had what was basically a hyperextension knee injury. Ever since then, the left knee pain had been significant, had increased and then persisted. He complained of sharp pains in the popliteal area and also around the anterior knee. He did not complain of significant instability. Employee had a particular problem going up hills. He continued to work. He also briefly mentioned his right hip. When Dr. Lapkass had seen him earlier for his right knee, he had also mentioned the right hip. He had been having a little discomfort in the right hip for some time but said he really aggravated the situation at the same time he injured his right knee. The right hip

continued to be significantly painful. It hurt him when he sits and occasionally "clicks and snaps." The pain was near the groin. Dr. Lapkass reviewed plain film x-rays of the left knee, which were reported elsewhere. Right hip x-rays obtained two weeks earlier showed good joint space but Employee had a bony bump at the superior femoral head and neck junction. Dr. Lapkass' assessment was: left knee pain with severe, medial compartment arthritis and possible superimposed meniscal tears and anterior cruciate ligament tear; radiographic findings of femoral acetabular impingement. Dr. Lapkass was "very suspicious" of a labral tear. Dr. Lapkass would review the left knee MRI and then decide how to proceed. He discussed with Employee the entire panoply of treatment from bracing through total knee replacement. As for the right hip, Dr. Lapkass said the only way to confirm a labral tear would be to obtain an MRI arthrogram. Employee wanted to move ahead with this because the hip "really hurt." Following the MRI arthrogram result, they would discuss proceeding (Lapkass report, October 30, 2009).

14) On October 30, 2009, Employee filled out a left knee MRI form. He stated he had pain, decreased range of motion and instability. He gave a history of "twisted knee" and the duration of symptoms since 2007 (MRI form, October 30, 2009).

15) On October 30, 2009, Employee had a left knee MRI without contrast. The radiologist stated Employee had pain and instability since a twisting injury in 2007. There was nothing with which to compare this MRI. The impression was: severe attenuation of the entire medial meniscus with a degenerated meniscal flap; tricompartmental chondral and degenerative changes; severe partial tear and degeneration of the ACL, which appears chronic (MRI, October 30, 2009).

16) On October 30, 2009, a left knee x-ray showed "bone on bone" in the medial compartment; and the lateral joint space was well-maintained. There were patellofemoral changes and narrowing of the inter-condyle notch (x-ray report, October 30, 2009).

17) On October 30, 2009, Dr. Lapkass released Employee to return to full duty work without any restrictions (Lapkass release, October 30, 2009).

18) On November 3, 2009, Employee had a right hip MRI with contrast. The radiologist's impression was: anterior to posterior, inferior, right acetabular labral complex tearing and degeneration. Moderate, multilevel lumbar degenerative disc disease (MRI, November 3, 2009).

19) On November 25, 2009, Dr. Lapkass called Employee's wife to report the results from Employee's right hip MRI arthrogram and left knee MRI. Dr. Lapkass advised that the MRI

showed significant tearing and degeneration of the labrum in the right hip. The left knee MRI demonstrated "severe problems." He opined these tests confirmed "very significant arthritis." Employee's prior right knee MRI showed both medial and lateral tears. Employee's wife advised he would probably go for right hip and right knee arthroscopy. She thought Employee was going to opt for a left total knee replacement. Employee's wife thought he probably would have the right hip and right knee arthroscopy at the same time. She wanted Dr. Lapkass to schedule this for him at the earliest available date. She was going to discuss it with Employee when he returned from a trip to Texas (Lapkass report, November 25, 2009).

20) On August 26, 2010, Dr. Lapkass performed right knee arthroscopy with partial medial and lateral meniscectomies (Operative Report, August 26, 2010).

21) On August 26, 2010, Dr. Lapkass also performed a right hip arthroscopy with acetabular labral repair and femoral osteoplasty (*id*.).

22) On August 30, 2010, Dr. Lapkass prescribed physical therapy for the recent right hip and knee arthroscopy (Lapkass prescription, August 30, 2010).

23) On September 1, 2010 through September 8, 2010, Employee attended physical therapy for his right hip and knee following surgery (physical therapy reports, September 1, 2010 through September 8, 2010).

24) On September 8, 2010, Employee told the physical therapist he was leaving town and would be riding a motorcycle about 5,000 miles. He was "cleared for WB," which is an abbreviation for "weight bearing" (physical therapy note, September 8, 2010; experience, judgment and inferences from the above).

25) On September 8, 2010, Employee saw Dr. Lapkass' physician assistant, PA-C Welker for follow-up. He was doing "extremely well" and "felt great." Employee had good range of motion in his right knee. He was given permission to start increasing weight-bearing as tolerated and was allowed to go on his motorcycle trip so long as he was on aspirin and wore his compression socks (Welker report, September 8, 2010).

26) On October 6, 2010, Employee returned from his two-week motorcycle ride "WBAT," which is an abbreviation for "weight-bearing as tolerated." He attended physical therapy and the therapist opined Employee was "on track and progressing" (chart note, October 6, 2010).

27) On October 6, 2010, Employee saw Dr. Lapkass six weeks out from his two surgeries on the right hip and knee. He was doing "amazingly well." Employee said two weeks after surgery

he flew to Oklahoma and started a 3,800 mile motorcycle ride, which he completed even though about two weeks into it "he had a significant crash." He had just gotten home and was not complaining of pain in either the hip or the knee. The "click" Employee had in his right knee preoperatively was gone. He wanted to go back to work the following week (Lapkass report, October 6, 2010).

28) On October 6, 2010, Dr. Lapkass released Employee to return to work at full duty without restrictions, effective October 11, 2010 (Lapkass release, October 6, 2010).

29) On October 7, 2010, Dr. Lapkass completed a Liberty Northwest insurance form recommending Employee returned to full duty, heavy work effective October 11, 2010 (Liberty Northwest form, October 7, 2010).

30) On November 12, 2010, Employee saw Dr. Lapkass again for his right knee and right hip. He reported "absolutely" no pain complaints in either the hip or knee and had long since returned to full work. He had absolutely full range of motion in his right knee. The hip also had "smooth, painless motion." He was doing "exceedingly well" (Lapkass report, November 12, 2010).

31) On January 3, 2011, Dr. Lapkass replied to a note from Tracy Mears at Liberty Northwest referencing the October 14, 2009 work injury. He perceived some inconsistency in her request because she switched from the right hip and right knee to the right shoulder and right knee and then to the left shoulder. Dr. Lapkass explained he had not seen Employee for any shoulder injuries. He had been treating his right hip and right knee injuries. Mears' first question was whether Employee has reached "maximum medical improvement" in regards to his right knee and hip injury. Dr. Lapkass opined: "I would say that he has." When last seen on November 12, 2010, Employee was doing very well. Dr. Lapkass stated the October 14, 2009 injury resulted in a permanent partial impairment (PPI) rating, but he does not perform them, so he referred Employee to Declan Nolan, M.D., for the rating (Lapkass report, January 3, 2011).

32) On January 21, 2011, Employee saw Dr. Lapkass to recheck his combined right knee arthroscopy and right hip surgery from August 26, 2010. He was then four and one half months post-surgery and according to Dr. Lapkass, employee continued "to do exceedingly well." He did not have any hip pain complaints. He had "perhaps lost a little bit of motion" but he was very happy with it. Employee was also very happy with the right knee. However, after a long day on his feet, which for him was 12 to 17 hours, Employee started to develop some pain and swelling in the right knee. Otherwise he was doing well. Employee came in to see Dr. Lapkass

to discuss: first, the doctor had recently received a letter from his workers' compensation carrier about Employee's status and medical stability. Dr. Lapkass told Employee he responded to this query and said Employee was medically stable in regards to his right hip and right knee and could be referred for a PPI rating. Second, Employee wanted to talk about his left knee. Dr. Lapkass recalled they had discussed left knee replacement "perhaps at some point." Dr. Lapkass referred Employee to Dr. Nolan for a PPI rating and encouraged him to schedule his left knee surgery at his convenience (Lapkass report, January 21, 2011).

33) On February 6, 2011, Dr. Nolan saw Employee on referral for a PPI rating. He told Dr. Nolan he had hurt his right knee on October 14, 2009, when he stepped in a hole while at work in a field. Dr. Nolan examined the entire right hip and right knee, and gave Employee a six percent whole person PPI rating. He noted Employee had returned to work at full duty in heavy-duty work (Nolan report, February 6, 2011).

34) On March 14, 2011, Employer completed a compensation report stating it paid Employee temporary total disability for the 2009 injury from August 26, 2010, through October 11, 2010, and paid Employee six percent PPI on March 9, 2011 (Compensation Report, March 14, 2011).

35) On June 6, 2011, Employee saw Dr. Lapkass again for his right knee. Notwithstanding his preexisting degenerative arthritis, Employee "did remarkably well up until about a month or six weeks ago when the knee started to become painful again with intermittent swelling." Employee told Dr. Lapkass he had been working about 100 hours a week since summer began. His work was very physical and the right knee had started bothering him. Dr. Lapkass obtained standing x-rays for the right knee, which showed severe lateral compartment joint space narrowing and some moderate medial compartment joint space wearing as well. The assessment was: degenerative osteoarthritis, right knee with possible overlapping internal derangement. He recommended a cortisone injection. They also discussed possible future surgery if necessary. Dr. Lapkass provided a cortisone injection (Lapkass report, June 6, 2011).

36) On June 6, 2011, Employee also saw Dr. Lapkass for his left knee. Dr. Lapkass found "bone on bone" in the medial compartment of the left knee. Dr. Lapkass recalled that he and Employee had previously discussed left knee replacement and Employee wanted to move ahead with it now. Clinically, Employee had no knee instability. Dr. Lapkass did not think arthroscopy would be sufficient given Employee's bone on bone condition. He took new x-rays and compared those to those he took two years earlier (Lapkass report, June 6, 2011).

37) On June 10, 2011, Dr. Lapkass referred Employee to physical therapy following his June 14, 2011 surgery, which he was soon to have (Lapkass referral, June 10, 2011).

38) On June 14, 2011, Dr. Lapkass replaced Employee's left knee. The pre- and post-operative diagnoses were "end-stage medial compartment degenerative arthritis, left knee" (Operative Report, June 14, 2011).

39) On June 23, 2011 through June 28, 2011, Employee resumed physical therapy and said his left knee got "stiff and sore" but was doing "okay." His knee locked up on him on the prior Saturday after sitting in bleachers (physical therapy reports, June 23, 2011 through June 28, 2011).

40) On June 29, 2011, Dr. Lapkass wrote a "to whom it may concern" letter in respect to Employee's left knee addressing the time lag between his first visits concerning the left knee and his surgery date. Dr. Lapkass says he first saw Employee on October 30, 2009. He recalled Employee had mentioned his left knee to Dr. Lapkass in previous visits, "in passing." However, on October 30, 2009, Employee said his left knee problem started while at work for Employer roughly two years prior to the October 2009 visit. Employee had immediate pain but then "things somewhat subsided" with intermittent, relatively mild discomfort. When symptoms re-aggravated, Employee requested a formal evaluation. Dr. Lapkass did radiographic studies that showed extensive tearing of the medial meniscus and also showed he was developing degenerative changes in the medial compartment. He and Dr. Lapkass discussed options in respect to his left knee. Notably, Dr. Lapkass said Employee "is an extremely stoic and motivated individual to put off doing anything for a couple more years." When Employee finally exhibited ongoing symptoms of significant severity "even for him," he decided to finally pursue the surgical option and that is how he came to surgery on June 14, 2011. In Dr. Lapkass' opinion, regarding the left knee, "the surgery is directly related to his original injuries from four years ago." The "only reason for the time lag" is that Employee was exceptionally tolerant to pain and was "extremely motivated to continue working" without any interruption. However, in Dr. Lapkass' opinion, it "finally got the best of him" and Employee decided to pursue "the surgical option." Dr. Lapkass opined the time lag is more a "testament and credit to his motivation and demeanor" than anything else. Dr. Lapkass stated: "I strongly feel that most people would have addressed this in much shorter order but Mr. Hamilton is certainly not 'most people'" (Lapkass report, June 29, 2011).

41) On June 30, 2011 through July 19, 2011, Employee continued with physical therapy. He was generally doing better. His left knee was sore but he was doing "okay." He lacked flexibility like he had before. His left knee was stiff sometimes and he had muscle soreness. The left knee did not do well on uneven rocks or other surfaces. Employee's primary limitation was stiffness and he was unable to get his foot up to put a sock on (physical therapy notes, June 30, 2011 through July 19, 2011).

42) On August 1, 2011, Employee was just over six weeks from left knee replacement surgery and he was "doing great." He had no left knee pain complaints. He was ambulating without any aids. Everything was going well but he was certainly "not yet ready to go back to climbing poles." Employee would continue with physical therapy and Dr. Lapkass would see him in about six weeks to see how he was doing clinically and "possibly by that time he may be able to return to work, but we will see" (Lapkass report, August 1, 2011).

43) On August 12, 2011, Employee continued with physical therapy and reported he had tried and successfully climbed a pole and felt comfortable doing it. He had also been out hunting without incident to his left knee and felt ready to go back to work (physical therapy report, August 12, 2011).

44) On August 17, 2011, Employee saw Dr. Lapkass again for his left knee. He was supposed to have been seen in about six weeks but, he had gone to his cabin at Larson Bay and had done a lot of physical work "and did great." When he returned home, Employee tried climbing poles and found he was able to do so without any problem. Dr. Lapkass reported: "He basically comes in today saying he would like a release to return to full duty. I provided him with this. He will continue with activity to comfort." Dr. Lapkass suggested Employee return in about one year for routine follow-up of the replaced left knee (Lapkass report, August 17, 2011).

45) On August 17, 2011, Dr. Lapkass released Employee to full duty work without restrictions effective August 18, 2011 (Lapkass release, August 17, 2011).

46) On September 9, 2011, Employee saw Dr. Lapkass for his right hip. He was just over one year out from his right hip arthroscopic surgery. Dr. Lapkass reported: "The hip is doing great, and he has no complaints about it" (Lapkass report, September 9, 2011).

47) On September 9, 2011, Employee also saw Dr. Lapkass for follow-up on his right knee. He had done well but was starting to have progressively increasing symptoms again including aching. Dr. Lapkass and Employee had discussed injections in the past and Employee wanted to

try those. In the long-term, Employee planned to have the right knee replaced but wanted to put surgery off for a while (Lapkass report, September 9, 2011).

48) On September 9, 2011, Employee had his first right knee injection (Lapkass report, September 9, 2011).

49) On September 9, 2011, Employee also saw Dr. Lapkass for follow-up on his left knee replacement surgery. He was roughly three months from surgery. Employee reported for the most part "the knee is doing great." However, about one week prior, Employee had developed some intermittent "snapping or catching" on the lateral aspect of his left knee. This occurred if Employee had been sitting and then got up. It was not painful but did "catch." He was climbing up and down poles without any problem and was "very happy" with the knee. On examination, Employee had no effusion; and had absolutely full range of knee motion; all orthopedic tests were negative. However, there was a definite, reproducible "pop" with active range of motion. It was not painful. X-rays showed Employee was developing a "little stress response" at the tibial component but there was no evidence of loosening. Dr. Lapkass did not know specifically what the "pop" was. He thought it might be scar tissue. Dr. Lapkass recommended following this sign to see if it persisted (Lapkass report, September 9, 2011).

50) On September 16, 2011, Employee saw Dr. Lapkass for his second right knee injection. He had one previous right knee injection but it reportedly did not make any difference (Lapkass report, September 16, 2011).

51) On September 16, 2011, Employee saw Dr. Lapkass and said the left knee was doing "very well." Dr. Lapkass had already returned Employee to full work months earlier. Dr. Lapkass opined Employee had reached "maximum medical improvement" and his left knee was medically stable. He referred Employee for a PPI rating (Lapkass report, September 16, 2011).

52) On September 16, 2011, Employee saw Dr. Nolan for a left knee PPI rating. Employee reported that since 2007 he had multiple left knee injuries, which he said had "been decided to be related to his work." Employee responded well to treatment. He had finished his physical therapy. He had residual mild pain and swelling in his left knee when he performed hard work. Employee denied any previous injury or diagnosis to the left knee prior to 2007. He denied previous PPI ratings on the left knee. Dr. Nolan noted, there was, however, in the records a six percent PPI rating for the right knee. Using the *Guides to the Evaluation of Permanent*

Impairment, Sixth Edition, (*Guides*) Dr. Nolan provided an eight percent whole person PPI rating for Employee's left knee (Nolan report, September 16, 2011).

53) On September 23, 2011, Employee saw Dr. Lapkass for his third, right knee injection. The first two reportedly did not make a "huge difference, maybe a little" (Lapkass chart note, September 23, 2011).

54) On October 13, 2011, Dr. Lapkass responded to Liberty Northwest's letter in regard to Employee's right knee. He opined the October 14, 2009 work injury to Employee's right knee and hip was "the substantial cause" of the need for three recent knee injections. The further treatment he needs, which is reasonable and necessary secondary to the October 14, 2009 work injury, is a total knee replacement (Lapkass report, October 13, 2011).

55) On October 26, 2011, Dr. Lapkass released Employee to full duty with no work restrictions effective October 26, 2011 (Lapkass release, October 26, 2011).

56) On March 3, 2012, Employee saw Keith Holley, M.D., for an employer's medical evaluation (EME) for the October 14, 2009 right knee and right hip injuries. Dr. Holley reviewed Employee's medical records and examined him. Employee's chief complaint was right knee pain. He gave a consistent history of the work injury. He had arthroscopic surgery for both the right hip and right knee on August 26, 2010, and did well in the sense that his pain went away. However, about a year later Employee again began noticing pain in the right knee. Employee went through "supplementation injections" with Dr. Lapkass, which helped for a few months but soon wore off. Employee's attending physician was recommending total knee replacement. Dr. Holley diagnosed: right knee osteoarthritis with degenerative medial and lateral meniscus tears, preexisting but symptomatically aggravated by the patient's injury of October 14, 2009; status post right knee arthroscopy administratively accepted under this claim; and a right hip cam-type femoroacetabular impingement and acetabular labral tear, preexisting but symptomatically aggravated by the October 14, 2009 injury. The injury was consistent with the diagnosed conditions. The injury was not the cause of the underlying degenerative conditions in the right hip and right knee. The October 14, 2009 work injury was not "the substantial cause" of his current right knee condition and future need for total knee replacement surgery. The substantial cause of his right knee condition and need for knee replacement surgery was preexisting osteoarthritis of the knee and a natural progression of this degenerative condition. Dr. Holley opined the October 14, 2009 incident caused a "temporary aggravation" of

the preexisting condition in the right hip and right knee. In Dr. Holley's opinion, this temporary aggravation had resolved. A total knee replacement was medically necessary and reasonable, but in his view, the October 14, 2009 work injury was not the substantial cause of the need for this treatment. He anticipated about three months' additional treatment after total knee replacement (Holley EME report, March 3, 2012).

57) On March 14, 2012, Employee returned to Dr. Lapkass complaining of right knee crepitus and "popping." Dr. Lapkass gave him a fourth, right knee supplementation injection (Lapkass report, March 14, 2012).

58) On March 14, 2012, Dr. Lapkass released Employee to return to full duty effective that date without any restrictions (Dr. Lapkass release, March 14, 2012).

59) On March 23, 2012, Dr. Lapkass performed a fifth right knee supplementation injection. Employee reported he definitely felt the difference after the first injection of the second series last week (Lapkass report, March 23, 2012).

60) On March 30, 2012, Dr. Lapkass performed a sixth right knee supplementation injection. Employee reported he definitely felt some benefit (Lapkass report, March 30, 2012).

61) On March 30, 2012, Dr. Lapkass released Employee to return to work full duty with no restrictions effect that date (Lapkass release, March 30, 2012).

62) On April 9, 2012, Employer filed a controversion in the 2009 case relying on Dr. Holley's EME report (Controversion Notice, April 9, 2012).

63) On May 8, 2012, Employee through counsel filed a claim in the 2009 case seeking medical costs; interest; attorney fees and costs; and gave as the reason for filing that his benefits had been controverted. The injury description was as stated on Employee's injury report for the 2009 injury (claim, May 8, 2012).

64) On March 23, 2012, Employee saw Dr. Lapkass for follow-up on his left knee. He was about nine months post-op. Overall he was "doing well." Employee had no left knee pain with walking, climbing or other activities. Occasionally, when he was standing still, Employee's left knee would suddenly feel like it "buckles." He occasionally felt a little "click or snap" on the lateral side of the left knee. On examination, the clicking was not reproducible. Dr. Lapkass advised Employee it would take about two years for the left knee to fully stabilize. He should follow-up in one year (Lapkass report, March 23, 2012).

65) On June 29, 2012, Employee was one year from his left knee replacement surgery. He had no real complaints about the left knee except "occasional clicking or grinding" on the lateral side. The knee replacement was doing well. He was developing progressive arthritis of the lateral compartment. Dr. Lapkass advised Employee that his lateral side was narrowing and this was producing more valgus. Dr. Lapkass opined this would continue to degenerate over time and if it became bothersome, Employee would need to consider revision to his total knee replacement (Lapkass report, June 29, 2012).

66) On June 29, 2012, Dr. Lapkass completed a release for Employee to return to full duty work with no restrictions (Lapkass release, June 29, 2012).

67) On September 5, 2012, Employee returned to Dr. Lapkass for his left knee, denying any "new injury." He said his lateral left knee was in constant pain. Dr. Lapkass performed a steroid injection. Left knee x-rays showed his lateral joint space was severely narrowed to where he was "almost bone on bone." Employee told Dr. Lapkass that over the past month or two he had developed progressively increasing lateral side knee pain. When he was climbing poles he had no knee pain. When he kicked his left leg out to the side, Employee also did not have any knee pain. Employee had been working "extremely hard." There had been a bad windstorm the previous night, which knocked power out over much of the city and Employee had been working constantly since 6:00 AM the prior day. On examination, Dr. Lapkass found mild to moderate swelling in the left knee. Dr. Lapkass' assessment was: 15 months status post left knee replacement with advancing lateral compartment arthritis. They discussed options including bracing, injections and a "revision" total knee replacement. Employee wanted to go forward with a total knee replacement revision, but at that time he needed to remain working. Consequently, Dr. Lapkass injected the left knee instead (Lapkass report, September 5, 2012).

68) On September 5, 2012, Dr. Lapkass released Employee to return to work, full duty with no restrictions (Lapkass release, September 5, 2012).

69) On March 20, 2013, Dr. Lapkass reevaluated Employee. In respect to his left knee, Employee reported the left knee replacement had "worked well" for him. However, over time, his lateral compartment had progressively worn out. Dr. Lapkass recalled that in September they had discussed left knee treatment options. On this then-current visit, Employee said his knee had continued to steadily worsen to the point where it was getting to be a major problem "just getting around" on it. Employee's left knee x-rays showed he was now completely "bone on bone" on

the lateral side. He also had significant patellofemoral arthritis. Dr. Lapkass' assessment was: progression of severe osteoarthritis in the lateral left knee. Employee wanted to proceed with a total knee replacement (Lapkass report, March 20, 2013).

70) On May 2, 2013, Employee through counsel filed a claim requesting unspecified temporary total disability (TTD); permanent total disability (PTD); PPI; medical costs; transportation costs; interest; and attorney's fees and costs. The reason for filing the claim was: "Employer has refused recommended medical treatment." The body part listed is "left knee." The injury description is identical to that found on Employee's injury report (Workers' Compensation Claim, May 2, 2013).

71) On May 23, 2013, Employee saw Timothy Borman, M.D., for an EME for the August 10, 2007 injury. Although he also reported right knee symptoms, Employee was being evaluated regarding only his left knee. He described left knee stiffness, weakness, and pain and chronic swelling. Employee noted crepitus with range of motion and with walking. He also had balance difficulties with his left knee. He denied left knee instability. Employee's pain was constant and difficult to characterize. It ranged from "4/10 to 8/10" on a pain scale. He preferred to not take medication. Employee's knee pain worsened with prolonged walking and especially with walking on uneven terrain. He had pain when he stood from a sitting position. He also had pain with climbing and descending stairs. Employee had marked pain climbing in and out of trucks, especially when he was required to climb utility poles. He avoided kneeling, squatting, hunting and fishing because of his left knee. Overall Employee felt his left knee condition had worsened since his August 10, 2007 work injury. Employee also gave a history of standing on a log to install an electric meter, when the log rolled and he twisted his knee. Dr. Borman diagnosed severe degenerative arthritis of the left knee, post unicompartmental knee replacement. He also found evidence of arthritis and post-surgical changes in the left knee. Employee had mild, ligamentous instability of the left knee secondary to collapse of the lateral compartment. In Dr. Borman's opinion, substantial factors in bringing about "the diagnosed conditions" include: genetics; aging leading to left knee degenerative arthritis; and the August 10, 2007 work injury. Dr. Borman opined it was a "close call," as to which of the identified substantial factors is "the most significant factor" contributing to "each of the diagnosed conditions." He said although Employee reported the August 10, 2007 injury, it was not a significant enough injury for him to seek any treatment until October 30, 2009. In fact, Dr. Borman noted Employee's right knee was

more symptomatic than his left knee as demonstrated by the fact he had right knee MRI imaging done on October 19, 2009, and because he did not seek further diagnostic evaluation regarding his left knee until October 30, 2009, 26 months after his reported left knee injury of August 10, 2007. Dr. Borman opined Employee also had end-stage degenerative arthritis of both knees. In his opinion, the most significant factor contributing to Employee's left knee was "genetics and aging." His left knee was medically stable. Treatment to date had been reasonable and necessary notwithstanding causative issues. Genetics and aging were also the most significant factor in the need for left knee treatment. Further treatment for Employee's left knee would include total knee replacement. Dr. Borman stated this would be necessary notwithstanding causation. Genetics and aging would be the main cause for that as well. In Dr. Borman's view, one month following the reported work injury to Employee's left knee, the need for work-related treatment ended; in other words, by September 2007. Employee reportedly was "currently working as a cable splicer without restriction," as of this EME and Dr. Borman stated he could continue to do that. Dr. Borman did not have the cable splicer job description that was supposed to be attached. Nevertheless, as Employee was currently, reportedly working as a cable splicer, Dr. Borman opined he could continue to do it without restriction. Dr. Borman stated Employee had a 31 percent permanent impairment of the left lower extremity but none of this was attributable to the August 10, 2007 left knee injury (Borman EME report, May 23, 2013).

72) On June 20, 2013, Employer answered Employee's claim admitting TTD from June 14, 2011 August 17, 2011; medical costs through May 23, 2013; and transportation costs. It denied TTD following May 17, 2011; PTD; PPI; medical costs which were not reasonable, necessary and work-related and all medical costs following May 23, 2013; transportation costs through May 23, 2013, which were not reasonable; all transportation costs following May 23, 2013; interest; and attorney's fees and costs. Employer contended Employee was released to return to full duty employment by Dr. Lapkass, effective August 18, 2011. It also stated Dr. Borman evaluated Employee on May 23, 2013, and said "genetics and aging" were the most significant factors contributing to Employee's left knee condition. The left knee was deemed medically stable warranting no further treatment in relation to this injury. Employee told Dr. Borman he was currently working as a cable splicer without any restrictions. Therefore, no additional benefits were due (Borman EME report, May 23, 2013).

73) On June 20, 2013, Employer filed a controversion based on the facts set forth in its answer (Controversion Notice, June 20, 2013).

74) On July 17, 2013, Dr. Lapkass completed a "check-the-box" letter written by attorney Melaney and stated the August 10, 2007 work injury was the primary cause of Employee's need for left knee replacement (Lapkass letter, July 17, 2013).

75) On August 6, 2013, Employee filed a petition requesting a second independent medical evaluation (SIME) (Petition, August 6, 2013).

76) On August 29, 2013, Employer filed a non-opposition to the SIME petition (non-opposition, August 29, 2013).

77) On January 14, 2014, the parties attended a prehearing conference and stipulated to the SIME and began the SIME process (Prehearing Conference Summary, January 14, 2014).

78) On February 12, 2014, Employee saw Dr. Lapkass to recheck his right knee. Dr. Lapkass reviewed the right knee findings over the years and concluded Employee has had "severe injury" to both menisci and "very significant degenerative arthritis." He suspected "his condition may well be secondary to his work" or "at the minimum be severely exacerbated by his work." Employee had improvement after the arthroscopy, but over time his right knee had worsened. Now he had chronic pain and crepitus. However, Employee continued to work in spite of feeling that his right knee was "sloppy." Dr. Lapkass' impression was: advanced degenerative arthritis in his right knee. Employee's only surgical option was total knee replacement. Employee wanted to proceed with this but was "dealing with workers' compensation." The x-rays demonstrated "bone on bone" degenerative arthritis (February 12, 2014).

79) On March 25, 2014, an adjuster and Employee's attorney attended a prehearing conference in the 2009 case. There was an unopposed affidavit of readiness for hearing so the designee set a hearing for June 12, 2014 (Prehearing Conference Summary, March 25, 2014).

80) On April 3, 2014, the parties attended an emergency prehearing at Employer's request. Employer wanted to join the left and right knee claims and augment issues and records for the scheduled SIME. The June 12, 2014 hearing was continued by stipulation, the parties agreed to update the SIME form to include both knees, and updated their SIME questions (Prehearing Conference Summary, April 3, 2014).

81) On April 4, 2014, Employer filed an answer to Employee's claim in the 2009 case. It admitted medical costs through March 3, 2012, but denied medical costs which were not

reasonable, necessary and work-related; interest; attorney fees and costs. Employer based its defense on Dr. Holley's EME report (Answer, April 4, 2014).

82) On April 7, 2014, the parties filed a formal stipulation to join the 2007 and 2009 cases together and to continue the June 20, 2014 hearing. Hearing officer Ringel approved the stipulation (Stipulation, April 7, 2014).

83) On April 12, 2014, Employee electronically reported a new injury. Employer knew about this alleged injury on April 15, 2014. The body part is his "knee." The report stated Employee's left knee "gave out" while climbing into his company truck. There are no medical records filed in this case (Report of Occupational Injury or Illness, April 12, 2014; observations).

84) On May 5, 2014, Employee filed a hearing request on his May 17, 2012 claim (Affidavit of Readiness for Hearing, May 2, 2014).

85) On May 8, 2014, Employer filed request for cross-examination of Dr. Lapkass' April 30, 2014 report (Request for Cross-Examination, May 8, 2014).

86) On June 10, 2014, Employee saw James Scoggin, M.D., in Hawaii for an SIME on his August 10, 2007 left knee and October 14, 2009 right knee work injuries. To this point, Employee's history given to all examining physicians had been remarkably consistent. However, at this SIME appointment, Employee's history became muddled. Employee stated he injured his left knee on August 10, 2007, when he "stepped in a hole and fell." He did not go to the emergency room. He told Dr. Scoggin he eventually went to a surgeon who did surgery and he did pretty well until he started noticing a clicking in the left knee. According to Dr. Scoggin, Employee is a poor historian and cannot recall how soon after the 2007 injury he required left knee surgery. He did "okay" for a while but then it got worse and his surgeon said he needs a total knee replacement. Employee next reported that on April 12, 2014, he was on a trouble call and he stepped out of a bucket truck, missed with his right leg and foot, and hyper-flexed his left knee. Employee said his left knee hurt "a lot more" since then and the grinding has gotten worse. Employee described his right knee injury and said he was walking down a hill and hit his right knee on a "big lug nut" on a "large truck tire." Employee was not sure if that was the correct injury or not. He said he hurt his right knee before he hurt his left knee. Employee further noted he had a right knee and right hip arthroscopy. Thereafter, the right knee continued to hurt. The SIME physician noted Employee had his dates and injuries "mixed up." Employee also said he had a new injury on April 12, 2014, and he last saw his orthopedic surgeon,

presumably Dr. Lapkass, after the April 12, 2014 work injury. Employee advised Dr. Scoggin that his orthopedic surgeon was recommending knee replacement surgery on both knees. Employee's main complaint on this SIME visit was left knee pain. It was at an "8/10" pain level. His next complaint was right knee pain which can be as high as "5/10 to 6/10." The right knee and left knee pain were both worse if he bends too much. His right hip was "fine" and he had no pain there. Employee advised he had been taken off work indefinitely since the April 2014 injury. The last medical record given to the SIME was Dr. Lapkass' report from February 12, 2014. This is also the last medical report in the agency file, other than this SIME report. Dr. Scoggin's diagnostic impression was: left knee osteoarthritis, nonindustrial; left knee arthroplasty performed for nonindustrial left knee osteoarthritis; right knee medial and lateral meniscus tears, industrial; right knee osteoarthritis nonindustrial and obesity. Causes of Employee's "disability, or need for medical treatment" included this doctor's explanation of why Employee has osteoarthritis in his knees. The causes of the osteoarthritis were advancing age, genetic factors and obesity. Therefore, Dr. Scoggin concluded Employee's left knee osteoarthritis is due to age, obesity and genetic factors and "has no relationship to the injury of August 10, 2007." Dr. Scoggin determined Employee had reported his left knee injury differently to different providers and thought these various injuries were not relevant to his "left knee condition." On the other hand, he opined Employee's "right knee osteoarthritis is a result of his right knee injury of August 10, 2007, which combined with the preexisting osteoarthritis of the right knee to produce a permanent change in the preexisting condition." Dr. Scoggin reasoned the right knee was work-related because Employee needed treatment for the right knee within a few days of injury, whereas the left knee went on for over two years before Employee saw a physician for any treatment. Dr. Scoggin's opinion includes the right knee total replacement surgery, which was contemplated. Employee's disability for the right knee continued. He was not medically stable in respect to his right knee. Assuming he has his right knee replaced, Employee will be stable approximately eight months postoperatively assuming a good result. Employee told Dr. Scoggin he wanted to work for three more years. Dr. Scoggin opined a total right knee replacement with a good result should enable him to return to work although some work restrictions may be appropriate. As for PPI ratings, Dr. Scoggin rated the left knee at 75 percent impairment of the lower extremity under the Fifth Edition of the *Guides*, and 59 percent impairment of the left lower extremity under the Sixth Edition, both of which he

said are "nonindustrial." For the right knee, Dr. Scoggin rated under both *Guides* editions and derived 50 percent under the Fifth Edition and 50 percent under the Sixth Edition. He attributed 50 percent of the right knee PPI to preexisting right knee osteoarthritis and 50 percent to Employee's October 14, 2009 work injury (Scoggin SIME report, June 10, 2014).

87) On June 18, 2014, Employee filed an amended claim through counsel clarifying his claim for TTD from April 12, 2014, through "ongoing," apparently based upon the April 12, 2014 left knee injury; alternatively, PTD from April 12, 2014 through "ongoing"; PPI; medical costs; transportation costs; interest; and attorney's fees and costs. The reason for filing this claim was that the benefits had been controverted (Workers' Compensation Claim, June 18, 2014).

88) On July 17, 2014, Employer filed a notice controverting TTD requested from April 12, 2014 forward; PTD; PPI; all medical costs after May 23, 2013, in respect to the left knee; all medical costs for the right knee; all transportation costs after May 23, 2013; all transportation costs in relation to the right knee; interest; attorney's fees and costs. The reason given was reliance on Dr. Lapkass and EME Drs. Borman, and Holley (Controversion Notice, July 17, 2014).

89) On July 17, 2014, Employer answered Employee's amended claim and denied everything in conformance with the above-referenced controversion notice (Answer, July 17, 2014).

90) On July 24, 2014, Employer filed an amended answer to Employee's amended claim. The amended answer provided additional detail as to the medical evidence Employer relied upon to deny the claim (Amended Answer, July 24, 2014).

91) On July 24, 2014, Employer filed an amended notice denying TTD; PTD; PPI; medical costs; transportation; interest; and attorney's fees and costs. The amended notice gave more detail information as to reasons for Employer's denial (Controversion Notice, July 24, 2014).

PRINCIPLES OF LAW

> **AS 23.30.001. Intent of the legislature and construction of chapter**. It is the intent of the legislature that
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> > 1) this chapter be interpreted . . . to ensure . . . quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers. . . .

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

> **AS 23.30.010. Coverage.** (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.
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> **AS 23.30.120. Presumptions.** (a) In a proceeding for the enforcement of a claim for compensation under this chapter it is presumed, in the absence of substantial evidence to the contrary, that
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> (1) the claim comes within the provisions of this chapter . . . .

An injured employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski v. Best Western Golden Lion*, 813 P.2d 286, 292 (Alaska 1991). The presumption's application involves a three-step analysis. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381 (Alaska 1991). First, an employee must establish a "preliminary link" between the claim and his employment. An employee need only adduce "some," "minimal," relevant evidence establishing a "preliminary link" between the claim and the employment. *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987). The witnesses' credibility is of no concern in this first step. *Excursion Inlet Packing Co. v. Ugale*, 92 P.3d 413, 417 (Alaska 2004).

Second, once the preliminary link is established, the presumption is raised and attaches to the claim. The injured worker's employer has the burden to overcome the raised presumption by coming forward with substantial evidence showing the claim is not compensable. *Miller v. ITT Arctic Services*, 577 P.2d 1044, 1046 (Alaska 1978). Credibility and weight accorded the employer's evidence is deferred until after it is decided if the employer produced a sufficient quantum of evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Compensation Board*, 880 P.2d 1051, 1054 (Alaska 1994); *citing Big K Grocery v. Gibson*, 836 P.2d 941 (Alaska 1992). If the employer produces substantial evidence an injury is not work-related and thus not compensable, the presumption drops out, and the employee must prove all case elements by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1381; *citing*, *Miller v. ITT Services*, 577 P 2d. 1044, 1046. The party with the burden of proving asserted facts by a preponderance of evidence must "induce a belief" in the fact finders' minds that the asserted facts are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). Board decisions must be supported by "substantial evidence," *i.e.*, "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Miller*, 577 P.2d at 1049.

For injuries occurring after the 2005 Act amendments, if the employee establishes the link, the presumption may be overcome at the second stage when the employer presents substantial evidence demonstrating a cause other than employment played a greater role in causing the disability or need for medical treatment. *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150, at 7 (March 25, 2011). Because the board considers the employer's evidence by itself and does not weigh the employee's evidence against the employer's rebuttal evidence, credibility is not examined at the second stage. *See, e.g., Veco, Inc. v. Wolfer*, 693 P.2d 865, 869-70 (Alaska 1985).

If the board finds the employer's evidence is sufficient to rebut the presumption, it drops out and the employee must prove his case by a preponderance of the evidence. This means the employee must "induce a belief" in the fact finders' minds that the facts being asserted are probably true. *Saxton*, 395 P.2d at 72 (Alaska 1964). In the third step, evidence is weighed, inferences are drawn from the evidence, and credibility is considered. *Ugale*, 92 P.3d 413 at 417.

> **AS 23.30.122**. **Credibility of witnesses**. The board has the sole power to determine the credibility of a witness. A finding by the board concerning the weight to be accorded a witness's testimony, including medical testimony and reports, is conclusive even if the evidence is conflicting or susceptible to contrary conclusions. The findings of the board are subject to the same standard of review as a jury's finding in a civil action.

ANALYSIS

Does Employee have compensable work injuries to his knees and right hip?

a) The left knee.

Employee contends he injured his left knee on August 10, 2007, while he was performing a reconnect and standing on a piece of wood that rolled out from underneath him while at work for Employer. He contends he received, and continues to need, medical care for this event and will suffer disability as a result of this work injury. Employer contends if Employee had a work injury to his left knee, it was temporary and any such injury has long ago been superseded by Employee's age and genetics, which resulted in degenerative changes for which he now seeks treatment. These contentions raise factual issues to which the presumption of compensability applies. AS 23.30.120; *Sokolowski*.

Employee raises the presumption with his medical history concerning his left knee injury and subsequent symptoms as reported in his medical records. This is supported by Dr. Lapkass' opinion the left knee was injured at work with Employer, and this injury eventually resulted in ongoing need for medical treatment, including but not limited to previous total left knee replacement surgery and prescribed revision. *Cheeks*. Witness credibility and evidence weighing are inapplicable at this stage. *Ugale*. With this evidence, Employee attaches the presumption to his left knee injury. *Miller*. Employer successfully rebuts the presumption with evidence from Dr. Borman, who opined, though it was a "close call," the work injury with Employer was not the substantial cause of the need for any left knee treatment or disability by September 2007. Rather, Dr. Borman said preexisting degeneration, aging and genetics was the substantial cause in Employee's need for medical care and any resulting disability or impairment for his left knee after September 2007. *Runstrom*. This rebuttal evidence causes the

presumption to drop out and requires Employee to prove all elements of his left knee claim by a preponderance of the evidence. *Saxton*.

Employee promptly reported his August 10, 2007 left knee injury to Employer. However, the medical records disclose Employee sought no medical care for his left knee through October 17, 2009, more than two years after the injury occurred. Meanwhile, within three days of his October 14, 2009 right knee injury, Employee saw a physician, gave a history consistent with the October 14, 2009 event and complained about right knee pain. One would think if Employee's left knee also bothered him, he would have told his physician while being examined for his right knee. But the contemporaneous medical records do not mention any left knee complaints. Employee saw Dr. Lapkass extensively for years for right knee treatment but still the records do not demonstrate he ever complained of his left knee until October 30, 2009. Clearly, by October 2009, Employee had only recently mentioned his left knee to Dr. Lapkass who requested that he return for a separate evaluation to address the left knee.

Dr. Lapkass eventually, in retrospect, opined Employee probably injured his left knee on August 10, 2007, and this injury gradually led to his need for left knee medical treatment, which included total, left knee replacement surgery and recommended revision. But, because there is no contemporaneous medical record showing Employee ever had left knee symptoms for over two years, Dr. Lapkass' retrospective recollection of Employee having told him about the left knee symptoms at some earlier, unspecified time is given less weight. It is unlikely a busy orthopedic surgeon would specifically recall a patient mentioning another symptom complex "in passing" years after the fact without considerable patient prompting. AS 23.30.122.

By contrast, EME Dr. Borman stated, though it was a "close call," the most significant factor in causing the need for treatment to Employee's left knee after September 2007 was Employee's genetics and aging. Dr. Borman opined the left knee injury was not significant enough to require any treatment for over two years. This supported his conclusion that the August 10, 2007 left knee event was not the substantial cause of Employee's need for treatment and any resulting disability or impairment after September 2007. Similarly, SIME Dr. Scoggin stated osteoarthritis in the left knee caused by advancing age, genetic factors and obesity is the

substantial cause of the need for Employee's medical treatment for his left knee. Dr. Scoggin's opinion is given significant weight, because he is an impartial SIME physician and his reasoning comports with the medical evidence and with Dr. Borman's opinion. AS 23.30.122.

Based on this evidence, Employee cannot prove by a preponderance of the evidence that his August 10, 2007 work event with Employer is the substantial cause of his need for any left knee medical treatment after September 2007, beginning in 2009 and continuing thereafter. Employee's need for left knee medical treatment beginning in 2009 did not "arise out of or in the course of" his employment with Employer. AS 23.30.010(a). The time between the reported injury and the eventual medical treatment, absent any contemporaneous medical documentation of symptoms or complaints, is simply too long to support causation under these particular facts. *Rogers & Babler*; *Saxton*. Employee's August 10, 2007 left knee injury with Employer will be found not a continuing, compensable injury, and Employer will not be held liable for any benefits related to the left knee under the Act after September 2007.

As for the April 2014 left knee injury, Employee failed to attach the presumption, because he provided no medical evidence, which might have included his own statements to his physician about how this incident occurred, in respect to this alleged event. AS 23.30.122; *Cheeks*. Without the presumption, Employee must prove by a preponderance of the evidence that his April 2014 left knee injury is the substantial cause of any current need since that date for medical care or for any disability. AS 23.30.010(a); *Runstrom*. As the record does not disclose any such evidence, Employee cannot meet this burden. *Saxton*. Even assuming Employee somehow raised the presumption in respect to the April 2014 left knee injury, Employer would have rebutted it with the same medical evidence by which it rebutted the August 10, 2007 left knee injury and the preponderance of medical evidence would support the same result. Consequently, Employer will be found not liable for any benefits related to the April 2014 left knee injury.

b) The right knee.

Employee contends he injured his right knee on October 14, 2009, while he was walking through a field and stepped into a hole while at work for Employer. He contends he continues to need medical care and will suffer disability as a result of this work injury. Employer contends if

Employee had a work injury to his right knee, any such injury has long been superseded by Employee's age and genetics, which resulted in degenerative changes for which he now seeks treatment. These contentions raise factual issues to which the presumption of compensability applies. AS 23.30.120; *Sokolowski*.

Employee raises the presumption with his medical history concerning his right knee injury and subsequent symptoms as reported in his medical records, supported by Drs. Trombley's, Lapkass' and Scoggin's opinions that the right knee was injured at work with Employer. They further state this injury resulted in ongoing need for medical treatment, including but not limited to proposed total right knee replacement surgery. *Cheeks*. Witness credibility and evidence weighing are inapplicable at this stage. *Ugale*. With this evidence, Employee attached the presumption to his right knee injury. *Miller*. Employer successfully rebuts the presumption with evidence from Dr. Holley, who opined the work injury with Employer was not the substantial cause of the need for any right knee treatment or disability. Rather, Dr. Holley said preexisting degeneration, aging and genetics were the substantial cause in Employee's need for medical care and any resulting disability or impairment for his right knee. *Runstrom*. This rebuttal evidence causes the presumption to drop out and requires Employee to prove all elements of his right knee claim by a preponderance of the evidence. *Saxton*.

Employee promptly reported his right knee injury to Employer. Unlike the case with his left knee injury, within three days, Employee saw a physician and gave a history of having stepped into a hole while working for Employer and injuring his right knee. He subsequently began treating with Dr. Lapkass to whom he gave a consistent history. Radiologists performing MRI scans also consistently recorded the same history and his physicians noted objective swelling in the right knee. Thereafter, Employee continued to work for Employer and, according to his medical records, continued to aggravate and accelerate his right knee degeneration. Within the year, Dr. Lapkass performed arthroscopic surgery on Employee's right knee with some success. Dr. Lapkass repeatedly released Employee to return to full duty, with no physical restrictions. As he continued to work for Employer, Employee noticed progressively increasing right knee symptoms especially after working 12 to 17 hours per day. As Employee's right knee symptoms continued to increase, Dr. Lapkass recommended continuing, ever escalating treatment.

Employee went from arthroscopic surgery to serial knee injections, which provided some, temporary relief, to Dr. Lapkass eventually recommending a right, total knee replacement secondary to his October 14, 2009 work injury, on October 13, 2011. Dr. Lapkass is credible, and because he treated Employee for several years following his right knee injury, his opinions are given considerable weight. AS 23.30.122; *Ugale*.

By the time Employee saw SIME Dr. Scoggin, his memory concerning his knee injuries was confused and he mixed up the dates and events. Dr. Scoggin noted this, and it is obvious from the history Employee gave Dr. Scoggin. Based upon Employee's confused history and upon his record review and physical examination, Dr. Scoggin nonetheless opined "the substantial cause" of Employee's need for past and additional medical care for his right knee was his October 14, 2009 work injury. Dr. Scoggin noted Employee saw a physician within a few days of the right knee injury, continue to work and was treated conservatively and then more aggressively and he now requires a total, right knee replacement surgery before he can be considered medically stable. It is apparent the October 14, 2009 work injury and subsequent treatment caused a permanent change in Employee's right knee. Dr. Scoggin's right knee causation opinion is credible and given great weight. AS 23.30.122.

By contrast, EME Dr. Holley opined while Employee's right knee symptoms were temporarily aggravated by the October 14, 2009 work injury, the injury was not the substantial cause of his then-current right knee condition and future need for treatment including a total, right knee replacement as of March 3, 2012. He opined the substantial cause of Employee's need for a total, right knee replacement surgery was his preexisting osteoarthritis and a natural progression of this degenerative condition. As Dr. Holley saw Employee but once, and his opinion contradicts Dr. Lapkass, who saw Employee over the course of years for his right knee, and SIME Dr. Scoggin who is an impartial examiner, Dr. Holley's opinion is given lesser weight. AS 23.30.122.

Given the credible medical evidence, and the greater weight accorded Drs. Lapkass and SIME Scoggin's opinions, Employee has proven, by a preponderance of the evidence, that his October 14, 2009 work injury with Employer was, and remains, the substantial cause of medical

treatment for his right knee, including but not limited to recently prescribed total, right knee replacement surgery. Employee's October 14, 2009 right knee injury with Employer will be found a continuing, compensable injury for which Employer is liable for all benefits to which Employee might be entitled under the Act.

c) The right hip.

Employee contends he injured his right hip at the same time he injured his right knee on October 14, 2009, when he stepped into the hole. Employer does not dispute this but contends the right hip injury was minor and after being treated by arthroscopic surgery, the injury has long since resolved. The medical record does not disclose any recommendation for any additional medical care for Employee's right hip. By November 12, 2010, Employee reported to a surgeon that he had absolutely no pain complaints in his right hip. His right hip had "smooth, painless motion." The record does not disclose any medical care or even an examination since late 2010 for the right hip. Therefore, as there is no evidence Employee continues to suffer any symptoms or has any recommendation from a physician for additional, continuing medical care for his right hip, he currently does not have a compensable, right hip injury.

CONCLUSION OF LAW

Employee's left knee is not a compensable injury after September 2007; Employee's right knee was and remains a compensable injury; Employee's right hip was but is no longer a compensable injury.

ORDER

1) Employee's August 10, 2007 left knee injury is not a compensable event under the Act after September 2007.
2) Employee's October 14, 2009 right knee injury was and remains a compensable event under the Act.
3) Employee's October 14, 2009 right hip injury was a compensable event, but is no longer compensable under the Act.

Dated in Anchorage, Alaska on January 13, 2015.

ALASKA WORKERS' COMPENSATION BOARD

_____
William Soule, Designated Chair

_____
Amy Steele, Member

_____
Rick Traini, Member

APPEAL PROCEDURES

This compensation order is a final decision. It becomes effective when filed in the office of the board unless proceedings to appeal it are instituted. Effective November 7, 2005 proceedings to appeal must be instituted in the Alaska Workers' Compensation Appeals Commission within 30 days of the filing of this decision and be brought by a party in interest against the boards and all other parties to the proceedings before the board. If a request for reconsideration of this final decision is timely filed with the board, any proceedings to appeal must be instituted within 30 days after the reconsideration decision is mailed to the parties or within 30 days after the date the reconsideration request is considered denied due to the absence of any action on the reconsideration request, whichever is earlier. AS 23.30.127.

An appeal may be initiated by filing with the office of the Appeals Commission: 1) a signed notice of appeal specifying the board order appealed from and 2) a statement of the grounds upon which the appeal is taken. A cross-appeal may be initiated by filing with the office of the Appeals Commission a signed notice of cross-appeal within 30 days after the board decision is filed or within 15 days after service of a notice of appeal, whichever is later. The notice of cross-appeal shall specify the board order appealed from and the ground upon which the cross-appeal is taken. AS 23.30.128.

RECONSIDERATION

A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accord with 8 AAC 45.050. The petition requesting reconsideration must be filed with the board within 15 days after delivery or mailing of this decision.

MODIFICATION

Within one year after the rejection of a claim, or within one year after the last payment of benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, a party may ask the board to modify this decision under AS 23.30.130 by filing a petition in accord with 8 AAC 45.150 and 8 AAC 45.050.

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of JIM HAMILTON, employee / claimant v. CHUGACH ELECTRIC ASSOCIATION, INC., employer; LIBERTY INSURANCE CORPORATION, insurer / defendants; Case Nos. 200712999, 200916499, and 201407529; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on January 13, 2015.

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Vera James, Office Assistant