# ALASKA WORKERS' COMPENSATION BOARD

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

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| RICHARD ROBERGE,<br><br>Employee,<br>Claimant,<br><br>v.<br><br>AMCL JUNEAU,<br><br>Employer,<br>and<br><br>ARCTIC SLOPE REGIONAL CORPORATION,<br><br>Insurer,<br>Defendants. | ) | FINAL DECISION AND ORDER<br><br>AWCB Case No. 201410169<br><br>AWCB Decision No. 19-0090<br><br>Filed with AWCB Juneau, Alaska on September 5, 2019 |

Richard Roberge's (Employee) April 26, 2019 claim was heard on August 6, 2019 in Juneau, Alaska, a dated selected on June 12, 2019. A May 17, 2019 affidavit of readiness (ARH) for hearing request gave rise to this hearing. Attorney Eric Croft appeared and represented Employee, who appeared and testified. Attorney Nora Barlow appeared and represented AMCL Juneau and Arctic Slope Regional Corporation (Employer). Kaj Johansen, M.D., appeared and testified on Employee's behalf. Dennis Chong, M.D., appeared and testified on Employer's behalf. *Roberge v. ASRC Construction Holding Co.*, AWCB Decision No. 18-0128 (December 14, 2018) (*Roberge I*) denied Employee's November 5, 2015 claim for failure to timely request a hearing under AS 23.30.110(c). *Roberge v. ASRC Construction Holding Co.*, AWCB Decision No. 19-0063 (June 4, 2019) (*Roberge II*) denied Employee's May 26, 2017 claim for failure to timely request a hearing under AS 23.30.110(c) and remanded the reemployment benefit

administrator designee's ineligibility determination. The record closed at the hearings conclusion on August 6, 2019.

## ISSUES

Employee contends the work injury is the substantial cause of his need for the left brachial plexus decompression surgery recommended and performed by Dr. Johansen. He contends the EME and SIME physicians' opinions failed to rebut the presumption of compensability. Alternatively, Employee contends his treating physician's opinions, Drs. French and Johansen, proved by a preponderance of the evidence the work injury is the substantial cause of his need for decompression surgery and the surgery was reasonable and necessary. He requests an order granting his April 26, 2019 claim.

Employer contends the work injury is not the substantial cause of Employee's need for left brachial plexus decompression surgery because the work injury could not cause a left brachial plexus injury. It contends it rebutted the presumption with the EME physician opinions and an SIME opinion. Employer contends Employee failed to prove his claim by a preponderance of the evidence. It requests an order denying Employee's April 26, 2019 claim.

1) **Was the work injury the substantial cause of Employee's need for left upper extremity medical treatment? If so, was the left shoulder decompression surgery reasonable and necessary?**

Employer contends Employee's April 26, 2019 claim merges with his November 5, 2015 claim which was denied for failure to timely request a hearing under AS 23.30.110(c) in *Roberge I*. It contends the medical treatment sought in the April 26, 2019 claim was the same sought in the November 5, 2015 claim, specifically the left brachial plexus decompression surgery. Employer contends the recommendation for the decompression surgery for the April 26, 2019 claim was based on the same medical history and the same theory and nature of the injury as the November 5, 2015 claim. It requests an order denying and dismissing Employee's April 26, 2019 claim.

Employee contends that new medical treatment, the decompression surgery performed by Dr. Johansen, entitles him to restart the statute of limitations for medical benefits. He requests an order awarding him medical costs for the decompression surgery.

2) **Is Employee's April 26, 2019 claim for medical treatment barred by AS 23.30.110(c)?**

## FINDINGS OF FACT

All *Roberge I* and *Roberge II* factual findings and conclusions are incorporated herein by reference. The following finding are reiterated from *Roberge I* or *Roberge II* or are established by a preponderance of the evidences establishes the following facts and factual conclusions:

1) On May 14, 2014, Employee injured his left shoulder while carrying rebar. (First Report of Injury, June 16, 2014).

2) On May 21, 2014, Employee sought care with Donald Lehmann, M.D., for sudden left shoulder pain in the acromioclavicular joint and subacromial region. He injured his left shoulder on the job when pushing off with his left arm while carrying rebar. It hurt when actively moved overhead above shoulder level. Employee's subacromial bursa was tender upon palpitation, his left shoulder distal clavicular end was elevated and impingement tests elicited pain. Dr. Lehmann diagnosed left rotator cuff tendinitis and left impingement syndrome. (Lehmann orthopedic evaluation, May 21, 2014).

3) On June 19, 2014, Employee complained of left shoulder pain when he actively moved his arm overhead above shoulder level, difficulty lying on his left shoulder and joint stiffness. His left acromioclavicular joint was not tender on palpitation and his left shoulder distal clavicular end was not elevated. Dr. Lehmann recommended a left shoulder MRI. (Lehmann chart note, June 19, 2014).

4) On September 30, 2014, Dr. Lehmann wrote a letter to Employee and stated his MRI did not reveal a rotator cuff tear but did reveal a shoulder injury and arthritis and both were probably contributing to his symptoms. Dr. Lehmann recommended consulting an orthopedic surgeon. (Lehmann letter, September 30, 2014).

5) On October 27, 2014, orthopedist Cary Keller, M.D., evaluated Employee and diagnosed impingement, degenerative AC joint disease and capsule attenuation with an anterior labral tear secondary to trauma. He recommended arthroscopic surgical repair. (Keller chart note, October 27, 2014).

6) On November 10, 2014, Employee visited H. Graeme French, M.D., an orthopedic surgeon, for left shoulder pain. He stated he had 200 pounds of rebar on his right shoulder and was standing in a hole and when he pushed up with his left arm while trying to climb out of the hole, he felt a pop in his left shoulder and had acute shoulder pain, including burning and tingling in the lateral aspect. Afterwards, his left arm felt significantly weaker and he limited heavy lifting. Employee tried physical therapy, a steroid injection and modified his activities. He reported continuing left shoulder pain, popping, clicking, weakness and left arm numbness. Dr. French found no evidence of carpal tunnel or Guyon's canal. Employee's left shoulder was tender over the coracoid-acromial arch, biceps tendon, posterior joint line, supraclavicular brachial plexus and spinoglenoid notch. Dr. French diagnosed left anterior shoulder joint instability, left superior labral, from anterior to posterior (SLAP) lesion and a left brachial plexus injury. He recommended left shoulder surgery. (French chart note, November 10, 2014).

7) On December 1, 2014, Employee reported left arm numbness. He was tender over the supra- and infra-clavicular brachial plexus, coracoid-acromial arch, biceps tendon, posterior joint line, and spinoglenoid notch. Dr. French was easily able to dislocate Employee's left shoulder in an anterior inferior direction and observed a labral click. He recommended a left shoulder examination under anesthesia, arthroscopy, Bankart repair, SLAP reconstruction, biceps tenodesis and acromloclavicular resection arthroplasty. (French chart note, December 1, 2014).

8) On December 2, 2014, Dr. French performed left shoulder arthroscopic surgical repair, including anterior and posterior Bankart repair, biceps tenodesis, SLAP reconstruction, rotator interval closure, subcoracoid and subacromial bursectomy and microfracture of the inferior glenoid and acromioclacicular resection arthroplasty. (French operative report, December 2, 2014).

9) On December 10, 2014, Employee reported his radiating left arm pain and hand pain was significantly better since surgery but he still had tingling in his left ring and little fingers. He still had significant sensory loss in the left hand median nerve distribution, findings of left carpel tunnel syndrome and mild swelling in his left arm. Some of Employee's numbness and tingling

was related to his left brachial plexus traction injury. Dr. French recommended continuing his home exercise program. (French chart note, December 10, 2014).

10) On January 9, 2015, Employee still had numbness and parathesia in his left hand and continued to have tenderness over the supra- and infra-clavicular brachial plexus. Dr. French recommended he continue his exercise program. (French chart note, January 9, 2015).

11) On February 20, 2015, Employee's supraclavicular plexus, infraclavicular and spinoglenoid notch were mildly tender and his pectoralis minor was moderately tender. His radial tunnel, cubital tunnel, carpel tunnel and Guyon's canal were not tender. Employee continued to report radiating numbness and paresthesia down his left arm, particularly with overhead use of his arm, and left arm weakness. He was rehabilitating his left shoulder with a home exercise program and was making excellent progress. The Roos test and upper extremity stress test were both positive. Dr. French diagnosed a left brachial plexus injury and recommended Employee continue his home exercise program. (French Chart Note, February 20, 2015).

12) On March 30, 2015, Employee reported continuing left arm pain and numbness but his left shoulder pain was gradually improving and he was no longer using narcotics. Dr. French recommended he continue his home exercise program. (French Chart Note, March 30, 2015).

13) On May 18, 2015, Employee was mildly tender over his left supraclavicular and infraclavicular brachial plexus and was moderately tender over the median and ulnar nerves crossing his left wrist. Dr. French thought Employee had left shoulder bursitis and osteoarthritis and injected Marcaine and Celestone into his shoulder. Employee reported a 50 percent reduction in left shoulder pain five minutes after the injection. Dr. French thought he probably had significant low median and ulnar nerve compressions and recommended electrical diagnostic testing for left carpal tunnel syndrome and low ulnar nerve compression. (French Medical Report, May 18, 2015).

14) On July 31, 2015, Theresa McFarland, M.D., an orthopedic surgeon, and Lewis Almaraz, M.D., a neurologist, examined Employee for an Employer's Medical Evaluation (EME). Employee stated he injured his left shoulder at work when he had a large amount of rebar balanced on his right shoulder and was preparing to walk up an embankment and he reached out and pushed himself off the wall using his left hand. He felt and heard a pop that sounded like a stick breaking. Initially Employee had minor pain but it began worsening the next day and then progressively continued to worsen. He stated there was no dislocation or feeling of instability it

was simply painful with movement beyond the horizontal. After the industrial injury but before his shoulder surgery, he noticed numbness and tingling in his left hand and fingers. Drs. McFarland and Almaraz opined Employee's work injury is not the substantial cause of his need for an electromyogram (EMG) and nerve conduction study (NCS); rather his intervening development of left cubital tunnel and carpal tunnel syndrome is the substantial cause of Employee's need for these studies. No further treatment was reasonable for Employee's work-related left shoulder strain and he was medically stable. Employee "may require assistance with lifting overhead, using both hands, of greater than 25 pounds" and those restrictions are attributable to the work injury. If his cubital tunnel and carpel tunnel syndromes are properly treated, he should be able to perform the superintendent job with the recommended restrictions. They opined Employee has a six percent permanent partial impairment (PPI) related to the work injury. (McFarland and Almaraz EME report, July 31, 2015).

15) On September 2, 2015, Employee continued to experience radiating left arm pain and numbness and sensory loss in his left hand. Repeated and overhead left arm use severely aggravated the symptoms. His left shoulder range of motion was normal and he had tenderness over the supraclavicular brachial plexus, infraclavicular brachial plexus, cubital tunnel, Guyon canal and carpal tunnel. A Roos test and upper extremity stress test were positive, radiating to hand without radial pulse diminution. Dr. French opined Employee had progressive findings of a left neurogenic thoracic outlet syndrome (nTOS) and no clinical findings of a left cubital syndrome or a more distal nerve entrapment except for minimal tenderness of the ulnar nerve and median nerve in the left forearm and wrist. He referred Employee to Dr. Johansen for surgical treatment of nTOS. Dr. French wrote a letter addressed to the claims adjuster disagreeing with Drs. McFarland's and Almaraz's conclusions in the July 31, 2015 EME report. He contended they ignored Employee's whole left arm numbness and failed to examine him for a left brachial plexus injury or compression injury to the brachial plexus. Dr. French agreed Employee had mild tenderness over the left ulnar nerve but opined it was due to his left brachial plexus injury caused by a heavy traction injury during his work injury. (French chart note, September 2, 2015; French letter, September 2, 2015).

16) On September 18, 2015, Drs. McFarland and Almaraz reviewed Dr. French's September 2, 2015 letter and chart note. They stated their opinions had not changed:

> I disagree with Dr. French's re-statement of the history, as this is not the same history provided by [Employee] or substantiated in the medical record. [Employee] has a discrete left shoulder strain that did not result in any type of nerve traction injury. The nerve symptoms developed many months after his injury, shortly before his surgery was performed. He may have an electrodiagnostic test that would confirm neurogenic thoracic outlet syndrome, but even if so, this would not be related to the industrial injury, on a more-probable-than-not basis. (McFarland and Almaraz EME addendum, September 18, 2015).

17) On September 28, 2015, Employer denied medical treatment for Employee's right shoulder, temporary total disability (TTD), temporary partial disability (TPD), and PPI benefits related to thoracic outlet syndrome or nerve injury based on Drs. McFarland's and Almaraz's EME reports. It contends Employee sustained a work-related left shoulder strain and non-work related cubital tunnel and carpal tunnel syndrome and no further treatment is reasonable for his shoulder injury. Employer contended Employee's work injury did not cause any type of nerve traction injury. (Controversion Notice, September 28, 2015).

18) On September 30, 2015, Employee reported continuing severe sensory loss throughout his left hand and arm. Dr. French recommended a left upper extremity EMG and NCS to evaluate him for a left low median and ulnar nerve compression. If Employee had significant abnormalities across the left wrist, he recommended treating the carpal tunnel syndrome and ulnar nerve compression prior to decompression of his nTOS. Dr. French stated the mechanism of injury was sufficient to result in nTOS and opined all of Employee's left upper extremity symptoms were caused by the work injury. He referred Employee to Dr. Johansen for surgical treatment of nTOS. (French Chart Note, September 30, 2015).

19) On October 5, 2015, Employer denied medical treatment for Employee's left shoulder, TTD, TPD and PPI related to thoracic outlet syndrome or nerve injury. (Controversion Notice, October 5, 2015).

20) On November 5, 2015, Employee sought TTD from August 19, 2015 through medical stability, PPI greater than six percent, medical costs, penalty, interest and attorney's fees. Employee also sought a weekly compensation rate of $1,143, medical treatment recommended by Dr. French, authorization for a referral to Dr. Johansen and a Second Independent Medical Evaluation (SIME). (Claim for Workers' Compensation Benefits, November 5, 2015).

21) On December 2, 2015, Employer filed a controversion notice denying TTD from August 19, 2015 ongoing, PPI greater than six percent, all medical benefits after July 31, 2015, compensation rate adjustment, penalty, interest and attorney's fees and costs based on the July 31, 2015 EME report. It relied on the July 31, 2015 EME report to contend no additional medical care was reasonable or necessary. (Controversion Notice, December 2, 2015).

22) On January 20, 2016, Dr. French checked "yes" when asked to predict whether Employee will have permanent physical capacities to perform the physical demands of a Construction Superintendent, a Construction Worker and three other positions Employee held within the last ten years. He also added a written comments, "[W]ith TOS treatment only" and "[O]nly with TOS treatment." He predicted Employee will have a PPI rating greater than zero as a result of the work injury and commented that Employee will be permanently disabled without the treatment. (French response, January 20, 2016).

23) On February 22, 2016, Employee filed a claim seeking review of the RBA eligibility determination and attorney fees and costs. (Claim, February 22, 2016).

24) On February 22, 2016, Employee requested a hearing on his February 22, 2016 claim. (ARH, February 22, 2016).

25) On February 29, 2016, Employer deposed Dr. French. (French Deposition, February 29, 2016). Employee told him he was carrying a load of rebar weighing about 200 pounds while climbing out of a hole and he pushing himself up with his left arm and he felt a pop and acute shoulder pain. *Id*. at 11. Dr. French stated the mechanism of injury was consistent with shoulder subluxation or tearing of the rotator cuff. *Id*. at 12. He stated it was not a traction injury but more like a leverage injury. *Id*. Dr. French believed Employee subluxated his shoulder breaking the vacuum in the shoulder and explained he basically leveraged the shoulder out of joint stretching the nerve. *Id*. If Employee's shoulder was not down but to the side, it would make the injury more likely because there was more leverage. *Id*. at 12-13. Employee could have carpel tunnel syndrome or the thoracic outlet syndrome could be causing persistent tenderness and positive stress test for carpel tunnel syndrome and ulnar nerve compression at the wrist. *Id*. at 30. NTOS is a compression syndrome. *Id*. at 35. Stretching the nerve causes scarring in and around the nerve and as the scar matures around the nerve, it can result in compression. *Id*. at 37. If the EMG has abnormal findings at the wrist, then treatment of the wrist also has to be considered. *Id*. at 40. If there is a small injury to the brachial plexus, the nerve conduction will

bypass the injury and the injury would be invisible because the nerve fibers interconnect but the wrist and elbow are not anastomosis, so the NCS is more accurate at picking up a wrist or elbow nerve injury. *Id*. at 41. NTOS should generally be negative on an EMG until at the very end when the arm is severely paralyzed and completely atrophied. *Id*. at 43. One of the reasons to get an EMG and NCS is to distinguish between brachial plexus injury and nTOS and another is to see if there is more generalized neuropathy, like from diabetic neuropathies. *Id*. at 43. He ordered an EMG and NCS to look at Employee's carpel tunnel and ulnar nerve compression. *Id.* at 44. An adequate carpel tunnel exam should pick up nerve root patterns from the neck, a ruptured brachial plexus and familial neuropathy. *Id*. at 44. He does not think Employee has a ruptured brachial plexus because his motor function is too good nor does he think Employee has familial neuropathy because he has one-arm symptoms. *Id*. If Employee has no findings of nTOS he does not need a referral to Dr. Johansen and if all he has is hand findings, he probably needs a carpel tunnel release. *Id*. at 64.

26) On February 29, 2016, Employer deposed Employee. (Employee Deposition, February 29, 2016). Employee does not have chronic neck pain. *Id*. at 35. Employee walked down in a 60 by 20 feet hole to clean up rebar. *Id*. at 48. The rebar was different lengths and he picked them up and put them on his shoulder. The rebar dragged on the ground because he only picked up one end to drag them out. *Id*. at 49. Employee thought he carried 70 or 80 pounds, not 200 pounds. *Id*. at 51. He placed the rebar on his right shoulder and used his left arm to push off the abutment and go up the hill. *Id*. at 51-52. Employee was standing when he pushed off with his arm a little bit above shoulder height and felt a pop and sharp pain in his shoulder. *Id*. at 52-53. It was sore the next day and steadily got worse. *Id*. at 54. He continued working until November but he quit lifting. *Id*. at 55-56. Eventually, he could barely lift his arm and it hurt. *Id*. at 56. Employee had tingling and numbness in his forearm. *Id*. at 64. He did not have radiating pain from his shoulder down to his arm. *Id*. at 65. Employee did not have any burning or tingling in his shoulder after the injury, he just felt pain. *Id*. at 65. When his shoulder totally relaxes, he feels movement in there and that started immediately after the injury. *Id*. at 70. He does not have pain in his arm. *Id*. Employee cannot lift overhead. *Id*. His whole left arm is only numb when he rides his motorcycle. *Id*. at 71. Wearing a seatbelt across his collar bone, the pressure and rubbing, bothers him so he shoves it off his arm when driving. *Id*. at 72-74. Employee felt

numbness and tingling in his left hand right after the injury and it progressively worsened. *Id*. at 78-79. His hand is constantly numb. *Id*. at 82.

27) On March 18, 2016, Employer denied Employee's appeal of the RBA eligibility evaluation and attorney fees and costs. It contended the RBA-designee did not abuse her discretion in determining Employee was ineligible for reemployment benefits. (Controversion Notice, March 18, 2016).

28) On May 16, 2016, Employer controverted AS 23.30.041(k) stipend as of February 25, 2016 because the RBA-designee found Employee ineligible for reemployment benefits and contended it overpaid stipend benefits. (Controversion Notice, May 16, 2016).

29) On September 2, 2016, Dennis Chong, M.D., examined Employee for an EME. He diagnosed a work related left shoulder sprain or strain, pre-existing left shoulder SLAP tear temporarily aggravated by the work injury and bilateral carpel tunnel syndrome unrelated to, and not caused by or not aggravated by the work injury. Dr. Chong opined there was no evidence of neurogenic or vasculogenic thoracic outlet syndrome. He stated there was no documentation to diagnose a brachial plexus injury and disagreed with Dr. French's diagnosis. Dr. Chong stated Dr. French's approach to diagnosing and treating was very unique and "not found in community practice with his peers." He was unaware of any medical literature which supported Dr. French's approach. Dr. Chong opined it would be rare for a shoulder sprain or strain to result in a brachial plexus injury and Employee's mechanism of injury would not result in a brachial plexus injury. He agreed Employee should have an EMG and NCS for non-work related carpel tunnel syndrome. Dr. Chong "categorically disagreed" with Dr. French's recommendation of a left brachial plexus surgery and stated the surgery would likely result in substantial worsening of his symptoms. He opined Employee reached medical stability on July 31, 2015. (Chong EME report, September 2, 2016).

30) On September 22, 2016, Lorne Direnfeld, M.D., a neurologist, examined Employee for an SIME. He diagnosed left shoulder pain and left hand sensory complaints, likely secondary to a combination of carpel tunnel syndrome and ulnar neuropathy at the wrist or elbow. Dr. Direnfeld noted several different potential causes of Employee's left hand sensory complaints, including: (1) thoracic outlet syndrome, (2) cervical radiculopathy, and (3) carpel tunnel syndrome and ulnar neuropathy. He believed cervical radiculopathy unlikely because the distribution of symptoms extended over at least four nerve root levels, C6, 7 and 8 and T1. Dr.

Direnfeld opined the pathophysiologic mechanism provided by Employee and in the records was unlikely to have resulted in shoulder dislocation which could have stretched the brachial plexus and noted neither Dr. Lehmann on May 21 and June 19, 2014, nor Dr. Keller on October 27, 2014, documented any sensory complaints or diagnosed a history of dislocation. He stated,

> Considering all of the currently available data, the most likely cause of [Employee's] left hand sensory symptoms includes median nerve entrapment at the wrist and ulnar nerve entrapment at the wrist or elbow.
>
> Additional investigations that would be helpful in clarifying [Employee's] diagnosis include an EMG and nerve conduction study in the upper extremities.
>
> Additional investigations that may be required, depending on the results of neurophysiologic studies include imaging studies of the cervical spine.
> . . . .

Dr. Direnfeld opined Employee's left hand sensory symptoms are most likely attributable to personal medical conditions including carpel tunnel syndrome and ulnar neuropathy, at either the wrist or elbow. An EMG and NCS would be helpful in confirming his clinical impression and clarifying the location of the lesion causing Employee's ulnar distribution symptoms. The work injury did not aggravate, accelerate or combine with a pre-existing condition to cause disability or need for medical treatment. Dr. Direnfeld stated although it was unlikely, the results of an EMG and NCS could "conceivably impact" the answer to whether the work injury aggravated, accelerated or combined with a pre-existing condition to cause disability or need for medical treatment. He opined carpel tunnel syndrome and ulnar sensory neuropathy would not be attributable to the mechanism of the work injury. After reviewing SCODRDOT job descriptions for a Construction Superintendent and a Construction Worker, Dr. Direnfeld opined Employee is able to work as a foreman/construction supervisor "without any limitations or restrictions to the extent that this work is primarily supervisory." However, Employee has some limitations regarding his left shoulder range of motion and problems with sensation in his left hand. Dr. Direnfeld refrained from giving a PPI rating because Employee was not medically stable "from a neurologic perspective." He said,

> Although currently it is medically probable Employee's left hand sensory symptoms are not related to the work injury, this impression is derived from an incomplete database. If an EMG and nerve conduction study is done (and ideally

> this should be done in both upper extremities), I will be glad to review the results of that study and further address the questions.

Dr. Direnfeld deferred orthopedic treatment questions to Floyd Pohlman, M.D., and stated no additional treatment is required for the "neurologic aspects" of the work injury based on the currently available data. (Direnfeld SIME report, September 22, 2016)

31) On September 23, 2016, Dr. Pohlman, an orthopedist, examined Employee for a SIME. When asked to list all causes of Employee's disability or need for treatment, he stated (1) left shoulder SLAP lesion, (2) partial tear of the left shoulder biceps tendon, (3) left shoulder acromioclavicular arthrosis and (4) left shoulder impingement syndrome. Dr. Pohlman opined the SLAP lesion and biceps tendon lesions were work-related and the pre-existing acromioclavicular arthrosis combined with the other injuries to aggravate the acromioclavicular arthrosis and resulted in a permanent change. He opined the substantial cause of Employee's disability was the partial rupture of the biceps tendon as well as the SLAP lesion and the pop Employee heard at the time of the injury was likely the partial rupture of the biceps tendon, causing the SLAP lesion. Employee was medically stable as of July 31, 2015 and he was able to return to work with restrictions. Dr. Pohlman opined no further treatment was necessary for Employee's shoulder injury. Dr. Pohlman assessed an eight percent PPI rating. (Pohlman SIME report, September 23, 2016).

32) On February 6, 2017, Dr. French opined Employee sustained a severe traction injury where he pulled his shoulder out of joint and injured his brachial plexus which continued to cause significant left arm numbness and weakness. He performed scalene block injections to evaluate Employee's nTOS:

> [Dr. French] 1st injected his anterior scalene with 2 mL of Xylocaine. There was continuous dystonic firing of the anterior scalene prior to the injection. The patient had significant improvement in the sensation in his ring and little fingers following injection of the anterior scalene. [He] then injected his middle scalene with 2 mL of Marcaine. The patient had severe dystonic activation of the scalene muscle prior to the injection. Following the injection he had near normal sensation in his long ring and little fingers with still severe numbness of his thumb and index finger. [Dr. French] then injection his pectoralis minor with 3 mL of 0.5 [percent] Marcaine. The patient had near complete return of normal sensation in the entire hand following the pectoralis minor injection including near normal sensation in the thumb and index finger.

He referred Employee to Dr. Johansen for left brachial plexus decompression because his response to the injections suggested he would have a 90 percent chance of significant improvement of neurologic function in his left arm. (French Medical Report, February 6, 2017).

33) On April 5, 2017, Employee filed a letter addressed to Dr. Direnfeld and served it upon Employer, stating:

> Thank you for your evaluation of [Employee] and your report dated September 28, 2016. On Page 51, you recommend further testing. "Additional investigations that would be helpful in clarifying [Employee]'s diagnosis include an EMG and nerve conduction study in the upper extremity." The insurance company has not agreed to this further testing.
>
> On February 6, 2017, [Employee] had a scalene block injection that provided [Employee] substantial but temporary relief. "The patient had near complete return of normal sensation in the entire hand following the pectorals minor injection, including near normal sensation in the thumb and index finger." Please review this medical record. If the results of the injection change any of your conclusions, let the Board and the parties know in a supplemental report. In particular, please inform us if you still feel that an EMG and nerve conduction study would be diagnostically useful. (Letter, April 5, 2017).

34) On April 24, 2017, the division received a letter from Dr. Direnfeld responding to Employee's April 5, 2017 letter stating, the recommendations he made "continue to apply." He said:

> The injections administered by Dr. French do not rule out the role of potential more peripheral neurologic pathology as it may contribute to [Employee's] symptom complex which may require a different approach to treatment or may adversely affect the results of treatment for the potential diagnosis of neurogenic thoracic outlet syndrome. (Direnfeld letter, April 24, 2017).

35) On May 26, 2017, Employee filed a claim requesting medical treatment recommended by Dr. Direnfeld. (Claim, May 26, 2017).

36) On June 19, 2017, Employer denied the EMG and NCS recommended by Dr. Direnfeld. (Controversion Notice, June 19, 2017).

37) On June 20, 2018, Dr. Johansen opined Employee's work injury caused Employee's need for left arm and hand medical treatment. He diagnosed nTOS:

> It seems likely that he had both direct brachial plexus traction injury, which has resolved itself over time, as well as worsening scalene muscle fibrosis and compression of the brachial plexus, resulting in his neurogenic thoracic outlet syndrome symptoms. The onset of his symptoms was delayed for a period of time, which is in fact what is seen in the course of neurogenic thoracic outlet syndrome following such injuries.

He reviewed "various IMEs" and fully disagreed with their conclusions. His diagnosis was "confirmed strongly (although only transiently) positive response to scalene blocks. . . ." Dr. Johansen believed Employee will remain symptomatic and unable to carryout workplace activities until he undergoes treatment of his nTOS. (Johansen Medical Report, June 20, 2018).

38) On July 5, 2018, Dr. Johansen stated Employee's left arm and hand symptoms, including numbness, pain and weakness, arise from nTOS, related predominately to spasm and scarring of the left scalene muscles in the anterolateral neck and "there is potentially some degree of residual brachial plexopathy" due to the work injury and the subsequent left shoulder subluxation. He opined no additional tests are necessary to evaluate Employee's chronic left upper extremity neuromuscular dysfunction and recommended "thoracic outlet decompressive surgery." Dr. Johansen stated, "Vascular studies, imaging techniques and electrodiagnostic evaluation lack sensitivity and specificity for diagnosing neurogenic thoracic outlet syndrome" and are "not helpful in making or ruling out" nTOS. He also opined Employee was currently unable to work without any restrictions or limitations. (Johansen letter, July 5, 2018).

39) On September 6, 2018, Employer petitioned to dismiss Employee's November 5, 2015 claim under AS 23.30.110(c). (Petition, September 6, 2018).

40) On December 14, 2018, *Roberge I,* an interlocutory decision, issued and denied Employee's November 5, 2015 claim for failure to timely request a hearing under AS 23.30.110(c) and granted Employer's September 6, 2018 petition to dismiss. (*Roberge I*).

41) On January 29, 2019, the Alaska Workers' Compensation Appeals Commission (AWCAC) held *Roberge I* was a final order for purposes of appeal because the decision making process was complete and the result directly affected the parties. It stated Employee's other claims remained open and may proceed forward even while he appealed *Roberge I*. (*Roberge v. ASRC Construction Holding Company*, AWCAC Order Appeal No. 19-001, January 29, 2019).

42) On February 20, 2019, Employee continued to have findings for severe left arm nTOS. Dr. French opined he may have "a component of some traction injury to the nerves which would not

be able to recover" and his response to the scalene blocks suggests he had a 90 percent change of significant improvement with decompression of his brachial plexus. (French chart note, February 20, 2019).

43) On April 26, 2019, Employee sought the medical treatment recommended by Dr. Johansen, interest and attorney fees and costs. (Workers' Compensation Claim, April 26, 2019).

44) On May 17, 2019, Employer denied medical treatment recommended by Dr. Johansen, interest and attorney fees and costs. It contended Employee's April 26, 2019 claim is barred under AS 23.30.110(c) and by the doctrine of claim splitting. Employer relied on Drs. Direnfeld's, Pohlman's and Chong's opinions to contend Employee did not suffer a shoulder dislocation that caused a brachial plexus stretching or traction injury. (Controversion Notice, May 17, 2019).

45) On May 21, 2019, Employer answered Employee's April 26, 2019 claim and contended it was barred by AS 23.30.110(c) because it sought the same medical treatment in Employee's November 5, 2015 claim which was dismissed in *Roberge I*. (Answer, May 21, 2019).

46) On June 4, 2019, *Roberge II* issued and denied Employee's May 26, 2017 claim for failure to timely request a hearing under AS 23.30.110(c) and remanded back the reemployment benefit administrator designee's ineligibility determination. It found Dr. French less credible because his opinions and testimony have been inconsistent in regards to his recommendation for an EMG and NCS and held Employee was not entitled to an EMG and NCS. (*Roberge II*).

47) On July 15, 2019, Dr. Johansen performed a left thoracic outlet decompression. (Johansen operative report, July 15, 2019).

48) On July 17, 2019, Charles Hunter, M.D., examined biopsies of Employee's scalene lymph node and scalene muscle. He diagnosed no evidence of granulomas or malignancy in Employee's scalene lymph node and "foci of dense fibrosis" with no significant inflammation in his scalene muscle. (Hunter pathology report, July 17, 2019).

49) On August 2, 2019, Dr. Chong examined Employee for an EME. Employee stated he felt wonderfully better in terms pain symptom relief, hand sensation return and increased grip strength the same day as the July 15, 2019 surgery while still in the recovery room. He reported having residual numbness in left index finger on the ulnar side and little finger on the ulnar side. Employee planned on flying up to Juneau, Alaska, next week and seeking employment. His left hand grip strength was stronger than his right hand and his bilateral shoulder were not

symmetrical in all planes. Thoracic outlet syndrome positional testing was negative for distal neurological symptoms and the elevated arm stress tests/EAST were negative. Dr. Chong found no evidence of carpel tunnel syndrome and opined Employee's greater left hand grip strength was not physiologically consistent after thoracic outlet decompression surgery. He stated Employee's left shoulder range of motion improvement was not consistent anatomically or structurally after thoracic outlet decompression surgery. Dr. Chong diagnosed "a seemingly miraculous recovery of restoration of sensation" which was inexplicable both anatomically and physiologically. He noted Employee's miraculous recovery of sensation immediately postoperative and substantial increase in hand grip strength within two weeks "is not consistent with normal physiological recovery." Dr. Chong disagreed with Dr. French's opinion because Employee did not meet the diagnostic criteria for nTOS as required under the "Work-Related Neurogenic Thoracic Outlet Syndrome Diagnosis and Treatment" guideline issued by the Washington State Department of Labor and Industries and because scalene blocks are not diagnostic. He opined Employee did not have symptoms consistent with a "brachial plexus distribution" as he did not have tenderness to palpitation, physical examination of brachial plexus provocative testing was negative and he did not have electrodiagnostic or vascular testing. Dr. Chong opined Employee presented with symptoms consistent with "cervical brachial syndrome," which is controversial because a variety of nonspecific symptoms can fulfill the pain condition diagnosis, and there is no evidence-based treatment, the only suggested treatment is botulinum injections. (Chong EME report, August 2, 2019).

50) On August 6, 2019, Employer filed a Washington State Department of Labor & Industries guideline entitled "Work-Related Neurogenic Thoracic Outlet Syndrome Diagnosis and Treatment." It was developed by the Washington State's Industrial Insurance Medical Advisory Committee and its subcommittee on Upper Extremity Entrapment Neuropathies and is based on the weight of the best available clinical and scientific evidence from a systematic review of the literature and a consensus of expert opinion. Medical literature described two categories of nTOS, "true" nTOS and "disputed" nTOS. A diagnosis of true nTOS requires electrodiagnostic study (EDS) abnormalities showing evidence of brachial plexus injury. Disputed nTOS describes cases of nTOS for which EDS abnormalities have not been demonstrated:

> A case definition of confirmed nTOS includes appropriate symptoms, objective physical findings and abnormal EDS. A provisional diagnosis of nTOS may be

made based upon appropriate symptoms and objective signs, but confirmation of the diagnosis requires abnormal EDS. Classic symptoms of nTOS include pain, paresthesias or weakness in the upper extremity. Paresthesias most commonly affect the right and small fingers. Symptom severity tends to increase after certain activities and worsens at the end of the day or during sleep.

Signs on examination may include tenderness to palpitation over the brachial plexus, the scalene muscles, the trapezius muscles, or the anterior chest wall. Although tenderness may be a useful objective finding, it cannot support the diagnosis of nTOS alone. Advances cases of nTOS are characterized by objective signs of weakness of the hand, loss of dexterity of the fingers, and atrophy of the affected muscles.

Provocative tests have been described that may help corroborate the diagnosis of nTOS. . . . Provocative tests include:

- The elevated arm stress test (EAST or Roos test) - the patient places the affected arm in full abduction and external rotation and then opens and closes the hands slowly for 3 minutes. This test constricts the costoclavicular space. It is considered abnormal if typical symptoms are elicited and the patient cannot sustain this activity for the full 3 minutes.
- The Adson test - the patient extends the neck and rotates the head toward the involved extremity, which is held extended at the side. This test constricts the interscalene muscle. It is considered abnormal if a change in the radial pulse is detected when the patent inhales deeply and holds their brief. . . .

EDS abnormalities are required to objectively confirm the diagnosis of nTOS. Given the uncertainties in diagnostic assessment of nTOS, EDS should be obtained as soon as the diagnosis is considered. EDS may help gauge the severity of injury. Importantly, EDS can help exclude conditions that may mimic nTOS, such as ulnar nerve entrapment or cervical radiculopathy.

. . . .

Anterior scalene muscle (ASM) blocks have been used in the evaluation of suspected nTOS. However, this test has poor specificity for nTOS, and there is no substantial evidence that ASM can reliable confirm the diagnosis of nTOS. Therefore, ASM blocks conducted as a diagnostic tool for nTOS will not be authorized.

. . . .

Non-surgical therapy may be considered for cases in which a provisional diagnosis of nTOS has been made. Surgical treatment should be provided only for cases in which the diagnosis of nTOS has been confirmed by abnormal EDS. . . .

. . . .

> Although Botulinum toxin (Botox) injections of the scalene muscles have been reported to relieve nTOS symptoms, preliminary results of a randomized trial showed no clear clinical improvement related to this treatment. In addition, it appears that there are substantial technical challenges and potentially severe adverse effects from this procedure. Therefore, Botox injections conducted as a diagnostic tool or for treatment of nTOS will not be authorized.
> . . . .

(Work-Related Neurogenic Thoracic Outlet Syndrome Diagnosis and Treatment, August 6, 2019).

51) Employee testified he feels great after his left brachial plexus decompression surgery. The tingling and numbness in his hands has gone away, he has only a little tingling in his index finger, but he cannot lift his arm above shoulder level without feeling it catching and causing pain in his shoulder. Employee wants to get back to work but cannot because he has not been released to return to work. He feels he can go back to work but there will be somethings he cannot do because he cannot lift what he used to. Employee cannot meet all the job requirements for his previous job description at this time but he can do most of them. He had to sell his house, truck, four wheeler and motorcycle after the work injury because he has not had income for disability or for work. Employee did little jobs for friends and "has been living on nickels and dimes." His sister told him to call and ask Dr. Johansen to do the surgery. Employee contacted Dr. Johansen in July about the surgery because he wanted to go back to work. Dr. Johansen agreed to do the surgery if he agreed to pay for it himself. Employee called Dr. Johansen the Thursday before the operation, which occurred the following Monday. The last time he saw Dr. Johansen was in 2018. Dr. Johansen examined him before the surgery but did not perform any tests. Employee used his left hand the last four years but he could not feel it, he would have to look at it. He can move his arm around without any shoulder pain after the surgery. Employee's shoulder pain went away and then pain came back in his hand the last year and a half to two years. He developed constant pain going down his arm in the last two years; the pain was chronic and was getting worse and worse over time. (Employee).

52) Dr. Johansen testified he has performed approximately 1,500 nTOS surgeries since 1998. NTOS is not a new diagnosis; it used to be controversial. There is a 700 page, 70 author textbook published in 2013 which he believes proves it is an established diagnosis with an understood cause and natural history and a somewhat understood treatment. Dr. Johansen believes Employee's work injury resulted in a direct brachial plexus injury and development of

nTOS over time. He suffered a traction injury to his brachial plexus, which means it got tugged on, pulling the nerves away from the nerves in the cervical spinal cord. The same sort of injury can also and frequently does develop into nTOS. NTOS is damage to the scalene muscles in the neck which surround the nerves of the brachial plexus and results in spasm, inflammation and scarring resulting in the symptoms of nTOS. Employee's recovery is not miraculous; it is the expected response having confirmed the diagnosis of nTOS and treating it appropriately. He anticipates Employee's symptom improvement will continue. Dr. Johansen disagrees with Dr. Chong's opinion that Employee did not meet the diagnostic criteria for nTOS because he adheres to inaccurate Washington State guidelines to diagnose and treat nTOS. If Employee had carpel tunnel, the surgery he performed would not have improved Employee's hand numbness and tingling symptoms. The dense fibrosis in the scalene muscle pathology report is a universal finding in nTOS. The delay in development of hand pain, numbness and tingling are obligatory symptoms in nTOS. Dr. Johansen opined the work injury is the substantial cause of Employee's disability and need for medical treatment. His diagnostic algorithm for nTOS requires: some sort of injury after which, with some delay, the symptoms of pain, numbness, tingling and/or weakness start in the neck and extend into the arm in a lower truck distribution into the medial side of form arm and the wrist and hand; an appropriate history of symptoms and worsening of symptoms with arm out front or overhead; and positive physical findings, including tenderness over the nerves and scalene muscles, weakness in appropriate fingers and a positive response to several provocative tests like the brachial plexus tension test and Roos test. The brachial plexus tension test involves holding one's arms out parallel to the floor with the head tilted to the neck away from the injured shoulder and arm. If the tension test worsens symptoms in the affected upper extremity, it means it is a positive test and Employee had a positive test. The Roos test involves holding arms upright in a "hands up" position for three minutes while opening and closing the hands; patients with nTOS must drop their arms within seconds or a most a minute, which Employee did after 15 seconds. Dr. Johansen also ruled out alternative diagnoses, like carpel tunnel syndrome and cervical spine symptoms. Because Employee's hand numbness involved the fourth and fifth fingers and not the thumb and first two fingers, which is characteristic of carpel tunnel syndrome, carpel tunnel syndrome was ruled out. The symptoms for patients with nTOS either stay the same all the time or get worse over time until the arm becomes functionless. The final part of his diagnostic algorithm is positive response to a scalene

block. If the scalene block results in a positive result, there is more than a 95 percent change the patient has nTOS. If it results is no positive result, the patient is more than 95 percent likely not to have nTOS. The scalene block test is the "work horse" that helps confirm the presence or absence of nTOS. Dr. Johansen will not perform a decompression surgery unless a patient meets all the diagnosis algorithm criteria. The Washington State's diagnostic guideline is flawed because it requires an abnormal electrodiagnostic study. He wrote a chapter in the 700 page textbook he previously mentioned that states vascular laboratory tests are not helpful in diagnosing nTOS, electrodiagnostic studies are usually normal which is not helpful, and x-rays and MRIs are not helpful. The Washington State guidelines explicitly exclude nTOS for which treatment can be useful and deny the utility of the scalene block test. It permits intervention in direct brachial plexus injuries, for which no treatment helps. The Washington state guidelines are based upon a study completed in 2000 in the journal of neurology, where the patients were treated between 1989 and 1995, before the scalene block was present. The study purports to prove surgery for nTOS does not work because only a small minority were able to return to work, even though a majority of the patients reported they would undergo the surgery again because it helped their symptoms. Dr. Johansen examined Employee in 2018 and before the surgery on July 15, 2019. A positive scalene test would relieve partially or wholly the pain, numbness, tingling and/or weakness within a few minutes and after the blocks wear off, the symptoms would return unabated. The diagnosis and treatment of nTOS is not in dispute in the medical community. The chapter he wrote in the textbook is entitled, "Controversies in NTOS: Are laboratory tests necessary in patients with NTOS." The controversies surround whether laboratory testing is helpful in ruling in or out a diagnosis of nTOS and are not about whether the condition itself is controversial. The Washington State guidelines are misleadingly incorrect. Dr. Johansen testified at the hearing when the Washington State guidelines were discussed and his testimony was rejected. In the end of September, Dr. Johansen is presenting results at the Western Vascular Society meeting regarding a series of 500 patients managed identically to Employee in which he demonstrates a 91 percent significant and durable improvement, like that experienced by Employee, and challenging the idea the first rib needs to be removed in the decompression surgery. His study has not been subjected to peer review at this time. Dr. Johansen's diagnostic criteria is based on his own experience and that of a consortium of physicians in North America who see many patients with nTOS. He did not have access to

Employee's past medical records due to a change in the database he uses but he reviewed Dr. French's medical records when he evaluated Employee in 2018. Dr. Johansen's understanding of the work injury event is Employee was carrying rebar and suddenly lost control of it and his left arm was pulled sharply away from his body which resulted in the original shoulder injury and resulted in the evidence he had nTOS. When provided Employee's description of the work injury, he stated shoulder instability can result in a small but definite traction injury in the brachial plexus and any injury that results in the need for a Bankart repair and re-stabilization of the left shoulder, such as that performed by Dr. French on Employee, can result in nTOS. While a majority of patients with nTOS have their symptoms in a lower trunk distribution, meaning the last two fingers, upon occasion the whole hand can become numb. His response to the scalene blocks do not invalidate the diagnosis, treatment or outcome. If Employee had carpel tunnel in addition to nTOS, he would have retained some of those symptoms. There are two pieces of evidence proving his scalene muscles were unusually damaged. The first was the finding of "dystonic" Dr. French described in using the electrical assessment of the scalene muscles when he did the block - ordinarily they have to be really badly damaged to have this dystonic picture. Secondly, the pathologist does not usually comment on a severely scarred scalene muscle but in this case he did. Employee is a perfect example that the nerve compression did not result in lasting injury because he almost immediately got better once the compressing muscle had been removed, suggesting the nerve was not damaged by the chronic compression. Dr. Johansen stated he was not a neurologist and could not explain how a nerve compressed for at least four to five years, when relieved by decompression surgery, could result in immediate resolution of symptoms. (Dr. Johansen).

53) Dr. Chong testified there are significant areas of controversy in nTOS. Washington State is the first and only entity that convened a group of specialists well recognized in their fields, including physiatrist, neurosurgery, general surgery, vascular surgery, orthopedic surgeons and neurologists, to examine medical evidence and determine criteria to diagnose nTOS. The guideline is the best accepted means to come to an nTOS diagnosis. The criteria requires symptoms, signs and EDS. The symptoms include pain, numbness, tingling and weakness affecting the upper limb. These symptoms commonly affect the inside part of the arm ending in the ring and small finger. The required symptoms are pain, numbness and tingling; patients often do not notice weakness until tested by a physician. A sign of nTOS includes tenderness in

the muscles posterior cervical triangle - in the trapezius muscle, sternocleidomastoid muscle and scalene muscles. Chest muscles can also be involved. The other area of tenderness is the supraclavicular notch. If a patient has had TOS compression for a sufficiently long time it will cause nerve damage, the physician will observe muscle atrophy in palm and forearm. Dr. Chong would expect this to occur after a year of compression and often times shorter than a year. He did not observe atrophy in Employee's palm or forearm. Dr. Chong disagrees with Dr. Johansen's diagnosis method because it depends almost solely on his interpretation of the findings upon physical examination. The Roos test is one possible test but is insufficient in of itself to make a diagnosis of nTOS because each of the provocative tests has a false positive percentage. The scalene injection test is not used to confirm diagnosis of nTOS because the anesthetic diffuses throughout the entire area making it impossible to determine whether the patient has a TOS diagnosis. The most sensitive test is the elevated arm stress test or EAST and a positive test is clearly numbness traveling up inside of arm and affecting the ring and little finger. The pathology report did not report an enlarged muscle, if Employee's muscle had been contracting all these years there should have been an enlarged muscle. If there was direct injury to the brachial plexus, there would have been extensive scar tissue and extensive scar tissue was not noted in the pathology report. If the nerve had been compressed for many years, the nerve would die, and if pressure is relieved, the peripheral nerves would grow back at the rate of one to two centimeters per month. It should have taken two to three years for Employee's nerves to grow back. His dramatic recovery response is not scientifically explainable; there is no explanation for Employee's miraculous recovery. Normal recovery presentation after decompression surgery is decreasing pain in the first week, decreasing numbness and tingling over several months and decreasing weakness taking more than one year. Dr. Chong opined Employee did not sustain a brachial plexus injury because the mechanism of injury could not lead to such an injury. There are two ways to injure the brachial plexus, the first is blunt force trauma and the second is a traction injury which means the nerves were pulled very hard. The description of the injury of "pushing off" in the medical record does not lead to a traction injury because the nerve was never pulled. The clinical records do not show a dislocation. There is no explanation of why a brachial plexus decompression would relieve Employee's total hand numbness. Employee does not currently have clinical findings on examination for carpel tunnel. (Dr. Chong).

54) The parties agreed the correct employer was AMCL Juneau. (Record).

55) The parties agreed Employee reserves his right to seek an award of attorney's fees and costs until after this decision and after action on his appeals and Employer reserves its right to object. The parties agreed to reserve the compensation rate adjustment issue and any defenses. (*Id*.).

## PRINCIPLES OF LAW

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.

> **AS 23.30.095. Medical treatments, services, and examinations.** (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. . . . It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require. . . .

When the board reviews a claim for medical treatment made within two years of an undisputed work-related injury, its review is limited to whether the treatment sought is reasonable and necessary. *Philip Weidner & Associates, Inc. v. Hibdon*, 989 P.2d 727 (Alaska 1999). *Hibdon* addressed the issues of reasonable of medical treatment:

> The question of reasonableness is 'a complex fact judgment involving a multitude of variables.' However, where the claimant presents credible, competent evidence from his or her treating physician that the treatment undergone or sought is reasonably effective and necessary for the process of recovery, and the evidence is corroborated by other medical experts, and the treatment falls within the realm of medically accepted options, it is generally considered reasonable. (Citations omitted). (*Id*. at 732).

> **AS 23.30.110. Procedure on claims.**
> . . . .
>
> (c) Before a hearing is scheduled, the party seeking a hearing shall file a request for a hearing together with an affidavit stating that the party has completed necessary discovery, obtained necessary evidence, and is prepared for the hearing. . . . If the employer controverts a claim on a board-prescribed controversion notice and the employee does not request a hearing within two years following the filing of the controversion notice, the claim is denied. . . .

An employee's "claim" for benefits, *i.e.*, his pleading, is differentiated from the employee's right to benefits. Both a worker's right to compensation and his claim may be controverted, but only a controverted claim starts the two-year time period for requesting a hearing. AS 23.30.110(c) requires an employee to timely prosecute a claim once the employer controverts the claim. A "claim" for AS 23.30.110(c) purposes is a "written claim for compensation." *Jonathan v. Doyon Drilling, Inc*., 890 P.2d 1121, 1123-24 (Alaska 1995).

The Alaska Supreme Court compared AS 23.30.110(c) to a "statute of limitations." *Suh v. Pingo Corp*., 736 P.2d 342, 346 (Alaska, 1987). However, it also differs in a sense from a pure statute of limitations because:

> In *Doyon Drilling*, we held that the word 'claim' in section 110(c) refers only to the employee's written application for benefits, not the employee's right to compensation (citations omitted). Therefore, while the expiration of the two-year period in section 110(c) results in dismissal of the particular claim, it does not

> prevent the employee from applying for different benefits, or raising other claims, based upon a given injury. In this sense the provision differs from a statute of limitations, which terminates all rights emerging from a cause of action. Nevertheless, as to the particular claim dismissed under its strictures, section 110(c) resembles a statute of limitations. *Tipton v. ARCO Alaska, Inc.*, 922 P.2d 910, 913 n. 4 (Alaska 1996) (citations omitted).

In *Tipton*, the Alaska Supreme Court said AS 23.30.110(c) requires an employee to request a hearing within two years of the controversion, or face claim dismissal. However, *Tipton* also said the statute of limitations defense is "generally disfavored," and neither "the law [n]or the facts should be strained in aid of it." (*Id.* at 913).

In *Summers v. Korobkin Construction*, 814 P.2d 1369, 1371-73 (Alaska 1991), an injured worker filed a claim seeking a decision from the board on whether his injury was "compensable." His doctor said he might need neck surgery and a major factor in the worker's decision whether to pursue surgery was whether the employer would pay for it. The board declined to hear the case noting there was no actual "controversy," since the injured worker had not received any medical care for over a year, and there were no unpaid work-related medical bills or other claims. The superior court agreed. Reversing, the Alaska Supreme Court stated:

> [The Act] also provides that the right to compensation is contingent upon filing a claim. AS 23.30.105. The procedure on claims is established by AS 23.30.110. AS 23.30.110(a) states that 'the board may hear and determine all questions in respect to the claim.' AS 23.30.110(c) requires that the party seeking a hearing file a request for a hearing. . . .
> . . . .
>
> [The Act] does not define 'claim.' It is significant, however, that the right to compensation is contingent upon filing a claim. AS 23.30.105. . . . Under this section of the act, the only requirement for a claim is knowledge of a disability and its work-relatedness. There is no requirement that the injured worker have incurred unpaid medical expenses (footnote omitted).
>
> As Summers filed a claim under the statute, we disagree with the superior court's determination that the Board correctly denied Summers a hearing on the basis that he had no claim pending before the Board at the time set for hearing. The text of AS 23.30.110(c) reflects that the legislature intended to award injured workers the right to a hearing on their claims. Pursuant to the provisions of AS 23.30.105, the only prerequisite for filing a claim is a work-related injury. . . .

> . . . The dispute between the parties created a 'controversy' which, under the law, entitled the worker to a determination (footnote omitted).
> . . . .
>
> Here, Korobkin disputed many aspects of Summers' application for adjustment of claim. Korobkin's answer advanced numerous defenses to Summer's claim, including that Summers' injury was not work-related. . . . Summers is entitled to a hearing on Korobkin's defenses. If Summers prevails, Korobkin will still be able to controvert Summers' claim at a future hearing, if the grounds for controversion arise after the initial hearing. AS 23.30.130. However, a worker in Summers' position, who has been receiving treatment for an injury which he or she claims occurred in the course of employment, is entitled to a hearing and prospective determination on whether his or her injury is compensable.

In *Bailey v. Texas Instruments, Inc*., 111 P.3d 321 (Alaska 2005), the Alaska Supreme Court addressed a case where an injured worker filed three claims and each was controverted. At hearing, the board dismissed all three claims, treating the second two "as merging" with the first because "they were for the same benefits originally sought." Since the first claim was time barred under AS 23.30.110(c), the board reasoned the other two were also time-barred because they "merely restated" the first claim and were governed by the first statute of limitations and resultant dismissal. Reversing as to the third claim, *Bailey* held the claimant "did not simply refile the 1997 claim in 2001; rather, he sought compensation for different expenses." *Bailey*, 111 P.3d at 325. AS 23.30.110(c) did not operate to deny the third claim. *Bailey* further explained:

> It is true that Bailey apparently sought the same type of medication in each of his claims. But the fact that Geophysical succeeded in controverting the 1997 pharmacy bills because Bailey failed to file a timely request for a hearing does not mean that Bailey can never again claim reimbursement for narcotics or benzodiazepines. (*Id*.).

Over the lifetime of a workers' compensation case, many claims may be filed as new disablements or medical treatments occur. *Egemo v. Egemo Construction Company*, 998 P.2d 434, 440 (Alaska 2000). In *Egemo* the Court held, "new medical treatment entitles a worker to restart the statute of limitations for medical benefits." *Id*.

In *University of Alaska Fairbanks v. Hogenson*, AWCAC Decision No. 074 (February 28, 2008), the commission held when a claim for benefits expires under AS 23.30.110(c) and is dismissed, a later-filed claim for the same benefits for the same injury may not revive the expired claim, but that a later-filed claim for the same benefits on a different nature of injury previously unknown to the employee, or for a different benefit from the same injury, is not extinguished with the earlier claim. *Id.* at 10. A denial and dismissal of a particular claim under AS 23.30.110(c), after the claimant is given notice and opportunity to present evidence and argue against dismissal of the claim, has the effect of dismissal with prejudice, and precludes raising a later claim for the same benefit, arising from the same injury, against the same employer, based on the same theory (nature) of injury. *Id*. at 14.

> **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
>
> (1) the claim comes within the provisions of this chapter; . . . .

Under AS 23.30.120(a), benefits sought by an injured worker are presumed to be compensable, and the burden of producing evidence is placed on the employer. *Sokolowski v. Best Western Golden Lion Hotel*, 813 P.2d 286 (Alaska 1991). The Alaska Supreme Court held the presumption of compensability applies to any claim for compensation under the Alaska Workers' Compensation Act (Act). *Meek v. Unocal Corp.*, 914 P.2d 1276 (Alaska 1996). An employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski* at 292. A three-step analysis is used to determine the compensability of a worker's claim. At the first step, the claimant need only adduce "some" "minimal" relevant evidence establishing a "preliminary link" between the injury claimed and employment. *McGahuey v. Whitestone Logging, Inc.*, 262 P.3d 613, 620 (Alaska 2011). The evidence necessary to attach the presumption of compensability varies depending on the claim. In claims based on highly technical medical considerations, medical evidence is often necessary to make that connection. *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). In less complex cases, lay evidence may be sufficiently probative to establish causation. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Witness credibility is not weighed at this step in the analysis. *Resler v. Universal Services Inc.*, 778 P.2d 1146, 1148-49 (Alaska 1989).

At the second step, once the preliminary link is established, the employer has the burden to overcome the presumption with substantial evidence. *Wien Air Alaska v. Kramer*, 807 P.2d 471 (Alaska 1991) (quoting *Smallwood* at 316). To rebut the presumption, an employer must present substantial evidence that either (1) something other than work was the substantial cause of the disability or need for medical treatment or (2) that work could not have caused the disability or need for medical treatment. *Huit v. Ashwater Burns, Inc.*, 372 P.3d 904 (Alaska 2016). "Substantial evidence" is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Tolbert v. Alascom, Inc.*, 973 P.2d 603 (Alaska 1999). When medical evidence offered to rebut the presumption is uncertain or inconclusive, the presumption is not overcome. *Bouse v. Fireman's Fund Insurance Co*., 932 P.2d 222 (Alaska 1997). At the second step of the analysis, the employer's evidence is viewed in isolation, without regard to the claimant's evidence. Issues of credibility and evidentiary weight are deferred until after a determination whether the employer has produced a sufficient quantum of evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051 (Alaska 1994).

In *Kessick v. Alyeska Pipeline Service Co*., 617 P.2d 755 (Alaska 1980), the Alaska Supreme Court discussed objective medical evidence, and substantial evidence to support a board decision. Reversing the board's denial of benefits, *Kessick* said:

> Nor does the lack of objective signs of an injury in and of itself preclude the existence of such an injury. (Citation omitted). There are many types of injuries which are not readily disclosed by objective tests.
>
> The Board's findings that Kessick's right knee jerk had returned and that there was no longer any atrophy in his right leg are also unpersuasive. Although these facts do indicate that Kessick was recovering, we believe that no reasonable person would infer that the effects of Kessick's injury had totally subsided, particularly in light of Dr. Lindig's testimony.
>
> Finally, we believe that the Board's reliance on Dr. Mead's estimate of a six to nine recovery period is misplaced. First, we do not believe that a reasonable person would accept as conclusive a nine-month old prediction that recovery would take approximately six to nine months when a subsequent diagnosis indicates that the patient has not yet recovered. . . . (*Id*. at 758).

If the presumption is raised but not rebutted, the claimant prevails and need not produce further evidence. *Williams v. State*, 938 P.2d 1065 (Alaska 1997). In the third step, if the employer successfully rebuts the presumption, it drops out, and the employee must prove his case by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379. At this last step, evidence is weighed and credibility is considered. To prevail, the claimant must "induce a belief" in the minds of the fact-finders the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71 (Alaska 1964).

> **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.

Credibility findings are binding. *Smith v. CSK Auto, Inc.,* 204 P.3d 1001 (Alaska 2009). When doctors' opinions disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.*, AWCAC Decision No. 087 (August 25, 2008).

## ANALYSIS

**1) Was the work injury the substantial cause of Employee's need for left upper extremity medical treatment? If so, was the left shoulder decompression surgery reasonable and necessary?**

Employee's April 26, 2019 claim seeks medical treatment, specifically the left shoulder decompression surgery recommended by Dr. Johansen, and the presumption compensability applies to this issue. AS 23.30.010(a); AS 23.30.095(a). Employer concedes Employee raised the presumption of compensability but contends Drs. McFarland's, Almaraz's, Chong's and Direnfeld's opinions rebut the presumption because they determined Employee did not suffer from nTOS and his symptoms are due to some type of carpal tunnel or ulnar neuropathy unrelated to the work injury. AS 23.30.120(a)(1); *Meek*; *Sokolowski*; *McGahuey*; *Smallwood*; *Veco*; *Resler*. Employee contends Drs. McFarland's, Almaraz's, Chong's and Direnfeld's opinions do not rebut the presumption of compensability and he should prevail on his claim for

medical benefits for the decompression surgery performed by Dr. Johansen which was reasonable and necessary. AS 23.30.120(a)(1); *Williams*.

To rebut the presumption, Employer must provide substantial evidence, viewed in isolation without a determination of credibility and weight, providing an alternative explanation excluding work-related factors as the substantial cause of Employee's need for decompression surgery or directly eliminating any reasonable possibility that employment was a factor in causing the need for decompression surgery. AS 23.30.010(a); *Kramer*; *Norcon*; *Huit*. Employer relies on Drs. McFarland's, Almaraz's, Chong's and Direnfeld's opinions that the mechanism of the work injury could not injure the brachial plexus so the work injury could not have caused Employee's need for decompression surgery. Drs. McFarland, Almaraz and Direnfeld also opined Employee's symptomology was caused by non-work related carpel tunnel syndrome. Dr. Chong also opined decompression surgery was not reasonable or necessary because the Washington State guideline precludes it without a positive EDS. Employer provided substantial evidence that rebutted the presumption. *Tolbert*.

Because Employer rebutted the presumption of compensability, Employee must prove his claim by a preponderance of the evidence. *Koons*. Drs. French and Johansen opined the work injury caused Employee's left upper extremity symptomology because it injured his brachial plexus directly and by compression from scarring and recommended decompression surgery to relieve the symptomology. While *Roberge II* found Dr. French less credible because his opinions and testimony have been inconsistent in regards to his recommendation for an EMG and NCS, Dr. French consistently recommended decompression surgery for nTOS since September 2015. There are credibility issues with Dr. Johansen's hearing testimony because his recollection of the mechanism of the work injury was incorrect. However, he testified he relied on Dr. French's medical records when he diagnosed nTOS and recommended decompression surgery in 2018, and Dr. French's records contain an accurate description of the injury, which were not available during his testimony. Dr. French has a special interest in the outcome of Employee's decompression surgery because it supports his medical opinion and research regarding diagnosing nTOS with scalene block injections and treatment for nTOS.

None of the physicians in the record disputed Employee's left upper extremity symptomology. Drs. McFarland, Almaraz and Chong all opined Employee's need for medical treatment was caused by non-work related carpel and cubital tunnel syndromes. However, after the decompression surgery, Dr. Chong concluded Employee had no symptoms of carpel tunnel syndrome. Drs. McFarland and Almaraz did not review the July 15, 2019 decompression surgery operative note and did not examine Employee after the surgery. They did opine that should Employee have nTOS, it would not be related to the work injury because it developed many months afterwards. Drs. McFarland and Alamaraz could provide no other cause of Employee's left handed symptomology other than the carpel tunnel syndrome ruled out by Dr. Chong. There is no evidence of another injury or cause of Employee's left upper extremity symptomology.

Drs. Direnfeld and Chong opined the mechanism of the work injury was unlikely to result in shoulder dislocation which could have stretched the nerve. However, a November 10, 2014 chart note documented shoulder instability and a December 1, 2014 chart note documented Employee's left shoulder was easily dislocated. Drs. French and Johansen opined Employee developed compression of the brachial nerve due to scarring around the brachial plexus nerves caused by the work injury which stretched the nerves. Dr. Chong is the only physician relied upon by Employer who reviewed the July 15, 2019 decompression operative note and examined Employee afterwards. His opinion will be given more weight than Drs. Direnfeld, McFarland and Almaraz. AS 23.30.122; *Smith*. After the decompression surgery, his opinion changed from his September 2, 2016 EME report because he acknowledged Employee presented with symptoms consistent with "cervical brachial syndrome." Dr. Chong could not offer an explanation as to Employee's miraculous recovery but was able to rule out carpel tunnel syndrome, the only other proffered cause of his left upper extremity symptomology.

The medical record shows Employee had positive provocative tests, tenderness over the brachial plexus and parethesias and pain in his left upper extremity, which are considered appropriate symptoms and objective physical findings supporting an nTOS diagnosis according to Drs. French and Johansen and the guideline used by Dr. Chong. There is no other explanation for his left upper extremity symptomology. Dr. Chong concluded surgery was not needed because the

Washington State guideline precluded it, since there was no abnormal EDS and suggested botulinum injections. The Act requires the treatment to be reasonable and necessary; it does not require the use of the Washington State guideline to diagnose and treat nTOS. AS 23.30.095(a); *Hibdon*. Employee presented credible evidence, in his testimony and Dr. Chong's EME report, that his decompression surgery was effective as most of his left upper extremity symptomology resolved afterwards. Dr. Chong's opinion regarding reasonable and necessary medical treatment is given less weight than Dr. Johansen's, as he could not provide another explanation for Employee's left upper extremity symptomology or his recovery after surgery and he suggested another treatment which is not authorized under the guideline he purports to follow. AS 23.30.122; *Smith*; *Moore*. The preponderance of the evidence is that the work injury was the substantial cause of Employee's need for medical treatment for left upper extremity symptomology and the decompression surgery was reasonable and necessary. *Saxton*.

**2) Is Employee's April 26, 2019 claim for medical treatment barred by AS 23.30.110(c)?**

Employer contends Employee's April 26, 2019 claim should be denied because *Roberge I* denied his November 5, 2015 claim under AS 23.30.110(c) and he sought the same medical benefit based on the same medical history and the same theory and nature of the injury and therefore, the claims merged. Employee's November 5, 2015 claim sought medical treatment recommended by Dr. French and authorization for a referral to Dr. Johansen. Employer's December 2, 2015 controversion denied all medical benefits after July 31, 2015. Employee's April 26, 2019 claim sought medical treatment recommended by Dr. Johansen, the left shoulder decompression surgery Dr. Johansen performed on July 15, 2019.

A missed hearing deadline under AS 23.30.110(c) only ends the claimant's right to the benefits actually claimed and controverted. *Jonathan*. Employee retained his right to make claims for other, different benefits not previously claimed, controverted and denied for failure to file a timely hearing request. *Jonathan*; *Suh*; *Tipton*. Employee contends his April 26, 2019 claim seeks a new medical benefit, specifically the July 15, 2019 left shoulder decompression surgery performed by Dr. Johansen. New medical treatment restarts the statute of limitations for medical expenses. *Egemo*. Employee's November 5, 2015 sought authorization for medical treatment

recommended by Dr. French. Dr. French first referred Employee to Dr. Johansen for surgical treatment of nTOS on September 2, 2015. He recommended nTOS decompression surgery and referred Employee to Dr. French again for surgical treatment of nTOS on September 30, 2015. Employee clearly sought authorization for surgical treatment of nTOS in his November 5, 2015 claim and again in his April 26, 2019 claim. His claims seek the same medical treatment arising from the same injury against the same Employer. *Hogenson*.

Dr. Johansen recommended decompression surgery on June 20, 2018 and performed it on July 15, 2019. An opinion from a new physician does not justify treating a recommendation for medical treatment as a new medical benefit unless it is based on a different theory or nature of the injury that was previously unknown to Employee. *Hogenson*. Dr. Johansen opined the work injury caused a direct brachial plexus injury and scar tissue and caused inflammation and scarring which resulted in the symptoms of nTOS. This is the same nature and theory of injury Dr. French made in his February 29, 2016 deposition. Employee's April 26, 2019 claim seeks the same medical treatment, the decompression surgery, arising from the same injury against the same employer based on the same theory or nature of injury as the November 5, 2015 claim denied under AS 23.30.110(c) in *Roberge I*. *Rogers & Babler*. While the July 15, 2019 surgical medical records were not in existence when the claims were filed on November 5, 2015 and April 26, 2019, undergoing the same surgical procedure Employee sought authorization for is not new medical evidence which restarted the statute of limitations. Unlike *Bailey*, where the claimant's third claim sought reimbursement for prescription expenses incurred after the first two claims, Employee sought a prospective determination for a surgical procedure and now seeks reimbursement for the same surgical procedure. Employee's April 26, 2019 claim is denied under AS 23.30.110(c).

## CONCLUSIONS OF LAW

1) Employee's work injury was the substantial cause of his need for left upper extremity medical treatment and the decompression surgery was reasonable and necessary.
2) Employee's April 26, 2019 claim will be denied under AS 23.30.110(c).

## ORDERS

1) Employee's April 26, 2019 claim is denied and dismissed.

Dated in Juneau, Alaska on September 5, 2019.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Kathryn Setzer, Designated Chair

/s/
Charles Collins, Member

/s/
Bradley Austin, 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 RICHARD ROBERGE, employee / claimant v. AMCL JUNEAU, employer; ARCTIC SLOPE REGIONAL CORPORATION, insurer / defendants; Case No. 201410169; dated and filed in the Alaska Workers' Compensation Board's office in Juneau, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on September 5, 2019.

/s/
Dani Byers, Technician