ALASKA WORKERS' COMPENSATION BOARD

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

BART ELLIOTT, Employee, Claimant, v. BEESON PLUMBING, INC., Employer, and ARROWOOD INDEMNITY COMPANY, Insurer, Defendants.	)	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 200002997 AWCB Decision No. 19-0105 Filed with AWCB Anchorage, Alaska on October 11, 2019

Beeson Plumbing's (Employer) June 5, 2019 petition to dismiss and Bart Elliott's (Employee) March 28, 2019 petition for a second independent medical evaluation (SIME) were heard on September 11, 2019, in Anchorage, Alaska, a date selected on July 11, 2019. A June 5, 2019 affidavit of readiness for hearing gave rise to this hearing. Employee represented himself, appeared and testified. Attorney Rebecca Holdiman-Miller appeared and represented Employer and its insurer. The record closed at the hearing's conclusion on September 11, 2019.

ISSUES

Though not included as an issue for hearing, Employer contends Employee's right to benefits for his alleged hip and back injuries are precluded under AS 23.30.100. It contends by September 19, 2017, Employee knew his hip injuries may be work-related but failed to report them timely. Similarly, it contends he never gave notice of his back injury until the hearing. Therefore,

Employer seeks an order barring Employee's hip and back claims for failure to give timely notice.

Employee did not directly address this issue. This decision presumes he opposes Employer's request to dismiss for failure to give timely notice.

1) Is Employer's notice defense ripe for adjudication?

Employer contends Employee's right to all compensation is barred because he failed to file a claim for it within two years after he had knowledge of the nature of his disability, its relation to his employment and after disablement. It contends it paid disability benefits in 2000 and Employee waited 19 years before filing a claim for additional benefits. Employer seeks an order dismissing his claim for all benefits in accordance with AS 23.30.105.

Employee did not directly address this contention, but opposes having his claim barred.

2) Is Employee's right to disability benefits barred for failure to timely file a claim?

Employee contends there are significant medical disputes between his attending physicians and employer's medical evaluator (EME). He requests an SIME to resolve these disputes.

Employer contends Employee's SIME request is untimely because his claim for benefits is untimely. Alternately, it contends he waived his right to request an SIME because he failed to request it timely. Employer contends Employee relies on a medical dispute between two attending physicians, which is not a proper bases to obtain an SIME. It further contends Employee had no objective evidence showing knee pathology and his attending physicians may not have been aware of his entire medical history when offering their opinions. It opposes an SIME.

3) Should there be an SIME?

FINDINGS OF FACT

A preponderance of the evidence establishes the following facts and factual conclusions:

1) On February 9, 2000, Employee, age 22, slipped on the ice and fell, hurting his right knee while working for Employer as a laborer. (Report of Occupational Injury or Illness, February 9, 2000).

2) On February 10, 2000, Employee sought medical care and was anxious to get back to work. Gay Petro, PA, diagnosed a right knee sprain. X-rays taken the same day showed, "Normal appearance to the right knee." (Petro report; x-ray report, February 10, 2000).

3) On February 16, 2000, John Roberts, PA-C, examined Employee, took x-rays and diagnosed a medial collateral ligament sprain with a possible retinacular strain or tear. (Roberts report, February 16, 2000).

4) On March 9, 2000, Bret Mason, D.O., examined Employee, said he would have expected him to have noted improvement after three to four weeks and said the fact he was still having "9/10" pain "deserves MRI evaluation." (Mason report, March 9, 2000).

5) On March 10, 2000, Employee underwent a right knee magnetic resonance imaging (MRI). The radiologist read it as a "normal right knee MRI." (MRI report, March 10, 2000).

6) On March 23, 2000, Dr. Mason reviewed Employee's MRI, examined him and charted his knee popped and Employee was insistent something was wrong with it. Dr. Mason diagnosed left knee pain recalcitrant to conservative management and noted some knee lesions are difficult to see on MRI. He suggested arthroscopic surgery. (Mason report, March 3, 2000).

7) On April 3, 2000, Dr. Mason performed arthroscopic surgery on Employee's right knee. (Operative Note, April 3, 2000).

8) On May 16, 2000, Employee was six weeks post right knee surgery. He was doing well until he stepped into a hole and wrenched his knee. Employee's knee would give out while going down stairs. Dr. Mason reviewed his surgical notes and found all joint structures were normal. However, he had found Employee had thick hypertrophic synovitis throughout all knee compartments and during surgery, Dr. Mason surgically eradicated it and cleaned up the articular surface. He prescribed more aggressive physical rehabilitation. (Mason report, May 16, 2000).

9) On June 20, 2000, Employee had problems with right knee pain, locking and popping. Dr. Mason diagnosed patellar tracking issues and weak muscle tone possibly related to Employee's bilateral foot hyperpronation. He prescribed taping, aggressive physical therapy, an orthotic to realign Employee's feet and a possible second opinion. (Mason report, June 20, 2000).

10) On July 6, 2000, Employee reported improvement and was still anxious to get back to work. Dr. Mason prescribed a specific brace to control his patella tracking. (Mason report, July 6, 2000).

11) On July 7, 2000, Employer made its last disability payment to Employee. (Compensation Report, July 7, 2000).

12) At hearing, Employee testified he retained at least one original compensation report from 2000. In 2000, these reports all had standardized language on the back stating in part:

> 42. **TO EMPLOYEE**. . . . **READ CAREFULLY**
>
> a. This report means the insurer/employer has begun, stopped or changed your compensation payments. The insurer/employer should continue to pay for medical treatment for your injury for at least two years after your injury date. Although the law lets the insurer/employer stop medical payments two years after your injury date, you may file a written claim asking the Alaska Workers' Compensation (AWC) Board to authorize additional medical payments for treatment necessary to your recovery.
>
> b. **YOU HAVE TWO YEARS FROM THE DATE OF THE COMPENSATION PAYMENT TO FILE A WRITTEN CLAIM FOR ADDITIONAL COMPENSATION PAYMENTS**.
>
> . . . .
>
> c. **IF YOU BELIEVE THIS REPORT CONTAINS MISTAKEN INFORMATION, IF PAYMENTS HAVE STOPPED AND YOU CANNOT WORK BECAUSE OF YOUR INJURY, OR IF YOU HAVE QUESTIONS, CONTACT THE PERSON WHO SUBMITTED THE REPORT AT THE PHONE NUMBER OR ADDRESS GIVEN ON THE FRONT OF THIS REPORT. IF YOU AND THAT PERSON CANNOT AGREE, OR IF YOU STILL HAVE QUESTIONS, CONTACT THE NEAREST AWC BOARD OFFICE**. . . . (Emphasis in original).

The Compensation Report forms provided the addresses and telephone numbers for Division offices in Anchorage, Fairbanks and Juneau. (Employee; Compensation Report, April 21, 2000).

13) On July 14, 2000, PA-C Roberts fitted Employee with a special brace to enable him to return to work. (Roberts report, July 14, 2000).

14) On July 19, 2003, Employee reported falling three feet while at work for Veco Alaska, Inc., and landing on a six-inch pipe laying on the floor, striking his lower right back. (Physician's Report, July 22, 2003).

15) On July 21, 2003, Employee sought care for his fall at work on July 19, 2003. His foot slipped and he fell onto his back from a distance between three to five feet off the floor. Employee reported pain in his mid-back only. (Prudhoe Bay Industrial Clinic report, July 21, 2003).

16) On July 23, 2003, Derek Hagan, D.O., diagnosed Employee with a lumbar strain resulting from his July 19, 2003 work injury with Veco. His lumbar spine x-rays were normal. (Physician's Report; x-ray report, July 23, 2003).

17) On July 23, 2003, Dr. Hagan took Employee's history, which was, "Significant for an injury to the right knee more than a year ago that has resolved completely. It is not bothering him today." On examination, Dr. Hagan noted "an old scar in the right lower region" in Employee's lower back, where he felt his symptoms. The nurse's note says Employee also had pain in his "upper right hip." (Hagan report; nurse's note, July 23, 2003).

18) On January 6, 2010, Employee saw an unidentified provider at Valley Chiropractic Clinic for cervical spasms. He continued treating at this clinic periodically until October 27, 2017. In summary, the individual entries for each visit or telephone contact state:

- January 6, 2010; "onset" January 2, 2010. Employee had a history of back and neck injuries over the last 10 to 15 years. He had been roofing and moved 7,200 pounds of material. He had a bad accident in 1999 and was laid up for six to eight months. He reported having several concussions over the years and broken bones but his only surgery to date was right knee surgery in 2001. He had been seen at this clinic once or twice in the 1990s. There was no reference to the 2000 work injury and Employee did not mention any connection with that injury to his other body-part complaints.
- January 8, 2010. Employee had cervical and thoracic complaints.
- July 17, 2012; "onset" July 16, 2012. Employee said he was picking up a 40 pound block and felt pain in his lumbar spine. His occupation was "whoever pays." He did not mention his right knee.
- July 18, 2012. Employee still had low back pain and could not pull up his socks. He had pain radiating down his right leg to his foot.
- July 20, 2012. Employee's low back was still stiff and painful with pain radiating down his right leg to his knee.
- July 23, 2012. Continued lumbar pain with right posterior leg pain to his knee.
- July 25, 2012. He had the same symptoms as in his prior visit.
- August 2, 2012. The clinic called Employee to see how he was doing. He was doing better but his low back was still sore.
- October 9, 2013; "onset" October 1, 2013. Employee was shoveling a hole in a crawl space and felt his low back pop. He later worked in the rain, sat while driving in his car while wet, got a cold chill and again felt it pop.

- October 11, 2013. Employee had cervical and mid-back pain.
- October 11, 2013. He was improving slightly with his neck and back pain.
- October 14, 2013. Employee was still having problems in his mid-back when picking items up off the floor.
- October 16, 2013. He was feeling much better. Chiropractic manipulation to his spine continued.
- September 29, 2014; "onset" September 29, 2014. Employee had immediate pain after reaching behind him to open a car door. He had occasional numbness in both feet and cervical, mid-back and low-back pain. Sleeping was almost impossible.
- October 1, 2014. He was moving around much easier.
- October 3, 2014. Employee's symptoms continued to improve with treatments.
- October 6, 2014. His low back was extremely sore the last two days.
- October 8, 2014. His low back pain was improving.
- October 13, 2014. Employee's neck was feeling better but he worked on a valve cover a day prior and now had low back pain.
- October 15, 2014. His neck was stiff but he was sleeping better.
- October 20, 2014. Employee had worked over the weekend and after seven or eight hours, he had neck and back pain and could hardly move.
- October 22, 2014. Employee was bending over a day prior and had lumbar pain and bilateral leg pain radiating to his feet.
- October 24, 2014. His right leg was doing better without pain and after working around the house he had minimal low back pain.
- October 27, 2014. Employee's right leg and low back pain had increased after working around the house for several hours. (Valley Chiropractic Clinic notes, January 6, 2010 through October 27, 2017).

19) On February 4, 2013, Dr. Mason evaluated Employee's right knee on referral from Employee's "friend." The report states in part:

> The patient presents today with right knee problems. He injured this at work in 2000 and Dr. Mason did surgery which consisted of an arthroscopy of meniscus. His pain is still an issue, but the past six months he has been complaining of popping, locking and catching. . . . His pain level is 6-7/10. . . . He presents today for orthopedic evaluation.

Employee said he had joint pain in his right knee. He worked as a Roustabout. Upon examination, Employee had "complaints of pain at the medial and lateral joint line that are out of proportion to physical findings." X-rays were normal. Dr. Mason diagnosed right knee synovitis or possible meniscus tear. He suggested a right knee MRI. Most notably, he said:

> However, the patient relates this to an on-job injury he had back in 2000. However, it would be unusual to have an internal derangement for 12 years that was never investigated. Apparently we did surgery back in 2000 and then he got

> better for a couple of years by history and then started having problems again in his knee. However, on today's exam, once again, I would say complaints [are] out of proportion to physical findings. (Mason report, February 4, 2013).

20) A February 4, 2013 x-ray of both knees demonstrated no significant findings. The reviewing radiologist opined there was no "likely radiographic explanation for the reported history of right knee pain." (X-ray report, February 4, 2013).

21) On October 9, 2013, Employee saw a provider at Valley Chiropractic Clinic for lumbar symptoms. On his intake form, Employee stated he was, "Shoveling a hole in a crawl space; felt back pop out." He listed his employer as, "Richie General Construction." (Valley Chiropractic Clinic note; Update, October 9, 2013).

22) On September 29, 2014, Employee saw a provider at Valley Chiropractic Clinic for either cervical or lumbar symptoms. (Valley Chiropractic Clinic note, September 29, 2014).

23) On October 27, 2014, Employee reported his spine symptoms spiked over the weekend without any known cause. (Valley Chiropractic Clinic note, October 27, 2014).

24) On August 15, 2015, Employee presented at the emergency room with chest pain, high blood pressure and acute low back pain. He said his low back symptoms began gradually approximately two weeks prior. Employee reported a long history of chronic back pain. He twisted his back three weeks earlier and had pain since. Employee said he had some lower extremity weakness and his legs had been giving out at times but were not numb. Employee said "his knee has been bothering him since his surgery in 2001." (Emergency Room report, August 15, 2015).

25) On August 15, 2015, Employee's lumbar spine MRI showed mild disc desiccation at L5-S1 with a right disc bulging associated with a small, right-sided annular tear. The radiologist opined these findings could be contributory to nonspecific back pain. Otherwise, Employee's lumbar spine MRI was normal. The history given to the radiologist concluded, "Low back pain without trauma/injury." (MRI report, August 15, 2015).

26) On August 18, 2015, Employee reported his main concern was chronic low back pain. He said his back problems began in high school and Employee related them to hockey and other sports and working in construction and welding. He mentioned having severe right knee pain in 2000, with a negative MRI but during surgery the physician found a tear and repaired it

successfully. He reported wearing an orthotic lift in his right shoe since then. (SCHC report, August 18, 2015).

27) On November 2, 2015, Employee saw his family practice provider for hypertension treatment. He reported to continually have "severe back pain" and was awaiting a referral to Algone Pain Clinic. (SCHC report, November 2, 2015).

28) On January 6, 2016, Employee said he had back pain for five years and was concerned because he had work to do and wanted his back fixed. (SCHC report, January 6, 2016).

29) On January 28, 2016, Thomas Grissom, M.D., examined Employee and recommended a lumbar epidural steroid injection for diagnosis and treatment. (SCHC report, January 28, 2016).

30) On January 29, 2016, Stephen Shortridge, PA-C, saw Employee primarily for low back pain. The pain began approximately June 15, 2012. Employee reported several falls from ladders 20 feet or more over the years and much heavy lifting in construction. His second complaint was chronic right knee pain and said, "The injury is work-related." PA-C Shortridge opined Employee's back pain came from an inflamed SI joint. He recommended an SI joint injection. As for the knee, he prescribed a knee injection and bilateral knee x-rays. Employee was taking 7.5 mg Norco, which he said was not managing his pain. PA-C Shortridge increased the dosage to 10 mg and added Mobic, 15 mg. (Shortridge report, January 29, 2016).

31) On February 1, 2016, Employee's bilateral knee x-rays for chronic right knee pain were both negative. (X-ray report, February 1, 2016).

32) On February 12, 2016, Employee had an SI joint injection. (Matthew Peterson, M.D., report, February 12, 2016).

33) On February 24, 2016, bilateral hip x-rays were within normal range with no findings specific to the right hip. (X-ray reports, February 24, 2016).

34) On March 2, 2016, Dr. Grissom gave Employee a right epidural steroid injection at L4-5 and L5-S1 for lumbar radiculopathy on the right side. (Operative Report, March 2, 2016).

35) On March 16, 2016, Raza Jafri, M.D., gave Employee medial branch blocks at L3, L4, L5 and S-1 for lumbar spondylosis without myelopathy. (Operative Report, March 16, 2016).

36) On May 24, 2016, Employee's right knee MRI disclosed a deep, partial-thickness unstable chondral flap and evidence of a prior knee arthroscopy. The history given to the radiologist included, "Chronic right knee pain. Prior right knee surgery." (MRI, May 24, 2016).

37) On April 5, 2016, Curtis Mina, M.D., examined Employee who provided a history of hurting his back five years ago while removing a wall. He had intermittent chiropractic treatment since and his pain radiated down the back of his right leg. Injections did not provide significant relief and he was looking for additional treatment options. Employee reported he was told he may have hip osteoarthritis. Hip x-rays showed minimal sclerosis and well-preserved hip joints. Dr. Mina did not think Employee's symptoms were related to hip arthritis and he would avoid surgical intervention for degenerative disc disease. Dr. Mina suggested pain management and possible nerve ablations. (Mina report, April 5, 2016).

38) On May 6, 2016, Dr. Peterson gave Employee a diagnostic, right L5-S1 facet joint block, which had negative results. (Operative Report, May 6, 2016).

39) On May 17, 2016, Employee presented to the emergency room following a motor vehicle accident. He was passing a garbage truck on the right when the truck turned into his car, hitting it just behind the driver-side door. His car spun around and he hurt his neck and low back. Head, neck and back x-rays were within normal limits. (Emergency Room report, May 17, 2016).

40) On May 20, 2016, Employee reported continuing body aches and pains from his motor vehicle accident three days earlier. (Emergency Room report, May 20, 2016).

41) On May 24, 2016, a right knee MRI for chronic right knee pain and prior right knee surgery disclosed a deep, partial-thickness unstable chondral flap and evidence of the prior knee arthroscopy. (MRI report, May 24, 2016).

42) On June 6, 2016, Zach Kyle, PA-C, reviewed Employee's right knee MRI and recommended arthroscopic evaluation or, in the alternative, knee injections. (Kyle report, June 6, 2016).

43) On June 13, 2016, a lumbar computerized tomography (CT) showed a central, radial tear at the annulus at L4-5 and a complex annular tear versus a possible direct injection of contrast material into the annulus at L5-S1. (CT report, June 13, 2016).

44) On August 9, 2016, Dr. Mina saw Employee for lumbar pain, diagnosed discogenic back pain and recommended a lumbar fusion at L5-S1. (Mina report, August 9, 2016).

45) On September 19, 2016, Dr. Mina performed an anterior lumbar interbody fusion at L5-S1 on Employee for degenerative disc disease. (Operative Report, September 19, 2016).

46) On October 25, 2016, Employee told Adam Ellison, M.D., he had a history of right knee pain "that has been bothering him since about the year 2000." He recounted his slip on the ice with resulting knee pain and surgery shortly thereafter. "The patient states the pain has never gotten better after the knee surgery." His pain has gotten worse over the past few months. He is looking for options to improve his knee pain. On examination, Dr. Ellison found a positive patellar grind test. He diagnosed a cartilage defect on the under surface of the patella but noted there were not many good options to fix it. One option short of a joint replacement would be a juvenile cartilage transplantation. Employee wanted to proceed. (Ellison report, October 25, 2016).

47) On November 2, 2016, Employee told Dr. Mina his back surgery was successful and his lower extremity symptoms had nearly resolved. (Mina report, November 2, 2016).

48) On November 18, 2016, Dr. Ellison performed a right knee arthroscopy with limited debridement and synovectomy, with an open microfracture and grafting with a bio-cartilage graft to address Employee's right knee patellar chondral lesion with a medial plica. (Operative Report, November 18, 2016).

49) On January 23, 2017, Employee sought a referral from his family physician to a surgeon for left hip pain, chronic for the last seven to 10 years. He stated "the pain began in 2000, after a knee injury led to knee surgery. After this he states he had significant knee pain, causing him to put increased stress on his right leg/hip. He then had a back surgery in 2007 which he states, caused further stress to his right hip." (SCHC report, January 23, 2017).

50) On January 26, 2017, Employee told Dr. Mason his right knee still hurt and he was "not happy." He reportedly had seen Dr. Mason three times, x-rays had been done and he was told the knee was fine and to go back to work. Employee reported pain over the patella and posterior knee with locking, giving-way and popping. He had no clicking, grinding or catching. He saw Dr. Mason on this occasion for a second opinion; Dr. Mason found him "hostile" because he had operated on the knee 17 years earlier and Employee felt his knee had never improved. According to Employee, another orthopedic physician told him Dr. Mason's surgery "was botched." Employee refused to allow Dr. Mason to examine his knee. Nonetheless, Dr. Mason reviewed his x-rays and an MRI. He found good articular cartilage, joint space alignment and bone density. Dr. Mason explained abnormalities Employee pointed out on the x-ray were normal knee anatomy as demonstrated by a knee model. Dr. Mason read the MRI as completely

normal. However, he noted the radiologist mentioned a displaced chondral flap, which Dr. Mason could not see. He said this might explain his patellofemoral dysfunction and his complaints. In Dr. Mason's opinion, it certainly would not explain the pain he had posterior in the knee or "what he describes as complete disability." Dr. Mason diagnosed patellofemoral dysfunction in the right knee. He recommended Employee return to Orthopedic Physicians Alaska for arthroscopic evaluation with procedures as indicated. Dr. Mason stated:

> Apparently, he's had 17 years of longevity of symptoms and, despite near-normal findings on MRI, the question is could we all be missing something that could be discovered and treated arthroscopically. I think, based on what he states is 17 years of disability, that it would be worth at least arthroscopic diagnostic evaluation. (Mason report, January 26, 2017).

51) On January 31, 2017, Employee told Dr. Ellison his knee was just as painful as it was prior to his most recent surgery. The knee was still locking up and aching. Dr. Ellison could not understand or explain why Employee still had locking symptoms in his right knee. He had no signs of meniscal pathology and his pain was coming from the patellofemoral region. Dr. Ellison recommended a steroid injection to reduce irritation and a total knee replacement since the other options had not worked for him. (Ellison report, January 31, 2017).

52) On February 2, 2017, Employee had left hip pain. He had no specific trauma that caused it. Dr. Ellison diagnosed left hip pain and suspected he had a labral pathology. He recommended a left hip MRI. (Ellison report, February 2, 2017).

53) On February 8, 2017, Employee and Joanne Pride from Wilton Adjusters (Wilton) called the division to discern the current claim administrator. Division staff explained that Northern Adjusters (Northern) obtained this account in 2006. (ICER's database, February 8, 2017).

54) On February 17, 2017, a left hip arthrogram disclosed no fracture, osteoarthritis or other abnormality. (Arthrogram, February 17, 2017).

55) On February 17, 2017 a left hip MRI with contrast showed changes consistent with cam-type femoral acetabular impingement with a relatively focal labrum tear, and mild adjacent chondrosis. (MRI report, February 17, 2017).

56) On February 21, 2017, Employee reported substantial pain and discomfort in his left hip "extending back several months." He did not recall specific trauma or injury that caused the pain to begin. Dr. Ellison recommended surgical treatment. (Ellison report, February 21, 2017).

57) On March 6, 2017, Dr. Ellison operated on Employee's left hip for a labral tear and several acetabular impingement lesions. (Operative Report, March 6, 2017).

58) On April 11, 2017, Employee saw Algone Pain Clinic for medication follow-up. He reported increased right knee and lumbar pain. The report lists "01/2006 work injury" as the onset for Employee's right knee pain. (Kyle report, April 11, 2017).

59) On April 13, 2017, Dr. Ellison evaluated Employee's post-surgical left hip and reviewed his right knee pain. Dr. Ellison found Employee's kneecap "does catch a little bit on flexion-extension." Right knee x-rays were normal appearing with some changes seen in the patella on the lateral view. Given Employee's prior unsuccessful right knee treatments, Dr. Ellison recommended a unicompartmental patellofemoral replacement. (Ellison report, April 13, 2017).

60) On May 19, 2017, Employee reported back and right hip arthritis, a lumbar spine injury, right hip and knee joint problems, right leg numbness, lumbar fusion history and chronic pain to his back, hips and knee. He reported seeing The Sunshine Clinic for his primary care. Employee could climb stairs without getting shortness of breath, but said he was limited by pain in his knee and his back. Employee reported having chronic pain managed by Algone Clinic. He reported a motor vehicle accident in May 2016, in which he suffered "back problems." He had chiropractic care for his back and right hip, epidural steroid injections and back surgery in September 2016. (Preadmission Report, May 19, 2017).

61) On May 23, 2017, Dr. Ellison evaluated Employee's right knee for a patellofemoral replacement. In the history section, the report states:

> States recently his kneecap is starting to displace to the side which it has not done before. Bart has a long history of pain from his right knee. He has had pain in his need for more than 20 years and it relates back to injuries has had since high school. (Ellison report, May 23, 2017).

62) On June 5, 2017, Dr. Ellison operated on Employee's right knee, diagnosed right knee patellofemoral arthritis and performed a right knee patellofemoral joint arthroplasty. The report states, "Mr. Elliott is a 39-year-old gentleman with a history of substantial patellofemoral related pain extending back over 15 years. He has failed several previous procedures and continued having a locking, catching sensation coming from his patella and pain on the under surface of the patella." (Operative Report, June 5, 2017).

63) On June 20, 2017, Employee still had significant pain and was not happy with his June 5, 2017 surgical results. (Ellison report, June 20, 2017).

64) On July 10, 2017, Valley Chiropractic Clinic sent Employee's chart to Northern. (Valley Chiropractic Clinic note, July 10, 2017).

65) On August 4, 2017, a right knee MRI disclosed normal medial and lateral menisci, patellofemoral arthroplasty changes without overt changes, normal anterior and posterior cruciate ligaments, normal medial and lateral collateral ligaments, and joint effusion, synovitis and a small popliteal cyst. (MRI report, August 4, 2017).

66) On August 24, 2017, a right hip arthrogram for right hip pain found no fracture, osteoarthritis or other abnormality. (Arthrogram report, August 24, 2017).

67) On August 24, 2017, a left hip MRI with contrast for left hip pain showed an interior acetabular labrum tear but no visible chondral injury and an abnormal anterior femoral head-neck contour, which likely contributed to a cam-type impingement. (MRI report, August 24, 2017).

68) On August 29, 2017, upon reviewing recent imaging, Dr. Ellison diagnosed a right hip sprain. (Ellison report, August 29, 2017).

69) On August 31, 2017, Valley Chiropractic Clinic sent Employee an itemized statement for services rendered between January 6, 2010, and August 31, 2017. The statement listed Employee's then-current diagnoses as: lumbar, sacrum/sacroiliac and thoracic subluxation, multiple cervical vertebrae subluxation and sciatic neuralgia. The itemization begins with spinal manipulations on January 6, 2010, continues with intermittent chiropractic modalities, and ends on October 27, 2014, with spinal manipulation. Employee made cash payments totaling $1,135 including a discount for cash payment. (Valley Chiropractic Clinic Itemized Statement, August 31, 2017).

70) On September 19, 2017, Employee told Dr. Ellison he needed a letter to give to his insurance adjuster. In reference to his right hip, Employee "attributes the pain in his bilateral hips to a change in gait with regards to his knee injury." He wanted to move forward with arthroscopic right hip surgery. Dr. Ellison wrote a "to whom it may concern" letter at Employee's request stating:

> Bart Elliott has been a patient under my care over the past year and a half. He has a significant history of right knee pain and [sic] di [sic] result from an injury from

> a work-related environment more than a decade ago. Patient has undergone several surgeries for his knee pain in the past 20 years. At this point he has most recently undergone a patellofemoral replacement surgery. Because of his substantial knee pain he has walked with a limp for most of his life. In the past few years he has developed pain in both of his hips. He has been diagnosed with bilateral labral tears as well as impingement lesions. He has undergone surgery in the left which was successful for help [sic] treat some of his pain [sic] is currently scheduled to undergo surgery on his right side. With the lack of any other trauma that would explain his hip pain it is reasonable to assume that the injuries that have been diagnosed in his hips are related to his walking with a limp from his knee trauma. Please consider evaluating his hip pathology as a possible result from his Worker's Compensation claim for his work-related knee injury. (Ellison report; letter, September 19, 2017).

71) Employee testified he had no idea what prompted Dr. Ellison to prepare this letter. (Employee).

72) On October 9, 2017, Dr. Ellison operated on Employee's right hip and diagnosed a labral tear with a cam impingement lesion. (Operative report, October 9, 2017).

73) On October 27, 2017, Charles Craven, M.D., performed a record review employer's medical evaluation (EME). After reviewing Employee's records, Dr. Craven diagnosed the following, which he said are related to the February 9, 2000 injury: right knee strain; right ankle sprain; and arthroscopy on April 3, 2000. He opined Dr. Mason's surgical findings in April 2000, included synovitis and an inflamed plica band, which the work injury was a substantial factor in causing. However, he also noted the arthroscopy showed no evidence of internal derangement in all internal structures including all cartilage surfaces in both menisci. Dr. Craven opined Employee's chronic back pain and lumbosacral fusion at L5-S1, ongoing right knee pain and patellofemoral chondromalacia identified in May 2016, his right knee arthroscopy and osteochondral autograft transfer procedure in October 2016, his right knee patellofemoral arthroplasty in 2017, his left hip cam-type femoral acetabular impingement found in February 2017, his left hip arthroscopy and femoroacetabular and labral repair in March 2017, and his right hip pain and related radiographs in April 2017, were unrelated to the work injury. He pointed to several accidents and injuries Employee had in the post-work-injury years, though none mention a right knee injury, and aging, genetics and "other life circumstances unrelated" to the work injury to conclude the injury was not contributory toward Employee's subsequent right knee "issues" given his benign MRI in 2000, and Dr. Mason's arthroscopic findings. As for the hip "conditions," Dr. Craven opined the work injury did not cause the anatomic condition found

in Employee's hips. He did not address the possibility the work injury aggravated Employee's preexisting anatomic hip condition. Dr. Craven found no relationship between Employee's chronic back pain and the work injury. When asked if the work injury was a substantial factor in bringing about "the current conditions and/or disability," Dr. Craven said it was not. In his view, Employee reached medical stability for his accepted right knee injury by March 25, 2000. He gave opinions on medical stability for other conditions but stated none are work-related. Dr. Craven said all treatment Employee received since 2010, has been reasonable and necessary, but not work-related. Only Employee's right hip needs further care, but he opines it is not work-related. (Craven report, October 27, 2017).

74) Dr. Craven was able to give the above opinions without seeing the patient. (*Id*.).

75) On December 11, 2017, Employer denied Employee's rights to benefits for any body part other than the right knee, and all benefits for the right knee beyond May 25, 2000. Employer based its denial on: Its contention Employee reported only a right knee injury and any other newly claimed body parts are barred by AS 23.30.100; he failed to file a claim for additional compensation within two years of Employer's last benefits payment in April 2000; and Dr. Craven opined effects from Employee's right knee injury reached medical stability by May 25, 2000, without need for further treatment. Employer served this notice on Employee on the same date. (Controversion Notice, December 11, 2017).

76) On February 5, 2018, Employer's adjuster wrote to Alaska Spine Institute stating she had received bills for a December 14, 2017 service date. The letter advised the provider the bills were denied and attached the December 11, 2017 Controversion Notice providing the reasons. (Jessica Rush letter, February 5, 2018).

77) On February 6, 2018, Dr. Ellison performed a preoperative evaluation for Employee's right knee surgery. The reports states, "Given his history of knee pain over the past 20 years he wants to proceed forward with knee replacement at this time." (Ellison report, February 6, 2018).

78) On February 19, 2018, Dr. Ellison operated on Employee's right knee and diagnosed osteoarthritis with failure of a previous patellofemoral unicompartmental knee replacement. Dr. Ellison noted Employee had a long history of substantial pain and difficulties in his right knee. (Operative Report, February 19, 2018).

79) On March 29, 2018, an unidentified person completed a seven-question "Bart Elliott v. Beeson Plumbing" questionnaire. The document appears to have been prepared by an adjuster or

attorney. The person responding to and signing the questionnaire diagnosed Employee with "osteoarthritis, posttraumatic to patellofemoral joint." The person opined the work injury was "the substantial cause" of the disability or need for treatment, presumably for the diagnosis. The work injury did not aggravate, accelerate or combine with any preexisting condition according to the author. Yet, the person stated the injury caused a permanent aggravation. The questionnaire states Employee is not medically stable, cannot safely return to work but could do sedentary duties with limited walking and standing, limitations which may improve and decrease in two to three months. The author said Employee's treatment had been reasonable and necessary and he needed to continue with physical therapy to strengthen his leg. (Unidentified report, March 29, 2018).

80) Employee testified an attorney with whom he consulted provided the above-referenced questionnaire to Dr. Ellison, who completed and signed it on March 29, 2018. The parties stipulated Dr. Ellison completed the March 29, 2018 questionnaire. (Employee; record).

81) On March 6, 2019, Employee claimed permanent total disability, a finding Employer made an unfair or frivolous controversion, medical and related transportation costs, a late payment penalty and interest. Employee said, on February 9, 2000, he was told to move several boxes containing plumbing supplies and was pushing a wheelbarrow when he slipped on ice, "did the splits," and his right knee gave out. He filed his claim to get more medical care for his right knee after Employer denied benefits. Although the same claim appears to have been filed twice, this was Employee's first and only claim filed in this case. (Claim for Workers' Compensation Benefits, March 5, 2019; agency record).

82) Employee's testimony at hearing showed he did not understand what permanent total disability meant and was actually seeking either temporary total or temporary partial disability benefits. (Employee; experience, judgment and inferences drawn from the above).

83) On April 2, 2019, the board designee reviewed Employee's filings and Employer's responses, which included two similar claims and an SIME petition from Employee and two Controversion Notices and two answers from Employer. The designee apprised Employee of his right to obtain legal counsel, reportedly gave him a pamphlet entitled "Workers' Compensation and You" and advised him it was also available online and provided him with the link, suggested he call a Workers' Compensation Technician at Division offices if he had any questions regarding his claim, explained the statute of limitations set forth in AS 23.30.110(c), advised him

how to obtain an SIME and explained electronic filing. (Prehearing Conference Summary, April 2, 2019).

84) On May 1, 2019, the parties briefly discussed postponing Employee's SIME petition pending discovery and Employee did not object to a short delay. The designee again explained the §110(c) deadline. (Prehearing Conference Summary, May 1, 2019).

85) On May 9, 2019, Employee saw physicians for his knee swelling, stiffness and pain and his low back and hips and said he had these symptoms since 2000 for his knee and 2012 for his back and hips. He told these providers he had right knee surgery "in 2001," and the surgeon, "Left a huge hole in his knee." (Central Peninsula Bone & Joint Center reports, May 9, 2019).

86) On May 9, 2019, a right hip MRI found a normal femur angle at "less than 55 degrees" and no evidence of a focal labral tear. There was no marrow edema, fracture, dislocation, avascular necrosis and no muscle or tendon signal abnormalities. Right knee x-rays showed a total knee arthroplasty without fracture or hardware failure but with prominent knee joint effusion. (MRI report; x-ray report, May 9, 2019).

87) On June 5, 2019, Employer asked for an order dismissing Employee's claims for all benefits, in accordance with AS 23.30.105. It contended he waited 19 years following his February 9, 2000 work injury to file a claim for benefits. Employer claims prejudice from this late filing. (Petition, June 5, 2019; Addendum A).

88) On June 5, 2019, the designee explained how Employee could request a hearing. When the parties could not agree to move forward with an SIME, Employee said he would file a hearing request to take the matter before the board. The designee provided Employee with a precise date deadline for requesting a hearing on his claim. (Prehearing Conference Summary, June 6, 2019).

89) On June 20, 2019, Michael Reyes, M.D., reviewed Employee's imaging and said he was unable to explain his severe groin pain. He thought the right knee CT showed internal rotation though he admitted unfamiliarity with the artificial knee joint used in this instance. He planned to contact the manufacturer to inquire if it was possible to do a femoral revision only and retain the tibial component. If there was a true malrotation, Dr. Reyes would consider revising Employee's total knee arthroscopy, which he called "a HUGE operation" with recovery up to one year. He was concerned Employee was on chronic opiates. Before addressing the knee, however, Dr. Reyes suggested revisiting his right hip pain with a hip injection, physical therapy

and investigating a neurogenic source for Employee's groin pain. (Reyes report, June 20, 2019; emphasis in original).

90) On June 11, 2019, another right hip MRI for persistent hip pain after hip arthroscopy showed no focal labral tear, marrow edema, fracture, dislocation, avascular necrosis or gross muscle or tendon signal abnormality. (MRI report, June 11, 2019).

91) On June 11, 2019, a right knee CT showed a total knee arthroplasty, anatomic alignment, no fracture, dislocation or gross hardware issue but moderate effusion. (CT report, June 11, 2019).

92) On June 27, 2019, Employee had a right hip steroid injection. (Report, June 27, 2019).

93) On July 11, 2019, the designee set a hearing for September 11, 2019, on Employee's March 28, 2019 SIME petition and Employer's June 5, 2019 petition to dismiss. Employer's June 5, 2019 petition raises only a statutory defense under AS 23.30.105. It did not include a defense under AS 23.30.100. (Prehearing Conference Summary, July 11, 2019; Petition, June 5, 2019).

94) There are significant medical disputes between Employee's attending physician Dr. Ellison, and Employer's EME Dr. Craven as to causation, medical stability and need for additional care for Employee's right knee and his hips. These disputes are set forth predominantly in Dr. Ellison's September 19, 2017 and March 29, 2018 reports and Dr. Craven's October 27, 2017 report. Employee has never been rated for permanent partial impairment for any consequences of his February 9, 2000 work injury. (Experience, judgment and inferences drawn from the above).

95) Employer objects to an SIME. It contends the March 29, 2018 questionnaire is too vague, contradicts a former opinion from the same physician and Employer's discovery is not yet complete, as this issue is almost 20 years old. Furthermore, Employer contends there are numerous, superseding intervening accidents and injuries causing Employee's continuing need for treatment. (Record).

96) At hearing on September 11, 2019, Employee gave the following, relevant testimony:

- His current and continuing need for right knee, bilateral hip and low back are caused by his February 9, 2000 work injury with Employer. His altered gait from his right knee injury has affected his hips and low back.

- In July 2012, Employee worked for a friend who had a landscaping job and paid him $10 per hour to tear apart a concrete block wall. While lifting a block, his knee popped forward about two inches, "which it did every once in a while." He also felt searing pain in his lower back. Employee said his knee popping forward was his chief complaint "ever since [his] first surgery." This problem persisted after the block wall incident. Employee does not think he hurt his right knee on this occasion but he "blew out [his] back." In other words, Employee contends he hurt his low back on this occasion only because his right knee gave out and his right knee gave out because of his 2000 work injury with Employer.
- After the February 9, 2000 work injury and before the 2012 block wall incident, Employee said he had no low back pain although he had some bruises and upper back issues that always resolved. His symptoms persisted and eventually he had to get his low-back fused.
- Employee said, in 2012, after the wall incident, he contacted Wilton to ask for help because his right knee was "messing up [his] life." Someone at Wilton referred him to Northern.
- Employee said he called Northern on the same day he called Wilton, probably in August 2012. He said the person he spoke with said there was nothing they could do. He later testified he spoke with Wilton over the years or Northern and they always told him there was nothing they could do.
- As of his April 26, 2017 statement to the adjuster, Employee had not had a full-time job on the payroll for four to five years, or since 2013, but occasionally did "scab work."
- When asked what physical problem kept him from working full-time between 2013 and 2017, Employee said it was his back. His "knee hurt like hell but [he] could still move," his hips hurt but he could "power through that," but his back kept locking up. He would have kept trying to work during this time had his back not hurt. He described his back problems as "devastating."
- Ritchie Excavation in Anchorage was the last "real job" Employee had, in 2013. Since he gave his April 26, 2017 statement, Employee has only worked for his mother helping out in her bar doing things like stocking beer. He has not had a "real job."

- Employee returned to Dr. Mason in 2013, having been told by the insurance adjuster in 2008, that he was the only person Employee could see. He returned to Dr. Mason because his "knee was ruining [his] life." It was continually locking up and giving out. Employee said he had the symptoms since about one year following his 2000 surgery.
- Regarding his May 17, 2016 motor vehicle accident, Employee said he did not hurt his knee but wrenched his back in that event.
- Employee thinks Employer's adjuster in 2012, knew he was claiming his then-current right knee symptoms related back to his work injury with Employer because he told them as much. He paid for several right-knee-related medical bills beginning in 2003 through 2012, and paid for the February 2013 visit with Dr. Mason for his knee because he thought the insurer had cut him off. Employee said the adjuster told him in 2003, that Dr. Mason said there was nothing wrong with his right knee so there was nothing further the insurer could or would do. The same discussions with an adjuster happened in 2006, 2008 and 2012.
- Employee saw Dr. Ellison in October 2016, because he was looking for someone to help with his knee. He had no new injury; he simply wanted somebody to address his chronic right knee pain.
- Employee first made the connection between his right knee injury with Employer and his hips and back as follows: He first connected his right knee to his hips in 2006, because he was limping around all the time and his hips started hurting. When his knee popped forward and he blew out his back in 2012, his chiropractor also had to adjust his left hip.
- Employee first asked a physician about a connection between his right knee and his hips when he started getting Medicaid health benefits, in 2015. Emergency room physicians told him there might be a connection. The second time he saw Dr. Ellison in 2016, he asked him to comment on a connection between his right knee and his low back.
- When Employee had his second right knee surgery on November 18, 2016, he was already off work because of his back, perhaps for as long as three years since he last worked at Ritchie Excavation.
- Employee never work for Employer again after his 2000 work injury.

- Employee knew Dr. Ellison thought it was reasonable to conclude his hip symptoms were related to limping following his knee surgeries by his second visit with Dr. Ellison in November 2016.
- Employee said he told his medical providers for his second right knee surgery in 2016, that it was related to his 2000 work injury with Employer. With exception of bills incurred in 2000, Medicaid paid all his medical bills for his work-related injuries. A few days after Employee's September 19, 2016 back surgery, the Attorney General's office contacted him and suggested he file a workers' compensation claim. He assumed Alaska Medicaid wanted its money back.
- He may have called adjuster Erin Havard in February 2017; he went to his office and asked him to reopen this case. On February 28, 2017, Employee signed a medical record release for the adjuster. He was also advised to contact the board.
- Employee had work injuries before and after this one, though he said they were minor.
- Employee personally visited Wilton in 2003 and 2006, to ask about his case. He personally visited Northern in 2017, to make an inquiry about it.
- Employee said he "should have read the manual" explaining workers' compensation benefits, implying he received but did not read it.
- Employee did not understand what permanent total disability meant.
- He is claiming past temporary total or temporary partial disability benefits as follows: For his back -- August 15, 2015, based on the Willow Clinic sending him to the hospital. For his hips -- August 15, 2015, when doctors at the emergency room told him to stop working. For his right knee -- August 15, 2015, when he stopped working at a doctor's direction. He claims temporary total or temporary partial disability benefits continuing to the present.
- Employee still has the April 21, 2000 Compensation Report, but conceded he did not read the entire form. The first time he contacted Division offices was in 2017.
- He did not disagree with the division's database showing his first contact with the division was on February 8, 2017, when Employee and adjuster Joanne Pride from Wilton called.

97) Based on Employee's medical records and his testimony, his right knee, bilateral hips and low back were not latent injuries. (Experience, judgment and inferences drawn from the above).
98) Although Employee clarified his disability claim at hearing, he did not clarify the specific medical care he seeks or dates for medical treatment he claims. (Record).
99) Employee was 22 years old on his February 9, 2000 injury date. When his knee gave out in 2012 or 2013, and allegedly injured his low back, he was approximately 35 years old. He is now approximately 41. At hearing, Employee was articulate, expressed himself clearly with conviction and represented himself well for a lay person. He is a reasonable person. The record does not show his education level. (Observations and inferences drawn from the above).

PRINCIPLES OF LAW

The board may base its decision not only on direct testimony and other tangible evidence, but also on its "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 23.30.100. Notice of injury or death**. (a) Notice of an injury . . . in respect to which compensation is payable under this chapter shall be given within 30 days after the date of such injury . . . to the board and to the employer.
>
> (b) The notice must be in writing, contain the name and address of the employee, a statement of the time, place, nature, and cause of the injury or death . . . and be signed by the employee or by a person on behalf of the employee. . . .
>
> (c) Notice shall be given to the . . . employer by delivering it to the employer or by sending it by mail addressed to the employer at the employer's last known place of business. If the employer is a partnership, the notice may be given to a partner, or if a corporation, the notice may be given to an agent or officer upon whom legal process may be served or who is in charge of the business in the place where the injury occurred.
>
> (d) Failure to give notice does not bar a claim under this chapter
>
> > (1) if the employer, an agent of the employer in charge of the business in the place where the injury occurred, or the carrier had knowledge of the injury or death and the board determines that the employer or carrier has not been prejudiced by failure to give notice;

> (2) if the board excuses the failure on the ground that for some satisfactory reason notice could not be given;
>
> (3) unless objection to the failure is raised before the board at the first hearing of a claim for compensation in respect to the injury or death.

> **AS 23.30.095. Medical treatments, services, and examinations**. . . .
> . . . .
>
> (k) In the event of a medical dispute regarding . . . causation, medical stability . . . degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's independent medical evaluation, the board may require that a second independent medical evaluation be conducted by a physician or physicians selected by the board from a list established and maintained by the board. . . .

> **AS 23.30.105. Time for filing of claims**. (a) The right to compensation for disability under this chapter is barred unless a claim for it is filed within two years after the employee has knowledge of the nature of the employee's disability and its relation to the employment and after disablement. However, the maximum time for filing the claim in any event other than arising out of an occupational disease shall be four years from the date of injury . . . except that if payment of compensation has been made without an award on account of the injury . . . a claim may be filed within two years after the date of the last payment of benefits under AS 23.30.041, 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215. It is additionally provided that, in the case of latent defects pertinent to and causing compensable disability, the injured employee has full right to claim as shall be determined by the board, time limitations notwithstanding. . . .

Morrison-Knudsen Co. v. Vereen, 414 P.2d 536 (Alaska 1966) said AS 23.30.105's purpose is to insure employers have reasonable, timely opportunity to investigate and defend against claims. In *Larson's Workers' Compensation Law*, Professor Larson discusses issues to consider in determining whether a limitations statute for filing a workers' compensation claim has begun to run:

> The time period for notice of claim does not begin to run until the claimant, as a reasonable person, should recognize the nature, seriousness and probable compensable character of his injury or disease (7 Arthur Larson & Lex Larson, *Larson's Worker's Compensation Law* §126.05[1], at 126-18 (2001)).

Dafermo v. Municipality of Anchorage, 941 P.2d 114, 119 (Alaska 1997) cited from precedent explaining what constitutes a "latent" injury. "[A]n injury is latent so long as the claimant does

not know, and in the exercise of reasonable diligence (taking into account his education, intelligence, and experience) would not have come to know, the nature of his disability and its relation to his employment" (citation omitted).

In *Egemo v. Egemo Construction Co*., 998 P.2d 434 (Alaska 2000), the claimant suffered back, right and left fibula fractures and a left tibia fracture at work in 1967. He had surgery on his left leg in 1968. His doctor told him he may have severe arthritis in the future. The employer paid all applicable benefits. Between 1968 and 1996, the claimant had back, knee and leg problems but did not file claims for any disability or medical benefits although he knew the carrier would have paid them. In 1987, the claimant consulted a physician who recommended arthroscopic surgery on both knees. Not wanting to take time off work, the claimant declined. He consulted additional surgeons in 1987 and 1988, and had arthroscopic surgery on his knees in 1988. He took time off work to recuperate and then returned to work. Claimant had back problems beginning in 1989, requiring multiple surgeries. He continued to have back, ankle and foot pain; the latter two had been present since his work injury in 1967, but slowly worsened over the years. In 1995, a doctor recommended surgery to correct a left leg deformity arising from the 1967 work injury. Another physician suggested the employee fix his back before repairing the leg problem. Yet another doctor opined the claimant's ankle pain was caused by his 1967 left leg injury. In 1997, the board's doctor opined the 1967 work injury caused the left tibial malunion, which contributed to pain in the left knee and ankle. The employer's medical evaluator for the most part agreed with the board's doctor. The claimant had the left leg surgery in February 1998.

The employee filed his claim in October 1996. He sought medical benefits, temporary total disability beginning in June 1996, attorney fees and interest. The employer and carrier stipulated the leg surgery was compensable, although they did not pay the medical benefits pending a hearing on the employee's pending claim. The claimant contended the employer's voluntary agreement to pay medical benefits for the left leg procedure entitled him to related time-loss benefits. After a hearing, the board in 1997, ordered medical benefits for the left leg surgery but denied related time-loss benefits. Noting the claimant was required to file his claim within two

years of his knowledge of the disability, its relationship to his employment and after disablement, the board concluded he had not timely filed under AS 23.30.105.

On appeal, *Egemo* said the date when the employee learned of his disability is a factual question left to the board, a finding which must be supported by such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Id*. at 438. His employer bore the burden to establish its "disfavored" affirmative defense that the employee failed to timely file a claim. *Id*.

Egemo found "disability" meant incapacity because of injury to earn wages the employee was receiving at the time of injury. It held a claim for disability is a written pleading requesting money for the inability to earn wages because of a work-related injury. *Egemo* found the employee filed his claim nearly two years before he took time off for work for his 1998 left leg surgery. Thus, although he knew in 1987, when a doctor told him he would someday need surgery, he did not become disabled until he had wage loss in 1998. His claim became ripe in 1998. *Egemo* said:

> [The insurer] argues that Egemo's theory of ripeness should be rejected because it revives a claim every time a worker loses work time due to medical treatment. That characterization is not entirely correct. A claim is ripe only when it involves a work-related injury . . . that causes wage loss (footnote omitted). Only if the new medical treatment causes the wage loss is there a new claim, restarting the statute of limitations. In the same way that medical claims are revived whenever there is new treatment, (footnote omitted) disability claims related to the new treatment are revived. (*Id*. at 439).

Egemo held an injury may result in multiple disability periods. It said "each period of disability is characterized by a conjunction of a work-related injury . . . and wage-loss. If these two factors are present, the clock begins anew." (*Id*. at 439-40). *Egemo* cited from the court's precedent and said "one does not know the nature of one's disability and the relationship of the disability to one's employment until one knows of the disability's full effect on one's earning capacity. The mere awareness of the disability's full physical effects is not sufficient" (footnote omitted). *Id*. at 440. *Egemo* further noted, in any case, "both the knowledge and the disablement must be conjoined before the employee is required to file a claim." *Id*.

The board in *Egemo* found the claimant was disabled in 1988 from a knee surgery and concluded he did not file his claim until more than two years after disablement from that surgery. But the Alaska Supreme Court in *Egemo* held its "conclusion that a new medical treatment resulting in a new period of wage loss constitutes a new disability moots this argument." *Id*. *Egemo* further held AS 23.30.105's intends "that two years after disablement is the *latest* an employee would be allowed to file," to protect the employer "against claims too *old* to be successfully investigated and defended" (emphasis in original). *Id*.

Roberge v. ASRC Construction Holding Co., AWCAC Decision No. 269 (September 24, 2019), addressed a case arising under AS 23.30.110(c), the statute requiring a claimant to request a hearing within two years of the date an employer controverts a claim. In reversing the board's decision dismissing a claim based on an untimely hearing request, *Roberge* stated:

> Yet the idea of a hearing not being held on the merits of a claim is strongly disfavored by the Court and the Board has an obligation to determine if there is a way around the running of the .110(c) defense. *Id*. at 15.

The Alaska Supreme Court said in *Richard v. Fireman's Fund*, 384 P.2d 445 (Alaska 1963), that the board owes to every claimant a duty to fully advise them as to all facts which bear upon their condition and their right to compensation and to instruct them on how to pursue that right.

> **8 AAC 45.050. Pleadings**. . . .
> . . . .
>
> (e) Amendments. A pleading may be amended at any time before award upon such terms as the board or its designee directs. If the amendment arose out of the conduct, transaction, or occurrence set out or attempted to be set out in the original pleading, the amendment relates back to the date of the original pleading.
> . . .
>
> **8 AAC 45.065. Prehearings**. . . .
> . . . .
>
> (c) After a prehearing the board or designee will issue a summary of the actions taken at the prehearing, the amendments to the pleadings, and the agreements made by the parties or their representatives. The summary will limit the issues for hearing to those that are in dispute at the end of the prehearing. Unless modified, the summary governs the issues and the course of the hearing.

> **8 AAC 45.070. Hearings**. . . .
> . . . .
>
> (g) Except when the board or its designee determines that unusual and extenuating circumstances exist, the prehearing summary, if a prehearing was conducted and if applicable, governs the issues and the course of the hearing. . . .
>
> **8 AAC 45.092. Second independent medical evaluation**. . . .
> . . . .
>
> (g) If there exists a medical dispute under AS 23.30.095(k). . . .
> . . . .
>
> (2) a party may petition the board to order an evaluation; the petition must be filed within 60 days after the party received the medical reports reflecting a dispute, or the party's right to request an evaluation under AS 23.30.095(k) is waived;

ANALYSIS

1) Is Employer's notice defense ripe for adjudication?

Issues decided at hearings are limited to those raised by the parties as set forth in the controlling prehearing conference summary. 8 AAC 45.065(c); 8 AAC 45.070(g). The controlling prehearing conference summary in this case is dated July 11, 2019. On that date, the designee set a hearing for September 11, 2019, and identified Employee's March 28, 2019 SIME petition and Employer's June 5, 2019 petition to dismiss as the only issues. The only basis for dismissal in the June 5, 2019 petition was Employer's defense that Employee failed to timely file a claim under AS 23.30.105. Nevertheless, Employer's hearing brief raised a notice defense under AS 23.30.100 and Employer argued it at hearing. There is nothing unusual or extenuating about a notice defense and no reason Employer, represented by experienced counsel, could not have raised the §100 issue at the last prehearing conference. Because the issue was not set for hearing, it is not ripe for decision. .

Alternately, and assuming the §100 notice defense was ripe for decision, Employee's injury report shows he gave Employer written notice of his February 9, 2000 right knee injury on February 9, 2000. This same form shows Employer knew about his right knee injury on

February 9, 2000. Thus, there is no dispute on this point. Employer contends he had an added obligation to give supplementary notice every time he became aware his February 9, 2000 right knee injury caused some other body part to develop symptoms or require medical treatment. Employer in its brief and oral arguments provided no authority for this contention.

2) Is Employee's right to disability benefits barred for failure to timely file a claim?

This decision does not resolve Employee's claim on its merits. This analysis simply resolves Employer's June 5, 2019 petition. To do so, it assesses what Employee knew and when he knew it. It does not necessarily accept his account in full, and any weight accorded his testimony and the medical evidence must await a merits hearing. Employer seeks an order barring Employee's right to all benefits and wants his March 6, 2019 claim dismissed because he failed to timely file it. AS 23.30.105 expressly bars only the "right to compensation for disability" unless a claim for disability is filed within two years after Employee had knowledge of the nature of his disability, its relation to his employment injury and after he became disabled. Therefore, under the statute's plain language, only his claims for disability compensation may be barred.

At the September 11, 2019 hearing, it became obvious Employee did not understand what disability benefit he was claiming. *Richard*. His claim requests permanent total disability, but when asked, Employee did not understand that concept. He clarified his claim was for temporary partial or temporary total disability benefits. For purposes of this decision, it is assumed Employee orally amended his claim at hearing to a claim for temporary partial or temporary total disability benefits beginning on August 15, 2015, and continuing. 8 AAC 45.050(e).

The commission in *Roberge*, recently said in a case arising under a different limitations statute, AS 23.30.110(c), that the fact-finders have "an obligation to determine if there is a way around the running of the .110(c) defense." *Roberge* based this conclusion on its understanding that "the idea of a hearing not being held on the merits of a claim is strongly disfavored." Dismissing a case under AS 23.30.105 is also disfavored. *Egemo*. Under *Roberge*, this decision similarly will determine if there is a "way around" Employer's §105 defense. Employer has the burden to

prove this affirmative defense. *Egemo*. Employer relies primarily on Employee's medical records and his testimony. This decision will address the three prongs of this defense separately.

A) When did Employee have knowledge of the nature of his disability?

In other words, when did Employee understand why he could not earn wages? The date Employee learned why he was disabled is a factual question that this decision has authority to resolve. *Egemo*. Employee is a reasonable person and expresses himself well. *Larson*. Employee knew immediately on February 9, 2000, he had hurt his right knee; Dr. Mason operated on it in 2000. It bothered him continuously until July 6, 2000, when PA-C Roberts fitted him with a brace to control his patella tracking. His knee injury was not latent. *Dafermo*. There are no medical records showing Employee complained about his right knee again until February 4, 2013, when he returned to see Dr. Mason. Employee said he saw Dr. Mason because an adjuster in 2008 told him he could only see him for this injury. When asked why he returned to Dr. Mason in 2013, Employee said his "knee was ruining [his] life." Employee testified he had locking and giving-out symptoms since approximately one year following his 2000 surgery. On that 2013 visit, he referenced his 2000 work injury and told Dr. Mason his right knee had been popping, locking and catching for the past six months. In 2013, when he saw Dr. Mason, Employee was expressly associating his right knee symptoms to his February 9, 2000 work injury.

Eventually, Employee stopped working in 2013. His last "real job" in 2013 was with Ritchie Excavation. Thereafter, he was disabled either partially or totally between 2013 and 2017, until at some point he went to work helping at his mother's bar. Employee insistently testified that on several occasions, in 2003, 2006, 2008 and 2012, he contacted Wilton and eventually Northern to inquire about his case. He said the Wilton adjuster told him there was nothing she could do because Dr. Mason told her in 2003, that his case was resolved. In 2012, after the block wall incident, he contacted Wilton because his right knee was "messing up [his] life." Wilton referred him to Northern, which he also called on the same day. This testimony implies Employee consistently related his disability to his February 9, 2000 work injury. He would not have contacted Wilton or Northern if he did not know his right knee still had symptoms, and was beginning to affect other body parts like his back and hips, and if he did not expect them to pay

him benefits. *Rogers & Babler*. Most importantly, Employee testified the adjuster knew in 2012, he was claiming that his then-current right knee symptoms related back to his 2000 work injury, because that is what he told her in 2012. As for his hips and back, Employee testified he first made the connection between his right knee injury and his hips in 2006, because he was limping around all the time, and his back in 2012, when his knee popped forward and he blew out his back as a result.

On August 15, 2015, the date Employee's claim for disability and medical benefits begins, he went to the emergency room reporting chronic back pain from twisting his back three weeks prior. He mentioned his knee had been bothering him since his first knee surgery, which he incorrectly identified occurred in 2001, rather than in 2000. On August 18, 2015, he again mentioned severe right knee pain in 2000. On January 29, 2016, Employee told PA-C Shortridge his low back pain, which had begun approximately June 15, 2012, and his right knee pain, were "work-related." On March 24, 2016, a right knee MRI disclosed a problem in the patellar facet and showed evidence of a prior knee arthroscopy. The history given to the radiologist included, "Chronic right knee pain. Prior right knee surgery." On April 5, 2016, Dr. Mina examined Employee for his lower back, which he said he injured five years earlier while removing a wall. At hearing, Employee explained that his right knee slipped forward causing his leg to buckle while he was lifting a 40 pound concrete block. He contends the right knee buckled, as it occasionally did since his work injury, because of the February 9, 2000 injury with Employer. As Employee put it, the knee buckling while removing the block wall and this motion "blew [his] back out."

Employee's accounts in his medical records and hearing testimony demonstrate he knew all along his February 9, 2000 work injury is what caused his inability to work. Employee testified he told his medical providers for his second right knee surgery in 2016, that it was related to his 2000 injury. He agreed he may have called adjuster Havard in February 2017. On February 28, 2017, he signed medical releases for the adjuster. He would not have done these things if he did not think Employer had some liability for his benefits. Based solely on this evidence, Employee knew the reason he could not work all along. *Rogers & Babler*.

Assuming some medical evidence was necessary to inform Employee about the nature of the reason he could not work, he testified he first asked a physician about a connection between his right knee injury and his hips when he began getting Medicaid health benefits in 2015. He said an emergency room physician in 2015, told him there might be a connection. On November 18, 2016, when he saw Dr. Ellison, Employee asked him to comment on a connection between his right knee and his low back. Employee said he knew Dr. Ellison thought it was reasonable to conclude his hip symptoms were related to limping following his knee surgeries by the time he saw Dr. Ellison for the second time on November 18, 2016. Employee's injury and its alleged sequela is not complicated. Assuming he needed medical evidence to understand why he could not work, he surely knew by November 2016 that his right knee injury with Employer could have affected both hips and his low back, which he says precluded him from working and rendered him disabled.

B) When did Employee know its relation to his employment injury?

As demonstrated above, Employee knew from February 9, 2000, that his ongoing right knee symptoms related back to his injury with Employer. He attributed his 2013 right knee popping incident to wrenching his back while he was carrying a heavy concrete block. Employee's testimony categorically associated the low back injury to his right knee giving away. Similarly, he contends limping with an altered gait was responsible for his bilateral hip symptoms. His medical records and testimony suggest he made the connection when the symptoms began. Medical opinions Employee received from emergency room doctors and from Dr. Ellison in 2015 and 2016, respectively, supported what Employee already knew -- his inability to work caused by knee, back, or hip pain, was allegedly directly related to his February 9, 2000 right knee injury. *Rogers & Babler*.

C) When did he became disabled?

Though Employee's testimony on this issue is vague, it appears he became temporarily partially or totally disabled in 2013, when he last worked full time for Richie Excavation. The precise earliest disability date, however, is irrelevant because Employee's claim for disability benefits begins August 15, 2015, for his back, hips and right knee. Employee chose this date to begin his

disability claim because on that occasion Willow Clinic sent him to the hospital, emergency room doctors told him to stop working and he stopped working at his doctor's direction.

Since he only claims disability benefits beginning August 15, 2015, this decision must determine if he filed his claim for disability benefits within two years of the date he had knowledge of the nature of his disability (*i.e.*, the reason he could not work), its relationship to his employment injury and after he became disabled. AS 23.30.105. Given the above analysis, and assuming he needed medical opinions to support his own understanding, Employee by his own admission and through medical records, knew the nature of his disability and its relationship to his employment injury as follows: Regarding Employee's low back, the record does not disclose any medical opinion connecting the right knee injury to Employee's low back symptoms. Only his testimony about his knee popping forward, causing him to wrench his back while he was carrying a 40 pound concrete block, connects the two. That knowledge came to him when that incident happened in 2013. In respect to his knee and hips, emergency room physicians told him there might be a connection in 2015, when he started getting Medicaid health benefits. Dr. Ellison reaffirmed this on November 18, 2016, when he said it was reasonable to conclude his hip symptoms were related to limping following his knee surgeries. Employee did not say exactly how he knew Dr. Ellison knew this, but a reasonable inference from his testimony is that Dr. Ellison told him as much. *Rogers & Babler*. That leaves for consideration the relevant date Employee became disabled.

The Alaska Supreme Court in *Egemo* addressed this issue in detail. *Egemo* held, in the same way medical claims are revived whenever there is "new treatment," disability claims related to the new treatment are also revived. Both knowledge of the disability and disablement must conjoin before Employee was required to file a claim. *Id*. Employee filed his claim on March 6, 2019. Coincidentally, exactly two years earlier on March 6, 2017, Dr. Ellison operated on Employee's left hip. The left hip operation constituted "new treatment" for Employee's alleged injuries and revived any claim Employee could make for disability. However, Employee did not file a claim for disability within two years of the date in 2013, when he contends he became disabled when his right knee buckled causing him to wrench his back while he was carrying a 40 pound concrete block, or the date in 2015, when emergency room doctors told him there might

be a connection between his knee injury and his hips, or November 18, 2016, when Dr. Ellison said his hip symptoms were related to limping following his knee surgeries. He even kept the April 21, 2000 Compensation Report, which gave general information about how to file a claim or contact the division for assistance. But Employee took no legal action until March 2019. Consequently, to this extent Employee's petition will be granted and Employee's right to disability benefits before March 6, 2017, is barred for his failure to timely file a claim. AS 23.30.l05; *Egemo*.

On the other hand, Employee's right to disability benefits beginning March 6, 2017, and continuing is not barred under AS 23.30.105, because he filed a claim for disability benefits within two years of "new treatment" he had on March 6, 2017, which revived his disability claim. *Egemo*. Further, there is no prejudice to Employer. Dr. Craven was able to offer medical opinions without seeing Employee. *Vereen*. Employee did not specify the date his medical claim began. However, this decision assumes it too begins August 15, 2015. He can clarify this date at a prehearing conference. To the extent Employer's petition seeks an order dismissing his medical or other claims under AS 23.30.105, it will be denied because the statute does not apply to anything other than disability compensation. Employee's right to claim other benefits and Employer's right to all defenses are retained.

3)Should there be an SIME?

Employee requests an SIME. AS 23.30.095(k). EME Dr. Craven believes Employee's February 9, 2000 work injury resolved, in all respects, by no later than May 25, 2000. On October 27, 2017, he opined Employee is medically stable, he needs no further work-related medical care and his work injury did not cause his conditions nor was it a substantial factor in Employee's need for treatment to his right knee, hips or low back. Based on his opinion, Employer controverted Employee's right to benefits on December 11, 2017, and eventually his claim. On March 29, 2018, Dr. Ellison signed a questionnaire stating the February 9, 2000 work injury was the substantial cause of Employee's disability and need for treatment. Dr. Ellison said Employee is not medically stable, cannot safely returned to work without limitations and needs additional treatment at least to his right leg. There are clear medical disputes between Dr. Craven and Dr. Ellison.

Employee's March 28, 2019 SIME petition is not timely because it was not filed within 60 days of the date Employee had Dr. Craven's October 27, 2017 EME report and Dr. Ellison's March 29, 2018 questionnaire. Employee waived his right to request an SIME. 8 AAC 45.092(g)(2). However, the potential benefits at stake here are significant and include at least reimbursing Employee or Medicaid for any work-related medical expenses and Employee's current claim for disability benefits. Employee has never been rated for permanent partial impairment at least for his right knee. This creates a gap in the medical evidence. Given the disparate medical opinions, numerous body parts involved and the unusual nature of Employee's claims, an SIME will be helpful in resolving Employee's medical and his disability claims notwithstanding his tardy request. Therefore, this decision will deny his March 28, 2019 petition for an SIME but order one on its own motion. *Bah*.

CONCLUSIONS OF LAW

1) Employer's notice defense is not ripe for adjudication.
2) Employee's right to some disability benefits is barred for failure to timely file a claim.
3) There should be an SIME.

ORDER

1) Employer's June 5, 2019 petition to dismiss Employee's claim is granted in part and denied in part, in accordance with this decision.
2) Employee's right to compensation for disability before March 6, 2017 is barred.
3) Employee's right to compensation for disability from March 6, 2017, and continuing, is not barred, in accordance with this decision.
4) Employee's right to claim benefits and other relief from March 6, 2017, and continuing, is not barred, in accordance with this decision.
5) Employer retains any and all defenses to Employee's claims for medical benefits and other relief beginning August 15, 2015, and continuing, as reflected in his March 6, 2019 claim, as amended at hearing, in accordance with this decision.
6) Employee's March 28, 2019 petition for an SIME is denied.

7) This decision on its own motion orders an SIME addressing causation, medical stability, degree of impairment, functional capacity, and the amount and efficacy of the continuance of or necessity of treatment for Employee's right knee, bilateral hips and low back.

8) The parties are directed to schedule and attend a prehearing conference at which time the designee will advise the parties how to proceed with the SIME process.

9) The designee is directed to advise Employee as to the date by which he must request a hearing, or request more time to request a hearing, to avoid having his claim dismissed under AS 23.30.110(c).

10) The designee shall advise Employee how to amend his claim formally at the next prehearing conference; Employer may amend its answer accordingly.

Dated in Anchorage, Alaska on October 11, 2019.

ALASKA WORKERS' COMPENSATION BOARD

/s/
William Soule, Designated Chair

/s/
Robert C. Weel, Member

/s/
Rick Traini, Member

PETITION FOR REVIEW

A party may seek review of an interlocutory other non-final Board decision and order by filing a petition for review with the Alaska Workers' Compensation Appeals Commission. Unless a petition for reconsideration of a Board decision or order is timely filed with the board under AS 44.62.540, a petition for review must be filed with the commission within 15 days after service of the board's decision and order. If a petition for reconsideration is timely filed with the board, a petition for review must be filed within 15 days after the board serves the reconsideration decision, or within 15 days from date the petition for reconsideration is considered denied absent Board action, whichever is earlier.

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 Interlocutory Decision and Order in the matter of Bart Elliott, employee / claimant v. Beeson Plumbing, Inc., employer; Arrowood Indemnity Company, insurer / defendants; Case No. 200002997; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on October 11, 2019.

/s/
Nenita Farmer, Office Assistant