ALASKA WORKERS' COMPENSATION BOARD

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

JASON VANDERPOOL,	)	
	)	
Employee,	)	FINAL DECISION AND ORDER
Claimant,	)	
	)	AWCB Case No. 201700230
v.	)	
	)	AWCB Decision No. 23-0081
STATE OF ALASKA,	)	
	)	Filed with AWCB Juneau, Alaska
Self-Insured Employer,	)	on December 22, 2023
Defendants.	)	
	)	

Jason Vanderpool's (Employee) August 16, 2021 amended claim was heard on the written record November 21, 2023, in Juneau, Alaska, a date selected on September 29, 2023. A July 24, 2023 hearing request gave rise to this hearing. Attorney Timothy Twomey represented Employee. Attorney Justin Tapp represented the State of Alaska (Employer). *Vanderpool v. State of Alaska*, AWCB Dec. No. 21-0124 (December 28, 2021) (*Vanderpool I*) granted Employer's petition to dismiss Employee's January 31, 2019 claim under AS 23.30.110(c). The record closed at the hearing's conclusion on November 21, 2023.

ISSUES

Employee contends he incurred over $90,000 in medical expenses for medical treatment related to the January 1, 2017 work injury. He requests an order requiring Employer to pay medical costs in full since the January 1, 2017 work injury and to pay ongoing medical costs. Alternatively, Employee requests reimbursement of medical expenses incurred from the date of the after-claim controversion or since his August 16, 2021 amended claim. His hearing brief did not address related transportation costs.

Employer contends Employee's August 16, 2021 amended claim for a back, left knee and big toe injury relates back to the January 31, 2019 claim which was dismissed in its entirety in *Vanderpool I*. It contends the only difference between the claims was the narrative Employee added to the description of the nature of the injury which added a big toe injury and the medical costs he forgot to include on the first claim. Employer contends the entirety of Employee's second claim should be denied based upon res judicata. It contends Employee failed to timely file a claim and it should be barred under AS 23.30.105. Employer contends it is extremely prejudiced by the late filed claim as it prevented Employer from conducting its own investigation and raising defenses on the big toe injury. It contends there is no medical record documenting the big toe injury described in the description attached to the August 16, 2021 claim or prescribing the described course of treatment. Employer contends whether the work injury was the substantial cause of any disability or need for treatment for Employee's big toe is a complex medical issue and Employee failed to raise the presumption of compensability. It requests an order denying his August 16, 2021 claim.

1) Is Employee entitled to medical and transportation costs?

Employee contends his work injuries have reached maximum medical improvement (MMI). He requests an order directing Employer to pay for a permanent partial impairment (PPI) rating.

Employer contends Employee's second claim seeks the same PPI benefits requested in the first claim and the second claim is an attempt to salvage the PPI benefits dismissed in the first claim. It requests an order denying his August 16, 2021 claim for PPI benefits based upon res judicata.

2) Is Employee entitled to PPI benefits?

Employee's hearing brief did not address his claim for additional temporary total disability (TTD) benefits.

Employer contends Employee's second claim seeks the same TTD benefits requested in the first claim and the second claim is an attempt to salvage the TTD benefits dismissed in the first claim. It requests an order denying his August 16, 2021 claim for TTD benefits based upon res judicata.

3) Is Employee entitled to TTD benefits?

Employee's hearing brief did not address his claims for penalty and interest.

Employer contends Employee's second claim seeks the same penalties and interest requested in the first claim and the second claim is an attempt to salvage the penalties and interest dismissed in the first claim. It requests an order denying his August 16, 2021 claim for penalty and interest based upon res judicata.

4) Is Employee entitled to penalty and interest?

Employee's hearing brief did not address his request for a finding that Employer unfairly or frivolously controverted benefits.

Employer contends Employee's second claim requests the same finding of unfair or frivolous controvert requested in the first claim and the second claim is an attempt to salvage the dismissed request. It requests an order denying his August 16, 2021 claim for a finding of unfair or frivolous controvert based upon res judicata.

5) Is Employee entitled to a finding that Employer unfairly or frivolously controverted benefits?

Employee's hearing brief did not address his claim for attorney fees and costs and he did not file an affidavit of attorney fees and costs.

Employer contends Employee's second claim requests the same benefits sought in the first claim and should be denied based upon res judicata. It requests an order denying his August 16, 2021 claim for attorney fees and costs.

6) Is Employee entitled to attorney fees and costs?

FINDINGS OF FACT

The following facts and factual conclusions are established by a preponderance of the evidence or are reiterated from *Vanderpool I*:

1) On April 20, 2011, Employee reported his neck and upper back pain symptoms returned and were the same as when he was last seen. He treated with physical therapy for the last year and it was very effective. John Bursell, MD, prescribed additional physical therapy. (Bursell record, April 20, 2011).

2) From May 25, 2011 to August 6, 2012, Employee had 26 physical therapy appointments for neck pain, low back pain and tightness, particularly while lying in bed, and upper back/shoulder pain. (Physical Therapy Notes, May 25, 2011 to August 6, 2012).

3) From February 3, 2013 to May 8, 2013, Employee had 10 physical therapy appointments for neck and upper back pain and headaches. Cervical and thoracic MRIs demonstrated mild disc degeneration in his cervical spine without stenosis and thoracic disc extrusions. (Physical Therapy Notes, February 3, 2013 to May 8, 2013).

4) On August 21, 2014, Employee reported low back pain with right sciatica. His symptoms started the Sunday prior when he was at the gym doing an overhead press. Employee had right lower extremity weakness but no numbness. He took two days off from work for pain. Dr. Bursell prescribed a course of oral steroids, Vicodin and Flexeril. (Bursell record, August 21, 2014).

5) On January 23, 2015, Employee reported he was walking his dog the day before when he slipped and fell, landing on his buttocks and back of head. He went to the emergency room, underwent imaging and was prescribed narcotics. Employee's request for an additional prescription was denied. (Daniel Kim, MD, chart note, January 23, 2015).

6) On February 2, 2015, Employee was diagnosed with sciatica and back pain after slipping on ice on January 22, 2015, and a subsequent motor vehicle accident where he was hit from behind. He was prescribed oral steroids, Mobic and massage therapy. (Sarah Nieko, PA-C, progress note, February 2, 2015).

7) On June 15, 2015, Employee complained of right-sided sciatica. He had something similar five years ago when lifting and twisting but it went away after three or four weeks of mild pain medicine, nonsteroidals and muscle relaxants. Employee's current episode began a week earlier

for no clear reason. The pain radiates through his right buttocks and thigh to the lateral aspects of his right calf. Employee was prescribed Flexeril and Norco. (A. Malter, MD, chart note, June 15, 2015).

8) On February 5, 2016, Employee slipped on ice while getting out of his pickup and fell the day before. He impacted on his right gluteal area on the door ledge. Employee reported pain in his mid-upper sacrum and a radicular component down his right leg along the lateral thigh, behind the knee to the lateral malleolus. He was diagnosed with acute right sided lumbar radiculopathy and a single contusion and prescribed oxycodone. (Bartlett Regional Hospital Emergency Room Report, February 5, 2016).

9) On April 16, 2016, Employee complained of back pain after standing and falling off of a chair while working on a car and hitting the right side of his ribs and back on the fender. The pain radiated from right back down buttocks and thigh. He also had upper and lower lumbar spine pain radiating down to his right and left buttock. Employee was diagnosed with back pain, radiculopathy and right sided sciatica and was prescribed Flexeril and Vicodin. (Bartlett Regional Hospital Emergency Room Report, April 16, 2016).

10) On June 5, 2016, Employee went to the emergency room for right lower back pain that radiated down the back of his right leg. It began after a fall two days prior. Employee had full strength and no gross sensory deficit in his right lower extremity other than a chronic perineal nerve injury secondary to a gunshot wound in the right lower extremity lateral proximal calf area and he was unable to dorsiflex his big toe. He was diagnosed with acute low back pain and acute right lower extremity peripheral radiculopathy and prescribed ibuprofen and oxycodone-acetaminophen. (Maui Memorial Medical Center Emergency Room Report, June 5, 2016).

11) On September 12, 2016, Employee reported back pain that began two weeks prior; it had been waxing and waning. He had similar symptoms previously in June 2016 when he fell on the beach in Hawaii. Employee's current pain was similar in character to that incident but was slightly worse in intensity. He was diagnosed with acute lumbar spine pain and right sided sciatica, and prescribed hydrocodone. (Bartlett Regional Hospital Emergency Room Report, September 12, 2016).

12) On January 1, 2017, Employee reported a traumatic injury to multiple body parts caused by ice or snow. He did not otherwise describe the event. (*Vanderpool I*).

13) On January 1, 2017, Employee went to the emergency room complaining of mild left upper extremity pain in his forearm and wrist, moderate lower back pain with radiation to the left leg and left knee pain. He said he slipped on ice about one hour ago and landed forward on his left knee, hand and elbow. Employee reported a headache and neck pain. Left knee x-rays found no acute osseous abnormality. He was referred to Daniel Harrah, MD, and instructed to take over-the-counter Motrin. (Emergency room report, January 1, 2017; X-ray report, January 1, 2017).

14) On January 19, 2017, Dr. Harrah referred Employee for a left knee magnetic resonance imaging (MRI) and restricted Employee from working. (Harrah chart note, January 19, 2017; Return to Work Recommendation, January 19, 2017).

15) On January 2, 14 and 21, 2017, Employee treated at Juneau Urgent Care for left knee pain and upper central back pain after falling at work. (Juneau Urgent Care medical records, January 2, 14 and 21, 2017).

16) On January 24, 2017, a left knee MRI showed medial plica, nearly one centimeter wide abutting the medial patellar facet and mild ACL scarring with thickening, suggesting an old mild sprain but no bowing. (MRI report, January 24, 2017).

17) On January 26, 2017, Dr. Harrah injected Employee's left knee with Kenalog, lidocaine and Marcaine and Employee reported nearly instant relief. (Harrah chart note, January 26, 2017).

18) On February 9, 2017, a thoracic MRI demonstrated disc degeneration at T9-10 with desiccation, Schmorl's node formation and right three-millimeter paracentral disc extrusion, caudal extension of disc material in relation to the disc space and resultant thecal sac effacement; disc degeneration, disc space narrowing, endplate irregularity, and common Schmorl's node formation from T5 through T12 with small protrusions at T6-7 and T7-8 with no evidence of neural element compression or stenosis. (MRI report, February 9, 2017).

19) On February 13, 2017, Employee underwent a thoracic epidural catheter placement with subsequent epidural steroid injection with preferential flow at T5-6 through T9-10. (Operative report, February 13, 2017).

20) On February 16, 2017, Employee reported the left knee injection helped considerably but that he still had lateral pain where the impact occurred when he fell. Dr. Harrah referred him to physical therapy. If Employee's pain did not improve, then Dr. Harrah would recommend a steroid injection at the iliotibial band (ITB). If Employee's pain did not improve after the steroid

injection, he would recommend either another injection or arthroscopic plica resection. (Harrah chart note, February 16, 2017).

21) On March 10, 2017, Employee reported the thoracic epidural steroid injection really helped but the pain had since returned. John Bursell, MD, referred Employee for another injection and then physical therapy. (Bursell medical record, March 10, 2017).

22) Employee underwent physical therapy at Juneau Bone & Joint from March 22, 2017 through July 26, 2018. (Physical therapy notes, March 22, 2017 through July 26, 2018)

23) On March 23, 2017, Dr. Harrah stated,

> If the plica continues to be painful we could try another injection. He should also continue with physical therapy. If he wishes to proceed with surgery there would be a resection of the plica and I would expect him to recover fully and be able to use his knee normally. He may also require an injection of the ITB. I will see him back in two to three weeks for follow up. We also discussed the reason for his symptoms. He did not have any symptoms prior to the injury and I think that the injury was the reason that his knee became symptomatic. I would expect with the proper treatment that he would return to being asymptomatic. (Harrah chart note, March 23, 2017).

24) On April 25, 2017, Dr. Bursell responded to questions from the claim administrator and said Employee was not capable of returning to unrestricted work as a Juvenile Justice Officer, providing work restrictions, including limited lifting to 20 pounds, no grappling/restraining residents. He said the date of medical stability was unknown, but Employee would have a ratable impairment. (Bursell response, April 25, 2017).

25) On May 31, 2017, a lumbar spine MRI demonstrated an L5-S1 mild intervertebral annular disc bulge with a small broad-based central/left paracentral protrusion abutting the thecal sack and S1 nerve roots bilaterally and mild central canal stenosis; an L4-5 mild annular intervertebral disc bulge with a very small central protrusion and mild central canal stenosis; and small central right paracentral protrusion at T11-12 intervertebral disc. (MRI report, May 31, 2017).

26) On June 1, 2017, a cervical MRI showed mild changes of spondylosis unchanged from the prior study on May 5, 2010, with no evidence of disc herniation or stenosis. (MRI report, June 1, 2017).

27) On June 6, 2017, Employee stated his low back and right hip and leg symptoms were his primary concern. Dr. Bursell recommended selective spinal injection therapy. Employee reported trouble sleeping at night due to upper back pain and requested medication. Dr. Bursell

prescribed hydrocodone for use at night and referred him to another provider for physical therapy. (Bursell medical record, June 6, 2017).

28) On June 12, 2017, Dr. Bursell performed a right S1 transforaminal epidural steroid injection for low back pain with right lumbar radiculopathy. (Bursell operative report, June 12, 2017).

29) On July 19, 2017, Employee noted improved mobility but no pain relief from physical therapy, it helped with pain at the time, but it would return later. Dr. Bursell referred Employee to massage therapy. (Bursell medical record, July 19, 2017).

30) On August 1, 2017, Dr. Bursell responded to question from the claims administrator and stated Employee was not released to work at his last appointment and his estimated disability length was "to be determined." (Bursell response, August 1, 2017).

31) On August 8, 2017, Employee reported he was fishing last Thursday, and his left knee gave out and he fell. He bruised the front of his knee and scraped the front of his legs. Dr. Harrah reasoned the excellent relief Employee felt from the left knee steroid injection confirmed his knee pain was intraarticular. He recommended proceeding with surgery. There is no report of a big toe injury. (Harrah chart note, August 8, 2017). The Thursday before August 8, 2017 was August 3, 2017. (Observation).

32) On August 14, 2017, Employee reported his thoracic and lumbar pain symptoms were persisting and were essentially unchanged from when he was last seen. There have been no improvements over the last month even though he'd been working with physical and massage therapy. Dr. Bursell referred Employee to the Lake Washington Sports & Spine Clinic for a spine consultation. There is no report of a big toe injury. (Bursell medical record, August 14, 2017).

33) On September 12, 2017, Dr. Bursell recommended Employee see Leah Concannon, MD, at the Harborview Spine Clinic because the Lake Washington Sports & Spine Clinic does not see workers' compensation patients. (Bursell medical record, September 12, 2017).

34) On September 16, 2017, a lumbar spine MRI demonstrated minimal disc bulge more prominent on the left with no spinal stenosis and minor left foraminal narrowing at L1-2; minimal disc bulge more prominent extending into the left foramina with minor foraminal narrowing and no spinal stenosis at L2-3; shallow disc bulge with no significant spinal canal or foraminal stenosis at L3-4; broad based disc bulge mildly effacing the anterior fecal sack and traversing L5 nerve roots with mild spinal canal narrowing and mild bilateral formal narrowing

at L4-5; and moderate disc height loss and broad based disc protrusion with spondylosis at L5-S1 with mild bilateral foraminal narrowing and effacement of the anterior thecal sack and the traversing S1 nerve roots with moderate lateral recess of effacement and mild moderate spinal canal narrowing. A thoracic spine MRI showed mild degenerative disc disease and facet osteoarthritis. A cervical spine MRI showed minor degenerative changes. (MRI reports, September 16, 2017).

35) On November 22, 2017, Dr. Bursell reviewed a bone scan which showed a slight uptake in the left ninth rib and L3 spinous process with suspicion for prior trauma. (Bursell medical record, November 22, 2017).

36) On December 20, 2017, Employee reported his upper back pain had been increased over the last few weeks and he experienced dizziness he lays down on his back putting pressure on the painful area. When his upper back pain increased it caused neck pain and headaches. Employee's low back pain was unchanged, and he required hydrocodone every day or two. (Bursell medical record, December 20, 2017).

37) On March 6, 2018, Employee reported his upper back seemed to be improving but there was no change in his lower back pain symptoms. Dr. Bursell reviewed the pelvis MRI with Employee and stated it found no abnormality in the sacroiliac joints. Virginia Mason requested further information regarding his "workup." (Bursell medical record, March 6, 2018).

38) On April 19, 2018, Employee continued to have left knee pain in the same region along the medial retinaculum. He wanted to try another steroid injection because he got good relief from the previous injection. Dr. Harrah injected Employee's left knee with Kenalog lidocaine and Marcaine. Employee said his left pain went away and the pain radiating up and down the leg was also gone after the injection. (Harrah chart note, April 19, 2018).

39) On May 8, 2018, Employee's low back and upper back pain and symptoms were unchanged. (Bursell medical record, May 8, 2018).

40) On May 15, 2018, Employee reported a previous gunshot wound to the lower right leg when he was a teenager, which split the proximal peroneal nerve longitudinally without severing it. He had right foot drop for a couple of months and could dorsiflex his right foot but not his right big toe. He complained of mild numbness and tingling on the posterior aspect of his right thigh, anterior right lower leg, and on the top of his right foot and worsening right leg weakness causing him to fall several times because it gives out. Thomas Curtis, MD, assessed thoracic

back pain, lumbar sprain, left knee strain, cervical spondylosis, lumbar degenerative disc disease, L5-S1 disc protrusion, T11-12 disc protrusion, right arm and leg paresthesia and borderline calcium nutrition. He stated:

> It is possible that tingling in his right leg is caused by aggravation of right peroneal nerve by traction or compression during this industrial injury, the peroneal nerve being more susceptible to injury because of earlier traumatic injury to it. Today his right low back pain behaved more like discogenic etiology than like sacroiliac joint. Images were not available for me today. Discogenic pain can be caused by intrusion of nuclear material into the outer third of the anulus fibrosis. It is possible he has right lumbar facet joint pain, and medial branch block testing may be considered. I recommend x-rays to check for possible spondylosis and flexion and extension views to rule out abnormal movement. The popping in his lower back might or might not be his sacroiliac joints. Even though there was no pain on sacroiliac joint provocative testing today, injection of the sacroiliac joint still is a reasonable consideration. Neurological symptoms in both arms are curious. Electrodiagnosis of his arms and legs might be revealing. Consideration can be given to consultation with a neurologist. It is reasonable to check a vitamin D level and serologies looking for the possibility of inflammatory systemic disease. (Curtis consultation note, May 15, 2018).

41) On June 7, 2018, Dr. Bursell performed a right sided iliac joint steroid injection for low back pain. (Bursell operative report, June 7, 2018).

42) On July 2, 2018, Employee reported the right sided iliac joint steroid injection reduced his pain for two and a half hours and it gradually returned. Dr. Bursell stated it confirmed it as a "major player in the right sided low back symptoms." (Bursell medical report, July 2, 2018).

43) On July 23, 2018, Employee continued to experience recurrent low back pain due to his sacroiliac joint and no changes were reported. (Bursell medical report, July 23, 2018).

44) On August 9, 2018, Dr. Harrah recommended a left knee arthroscopic evaluation resection of the plica and evaluation of the menisci and other structures. He expected the recovery to be fairly straightforward and anticipated Employee would have a significant decrease in left knee pain. (Harrah chart note, August 9, 2018).

45) On September 10, 2018, Dr. Curtis assessed persistent mechanical low back pain and referred Employee for a neurosurgery spine consultation and to pain management. Employee asked about non-addictive pain relief medicines and Dr. Curtis said Employee's primary care provider may wish to consider duloxetine or gabapentin. He provided Employee a one-month supply of

duloxetine and directed him to follow up with his primary care provider. (Curtis clinic note, September 10, 2018).

46) On October 4, 2018, Employee reported continuing to experience left lateral foot pain from an inversion injury a number of months ago. Dr. Bursell stated the left lateral foot pain may represent cuboid syndrome and Employee did well with cuboid mobilization maneuver and taping. He prescribed a trial of gabapentin for pain control. (Bursell record, October 4, 2018).

47) On October 8, 2018, a lumbar spine MRI showed mild multi-level lumbar degenerative spondylosis, greatest at L4-5 and L5-S1, with no high grade central or neural femoral narrowing, mildly narrowed lateral recesses at L4-5 and L5-S1 and mild generalized L5-S1 disc bulge which may contact the traversing S1 nerve roots but it was "of uncertain clinical relevance." It found no evidence of nerve root impingement. (MRI report, October 8, 2019).

48) On October 8, 2018, Employee reported back pain and discomfort going down his right leg since a slip and fall on ice on January 1, 2017. He tried oral medications, physical therapy, home exercise, an epidural and sacroiliac (SI) joint injections. Employee reported the most relief from the SI injection. He complained of cracking and popping in his back. Robert Ryan, MD, reviewed Employee's MRI "which actually looks very good" as he had no significant central or foraminal stenosis in his lumbar spine. While it showed "some small broad-based disks" and "a little bit of loss of height at L5-S1," it was "quite minimal overall." Dr. Ryan reassured Employee the popping or shifting he sensed was not associated with any significant mechanical instability as his x-rays showed no evidence of instability with dynamic movements. He opined there was no role for surgery for Employee's back or leg pain at this time because there was no obvious area of tight narrowing or of a large-herniated disk fragment causing nerve root compression or instability. Dr. Ryan encouraged Employee to follow up with Dr. Bursell and consider more injection therapy and to continue to work on core strength, stretching and flexibility. (Ryan consultation report, October 8, 2018).

49) On October 8, 2018, an electrodiagnostic evaluation found Employee's nerve conduction in his upper and lower extremities were normal, with the exception of absent peroneal motor responses from the extensor digitorum brevis. It found no evidence of right lower extremity neuropathy or radiculopathy. (Electromyography report, October 8, 2018).

50) On October 8, 2018, Nicholas Eley, PA-C, evaluated Employee for a possible spinal surgical intervention. He opined no urgent surgical intervention was warranted as Employee had a very

mild disc protrusion and his foramen appear fairly wide open. Dr. Eley noted the mild degenerative changes were worse on Employee's left when compared to the right which also supported continued conservative management because the left side was his main side of pain. He found neurosurgical intervention unlikely to improve his low back pain at this time. Dr. Eley recommended continuing with SI joint injections and possibly even facet blocks or injections continuing to follow up with the chronic pain doctor. He concluded Employee was not a candidate for a SI joint fusion because he did not have significant pain with provocative maneuvers or pressure over the SI joint. (Eley chart note, October 8, 2018).

51) On October 17, 2018, R. David Bauer, MD, examined Employee for an employer's medical evaluation (EME) and diagnosed a left lower extremity contusion without evidence of any objective or permanent harm to the structure of the body, lumbar spine and sacroiliac joint sprains, preexisting lumbar degenerative disease with no evidence of aggravation or of radiculopathy or other objective condition within the lumbar spine. Dr. Bauer stated the cause of the contusion and sacroiliac joint injury was the work injury. He opined no further medical treatment was necessary for any condition. Dr. Bauer found no objective finding to suggest that left knee arthroscopic surgery would be indicated as Employee had, and always has had, a negative McMurray and the MRI did not show a meniscal tear. He said the odds of there being a clinically significant meniscal tear that was missed on the MRI is less than five to ten percent. Dr. Bauer concluded the medial plica was not a substantial source of Employee's symptoms because the current findings of subjective tenderness upon examination were lateral. A sacroiliac joint fusion was not indicated for Employee's mechanical nonspecific pain with no major pelvic fracture or significant abnormalities. Dr. Bauer opined surgical intervention was not necessary for Employee's lumbar spine because his spine did not appear to be the major source of his condition and a fusion or disc replacement is not likely to improve his symptoms to any significant degree. He stated Employee reached medical stability, had no permanent impairment rating and the medical treatment had been reasonable and necessary. Dr. Bauer "would not recommend any palliative care" and specifically stated he would not recommend ongoing use of narcotic medication given Employee's history of depression and anxiety and found no condition for which gabapentin would be indicated. The "Past Medical History" provided by Employee did not include the previous gunshot wound, the "History of Present Illness" provided by Employee did not include a big toe injury, and Employee's "Current Pain

Complaints" did not include his big toe. Employee did not include pain in his big toe on the "Pain Diagram" he filled out. (Bauer EME report, October 17, 2018).

52) Employer paid TTD benefits from January 2, 2017 to October 21, 2018. (SROI, May 17, 2019).

53) On October 22, 2018, Thomas Curtis, MD, opined Employee had not reached MMI. He concluded left knee diagnostic arthroscopy surgery was indicated and prudent to repair impairment found, such as possible plica or meniscus tear. Dr. Curtis recommended a thoracic spine MRI if one had not yet been obtained and a possible medial branch block, followed up radiofrequency ablation at the mid-thoracic level. (Curtis clinic note, October 22, 2018).

54) On October 30, 2018, Dr. Bursell referred Employee to physical therapy for his upper back pain symptoms, to Dr. Harrah for left knee arthroscopy and refilled the hydrocodone prescription and provided a new prescription for gabapentin, which had been helpful in dulling pain symptoms. (Bursell medical record, October 30, 2018).

55) On November 9, 2018, Employer denied all benefits based upon Dr. Bauer's EME report:

> Per Dr. R. David Bauer's October 17, 2018 Employer's Independent Medical Evaluation report the employee is "medically stable" and there is no Permanent Partial Impairment as a result of the January 1, 2017 work related slip and fall.
>
> Per Dr. Bauer's report the medical treatment the employee has received has been reasonable and necessary and no further medical treatment is necessary for any condition diagnosed. (Controversion Notice, November 9, 2018).

56) On November 27, 2018, Employee reported his right lower back pain was unchanged from when he last saw Dr. Bursell, and his left knee continued to bother him. Dr. Bursell disagreed with Dr. Bauer's EME report regarding medical stability for Employee's sacroiliac dysfunction, but provided no reason, and his left knee because his left knee would likely benefit from arthroscopy. (Bursell report, November 27, 2018).

57) On December 18, 2018, Employee reported his pain symptoms were essentially unchanged. He said that nine days ago he was walking, and his left knee buckled, causing him to injure his right first toe. Employee could not dorsiflex the first toe due to a prior injury and it was rolled under his good to plantar flexion. Since then, he experienced "a bit of first toe pain." Dr. Bursell diagnosed a likely sprained right first metatarsophalangeal joint and recommended he

wear a stiff soled shoe and limit weight bearing. Imaging was only recommended if the pain did not improve over the next week. (Bursell record, December 18, 2018).

58) On January 15, 2019, Employee reported burning upper back pain and a sharp pain in his right lower back while bending over to change a filter on his truck. There was no mention of continuing big toe pain. (Bursell record, January 15, 2019).

59) On January 31, 2019, Employee sought TTD and PPI benefits, transportation costs, a finding of unfair or frivolous controvert, a penalty for late paid benefits, interest and attorney's fees and costs as he "slipped on ice that had been irregularly placed" and injured his left knee and back. (*Vanderpool I*).

60) On February 21, 2019, Employer denied Employee was entitled to transportation costs and TTD benefits after October 17, 2018 because he reached medical stability, PPI benefits because he did not suffer a permanent impairment, a finding of unfair or frivolous controvert because its controversion was based upon Dr. Bauer's EME report, and penalty for late paid compensation, interest and attorney fees and costs because it timely paid all benefits. (Answer, February 21, 2019).

61) On February 27, 2019, Dr. Bursell responded to questions from Employee's attorney. He diagnosed thoracic back pain with T9-10 disc extrusion, low back pain with right sacroiliac joint dysfunction and left knee pain with possible symptomatic plica and opined the work injury was the substantial cause of Employee's disability and need for treatment. Dr. Bursell answered the work injury had not resolved at this time and a left knee arthroscopy, right sacroiliac joint stabilization procedure - prolotherapy or fusion therapy were required and the work injury was the substantial cause of his ongoing need for medical treatment. He opined Employee did not reach medical stability and he disagreed with Dr. Bauer's EME reports. Dr. Bursell expected Employee to have a ratable permanent impairment at medical stability. (Bursell response, February 27, 2019).

62) On February 28, 2019, Employer filed and served upon Employee by first-class mail a controversion notice denying all benefits effective October 17, 2018:

> Per Dr. R. David Bauer's October 17, 2018 Independent Medical Evaluation report, the employee is "medically stable" as of October 17, 2018 and there is no Permanent Partial Impairment as a result of the January 1, 2017 work related slip and fall.

> Per Dr. Bauer's report, the medical treatment the employee has received has been reasonable and necessary and no further medical treatment is necessary for any condition diagnosed. All benefits are denied as of the date of medical stability of October 17, 2018. (Controversion Notice, February 28, 2019).

63) On March 27, 2019, Employee said his upper back pain decreased somewhat but his lower back pain remained unchanged. He fell on stairs when hip and back pain caused his leg to give out. Dr. Bursell noted Employee used hydrocodone and ibuprofen for pain control. (Bursell medical record, March 27, 2019).

64) On May 22, 2019, Employee reported no change to his thoracic or lumbar spine and intermittent right heel pain which tended to arise when he was off his feet. Oral steroids did not help with decreasing pain symptoms. Employee went on a trip to Georgia recently which caused his pain to increase. Dr. Bursell continued hydrocodone medication. (Bursell medical record, May 22, 2019).

65) On May 30, 2019, Employee filed Dr. Bursell's February 27, 2019 response. (Medical Summary, May 30, 2019).

66) On June 2, 2019, Dr. Bauer reviewed Dr. Bursell's December 20, 2017 record, Dr. Curtis' September 10, 2018 record, Dr. Ryan's October 8, 2018 record, Dr. Eley's October 8, 2018 record and the October 8, 2018 lumbar spine MRI and electrodiagnostic study. He stated the additional records did not change his opinion. Dr. Bauer said arthroscopic left knee surgery is "not indicated, would not be beneficial and would not be related to any condition caused by" the work injury as plica are not caused by industrial injuries nor are they aggravated by the contusion Employee suffered. He also noted exploratory surgery to determine whether there is a left knee meniscal tear not seen on imaging is often not successful. Dr. Bauer noted the neurosurgery evaluation demonstrates normal age-appropriate lumbar spine degenerative changes, which are not an explanation for Employee's ongoing pain. He concluded no further treatment was needed for Employee's lumbar spine. (Bauer addendum EME report, June 2, 2019).

67) On June 12, 2019, Employee reported his thoracic and lumbar back pain remained unchanged. He managed the pain with hydrocodone and gabapentin. (Bursell record, June 12, 2019).

68) On July 16, 2019, Employee reported increased right-sided lower back pain; it felt like his right SI joint was popping in and out of place causing pain to radiate down his right leg. Dr. Bursell recommended prolotherapy. (Bursell record, July 16, 2019).

69) On August 15, 2019, Employee said his pain symptoms persisted in his upper and lower back, right SI joint region and he experienced difficulty managing pain. His left knee also continued to hurt. Employee continued to manage pain with hydrocodone and gabapentin. (Bursell record, August 15, 2019).

70) On September 11, 2019, Dr. Bursell was waiting for insurance approval before further treatment was provided. He continued Employee's hydrocodone and gabapentin medications. (Bursell record, September 11, 2019).

71) On September 17, 2019, Employee was taken by ambulance to the emergency room. Four hours earlier he had been working with a shampooer and believed it aggravated an old back injury he sustained two years ago. (Capital City Fire Rescue City and Borough of Juneau Patient Care Report, September 17, 2019). Employee reported tingling in both feet, which was a new symptom. His pain was in his upper lumbar spine, and it radiated to the right and left buttock, right side was worse than the left. Employee was given fentanyl which did not significantly change his pain. He had chronic L5/S1 back pain since he fell on ice and it was still present. Employee reported having similar symptoms several times, including an episode similar to this one two weeks ago with acute pain and spasm. (Bartlett Regional Hospital Emergency Room Report, September 17, 2019).

72) On September 24, 2019, Employee followed up with Dr. Bursell after experiencing severe lower back pain on September 17, 2019 when he stood up from shampooing the carpet. He was evaluated at the ER, treated with diazepam and given an oral steroid prescription. Employee said the diazepam was helpful in symptom control, but he did not start the oral steroid. Dr. Bursell recommended taking oral steroids and refilled hydrocodone and diazepam prescriptions. (Bursell record, September 24, 2019).

73) On October 23, 2019, Employee reported his lower back went out again last Saturday and he was able to rest and calm it down. He also reported a 20-minute episode at night when he woke up with lower back pain with right lower extremity numbness and weakness. The right lower extremity function slowly returned to normal, but Employee had to be careful with how he walked as his right leg did not "feel stable." Dr. Bursell recommended Employee monitor for recurrent of radicular symptoms and refilled hydrocodone and diazepam prescriptions. (Bursell record, October 23, 2019).

74) On November 19, 2019, Employee reported he still experienced aching in his lower back but it had not “gone out” since his last appointment. He also complained of bilateral intermittent lower extremity pain. Employee managed his pain with gabapentin and hydrocodone. (Bursell record, November 19, 2019).

75) On December 4, 2019, Employee reported his lower back “locked up again” four days ago but he was able to rest and work through it over time. Two days prior he woke up with significant pain in his right anterior thigh requiring a small amount of hydrocodone for pain control. Employee’s SI joint pain was persisting. He was interest in scheduling prolotherapy to treat the right SI joint instability. Dr. Bursell ordered a lumbar spine MRI for right SI joint prolotherapy and refilled the hydrocodone prescription. (Bursell record, December 4, 2019).

76) On December 6, 2019, a lumbar spine MRI showed, “Mild annular bulge of the L5-S1 enter vertebral disc with a small broad based central/left paracentral protrusion abutting the thecal sack and S1 nerve roots bilaterally unchanged. Mild central canal stenosis. Mild annular bulge of the L4-5 intervertebral disc with a very small central protrusion unchanged. Mild central canal stenosis. Small central right paracentral protrusion of the T11-12 intervertebral disc unchanged. No interval change compared with 05/31/2017.” (MRI report, December 6, 2019).

77) On April 13, 2020, Dr. Bursell wrote a letter stating:

> Jason Vanderpool is a patient who is under my care for treatment of a work injury which occurred on 01/01/17. This injury has resulted in lower back pain with right sacroiliac joint dysfunction, right lower extremity radicular pain with underlying L5-S1 disc bulge/protrusion and left knee pain. He is currently treated with conservative interventions for the lumbar spine and right sacroiliac joint. If these are ineffective then surgical intervention with L5-S1 discectomy and right sacroiliac joint fusion may be necessary. Mr. Vanderpool has also been under the care of his left knee injury with Daniel Harrah MD, orthopedic surgery, who has recommended treatment with a left knee arthroscopy to address a symptomatic plica. (Bursell Letter, April 13, 2020).

78) On June 16, 2021, Employer requested Employee’s January 31, 2019 claim be dismissed under AS 23.30.110(c), contending he had not requested a hearing within two years of Employer’s February 28, 2019 post-claim controversion. It also requested a written record hearing on its petition. (*Vanderpool I*).

79) On July 1, 2021, Employee followed up after a bilateral L4-5 medial branch block and stated he felt relief for an hour and then the pain returned. He noted his right heel pain also resolved

when his lower back pain decreased. Employee elected to proceed with confirmatory blocks at the bilateral L4- and L5 medial branch blocks in preparation for radiofrequency neural ablation procedures. (Bursell medical record, July 1, 2021).

80) On August 2, 2021, Employer denied all benefits:

> On February 28, 2019, the employer filed a Controversion Notice in response to the Workers' Compensation Claim filed by the employee on January 31, 2019.
>
> Per AS 23.30.110(c), "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."
>
> The employee has not requested a hearing and over two years has passed since the filing of the controversion notice. Therefore, all benefits[sic] are denied under AS 23.30.110(c). (Controversion Notice, August 2, 2021).

81) On August 16, 2021, Employee sought TTD and PPI benefits, past and future medical costs, transportation costs, a penalty for late paid compensation, interest, an unfair or frivolous controversion finding, and attorney's fees and costs for his same work injury date. He described the injury as, "Slipped on ice that had been irregularly placed. Left knee and back injuries. See attached." Employee also attached the following statement under the description of the injury:

> My leg went out (as it frequently does) and I fell in August 2017 while fishing and messed up my big toe. It got better, then worse, and in 2019 I went to the doctor. He wanted to do x-rays and an MRI, but I could not afford it because I did not have insurance. It started bothering me again and got progressively worse. Now that I have insurance, I went to the doctor again to get it checked. He took x-rays and said that I have arthritis in that toe due to a traumatic injury, which he said was a direct result of the fall that I had in 2017. He gave me a steroid shot to see if it would help, and it did. It is supposed to last about 3 months. The doctor said the only way to really fix it is to do surgery to remove the joint and put a plate in. The toe thing was a direct result of me falling. The fall was a direct result of my workplace injury, which caused my leg to give out due to my SI joint. (Amended Claim for Workers' Compensation Benefits, August 16, 2021).

82) On September 9, 2021, Employer denied all benefits related to Employee's foot and great toe contending there is no medical evidence relating the work injury to a fall on an unspecified date in August 2017, nor is there medical evidence proving the work injury is the substantial cause of his need for foot or toe treatment. (Controversion Notice, September 9, 2021).

83) On December 28, 2021, *Vanderpool I* issued and granted Employer's petition to dismiss Employee's January 13, 2019 claim for failing to strictly or substantially comply with AS 23.30.110(c). It dismissed Employee's January 31, 2019 claim but did not dismiss Employee's August 16, 2021 amended claim because Employer did not request dismissal of it in its petition or brief and it was not set as an issue for hearing. *Vanderpool I* concluded it could not address whether Employee's August 16, 2021 amended claim survived dismissal of his January 31, 2019 claim. (*Vanderpool I*).

84) On January 18, 2022, Employee said he had been planning to move down south and have surgery, but it did not work out and he was moving back to Juneau. He reported that about one-and-a-half months prior he developed pain in his anterior thighs, and it had increased over time. Employee described the pain as stabbing, aching and dull and greater on the right than the left. It felt like something "shifted in his back." His right heel pain resolved but his lower extremity weakness increased. Dr. Bursell diagnosed radiculopathy and prescribed oral steroids and refilled the hydrocodone prescription. (Bursell record, January 18, 2022).

85) On February 11, 2022, Employee said the medications helped him function but his low back pain with radiculopathy remained unchanged since completing oral steroids. Dr. Bursell prescribed hydrocodone to help manage his symptoms while he was out of town moving back to Juneau. He discussed possibly referring Employee for an updated lumbar spine MRI once Employee obtained insurance coverage due to increased pain symptoms. (Bursell record, February 11, 2022).

86) On March 16, 2022, Employee reported his low back pain with sacroiliac dysfunction and lumbosacral radiculopathy symptoms remained unchanged except the right heel pain returned. He said he recently fell due to sudden onset of sharp lower back pain while walking on uneven ground. Employee managed chronic pain with hydrocodone, ibuprofen and gabapentin. Dr. Bursell refilled his prescriptions. (Bursell record, March 16, 2022).

87) On April 13, 2022, Employee reported an increased burning sensation at L5-S1 for the last week and a half and increased right heel pain. He also complained of an increase in upper right back pain that tended to come and go. In five weeks, Employee expected to get insurance and would be able to pursue a new lumbar spine MRI. He continued to use hydrocodone, gabapentin and ibuprofen for pain control. Dr. Bursell diagnosed persistent lower back pain with

lumbosacral radiculopathy. He felt the right-sided lower back was likely myofascial in nature. Employee declined a trigger point injection. (Bursell record, April 13, 2022).

88) On April 20, 2022, Dr. Bursell spoke with Employee's attorney to provide an update on the current treatment plan which included obtaining a lumbar spine MRI scan, continued pain management and consideration for surgical consultation versus repeat selective spinal injections/ prolotherapy depending on the MRI findings. (Bursell note, April 20, 2022).

89) On May 11, 2022, Employee said his symptoms were unchanged. Dr. Bursell stated he was stable with the medication used to manage his chronic pain symptoms. He refilled the hydrocodone prescription. (Bursell record, May 11, 2022).

90) On May 31, 2022, Employee reported increased pain due to increased activity with nice weather. He felt pain in the lower back radiating to his knees and intermittently to his right heel and in the right sacroiliac joint region when he put his right foot down on the ground. Employee complained of left knee pain and said it felt like something inside the knee caught when he squatted and then stood up. He said the gabapentin helped with the radicular heel pain. Dr. Bursell ordered a lumbar spine MRI. (Bursell record, May 31, 2022).

91) On July 13, 2022, Employee told Dr. Bursell he was unable to get the MRI due to unexpected travel and reported his pain had not improved since the last visit. (Bursell record, July 13, 2022).

92) On November 2, 2022, Employee stated his chronic low back pain with right lumbosacral radiculopathy and left knee pain persisted and he ran out of medication a month ago. He was managing his pain with high doses of ibuprofen. Dr. Bursell resumed treatment with gabapentin and hydrocodone. (Bursell record, November 2, 2022).

93) On November 30, 2022, Employee continued to have low back pain with pain radiating down into his left leg that was worse at night. He used hydrocodone and gabapentin to manage chronic pain. Dr. Bursell refilled the hydrocodone prescription. (Bursell record, November 30, 2022).

94) On December 22, 2022, Dr. Bursell refilled hydrocodone for persistent and chronic low back pain with right lumbosacral radiculopathy. (Bursell record, November 30, 2022).

95) On January 18, 2023, Employee reported the low back pain with right lower extremity radicular pain and thoracic back pain symptoms increased over the last couple of months and was limiting his activities. He used hydrocodone, gabapentin and ibuprofen to control the pain symptoms. Dr. Bursell refilled hydrocodone and gabapentin for persistent and chronic low back

pain with right lumbosacral radiculopathy and thoracic back pain symptoms. (Bursell record, January 18, 2023).

96) On February 15, 2023, Employee reported increased right-sided low back pain and SI joint pain and increased right leg weakness, especially when getting up from bed. He used hydrocodone, gabapentin and ibuprofen to control the pain symptoms. Dr. Bursell refilled his prescriptions. (Bursell record, February 15, 2023).

97) On March 13, 2023, Employee felt increased weakness in both legs for the past week and reported a throbbing sensation in his right leg. He used hydrocodone, gabapentin and ibuprofen to control the pain symptoms. Dr. Bursell refilled the hydrocodone prescription. (Bursell record, March 13, 2023).

98) On April 11, 2023, Employee continued to experience intermittent weakness in both legs. He used hydrocodone, gabapentin and ibuprofen to control the pain. Dr. Bursell refilled the hydrocodone prescription. (Bursell record, April 11, 2023).

99) On May 31, 2023, Employee reported increased back pain in his lower right side making sleep difficult and a throbbing sensation in his right leg. He used hydrocodone, gabapentin and ibuprofen to control the pain symptoms. Dr. Bursell refilled the hydrocodone prescription. (Bursell record, May 31, 2023).

100) On February 22, 2023, Employer controverted the benefits sought in Employee's January 31, 2019 claim, contending *Vanderpool I* dismissed his previous claim in its entirety. (Controversion Notice, February 22, 2023).

101) On January 23, 2023, Employee filed a medical summary with the medical records from Dr. Bursell dated January 18, 2022 to May 31, 2023. (Medical Summary, January 23, 2023).

102) On September 29, 2023, the Board designee scheduled a written record hearing on Employee's August 16, 2019 amended claim for TTD and PPI benefits, medical and transportation costs, penalty, interest, a finding of unfair and frivolous controvert and attorney's fees and costs. (Prehearing Conference Summary, September 29, 2023).

PRINCIPLES OF LAW

AS 23.30.001. Legislative intent. It is the intent of the legislature that

> (1) this chapter be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter;
>
> (2) workers' compensation cases shall be decided on their merits except where otherwise provided by statute;

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 23.30.095. 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. However, if the condition requiring the treatment, apparatus, or medicine is a latent one, the two-year period runs from the time the employee has knowledge of the nature of the employee's disability and its relationship to the employment and after disablement. 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 medical care is required, the injured employee may designate a licensed physician to provide all medical and related benefits. . . .
>
> (o) Notwithstanding (a) of this section, an employer is not liable for palliative care after the date of medical stability unless the palliative care is reasonable and necessary (1) to enable the employee to continue in the employee's employment at the time of treatment, (2) to enable the employee to continue to participate in an approved reemployment plan, or (3) to relieve chronic debilitating pain. A claim for palliative care is not valid and enforceable unless it is accompanied by a certification of the attending physician that the palliative care meets the requirements of this subsection. A claim for palliative care is subject to the requirements of (c) - (n) of this section. If a claim for palliative care is controverted by the employer, the board may require an evaluation under (k) of this section regarding the disputed palliative care. A claim for palliative care may be heard by the board under AS 23.30.110.

Injured workers must weigh many variables when deciding whether to pursue a certain course of medical or related treatment. An important treatment consideration in many cases is whether a physician's recommended treatment is compensable under the Act. *Summers v. Korobkin*, 814

P.2d 1369, 1372 (Alaska 1991). Thus, an injured worker is entitled to a hearing and a prospective determination on whether medical treatment for his injury is compensable. *Id.* at 1373-74.

> **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, and the right to compensation for death is barred unless a claim therefor is filed within one year after the death, except that, if payment of compensation has been made without an award on account of the injury or death, 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.
>
> (b) Failure to file a claim within the period prescribed in (a) of this section is not a bar to compensation unless objection to the failure is made at the first hearing of the claim in which all parties in interest are given reasonable notice and opportunity to be heard.

The statute of limitations under AS 23.30.105(a) is an affirmative defense which must be raised in response to a claim. *Horton v. Nome Native Community Ent.*, AWCB Decision No. 94-0139 (June 16, 1994). The employer bears the burden of proof to establish the affirmative defense the claimant failed to timely file a claim. *Egemo v. Egemo Construction Co*., 998 P. 2d 434, 438 (Alaska 2000). The purpose of AS 23.30.105(a) is to "'protect the employer against claims too old to be successfully investigated and defended.'" *Morrison-Knudson Co. v. Vereen,* 414 P.2d 536, 538 (Alaska 1966) (citing 2 Larson, Workmen's Compensation s 78.20 at 254 (1961)). However, an employee must have "actual or chargeable knowledge of his disability and its relation to his employment" to start the running of the two-year period under §105(a). *Collins v. Arctic Builders, Inc.,* 31 P.3d 1286, 1290 (Alaska 2001). In *Leslie Cutting Inc. v. Bateman*, 833 P.2d 691 (Alaska 1992), the Alaska Supreme Court (Court) clarified that when an injured worker believed a condition was controlled by medication, the statute of limitations at AS 23.30.105(a) started running only when the worker discovered the treatment no longer controlled the disability. *Id.* at 694. "The mere awareness of the disability's full physical effects is not

sufficient" to trigger the running of the statute. *Id.* The statute is only triggered when "one knows of the disability's full effect on one's earning capacity." *Id.* Similarly, in *Egemo*, the Court held the statute of limitations at AS 23.30.105(a) starts running only when the injured worker (1) knows of the disability, (2) knows of its relationship to the employment, and (3) must actually be disabled from work. *Id.* at 441. A claim is not "ripe," requiring filing under AS 23.30.105(a) until the work injury causes wage loss. *Id.* at 438-439.

> **AS 23.30.110. Procedure on claims.** . . . (c) . . . 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.

Tipton v. ARCO Alaska, Inc., 922 P.2d 910, 913 n. 4 (Alaska 1996) noted dismissal under AS 23.30.110(c) does not prevent the employee from applying for different benefits, or raising other claims, based upon a given injury. The Court distinguished dismissal of a specific claim from dismissal of the entire case, stating AS 23.30.110(c) is not a comprehensive "no progress rule." *Wagner v. Stuckagain Heights*, 926 P.2d 456, 459 n. 7 (Alaska 1996). Over the lifetime of a workers' compensation case, many claims may be filed as new disablements or medical treatments occur. *Egemo* held, "new medical treatment entitles a worker to restart the statute of limitations for medical benefits."

In *Bailey v. Texas Instruments*, 111 P.3d 321 (Alaska 2005), the Court held dismissal of a claim does not necessarily preclude an employee from filing a later claim for medical costs incurred subsequent to that dismissal. Dismissal under AS 23.30.110(c) can create a later issue. In *University of Alaska Fairbanks v. Hogenson*, AWCAC Decision No. 074 (February 28, 2008), the Alaska Workers' Compensation Appeals Commission (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.

The Court has held res judicata, or claim preclusion, applies to workers' compensation cases. However, "it is not always applied as rigidly in administrative proceedings as it is in judicial proceedings. When applicable, res judicata precludes a subsequent suit 'between the same parties asserting the same claim for relief when the matter raised was or could have been decided in the first suit.' It requires that '(1) the prior judgment was a final judgment on the merits, (2) a court of competent jurisdiction rendered the prior judgment, and (3) the same cause of action and same parties or their privies were involved in both suits.'" The rule against claim splitting provides that "all claims arising out of a single transaction must be brought in a single suit, and those that are not become extinguished by the judgment in the suit in which some of the claims were brought." When analyzing claim splitting, "the relevant inquiry is not whether the two claims are grounded in different theories, but whether they arise out of the same transaction or core set of facts." *Robertson v. American Mechanical, Inc.*, 54 P.3d 777, 780 (Alaska 2002).

McKean v. Municipality of Anchorage, 783 P.2d 1169 (Alaska 1989), held res judicata applies in workers' compensation cases and set forth the test to determine when res judicata or its subset collateral estoppel may be applied in a particular workers' compensation case:

> (1) The plea of collateral estoppel must be asserted against a party or one in privity with a party to the first action;
>
> (2) The issue to be precluded from relitigation by operation of the doctrine must be identical to that decided in the first action;
>
> (3) The issue in the first action must have been resolved by a final judgment on the merits. *Id*. at 1171.
>
> **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;

Benefits sought by an injured worker are presumptively compensable and the presumption applies to any claim for compensation under the Act. *Meek v. Unocal Corp*., 914 P.2d 1276 (Alaska 1996). The presumption's application involves a three-step analysis. To attach the presumption, and without regard to credibility, an injured employee must first establish a "preliminary link" between his injury and the employment. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 610 (Alaska 1999). Medical evidence may be needed to attach the presumption of compensability in a complex medical case. *Burgess Constr. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). In less complex cases, lay evidence may be sufficiently probative to establish the link. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985).

Once the presumption attaches, and without regard to credibility, the employer must rebut the raised presumption with "substantial evidence." *Huit v. Ashwater Burns, Inc*., 372 P.3d 904 (Alaska 2016). If the employer's evidence rebuts the presumption, it drops out and the employee must prove his claim by a preponderance of the evidence. *Id*. This means the employee must "induce a belief" in the factfinders' minds that the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). In the third step, evidence is weighed, inferences are drawn, and credibility is considered. *Huit*. The Court has repeatedly held the fact symptoms arose after an event is insufficient to establish causation in workers' compensation cases. *Lindhag v. State*¸123 P.3d 948 (Alaska 2005); *Rivera v. Wal-Mart Stores, Inc.*, 247 P.3d 957 (Alaska 2011); *Buchinsky v. The Arc of Anchorage*, Slip Op. S-15547 (Alaska 2016).

> **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.

The board's credibility findings and weight accorded evidence are "binding for any review of the Board's factual finding." *Smith v. CSK Auto, Inc.*, 204 P.3d 1001; 1008 (Alaska 2009). If the board is faced with two or more conflicting medical opinions, each of which constitutes substantial evidence, it may rely on one opinion and not the other. *DeRosario v. Chenega Lodging*, 297 P.3d 139, 147 (Alaska 2013). The board alone is charged with determining the

weight it will give to medical reports. *Smith v. University of Alaska, Fairbanks*, 172 P.3d 782, 791 (Alaska 2007).

> **AS 23.30.145. Attorney fees.** (a) Fees for legal services rendered in respect to a claim are not valid unless approved by the board, and the fees may not be less than 25 percent on the first $1,000 of compensation or part of the first $1,000 of compensation, and 10 percent of all sums in excess of $1,000 of compensation. When the board advises that a claim has been controverted, in whole or in part, the board may direct that the fees for legal services be paid by the employer or carrier in addition to compensation awarded; the fees may be allowed only on the amount of compensation controverted and awarded. When the board advises that a claim has not been controverted, but further advises that bona fide legal services have been rendered in respect to the claim, then the board shall direct the payment of the fees out of the compensation awarded. In determining the amount of fees the board shall take into consideration the nature, length, and complexity of the services performed, transportation charges, and the benefits resulting from the services to the compensation beneficiaries.
>
> (b) If an employer fails to file timely notice of controversy or fails to pay compensation or medical and related benefits within 15 days after it becomes due or otherwise resists the payment of compensation or medical and related benefits and if the claimant has employed an attorney in the successful prosecution of the claim, the board shall make an award to reimburse the claimant for the costs in the proceedings, including reasonable attorney fees. . . .
>
> **AS 23.30.155. Payment of compensation.** (a) Compensation under this chapter shall be paid periodically, promptly, and directly to the person entitled to it, without an award, except where liability to pay compensation is controverted by the employer. . . .
>
> (b) The first installment of compensation becomes due on the 14th day after the employer has knowledge of the injury or death. On this date all compensation then due shall be paid. Subsequent compensation shall be paid in installments, every 14 days . . . .
>
> (d) . . . . If the employer controverts the right to compensation after payments have begun, the employer shall file with the division . . . a notice of controversion not later than the date an installment of compensation payable without an award is due.
>
> (e) If any installment of compensation payable without an award is not paid within seven days after it becomes due . . . there shall be added to the unpaid installment an amount equal to 25 percent of the installment.
>
> . . . .

> (o) The director shall promptly notify the division of insurance if the board determines that the employer's insurer has frivolously or unfairly controverted compensation due under this chapter. After receiving notice from the director, the division of insurance shall determine if the insurer has committed an unfair claim settlement practice under AS 21.36.125.
>
> (p) An employer shall pay interest on compensation that is not paid when due. . . .

An employer must begin paying benefits within 14 days after receiving knowledge of an employee's injury, and continue paying all benefits claimed, unless or until it formally controverts liability. *Suh v. Pingo Corp.*, 736 P.2d 342, 346 (Alaska 1987). The penalty provision gives employers a direct financial interest in making timely benefit payments. *Granus v. Fell*, AWCB Decision No. 99-0016 (January 20, 1999). It has long been recognized that the statute provides penalties when employers fail to pay compensation when due. *Haile v. Pan Am. World Airways*, 505 P.2d 838 (Alaska 1973). An employee is also entitled to penalties on compensation due if compensation is not properly controverted by the employer. *Williams v. Abood*, 53 P.3d 134, 145 (Alaska 2002). If an employer neither controverts employee's right to compensation, nor pays compensation due, the statute imposes a penalty. *Harp v. ARCO Alaska, Inc.*, 831 P.2d 352, 358 (Alaska 1992).

A controversion notice must be filed "in good faith" to protect an employer from a penalty. *Harp* at 358. "In circumstances where there is reliance by the insurer on responsible medical opinion or conflicting medical testimony, invocation of penalty provisions is improper." But when nonpayment results from "bad faith reliance on counsel's advice, or mistake of law, the penalty is imposed." *State of Alaska v. Ford,* AWCAC Decision No. 133, at 8 (April 9, 2010) (citations omitted). "For a controversion notice to be filed in good faith, the employer must possess sufficient evidence in support of the controversion that, if the claimant does not introduce evidence in opposition to the controversion, the Board would find that the claimant is not entitled to benefits." *Harp* at 358 (citation omitted). Evidence in Employer's possession "at the time of controversion" is the relevant evidence reviewed to determine its adequacy to avoid a penalty. *Id*. If none of the reasons given for a controversion are supported by sufficient evidence to warrant a decision the claimant is not entitled to benefits, the controversion was "made in bad faith and was therefore invalid" and a "penalty is therefore required" by AS 23.30.155. *Id*. at 359. *Vue v. Walmart Associates, Inc.*, 475 P.3d 270 (Alaska 2020), stated valid

controversion notices must give notice of disputed issues, which an employee can then use to pursue a claim. *Vue* also adopted *Harp*'s standard to evaluate unfair and frivolous controversion claims.

> **AS 23.30.185. Compensation for temporary total disability.** In case of disability total in character but temporary in quality, 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the disability. Temporary total disability benefits may not be paid for any period of disability occurring after the date of medical stability.

> **AS 23.30.190. Compensation for permanent partial impairment; rating guides.** . . .

Stonebridge Hospitality Associates, LLC v. Settje, AWCAC Dec. No. 153 (June 14, 2011), held when a PPI claim is ripe for adjudication, and not merely hypothetical, the claimant is required to obtain a rating and present it at hearing if she wants a PPI benefits award.

> **AS 23.30.395. Definitions.** In this chapter,
> . . . .
>
> (9) "chronic debilitating pain" means pain that is of more than six months duration and that is of sufficient severity that it significantly restricts the employee's ability to perform the activities of daily living;
> . . . .
>
> (28) "medical stability" means the date after which further objectively measurable improvement from the effects of the compensable injury is not reasonably expected to result from additional medical care or treatment, notwithstanding the possible need for additional medical care or the possibility of improvement or deterioration resulting from the passage of time; medical stability shall be presumed in the absence of objectively measurable improvement for a period of 45 days; this presumption may be rebutted by clear and convincing evidence;
>
> (29) "palliative care" means medical care or treatment rendered to reduce or moderate temporarily the intensity of pain caused by an otherwise stable medical condition, but does not include those medical services rendered to diagnose, heal, or permanently alleviate or eliminate a medical condition;

ANALYSIS

1) Is Employee entitled to medical and transportation costs?

Employer contended Employee's August 16, 2021 amended claim should be barred under AS 23.30.105. However, AS 23.30.105 would only bar Employee's right to disability compensation, not medical benefits.

a) Back and left knee

Employer contended res judicata bars Employee's August 16, 2017 amended claim because his January 31, 2019 claim was denied and dismissed in *Vanderpool I*. Employee requests an order directing Employer to pay all medical benefits incurred since the January 31, 2017 work injury, or alternatively, the medical costs incurred since the August 16, 2017 amended claim and to pay ongoing medical costs. Employee's January 31, 2019 claim sought transportation costs related to medical benefits but did not seek medical costs for injuries to his left knee and back he sustained when he "slipped on ice that had been irregularly placed" on January 1, 2017. On August 16, 2021, Employee filed an amended claim seeking past and future medical costs for injuries to his left knee and back he sustained when he "slipped on ice that had been irregularly placed" on January 1, 2017, and for an injury to a big toe in August 2017, when he fell while fishing, contending the fall was a "direct result" of the work injury.

Employees are allowed to seek different benefits after a previous claim was dismissed under AS 23.30.110(c) because it is not a comprehensive "no progress rule." *Tipton*; *Wagner*. Claims may be filed when new medical treatments occur. *Egemo*. An employee may file a claim for medical costs incurred subsequent to the dismissal of the previous claim. *Bailey*. A later-filed claim for the same benefits based upon a different nature of injury previously unknown to the employee is not extinguished with the earlier dismissed claim. *Hogenson*. However, a denial and dismissal of a claim under AS 23.30.110(c) after the employee was given notice and opportunity to present evidence and argue against dismissal is a dismissal with prejudice and precludes the employee from pursuing a later-filed claim for the same benefit, arising from the same injury, against the same employer based upon the same theory or nature of injury. *Hogenson*. Res judicata precludes a subsequent suit between the same parties asserting the same claim when the matter raised was or could have been decided in the first suit when the prior judgment was a final judgment on the merits made by a competent jurisdiction and the same cause of action and parties were involved. *Robertson*. The issue to be precluded from relitigation by collateral

estoppel must be identical to that decided in the first action. *McKean*. The rule against claim splitting provides all claims arising from a single transaction must be brought in a single suit and those that are not become extinguished in the judgment in the suit where only some of the claims were sought. *Robertson*. It requires analyzing whether the claims arose out of the same transaction or core set of facts. *Id*.

Employer denied all benefits based upon Dr. Bauer's EME report on November 9, 2018. Employee's January 31, 2019 claim sought transportation costs related to medical costs and TTD benefits, among other issues; however, it did not seek medical costs. Employee filed medical evidence, such as Dr. Bursell's February 27, 2019 response, regarding medical treatment and TTD benefits for the work injury, but provided no evidence regarding transportation costs. When he filed his January 31, 2019 claim, he knew Dr. Bursell recommended medical treatment related to his work injury, which he knew Employer had already controverted and contended was not reasonable or necessary based upon Dr. Bauer's EME report.

Vanderpool I denied and dismissed Employee's January 31, 2019 claim under AS 23.30.110(c); it is a final judgment from a competent jurisdiction and the same parties were involved. *Robertson*. His August 16, 2021 amended claim sought medical expenses going back to the date of injury and transportation costs and TTD benefits again. The August 16, 2021 amended claim arose from the same core set of facts and are based on the same injury theory as the January 31, 2019 claim because Employee contended he slipped and fell on ice and injured his left knee and back on January 1, 2017 in both and he relied upon the same medical evidence to prove both claims. *Robertson*; *Hogenson*.

It is understandable Employee wanted a prospective determination before pursuing the medical treatment recommended by Dr. Bursell before pursuing it and claimants are entitled to such a prospective determination. *Summers*. However, it would not be quick, efficient, fair or predictable at a reasonable cost for Employer to split his request for medical benefits from his request for transportation costs and TTD benefits, as the medical evidence he relied upon to prove both medical treatment and TTD benefits are the same and were in the record and his medical claim was ripe when he filed his January 31, 2019 claim. AS 23.30.001(1).

Nonetheless, the Act requires cases to be decided on their merits except where otherwise provided by statute. AS 23.30.001(2). Thus, Employee's right to medical benefits incurred before February 28, 2019, the date Employer controverted Employee's January 31, 2019 claim, became extinguished in *Vanderpool I* pursuant to res judicata and the rule against claim splitting. *Robertson*; *Bailey*; *Egemo*; *McKean*.

Even if Employee's right to medical benefits before February 28, 2019, were not extinguished pursuant to res judicata and the rule against claim splitting, he failed to prove his entitlement to medical benefits. The presumption of compensability applies to Employee's claim for medical benefits for his left knee and back. AS 23.30.120(a); *Meek*. Employee raised the presumption for his left knee injury with Dr. Harrah's March 23, 2017 chart note stating the reason Employee's left knee became symptomatic was the work injury and recommended physical therapy, another injection or surgery and Dr. Curtis' October 22, 2018 clinic note stating a left knee diagnostic arthroscopy surgery was indicated to repair a plica or meniscus tear. *Tolbert*; *Smallwood*. He raised the presumption for his back injuries with Dr. Bursell's February 27, 2019 response and April 13, 2020 letter stating if conservative treatment was not effective then right sacroiliac joint fusion and L5-S1 discectomy may be necessary.

Employer rebutted the presumption with Dr. Bauer's opinion stating Employee reached medical stability, no further medical treatment was necessary for Employee's left knee, sacroiliac joint injury or lumbar spine, there was no condition for which gabapentin would be indicated and recommending against narcotic medication and Employee's plica was not caused by the work injury. *Huit*.

Dr. Bursell stated if conservative treatment was not effective, then right sacroiliac joint fusion and L5-S1 discectomy may be necessary. Drs. Ryan and Eley both opined there was no role for surgery in Employee's sacroiliac joints or lumbar spine because there was no joint instability with movement, no obvious area of tight narrowing or of a large-herniated disc fragment causing nerve root compression or instability, he only had very mild disc protrusion and his foramen appeared fairly wide open, and he had no significant pain with provocative maneuvers or pressure over the SI joint. Dr. Bauer opined a sacroiliac joint fusion was not indicated because

there were no significant abnormalities in imaging and his pain was nonspecific and for surgical intervention was not necessary for Employee's lumbar spine because his spine did not appear to be the major source of his condition and a fusion or disc replacement is not likely to improve his symptoms to any significant degree. His opinions will be given more weight as they are consistent with the specialist Employee saw upon Dr. Bursell's recommendation. AS 23.30.122; *DeRosario*; *Smith*. The preponderance of the evidence is that lumbar spine or sacroiliac surgeries are not necessary. *Huit*.

Dr. Bursell's April 25, 2017, August 1, 2017 and February 27, 2019 medical records said Employee was not stable but did not predict when he would become medically stable. Dr. Bursell's July 23, November 27 and December 18, 2018 records indicate his back pain remained unchanged. The preponderance of the evidence is that Employee's back injury reached medical stability in October 2018, because it showed no objectively measurable improvement for over 45 days. AS 23.30.122; *DeRosario*; *Smith*.

An employer is not liable for palliative care after medical stability unless it is reasonable and necessary to enable the employee to continue in his employment at the time of treatment, to enable him to continue to participate in an approved reemployment plan or to relieve chronic debilitating pain. A claim for palliative care must be accompanied by certification from the employee's attending physician that the care meets one of the requirements. AS 23.30.095(o). "Palliative care" means medical treatment provided to reduce or moderate temporarily the intensity of pain caused by an otherwise medically stable medical condition, but it does not include medical treatment to diagnose, heal or permanently alleviate a medical condition. AS 23.30.395(29). "Chronic debilitating pain" is pain lasting more than six months and is severe enough to significantly restrict the employee's ability to perform the activities of daily living. AS 23.30.395(9).

Dr. Bauer stated no further treatment was necessary, gabapentin was not indicated, and he recommended not using narcotics. Dr. Eley recommended continuing with SI joint injections and possibly even facet blocks or injections and continuing to follow up with the chronic pain doctor. Dr. Ryan encouraged Employee to follow up with Dr. Bursell and consider more

injection therapy and to continue to work on core strength, stretching and flexibility. Dr. Bursell's medical records stated Employee used hydrocodone, gabapentin and ibuprofen to control pain symptoms since 2018, and prolotherapy, injections and branch blocks were recommended. But no physician made a certification that any recommended treatment would enable Employee to continue in his employment at the time of treatment or to continue to participate in an approved reemployment plan or would relieve chronic debilitating pain. Employee has not proven by a preponderance of evidence that the treatment recommended by Dr. Bursell for his back injury is necessary. AS 23.30.095(o).

Dr. Bauer opined plica are not caused by work injuries nor was Employee's aggravated by the contusion he suffered. Dr. Harrah recommended left knee arthroscopic surgery for a medial plica and possible meniscal tear and opined the work injury caused his knee to become symptomatic because Employee did not have any symptoms prior to the injury. The Court has repeatedly held the fact symptoms arose after an event is insufficient to establish causation in workers' compensation cases. *Lindhag*. Dr. Bauer found nothing objective to suggest that left knee arthroscopic surgery would be indicated as Employee had a negative McMurray and the MRI did not show a meniscal tear. He also concluded the medial plica was not a substantial source of Employee's left knee symptoms because the subjective tenderness findings upon his examination of Employee's knee were lateral.

Dr. Bauer's opinion will be given more weight than Dr. Harrah's because Dr. Harrah's opinion is not sufficient to establish causation, his February 16, 2017 chart note also documented that Employee's left knee pain was lateral, and he recommended an ITB injection. There is no positive McMurray test noted in any medical record and Employee's left knee MRI did not show a meniscal tear. AS 23.30.122; *DeRosario*; *Smith*. Employee has not proven by a preponderance of the evidence that the need for left knee arthroscopic surgery recommended by Dr. Harrah is substantially caused by the work injury, and necessary. *Huit*.

b) Big toe

Employee's August 16, 2021 amended claim described an immediate injury to his big toe in August 2017, which he contended was caused by his leg giving out due to his back injury and

stated his big toe injury was evaluated in 2019 and additional medical treatment was recommended, specifically x-rays and an MRI. Based on his claim description and Dr. Bursell's December 18, 2018 medical record the big toe injury was a known injury at the time he filed both claims, it was not a different nature of injury previously unknown to the employee when he filed his January 31, 2019 claim. *Hogenson*. His right to medical benefits incurred before January 31, 2019, for his big toe also became extinguished in *Vanderpool I* pursuant to the rule against claim splitting. *Robertson*.

Employee failed to establish a preliminary link between his need for big toe medical treatment and the work injury. Employee's August 16, 2021 amended claim description stated his big toe got better after it was first injured in August 2017, then worse before he sought treatment in 2019 when imaging was recommended. Then he said it got better before it started bothering him yet again and "got progressively worse" and he sought treatment again and his physician discussed surgery. The only the December 18, 2018 medical record that included a report Employee injured his right big toe, also mentioned the previous right big toe injury and only recommended imaging if Employee continued to experience pain. But no medical report includes a report of continuing big toe pain or recommended imaging or surgery for his big toe and none state the work injury was the substantial cause of any big toe medical treatment.

An October 4, 2018 medical record also reported a left foot injury, but it did not indicate whether the work injury was the substantial cause. Employee's August 16, 2021 amended claim does not indicate which big toe he contended was injured due to the work injury. The medical record contains evidence of a preexisting right big toe injury from a gunshot wound which affected his proximal peroneal nerve and caused him to be unable to dorsiflex his right big toe. Based upon the medical record and Employee's description of the big toe injury, this is a medically complex case and an expert medical opinion concerning causation is required. *Rogers & Babler*; *Smallwood*. Employee's August 16, 2021 amended claim description is insufficient evidence to establish a preliminary link. Employee did not provide any medical opinion addressing whether his work injury was the substantial cause of his need for big toe medical treatment. Therefore, Employee failed to establish a preliminary link between the work injury and his need for big toe medical treatment. Employee is not entitled to medical and related transportation costs. His

request for an order requiring Employer to pay for past and continuing medical and transportation costs will be denied.

2) Is Employee entitled to PPI benefits?

Employee contend his work injuries have reached MMI and requests an order directing Employer to pay for a PPI rating. His January 31, 2019 claim sought PPI benefits and it was dismissed in *Vanderpool I* under AS 23.30.110(c). *Vanderpool I* denied and dismissed Employee's January 31, 2019 claim for TTD benefits, it is a final judgment by a competent jurisdiction and the same parties were involved. *Robertson*. The August 16, 2021 amended claim arose from the same core set of facts and are based on the same injury theory as the January 31, 2019 claim because Employee contended he slipped and fell on ice and injured his left knee and back on January 1, 2017, in both. *Robertson*; *Hogenson*. Employee never identified the date of MMI in his pleadings or brief and did not identify any medical records addressing MMI. The only medical record from Employee's treating physician addressing MMI was Dr. Curtis' October 22, 2018 clinic note that stated EE had not reached MMI.

Dr. Bauer opined Employee had no ratable impairment on October 17, 2018. Employee produced no new medical evidence indicating when he reached MMI. Employee's January 31, 2019 and August 16, 2021 amended claim both sought PPI benefits and the dispute between the parties remains the same between the same parties, based upon the same medical evidence. Therefore, res judicata precludes an order directing Employer to pay for a PPI rating. *Robertson*; *McKean*; *Egemo*.

When a PPI claim is ripe for adjudication, the claimant is required to obtain a rating and present it at a hearing. *Settje*. Employee contended he reached MMI, which is when a PPI rating is performed, so his claim is not hypothetical, and it is ripe for adjudication. Because Employee presented no PPI rating higher than zero percent, his PPI claim will be denied. AS 23.30.190; *Settje*.

3) Is Employee entitled to additional TTD benefits?

Employer paid TTD benefits from January 2, 2017 to October 21, 2018. Employee's January 31, 2019 claim sought TTD benefits and it was dismissed in *Vanderpool I* under AS 23.30.110(c). His August 16, 2021 amended claim also sought TTD benefits, but his hearing brief did not address this issue. *Vanderpool I* denied and dismissed Employee's January 31, 2019 claim for TTD benefits, it is a final judgment by a competent jurisdiction and the same parties were involved. *Robertson*. The August 16, 2021 amended claim arose from the same core set of facts and are based on the same injury theory as the January 31, 2019 claim because Employee contended he slipped and fell on ice and injured his left knee and back on January 1, 2017 in both. *Robertson*; *Hogenson*.

The only medical records from Employee's treating physicians addressing medical stability was Dr. Bursell's April 25, 2017 response to questions from the claim administrator and the February 27, 2019 response to questions from Employee's attorney, both said he was not medically stable. Dr. Bauer opined Employee reached medical stability in October 2018. Employee produced no new medical opinion from his physician indicating when he reached medical stability. Employee's January 31, 2019 claim, and August 16, 2021 amended claim sought TTD benefits for the same time period, from the date Employer stopped paying benefits, October 22, 2018, until medical stability, and the disputes remain the same between the same parties based upon the same medical evidence. Employee's August 16, 2021 amended claim seeks TTD benefits for the same period as his January 31, 2019 claim; there is no new period of disablement sought in the August 16, 2021 amended claim. *Bailey*; *Egemo*. Res judicata precludes an award of TTD benefits sought in Employee's August 16, 2021 amended claim.

Employer contended Employee's August 16, 2021 amended claim for TTD benefits should also be barred for late claim filing. The two-year time limit in AS 23.30.105 commenced from the date of injury, date of disablement or the date latent defects manifested, whichever came later. Employee's disablement began the date of injury, January 1, 2017, and Employer paid benefits until October 21, 2018. Employee's August 16, 2021 amended claim failed to claim TTD benefits within two years after disablement. Employee's August 16, 2021 amended claim also described an immediate injury to his big toe in August 2017 caused by the work injury. Employee failed to claim TTD benefits for a big toe injury within two years after he first

acquired knowledge of the injury on August 3, 2017, and disablement related to his big toe began. AS 23.30.105(a); *Morrison-Knudsen; Bateman*.

Employee did not state which big toe was injured in his August 16, 2021 amended claim. He delayed informing his physicians he injured his toe and did not inform Dr. Bauer of any big toe injury at the October 17, 2018 EME. Employee failed to inform Employer of his right toe injury and to provide medical records documenting the 2019 medical treatment he alleged he underwent in 2019 and the surgery recommendation in his August 16, 2021 amended claim. Medical records show Employee sustained a previous injury to his proximal peroneal nerve which caused him to be unable to dorsiflex his right big toe. Employer was prejudiced by Employee's late filed big toe claim as it prevented it from properly investigating and defending against it. *Morrison-Knudsen*.

Even if res judicata did not preclude an award of TTD benefits and Employee timely filed a big toe claim, he failed to establish a preliminary link between his work injury and disability for his big toe. AS 23.30.120(a); AS 23.30.185. Employee failed to provide medical evidence documenting a big toe injury occurred due to the work injury in August 2017 and there is no medical record relating any imaging or surgery or period of disablement to the big toe injury. Employee failed to identify which big toe he injured in his August 16, 2021 amended claim and the medical records contain a preexisting non-work-related right big toe injury and a left foot injury. Whether an injury to Employee's big toe is the substantial cause of any period of disablement related to his work injury is a medically complex issue, and Employee's August 16, 2021 amended claim description is insufficient evidence to establish a preliminary link. *Rogers & Babler*; *Smallwood*. Employee did not provide any medical opinion addressing whether the work injury was the substantial cause of his disability due to his big toe. Therefore, Employee failed to establish a preliminary link between the work injury and any period of disablement due to his big toe injury. Employee's request for an order requiring Employer to pay for TTD benefits will be denied.

4) Is Employee entitled to penalty and interest?

Because Employee is not entitled to benefits, he is not entitled to penalty for late paid compensation, or interest. AS 23.30.155(e), (p).

5) Is Employee entitled to a finding that Employer unfairly or frivolously controverted benefits?

For a controversion notice to be filed in good faith, the employer must possess sufficient evidence in support of the controversion that, if the claimant does not introduce evidence in opposition to the controversion, the claimant is not entitled to benefits. *Harp*. Evidence in Employer's possession at the time of controversion is the relevant evidence reviewed to determine its adequacy to avoid a penalty. *Id*. If none of the reasons given for a controversion are supported by sufficient evidence to warrant a decision the claimant is not entitled to benefits, the controversion was made in bad faith and was therefore invalid and a penalty is required. *Id*.

On November 9, 2018 and February 28, 2019, Employer denied all benefits effective October 17, 2018 based upon Dr. Bauer's EME report, which concluded Employee was medically stable with no permanent impairment and no additional medical treatment was reasonable or necessary for the back and left knee work injuries. His opinion was sufficient evidence to warrant a decision Employee was not entitled to TTD and PPI benefits and medical costs. The November 9, 2018 and February 28, 2019 controversion notices were made in good faith. *Harp*.

On September 9, 2021, Employer controverted all benefits related to Employee's foot and great toe contending there is no medical evidence relating the work injury to a fall in August 2017, nor is there medical evidence proving the work injury is the substantial cause of his need for foot or toe treatment. Employee did not provide medical evidence containing any recommended medical treatment for his big toe or concluding the work injury was the substantial cause of his need for the recommended big toe medical treatment and as determined above, it is a medically complex issue. Employer's September 9, 2021 controversion notice was supported by sufficient evidence to warrant a decision Employee was not entitled to benefits and it was made in good faith. *Harp*.

Employer's February 22, 2023 controversion contended *Vanderpool I* dismissed Employee's January 31, 2019 claim in its entirety and controverted the benefits sought in his January 31,

2019 claim. The February 22, 2023 controversion was made in good faith because it was based upon the undisputed fact that *Vanderpool I* dismissed Employee's January 31, 2019 claim under AS 23.30.110(c) and it was sufficient evidence to warrant a decision Employee was not entitled to benefits sought in Employee's January 31, 2019 claim. Therefore, Employer's February 22, 2023 controversion was made in good faith. *Harp*. Employee is not entitled to a finding of unfair or frivolous controversion. AS 23.30.155(o).

6) Is Employee entitled to attorney fees and costs?

Because Employee is not entitled to benefits, Employee is not entitled to attorney fees and costs. AS 23.30.145.

CONCLUSIONS OF LAW

1) Employee is not entitled to medical and transportation costs.
2) Employee is not entitled to PPI benefits.
3) Employee is not entitled to TTD benefits.
4) Employee is not entitled to penalty or interest.
5) Employee is not entitled to a finding that Employer unfairly or frivolously controverted benefits.
6) Employee is not entitled to attorney fees and costs.

ORDER

1) Employee's August 16, 2021 amended claim is denied.

Dated in Juneau, Alaska on December 22, 2023.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Kathryn Setzer, Designated Chair

/s/
Debbie White, 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 Jason Vanderpool, employee / claimant v. State of Alaska, self-insured employer / defendants; Case No. 201700230; dated and filed in the Alaska Workers' Compensation Board's office in Juneau, Alaska, and served on the parties by certified U.S. Mail, postage prepaid, on December 22, 2023.

/s/

Lorvin Uddipa, Workers' Compensation Technician