Alaska Workers' Compensation Appeals Commission

Municipality of Anchorage,
Appellant,

vs.

Mark Monfore,
Appellee.

Final Decision
Decision No. 081 June 18, 2008

AWCAC Appeal No. 07-013
AWCB Decision No. 07-0073
AWCB Case No. 200513917

Appeal from Alaska Workers' Compensation Board Decision No. 07-0073, issued on April 4, 2007, by southcentral panel members Rosemary Foster, Chair, and Robert S. Morigeau, Member for Labor; David Kester, Member for Industry, dissenting.

Appearances: Patricia Zobel, DeLisio, Moran, Geraghty & Zobel, for appellant Municipality of Anchorage. Charles W. Coe, Esq., for appellee Mark Monfore.

Commission proceedings: Hearing on motion for stay pending appeal May 22, 2007; stay granted by order issued June 7, 2007; oral argument presented March 18, 2008.

Commissioners: Jim Robison, Philip Ulmer, Kristin Knudsen.

This decision has been edited to conform to technical standards for publication.

By: Kristin Knudsen, Chair.

1. Introduction.

This appeal and cross-appeal arise from a board decision awarding an increase of three percent in permanent partial impairment, a penalty against an employer for late payment of medical bills, and a penalty against the employer for controversion of an impairment rating without sufficient evidence. The appellant asserts that the board erred by finding that Dr. Dietrich's letter was not substantial evidence overcoming a presumption that a claim based on Dr. Mulholland's rating was compensable and in relying on Dr. Mulholland's rating in the absence of a complete report. The appellant asserts that the board erred in penalizing the employer for failing to secure bills and statements from a provider. The appellant asserts the board failed to consider, before

awarding a penalty, that the provider's claim was not "valid and enforceable" under AS 23.30.095(c) until the board excused the failure to give notice of treatment. The appellee opposes these assertions, and cross-appeals, asserting that the penalty on medical benefits should be paid to the employee, as the provider was paid as a direct result of his contacts with the employer's adjuster.

The assertions regarding the award of permanent partial impairment compensation require the commission to decide if the board had substantial evidence in its record to find that Mark Monfore's permanent partial impairment rating was 32 percent. The commission must also decide if the board correctly applied the rule in *Harp v. ARCO Alaska, Inc.*[1] in awarding a penalty against the employer for a frivolous controversion. The parties' assertions regarding the penalty on medical benefits require the commission to construe the relationship between AS 23.30.095(c), AS 23.30.097(d) and AS 23.30.155(e), in order to determine when a medical bill is "due." The commission must also decide if a penalty on a medical bill is owed to the medical provider or the employee.

The commission determines that the board's findings regarding the rating and penalty are not fully supported by substantial evidence in the record. The board's decision contains internal inconsistencies that make it difficult for the commission to review the board's decision. Accordingly, the commission remands the case with instructions to the board for further findings.

The commission construes the word "claim" in the first sentence of AS 23.30.095(c) as meaning "right." Failure to provide notice acts as a claim-bar; but "notice" means sufficient notice that is adequate to alert the board and the employer of the general scope of treatment. Notice by the employee, if provided to the employer and the board, and adequate to alert the board and the employer of the general scope of treatment, is sufficient to avoid the claim-bar. However, in order to comply with AS 23.30.095(l) (substantially reenacted as AS 23.30.097(d)) and 8 AAC 45.082, a written

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[1] 831 P.2d 352 (Alaska 1992).

report from the provider is required to trigger the employer's obligation to pay the provider.

The statutes place the burden of reporting on the treatment provider. Therefore, the board's assessment of a penalty based on the employer's failure to "secure" reports and statements was error. The commission remands the claim for penalty to the board for rehearing. The commission determines that penalties on late paid medical expenses are owed to the recipient of the payment of the medical expense, not the recipient of the medical benefit. Because Providence Alaska Medical Center was not a party to the proceeding before the board, and there is no evidence that the employee was authorized to act on its behalf, the board should have required Providence, as the real party in interest, to appear before adjudicating Providence's interests where Providence's conduct is alleged to result in a bar to the employee's claim for payment.

2. Factual background.

Mark Monfore is a paramedic who injured his neck July 31, 2005, while catching a patient who fell as she entered the "medic rig."[2] He reported the injury August 23, 2005. The injury resulted in surgery to remove two disks and fuse vertebrae in his neck. The surgery, by James Eule, M.D., took place October 12, 2005, at Providence Hospital in Anchorage. Monfore returned to full work in August 2006.

a. The impairment ratings.

David Mulholland, D.C., performed an impairment rating at Dr. Eule's request. His report, dated August 29, 2006, compared a DRE-based[3] rating (28 percent) and the "range of motion" rating (32 percent) and awarded the higher of the two.[4] His report states "Ranges of motion were recorded by myself . . . and are included for your

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[2] R. 0001.

[3] A rating of permanent impairment based on the Diagnosis-Related Estimate method under the American Medical Assoc., *Guides to the Evaluation of Permanent Impairment* § 15.2 (5th ed.) (2006).

[4] R. 0150-53.

review."[5] However, the copy of the report filed with the board and sent to the employer's adjuster did not contain the recorded ranges of motion.

The adjuster sent Dr. Mulholland's rating to Thomas Dietrich, M.D., a neurosurgeon, for review. Dr. Deitrich reported on September 15, 2006, that

> As I understand Dr. Mulholland's rating calculations, he is calculating the range of motion model and adding the neurological impairments. The sensory impairments are doubled on the basis of bilateral involvement. There is no mention of bilateral involvement in any of the post operative notes. . . . I think this impairment would be best described using the DRE method, and he likely would be in the lower range of a Category IV. However, I do not feel comfortable doing a formal rating without actually evaluating Mr. Monfore.[6]

Dr. Dietrich evaluated Monfore on October 20, 2006. He reported that notwithstanding the lack of post operative report, Monfore had bilateral sensory impairment.[7] Using a DRE method, he would put Monfore's impairment at the upper range of the 25-28 percent category.[8] Because his measurements of range of motion totaled 29 percent impairment, which was slightly higher than the DRE based rating, he would award a 29 percent rating.[9] Dr. Dietrich noted he did not have Dr. Mulholland's range of motion calculations to compare to his own, "but it is possible that Mr. Monfore's range of motion has improved somewhat since the evaluation in August."[10]

b. The Providence hospital bill.

Providence Alaska Medical Center in Anchorage uses a medical business service, Health Services Northwest, located in Washington state to process its bills.[11] Health Services Northwest receives the billing from the hospital after the patient leaves and the

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5 R. 0152.

6 R. 0142.

7 R. 0127.

8 R. 0129.

9 R. 0129.

10 R. 0129-30.

11 Tr. 20:11-20.

account has been "coded."[12] It assembles the necessary documentation and sends it to the payer named by the facility for payment.[13]

Meghan Murdock, team manager for the Health Services Northwest team that processed the bill for Monfore's surgery, testified by telephone to the board regarding the computer record of the account.[14] She did not make computer entries herself, so she testified from what she knew based on policies and procedures and her understanding of the computer record.[15] She did not testify that she had a paper file before her.

Murdock testified that Health Services Northwest prepared a full statement of the Providence hospital charges, with supporting documents, and it was mailed to Ward North on May 22, 2006, about seven months after the surgery.[16] The address given by Murdock was a post office box in Anchorage.[17] She stated that the address for Ward North would have been different only "if the facility had coded it with that address or we were notified, you know, telephonically or in writing to send it to another address."[18] She testified that she had not seen any "address updates," so if a change was made she was not aware of it.[19] The only record of an address change in the computer record was a telephonic request on December 14, 2006, for name change from Ward North to NovaPro.[20]

Murdock testified to a number of contacts with Ward North in June, July, August and September 2006. She testified that in September, a person named Michaela called back, saying that she was unable to locate the billing or claim information and

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12 Tr. 21:22-23.

13 Tr. 21:24 – 22:4.

14 Tr. 23:2-18.

15 Tr. 50:10-20.

16 Tr. 25:20-24.

17 Tr. 26:7-9.

18 Tr. 26:17-19.

19 Tr. 43:17.

20 Tr. 44:9-12.

requesting another copy.[21] It was mailed on October 12, 2006.[22] On October 30, 2006, Health Services Northwest received a denial from Ward Strategic Claims Solutions, stating "they did not have a record for an open industrial claim for this date of injury."[23] The letter, admitted as hearing exhibit 1, said:

> We have no record of an industrial claim or injury. Please direct your patient to initiate the Self-insured Accident Report "SIF2" through their employer. Please resubmit your bill in 30 days.
>
> Per WAC 296-20 all bills submitted/resubmitted for payment must . . .

On receiving the letter, Murdock testified, Health Services Northwest generated a statement mailed to Monfore informing him of the denial.[24] Murdock testified that the computer record reflects that Monfore contacted Health Services Northwest on December 5, 2006, and that on December 14, 2006, NovaPro advised Health Services Northwest "of updated insurance information and request[ed] that we send the claim to them."[25]

Murdock testified that Health Services Northwest took some time to generate a corrected statement,[26] but that on January 23, 2007, a complete packet was sent to NovaPro.[27] According to Murdock, Health Services Northwest had been informed that payment had been sent, but it was not shown as posted in her computer record.[28] The lack of posting could be attributed to a delay between deposit and posting.[29]

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21 Tr. 29:3-7.

22 Tr. 29:12-13.

23 Tr. 29:23-25.

24 Tr. 30:17-31:1.

25 Tr. 31:3-5; 31:21-21.

26 Tr. 32:21-33:14.

27 Tr. 33:15-16.

28 Tr. 35:17-18.

29 Tr. 35:19-20.

Monfore confirmed that he received a bill from Providence on November 28, 2006, and he called Providence about it.[30] He testified he called "Bonnie" three times and never got a return call.[31] He testified that he reached Daisy at NovaPro, who told him on December 14, 2006, that there had been a mistake.[32]

Daisy Saffir testified that she had worked for Ward in Washington and in Alaska, and was familiar with the billings generated by Providence.[33] She testified that she could find no statements in the adjuster's file for Monfore's case that indicated receipt of the billing and records in May 2006.[34] She testified that the letter received by Health Services Northwest in October 2006 was a "send back" form generated by Ward Strategic Claims Solutions in Washington, which contained references to the Washington Department of Labor and Industries forms and administrative code.[35] Based on this form, she believed that the October 2006 packet had not been mailed to the office of Ward North Alaska, but to a Ward Strategic Claims Solutions office in Washington.[36] Saffir also testified that Ward North Alaska changed names in September 2006, it was not possible that Health Services Northwest had used the same name and address "they used all along."[37] Saffir testified that the first receipt of itemized billings and records from Providence for services to Monfore in surgery was January 26, 2007, and that they arrived by mail.[38] She testified the bills were sent to

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30 Tr. 70:10-23.

31 Tr. 70:23-71:1.

32 Tr. 71:1-8.

33 Tr. 80:11-24.

34 Tr. 91:8-17.

35 Tr. 92:10-93:17.

36 Tr. 93:18-22.

37 Tr. 99:10-25.

38 Tr. 98:1-23.

an auditing firm, and paid according to the audit on February 12 or 13, 2007.[39] The check, she testified, was cashed February 22, 2007.[40]

3. Proceedings before the board.

Monfore received his copy of Dr. Mulholland's impairment rating on September 8, 2006. He testified he mailed a copy to the adjuster and also personally delivered a copy.[41] He filed a claim on September 11, 2006, for payment of a permanent partial impairment compensation based on a 32 percent impairment rating.[42] This claim (for lump sum payment of permanent partial impairment compensation) was controverted on October 2, 2006. The controversion stated:

> There exists a dispute between the employee's physician and the employer's physician. PPI will be paid bi-weekly pending the outcome of the EME exam of the claimant. At this time, the employer's medical opinion on the amount of permanent impairment is in dispute. The balance of PPI will be paid upon resolution of the dispute.[43]

Monfore amended his claim in the course of a pre-hearing conference on November 2, 2006 to include interest and a penalty on the unpaid permanent partial disability compensation.[44] Monfore concedes that he was paid permanent partial impairment compensation of 29 percent on November 1, 2006. The controversion was refiled November 3, 2006 and limited to permanent partial impairment compensation "above 29 %" based on Dr. Dietrich's rating report.[45]

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39 Tr. 101:19-24, 101:25-102:1, 103:14-17;

40 Tr. 103:20-21.

41 Tr. 62:16-18. Although the appellee's brief claims that Monfore *delivered* the rating on Sept. 8, 2006 (Br. of Appellee at 5, 10), Monfore did not testify to the date he delivered the rating to Novapro. Sept. 8, 2006, the day Monfore testified he *received* the rating, was a Friday; Sept. 11, 2006, the day he filed his claim, was a Monday.

42 R. 0014-15.

43 R. 0012 (dated Sept. 28, 2006).

44 R. 0619.

45 R. 0013.

Monfore filed an affidavit of readiness to proceed to hearing on November 7, 2006.[46] A prehearing conference at the end of November resulted in an agreement for the September claim to be heard on March 6, 2007.[47]

On December 14, 2006, Monfore filed a new claim for payment of medical expenses, a penalty for late payment of the medical expenses, and interest.[48] This claim was answered December 19, 2006.[49] In a January 10, 2007, prehearing conference, Monfore's second claim was added to the matters to be heard on March 6, 2007.[50]

a. Arguments to the board.

Monfore argued to the board that the adjuster's payment of permanent partial impairment compensation on November 1, 2006, was late because the first controversion (based on Dr. Dietrich's September 2006 letter) was not a valid controversion. The second controversion (based on Dr. Dietrich's report) was also late, he argued, and a penalty was owed, because it was not filed within 21 days of receipt of Dr. Mulholland's rating. Monfore also argued that Dr. Deitrich's rating was not as accurate as Dr. Mulholland's rating. Monfore argued that the Health Services Northwest computer print-out, and Murdock's testimony, established that Health Services Northwest had repeatedly mailed the necessary reports and itemized billings to Ward North for payment, but that they had not been paid in full even at the time of hearing. He argued that *Williams v. Abood*[51] did not preclude a penalty. Monfore requested a penalty on the full amount of the bill.

The Municipality argued that, viewed in isolation, Dr. Dietrich's letter and report were sufficient to support a controversion. The bi-weekly payments, the Municipality

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46 R. 0019.

47 R. 0621.

48 R. 0247-48.

49 R. 0251-52. Appellee claims the answer was filed November 30, 2006, two weeks before Monfore's claim was filed. Br. of Appellee at 10.

50 R. 0625.

51 53 P.3d 134 (Alaska 2002).

argued, were a red herring; the payment of the complete rating was made shortly after Dr. Dietrich's rating report was received. Dr. Mulholland's ratings have been rejected repeatedly by the board, the Municipality argued, and should not be relied upon. The Municipality argued that the statute requires that the provider provide a report within 14 days of service to the board and employer; no report was generated until seven months later. Until the board forgives the provider, no bill is due and payable under AS 23.30.095(c). Therefore, the Municipality argued, no penalty for late payment could be due, as the provider's own testimony established that it did not file a report within 14 days.

b. The board's decision.

The board found that "due to errors on the part of Ward North aka NovaPro in not securing needed documentation to complete the billing process, the employee's [Providence Hospital] bill was . . . not paid until February 13, 2007."[52] The board found Murdock was a credible witness, and based on her testimony, the board found "the bill from the hospital and medical records were served on the employer through Ward North on May 22, 2006."[53] Ward North, the board said, "should have paid the bill much earlier than it actually did . . . ."[54] The board found that on receipt of the bill, "the medical reports . . . were not secured to allow for full documentation and verification of the bill. Consequently, it was not paid in a timely fashion."[55] The board concluded that a penalty "is due the provider based upon the employer's untimely payment."[56]

The board recited the well-known three-step presumption analysis that applies in workers' compensation cases[57] before stating its decision on the claim for permanent

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52 *Mark Monfore,* Bd. Dec. No. 07-0073 at 8 (April 4, 2007).

53 *Id.*

54 *Id*.

55 *Id*.

56 *Id.* at 8-9.

57 *Robinson v. Municipality of Anchorage*, 69 P.3d 489, 494 (Alaska 2003) (citing *Temple v. Denali Princess Lodge*, 21 P.3d 813, 816 (Alaska 2001)).

partial impairment compensation.[58] The board found that the employee had presented, in his testimony and Dr. Mulholland's report, sufficient evidence to attach the presumption that his claim for permanent partial impairment compensation was compensable.[59] The board found that "evidence from Dr. Dietrich . . . was sufficient to rebut the presumption raised by the employee as to the amount of the PPI rating."[60] The board then rejected Dr. Dietrich's rating and chose to rely on Dr. Mulholland's rating as "more accurate as it is based on the employee's actual condition and complete information."[61] The board noted Dr. Dietrich "thought there might have been some improvement in the employee's condition" to explain why his rating was lower.[62] Dr. Dietrich, the board explained, "did not have available to him the range of motion calculations performed by Dr. Mulholland."[63] For that reason, the board considered Dr. Mulholland's rating "most accurate in terms of the employee's actual condition."[64]

The board concluded a penalty was owed on the "29 % payment" of permanent partial impairment paid on November 1, 2006. Relying on *Sumner v. Eagle Nest Hotel*,[65] the board found payment was due September 29, 2006, 21 days after the employer had notice of the rating.[66] The board held that Dr. Dietrich's September 2006 letter was inadequate to controvert Dr. Mulholland's rating.[67] The board found a penalty was owed on the three percent difference between the two ratings as well, because "although the amount was legitimately under dispute, the employee should

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58 *Mark Monfore,* Bd. Dec. No. 07-0073 at 9-11.

59 *Id*. at 11.

60 *Id*.

61 *Id*.

62 *Id*.

63 *Id*. at 11-12.

64 *Id.* at 12.

65 894 P.2d 628 (Alaska 1995).

66 *Mark Monfore,* Bd. Dec. No. 07-0073 at 12.

67 *Id*. The board found that the controversion was "not appropriate as it did not cite a specific report or evidence challenging the Aug. 29, 2006 Mullholland rating."

have been seen for another rating before the 21 days for payment expired, or by September 29, 2006."[68] The controversion of the three percent was "not . . . in good faith under the *Harp* standard."[69] Because the controversion was "not based on a medical report with a factual determination contrary to Dr. Mulholland's 32% rating," the board concluded a penalty was owed on the additional three percent.[70]

4. Standard of review.

The commission must uphold the board's findings of fact if substantial evidence in light of the whole record supports the findings.[71] The commission does not consider evidence that was not in the board record when the board's decision was made.[72] A board determination of credibility of a witness who appears before the board may not be disturbed by the commission.[73]

However, the commission must exercise its independent judgment when reviewing questions of law and procedure within the Workers' Compensation Act.[74] The question whether the quantum of evidence is substantial enough to support a conclusion in the contemplation of a reasonable mind is a question of law.[75] If a provision of the Act has not been interpreted by the Alaska Supreme Court, the commission draws upon its specialized knowledge and experience of workers'

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68 *Id*. at 13.

69 *Id*.

70 *Id.*

71 AS 23.30.128(b).

72 AS 23.30.128(a).

73 AS 23.30.128(b).

74 AS 23.30.128(b).

75 *Land & Marine Rental Co. v. Rawls*, 686 P.2d 1187, 1188-89 (Alaska 1984) (citing *Miller v. ITT Arctic Serv.,* 577 P.2d 1044, 1046 (Alaska 1978)).

compensation[76] to adopt the "rule of law that is most persuasive in light of precedent, reason, and policy."[77]

5. Discussion.

a. The board's findings of fact regarding the choice of rating are inconsistent and incomplete.

The board's findings of the relative weight to be assigned competing physician's reports is conclusive and cannot be disturbed by the commission.[78] However, it is a question of law whether the board's findings of fact are supported by substantial evidence, that is, evidence that a reasonable mind could rely on to adopt a particular conclusion.[79] In this case, the board chose to rely on Dr. Mulholland's rating of permanent partial impairment over Dr. Dietrich's rating because, on comparing the two reports, the board found (1) Dr. Dietrich's rating had less value because Dr. Dietrich did not have Dr. Mulholland's range of motion results to compare with his results; (2) Dr. Dietrich suggested that the difference in result may be due to continuing improvement; and, (3) therefore, Dr. Mulholland's rating report was the most accurate.

The appellant argues that the board's reasoning was inconsistent; the board rejected Dr. Dietrich's rating because he was unable to compare his measurements to Dr. Mulholland's measurements, yet accepted Dr. Mulholland's report without his supporting measurements as "most accurate." The appellee, without addressing the board's reasoning argues that the board's choice between conflicting opinions must be

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[76] AS 23.30.007, 008(a). *See also Tesoro Alaska Petroleum Co. v. Kenai Pipeline Co.*, 746 P.2d 896, 903 (Alaska 1987); *Williams v. Abood,* 53 P.3d 134, 139 (Alaska 2002).

[77] *Guin v. Ha,* 591 P.2d 1281, 1284 n.6 (Alaska 1979).

[78] AS 23.30.122 ("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.").

[79] *DeYonge v. NANA/Marriott,* 1 P.3d 90, 94 (Alaska 2000).

upheld and that Monfore's "slight improvement over several months does not mean the Board has to use the later PPI rating."[80]

8 AAC 45.120(k)(9) requires the board, in evaluating the relative merits of reports, to give less weight to impairment rating reports that do not include "the extent of impairment and detailed factors upon which the rating is based." This regulation does not deprive the board of discretion when weighing credibility; it assures the board considers whether the reports are based on accurate and complete data. Because both Dr. Mulholland and Dr. Dietrich ultimately approached the rating by comparing the range of motion calculation with the DRE IV calculation, the range of motion measurements were "detailed factors upon which the rating is based." The range of motion component is the largest difference between the two ratings.[81] Dr. Mulholland's report did not include a record of his measurements, only his calculation of combined values. Dr. Dietrich provided a summary of his measurements in his report, as well as his calculation of combined values. A close examination of the record shows that Dr. Mulholland's range of motion measurements were not filed with the board. In effect, without the measurements on which his rating was based, Dr. Mulholland's report was incomplete.

In this case, the board rejected a report that contained measurements because it did not make a measurement comparison to a report that contained no measurements. The board clearly considered comparison of the range of motion measurements to be significant in weighing the relative merits of the competing opinions. Yet, the board gave greater weight to the report that did not include the record of the range of motion measurements on which the rating was based, without explaining why comparable measurements were no longer significant.

The board's finding that Dr. Mulholland's report is the "most accurate" is not based on evidence on which a reasonable mind could rely. Without both sets of

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[80] Br. of Appellee at 18.

[81] Dr. Mulholland calculated a total range of motion based impairment of 14 percent; Dr. Dietrich calculated a total range of motion based impairment of 9 percent.

measurements, no comparison could be drawn as to the accuracy of their respective measurements and calculations. The board's decision to reject the report *with* measurements (because its author could not compare his measurements to the report without measurements) and to find the report *without* measurements is more accurate is not logical. The board's finding of fact that Dr. Mulholland's report is "most accurate" is not supported by substantial evidence in light of the whole record; the commission may not affirm it.

The board may have intended to suggest that the rating closest in time to the decision that Monfore was medically stable is more accurate because Dr. Mulholland's rating does not include "improvement . . . resulting from the passage of time . . . ."[82] The relationship between the date Monfore reached medical stability and the date the rating examination was done may be relevant to the accuracy of the rating if improvement could be expected from the passage of time, but in this case the board appears to have assumed that a 30 percent improvement in function (as measured by range of motion) was the result of the passage of eight weeks time.

However, the board did not explain its reasoning clearly and there was no evidence that the passage of eight weeks could be expected to result in the measurable improvement in both sensory impairment and range of motion demonstrated in Dr. Dietrich's rating.[83] There is no evidence of where in Monfore's range of motion the improvement occurred. Finally, the board's comment that Dr. Mulholland's report is "based on the employee's *actual* condition and *complete* information" suggests the board believed Dr. Dietrich's report was not the result of an examination in which Monfore cooperated fully, but was based on a *false* condition and *incomplete* information. The commission is unable to discern what the board meant by this

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[82] AS 23.30.395(27).

[83] Dr. Mulholland calculated a combined bilateral sensory loss impairment of 12 percent; Dr. Dietrich calculated a combined bilateral sensory loss impairment of 9.6 percent, which he rounded up to 10 percent. The commission notes that the board cited Dr. Dietrich's statement that "it is possible that Mr. Monfore's range of motion has improved somewhat since the evaluation in August." However, Dr. Dietrich did not attribute that improvement to the mere passage of time or to any other cause.

comment. The board did not find that Dr. Dietrich's measurement technique was inadequate and, except noting Dr. Dietrich, like the board, did not have Dr. Mulholland's measurements, the board did not explain why Dr. Mulholland (who saw Monfore only once for a rating) had more information than Dr. Dietrich.

The defects in the board's decision may be cured by additional findings of fact. On remand, the board is directed to compare the *complete* reports, including the record of the range of motion measurements. The board is not required to take new evidence except a copy of the attachment to Dr. Mulholland's rating report recording Monfore's ranges of motion. However, if the board considered that proximity of the rating examination to the date of medical stability was a significant factor in its determination of the relative merits of the ratings, the board must take medical evidence on the issue whether the degree of improvement in Monfore's range of motion and sensory deficits would be expected as a result only from the passage of eight weeks. If the board finds that Dr. Dietrich did not examine Monfore's "actual condition" or that Dr. Mulholland had information available that Dr. Dietrich did not, the board is directed to identify the evidence on which it relied to make those findings.

b. The Municipality did not have a basis to controvert all of Dr. Mulholland's rating in September 2006; there is substantial evidence in the record on which findings may be based to support a conclusion that a penalty is owed on compensation payable under Dr. Dietrich's estimated rating.

AS 23.30.190(a) requires that compensation for permanent partial impairment be paid "in a single lump sum, except as otherwise provided in AS 23.30.041," without discount for present value considerations. AS 23.30.155(b) requires compensation to be paid within 14 days of the employer's knowledge of the injury. AS 23.30.155(e) requires:

> If any installment of compensation payable without an award is not paid within seven days after it becomes due, as provided in (b) of this section, there shall be added to the unpaid installment an amount equal to 25 percent of the installment. This additional amount shall be paid at the same time as, and in addition to, the installment, unless notice is filed under (d) of

> this section or unless the nonpayment is excused by the board after a showing by the employer that owing to conditions over which the employer had no control the installment could not be paid within the period prescribed for the payment. The additional amount shall be paid directly to the recipient to whom the unpaid installment was to be paid.

AS 23.30.155(d) provides that "[i]f the employer controverts the right to compensation after payments have begun, the employer shall file with the division and send to the employee a notice of controversion within seven days after an installment of compensation payable without an award is due."

In *Sumner v. Eagle Nest Hotel*, the Supreme Court held that lump sum payments of permanent partial impairment ratings under AS 23.30.190 are due 21 days after notice of the rating.[84] The Court said this interpretation of AS 23.30.155

> gives the employer adequate time to analyze a PPI rating, and establishes a consistent twenty-one day period for payment. There is a rational basis for the Board's decision. The decision comports with the historic workers' compensation framework and does not contradict any case or statute. Were we to apply our independent judgment, we would arrive at the same conclusion. Therefore, we affirm that decision.[85]

In *Hammer v. City of Fairbanks*,[86] the Supreme Court confirmed that knowledge, for purposes of determining when compensation is due under AS 23.30.155(b), occurs "not later than receipt of the rating."[87] The Supreme Court rejected the argument that "a facially valid PPI rating based on the [applicable AMA] Guidelines is necessary before [the] obligation to pay PPI benefits is triggered."[88] The Court approved the board's holding that the employer should have "paid the amount of PPI benefits clearly due, and controverted the remainder while it sought clarification."[89]

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84 894 P.2d at 631.

85 *Id.*

86 953 P.2d 500 (Alaska 1998).

87 953 P.2d at 505.

88 *Id.* at 506.

89 *Id.*

In this case, the Municipality did not controvert the entitlement to permanent partial impairment, only the "amount of permanent impairment." The employer's medical expert opinion, referred to but not cited directly, differed based on two points: that the DRE model, class IV, should be used, and that because there was no post surgical record of bilateral sensory loss, a single sensory loss value should be used. Dr. Dietrich's opinion clearly did not contradict all of the rating.[90] His objection to the sensory loss value was limited to inclusion of bilateral loss instead of unilateral loss, so Dr. Dietrich's letter also did not oppose six percent impairment (one-half Dr. Mulholland's rating) for unilateral sensory loss. The employer's adjuster would have been able to refer to the *Guides to the Evaluation of Permanent Impairment* to determine the amount of the rating which was unopposed by Dr. Dietrich's opinion. This is the amount that was "clearly due" and should have been paid while the employer sought clarification.[91] The uncontradicted evidence is that the employer paid permanent partial impairment compensation in biweekly installments until November 1, 2006. There is substantial evidence in the record to support the board's finding that the employer did not make timely payment of the lump sum of compensation clearly due. The decision that a penalty is due must be affirmed.

Instead of fixing the amount uncontradicted by Dr. Dietrich's September advice letter, the board relied on Dr. Dietrich's October evaluation report to find all the compensation subject to the penalty for late payment. However, the employer did not have that information in hand when the controversion was issued. We remand for recalculation of the permanent impairment estimate reflected in Dr. Dietrich's September 2006 letter and for redetermination of a penalty for late payment of that

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[90] Dr. Dietrich did not oppose a rating based on the DRE (Diagnosis-Related Estimate) method in the "lower range" of DRE IV – 25 percent – although it was not appropriate for a multi-level fusion in the same spinal region. American Medical Assoc., *Guides to the Evaluation of Permanent Impairment* (5th ed.) (2006) at §15.2a(4)(c).

[91] Monfore had returned to work and was not in the reemployment process under AS 23.30.041; weekly payment of permanent partial impairment was not an available option.

compensation. The board is instructed to subtract, from the amount that forms the basis for the penalty, any portion of the lump sum that was timely paid.

> *c. The board erred in holding that an employee should be examined by the employer's physician within 21 days of notice of a rating report in order to controvert payment of permanent partial impairment compensation.*

The board determined that the Municipality owed a penalty on the balance of compensation owed under the board's award because "although the amount was legitimately in dispute, the employee should have been seen for another rating before the 21 days for payment expired." The board cited no authority, and the workers' compensation statutes contain none, for the proposition that the employer must arrange an employer medical examination *and* receive a complete rating report within 21 days of notice of an employee's impairment rating in order to controvert a permanent partial impairment rating. The employer must have responsible medical opinion or contradictory medical testimony to support the controversion (if based on a medical issue). That opinion evidence, when viewed in isolation and without consideration of credibility, must be sufficient to rebut a presumption of compensability of the extent of impairment established by the employee's evidence.[92]

"Responsible medical opinion" does not mean that in every case the opinion must be supported by an examination of the employee.[93] Responsible medical opinion may be based on scientific principles widely accepted in the medical community, review

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[92] *Williams*, 53 P.3d at 146 ("[A]n employer must have sufficient evidence in order to make a good faith controversion"); *Dougan v. Aurora Elec. Inc.*, 50 P.3d 789, 794 (Alaska 2002) ("[A]n employer must have evidence that would justify denial of a compensation award in order to make a good faith controversion."); *but see Harp v. ARCO Alaska, Inc.*, 831 P.2d 352, 358 (Alaska 1992) ("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.").

[93] See *Williams*, 53 P.3d at 146-47, describing a pair of simultaneous and inconsistent prescriptions (for a home gym and formal physical therapy) as sufficient evidence to controvert payment of the home gym.

of the employee's medical records, and the specialized knowledge and training of the physician. For example, in a claim that turns on whether an employee's disease is the result of a blow to the spine, the opinion of an infectious disease specialist that the particular disease is caused by a virus which could not have been transmitted by a blow to the spine is sufficient to rebut an opinion that the disease is work-related, even if the specialist has not seen the claimant. In other cases, a physician must examine the worker in order to form an opinion. The board may not reject an opinion as the basis for controversion solely because it is not equal to the weight of the employee's evidence, because to do so is to weigh the opinion, instead of viewing it in isolation.

The Supreme Court held in *Harp v. ARCO Alaska, Inc*. that the employer must provide "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."[94] This rule does not require the employer who is responding to the employee's evidence of permanent partial impairment rating to produce such a great weight of evidence that it is predictable that the board *would* rely on the employer's rating over the employee's rating. The *Harp* formulation implies that the claimant has not yet introduced evidence to oppose the employer's evidence, as when the employer controverts continuing temporary disability compensation because the employee is medically stable. Impairment ratings may be sought and filed by the employee in the first instance, as it was in this case. The award of a penalty based on failure to obtain an employer medical examination and full report within 21 days of the employee's impairment rating, and consideration of only the second controversion, based on the October examination, was based on an erroneous assumption that only a full impairment evaluation would provide responsible medical evidence to controvert *any part* of Dr. Mulholland's report.

The board should have examined Dr. Dietrich's September 2006 letter to determine if it reflected responsible medical opinion that would rebut a presumption that the employee was entitled to permanent impairment of 32 percent, as opposed to

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[94] *Harp*, 831 P.2d at 358 (emphasis added).

a lower percentage. Dr. Dietrich, after reviewing the employee's treating physicians' reports, wrote that the absence of physician reports of post-surgical bilateral sensory loss made bilateral sensory loss and impairment [due to the injury] unlikely, contradicting one part of Dr. Mulholland's rating.[95] The physician who limits an opinion to that for which he or she has a valid medical basis is acting responsibly; Dr. Dietrich limited his opinion criticizing Dr. Mulholland's rating and cited his medical basis for his opinion. A statement that he would not give an impairment rating of his own until examining Monfore does not undermine the opinion opposing Dr. Mulholland's rating for bilateral nature of the sensory loss.

In this case, it is enough if the responsible medical opinion would overcome a presumption that Monfore's work related impairment included a 12 percent rating for bilateral sensory impairment. Dr. Dietrich's initial opinion that it was unlikely that Monfore's injury-related sensory loss was bilateral was sufficient to controvert more than a six percent rating for sensory loss until Dr. Dietrich reached a different conclusion after examining Monfore. The employer then amended the controversion, which was, as the board found, reflective of a "valid dispute." The employer had a valid basis for controversion of part of Dr. Mulholland's rating. Therefore, the board's assessment of a penalty on *all* of the permanent impairment compensation was error.[96]

> *d. AS 23.30.095(c) acts as a claim-bar if notice of treatment is not provided by the provider or employee to the employer and the board, but may be avoided by notice that is sufficient to alert the board and employer of the general scope of treatment.*

AS 23.30.095(c) provides in pertinent part:

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[95] Dr. Dietrich's opinion had a "factual basis" in the medical records he reviewed. His opinion was not merely "neutral" evidence because he expressed the opinion that bilateral sensory loss was "unlikely" *because* no record of bilateral post-surgical sensory loss was recorded, although, as his letter noted, sensory loss was recorded after surgery on one side. He later changed his mind, but that does not mean his first opinion lacked a basis in fact.

[96] The appellee did not argue that the text of the controversion was invalidly over-broad, and the board did not make its decision on that basis. The commission's decision does not address that issue.

> A claim for medical or surgical treatment, or treatment requiring continuing and multiple treatments of a similar nature is not valid and enforceable against the employer unless, within 14 days following treatment, the physician or health care provider giving the treatment or the employee receiving it furnishes to the employer and the board notice of the injury and treatment, preferably on a form prescribed by the board. The board shall, however, excuse the failure to furnish notice within 14 days when it finds it to be in the interest of justice to do so, and it may, upon application by a party in interest, make an award for the reasonable value of the medical or surgical treatment so obtained by the employee. When a claim is made for a course of treatment . . . .

In *Crawford & Co. v. Baker-Withrow*,[97] the Supreme Court described the meaning of the first two sentences of this statute for providers giving continuing or multiple treatments:

> The first sentence of subsection .095(c) requires a health care provider who furnishes continuing or multiple treatments of a similar nature to give notice of such treatment to the employer and the board within fourteen days following treatment. If notice is not given, the employee's claim for the treatments is not valid and enforceable against the employer. But, according to the second sentence, the board may excuse the failure to furnish notice in the interest of justice.

The same provision applies to those who provide surgical treatment. If no notice is given, the employee's claim for the treatment "is not valid and enforceable" against the employer.

In addressing the impact of the requirement for a written treatment plan for multiple treatments in AS 23.30.095(c), the Court held that it was not, unlike furnishing notice of treatment within 14 days, "waivable in the interest of justice."[98] The Court said that

> [w]hat remains is a question concerning the consequences of furnishing a treatment plan more than fourteen days after treatment begins. Does the fact that a plan is submitted late mean that all past and future treatments in excess of frequency standards are barred or are only past treatments-those occurring

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97 73 P.3d 1227, 1228-29 (Alaska 2003).

98 73 P.3d at 1229.

> more than fourteen days before the plan is furnished-barred? We believe that only past treatments should be barred . . .[99]

The Court did not suggest that the impact of failure to give notice, absent waiver by the board, had a different effect than failure to file a plan. Therefore, the consequence of failure to give notice of surgical treatment is to bar a claim for payment of the treatment.

The Supreme Court has noted the distinction between the right to payment of compensation and the written application for payment if the payment is controverted.[100] A similar distinction could be drawn in AS 23.30.095. In AS 23.30.095(h), the word "claim" is used to refer to a written application for payment: "upon the filing with the division . . . of a claim." On the other hand, there is no reference to "filing" in AS 23.30.095(c) in connection with the word "claim." Instead, the second sentence uses the word "application" to describe a specific request for board action; if the legislature had intended the word "claim" to refer to a "written application" in § .095(c), it would have had no reason to use the word "application" in the same section.[101] Instead, the word "claim" appears to have a broader meaning, referring to a right which is not enforceable or an action which is not valid, because of the failure of a required condition.[102]

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99 *Id*.

100 *Jonathan v. Doyon Drilling, Inc.,* 890 P.2d 1121, 1124 (Alaska 1995).

101 *See* 8 AAC 45.050(b), providing that "An application is a written claim."

102 *See*, *e.g.*, AS 23.30.100(d), "Failure to give notice does not bar a claim under this chapter, (1) if the employer . . . ." *Compare* statutes referring to marriage, AS 25.05.011 ("not valid without solemnization"); contracts, AS 45.02.201 ("is not enforceable by action or defense unless there is a writing"); a promise to contribute to a limited liability company, AS 10.50.280 (a promise by a member . . . to contribute property or services to the company is not enforceable unless the promise is stated in a writing"); a waiver of child support, AS 25.27.065 ("is not enforceable unless (1) the agreement is put in writing"); acts of the commission on judicial conduct, AS 22.30.050 ("act of the commission is not valid unless concurred in by a majority"); *with* statutes referring to specific documents, e.g., AS 10.06.418 ("A proxy is not valid after the expiration"); AS 21.84.080 ("preliminary certificate of authority is not valid after one year"); AS 23.10.110 ("written settlement agreement under this subsection is not valid

In *Hulsey v. Johnson & Holen,*[103] the Supreme Court addressed the issue of attorney fees that "are not valid unless approved by the board."[104] The effect of failure of this condition was that the attorneys, who performed services in respect of a petition to reopen Ms. Hulsey's claim for compensation, "*had no right to charge* Ms. Hulsey *a fee* for time spent on those efforts."[105] In the view of the commission, the effect of the claim bar in AS 23.30.095(c), raised by failure to give notice, is that there is no enforceable right to employer payment for medical treatment, unless the board waives the bar in the interest of justice.

In this case, the Municipality asserted that the employee or provider did not give notice to the board and the employer within 14 days of the surgery. An examination of the board record reveals that on October 18, 2005, Ward North received a record showing anesthesia provided for a "C5-6-7 anterior cervical discectomy, decompression, fusion" by surgeons James Eule, M.D., and Edward Voke, M.D., on October 12, 2005, at Providence Alaska Medical Center.[106] Ward North received a record of the electromyographic monitoring during surgery on October 25, 2005.[107] On the other hand, the board record shows that other Providence Alaska Medical Center medical records were received January 26, 2007 by NovaPro Risk Management. There is no board date stamp on these documents, but they are included in a lengthy medical summary filed at the board by the Municipality's attorney on February 27, 2007. In addition, Monfore testified that although he had copies of all his medical records, including the Providence records, he did not give copies to the adjuster or file them with a medical summary at the board.[108] This is evidence that the "health care provider

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unless submitted to the department"); AS 28.39.040 ("certificate of registration is not valid unless it is signed").

103 814 P.2d 327 (Alaska 1991).

104 *Id.* at 328, quoting AS 23.30.145(a).

105 814 P.2d at 329.

106 R. 0552-54.

107 R. 0559-60.

108 Tr. 77:4-79:3.

giving the treatment [and] the employee receiving it" failed to furnish to the employer and the board notice of the treatment, on a form prescribed by the board or otherwise, within 14 days of the treatment.

The board did not make findings that (1) the provider (Providence) or the employee gave, or did not give, notice to the Municipality *and* the board of the surgical treatment; (2) that, if given, the notice was given within 14 days following treatment; or, (3) if notice was not given, it was in the interest of justice to excuse the failure to furnish notice. The consequence of failure to give notice would be that a claim for payment of the Providence bill was not valid and enforceable.

If Providence had provided notice to the board within 14 days following surgery it would have prevented just such a dispute as was presented here, where a seven month delay in generating a statement and providing supporting records was followed by disputed assertions of statements and records faxed or mailed without response repeatedly, and months of payment delay. Notice to the board provides a means of verifying the address used to provide notice to the employer, it verifies when notice was given, it encourages timely payment, it provides a means of assuring that employer or insurer payment reserves are current and adequate, it ensures the board has a record of the providers of treatment to the employee in the event of subsequent disputes, and it ensures that the board is able to quickly resolve disputes.[109]

These advantages outweigh the burden on providers of services (or employees) to provide prompt notice.[110] The purpose of notice is not to provide the detailed billing

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[109] The commission's experience is that the practice of providing timely notice *to the board* has been more honored in the breach than the observance by many health care providers.

[110] The legislature assigned the duty to give notice to the physician, health care provider or employee. AS 23.30.095(c). This is consistent with the rule that the employee (or health care provider claiming on its own behalf) bears the burden of producing evidence of and proving medical expenses. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 607-08 (Alaska 1999) ("Allocation of this burden to the claimant makes sense because the extent of injury and amount of medical expenses are unique in each case, and the worker often has greatest access to such information. Because medical expenses are not presumed, a claimant has the burden of proving them by a

and report of services required by 8 AAC 45.082; the purpose is to avoid stale claims for payment of lost, forgotten, or delayed medical bills by requiring those who have the best access to the information about the treatment to give prompt notice to those who must pay for it. Therefore, the commission holds that notice is, as the statute provides, preferably given on a form approved by the board, but it is adequate to avoid the claim bar if it alerts the board and the employer to the general scope of treatment provided.

e. Employer liability for payment is triggered by receipt of the completed written report and itemized statement.

When Monfore was injured, AS 23.30.095(l) provided:

> An employer shall pay an employee's bills for medical treatment under this chapter, excluding prescription charges or transportation for medical treatment, within 30 days after the date that the employer receives the health care provider's bill or a completed report, whichever is later.[111]

8 AAC 45.082(d) provided:

> Medical bills for an employee's treatment are due and payable within 30 days after the date the employer received the medical provider's bill and a completed report on form 07-6102. Unless the employer controverts the prescription charges or transportation expenses, an employer shall reimburse an employee's prescription charges or transportation expenses for medical treatment within 30 days after the employer received the medical provider's completed report on form 07-6102 and an itemization of the prescription numbers or an itemization of the dates of travel, destination, and transportation expenses for each date of travel. If the employer controverts

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preponderance of the evidence.") (citation omitted). Requiring the employer to seek out and obtain all the employee's medical bills, as the board did in this case, improperly shifts the burden of production to the employer.

[111] This statute was repealed by § 74 ch. 10 FSSLA 2005 and re-enacted in slightly different form as AS 23.30.097(d):

> An employer shall pay an employee's bills for medical treatment under this chapter, excluding prescription charges or transportation for medical treatment, within 30 days after the date that the employer receives the health care provider's bill or a completed report as required by AS 23.30.095(c), whichever is later.

> (1) a medical bill or if the medical bill is not paid in full as billed, the employer shall notify the employee and medical provider in writing the reasons for not paying all or a part of the bill or the reason for delay in payment within 30 days after receipt of the bill and completed report on form 07-6102;
>
> (2) a prescription or transportation expense reimbursement request in full, the employer shall notify the employee in writing the reason for not paying all or a part of the request or the reason for delay within the time allowed in this section in which to make payment; if the employer makes a partial payment, the employer shall also itemize in writing the prescription or transportation expense requests not paid.

8 AAC 45.086 provided:

> (a) A provider who renders medical or dental services under the Act shall file with the board and the employer a substantially complete form 07-6102 within 14 days after each treatment or service.
>
> (b) The board will, in its discretion, deny a provider's claim of payment for medical or dental services if the provider fails to comply with this section.
>
> (c) For purposes of this chapter and AS 23.30.095, "continuing and multiple treatments of a similar nature" does not include a medical doctor's prescription for pharmaceutical products, a prosthesis or an orthotic device.

The statute and regulations require payment within 30 days after the date that the employer *receives* the completed form 07-6102 (medical report) and the bill in a form that permits review of the charges under 8 AAC 45.082(i).

In this case, based on the testimony of Maryann Murdock the board found that Providence, through Health Services Northwest, served a copy of the report and bill on the employer's adjuster on May 22, 2006.[112] The board found Murdock to be a credible

[112] Service may be effected by mail, but only if "mailed with sufficient postage and properly addressed to the party at the party's last known address." 8 AAC 45.060(b) Written proof of service must be filed with the board, or "the board will, in its discretion, refuse to consider a document when proof of its service does not conform to the requirements of this subsection." 8 AAC 45.060(c). The dispute here was whether the documents were "properly addressed." Murdock did not testify that she

witness, and the commission is bound by the determination of credibility. She testified that the computer record reflected that the records and bills were mailed to Ward North on May 22, 2006 *and* that the address on file for Ward North is a post office box in Anchorage.[113] She testified that a copy of the billing was faxed to Ward North Alaska on July 24, 2006, because Ward North was "unable to locate the billing or any of the information."[114] She also testified that they were mailed a second time in October 2006.[115] She was unable to identify the denial letter from Ward Strategic Claims Solutions in Washington state, which contained references to Washington state regulations, because she did not have the letter before her.[116] Murdock's testimony did not directly contradict evidence that the October 2006 denial letter from Ward Strategic Claims Solutions in Washington responded to billing from Health Services Northwest.

Although the board found the reports and billings were "served" on May 22, 2006, the board did not find when Ward North received them. Murdock's testimony established that Health Services Northwest recorded the reports and billings were mailed to Ward North. She testified the address "on file" was a post office box in Anchorage. She also testified that she had not seen any "address updates," so if a change was made, she was not aware of it.[117] Murdock's testimony did not eliminate the possibility that some records were mailed to Ward Strategic Claims Solutions in Washington, although it established that they were faxed, at least in part, to Ward North Alaska. The board made no findings that the records were mailed to the correct address, which was the major issue in dispute.

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had actual knowledge of mailing; she did not have a "paper" file before her. The computer record of events did not include in the contemporaneous entry the address to which the documents were mailed.

113 Tr. 26:3-9.

114 Tr. 27:19-24.

115 Tr. 29:9-14.

116 Tr.44:14-23.

117 Tr. 43:17.

AS 23.30.095(l) requires payment within 30 days after receipt of the bill and report. The board had some evidence to support a finding that the reports were mailed to Ward North; but it did not follow it with a finding that the records were mailed to the correct address, received (by mail or fax), and then misplaced or ignored by Ward North or NovaPro. Thus, the board failed to make a necessary finding for the imposition of a late payment penalty. The commission remands this issue to the board, with instructions to make additional findings of fact regarding the date the Municipality received the billings and reports; and to determine, in light of those findings, whether the Municipality is liable for a late payment penalty.[118]

On remand, the board is advised that a penalty under AS 23.30.155(e) is owed to the "recipient of the installment" on which the penalty is paid. In this case, the "installment" is the payment for medical treatment. The "recipient" is not the employee, but Providence. The penalty, if owed, must be paid to Providence.

The Municipality asserted, as a defense to the penalty, that Providence failed to file timely notice of treatment. The board made no attempt to require Providence to appear as an interested party, notwithstanding that a "person who may have a right to relief in respect to or arising out of the same transaction or series of transactions should be joined as a party."[119] There was no evidence in the record that Providence was

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[118] The record contains documents, apparently generated by Providence and date-stamped by Ward North America Anchorage on Oct. 25, 2005 (R. 0174-76, 180-83), concerning Monfore's surgery.

[119] 8 AAC 45.040(c), *Sherrod v. Municipality of Anchorage,* 803 P.2d 874 (Alaska 1990). *Compare* Alaska Rule of Civ. Pro. 19 ("A person . . . shall be joined as a party in the action if . . . the person claims an interest relating to the subject of the action and is so situated that the disposition of the action in the person's absence may (i) as a practical matter impair or impede the person's ability to protect that interest or (ii) leave any of the persons already parties subject to a substantial risk of incurring double, multiple, or otherwise inconsistent obligations.") *with* 8 AAC 45.040(j) ((j) ("In determining whether to join a person, the board or designee will consider (1) whether a timely objection was filed in accordance with (h) of this section; (2) whether the person's presence is necessary for complete relief and due process among the parties; (3) whether the person's absence may affect the person's ability to protect an interest, or subject a party to a substantial risk of incurring inconsistent obligations; (4) whether

informed of the request for penalty and authorized Monfore to act on its behalf.[120] When, as here, a penalty is contested based on a claim bar raised by the provider's failure to give timely notice under AS 23.30.095(c), the provider entitled to the penalty being adjudicated should be informed of the matter prior to the board's adjudication, and given an opportunity to appear, or to authorize another to proceed on its behalf.[121]

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a claim was filed against the person by the employee; and (5) if a claim was not filed as described in (4) of this subsection, whether a defense to a claim, if filed by the employee, would bar the claim.").

[120] The claim for medical treatment is Monfore's claim, AS 23.30.095(c), and Providence's right to a penalty is dependent on the compensability of Monfore's claim, but Monfore has no personal interest in the penalty on late payment of Providence's bill. Absent ratification by Providence, or its agreement to be bound by the outcome, the board should require the real party in interest to prosecute the claim for a penalty. *See Burns v. Anchorage Funeral Parlor*, 495 P.2d 70, 73-74 (Alaska 1972); *Municipality of Anchorage v. Baugh Constr. & Eng. Co.*, 722 P.2d 919, 925-26 (Alaska 1986); *Ruggles v. Grow*, 984 P.2d 509, 511-13 (Alaska 1999); *Tlingit-Haida Reg'l Elec. Auth. v. State,* 15 P.3d 754, 769 (Alaska 2001).

[121] There is evidence in the record that the board could rely on to establish that the employer had timely actual notice of the treatment provided by Providence. In such a case, the Municipality may not be able to assert that Providence's failure to provide substantially the same notice bars the employee's claim for payment. *See* AS 23.30.100(d) and cases construing it, *e.g.*, *Dafermo v. Municipality of Anchorage*, 941 P.2d 114 (Alaska 1997); *Williams v. State, Dep't of Revenue*, 938 P.2d 1065 (Alaska 1997); *Kolkman v. Greens Creek Mining Co.*, 936 P.2d 150 (Alaska 1997). The board did not make relevant findings, and this issue was not briefed, so it is not decided here.

6. Conclusion.

The board's decision is affirmed in part, vacated in part, and remanded for further findings, as directed by this decision. The commission does not retain jurisdiction.

Date: *18 June 2008* ALASKA WORKERS' COMPENSATION APPEALS COMMISSION

Signed
Philip Ulmer, Appeals Commissioner

Signed
Jim Robison, Appeals Commissioner

Signed
Kristin Knudsen, Chair

APPEAL PROCEDURES

This is a final decision on the merits of this appeal. The effect of this decision is to remand the decision on the amount of compensation awarded to the board for additional findings, to affirm the decision to award a penalty on late payment of compensation, to remand for more findings on the calculation of the penalty, to remand the issue of the penalty on late payment of medical bills to the board for further findings, to affirm the board's decision that any penalty on late paid medical bills is paid to the provider who received the late payment, and, to instruct the board to give notice of the proceedings on remand to the provider as the real party in interest. This decision is not the final administrative decision on Mr. Monfore's claim, but it is a final decision on this appeal, because the commission has not retained jurisdiction. If the board issues another decision after this remand, that decision may be appealed to the commission.

Effective November 7, 2005 proceedings to appeal a commission decision must be instituted in the Alaska Supreme Court within 30 days of the distribution of a final decision and be brought by a party in interest against the commission and all other parties to the proceedings before the commission, as provided by the Alaska Rules of Appellate Procedure. AS 23.30.129. Check the clerk's certificate of distribution in the box below for the date of distribution.

Other forms of review are also available under the Alaska Rules of Appellate Procedure, including a petition for review or a petition for hearing under the Appellate Rules. If you believe grounds for review exist under Appellate Rule 402, you should file your petition for review within 10 days after the date this decision was distributed.

If a request for reconsideration of this final decision is timely filed with the commission, any proceedings to appeal, if appeal is available, must be instituted within 30 days after

the reconsideration decision is mailed to the parties, or, if the commission does not issue an order for reconsideration, within 60 days after the date this decision is mailed to the parties, whichever is earlier. AS 23.30.128(f).

If you wish to appeal to the Alaska Supreme Court, or petition for review or hearing, you should contact the Alaska Appellate Courts **immediately**:

Clerk of the Appellate Courts
303 K Street
Anchorage, AK 99501-2084
Telephone 907-264-0612

RECONSIDERATION

A party may ask the commission to reconsider this decision by filing a motion for reconsideration in accordance with 8 AAC 57.230. The motion requesting reconsideration must be filed with the commission within 30 days after delivery or mailing of this decision.

CERTIFICATION

I hereby certify that the foregoing is a full, true and correct copy of the Alaska Workers' Compensation Appeals Commission's Final Decision No. 081, issued in *Municipality of Anchorage v. Mark Monfore*, AWCAC Appeal No. 07-013, dated and filed in the office of the Alaska Workers' Compensation Appeals Commission in Anchorage, Alaska, this *18th* day of *June*, 2008.

Signed
L. Beard, Appeals Commission Clerk

Certificate of Distribution

I certify that on *6/18/08* a copy of this Final Decision No. 081 in AWCAC Appeal No. 07-013 was mailed to Coe and Zobel at their addresses of record, and faxed to AWCB Appeals Clerk, WCD Director, Zobel and Coe.

Signed *6/18/08*
J. Ramsey, Deputy Clerk Date