BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS

IN THE MATTER OF:	)	
	)	
J M. J	)	OAH No. 10-0324-PER
	)	Div. R & B No. 2010-005

Decision

I. Introduction

J M. J, a Public Employees' Retirement System (PERS) member, is disabled and receives PERS nonoccupational disability benefits. She believes her disability was proximately caused by an August 2003 work injury because before the injury she did not have disabling neck pain and headaches, but over the years her symptoms have increased and become so pervasive that she can no longer work. The PERS Administrator does not deny that Ms. J suffered a work injury in August 2003, or that she is now disabled, but he contends the two are not related. Therefore, there is only one issue: whether Ms. J's disability was proximately caused by work.

A hearing was held over the course of several days, culminating in closing arguments on March 11, 2011. Ms. J was assisted by her husband.[1] Assistant Attorney General Toby Steinberger represented the Administrator.

II. Facts

Ms. J was hired by the State of Alaska as an Administrative Clerk in the spring of 2003. In August she, along with several other Division employees, were tasked with moving an office full of furniture and thousands of files from one floor to another. During this time Ms. J began to experience severe headaches and pain in her neck, back, and shoulders. Other employees working on the move had similar complaints.[2] However, unlike her co-workers, Ms. J's symptoms were constant, and they progressively worsened until, on August 19, 2003, upon waking she could not move her neck. She was 32 at the time.

Little is known about Ms. J's pre-August 2003 medical history other than she had two uneventful pregnancies, an appendectomy and a hysterectomy. She had never experienced

[1] "The administrative law judge may allow a self-represented party to be assisted by a person who is not an attorney and may impose reasonable limits on participation by the assistant." 2 AAC 64.160(a).

[2] Testimony of C S.

anything similar to her current complaints.[3] She sought treatment with Steven Henderson, D.C., whom she had treated with in the past.

Dr. Henderson diagnosed a cervical sprain/strain.[4] The expected recovery time for his type of soft-muscle injury in 90% of the population is four to six weeks.[5] Dr. Henderson excused Ms. J from work for one month and placed no restrictions on her return.[6] Once she returned to work her condition began to deteriorate. She required frequent breaks and could only perform tasks that involved limited lifting.[7] Dr. Henderson attributed these problems to her work space and believed ergonomic adjustments were necessary. He excused her from work until the adjustments were completed.[8] Four months later, she returned to work with instructions to slowly increase her hours to a full work day.

As time went on, Ms. J's condition improved. Her cervical range of motion returned. She started exercising. Ms. J began to complain of problems sleeping, and in April, 2004, she participated in a sleep study and stress test.[9] The report does not mention the August 2003 work injury but does reference a "head trauma in the distant past but is not aware of any lingering residual adverse effects."[10] Ms. J did not review this report prior to her appeal and did not know why that reference was there or what it is referring to. The only thing she could think of was that it must be referring to the August 2003 injury.[11] By April 2004 she felt as if the August 2003 injury was behind her and she was not aware of any lingering residual effects.[12]

In mid-May 2004, Ms. J was again moving files at work when the headaches returned and her neck and shoulder complaints resurfaced.[13] These symptoms were similar to those experienced with the August 2003 injury. She sought workers' compensation benefits and the May 2004 event was accepted by the employer as a work-related aggravation of the 2003 injury for purposes of workers' compensation.[14] In the Supervisor's Accident Investigation Report it

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3 Div. Exh. 1, Part A at 8; Testimony of J J; Testimony of S J.
4 Div. Exh. 1, Part A at 1 – 15.
5 Testimony of Steven Johnson M.D.
6 Div. Exh. 1, Part A at 30.
7 Div. Exh. 1, Part A at 32.
8 Div. Exh. 1, Part A at 32.
9 Div. Exh. 1, Part B at 232 – 243.
10 Div. Exh. 1, Part B at 233.
11 Testimony of J J.
12 Testimony of J J.
13 Div. Exh. 1, Part A at 103 – 104; Div. Exh. 17 at 52, 54.
14 J Exh. D at 14, 16.

was reported that the injury "may have exacerbated a previous injury."[15] She was let off work for one week. Upon return she was placed on light duty and participated in physical therapy until July 2004.[16]

Ms. J did not seek treatment until January 3, 2005. Her symptoms "flared-up" after her husband gave her a hug in mid – late December 2004.[17] After three treatments Dr. Henderson wrote a "To Whom it May Concern" letter stating that Ms. J. was treated for a "flare up in her neck and midback. This condition presented itself in past months while receiving care for work related injuries. It is my professional opinion that this flare-up is directly related to her initial work injury sustained on 08/18/03."[18]

Ms. J did not improve and Dr. Henderson referred her to Physician Assistant Michael L. Hansen for further evaluation. Mr. Hansen diagnosed cervical spine strain with muscle spasm, prescribed physical therapy, and referred Ms. J on to physiatrist[19] Susan Klimow, M.D.[20]

Dr. Klimow has a subspecialty in pain management and certification as an independent medical examiner.[21] In a letter to Mr. Hansen, Dr. Klimow writes that Ms. J's husband gave her a big hug, she heard a "pop" in her neck, and since then her symptoms have worsened. The history written by Dr. Klimow states that Ms. J had an August 2003 work injury and that Ms. J gradually "got better and intermittently, since that time, has had flare-ups, would go for a month or two with only a few headaches and little or no pain then she will suddenly have increased discomfort in the same area."[22] The history in Dr. Klimow's 2005 chart note does not mention the May 2004 injury. Several diagnostic tests were ordered and Dr. Klimow diagnosed cervical pain and whiplash, cervical degenerative disc disease at C5-C6, right shoulder pain with decreased range of motion, headaches, and right shoulder/arm pain.[23] After completing

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15 J Exh. D at 15.

16 J Exh. D at 13, 14; Div. Exh. 1, Part A at 74.

17 Div. Exh. 1, Part A at 78. The exact date of the onset of symptoms was not established. Dr. Henderson's chart note indicates that the "flare-up" started three to four weeks prior to her visit. The record also contains a chart note from an Urgent Care provider a few days after her visit with Dr. Henderson. The Urgent Care note states the triggering event occurring ten days prior to her visit. The note also provides that the hug triggered a sudden onset of pain similar to that she experienced from her 2003 work injury. Regardless, they all indicate the "flare-ups" started December 2004 after a hug from her husband.

18 Div. Exh. 1, Part A at 80.

19 A physiatrist is a physician who specializes in physical medicine and rehabilitation. http://www.merriam-webster.com/medical/physiatrist.

20 Div. Exh. 1, Part A at 83, 84, 287.

21 Div. Exh. 1, Part A at 88.

22 Div. Exh. 1, Part A at 88.

23 Div. Exh. 1, Part A at 90.

diagnostic testing, Dr. Klimow changed her assessment of Ms. J to reflect a diagnosis limited to recurrent cervical pain/strain and returned Ms. J to work and physical therapy.[24] By March 29, 2005, Ms. J noted improvement.[25]

A few months later Ms. J experienced a notable worsening of her neck pain and headaches.[26] She returned to Dr. Klimow, but Dr. Klimow had left the practice group so Ms. J was treated by Catherine A. Giessel, FNP-C.[27] Ms. Giessel's notes do not mention the August 2003 work injury. She diagnosed, consistent with prior complaints and diagnoses, cervical muscular pain, right shoulder pain with decreased range of motion, and headaches.[28]

By September 19, 2005, Ms. J's pain was interfering with her daily activities, including work.[29] She would improve over the weekend when not at work and upon returning, but noted that the slightest activity would exacerbate her condition.[30] Ms. J was willing to try a more aggressive and invasive approach to pain management, including facet blocks (injections into the facet joints of the vertebra) and oral steroids. [31] A facet block is used as a diagnostic tool to identify the source of pain as well as to treat the pain. [32]

Her first facet block was performed by Michel L. Geveart, M.D. He is a former practice partner of Dr. Klimow and has the same specialty and subspecialties as Dr. Klimow. The block was successful, providing Ms. J with significant pain relief and range of movement in her neck.[33] More importantly, because of the positive response to the block, they were able to identify facet syndrome as a pain generator.[34] This diagnosis stood up to the passage of time. In 2010, Ms. J was treated by pain specialist Steven Johnson, M.D. Dr. Johnson testified that what he was observing in 2010 was consistent with what he would expect given Ms. J's August 2003 injury and ongoing pain. This diagnosis would help provide a treatment plan for Ms. J. Three weeks

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24 Div. Exh. 1, Part A at 96, 97.

25 Div. Exh. 1, Part A at 96; Div. Exh. 1 Part B at 270.

26 Div. Exh. 1, Part A at 102. No triggering event is identified in the medical records.

27 Testimony of Ms. J.

28 Div. Exh. 1, Part A at 102.

29 Div. Exh. 1, Part A at 105; Div. Exh. 1, Part B at 279.

30 Div. Exh. 1, Part A at 105; Div. Exh. 1, Part B at 279.

31 Each vertebra has two sets of facet joints. They form the ball and socket joint that hinge the spine allowing it to move. A facet block is a procedure in which a needle is placed in to the facet joint for a nerve root block injection. http://www.cedars-sinai.edu/Medical-Professionals/Imaging-Center/Interventional-Neuroradiology/Facet-Block-or-Selective-Nerve-Root-Block.aspx.

32 *See, e.g., Id.*

33 Div. Exh. 1, Part A at 106, 107, 108; Div. Exh. 1, Part B at 280, 285, 288.

34 A chart note from October 18, 2005 lists as the diagnoses cervical neck pain, cervical facet syndrome, right shoulder pain, and headaches. Div. Exh. 1, Part A at 108.

later Ms. J returned to work with lifting and range of motion restrictions (no raising arms above shoulder height).[35]

On November 15, 2005, in association with the workers' compensation claim, Holm W. Neumann, M.D., P.H.D., and Richard L. Peterson, D.C., performed an employers' medical evaluation (EME).[36] Dr. Neumann is an orthopedic surgeon and Dr. Peterson is a chiropractor. They concluded that the August 2003 work injury caused a cervical sprain/strain that was temporary and expected to resolve in four to six weeks. They opined that Ms. J's ongoing complaints were the result of the normal degenerative process. Moreover, because they could not find a physical source for her complaints, they speculated that Ms. J could have been exaggerating. Based on Drs. Neumann and Peterson's opinions, the employer controverted Ms. J's workers' compensation claim.

The block began to fade. Ms. J's next treatment option was radio frequency lesioning.[37] This procedure was performed June 8, 2006 and was successful in relieving Ms. J's cervical pain. Two and a half months later, after playing with one of her grandchildren, Ms. J noted an increase in shoulder pain. Ms. Giessel's chart notes state that the symptoms were not related to facet syndrome, but rather attributable to muscle spasms and a possible migraine.[38]

In mid-February 2007, Ms. J was evaluated by board-certified orthopedic surgeon and medical evaluator John J. Lipon, D.O. Dr. Lipon performed a second independent medical evaluation (SIME) for the Workers' Compensation Board. He reviewed medical records and performed a physical examination. Dr. Lipon opined that he did not see any evidence of degenerative changes involving the facet joints on an MRI.[39] He was of the opinion that Ms. J's symptoms after May 2004 were inconsistent with a soft tissue injury consisting of a cervical and upper thoracic strain because such an injury would be expected to resolve within four to six weeks.[40] Finally, Dr. Lipon's original opinion was that any treatment after May of 2004 was not

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[35] Div. Exh. 1, Part A at 110.

[36] Div. Exh. 1, Part A at 111 – 127. This evaluation was performed in conjunction with Ms. J's workers' compensation claim.

[37] Div. Exh. 1, Part A at 143, 145, 148. Radio Frequency Lesioning or Radio Frequency Ablation is a treatment for chronic pain where a portion of the nerve tissue is heated, resulting in an interruption of the pain signal. http://www.webmd.com/cancer/tc/radiofrequency-lesioning-for-chronic-pain. Because the nerve will often regenerate the results are temporary and usually last for six to nine months. *Id.*

[38] Div. Exh. 1, Part A at 152 – 153; Agency Record at 521 – 529.

[39] Div. Exh. 4 at 28.

[40] Div. Exh. 4 at 30, 31.

related to the 2003 work injury.[41] However, during his testimony in this proceeding he changed his opinion, accepting that any treatment received through June 2004 was related to the 2003 work injury. He changed his opinion after receiving additional medical records establishing that Ms. J received physical therapy associated with her work injuries up through June 2004.

Ms. J obtained relief for several months, but by mid-September 2007, her pain and headaches began to return.[42] By April 2008, Ms. J was complaining of "severe neck pain" with no identified triggering event.[43] Her facet syndrome was now considered chronic.[44] The radiofrequency procedure was repeated May 15, 2008 and Ms. J noted a decrease in pain.[45]

That fall, Ms. J experienced a flare-up in pain after taking a short four-wheeler ride (a mile or two over a dirt/gravel road plus a section of pavement) with her husband.[46] She also noticed a "flare-up" early February 2009 following a game on the Wii that required a lot of arm movement.[47] Another medical branch block was performed in March 2009.

Ms. J's headaches were increasing in frequency and duration. By April 2009, they were her primary complaint; neck and back pain was secondary. A family friend, Stanley Trekell, D.C., ordered a positron emission tomography (PET) scan that was negative, "particularly of the cervical spine."[48] A PET scan is used to identify where there is an abnormal increase in metabolic or chemical activity.[49] If Ms. J had any sort of facet joint irritation, the PET scan would identify the area with an increase in activity.[50] Ms. J's PET scan was normal.[51]

After reading about occipital neuralgia, Ms. J made an appointment with neurologist Mary Downs, M.D.[52] Dr. Downs performed an occipital nerve block and Ms. J's pain

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41 Div. Exh. 4 at 30.
42 Div. Exh. 1, Part B at 299.
43 Div. Exh. 1, Part B at 300. The medical records do not identify a causal event.
44 *Id.*
45 Div. Exh. 1, Part B at 317, 327, 331, 345; Testimony of J J.
46 Div. Exh. 1, Part B at 345; Testimony of J J.
47 Div. Exh. 1, Part B at 348.
48 Div. Exh. 1, Part B at 388. A PET scan measures the metabolic activity at the cellular level.
49 Testimony of Dr. Lipon.
50 Testimony of Dr. Lipon.
51 Div. Exh. 1, Part B at 388.
52 Div. Exh. 1, Part B at 390, 392. "Occipital neuralgia is a distinct type of headache characterized by piercing, throbbing, or electric-shock-like chronic pain in the upper neck, back of the head, and behind the ears, usually on one side of the head. Typically, the pain of occipital neuralgia begins in the neck and then spreads upwards." http://www.ninds.nih.gov/disorders/occipitalneuralgia/occipitalneuralgia.htm.

improved.[53] Between her most recent facet block (March 2009) and occipital block, Ms. J's life was returning to normal.[54]

Around this same time, Ms. Giessel and Dr. Geveart's chart notes state a new diagnosis. No longer was the diagnosis chronic cervical facet syndrome, but rather it was now chronic neck pain, cervical osteoarthritis, and occipital neuralgia, status post-steroid injection.[55]

By mid-November Ms. J's headache had returned and she complained of a stiff neck. Upon examination, Dr. Downs noted Ms. J's neck muscles were loose and suggested Ms. J return to Dr. Geveart for evaluation.[56]

Dr. Geveart performed another facet block on November 24, 2009. The first week, Ms. J experienced a 90% improvement, dropping to 60% by the third week.[57] After a month, the efficacy of Ms. J's cervical injections started to wane and she was scheduled for a repeat procedure January 12, 2010.[58] The diagnosis remained chronic neck pain, cervical osteoarthritis and occipital neuralgia.

Ms. J began to consider whether she could continue working. She contacted the Division of Retirement and Benefits and was informed that if she was eligible for occupational disability benefits, she would receive 40% of her salary and medical benefits. The PERS provided her with a Physician's Statement form asking about Ms. J's condition, treatment options, etc. for Dr. Geveart to complete. For reasons not explained in the record, he declined to do so.[59]

Shortly thereafter she requested a copy of her medical records from Dr. Geveart and a referral from Dr. Downs to a pain specialist. Dr. Downs referred Ms. J to anesthesiologist and board-certified pain management specialist, Steven Johnson M.D.

Ms. J was first seen by Dr. Johnson on March 15, 2010. He has no specific recollection of reviewing Ms. J's medical records but believes he may have seen some going back to 2006.[60] Dr. Johnson explained that he relies upon the medical history provided by his patients.[61] He

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53 Div. Exh. 1, Part B at 396, 406.
54 Testimony of J J.
55 *See e.g.*, Div. Exh. 1, Part B at 389 (April 29, 2009 Chart Note) ("Her pain has migrated to the suboccipital nerve, although she remains with residual pain in the upper cervical region….").
56 Div. Exh. 1, Part B at 424.
57 Div. Exh. 1, Part B at 438.
58 Div. Exh. 1, Part B at 441.
59 Div. Exh. 1, Part B at 446 – 448.
60 Testimony of Dr. Johnson.
61 Testimony of Dr. Johnson.

testified that Ms. J identified the August 2003 work injury as the cause of her present condition.[62]

Dr. Johnson's initial diagnosis was mild cervical degenerative disc disease, cervical facet pain, and occipital neuralgia.[63] He performed a medial branch block.[64] The block brought Ms. J's pain level down to almost nonexistent for a few days.[65] Because of the success of the medial branch block, it was agreed that Ms. J would undergo another radio frequency lesion. After the procedure Ms. J's headaches notably improved.[66]

In keeping with prior experience, Ms. J's symptoms eventually returned and she noticed that her pain would improve over the weekend and increase while at work.[67] Dr. Johnson completed a PERS physician's statement for purposes of PERS disability benefits.[68]

On July 23 and 30, 2010, Dr. Johnson implanted spinal cord stimulators. This is an invasive procedure involving the implanting of electrodes, leads, and a battery in the spine and lower back.[69] As of September 1, 2010, Ms. Johnson reported a 60% improvement. By September 27, 2010, Ms. J had returned to work, and as before, with the return to work came an increase in symptoms, primarily headache.[70]

On October 10, 2010, Dr. Downs wrote a "To Whom it May Concern" letter explaining that Ms. J's symptoms are worsened with activity and that, while they have had some success with treatment, "the success is always reversed when the patient tries to return to work."[71] Dr. Downs' letter did not mention a cause for Ms. J's symptoms.

By this time, Ms. J was working part-time[72] When not at work, Ms. J experienced a 65% improvement. She reported to Dr. Johnson that

> Prolonged sitting, driving, and pulling and pushing activity makes this worse. Rest, spinal cord stimulator, her medication, ice, heat, and muscle cream helps her out.[73]

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62 Testimony of Dr. Johnson.
63 Div. Exh. 1, Part B at 465.
64 Div. Exh. 1, Part B at 464 - 466.
65 Div. Exh. 1, Part B at 471. The chart note for April 12, 2010 identifies the areas of pain as neck, shoulder, and upper back.
66 Div. Exh. 1, Part B at 475.
67 Div. Exh. 1, Part B at 477.
68 Div. Exh. 1, Part B at 479.
69 Testimony of Dr. Johnson.
70 Div. Exh. 1, Part B at 488.
71 Div. Exh. 1, Part B at 491.
72 Div. Exh. 1, Part B at 492.
73 Div. Exh. 1, Part B at 492.

The PERS consulting physician, Kim Smith, M.D., reviewed these records and reported that a reduction in pain is common while at home because an individual is able to control their activities.

On November 1, 2010, Dr. Johnson wrote a "To Whom it May Concern" letter. He wrote that, given no other specific event to explain the cause of her pain, it was reasonable to conclude that the August 2003 injury is the proximate cause of Ms. J's disability.[74]

On December 20, 2010, a Physical Capacities Evaluation (PCE) was conducted.[75] It revealed that Ms. J could no longer perform the duties of her position due to the onset of pain.[76] After reviewing the PCE and Drs. Downs and Johnson's letters in support of disability, Dr. Smith recommended the PERS Administrator find Ms. J presumably permanently disabled and grant her nonoccupational disability benefits.[77] Dr. Smith wrote that he could see no evidence that the disability was work related and recommended against occupational disability benefits.[78] The PERS Administrator agreed. Ms. J appealed the denial of occupational benefits and this proceeding followed.

At hearing Ms. J presented the testimony of several prior co-workers. These individuals testified, that while they did not see Ms. J on a regular basis at work or on a social basis outside of work, they did note a drastic change in her appearance over the years.
Her husband and son testified that prior to August 2003, Ms. J was a vibrant, happy, active woman who enjoyed family and church activities. After her August 2003 work injury, Ms. J could no longer participate in family activities and the slightest exertion resulted in either neck pain or headache.

Ms. J's testimony expanded upon the testimony of her husband and son, going into more detail regarding how she would feel better for periods of time only to have a "flare-up" occur. She testified that over time her symptoms waxed and waned. As time went on the periods of recovery were shorter and the pain became greater and of longer duration. She emphasized that it was only after August 2003 that her decline began.

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74 Div. Exh. 1, Part B at 494 – 495.

75 A physical capacities evaluation is performed by a rehabilitation specialist to assess whether an individual can perform certain physical requirements of a position.

76 Curvature of the cervical spine. Testimony of Gerald Warnock, M.D.

77 AR at 706 – 707.

78 AR at 709 – 710.

Dr. Johnson also testified. He believes, with a reasonable degree of medical certainty, that Ms. J's activity moving files and the repetitive arm movement is the proximate cause of her disability. His testimony established that the "gold standard" for diagnosing facet syndrome was a positive response to a facet block. This was unchallenged by Dr. Lipon. Dr. Johnson explained that he deals with pain on a daily basis and realizes the role of the facet joint in causing pain. Finally, Dr. Johnson opined that there are several mechanisms of injury that could cause facet trauma but the only one experienced by Ms. J is the August 2003 injury.

The division presented the testimony of Dr. Lipon and Gerald Warnock, M.D. Dr. Lipon has two board certifications: orthopedic surgery and independent medical examiner. Dr. Lipon has retired from the active practice of medicine and earns his living providing evaluations and teaching. Concerning Ms. J, he has provided two written reports containing his opinion. One report was prepared in association with the workers' compensation proceeding and one in this PERS proceeding. In both reports he opines that, with a reasonable degree of medical probability, work was not a substantial factor in her disability.[79]

The first report, completed in February 2007, consisted of a physical examination and a review of Ms. J's medical records.[80] The second report was a review of recent records. This report is dated November 23, 2010. This review included records related to treatment in 2004 that were not provided for review in the first report. After considering this new information, Dr. Lipon had one minor modification to his prior conclusion: that treatment received up through July 2004 was related to the August 2003 work injury. He affirmed his prior opinion that there was no new industrial injury in 2004, and any treatment received starting in January 2005 as a result of her husband's hug or at any time thereafter was not related to the August 2003 injury.[81]

As to Ms. J's current complaints, Dr. Lipon testified that he could not identify the cause of Ms. J's complaints and he went so far as to opine that her complaints were not physically or anatomically possible without other abnormal findings being present, such as deep tendon reflex

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[79] Testimony of Dr. Lipon.

[80] Dr. Lipon issued a June 2007 addendum to his February 2007 SIME report at the request of the employer. The addendum was written as his response to a letter from Dr. Geveart to Ms. J criticizing Dr. Lipon's SIME report. Both letters were written for purposes of litigation versus treatment or an independent medical evaluation on behalf of the workers' compensation board. Because of its mixed character, the addendum is closer to a document drafted for purposes of litigation than an independent medical evaluation and will be given the same weight as Dr. Geveart's letter. AR 86 – 88; AR 173 – 175.

[81] "Treatment through May of 2004, in my opinion, has been medically reasonable and necessary as it relates to the industrial claim date of August 19, 2003." AR at 82. AR at 682.

loss/asymmetry, muscle strength loss, and muscle atrophy.[82] Finally, he identified several events that could have caused Ms. J's disabling pain: the December 2004 hugging incident, the "flare-up" in August 2006 after playing with her grandchild, the September 2008 four-wheeler ride with her husband, and a February 2010 fall.[83]

Dr. Warnock, a board-certified radiologist, reviewed Ms. J's records. He saw no abnormalities and that the loss of curvature of the cervical spine (lordosis) noted in some of the MRIs could be the result of muscle spasm, but that it was not a possible cause of Ms. J's pain. Based on his review, he found no physical cause for Ms. J's complaints.

Included among the medical records are the results of several MRIs from over the years. The first MRI was on October 18, 2003. It revealed a small disc protrusion at C5-6 with no evidence of nerve involvement.[84] There was no change noted in the May 2004 or March 2005 MRI. In an MRI dated May 9, 2008, no abnormality was noted and the minimal disc protrusion was no longer visible. [85]

III. Discussion

A. *Legal Standard*

PERS provides its members with two types of disability benefits: occupational and nonoccupational. Eligibility for occupational disability benefits requires a state employee to (1) suffer a *work-related* injury or illness; (2) be permanently disabled as a result; and (3) terminate employment because of the disability.[86] Nonoccupational disability benefits require the same showing, except the injury or illness does not need arise from employment.[87] The PERS Administrator agrees that Ms. J is disabled. Therefore, the only issue to be established is whether the disability was proximately caused by Ms. J's employment. PERS occupational disability benefits do not replicate the purpose of workers' compensation. An employee claiming occupational disability has the "burden of establishing by a preponderance of the

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82 Div. Exh. 4 at 32.
83 AR at 678.
84 AR at 603.
85 Div. Exh. 1, Part B at 387; Div. Exh. 1, Part A at 92.
86 AS 39.35.410 (providing for occupational disability); AS 39.35.680(27) (defining "occupational disability").
87 AS 39.35.400 (providing for nonoccupatonal disability); AS 39.35.680(24) (defining "nonoccupational disability").

evidence that the disability was proximately caused by an injury which occurred in the course of employment."[88]

Even though they serve different purposes, the Alaska Supreme Court recognizes that workers' compensation and PERS occupational disability benefits claims share common principles and raise similar issues. For these reasons, the Court turns to analogous workers' compensation cases for guidance in PERS disputes.[89] One such principle imported to the PERS occupational disability analysis is the workers' compensation standard for causation.

This requires that Ms. J establish that it is more likely than not an on the job injury is a substantial factor in bringing about her disability.[90] It is a two-part test. First, Ms. J must prove that the disability would not have happened "but for" her August 2003 work injury.[91] Next she must attach legal responsibility. To "attach legal responsibility" means that a reasonable person would say that it is fair to hold the employer responsible for paying disability benefits in light of the causal role that the employment injury played in the eventual disability.[92] Stated another way, was work so significant and important a cause that the employer should be legally responsible.[93]

To resolve the issue of causation, it is necessary to first determine the nature of Ms. J's disability and then look beyond the sequence of events to the substance and persuasiveness of Ms. J's evidence.

B. *Ms. J Suffers from Facet Syndrome*

There is disagreement between the PERS physicians and Dr. Johnson regarding the nature of Ms. J's disability. Dr. Warnock and Dr. Lipon could not identify a cause for Ms. J's complaints. Dr. Johnson diagnosed Ms. J with cervical facet syndrome.

When questioned on cross-examination regarding his experience using a facet block as a diagnostic tool, Dr. Lipon admitted he did not have the training to speak to this and deferred to pain specialists. Dr. Johnson is a pain specialist. He established that a positive response to a facet block was the "gold standard" for diagnosing facet syndrome. Because Ms. J had

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88 *PERS v. Cacioppo*, 813 P.2d 679, 682 - 683 (Alaska 1991) (Occupational disability benefits under PERS is intended to promote continued public employment whereas workers' compensation protects a worker's ability to earn a certain wage).

89 *Id.* at 683.

90 *Id.* at 683.

91 *Shea v. PERS*, 267 P.3d 624, 633 (Alaska 2011).

92 *Shea v. PERS*, 267 P.3d 624, 633, 634 (Alaska 2011).

93 *Shea v. PERS*, 267 P.3d 624, 634 (Alaska 2011).

responded so well to the facet blocks she received over the years, it is more probable than not that Ms. J suffered from cervical facet syndrome, which caused chronic neck pain and occipital neuralgia resulting in her inability to perform her job.

C. *The Proximate Cause of Ms. J's Disability*

Having identified the disabling condition as cervical facet syndrome and its resulting chronic pain, it now falls to Ms. J to establish that it is more likely than not that her August 2003 work injury is the proximate cause of her disability.[94]

In an effort to compare before and after, Ms. J offered the lay testimony of past co-workers, her husband, and son. The testimony of her co-workers does not establish causation. They did not have extensive personal knowledge of her activities outside of work and she had only worked with them for six months before the injury.

Her husband and son's testimony provided a better picture of the change in Ms. J. They described a woman who, prior to August 2003, enjoyed camping, playing the violin at church, and family activities with her children and grandchildren. Ms. J has established by a preponderance of the evidence that she was injured in August 2003 and that she is now disabled. When viewed in its entirety it is reasonable to conclude that the August 2003 work injury is the proximate cause of her disability. This is supported by the consistency of complaints, the opinion of the only physician to treat her in 2003, 2004 and 2005, that in his opinion Ms. J's symptoms relate back to the August 2003 injury, and Dr. Lipon's testimony contradicting the asserted temporary nature of Ms. J's August 2003 injury.

Ms. J's pain complaints, while varying in intensity, have been consistent in nature from August 2003 to the present. This is not a case where Ms. J injured her lower back in 2003 and now is claiming disability due to chronic neck pain. Beginning in August 2003, Ms. J has complained of cervical pain and disabling headaches. While at times one symptom was more prominent than the other, the area and types of pain involved has not changed. It is not surprising that the headaches became the prominent complaint while Ms. J was experiencing cervical pain relief as a result of the facet blocks. Even when, in April 2009, the diagnosis

[94] *Doyon Universal Services v. Allen*, 999 P.2d 764, 770 (Alaska 2000) (applying substantial factor test in a workers' compensation context); *State, Public Employees' Retirement Board v. Cacioppo*, 813 P.2d 679, 683 (Alaska 1991) (applying the workers' compensation legal cause standard, whether work was a substantial factor in the disability, to PERS occupational disability claims).

contained in the chart notes changed, it still involved the same area and expression of symptoms: primarily disabling headaches and cervical pain.

Dr. Henderson opined that Ms. J's increase in symptoms as a result of Mr. J's hug in December 2004 was the same condition that had "presented itself in past months while receiving care for work-related injuries. It is my professional opinion that this flare-up is directly related to her initial work injury sustained on 08/18/03."[95]

Dr. Lipon tried to establish an undated change in Ms. J's condition by emphasizing 1) that Dr. Klimow, who had the same credentials as Dr. Geveart, did not diagnose facet syndrome and 2) that the type of injury reported would not be severe enough to cause facet syndrome.

The record establishes that Dr. Klimow did not perform a facet block and the two diagnostic tests performed were negative.[96] It does not necessarily follow that Dr. Klimow would not have eventually performed a facet block as a diagnostic test as did Dr. Geveart. The PERS contention that the mechanism of injury reported in 2003 would not be sufficient to cause facet syndrome, that something more traumatic such as a car accident (whiplash) would be required, is overcome by the consistent symptoms experienced by Ms. J. Moreover, Dr. Johnson testified that a severe muscle spasm could result in damage to the ligaments of the facet joint causing instability and facet syndrome. At a minimum, the undisputed fact that Ms. J's symptoms started immediately at the time of injury (not after) and the consistency in her complaints supports a finding that the August 2003 work injury set into motion a string of events resulting in disability. Furthermore, the other events identified in the record appear to be no more traumatic (or even less so) than the August 2003 injury.

Dr. Lipon's testimony and the medical record disprove the PERS contention that in 2003 Ms. J suffered a temporary sprain/strain resolved in four to six weeks. The unchallenged medical records from 2003 establish that when Ms. J attempted to return to work after four weeks, she suffered a relapse. As a result, she remained off work for four months while ergonomic changes were completed.

His testimony underscores that, from the beginning, Ms. J's injury did not respond as expected. Dr. Lipon admitted that, based on the medical records, treatment received almost a year later, up through June 2004, was reasonable and necessary treatment provided as a result of

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[95] Div. Exh. 1, Part A at 80.

[96] Dr. Klimow's medical records state that Ms. J reported, for the first time, right shoulder pain with decreased range of motion. *See e.g.,* Div. Exh. A, Part 1 at 90. However, at this time, as before and after the December 2004 hug, Ms. J's primary complaint remained neck and head pain.

the August 2003 injury. This corroborates Dr. Johnson's testimony that for 90% of the population suffering a sprain/strain healing would occur after four to six weeks, but Ms. J falls within the remaining 10%. His testimony on this point went unchallenged.

When the record is viewed in total, it is more than sufficient to establish that a reasonable person looking at Ms. J and her work and medical history would view the August 2003 work injury as a substantial factor in her disability.

IV. Conclusion

Ms. Js' disability was proximately caused by the August 2003 work injury. Therefore, she is eligible for PERS occupational disability benefits.

DATED this 29th day of February, 2012.

By: *Signed*
Rebecca L. Pauli
Administrative Law Judge

Adoption

This Order is issued under the authority of AS 39.35.006.

The Office of Administrative Hearings transmitted to the parties a proposed decision and order on February 29, 2012. By means of a notice that accompanied the proposed document, the parties were given until March 20, 2012, to submit proposals for action under AS 44.64.060(e). The Administrator submitted a proposal for action, requesting the record be reopened for purposes of determining whether the Member has recovered from her disability. A finding of recovery from disability once appointed to either occupational or nonoccupational disability, is a separate procedure found at 2 AAC 35.291, and is beyond the scope of this proceeding.

The undersigned, in accordance with AS 44.64.060, adopts this Decision and Order as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska Rule of Appellate Procedure 602(a)(2) within 30 days of the date of this decision.

DATED this 27th day of March, 2012.

By: *Signed*
Signature
Rebecca L. Pauli
Name
Administrative Law Judge
Title

[This document has been modified to conform to the technical standards for publication.]