BEFORE THE STATE OF ALASKA OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of:)
)
(T) V C)
) OAH No. 10-0565-PER
) Div. R&B No. 2010-014

DECISION

I. Introduction

V C was employed by the State of Alaska as a steward on the Alaska Marine Highway System (AMHS). On July 29, 2008, Ms. C incurred an on-the-job injury to her left hip and shoulder, and on March 19, 2009, she filed an application for occupational disability benefits.[1] On May 15, 2010, having exhausted all of her available leave, Ms. C informed AMHS that her medical condition prevented her from returning to work.[2] As a result, on June 15, 2010, she was administratively terminated from her position.[3] On October 1, 2010, the administrator denied her application for occupational disability benefits.[4] Ms. C appeals.[5]

The administrative law judge conducted a hearing on February 14, 2011, and a supplemental hearing on August 18, 2011. Ms. C testified, as did Dr. R W, her treating physician, and Dr. Kim Smith, a consulting physician for the Division of Retirement and Benefits. The administrative law judge concludes that Ms. C did not prove that at the time she terminated she was presumably permanently disabled from returning to her prior position as a steward due to her July 29, 2008, work injury.

II. Facts

V C began working for the Alaska Marine Highway System as a summer seasonal steward on May 18, 2007.[6] She was then 56 years old.[7] A steward on the AMHS performs a

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[1] R. 19-20. The application does not specify whether occupational or non-occupational disability benefits were requested, but it clearly identifies an on-the-job injury as the source of her disability. Because Ms. C has less than five years of credited service in the Public Employees Retirement System, she is ineligible for non-occupational retirement benefits. *See* R. 14; AS 39.35.400(a).

[2] R. 32.

[3] R. 29

[4] R. 8-9.

[5] R. 1.

[6] R. 26; VC testimony (0:25).

[7] R. 39.

variety of housekeeping, cleaning or galley duties, as assigned.[8] Ms. C's primary assigned duty was as a bartender.[9] In addition to being physically capable of carrying out their regular duties, stewards must also be physically capable of performing a variety of shipboard emergency tasks, which may require strenuous work for extended periods of time.[10]

Ms. C was diagnosed with uterine cancer on August 18, 2007, shortly before the end of her summer seasonal job. She left her position at AMHS and underwent chemotherapy.[11] She had cervical spine surgery in September, 2007.[12] Apparently due to her cancer condition and cervical spine surgery, Ms. C was deemed eligible for Social Security Disability Insurance benefits beginning in February, 2008.[13] She completed chemotherapy in on February 12, 2008,[14] which was followed by radiation treatment.[15] Ms. C was examined several times by Dr. R W in 2007-2008, and on some (but not all) occasions Ms. C reported lower back pain.[16] Preparatory to returning to work for the 2008 summer season, Ms. C was again examined by Dr. W, and she reported leg and right hip pain.[17] Dr. W had her lumbar spine x-rayed, noting "[m]ild disc height loss…throughout the lumbar spine and spondylotic changes…from the level of L2 through L5," as well as "[m]ild degenerative changes of the [sacroiliac] joints."[18] The conditions did not impair Ms. C's ability to work and, having recuperated from her cancer treatment, she returned to her former position at AMHS at the end of May, 2008.[19]

At around 8:20 a.m. on July 29, 2008, Ms. C was asleep in an upper bunk on the *M/V No Name* when an emergency maritime drill was called. Wakened by her roommate, Ms. C climbed

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8 R. 23.
9 *See* R. 26.
10 R. 24.
11 R. 128, 479-482.
12 R. 564. The nature of the surgery, and the reasons for it, are not stated in the record.
13 R. 526. A benefits analysis provided to Ms. C states, "You are currently eligible for a monthly cash payment of $778 from Social Security Disability Insurance." R. 526. It also states, "you started receiving cash benefits in February of 2008." *Id.*
14 R. 479
15 R. 483.
16 Ms. C did not report back pain on October 23, November 13, or December 24, 2007, or on January 22 or March 3, 2008. R. 136, 140, 143, 147, 149. However, she did report back pain on October 10, 2007, December 4, 2007 (2-3 months), and February 12 ("slight") and May 27 (for five days), 2008, and in her right toes on November 13, 2007. R. 134, 138, 145, 152.
17 R. 134.
18 R. 157.
19 *See* R. 174, 486 (returned to No Name in May, 2008, following radiation treatment); VC testimony (0:29).

out of the bunk. As she descended the ladder, her ankle gave way and she fell to the floor, hitting her left hip on an adjacent desk on the way down.[20]

Ms. C reported the injury to her employer but remained on the job, planning to visit Dr. W when the ship was scheduled to return to No Name in two days. Initially, she had some pain in her left hip, which she treated with over the counter medication. When the ship returned to No Name after two days, Ms. C found that Dr. W was out of town on vacation, and so she scheduled an appointment upon his return.[21] Initially, the over the counter pain medication was effective in limiting her pain, but toward the end of August the pain in Ms. C's left hip pain grew excruciating and she also began to experience pain in her right shoulder and right foot.[22] On August 26, she left work because she was unable to continue, due to pain from her left hip, right shoulder, and right foot.[23] Dr. W was still on vacation, and Ms. C was examined by Dr. O on August 27 concerning the pain in her left hip.[24] On August 30 Ms. C was admitted to No Name Hospital. She reported pain, primarily in her left hip; her right foot was swollen and her hip and shoulder were tender.[25] X-rays of her hip, shoulder, and foot appeared normal, apart from some soft tissue swelling, bony spurring and degenerative changes noted in the foot.[26] Her lumbar spine was deemed "grossly similar" to its condition when x-rayed in May.[27] The cause of her symptoms was not apparent.[28]

The source of Ms. C's hip pain became apparent when a CT scan on September 5 revealed "a complex multiloculated abscess from inside the left iliac fossa extending to the left SI [sacroiliac] joint and into the left buttock."[29] Antibiotics failed to resolve the infection, and a repeat CT scan on September 10 showed that the abscess had increased in size.[30] It was decided to transfer Ms. C to Seattle for treatment, and on September 10 she was medivaced to Seattle.[31]

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20 R. 38, 43, 401; VC testimony (0:05-0:08).
21 VC testimony (0:10).
22 R. 397, 401, 403, 413.
23 R. 38, 401; VC testimony (0:17).
24 R. 131-132.
25 R. 398, 403-404, 406-407, 412
26 R. 405, 407, 425 (hip x-ray), 428 (right shoulder x-ray), 432-433 (foot x-ray), 434 (pelvis x-ray).
27 R. 426, 435.
28 *See* R. 405. In the absence of a definitive diagnosis, Dr. W listed the reason for her hospitalization as polyarthritis. *See* R. 28.
29 R, 398, 402, 421-422.
30 R. 399, 417-418.
31 The flight left No Name at 10:18 p.m. on September 10 and arrived in Seattle at 12:35 a.m. on September 11. *See* R. 391, 399-400.

In Seattle she was treated with antibiotics and released on September 15.[32] Prior to her release, Ms. C reported that she still had pain in her left hip and right shoulder and ankle;[33] her shoulder pain was attributed to "most likely either a rotator cuff tendinitis or a slight dislocation/subluxation of the humeral head."[34] The foot pain differential diagnoses included septic arthritis, gouty polyarthritis, drug reaction, or reactive arthritis.[35]

On October 27, 2008, upon referral by Dr. W, Ms. C was seen by Dr. J B,[36] a physiatrist who practices in the area of physical rehabilitation.[37] Dr. B suspected a rotator cuff tear and planned to obtain an MRI of the right shoulder.[38]

On January 7, 2009, Ms. C met with a representative of the Social Security Administration, indicating that she wanted to return to work for AMHS, but did not want to lose her Social Security Supplemental Disability Insurance payments until she was sure that she had a "permanent, stable job that works well" for her.[39] On the recommendation of Dr. W, she enrolled in a training program for more sedentary work.[40]

On January 8, 2009, Dr. B ordered a right shoulder MRI, since no MRI had been performed following his examination in October.[41] Dr. B reported that Ms. C was unfit for duty on the AMHS as of January 17, 2009, due to her shoulder injury.[42] The right shoulder MRI, as he suspected, showed a rotator cuff tear.[43]

On January 19, Dr. B referred Ms. C to Dr. E H, an orthopedic surgeon.[44] Dr. H examined her shoulder. A supraspinatus test revealed pain and "associated mild weakness."[45] Dr. H reviewed Ms. C's MRI scans and noted a small tear of the right rotator cuff and

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32 R. 123; R. 236; R. 253-256 (Discharge Summary).
33 R. 267, 293 (pain at 7-8 of 10).
34 R. 295.
35 R. 295.
36 R. 236. Dr. W continued to report that Ms. C was in need of medical treatment due to the July 29 injury. *See* R. 46-49.
37 Testimony of Dr. W. *See* R. 190.
38 R. 236.
39 R. 527.
40 R. 535-545. *See* R. 537 ("After talking with Dr. W it was decided that work in a different occupation that was more sendentary would be appropriate.").
41 R. 235. This record erroneously references pain in the right hip and left shoulder. In fact, as Dr. B's other contemporaneous records confirm, the pain was in the left hip and right shoulder.
42 R. 27.
43 R. 242-243.
44 R. 234, 244.
45 R. 251.

recommended surgery.[46] Ms. C underwent rotator cuff arthroscopic surgery, performed by Dr. H, on February 6, 2009.[47] Following the surgery, Dr. H noted she had a "good" prognosis for returning to work.[48]

From the time she was released from the hospital in Seattle in September, 2008, through the winter of 2008-2009, Ms. C regularly reported pain in the left hip and right shoulder, and occasionally in the right foot.[49] Dr. B recommended physical therapy, primarily for the shoulder but also for the hip,[50] and Ms. C was evaluated by a physical therapist on March 3, 2009.[51] The physical therapist observed right shoulder range of motion of 120° flexion and 90° abduction and noted that she was "not having much pain" in the shoulder.[52] The physical therapist recommended a four to six week rehabilitative program for the left hip and right shoulder, with a "good" potential for rehabilitation.[53]

On March 17, 2009, Dr. B ordered MRI scans of the hip and lumbar spine to assess for nerve root compression and lab tests to check for a recurrence of a hip infection.[54] The March 18 hip MRI showed an "extensive abnormality involving the left sacroiliac joint," consisting of "[s]evere erosive change…with extensive adjacent bone marrow reactive change and adjacent soft tissue change."[55] These findings were consistent with an infection, although "[o]ther infMmatory arthropathy of the sacroiliac joints should also be considered."[56] A stress fracture was deemed unlikely as the source.[57] The March 18 lumbar spine MRI was "consistent with prior radiation therapy," and also showed some disc desiccation at the L1-S1 levels, with some extrusion and impingement on the right L5 nerve root.[58]

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46 R. 233, 251.

47 R. 110, 233, 246, 248-249.

48 R. 246.

49 *See* R. 121 (November 19; Dr. W; hip pain); R. 116 (December 29; Dr. W; lower back, hip and shoulder pain); R. 235 (January 8; Dr. B; shoulder, hip and bilateral foot pain) (this record erroneously references pain in the right hip and left shoulder. In fact, as Dr. B's other contemporaneous records confirm, the pain was in the left hip and right shoulder); R. 114 (January 22; Dr. W; shoulder pain); R. 232 (February 2; Dr. B; hip pain); R. 110 (February 12; Dr. W; hip pain); R. 231 (February 16; Dr. B; hip pain); R. 229 (February 26; Dr. B; left hip and foot pain); R. 226 (March 17; Dr. B; hip and leg pain; right foot cramps).

50 R. 229.

51 R. 228.

52 R. 228.

53 R. 228.

54 R. 226.

55 R. 239.

56 R. 239.

57 R. 239 (Dr. K).

58 R. 240 (Dr. K).

On March 20, 2009, Ms. C filed an application for occupational disability benefits.[59] Dr. B's report at that time noted that she had a right shoulder and left sacroiliac joint injury from the July 29, 2008, fall, and that she was unlikely to be able to return to work.[60] Dr. B reviewed the MRI scan of her sacroiliac joints, which showed "changes in the SI joint consistent with infection."[61] Dr. H found her shoulder doing well.[62] He opined, however, that "I still do not expect her to be able to do her former job."[63]

Ms. C continued with her physical therapy, which included treadmill walking, stretching and other exercises.[64] By the end of March her right shoulder range of motion had improved to 150° flexion and 135° abduction.[65] On April 7, she reported that her shoulder was "giving her very little difficulty;" her physical therapist reported that she still had "some strength and ROM deficits in the shoulder and hips" that warranted continued physical therapy, but was making good progress with both the shoulder and hip.[66] Ms. C reported that her shoulder was "doing great" and that her left hip was "getting stronger."[67] However, Dr. B doubted that "she will reach a level where she can return to work on the ferry due to physical restrictions."[68] On April 16, 2009, Ms. C was examined on behalf of her employer's Workers' Compensation insurer by a medical panel (employer's medical panel), which concluded that she had sustained a contusion to her left buttock followed by an abscess, which conditions had resolved, and was post-surgery for a rotator cuff injury to her right shoulder and should continue physical therapy on her right shoulder before a determination as to the shoulder condition could be provided.[69] The panel opined that upon completing physical therapy, she could return to work as a bartender.[70]

On April 14, Ms. C reported to her physical therapist that her shoulder was not causing any functional problems, and that her left hip was frequently better during the day but

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[59] R. 19-20.
[60] R. 191.
[61] R. 221. The date of the MRI is not stated. Presumably, Dr. B was referring to the March 18 MRI. *See* R. 239.
[62] R. 22.
[63] R. 245.
[64] *See, e.g.*, R. 219 (March 30), 220 (March 26), 225 (March 23).
[65] R. 220.
[66] R. 218.
[67] R. 215.
[68] R. 215.
[69] R. 71-84.
[70] R. 84.

bothersome in the evening and at night.[71] Her left hip pain persisted,[72] but Ms. C reported continued shoulder improvement.[73] On April 27, Ms. C reported that hip soreness was her main concern, but that it was not getting worse.[74] Ms. C reported to her physical therapist that she had gone golfing a couple of times, and with a shortened swing her shoulder had not been sore; walking the course she had no hip pain but did have some soreness in the evening.[75] By early May 4, Ms. C was able to perform her hip exercises without increasing pain,[76] and Dr. H reported that she was "essentially full ROM and good strength throughout."[77] He added, "[s]he has done very well and is nearing full recovery [from her shoulder surgery]."[78] The supraspinatus test was negative for pain or significant strength deficit.[79] Dr. B reported good progress with her physical therapy, with her right shoulder "doing good" and "less hip pain,"[80] and on May 14, 2009, Ms. C was discharged from physical therapy.[81] Her physical therapist reported she still had left hip pain.[82]

On June 2, 2009, Dr. B reported residual pain in the shoulder that was "not too much of a problem" and pain in the left hip and in her feet.[83] Dr. B reviewed the April 16 employer's medical panel report and generally concurred with its recommendations, but disagreed with the prediction that she would be able to return to work on the ferry.[84] On June 29, 2009, Dr. B ordered another MRI of the hip, which showed that the hip had been stable since March, 2009.[85] The radiologist provided differential diagnoses of inflammatory arthropathy or a degenerative process, and concluded that "the bilateral nature of the process as well as stability over time makes infection highly unlikely."[86]

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71 R. 213.
72 R. 212.
73 R. 209.
74 R. 208.
75 R. 207.
76 R. 206.
77 R. 205.
78 R. 205.
79 R. 205.
80 R. 202.
81 R. 201.
82 R. 201.
83 R. 200.
84 R. 200.
85 R. 238 (Dr. E S). Dr. B concurred that the June MRI was consistent with the March MRI. R. 199.
86 R. 238 (Dr. E S).

On June 30, 2009, Ms. C reported her hip pain as 2 out of 10.[87] Dr. B expressed doubt that she would ever be able to return to work on the ferry.[88] On July 28, 2009, Dr. B reported that Ms. C's left hip and right shoulder pain persisted, and that she was continuing with her home exercise program.[89] He reported that she "will not be able to return to work on the ferry" and that there was no treatment planned that would enable her to do so.[90] In August, Ms. C visited a foot specialist, Dr. M, who x-rayed her foot and diagnosed Lisfranc's fracture of the right foot.[91] On August 25, 2009, Dr. B reported continued improvement in her shoulder, and essentially unchanged condition in her hip.[92] Subsequently, Dr. B reported that Ms. C's hip, shoulder and foot conditions prevented her from returning to work; her hip pain had decreased to a level of 1-2 out of 10, and her foot was her most significant problem.[93] On October 20, 2009, Dr. B reported "persisting" left hip pain and right shoulder; he expressed "doubt" that she would reach the level for release to "full duty" work, as required for her position with AMHS.[94]

On October 29, 2009, the employer's medical panel re-examined Ms. C and her medical records.[95] The panel found her right shoulder had 170° flexion and 170° abduction, and it concluded that Ms. C had a 0° impairment of her right upper extremity and lower left extremity.[96] It also reviewed Dr. M's x-rays and concluded that he had misdiagnosed Lisfranc's fracture of the foot.[97] Following the examination, Ms. C's Workers' Compensation disability and medical payments were terminated.[98] On November 24, 2009, Dr. B reported that Ms. C's right shoulder was doing well and was not preventing her from returning to work.[99] He reported that her hip and right foot conditions were preventing her from returning to work, but that it was hoped that by the summer of 2010 she could return to work.[100] On December 15, 2009, Ms. C

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[87] R. 199.
[88] R. 199.
[89] R. 198.
[90] R. 192.
[91] R. 185-189. The report does not state that Dr. M took a foot x-ray on this occasion. However, other evidence shows that he did. *See* R. 67 (employer's medical panel reviews Dr. M's x-rays); R. 180 (Dr. M provided Ms. C with an x-ray for her use).
[92] R. 197.
[93] R. 196.
[94] R. 195.
[95] R. 61.
[96] R. 66, R. 69.
[97] R. 69.
[98] VC testimony (1:22); R. 2.
[99] R. 194.
[100] R. 104.

told Dr. B that she felt able to return to work, and he released her to “full duty” work, noting “some left hip pain, but it has improved over time” and that “[h]er shoulder is doing well.”[101]

On May 10, 2010, Ms. C informed AMHS that she was unable to return to work “for three medical reasons”, namely, right arm pain, discomfort in her left buttock, and hearing loss.[102] On June 15, 2010, Ms. C was administratively terminated from her position.[103] She has been found eligible for monthly disability benefits from the Social Security Administration.[104] In December, 2010, an MRI of her lumbar spine revealed a herniated disc at the L5 level.[105] In August, 2011, Dr. B examined Ms. C. He reviewed his notes from December 15, 2009, with her and concluded that “it sounds like in fact she wasn’t physically ready for return to her prior job.”[106] At that time, Dr. B was of the view that Ms. C had “bilateral lower extremity weakness with significant balance impairment” that would prevent her from returning to work for AMHS; he stated that the cause of the condition was unclear, but that it could be “spine related.”[107]

II. Discussion

A. Legal Standards

An employee is eligible for occupational disability benefits if the employee’s physical condition prevents the employee from performing her usual duties and “the proximate cause of the condition [is] a bodily injury sustained, or a hazard undergone, while in the performance and within the scope of the employee’s duties.”[108] A work injury is the “proximate cause” of a disabling condition if it is a substantial factor in the condition.[109] A work injury may be a substantial factor in the disability if it aggravates, accelerates, or combines with a pre-existing condition,[110] even if the pre-existing condition could independently have caused the disability.

[101] R. 193.
[102] R. 32.
[103] R. 29
[104] The record includes a letter dated July 26, 2010, stating that she is eligible Social Security disability benefits. R. 562. The date of the determination, the date of the commencement of the disability, and the nature of the benefit are not stated.
[105] R. 567-569.
[106] R. 565.
[107] R. 565.
[108] AS 39.35.680(27).
[109] State, Public Employees’ Retirement Board v. Cacioppo, 813 P.2d 679, 683 (Alaska 1991). *See generally*, Shea v. State, Department of Administration, Division of Retirement and Benefits, 267 P.3d 624, 631-634 (Alaska 2011) [hereinafter, “Shea”].
[110] Hester v. Public Employees’ Retirement Board, 817 P.2d 472, 475 (Alaska 1991) (adopting test identical to that applied in workers’ compensation cases) (hereinafter, “Hester”).

[111] A work injury may be a substantial factor in a disability if it aggravates the symptoms of a pre-existing condition (*e.g.*, pain), even if it does not aggravate the underlying physical condition.[112] The work injury is a substantial factor in the disability if (1) the disability would not exist but for the injury, and (2) a reasonable person would regard the work injury as a cause and attach responsibility to it.[113]

B. Summary

1. Work Injury

There is no dispute that Ms. C incurred a substantial injury on July 29, 2008. She fell from an upper bunk, or from an upper ladder step, directly onto an adjacent desk corner, striking her left hip against the desk as she fell to the ground. CT and x-ray examinations a month later showed an abscess, but no bony dislocation or fracture of the sacro-iliac joint. The administrator has not disputed that she sustained a significant injury in the form of a contusion to her left hip, and a torn rotator cuff of the right shoulder.

In addition to undisputed work injuries to her left hip and right shoulder, Ms. C currently has a herniated disc in the lumbar spine, and she has foot ailments. The administrator contends that neither of these conditions was sustained as a result of the 2008 work injury.

2. Disabling Condition

Ms. C's March, 2009, application for occupational disability benefits identified pain in the hip and lower extremities and difficulty in walking as disabling conditions.[114] Her May, 2010, notice to her employer referenced right arm pain and left buttock pain.[115] With her appeal, in October, 2010, she submitted a letter from Dr. W stating she "is still plagued by pain" in the left hip and right shoulder, and that she "could not do some of the requirements" of her job.[116]

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[111] State, Public Employees' Retirement Board v. Cacioppo, 813 P.2d 679, 683 (Alaska 1991).

[112] Hester, 817 P.2d at 476, note 7. *See* Shea, 267 P.3d at 631, n. 18; Lopez v. Administrator, Public Employees' Retirement System, 20 P.3d 568, 573-574 (Alaska 2001).

[113] The "but for" and "attach responsibility" features of the "substantial factor" test, which are derived from the common law test for causation in the tort context, had been adopted for purposes of workers' compensation cases before the court's decision in Cacioppo. *See* Doyon Universal Services v. Allen, 999 P.2d 764, 770 note 26 (Alaska 2000), *citing* Fairbanks North Star Borough v. Rogers & Babler, 747 P.2d 528, 532 (Alaska 1987); State v. Abbott, 498 P.2d 712, 726-727 (Alaska 1972). Those features of the substantial factor test were not specifically adopted in Cacioppo for purposes of occupational disability cases. In Shea, the court expressly clarified that the "but for" and "attach responsibility" elements apply in occupational disability cases arising under AS 39.35. Shea, 267 P.3d at 633.

[114] R. 19.

[115] R. 32. The notice also refers to hearing loss, but Ms. C has at no time alleged that her hearing loss is work-related.

[116] R. 3.

Taken together, these documents consistently identify two distinct disabling conditions: first, a functional loss in the left hip and right shoulder; second, chronic pain in those areas.

The administrator denied Ms. C's application on the ground that "[t]he documentation you provided does not substantiate your condition is a permanent disability."[117] The denial was based on the recommendation of Dr. Kim Smith, "as there is no objective evidence of permanent disability."[118] Dr. Smith had noted that to support her application, "evidence of the degree of current disability or a lack of functional capacity would be of the biggest benefit."[119]

3. Causation

It is undisputed that the condition of Ms. C's right shoulder at the time she terminated was the result of her work injury. Thus, with respect to pain and any functional disability associated with the right shoulder, causation is not at issue: the issue is whether the right shoulder condition was disabling. However, with respect to the left hip, both the existence of a disabling condition, and its cause, are at issue.

C. Ms. C Did Not Sustain Disabling Work Injuries To Her Lumbar Spine or Foot

During the year prior to her work injury, Ms. C occasionally reported lower back pain.[120] The x-rays of Ms. C's lumbar spine taken two months before the injury and one month after the injury were deemed "grossly similar": both showed degenerative conditions, but nothing unusual. The first indication of a more problematic condition was an MRI showing a disc extrusion in March, 2009, some eight months after the work injury, with impingement on the right L5 nerve root.[121] But when Ms. C reported that she was unable to return to work, in May, 2010, she cited pain in the left hip. Thus, even if the disc extrusion was a result of the July 29, 2008, work injury, Ms. C has not shown that it was a substantial factor in her disability at the time she terminated. Nor has Ms. C shown that she had a herniated disc at the time she terminated. That condition was diagnosed in December, 2010, some six months after she terminated, and if it had herniated prior to the date she terminated, Ms. C would have exhibited more pronounced symptoms.[122] For these reasons, Ms. C has not shown, by a preponderance of

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117 R. 8 (October 1, 2010).
118 R. 14 (October 1, 2010).
119 R. 17 (September 19, 2010).
120 *See* note 16, *supra*.
121 R. 240.
122 *See* Dr. S testimony; Dr. W testimony (0:12).

the evidence, that she had a disabling condition of the lumbar spine at the time she terminated her employment.

Ms. C identified difficulty in walking as contributing to her disability at the time she terminated, but she did not identify any specific foot problem then or in her subsequent notice and appeal. She testified that she has flat feet and bunions, and that neither of those conditions was work-related. Dr. M, a podiatrist, x-rayed Ms. C's foot in 2009 and diagnosed a Lisfranc's fracture; based on Ms. C's report to him he identified that as a work injury. However, the employer's medical panel reviewed Dr. M's x-rays and saw no sign of a fracture, and x-ray's of her foot taken in 2008 showed degenerative changes, but no sign of a fracture.[123] Moreover, when examined concerning the foot pain on August 30, 2008, Ms. C reported on onset within the past couple of days, and denied any trauma as a cause.[124] In any event, Ms. C did not show that a Lisfranc's fracture would have been presumably permanently disabling. In light of Ms. C's prior complaints of foot pain, the 2008 x-ray, and the employer's panel's review, Dr. M's diagnosis of a Lisfranc's fracture is not persuasive. Ms. C has not shown by a preponderance of the evidence that at the time of her termination she had a presumably permanent disabling condition of the right foot.

D. Ms. C's Hip and Shoulder Conditions Were Not Disabling

Medical opinions regarding the existence of a disability resulting from Ms. C's left hip and right shoulder condition have been provided by the employer's medical panel, as well as by Dr. W (Ms. C's primary treating physician), Dr. H (who performed the rotator cuff surgery), Dr. Smith (the administrator's consulting physician), and Dr. B (who supervised her rehabilitation).

1. Employer's Medical Panel

An employer's medical panel consisting of Dr. Lance Brigham (orthopedic surgery), Dr. Alvin Thompson (internal medicine) and Dr. Peter Mohai (rheumatology) twice examined Ms. C and her medical records, on April 16 and October 29, 2009.[125] The panel was selected and paid by Ms. C's employer's insurance carrier; one of its members specializes in orthopedic surgery. On the first occasion, the panel expressed the opinion that upon completing treatment, Ms. C could return to work as a bartender.[126] On the latter occasion, having completed treatment, the

[123] R. 432-433.
[124] R. 413.
[125] R. 72-84; R. 61-70.
[126] R. 84.

panel found that she had a zero percent impairment of the right upper extremity and the left lower extremity,[127] and it was of the opinion that she could return to "to her position as a bartender."[128]

There is no evidence that the panel was aware of the nature of the physical requirements of Ms. C's position as a steward on AMHS. Furthermore, an impairment rating for purposes of a Worker's Compensation examination is not persuasive for purposes of occupational disability under the Public Employees' Retirement System.[129] For these reasons, and because it was selected and paid by the employer's insurance provider, and notwithstanding that one of its members specializes in orthopedic surgery, the panel's opinion as to whether the right shoulder or left hip conditions were disabling is afforded little weight. Other medical opinions of the panel will be given the weight appropriate to the evidence supporting them.

2. Dr. H

Dr. H is an orthopedic surgeon. He performed the rotator cuff surgery and is therefore particularly qualified to speak to the long term prognosis with respect to that condition. As the treating physician, and because of his expertise, Dr. H's opinion would ordinarily be afforded substantial weight. However, Dr. H treated Ms. C for a relatively short period of time; also, he did not testify at the hearing. For these reasons, Dr. H's opinion is afforded less weight than Dr. W's and Dr. B's.

Dr. H expressed the opinion about seven weeks post-surgery that Ms. C would not be able to "do her former job."[130] He had earlier expressed the opinion that the "prognosis for return to work" was "good",[131] but that opinion did not specifically refer to her <u>prior</u> employment, and in light of his later, more specific, opinion, the earlier opinion is not persuasive that she could return to work in her former employment as a steward.

3. Dr. W

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127 R. 69.
128 R. 69.
129 A permanent partial impairment rating establishes the amount of an injured employee's benefit under AS 23.30.190, but is unrelated to the extent or existence of a disability within the meaning of AS 39.35. *Cf.* <u>Rydwell v. Anchorage School District</u>, 864 P.2d 526, 531 (Alaska 1993) ("Alaska's statutory scheme does not use [impairment ratings] to establish *disability*, which requires a discretionary analysis considering incapacity in relation to employment potential." [italic in original]).
130 R. 245 (3/26/2009).
131 R. 246 (2/17/2009).

Dr. W practices family medicine. He is Ms. C's primary treating physician and has followed her over an extended period. He is familiar with the physical requirements of her position as a steward.[132] He testified at the hearing and was subject to cross-examination. For the latter reasons, notwithstanding that he does not specialize in orthopedics or rehabilitative medicine, his opinion as to whether the hip and shoulder conditions were disabling is afforded substantial weight.

Dr. W has consistently opined that Ms. C will be unable to return to work for AMHS. At the hearing he testified that her right shoulder injury was disabling, due to the physical requirements of Ms. C's position as a steward for AMHS. He testified that her shoulder injury could result in adhesive capsilitis and reduced range of motion.[133] He added that, based on his examination of October 15, 2010, (which is not in the record) Ms. C's rotator cuff injury had left her with objective evidence of diminished physical capacity, in the form of reduced range of motion, pain with abduction, and decreased rotation.[134] Finally, he stated that, based on his long-standing treatment relationship with Ms. C, he believes that if she had been physically able to return to her former position, she would have done so.[135]

4. Dr. B

Dr. B is a physiatrist;[136] he practices in the areas of physical medicine and rehabilitation.[137] His practice directly relates to evaluating and assessing an individual's capacity for physical activity. He was aware of the nature of Ms. C's job requirements, including emergency response activities.[138] Because of his area of expertise, and because he treated Ms. C over a substantial period of time, Dr. B's opinion would ordinarily be given the greatest weight. However, because Dr. B did not testify and he was not subject to cross-examination, his opinion is afforded less weight than would otherwise be the case, and is given equal weight with Dr. W's.

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[132] *See* R. 3; VC testimony (1:13).
[133] Dr. W testimony (0:32).
[134] Dr. W testimony (0:30).
[135] Dr. W testimony (0:11).
[136] R. 62.
[137] Testimony of Dr. W. *See* R. 190.
[138] VC testimony (1:13).

Dr. B consistently opined over a lengthy period of time that Ms. C would be unable to return to work on the ferry,[139] and he specifically disagreed with the employer's panel's conclusion to the contrary.[140] However, in November, 2009, he expressed optimism that she could return to work on the ferry[141] and on December 15, 2009, he reported that she told him she felt able to return to work on the ferry, and he released her to return to "full duty" work, which, he explained, was required for her job on the ferry.[142] Subsequently, Dr. B opined that the work release had been premature.[143]

5. Dr. Smith

Dr. Smith, retained by the administrator, reviewed the medical records but did not examine Ms. C. As the administrator's retained expert, Dr. Smith owes a duty of impartiality, and he testified at the hearing and was subject to cross-examination. However, he did not personally examine Ms. C, and he is not expert in orthopedics or in another relevant specialty. For the latter reasons, his opinion in this matter is afforded less weight than Dr. W's (who treated Ms. C and testified at the hearing) and Dr. B's (who did not testify, but who treated Ms. C and specializes in rehabilitative medicine),[144] and equal weight to Dr. H's.

On September 10, 2010, Dr. Smith opined that Dr. B's December 9, 2009, release, coupled with the employer's panel's opinion, warranted denial of a claim for occupational disability.[145] Dr. Smith testified that in the absence of objective evidence of a functional incapacity, he was unable to support Ms. C's application.

6. Conclusion

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[139] *See, e.g.*, R. 191 (March 20, 2009); R. 199 (June 30, 2009) ("I doubt that she will ever be able to return to work on the ferry due to her physical restrictions."); R. 192 (July 30, 2009); R. 195 (October 20, 2009) ("she will not be able to be released to full-duty as required to go back to work on the ferries….I doubt she will reach that level").

[140] R. 200 ("The recommendations from [the panel] make sense with the exception that she may not be able to return to work due to the job requirements of working on the ferries.").

[141] R. 194 (November 24, 2009) ("The right shoulder…isn't keeping her from returning to work.").

[142] R. 193 (December 15, 2009) ("Hip pain Tanya is doing well at this point, and will be released to full-duty work.").

[143] R. 656 (Dr. B, 8/9/2011) ("I reviewed my last note with her, and it sounds like in fact she wasn't physically ready for return to her prior job.").

[144] The opinion of a non-treating physician who reviews medical records may not be automatically discounted on that ground. Rhines v. State, Public Employees' Retirement Board, 30 P.3d 621, 628-629 (Alaska 2001). However, in the absence of a finding of superior expertise, experience, knowledge, or other valid reasons, the opinion of a physician who has not examined or treated the patient may reasonably be afforded less weight than that of an examining or treating physician. *See generally* Lopez v. Administrator, Public Employees' Retirement System, 20 P.3d 568, 571 (Alaska 2001); Childs v. Copper Valley Electrical Association, 860 P.2d 1184, 1189-90 (Alaska 1993); Black v. Universal Services, Inc., 627 P.2d 1073, 1075 (Alaska 1981).

[145] R. 17.

In concluding that Ms. C had not shown that she was disabled, the administrator relied on the opinion of Dr. Smith, whose initial review relied on the opinion of the employer's medical panel and on Dr. B's December, 2009, release. However, the panel did not appear to be aware of the requirements of Ms. C's job position, and Dr. B's release was inconsistent with his prior opinion, stated on multiple occasions, that Ms. C would be unable to return to her former position,[146] and he subsequently recognized that his release was premature. Thus, neither the panel opinion nor Dr. B's release is persuasive, particularly in the absence of any testimony by those doctors at the hearing. If Dr. Smith's opinion rested on nothing more than what those prior medical experts had concluded, it would be equally unpersuasive. But Dr. Smith's opinion rested on more than just the other doctors' opinions: he also relied on his independent review of the medical records, which revealed an absence of objective medical evidence of a loss of function or physical capacity at the time Ms. C terminated her employment.

In terms of any functional disability, the medical records in evidence support Dr. Smith's observation. With respect to Ms. C's shoulder, the injury was a "small" rotator cuff tear[147] that escaped notice for some time. Prior to her termination Dr. H found her shoulder had fully recovered from the surgery, and that she had "essentially full ROM and good strength throughout."[148] Moreover, he found that the "[s]upraspinatus test is negative for pain or significant strength deficit,"[149] as compared with a positive test prior to the surgery,[150] and range of motion testing over time showed consistent improvement.[151] Dr. W testified that he found objective medical evidence of a loss of functional capacity (decreased range of motion, *etc.*) in an examination in October, 2010, after she terminated her employment.[152] However, that report was not placed in evidence or reviewed by Dr. Smith, and it is inconsistent with Dr. H's finding made prior to the date she terminated her employment. Ms. C's shoulder condition did not prevent her from playing golf (with a reduced swing), and before she was discharged from physical therapy, Ms. C reported to her physical therapist that her shoulder was not causing any

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[146] Dr. B provided the release after Ms. C's Workers' Compensation benefits were terminated. Ms. C testified that she believed that was why he had released her.

[147] R. 251.

[148] R. 205.

[149] R. 205.

[150] R. 251.

[151] *See* notes 52, 65, 96, *supra*.

[152] Dr. W testimony (0:30).

functional problems.[153] Taken as a whole, the objective evidence in the record does not support a finding of functional disability of the right shoulder.

The evidence regarding the hip is less extensive, but to the same effect. The employer's panel found, after examination, her "hip function to be unremarkable."[154] The injury to her hip was not a fracture or dislocation of the sacro-iliac joint. Ms. C was able to walk a golf course. Ms. C did not prove that her hip injury was functionally disabling.

Ms. C testified that she did not have the strength to do the tasks required for emergency response conditions, such as raising and lowering lifeboats.[155] Dr. W, based on his long-standing doctor-patient relationship with her, testified that he believes that if she could have gone back to work, she would have. But the evidence shows that at the time she terminated, Ms. C had told Dr. B that she felt capable of returning to work and he had released her for full duty, and yet she made no attempt to return to her prior position. Given the release and the absence of objective medical evidence of a loss of function or physical capacity at the time she terminated her employment, Ms. C has not shown, by a preponderance of the evidence, that her hip and shoulder conditions were functionally disabling at the time she terminated.

D. Ms. C Was Not Presumably Permanently Disabled By Chronic Hip and Shoulder Pain

The pain that Ms. C identified as disabling in her application and through the date she terminated was located in her left hip and right shoulder. At the hearing she testified that she had anticipated the pain in these areas would resolve over time, with physical therapy, but that it had not.[156] But Ms. C also testified that if it were not for the pain in her back, "we would not be here." This testimony, coupled with her report to Dr. B that she felt able to return to work, is persuasive evidence that she was not disabled by chronic pain in the left hip and right shoulder at the time she terminated her employment.

This conclusion is supported by the medical records. Before she was discharged from physical therapy, more than a year before she terminated her employment, Ms. C had reported continued shoulder improvement,[157] and she was able to golf without shoulder pain.[158] The

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153 R. 213.
154 R. 65.
155 VC testimony (1:12-1:14).
156 VC testimony (0:17).
157 R. 209.
158 R. 207.

supraspinatus test was negative for pain.[159] Upon discharge, her physical therapist did not note any complaints of continuing shoulder pain,[160] and Dr. B reported that any residual pain in the shoulder was "not too much of a problem."[161] In short, the clear preponderance of the evidence is that before she terminated her employment, Ms. C did not have disabling shoulder pain.

As for the hip, the evidence is undisputed that in June, 2009, a year before she terminated her employment, Ms. C had, as a result of the work injury and subsequent abscess, an "extensive abnormality" of the left sacro-iliac joint, including "[s]evere erosive change" and "extensive adjacent bone marrow reactive change and adjacent soft tissue change."[162] There is nothing in the record to suggest that this condition dissipated prior to her termination in June, 2010, and thus Ms. C would be entitled to disability if she could show that the condition was the result of the work injury, and was a substantial factor in a disability.

Both of those facts were disputed. As to whether the condition was the result of the work injury and subsequent abscess, when the condition was first identified, in a March, 2009, MRI, both the radiologist and the employer's medical panel agreed that it was due to the abscess.[163] However, after a subsequent MRI showed that the condition was unchanged, and was present in both the left and right sacro-iliac joints, a different radiologist concluded that an infection was "highly unlikely" as the cause of the condition.[164] Dr. Smith also was of the view that the damage to the left sacro-iliac joint was not due to the abscess. A degenerative process was identified as another possible cause.

As to whether the condition was a substantial factor in disabling chronic pain, neither the employer's panel nor Dr. Smith expressed an opinion as to whether the "extensive abnormality" observed in her left sacro-iliac joint was the cause of disabling pain. Another possible cause of her hip pain, the medical experts agreed, was the radiation treatments she had received for her cancer. Moreover, the pain appears to have been located in the buttock or muscle, rather than in the sacro-iliac joint.[165] Even more important, Ms. C herself classified her hip pain level prior to her discharge from physical therapy as only 1-2 in 10, which is well below the level of pain that

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[159] R. 205.

[160] R. 201.

[161] R. 200.

[162] This condition was first observed in an MRI taken on March 18, 2009. R. 239. A subsequent MRI, taken on June 20, 2009, was substantially the same. R. 238.

[163] R. 83.

[164] R. 238.

[165] *See, e.g.,* R. 32 ("My left bottom/buttock is still uncomfortable while walking."); R. 63.

might reasonably be regarded as disabling, and when examined by the employer's panel in October, 2009, she described her hip pain as "tolerable."[166]

Dr. W noted that Ms. C continued to have pain in her left hip and right shoulder in his 2010 letter in support of her appeal,[167] but in that letter he did not specifically identify her chronic pain as disabling, and the thrust of his letter is that she was functionally disabled, due to her physical condition irrespective of any pain. Although at the hearing Dr. W testified that the hip and shoulder injuries, coupled with the herniated disc, have left Ms. C with a complex chronic pain syndrome, the herniated disc was not shown to be work related, or in existence at the time she terminated her employment.

Because Ms. C did not show that at the time she terminated, her chronic pain from the hip and shoulder injuries was disabling, Ms. C has failed to meet her burden of proof.

IV. Conclusion

Ms. C did not prove by a preponderance of the evidence that her July 29, 2008, work injury was a substantial factor in a presumably permanent disability that was existed at the time she terminated her employment.

DATED June 14, 2012.

Signed
Andrew M. Hemenway
Administrative Law Judge

Adoption

The undersigned adopts this decision as final under the authority of AS 44.64.060(e)(1). Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 18th day of July, 2012.

By: *Signed*
Signature
Andrew M. Hemenway
Name
Administrative Law Judge
Title

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

166 R.63.
167 R. 3.