BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of	)	
	)	
L S	)	OAH No. 16-0700-PER
	)	Agency No. 2016-007

DECISION

I. Introduction

L S applied to the Division of Retirement and Benefits for occupational disability benefits from the Public Employee's Retirement System (PERS). The PERS Administrator (Administrator) denied her application because the Administrator determined that Ms. S's disability was not caused by a work-related injury.[1]

Because the evidence supports a finding that a work-related injury was the proximate cause of Ms. S's disability, the Administrator's decision is reversed.

II. Facts

A. Employment and application for occupational disability

L S began working as a special education assistant for the No Name School District (District) in 2000.[2] Special education assistants must be able to lift 40 pounds.[3] Due to budget issues, the District transferred Ms. S to a new school, No Name City Junior Middle School (No Name City), in the fall of 2011.[4] At No Name City, Ms. S worked in the classroom assisting moderate to severely disabled children. The work was more physically demanding than in previous positions. Ms. S, assisted by another special education aide, transferred disabled children throughout the day as part of her job duties.[5] Some children were able to assist with transfers, but others could not. Concerned that injury might result from her new job duties, Ms. S purchased private disability insurance.

In early 2012, Ms. S began experiencing shoulder pain.[6] In April 2012, Ms. S injured her knee while chasing after an autistic child during a fire drill.[7] Ms. S underwent knee surgery on

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1 R11 – R12.
2 Ex. L-3, verification of salary and service.
3 R59.
4 Ex. 1, 1 – 2.
5 S testimony.
6 Ex. 3; Ex. 8.
7 Ex. 2.

May 23, 2012. She returned to work in August of 2012.[8] Workers' compensation insurance paid the costs associated with the injury that are covered by workers' compensation.

In October 2012, a student hit Ms. S on the right side of her head with a basketball. Ms. S reported the incident to the school's administrative assistant, Ms. F, on the day it occurred.[9] Ms. S testified that it was a very hard hit. She "saw stars" but did not fall.[10] Ms. S did not miss work or seek medical attention. She reported to Ms. F that she experienced pain in her neck and shoulder immediately after being hit with the basketball.[11] Ms. S did not file an official report of injury because she had just recently returned to work after the workers' compensation claim for her knee.[12] Ms. S did not work for three weeks in October 2012, which gave her body a rest from the physical demands of the job.[13]

Despite physical therapy, Ms. S's shoulder pain worsened over time. Ms. S's last day of work at No Name City was May 23, 2013.[14] At the beginning of the next school year, on August 9, 2013, Ms. S went on medical leave for shoulder surgery.[15] On December 9, 2013, Ms. S's provider released her to return to work with a 25-pound lifting restriction.[16] Ms. S could not perform her job duties with the lifting restriction, and No Name City did not offer her a light duty option.[17] Ms. S's insurance coverage expired on December 31, 2013.[18] Ms. S filed a workers' compensation claim on January 6, 2014, for a shoulder injury.[19]

Ms. S remained in short-term leave of absence status until March 5, 2015, when the District terminated her employment.[20] The District terminated her because she had exhausted her leave and was not released to return to work.[21] On March 6, 2014, she filed a second

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8 Ex. D; S testimony.
9 S testimony; F testimony. The date of the injury is approximate.
10 R448.
11 F testimony.
12 S testimony. Ms. F may have reported the injury to her supervisor, but the record contained no evidence supporting this.
13 Ex. D; S testimony.
14 R60.
15 Ex. 7.
16 R546.
17 S testimony.
18 S prehearing brief.
19 R418.
20 R57. Ms. S's first short-term leave of absence covered April 10, 2014 through May 22, 2014. A second short-term leave of absence ran from August 4, 2014 through December 31, 2014.
21 R55; Ex. 27; K testimony.

workers' compensation claim based on the October 2012 basketball incident.[22] Workers' Compensation Division denied both claims.[23]

On March 11, 2015, Ms. S filed for disability benefits through the Division of Retirement and Benefits.[24] Ms. S's application sought occupational disability benefits based on work-related shoulder overuse injuries from heavy lifting and a neck injury caused by the 2012 basketball incident.[25] The Division approved Ms. S for non-occupational disability, but denied her occupational disability application.[26] Ms. S appealed the occupational disability denial. The parties agreed to dismiss that first appeal, however, so Ms. S could file additional information with the Division for its review.[27]

On May 13, 2016, the Division again denied Ms. S's occupational disability application.[28] Ms. S appealed.[29] A telephonic hearing was held on February 7 – 9 and March 6, 2017. C Xs, lay advocate, assisted Ms. S during the hearing. Ms. S testified on her own behalf. Ms. S called the following witnesses:

- Dr. M A, family practice doctor;
- Dr. F B, chiropractor;
- Dr. E C, chiropractor;
- S D, physical therapist;
- B E, therapist;
- L F, administrative assistant, No Name City Junior Middle School; and
- N G, special education teacher, No Name City Junior Middle School.

Siobhan McIntyre represented the Administrator, and Larry Davis, with the Division of Retirement and Benefits, attended. Four witnesses testified on the Administrator's behalf:

- Dr. U H, neurosurgeon;

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22 R113.
23 R69 – R71; R108; R115.
24 R47 – R53.
25 R47.
26 August 13, 2015.
27 *See Order of Dismissal,* OAH No. 15-1282-PER, October 22, 2015. The Division supplemented the agency record with over 300 pages of additional medical records. Many of the records were duplicates already contained in the initial record. At hearing, it appeared that the Division received and reviewed some, but not all, of Ms. S's medical records. Ms. S argued that the Division's denial was based on a review of incomplete medical records. The medical providers who testified were confident in their opinions based on the information that was reviewed.
28 R3.
29 R2.

- Dr. B J, orthopedic surgeon;
- Z K, human resources director, No Name School District;
- Marla Christenson, Division of Retirement and Benefits' benefits process manager.

B. Ms. S's medical history

Ms. S's medical issues developed over time, and a great deal of time was spent trying to determine the cause of her symptoms.[30] As such, Ms. S saw many providers between 2012 and 2017. The following gives a general overview of her providers, treatments, and outcomes.

1. 2012 – 2013

As discussed above, Ms. S underwent knee surgery on May 23, 2012. Her surgeon authorized her to return to work, without restriction, in July 2012. In December 2012, approximately two months after being hit in the head by the basketball, Ms. S began seeing Dr. K L, chiropractor, for hip or low back pain.[31] She also reported pain and range of motion issues in her shoulder and neck.[32] In January 2013, Ms. S reported her low back or hip, neck, and shoulder pain to C M, advanced nurse practitioner.[33] Ms. S reported neck pain after being hit in the head with a basketball and aggravation of shoulder pain from lifting students.[34] ANP M referred Ms. S to physical therapy.[35] Ms. S attended physical therapy treatments with S D at No Name Physical Therapy.[36]

On February 14, 2013, Ms. S had an MRI on her right shoulder.[37] The MRI showed that Ms. S had a type II acromion process without spur (the acromion bone is located under the roof of the shoulder), severe acromioclavicular osteoarthritis (a degenerative joint disease), and mild supraspinatus tendinopathy (inflammation of a tendon in the shoulder).[38] A type II acromion process predisposes an individual to nerve impingement.[39] On February 22, 2013, Ms. S went to see Dr. X N, who examined her for shoulder pain and reviewed her MRI.[40] Dr. N agreed with the radiologist report, and diagnosed degenerative AC joint disease and mild tendonitis in her

30 S testimony.
31 R395.
32 R395.
33 R285 – R288; Ex. A.
34 R285 – R288; Ex. A.
35 R285; Ex. A.
36 Ex. B; R314 – R389.
37 Ex. 5.
38 Ex. 5.
39 J testimony.
40 R591 – R593.

right shoulder.[41] Dr. N recommended anti-inflammatory medication, steroid injections, and potential surgery. He explained that lifting, pushing, and pulling all put strain on her AC joint, and did not believe therapy would be of much benefit.[42] Ms. S requested a lifting restriction, which Dr. N declined to give.[43]

Ms. S followed up with Dr. N O in April, May and July 2013.[44] Ms. S told Dr. O she had concerns with muscle atrophy in her right chest wall, as noted by her physical therapist.[45] When her shoulder pain did not subside with physical therapy, Dr. O referred her to an orthopedist.[46] Ms. S consulted orthopedist D P in August 2013.[47] Dr. P recommended shoulder surgery and referred Ms. S to Dr. B, a board-certified chiropractic neurologist for an electrodiagnostic evaluation of her shoulder.[48] The EMG revealed that Ms. S had a Neer impingement (a type of impingement of the acromion bone), with no evidence of radiculopathy (pain, numbness, tingling, or weakness caused by a compressed nerve).[49] During the August 30, 2013, evaluation, Dr. B noted that Ms. S did not have a history of shoulder or neck injury.[50]

On September 12, 2013, Dr. P performed shoulder surgery on Ms. S.[51] Ms. S followed up with Dr. P in September, October and December 2013.[52] On December 9, 2013, Dr. P released her to return to work with a 25-pound lifting restriction.[53] The surgery relieved some, but not all, of Ms. S's symptoms. Ms. S followed provider after-care instructions, including physical therapy, but her shoulder and neck continued to give her problems.

On December 19, 2013, Ms. S began treatment with chiropractor E C. His chart notes indicate that a 2011 fall on the ice affected Ms. S's neck, shoulder, and head.[54] Dr. C's intake notes do not mention the basketball incident.

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41 R591 – R593.
42 R591 – R593.
43 Ex. D.
44 R278 – R284.
45 R278.
46 R279.
47 Ex. 8.
48 Ex. 8 – Ex. 9.
49 Ex. 9.
50 Ex. 9. Dr. P performed arthroscopy with limited debridement, subacromial decompression with acromioplasy, and an open Mumford procedure.
51 Ex. 10.e
52 R546 – R552.
53 R546.
54 R234.

2. 2014

Ms. S continued treatment for shoulder and neck pain with Dr. C throughout 2014.[55] In February 2014, Ms. S returned to see Dr. P. Dr. P expressed concern over bruising from chiropractic treatment on Ms. S's scapular area.[56]

On March 5, 2014, Dr. M A examined Ms. S for neck and shoulder pain.[57] Ms. S requested, and Dr. A ordered, an MRI of Ms. S's head and neck.[58] On March 12, 2014, Imaging Associates performed an MRI of Ms. S's cervical spine.[59] The MRI showed degenerative Tes at her C4-C5 and C5-C6 disk margins with mild canal and severe right neural foramen stenosis (narrowing of the spinal canal and foramen, the opening in the vertebrae where nerves exit the spine).[60] The MRI also recorded disc protrusion with mild stenosis at C6-C7.[61]

On March 21, 2014, Ms. S met with Physician's Assistant N Q, who referred Ms. S to Orthopedist K R.[62] On April 8, 2014, Dr. R examined Ms. S for neck, shoulder, and arm pain.[63] Ms. S reported pain in her trapezius, shoulder and neck, with some pain in her arm.[64] She also noted occasional numbness and tingling in her fingers.[65] Dr. R reviewed x-rays and the MRI and confirmed cervical degenerative Tes.[66] Dr. R did not think surgery was appropriate because the source of Ms. S's pain was not clearly identified. Instead, he recommended trying epidural injections or nerve root blocks. On April 8, 2014, Dr. R released Ms. S to work with a 40-pound lifting restriction from April through October 8, 2014.[67] Dr. R did not test Ms. S's ability to lift. The next day, Physical Therapist D administered functional lifting tests which showed Ms. S could lift 30 pounds (not 40) before being limited by pain.[68]

On April 25, 2014, Dr. J performed an Independent Medical Exam (IME) as part of Ms. S's Workers' Compensation claim. Ms. S reported aching and burning over the right trapezius,

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55 R216 – R234.
56 R544.
57 R274 – R277. Dr. A, ANP M, and Dr. O all provide care out of No Name Health Center.
58 R274 – R277.
59 R294. The cervical spine is made up of seven vertebra, C-1 (top of the spine) through C-7 (base of neck).
60 R294.
61 R294.
62 R574 – R576.
63 R536.
64 R536.
65 R536.
66 R536.
67 Ex. 18; R568.
68 R237.

right upper chest, and scapula.[69] She also reported pins and needles and numbness in her right thumb.[70] Dr. J reviewed Ms. S's medical records, focusing on her shoulder issues.[71] He opined that Ms. S's shoulder was medically stable after successful surgery and that her trapezius pain was unrelated to her shoulder.[72]

On April 28, 2014, Ms. S went to the University of Washington, Neurosurgery and met with Dr. F T and Advanced Nurse Practitioner D U.[73] Dr. T discussed surgery as a possibility, but first recommended a conservative approach using steroid injections.[74] Ms. S met with Dr. K V to discuss pain management on May 12, 2014.[75] Dr. V noted severe stenosis compressing C5 and C6, and recommended epidural steroid injections.[76] Dr. V administered a steroid injection on June 27, 2014, which provided approximately seven weeks of moderate relief.[77] Ms. S met with Dr. T again in August 2014 to discuss surgical options.[78]

On September 5, 2014, Dr. H examined Ms. S and her medical records as part of a second IME associated with her Workers' Compensation claim.[79] Dr. H focused on her neck issues. Dr. H diagnosed degenerative cervical disc disease with severe right foraminal stenosis, and probable right C6 radiculopathy.[80] He surmised that Ms. S's neck condition was not medically stable, and recommended an inflatable cervical collar for traction with possible surgical intervention.[81] Dr. H did not conduct functional lifting tests, but noted that Ms. S should be capable of light to medium work with occasional lifting up to 40 pounds. Dr. H wrote that lifting would likely increase her pain, but the increased symptomology is unrelated to a work injury.[82]

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69 Ex. 20.
70 Ex. 20.
71 Ex. 20.
72 Ex. 20. Dr. J reviewed Ms. S's shoulder imaging after his initial report. In an October 2014 addendum, Dr. J's opinions remained the same after review of her MRI and x-rays.
73 Ex. 19.
74 Ex. 19.
75 R207 – R214.
76 R213.
77 R198; Ex. 19, p.15.
78 Ex. 19, p.15.
79 Ex. 22.
80 R458.
81 Ex. 22.
82 Ex. 22; R462.

After researching surgeons, Ms. S consulted Dr. M W with Sierra Neurosurgery Group in Reno, Nevada on November 19, 2014.[83] Dr. W recommended a C4-C5, C5-C6, C6-C7 anterior cervical decompression and instrumental fusion surgery (which fuses the cervical vertebra together).[84]

3. 2015

Dr. W performed surgery on Ms. S's neck on January 28, 2015. Ms. S attended post-operative consultations with Dr. W in February and March. The surgery relieved some, but not all, of her symptoms. In May 2015, Dr. W wrote that Ms. S's condition would continue to improve with physical therapy, and gave her a permanent 50-pound weight restriction.[85] Ms. S did not agree that she could lift 50 pounds.[86] Pain and tingling continued to increase in Ms. S's right arm and hand, and she began to experience symptoms in both hands.

In late 2015, Ms. S sought assistance from B E, licensed clinical social worker. Ms. E worked with Ms. S to address issues arising from loss of employment, injury, anxiety, and stress.[87]

4. 2016

On January 1, 2016, Ms. S completed a Functional Capacities Exam (FCE) at No Name Physical Therapy.[88] The FCE showed that Ms. S was able to physically perform at a light physical demand level.[89] Ms. S was unable to safely lift 20 pounds to shoulder level.[90] Ms. S continued attending physical therapy sessions at No Name from January through May 2016.[91] Ms. S also met with physical therapist K X in April 2016.[92]

Ms. S applied for Social Security Administration (SSA) disability benefits. On February 19, 2016, SSA denied her application.[93] According to the denial letter, Ms. S's medical records confirm a limitation in one upper extremity.[94] Based on this, SSA determined that although Ms.

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83 R186 – R189.
84 R186 – R188.
85 R177.
86 Ex. O-1.
87 Ex. F; E testimony.
88 R482 – R517.
89 R484.
90 R484.
91 R518 – R535.
92 Ex. E.
93 Ex. W.
94 Ex. W.

S could not safely return to work in her previous position, she could adjust to other work. Ms. S continues to struggle with pain and nerve damage today.[95]

C. Disability causation opinions

Ms. S asserted that work-related shoulder overuse and the basketball incident are responsible or partially responsible for her current disability.[96] These are explored in turn.

1. Shoulder overuse

The record established that Ms. S's shoulder symptoms primarily stem from degenerative (AC joint osteoarthristis) and congenital (type II acromion) sources. Dr. P, who performed Ms. S's shoulder surgey, advised Ms. S that because her acromion hook formation is a congenital issue, and the AC joint osteoarthritis is degenerative, pursuing workers' compensation would not be of great benefit.[97] Dr. J's testimony confirmed Dr. P's statements. He also opined that repeated heavy lifting was not a proximate cause or substantial factor in Ms. S's shoulder injury.[98]

Dr. J admitted that many factors come into play when exploring the cause of a condition or disease – body habitus, lifestyle, work and home activities, or trauma. He explained that ongoing trauma, like that experienced by NFL players, may cause or accelerate Tes. Dr. J saw no evidence that Ms. S's work activities contributed, combined with, or accelerated her shoulder issues. Lastly, Dr. J testified that Ms. S's shoulder surgery addressed both her acromion and AC joint issue.[99]

Dr. A, Ms. S's family practice provider, testified that overuse may aggravate or worsen a preexisting condition, but could not say with any certainty that Ms. S's lifting at work contributed to her shoulder issues. In an email to Ms. S, Dr. B wrote that he believes her shoulder injury was work-related.[100] However, at hearing, Dr. B testified that repetitive lifting *could* affect a shoulder over a long period of time. He did not testify that it did in Ms. S's case. In sum, none of Ms. S's providers testified to a causal relationship between Ms. S's job duties, her shoulder injury, and her disability.

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95 S testimony.
96 S testimony; R24; R88 – R89.
97 R544.
98 J testimony; Ex. 20.
99 Dr. J declined to give an opinion on Ms. S's neck and trapezius issues.
100 Ex. D.

2. Basketball incident

Like Ms. S's shoulder injury, the record is clear that Ms. S's neck issues are largely degenerative in nature. Dr. W, who performed Ms. S's spinal fusion, declined to identify a probable cause for Ms. S's neck issues, writing "unknown." Dr. R wrote that Ms. S had degenerative Tes to her neck, but that trauma could have contributed to her symptoms or caused the problem and need for further treatment.[101] Dr. R opined that it is difficult to identify causation with 100 percent definitiveness.[102]

Neurosurgeon U H identified the cause of Ms. S's neck issues as a degenerative disease with forminal stenosis, with age and genetics playing a role. He found no connection between the basketball incident and Ms. S's neck issues.[103] In Dr. H's opinion, Ms. S would have displayed immediate symptoms if the basketball incident caused a contusion of the nerve root. Dr. H testified that an incident like being struck in the head with a basketball could precipitate disc protrusion, but that Ms. S did not have disc protrusion.

Dr. H also stated that although heavy lifting exacerbates the pain in Ms. S's neck, it is unrelated to the basketball incident.[104] Lastly, Dr. H explained that genetics are the major contributor to manifestation of degenerative conditions, and lifestyle activities have little role.[105]

Contrary to Dr. H, Dr. A's workers' compensation physician's statement indicated that the basketball incident was a substantial cause in aggravating, accelerating, or making more symptomatic a preexisting neck condition.[106] She also stated that but for the October 1, 2012, injury (basketball incident), Ms. S would not suffer her neck symptoms to the same degree.[107] At hearing, Dr. A conceded that determining cause was difficult, but that trauma or injury could aggravate or make symptomatic a preexisting condition.[108]

Dr. C, a chiropractor who specializes in orthopedic assessments, testified to his belief that the trauma of the basketball incident affected Ms. S's neck issues. Specifically, Dr. C opined that the atrophy observed in both Ms. S's hands and in her right pectoralis indicate nerve root

101 R538.
102 R538.
103 Ex. 22.
104 Ex. 22.
105 H testimony.
106 Ex. A.
107 Ex. A.
108 A testimony.

entrapment due to disc injury, not degeneration alone.[109] Dr. C surmised that Ms. S's neck issues were initiated by trauma to the neck, most likely the impact from the basketball. In his opinion, Ms. S would not exhibit the same symptoms if she had not been hit with the basketball. Dr. C also testified that Ms. S regularly discussed the basketball incident, despite his failure to record this in his notes.

Dr. B, a chiropractor with a specialty in the musculoskeletal system and a sub-specialty in functional neurology and electrodiagnostic medicine, agreed that Ms. S's condition is degenerative and she likely would have displayed symptoms even had she not been hit in the head.[110] Dr. B testified credibly, however, that, in his opinion, the basketball incident was the precipitating event for Ms. S's neck issues.[111] Dr. B also stated that Ms. S's disabling condition would not present the same today had it not been for the basketball incident.[112] Lastly, Dr. B agreed that the basketball injury aggravated, accelerated, or combined with Ms. S's pre-existing condition to produce her disability.[113] In reaching this opinion, Dr. B considered the degenerative nature of Ms. S's neck issues, her medical records, both independent medical exams, and her history of reported injuries and other activities that caused her pain to flare.[114]

III. Discussion

A. Legal standards

An employee is eligible for occupational disability benefits under AS 39.35 if the employee's physical or mental condition presumably permanently 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."[115] "An employee claiming occupational disability benefits bears the burden of proving by a preponderance of the evidence that the disability was proximately caused by an injury which occurred in the course of employment."[116] "If one or more possible causes of a disability are occupational, benefits will be awarded where the record establishes that the

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109 B testimony.
110 B testimony; Ex. D-3.
111 Ex. D-3; B testimony.
112 B testimony.
113 B testimony.
114 Ex. D-3; B testimony.
115 AS 39.35.680(27).
116 *Shea v. State, Dep't of Admin. Div. of Retirement and Benefits*, 267 P.3d 624, 631 (Alaska 2011) (citing *State, Public Employees' Retirement Board v. Cacioppo*, 813 P.2d 679, 683 (Alaska 1991)); internal citations omitted.

occupational injury is a substantial factor in the employee's disability regardless of whether a nonoccupational injury could independently have caused disability."[117]

A work injury may be a substantial factor in the disability if it aggravates, accelerates, or combines with a preexisting condition, even if the preexisting condition could independently have caused the disability.[118] A work injury may be a substantial factor in a disability if it aggravates the disabling symptoms (*e.g.*, pain) of a preexisting condition, even if it does not aggravate the underlying physical condition.[119] Determining whether an injury is a substantial factor includes both actual and proximate cause. Actual cause requires a finding that the disability would not exist as it does "but for" the injury.[120] Proximate cause requires proof that reasonable persons would regard the work injury as a cause and attach legal responsibility to it.[121]

The parties agree that Ms. S's physical condition presumably permanently prevents her from performing her duties as a special education aide. The dispute is over the cause of Ms. S's disability. In short, the Administrator argues that Ms. S's shoulder and neck injuries are preexisting and degenerative in nature, and not work-related.[122]

B. Ms. S's shoulder injury does not qualify her for occupational disability benefits.

Ms. S's shoulder injury meets neither the actual "but for" nor the proximate "attach legal responsibility" prongs necessary for an award of occupational disability benefits. The evidence presented effectively rebutted Ms. S's theory that overuse of her shoulder at work is the cause of her disability.

Ms. S reported shoulder pain in early 2012. Multiple providers diagnosed the source of her pain as a preexisting, congenital AC arthritis and her type-2 acromion process. The lifting, twisting, and pulling required by her job may have temporarily aggravated these underlying conditions, but did not otherwise affect them.

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117 *Id.*

118 *Hester v. Public Employees' Retirement Board*, 817 P.2d 472, 475 (Alaska 1991) (adopting test identical to that applied in workers' compensation cases); *State, Public Employees' Retirement Board v. Cacioppo*, 813 P.2d 679, 683 (Alaska 1991).

119 *Hester*, 817 P.2d at 476, n. 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).

120 *Shea*, 267 P.3d at 633.

121 *Shea*, 267 P.3d at 633.

122 Division's post-hearing brief, at 2.

Dr. P wrote and Dr. J testified that Ms. S's shoulder injury was not work-related. Dr. J offered persuasive testimony regarding his experience with trauma-aggravated symptoms. In short, the surgery performed on Ms. S alleviated trauma-induced symptomology. Ms. S's medical records support Dr. J's testimony. Therefore, the evidence overall does not support attaching causation to Ms. S's repetitive lifting at work and her shoulder injury because any symptoms caused by work duties were only temporary.[123]

The same cannot be said for Ms. S's neck injury. It was only after Ms. S's successful shoulder surgery that she and her providers realized that neck issues were also the cause of her pain.

C. Ms. S's neck injury is a substantial factor in her disability.

Ms. S's neck issues (disc disease and stenosis), like her shoulder issues, are degenerative in nature. Based on this, it is likely that Ms. S's neck issues would have eventually emerged as problematic even absent the basketball incident. Age and genetics, therefore, are the primary cause of Ms. S's neck issues.

This conclusion, however, is not the end of the inquiry. Under the test for occupational disability, we must examine if the record supports a finding that 1) "but for" the October 2012 basketball incident Ms. S's disabling condition would not have occurred as it did, and 2) reasonable people would regard the injury as a cause and attach legal responsibility to the incident.

1. Actual cause

Three of Ms. S's providers, Dr. A, Dr. B and Dr. C, assign causation to the basketball incident. There are, however, several issues that must be examined before determining whether their opinions are persuasive.

One of the main hurdles to Ms. S's claim is the lack of clear temporal relation between getting hit in the head in 2012 and her neck injury. Ms. S did not report the incident to a provider until January 2013. After her report to ANP M, Ms. S only occasionally mentioned the basketball incident to providers until after her medical coverage ran out. It is clear that Ms. S

[123] *See, e.g., State, Dep't of Admin., Div. Ret. & Ben. v. Shea,* 394 P.3d 524, 534 (Alaska 2017) (*Shea III)* ("the relevant inquiry is whether prolonged sitting in some way precipitated or worsened the symptoms or the underlying disease process on a "presumably permanent[ ]" basis").

began attaching cause to the basketball incident in retrospect, holding more to this theory as time progressed.

Despite her intermittent reporting, the record supports a finding that the basketball incident did aggravate, accelerate, or combine with Ms. S's preexisting cervical condition to cause her disability. First, only a few months elapsed before Ms. S sought treatment. Ms. S testified credibly that her symptoms increased when she returned to school after a three-week break after the basketball incident. Although her primary reason for seeking chiropractic care with Dr. L in December 2012 was low back pain, she also reported neck and shoulder pain. Less than a month later she reported the basketball incident and associated pain to her primary care provider.

Second, Ms. S's intermittent ability to pinpoint causation conforms with her and her providers' explanation of her symptoms and treatment. Initially, she believed that most of her pain was shoulder-related. It was only after successful shoulder surgery, continued and developing pain, and a failure to return to full capacity that Ms. S and her providers suspected additional etiology.

In terms of timelines, Ms. S's case is distinguishable from *Shea III*. In *Shea III*, nearly three years lapsed between the end of Ms. Shea's employment and Ms. Shea identifying sitting at work as a cause to her medical providers.[124] The Court concluded that the delay was evidence that Ms. Shea herself did not regard her employment as a significant cause of the pain.[125] Here, Ms. S reported her injury and resultant pain to a school employee on the day of the incident, sought treatment two months later, and identified it as a possible cause to her primary care provider within four months. Accordingly, the temporal issue is resolved in Ms. S's favor.

Another difficulty is that Ms. S reported a number of other suspected causes for her pain – lifting a gallon of milk, a 2011 car accident, work-related transfers, and falling on ice. While these incidents all caused short-term discomfort, it is the mechanism of injury from the basketball strike that align with Dr. C and Dr. B's causation explanations. Dr. C testified credibly that Ms. S's atrophy strongly indicates a trauma-induced neck injury.[126] Dr. C and Dr.

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124 *Shea III*, 394 P.3d at 533.

125 *Shea III*, 394 P.3d at 533. *Shea III* discussed delays in reporting to a medical provider under the proximate cause prong. Temporal relationship between injury date and identification of the injury as a cause may relate to both the "but for" connection as well the reasonableness of assigning legal responsibility to it.

126 C testimony.

B both considered other causes and assigned responsibility to the basketball's impact.[127] The issue of multiple causation theories is also resolved in favor of Ms. S.

A final challenge to Ms. S's theory is Dr. H's expert opinion that the only cause of Ms. S's cervical spine issues is the contribution of genetics and age.[128] At hearing, Dr. H testified that an incident like the basketball injury could cause disc protrusion, but that Ms. S exhibited only foraminal narrowing, not protrusion. This statement is incorrect. The MRI report states "C6-C7 *disk protrusion* with mild canal stenosis."[129] Because it appears that the mistaken lack of disc protrusion was a factor in Dr. H's opinion, this inconsistency undermines Dr. H's opinion that the basketball incident had no effect on Ms. S's cervical spine issues.

Overall, the persuasive testimony of Ms. S's three treating health care providers outweigh the contrary evidence. Therefore, Ms. S established by a preponderance of the evidence that the basketball incident was more likely than not an actual cause of her disability.

2. Proximate cause

Proximate cause requires a finding that reasonable people would regard the basketball injury as a cause and attach legal responsibility to it. Although a close call, Ms. S reached the proximate cause threshold.

Here again, three of Ms. S's treating providers – all licensed, medical professionals, testified under oath to their opinions that being struck forcefully in the head by a basketball was a substantial factor in Ms. S's disabling condition. Each understood that Ms. S did not immediately report the incident to her providers, and did not consistently point to the basketball incident as the root cause of her pain.

The testimony from Ms. S's treating providers is a significant distinction from *In re U.H.*, an occupational disability denial that was upheld at the administrative appeal level. In *In re U.H.*, the only evidence supporting U.H.'s theory that she suffered a work-related disability was her subjective belief it was the case.[130]

Other facts that support a finding that reasonable people would attach legal responsibility to the basketball incident include:

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127 C testimony; B testimony.
128 R459.
129 R294. Emphasis added.
130 OAH No. 14-1480-PER (OAH 2015).

- Ms. S's credible testimony that her pain level increased and she began to have muscle spasms shortly after the incident;
- Ms. S seeking chiropractic treatment for the first time within two months of the incident;
- The lack of other intervening causes between the basketball incident and Ms. S seeking chiropractic care;
- Dr. B considered other reports of injury (auto accident, lifting milk, etc.) and identified the basketball incident as a precipitating event, and
- Dr. C's cogent explanation of Ms. S's symptoms and the likelihood of them being trauma-induced.

Overall, the evidence supports a finding that even though Ms. S's neck issues would have eventually emerged, reasonable people could find that the basketball incident combined with, accelerated, or aggravated her underlying degenerative condition. Thus, the basketball incident, a work-related injury, is a substantial factor in Ms. S's disability and she qualifies for occupational disability benefits.

Lastly, both parties suggest that provider opinions may be biased. Other than assumptions based on general testifying patterns, the record does not support these assertions.[131]

IV. Conclusion

Ms. S established by a preponderance of the evidence that the basketball injury is a substantial factor in her disability. Accordingly, the Administrator's decision to deny Ms. S occupational disability benefits is reversed.

DATED this 1st day of August, 2017.

Signed
Bride Seifert
Administrative Law Judge

[131] Dr. J and Dr. H were originally hired to provide IMEs and testimony for Ms. S's workers' compensation case. Both testify on behalf of employers in the vast majority of cases. Based on this, it is reasonable to infer that their opinions may generally favor employers or insurance companies. On the other hand, Dr. C, Dr. B, and Dr. A all have doctor-patient relationships with Ms. S and their opinions may align more closely with her desired outcome. These inferred biases, without additional support, do not weigh in favor of either party.

Adoption

On August 25, 2017, L S submitted filings that accepted the proposed decision and requested fees, penalties, and other relief for the delay in the award of occupational and non-occupational disability benefits. Her request is denied. An Administrative Law Judge may impose sanctions if a party acts in bad faith or used tactics frivolously or solely to cause unnecessary delay.[132] The record here does not support such a finding.

This Order is issued under the authority of AS 39.35.006. 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 R. App. P. 602(a)(2) within 30 days after the distribution date of this decision.

DATED August 28, 2017.

By: *Signed*
Signature
Bride A. Seifert
Name
Administrative Law Judge
Title

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

[132] 2 AAC 64.360(b).