BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of	)	
	)	
M D. C	)	OAH No. 18-0810-PER
	)	Agency No. 2018-006

DECISION AFTER PROPOSAL FOR ACTION

I. Introduction

M C terminated her employment as Position A for Employer A after she became unable to perform the duties of her job due to debilitating migraine headaches. She applied for nonoccupational disability benefits with the Public Employees Retirement System ("PERS"). The Division of Retirement and Benefits (DRB or the Division), as Administrator of PERS, denied her claim based on its determination that she is not "presumably permanently disabled." Ms. C appealed that decision, and a hearing was held before the Office of Administrative Hearings (OAH). Based on the record as a whole and after due deliberation, the Administrator's denial of Ms. C's claim is hereby reversed.

II. Facts

A. Background

M C has worked as a Position A with the State of Alaska for many years, including more than 15 years working as an Position B for Employer B beginning in October 1995.[1] She began working in her most recent position as the Position A for Employer A in September 2011.[2] She continued to work in that position, receiving all positive performance evaluations, until she resigned from her employment due to chronic, debilitating migraine headaches.[3] Ms. C gave notice of her resignation in mid-May 2018, intending to continue in the position until the Court System hired her replacement; that process took longer than anticipated, and her last day of employment was on September 4, 2018.[4]

Prior to her resignation, on May 13, 2018, Ms. C applied for nonoccupational disability benefits, based on the impact her migraine headaches were having on her ability to do her work as Position A.[5] The Administrator referred Ms. C's application to a medical consulting firm for

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1 Exh. 2, p. 7. In total, Ms. C accrued nearly 24 years of "paid-up service" in PERS. Exh. 2, p. 6.
2 *Id.*; C testimony.
3 Exh. 2, p. 12.
4 C testimony; *see* Agency Record (AR) p. 47.
5 AR pp. 39-44; C testimony.

review, and after receiving the firm's report, the Administrator denied her application by letter dated June 27, 2018, stating that "[t]he medical documentation you provided does not substantiate your condition is permanently disabled *[sic]* from performing the duties of Position A."[6] The Administrator's denial letter attached copies of the medical consulting firm's "Disability Peer Review Report" and an "Administrator's Statement for Disability Benefits," which paraphrased the conclusions reached in the consultant's report as follows:

> The physician consultant opined she does not have any significant abnormality on examination and the clinical data does [not] corroborate the self-reported severity or frequency of her condition. *She is therefore able to perform the duties of her job as a Position A*.[7]

Ms. C requested a hearing to contest the Administrator's decision denying her application for nonoccupational disability benefits. The hearing was held on February 4-5, 2019. Ms. C was represented by counsel Joseph Kalamarides and testified on her own behalf. Also testifying for Ms. C were her wife C J, friend O C, co-worker E J, primary care physician Dr. Julie Robinson, neurologist Dr. Franklin Ellenson, and Employer A Administrative Director D K. DRB was represented by Assistant Attorney General Siobhan McIntyre; testifying for DRB were expert witness Dr. Lynne Bell, and DRB Retirement Benefits Specialist III Melinda Voigt.

The parties stipulated to admission of all exhibits offered, including the entire Agency Record, with the exception of DRB's Exhibit A, which was withdrawn. The parties submitted post-hearing briefs in lieu of closing arguments on March 6, 2019, the record was closed, and the matter was taken under advisement.

B. Ms. C's migraines

Ms. C applied for nonoccupational disability benefits in May 2018 by submitting an application form to DRB. The form includes sections asking the applicant to "describe the nature of your disability" and "describe the cause of your disability." In response to these inquiries on the application form, Ms. C submitted a two-page, single-spaced typewritten statement, pertinent portions of which are set out below:

> **Describe the nature of the disability**
> My disability is chronic migraines. Since their onset as chronic in October 2017, I have had a new migraine attack every three to five days, sometimes with no break in between. [footnote omitted] The attack phase of the migraines last[s] for days. In addition, I suffer various intense symptoms during the prodrome and

[6] AR pp. 4-5.

[7] AR p. 6 (emphasis added), *paraphrasing* Disability Peer Review Report by Dr. Stephen Selkirk, at AR p. 13. Dr. Selkirk did not testify at the hearing, nor did DRB rely upon his findings to any significant extent.

postdrome phases of the migraine–typically the day before and the day(s) after. I have been averaging seven or eight migraines a month. That leaves only a handful of days–if any–each month where I am not either in a migraine attack, in the postdrome (or hangover) phase of a migraine, or sliding into the next one with the prodrome (or premonitory) phase. It is sometimes close to impossible to tell when one migraine ends and the next begins. The cycle is relentless; I do not get to recover to a level of normal functioning between episodes. … I'm wiped out.

These chronic migraines keep me from being able to do my job. As the only Position A for the state, I am required daily to problem solve, analyze legal and technical issues, draft language, and present solutions. My ultimate audience is the Alaska Supreme Court, to whom I regularly make oral and written presentations. Before the chronic migraines began, I ordinarily worked five to fifteen more hours a week than scheduled.

Since last fall, I have been working drastically limited hours. On a functional day, I might work for four hours. Most days, I work an hour or so or not at all. [footnote omitted] In a given week, I may be able to work a total of eight to twelve hours, or as few as four. Since November, most of the few hours I have been working have been from home (under the FMLA), because I don't have the energy to dress and get myself to the office most days. The most minimal of efforts exhaust me.

I spend days in bed, in the dark (due to photosensitivity). I look forward to "good" hours rather than good days since those are so rare. What constitutes "good" has changed dramatically for me. I'm happy to be able to shower, make myself a meal, or do a load of laundry. … Most exertion demands a multi-hour nap to recover.

On top of this profound physical fatigue, the disease prevents me from maintaining the focus and sustained mental acuity required of a Position A. Fatigue and brain fog impair my ability to think, organize my thoughts, speak, and write. Looking at computer screens and trying to read more than a paragraph or two, even with specially tinted glasses, literally makes my head hurt. Light and screens amplify my pain. My memory is impaired and I have difficulty tracking what I hear or retaining it for later. I struggle with simple math. It's as though my IQ has significantly dropped.

Preparing and moving rule change proposals through the committee process and to the Supreme Court is my prime responsibility. It requires me to make cogent written and oral presentations, answer questions, and explain how pieces fit together, both to my committees of expert attorneys and judges, and later to the Supreme Court. It is a unique position within the court system. As a member of the senior staff, I'm also expected to help implement and explain core programs and policies. But when I'm having migraines I can't do any of that.

I simply cannot do what I used to, inside or outside the court.

Describe the cause of the disability
I have been diagnosed with chronic migraines, a complex neurological disease that seriously impacts different physical and mental systems. (An MRI ruled out

> other explanations for my symptoms.) The attacks cause severe head and neck pain; profound fatigue; intense nausea, sometimes with vomiting and or diarrhea; light-headedness; and hyper-sensitivity to light, sound, smell and movement. (I lost 15 pounds due to the persistent nausea, pain, and loss of appetite. …) As noted in the previous response, the episodes also severely compromise my ability to think, express myself orally or in writing, or to understand or retain information presented to me. My mind is disordered. And I experience more deep depression and anxiety.
>
> I am being treated by a neurologist and my primary care physician. We have tried different acute and preventative treatments and strategies. But the therapies have only had modest effect.
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> My acute treatments include the triptan Eletriptan plus two Aleve, Zofran, Reglan plus Benadryl, and Lunesta. These medications provide some relief but do not abort the attack. I have to limit these medications to avoid triggering medication overuse headaches or serotonin syndrome. I regularly rely on my ice pack and eye mask for additional relief.
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> For preventative treatment, I took increasing doses of Topamax … over the course of two months without success. I began Botox treatments in December, yet my migraines remain as frequent as before the treatment and my number of migraine days has not decreased. I had an SPG nerve block in late March, but it failed to alter my migraine pattern. A sleep study ruled out obstructive breathing or other disturbances as migraine triggers. And at the suggestion of my primary care physician, I eliminated common dietary triggers for migraine from my diet with no effect.
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> The chronic migraines have severely limited my life since last fall. … Despite my and my medical team's best efforts, the treatments we have been using have not restored my health and my ability to perform my demanding job duties. While I certainly hope for improvements to my quality of life and functionality, I expect that chronic migraine will dominate my life for the foreseeable future.[8]

Ms. C had started tracking and recording data regarding her migraines beginning in February 2018. She attached copies of the detailed "migraine calendar" forms on which she recorded this data to her disability application in May 2018.[9]

C. Medical treatments

Prior to first experiencing migraine headaches, Ms. C had been treated for depression and anxiety beginning in approximately 2010.[10] In early 2017, she discussed certain side effects of

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[8] AR pp. 41-42. Because Ms. C was a very credible witness, and DRB did not seriously challenge any of her factual testimony regarding her migraines, these factual descriptions (and Ms. C's other related factual testimony) are adopted and incorporated by reference as part of the findings of fact of this decision.

[9] AR pp. 43-44. Ms. C continued recording her detailed migraine data on such calendars through the date of the hearing. *See* Exhs. 7, 8.

[10] C testimony. She had also previously been diagnosed with Graves' disease (a thyroid condition).

her anti-depressant medications with her primary care physician, Dr. Julie Robinson, and they changed their treatment approach at that time, replacing Lexapro with a combination of Prozac and Wellbutrin.[11] Ms. C had an office visit with Dr. Robinson on March 21, 2017; Dr. Robinson's records indicate that Ms. C's issues with depression and anxiety were being well addressed by the new combination of medications, and the side-effects that she had previously experienced with previous medications had been resolved.[12]

In early September 2017, Ms. C had an annual checkup with Dr. Robinson. Shortly after that appointment, she experienced two severe episodes of migraine headaches, from September 9 through 11 and September 23 through 26, 2017.[13] She wrote a letter to Dr. Robinson to record what she had experienced and to seek treatment.[14] Prior to that she had had no previous history of migraines. Ms. C met with Dr. Robinson, who prescribed Imitrex and Excedrin Migraine at that time.[15] Imitrex is an abortive medication, prescribed to be taken at the first sign of onset of a migraine.[16]

On October 8, 2017 Ms. C went to the emergency room at Alaska Regional Hospital on the third day of another severe migraine episode.[17] This was her second migraine episode that week.[18] Dr. Robinson subsequently ordered an MRI of Ms. C's brain, which was conducted on October 17, 2017. The MRI results did not reveal any physiological evidence of possible causes of her migraines.[19] On October 22, 2017 Ms. C met with Dr. Robinson again, and her prescribed treatment regime was changed to the abortive medication Treximet (instead of Imitrex) and the preventative medication Topamax.[20]

In mid-November 2017, Ms. C saw Dr. Robinson again. She reported that she was experiencing migraines about once every five days, with each episode lasting about three days.[21] They discussed whether her anti-depressant medications, Prozac and Wellbutrin, might be

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11 *Id.*; Dr. Robinson testimony.

12 *Id.; see* Exh. G, p. 100 ("[n]ew combination of Prozac and Wellbutrin is working wonderfully").

13 C testimony; Exh. G, p. 112.

14 *Id.*

15 Exh. G, p. 116.

16 Migraine treatments are classified as two types: abortive medications, designed to reduce the severity and shorten the duration of an ongoing migraine episode, and preventative or prophylactic medications, designed to prevent episodes from occurring before they start.

17 Exh. G, pp. 117-138.

18 Exh. G, p. 126. Ms. C had contacted the phone-in nurse made available to her through her Aetna health insurance coverage, and she had been advised to go to the ER. C testimony.

19 Exh. G, p. 113; Dr. Robinson testimony.

20 *Id*.

21 C testimony; Exh. G, p. 146.

playing a role in her migraines, but Dr. Robinson felt that it was unlikely because she had been on both medications for many months before the onset of her migraines.[22] At that time Dr. Robinson prescribed a different abortive medication, Relpax, and she referred Ms. C to Dr. Franklin Ellenson, a neurologist whom Dr. Robinson considered to be one of the best in Alaska.[23]

Ms. C saw Dr. Ellenson for the first time on December 18, 2017, accompanied by her spouse C J. Dr. Ellenson recorded that Ms. C had had her first two migraine episodes in September, describing them as "rapid onset head pain," "usually unilateral more often on the right than the left," associated with nausea and excessive sensitivity to light and sound, persisting for three days, and characterizing them as severe, "wavelike," and incapacitating.[24] He noted that she had "at least four attacks" of migraine episodes in October, each lasting two days or longer, and that she had also developed "daily head pain which has persisted," but which was less severe than that experienced during the acute migraine episodes.[25] Ms. C also reported to him that she had experienced unpleasant side effects from the preventative medication Topamax, in the form of forgetfulness, "word finding difficulty," and cognitive slowing.[26]

At the December 18, 2017 appointment, Dr. Ellenson and Ms. C discussed reducing and then stopping her Topamax dosage, and Dr. Ellenson prescribed a prednisone taper as an abortive medication.[27] Dr. Ellenson also recommended that she try Botox injections as a preventative treatment. He explained at the hearing that other preventative medications were contraindicated due to Ms. C's effective anti-depressant medication regime, as well as her asthma and low blood pressure.[28]

Ms. C received her first Botox treatment on December 26, 2017.[29] In the interim she had discontinued Topamax, and she reported improvement in her cognitive slowing issues and other side effects.[30] She saw Dr. Ellenson again on March 26, 2018 and gave him copies of her "headache calendars," where she recorded detailed information regarding each of her migraine

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22 *Id.*
23 *Id.*; Dr. Robinson testimony.
24 Dr. Ellenson testimony; Exh. G, p. 160.
25 *Id.*
26 *Id.*
27 Exh. G., p. 164.
28 *Id.*, Dr. Ellenson testimony.
29 Exh. G, pp. 169-170.
30 Exh. G, p. 166.

episodes.[31] The calendars showed that she had 20 days of migraines in January 2018, 21 days in February, and 20 in March up to the March 26 office visit.[32] In essence, she was experiencing about seven migraines per month, each lasting about three days.[33] She reported to Dr. Ellenson that she consistently experienced fatigue in the initial stages of an episode and "mental fogginess" following the acute portion of each migraine episode, and that she was napping three to four hours per day.[34] Ms. C received a second Botox injection that day.[35]

In March 2018 Dr. Ellenson prescribed a "sphenopalantine ganglion block" (SPG block), a procedure that seeks to treat migraines by anesthetizing a cluster of nerves behind the patient's nasal cavity. That procedure was performed on Ms. C on March 30, 2018.[36] Dr. Ellenson also referred her for a sleep study, which was performed on April 17, 2018. The SPG block did not provide any significant relief, and the sleep study revealed nothing abnormal.[37] In March 2018, Dr. Ellenson also prescribed a combination of Benadryl and Reglan (metoclopramide) as an abortive medication to be taken in combination with Relpax.[38]

In early May 2018, Ms. C contacted the neurology department of the Mayo Clinic to discuss consulting with them about her migraines. A migraine specialist there reviewed her medical records and informed her that it appeared that she was receiving appropriate treatment and therefore that it might not be "worth the trip" to travel to the lower-48 for a face-to-face consult.[39] In an abundance of caution, Ms. C set an appointment with the Mayo Clinic for July 2018, but ultimately she did not travel there for a consultation.[40]

During the summer of 2018, Dr. Robinson prescribed hormone therapy in another attempt to address Ms. C's migraine episodes. Dr. Robinson testified that she suggested this approach even though she "didn't think her migraines were hormonally mediated."[41] This effort took place between June and August 2018, but it was unsuccessful, as it apparently exacerbated the migraines and had undesirable side effects.[42]

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31 The headache calendars were included in the record. *See* AR 43-44, Exhs. 7, 8.
32 Exh. G, p. 181.
33 Exh. G, p. 185.
34 Exh. G, pp. 181, 186.
35 Exh. G, p. 184.
36 Exh. G, pp. 187-189.
37 Dr. Ellenson testimony; exh. G, p. 201.
38 Exh. G, p. 185.
39 C testimony; exh. H.
40 C testimony.
41 Dr. Robinson testimony; *see* exh. G, pp. 205-206, 208.
42 *Id.*

In July 2018, Dr. Ellenson prescribed monthly injections of Aimovig (erenumab), a relatively new preventative migraine treatment.[43] In addition, in October 2018 and January 2019, Ms. C received additional Botox injections.[44]

In his notes written in October 2018 and January 2019, Dr. Ellenson recorded that although Ms. C was experiencing some minor improvements in the number of headache-free days each month, she was still unable to work.[45] In January 2019, less than a month before the hearing, Dr. Ellenson recorded that despite her slight improvement, Ms. C was still experiencing migraine episodes more than half the days of each month.[46]

Drs. Robinson and Ellenson each filled out and submitted "Physician Statement" forms in support of Ms. C's application for nonoccupational disability.[47] The pertinent portions of Dr. Robinson's statement, under the heading "prognosis," are set out below (form inquiries are in normal font, physician responses are in italics):

> To what extent and in what way does the patient's disability restrict job performance? *Extreme fatigue, pain, fogginess - unable to work more than a few hours per week.*
>
> Do you expect the patient to improve on the current treatment to the extent that work can be performed in the future, and if so, when do you expect this improvement? *No.*
>
> Are there any treatment modalities planned for the future which may improve the condition to the extent that a return to the former work situation may be anticipated? Please specify. *No.*[48]

The same portions of Dr. Ellenson's statement are as follows:

> To what extent and in what way does the patient's disability restrict job performance? *Unable to tolerate work due to severe head pain.*
>
> Do you expect the patient to improve on the current treatment to the extent that work can be performed in the future, and if so, when do you expect this improvement? *I do expect improvement, but could take 6-12 months, recovery not guaranteed.*
>
> Are there any treatment modalities planned for the future which may improve the condition to the extent that a return to the former work situation may be anticipated? Please specify. *Continue Botox treatment.*[49]

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43 Exh. G., p. 214.
44 Exh. G, pp. 223, 230.
45 Exh. G, pp. 224, 231.
46 *Id.*
47 *See* exh. G, p. 204 (Dr. Robinson), exh. G, p. 203 (Dr. Ellenson).
48 Exh. G, p. 204.
49 Exh. G, p. 203.

At the hearing, Dr. Ellenson elaborated on these responses. When asked if he thought Ms. C's disability would continue into the foreseeable future, he testified that although it is a challenging thing to predict, and notwithstanding her slight improvements over the prior few months, Dr. Ellenson believed that her disability would likely continue over the next year. He opined that it would be difficult for her to work a full-time job in the foreseeable future, and trying to do so would be likely to "cause more days of incapacity."[50]

Dr. Robinson also was questioned at the hearing regarding her comments on the Physician's Statement form. She confirmed in her testimony that she continues to hold the opinion that Ms. C is unlikely to be able to return to work.[51]

D. Employer's statement of disability

Ms. C's supervisor at Employer A, general counsel O N, also filled out and submitted an "employer's statement of disability" form in connection with Ms. C's application for nonoccupational disability benefits.[52] The pertinent portions of the form and Ms. O's responses are set out below (form headings and inquiries are in normal font, employer responses are in italics):

> Effect of Disabilities on Duties: *Ability to write and speak clearly, analyze, problem solve, schedule and participate in meetings, and work on the computer severely compromised. Only able to work and perform for few hours a week. Productivity greatly diminished.*[53]
>
> [W]hat accommodations have been made [to aid Ms. C in performing her job]: *Computer screen filters, set up w/a laptop to work from home as able. Hours reduced under FMLA/AMLA.*
>
> If the employee's PERS application for disability is not approved and the employee desires to continue working, will the employee be retained and required to perform the duties that are currently assigned to the employee?" *No.*
>
> Will the employee be assigned to other duties? *No.*
>
> If the employee will not be retained in any capacity, please explain. *To my knowledge, Employer A does not have any comparable permanent full time positions that Ms. C could perform with her disability.*
>
> In order to be eligible for disability benefits, the employee must terminate employment "because of" disability. Are you aware of the reasons for termination or absence? *Yes.*

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50 Dr. Ellenson testimony.
51 Dr. Robinson testimony.
52 AR pp. 47-52.
53 AR p. 47.

If yes, please explain those reasons. *Unremitting and persistent chronic migraines.*[54]

E. Dr. Bell's independent medical examination

At DRB's request, on October 31, 2018 Ms. C underwent an independent medical examination (IME) performed by Dr. Lynne Bell, a neurologist based in Portland, Oregon. Dr. Bell has practiced as a neurologist and consulting independent medical examiner in neurology for over 20 years. At the hearing, the parties stipulated that Dr. Bell is qualified to testify as an expert in neurology and treatment of migraine headaches. Dr. Bell estimated that approximately 90% of her consulting IME work had been performed on behalf of defendants such as DRB.[55]

Ms. C's spouse C J attended the October 31, 2018 IME with Ms. C. They both testified at the hearing that when they arrived at Dr. Bell's office, her staff apparently did not know that Ms. C had a scheduled appointment, but Dr. Bell was nonetheless available. Ms. C and Ms. J both also testified that Dr. Bell did not have Ms. C's medical records available to her at the beginning of the appointment, then at some point during the examination she left the room and returned with some of the records. The result was that they both were left with a distinct impression that Dr. Bell had not reviewed the records prior to beginning the examination. Dr. Bell, on the other hand, testified that she had received Ms. C's records prior to the appointment and reviewed them before writing up her IME report. She testified she was unaware of any scheduling lapse or confusion regarding the appointment.[56]

In any event, Dr. Bell was able to meet with Ms. C, perform the examination and produce a written IME report.[57] Dr. Bell discussed her findings during her testimony at the hearing. Based on her examination of Ms. C, she concluded that she concurred with Dr. Ellenson's diagnosis of chronic migraines with co-existing anxiety, depression, and Graves' disease (a thyroid condition), and further concluded that the treatment provided by Drs. Robinson and Ellenson was appropriate, but "not exhaustive."[58] She felt that Dr. Ellenson's curtailment of Ms. C's preventative Topamax medication after only two months was premature, explaining that the dosage may not have been at an optimal level for the entire two month period, and that an appropriate migraine preventative medication trial should be conducted for from three to six

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54 *Id.*
55 Dr. Bell testimony.
56 Dr. Bell testimony.
57 Dr. Bell's October 31, 2018 IME report is included in the record of this matter at exh. E.
58 Dr. Bell testimony.

months at the optimal dosage level.[59] Dr. Bell opined, therefore, that at the time of the IME, Ms. C had not yet undergone a "fair treatment trial" of preventative medication.

Dr. Bell also opined that Ms. C's migraines could have been caused at least in part by what she characterized as the "recent change in her long-standing medication for treatment of depression," a reference to the early 2017 change from Lexapro to the combination of Prozac and Welbutrin.[60] Dr. Bell testified that consequently, she would recommend Ms. C undergo a formal psychiatric evaluation, including an interview and an MMPI profile (a personality testing profile), because with most chronic pain conditions there are co-existing psychological conditions that contribute to the "chronicity" of the pain condition.[61] In this context, Dr. Bell noted that Ms. C's recent change in her medication for depression was not "temporally too far before" when the migraine cycle had started. Dr. Bell acknowledged that Ms. C has been successfully treating her depression with her current regimen of medication, but nonetheless recommended that she address her migraines by undergoing behavioral treatment of depression, along with possibly trying a regimen of anti-depressant medications that "have been shown to help with migraines."[62] Dr. Bell also recommended that Ms. C obtain a second opinion from a migraine headache specialist.[63]

Regarding Dr. Ellenson's concerns that beta blockers are contraindicated by Ms. C's asthma, she opined nonetheless that beta blockers could be tried: "you've got someone with a disabling condition whose almost bedbound and certainly homebound, … and … that's something where you could work with a specialist treating the pulmonary problem… where one of those agents might be tried."[64] She also recommended that Ms. C try other anti-convulsants in the same drug class as Topamax, such as Neurontin or Lyrica, which have different side effects.[65] She also suggested that Ms. C could try another anti-convulsant, Depakote, while

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[59] *Id.* Dr. Bell also expressed skepticism as to Ms. C's complaints regarding the side effects of the Topamax, opining that they could have been symptoms of the migraines themselves. *Id.*

[60] After Dr. Bell's testimony was concluded, Dr. Robinson testified to an error by Dr. Bell, whereby she copied Dr. Robinson's March 2017 treatment notes into her report in a manner that appeared to date those notes much later in 2017 and thus closer to the September 2017 onset of the migraines. Whether this error played any role in Dr. Bell's ultimate opinion as to possible cause and effect from the change of depression medication is unclear.

[61] Dr. Bell testimony.

[62] *Id*.

[63] Dr. Bell suggested that the Mayo Clinic's response to Ms. C (i.e., that it had reviewed her records and wouldn't have done anything different) was somewhat dismissive, and that a second opinion should be pursued.

[64] *Id*.

[65] *Id*.

acknowledging it has potentially serious side effects that must be monitored. She added, however, that usually other anti-convulsants are tried before going to Depakote.[66]

In her written report, Dr. Bell noted that eligibility for disability benefits would require that Ms. C's migraines be a "permanent condition," and she cautioned that "I am not sure I understand what you mean by 'presumably permanent.'"[67] She then recorded her opinion that "this is not a permanent condition and further exploration of additional treatment trials and consultations with Psychiatry and a Headache Specialist … may prove useful and potentially curative, or at a minimum, lead to improved headache control and improved quality of life."[68] At the hearing, DRB's counsel pursued this issue further on direct examination of Dr. Bell, asking her if she would categorize Ms. C as permanently disabled. Dr. Bell asked for clarification of the legal meaning of the term, to which DRB's counsel responded by citing one portion of the relevant statutory definition: "disability that is totally and apparently permanent."[69] In response, Dr. Bell testified that Ms. C "is not permanently impaired … she has yet to undergo what I would consider a fair treatment trial to control what I believe to be a condition that could be better controlled with medication."[70] When asked by DRB's counsel if, with additional treatment, Ms. C would "more likely than not" be able to return to her previous position, Dr. Bell testified:

> I don't have a crystal ball. I just know she hasn't had all of the appropriate treatments before condemning her to being disabled permanently. So I can't say at this point when she hasn't even had the additional treatment trials, if she will be able to return to her job.[71]

She concluded her direct testimony by stating that in her opinion, more likely than not Ms. C's condition "will improve" with further additional treatment.[72]

On cross-examination by Ms. C's counsel, Dr. Bell confirmed her view that the treatment approaches rendered by Drs. Ellenson and Robinson have been appropriate. She reiterated her

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66 *Id.* Dr. Ellenson "rarely" prescribes Depakote for migraines, because of the potentially severe side effects. Dr. Ellenson testimony.

67 Exh. E, p. 16.

68 *Id.*

69 As further discussed below, the relevant Alaska statutory provisions predicate eligibility for disability on whether a person is terminated due to "a total and apparently permanent nonoccupational disability," which in turn is defined as a condition that "presumably permanently prevents" the person from satisfactorily performing their job duties. AS 39.35.400(a); AS 39.35.680(24).

70 Dr. Bell testimony.

71 *Id.*

72 *Id.*

opinion that Ms. C was disabled and unable do her job as of the time of the IME, and that at the time of the hearing she was still disabled.[73] She also restated her firm view that any appropriate preventative treatment regimen should be attempted for a minimum of three months or longer. She then clarified her opinion on the issue of the permanence of Ms. C's disability as follows: "I was asked if this is the end of the line, is this the way she's always going to be, and I said no, because she hasn't gone through all the treatments."[74]

III. Discussion

A. Eligibility standards

In this proceeding, Ms. C has the burden to establish that she is entitled to PERS non-occupational disability benefits.[75] Two Alaska statutory provisions set out the substantive standards relevant to a determination of eligibility. First, AS 39.35.400(a) provides: "An employee is eligible for a nonoccupational disability benefit if the employee's employment is terminated because of *a total and apparently permanent nonoccupational disability*, as defined in AS 39.35.680… ."[76] Second, AS 39.35.680 defines nonoccupational disability as follows: "'nonoccupational disability' means a physical or mental condition that, in the judgment of the administrator, *presumably permanently* prevents an employee from satisfactorily performing the employee's usual duties for an employer or the duties of another position or job that an employer makes available and for which the employee is qualified by training or education … ."[77]

In a relatively recent decision, the Alaska Supreme Court described the application of these provisions as follows:

> Pursuant to AS 39.35.680(24) ... , an employee must prove each of three distinct elements by a preponderance of the evidence as part of an application for … nonoccupational disability benefits: (1) There must be "a physical or mental condition"; (2) the condition must "prevent[ ] an employee from satisfactorily performing the employee's usual duties for an employer or the duties of another position or job that an employer makes available and for which the employee is qualified by training or education"; and (3) the condition must be "presumably

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73 *Id.* Thus, all three testifying physicians agreed that Ms. C is currently disabled and unable to work.

74 *Id.*

75 *State v. Cacciopo*, 813 P.2d 679 (Alaska 1991).

76 AS 39.35.400(a) (emphasis added). The statute also provides that "[a] member is not entitled to a nonoccupational disability benefit under this section unless the member files an application for the benefit with the administrator within 90 days after the member terminated employment." *Id.*

77 AS 39.35.680(24).

> permanent[ ].” The statutory test is conjunctive—an absence of any element is fatal to an employee's application for disability benefits.[78]

Thus, a determination of eligibility requires proof by a preponderance of the evidence that the member has a physical or mental condition that “presumably permanently” prevents her from satisfactorily performing her usual duties.[79] Ms. C satisfies her burden by establishing that it is “more likely true than not true” that her condition meets this definition of disability.[80]

“Presumably permanent” is not further defined by statute or regulation. However, other sections of the pertinent statutes and regulations provide some guidance in this regard. A Division regulation provides that “[n]onoccupational disability benefits cease when a member recovers from an injury or illness or is capable of working in any full-time position.”[81] In addition, AS 39.35.400(e) provides that a recipient of nonoccupational disability benefits must provide proof to the administrator on an annual basis of their continuing eligibility for benefits, and in the absence of such proof, their disability payments shall cease.[82] These provisions clearly embody the premise that a PERS member who has been found eligible for disability benefits may recover from their disability and be able to return to work. Accordingly, an interpretation of “presumably permanent” that would avoid inconsistency between the PERS statutes and implementing regulations is that a member can meet their burden by establishing by a preponderance of the evidence that he or she has a condition which *precludes performance of*

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78 *McKitrick v. Public Employees Retirement System,* 284 P.3d 832, 839 (AK 2012) (*affirming* OAH decision, *In re MM*, OAH No. 07-0524-PER (2009), which denied PERS member’s claim for occupational and nonoccupational disability benefits); *see also In re DJ,* OAH No. 16-1087-PER (2016), p. 11. AS 39.35.400(a) also requires that the member’s employment was terminated because of the disability; that factor, however, was not disputed in this case.

79 *In re MM*, OAH No. 07-0524-PER (2009), *citing State v. Cacciopo*, 813 P.2d 679 (Alaska 1991).

80 The “preponderance of the evidence” standard is met when a disputed fact is shown to be more likely true than not true. 2 AAC 64.290(e).

81 2 AAC 35.291(b). This regulation presumably was promulgated pursuant to the language of AS 39.35.400(b)(2), which provides that an eligible member’s last nonoccupational disability payment “shall be for the last month in which the disabled employee … recovers from disability.”

82 The complete language of the provision is: “A disabled employee receiving a nonoccupational disability benefit shall provide the administrator, one year after appointment to disability benefits and once each year thereafter until disability benefits cease, proof of continuing eligibility to receive disability payments under the Social Security Act. If the disabled employee is otherwise ineligible for a social security payment, the employee shall provide the administrator with sufficient medical evidence once each year to demonstrate that disability payments under the Social Security Act would be payable had the employee been otherwise eligible. If the disabled employee fails to provide the administrator with evidence of continuing eligibility for disability payments under the Social Security Act or other medical evidence required by the administrator within 30 days following each anniversary date, the disability benefits from the plan shall cease. If that information is subsequently provided to the administrator, benefit payments will resume beginning for the month following that in which the information is provided. When disability payments under the Social Security Act cease, it is the responsibility of the disabled employee to notify the administrator immediately.” AS 39.35.400(e). This requirement is reflected in the Administrator’s Statement for Disability Benefits issued to Ms. C, included in the record at AR p. 6.

work duties and, while it is possible that the condition may be treatable, *it is unknown whether or when recovery will occur*.[83] This is essentially the interpretation that was applied in the case of *In re MM*, OAH No. 07-0524-PER, a decision that has been affirmed by the Alaska Supreme Court.[84]

A more recent OAH decision, *In re DJ,*[85] elaborated on this interpretation of the "presumably permanent" standard. In that case the Division argued that the PERS member should have tried additional treatment modalities to alleviate her disability, which was based on back pain and sciatic pain due to chronic lumbar disc disease and nerve impingement.[86] The decision first observed that the issue to be addressed in that case was "not whether the disability could be *cured*," but whether the disability "could be sufficiently ameliorated by further treatment so that the member can go back to work."[87] Noting the approach adopted by the decision in *In re MM*, and taking into account the use of the modifiers "apparently" and "presumably" to modify the word "permanent," *In re DJ* held that "the term permanent should be applied reasonably," and it utilized a "sliding scale" to analyze whether a member's disability is "presumably permanent," as follows:

> If a member has made considerable effort to treat the disability with reasonable treatment modalities—to no avail—then the disability is more apparently and presumably permanent. On the other hand, if the evidence is strong that an additional reasonable modality would have ameliorated the member's disability, the disability appears to not be permanent.
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> …
>
> Under this sliding scale, the more thorough a member's pre-termination exploration of treatment modalities has been, the more convincing the evidence for a different modality must be. Thus, if a member has made a significant effort—which might include, for example, seeking different opinions, and trying reasonable treatment modalities as recommended by some of those consulted—then the Division would have to make a stronger showing that its post-termination suggestions would have been successful. On the other hand, when a member has not sought significant treatments for his or her disability, or has refused to pursue a recommended reasonable and safe treatment, the Division's expert's suggestions of reasonable possible alternative treatments that could have been tried will be

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83 *See In re MM*, OAH No. 07-0524-PER (2009) at 48, *aff'd on other grounds*, *McKitrick*, 284 P.3d 832 (AK 2012); *see also In re DJ,* OAH No. 16-1087-PER (2016).

84 *McKitrick,* 284 P.3d 832, 839 (AK 2012).

85 OAH No. 16-1087-PER (2016).

86 *In re DJ,* OAH No. 16-1087-PER, pp. 1, 24. As in Ms. C's case, in *DJ* the Division presented the testimony of "a nontreating physician [who] has suggested that further treatments could have been tried and might have been successful." *Id.*, p. 24.

87 *Id.* (emphasis in original).

> given weight even if there may be some uncertainty that the suggested alternatives will be effective in the member's case.[88]

Applying this approach to the disability claim in *In re DJ*, the administrative law judge (ALJ) reversed the Division's finding that the disability was not presumably permanent; the member had made a "significant effort" to obtain medical treatments to address her disability, and the ALJ concluded that the alternative treatment approaches proposed by the Division "were all speculative and general treatment modalities."[89]

Ms. C urges that this decision adopt the approaches utilized in the *In re MM* and *In re DJ* decisions.

B. DRB's interpretation of eligibility standards

As discussed above, the Division initially took the position in this matter that Ms. C's medical records did not establish that her "condition is permanently disabled *[sic]* from performing the duties of Position A," based on the following conclusions of the Division's consultant: Ms. C "is able to perform the duties of her job as a Position A without restrictions or limitations" and she "is not disabled from performing the duties of a Position A."[90] These statements by the Division and its consultant would lead a reasonable person to believe that the Division disputed Ms. C's assertion that she was unable to work due to her migraines. However, both parties' pre-hearing briefs appeared to indicate that only the "presumably permanent" element of the analysis was truly in dispute. Thus, during the first day of the hearing the administrative law judge inquired whether the Division was willing to stipulate that Ms. C met the first two elements of the showing required by *McKitrick*, i.e., that she has "a physical or mental condition" that prevents her from satisfactorily performing her usual duties. The Division declined to so stipulate, contending that a person's current disability cannot be decoupled from the concept of whether their disability is presumably permanent, and promising to further explain its position before the end of the hearing or in its closing brief.

The Division has never adequately articulated an explanation for declining to stipulate on this issue. In fact, subsequently the Division quoted in its post-hearing brief the three-part test set forth in *McKitrick*, and then explicitly stated: "There is only one issue presented in this

88 *Id.*, p. 25.
89 *Id.*, p. 28.
90 AR pp. 4, 6, 13.

matter: whether Ms. C has proved by a preponderance of the evidence that she is presumably permanently disabled."[91]

In any event, by the close of the evidence it was clear that the only issue in dispute in this case was whether Ms. C's disability is presumably permanent. The first two elements of the *McKitrick* standard were conclusively established by the testimony of every witness who testified in this proceeding, including the three physician witnesses. They all testified that Ms. C's migraines rendered her unable to perform the duties of her job at the time that she resigned from her position with Employer A.

Regarding the presumably permanent standard, the Division argues that the *In re DJ* decision was wrongly decided, and that to apply the *DJ* sliding scale in this case would result in an improper shifting of the burden of proof from Ms. C to the Division.[92] Instead, the Division argues that eligibility should be analyzed by examining whether "the member demonstrates by a preponderance of the evidence that *treatment is not available* to ameliorate the disability."[93] According to the Division's approach, the duration of an eligible member's disability must be "permanent, not temporary;"[94] the Division concludes that "[t]hus, a condition is not presumably permanently disabling if additional treatment *may* ameliorate a temporary disability."[95] The Division argues, therefore, that Ms. C's migraine-based disability is not "presumably permanent," because the testifying physicians all agreed that she is "not without further reasonable treatment options," and both Dr. Bell and Dr. Ellenson opined that she is likely to improve at some point in the future.[96]

C. Is Ms. C's disability presumably permanent?

Whether Ms. C is eligible for nonoccupational disability benefits turns on the interpretation of the term "presumably permanent." What does it mean to be "presumably permanently disabled"? The correct interpretation of this somewhat ambiguous terminology must take into account the fact that each disability claim is fact specific and unique, and it must reflect the principle that the PERS disability statutes and regulations shall be construed and applied together in a logical, coherent, harmonious manner.

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91 DRB's post-hearing brief at 15.
92 *Id.* at 23. Notably, the Division never addresses the interpretation set forth in *In re MM*.
93 *Id.* at 17 (emphasis added).
94 *Id.* at 16.
95 *Id.* (emphasis added).
96 *Id.* at 16-18.

DRB's proposed interpretation of "presumably permanent" fails to meet these requirements. DRB contends that in order to meet her burden of showing that her disability due to migraines is presumably permanent, Ms. C must demonstrate that "treatment is not available" to ameliorate her condition; "if additional treatment *may* ameliorate" her disability, then she is not presumably permanently disabled. The fallacy in this approach lies in its failure to take into account the complete structure of the scheme of statutes and regulations governing PERS disability benefits.

First, DRB's proposed interpretation ignores the requirement that the member must apply for disability benefits within 90 days of termination from employment.[97] DRB's interpretation would require Ms. C to undergo a long list of preventative treatment modalities before potentially qualifying for disability benefits, as described in detail in the testimony of the Divisions' expert, Dr. Bell. This is notwithstanding the fact that, as also explained by Dr. Bell, each of these modalities must be tried for three to six months before one can accurately assess their efficacy. Under DRB's view, Ms. C would have to wait many months or even years past her application deadline before she could even possibly be eligible. Such a "catch 22" result could not possibly have been intended by the Legislature in enacting AS 39.35.400.

Second, if one were to accept the interpretation of "presumably permanent" posited by DRB, it would in many cases render superfluous the concept embedded in the regulatory scheme that a disability recipient's condition may improve to the point that they are no longer eligible. This concept reflects the public policy that it is beneficial to encourage disabled members to continue to treat their disabling condition, so that they improve to the point that they can reenter the work force, once again be productive members of society, and no longer need disability benefits. The Division's proposed interpretation would essentially require a member to exhaust all reasonable treatment modalities before they could potentially become eligible. The requirement that they continue to treat their disability and provide proof of their continuing eligibility on an annual basis to the Administrator[98] would, in many cases, be rendered meaningless.

In contrast, the standards set out in the decisions in *In re MM* and *In re DJ* interpret "presumably permanent" in a manner that harmonizes the scheme of statutes and regulations that

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97 AS 39.35.400(a).
98 AS 39.35.400(e).

govern PERS nonoccupational disability. Under the *MM* standard, the member meets their burden by showing that their disabling condition prevents their performance of work duties and, while it is possible that the condition may be treatable, it is unknown whether or when recovery will occur.[99] This approach is consistent with the possibility that the member will continue to receive treatment for their condition, and that they may get better in the future and no longer be eligible for disability benefits, because they are able to return to work. It is important to note that the *In re MM* decision has been affirmed by the Alaska Supreme Court (albeit on other grounds). The Division could have cross-appealed the *In re MM* decision if it felt that the "presumably permanent" analysis in the decision was flawed, but apparently it chose not to do so.

Similarly, the *DJ* standard is a reasonable and common-sense approach to the question of how to apply the ambiguous "presumably permanent" standard in situations such as Ms. C's, where DRB contends that the member has failed to attempt additional treatment modalities to alleviate their disability. Contrary to the Division's argument in its post-hearing brief, the *DJ* standard does not result in an improper shifting of the burden of proof to the Division. Rather, it sets up a framework for analysis whereby the member, by submitting evidence of her significant effort to treat the disabling condition, essentially establishes a rebuttable presumption that the disability is "presumably permanent." The Division must then rebut the presumption by submitting evidence "that its post-termination suggestions would have been successful."[100] This framework is entirely consistent with the language and apparent intent of the statutes and regulations governing nonoccupational disability.

This decision finds that the approaches utilized in *In re MM* and *In re DJ* are appropriately followed in this case. It must be reiterated that the key consideration in this analysis is not whether the disability can be cured, but whether the disability can "be sufficiently ameliorated by further treatment so that the member can go back to work."[101]

Under the *MM* approach, Ms. C has met her burden of establishing that her migraine-based disability is presumably permanent. It is undisputed that her condition currently precludes her performance of her duties as Position A. Each of the medical professionals testifying at the hearing, including DRB's expert witness Dr. Bell, agreed that despite the treatments attempted to

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99 *In re MM*, OAH No. 07-0524-PER (2009), *aff'd on other grounds*, *McKitrick*, 284 P.3d 832 (AK 2012); *see also In re DJ,* OAH No. 16-1087-PER (2016).

100 *In re DJ,* p. 25.

101 *Id.*, p. 24.

date, Ms. C's migraine episodes have rendered her unable to work. No contrary factual evidence was presented as to the impact of Ms. C's symptoms on her ability to work.

Furthermore, the testimony of each of the testifying physicians also clearly established that, "while it is possible that the [migraine] condition may be treatable, it is unknown whether or when recovery will occur."[102] Again, recovery in this context means recovery to the point that the member can return to work. Even the Division's expert witness, Dr. Bell, testified that while she firmly believed Ms. C's condition will improve, she could not predict when or if Ms. C would ever be able to go back to work.[103]

The additional layers of analysis employed in *In re DJ* are particularly applicable to Ms. C's claim, given the Division's argument that she has failed to undergo other appropriate treatment modalities. Balancing the efforts undertaken by Ms. C and her physicians to treat her migraines, versus the strength of the evidence presented by the Division regarding the potential efficacy of the other available treatment modalities, one reaches the same result as under *In re DJ*. On the one hand, Ms. C has made more than a diligent effort to comply with the treatments employed by her physicians, to change her diet and lifestyle to attempt to forestall further migraine attacks, to track and record data regarding her migraines to attempt to better understand the condition, and to attempt new treatment modalities as recommended by her doctors. The Division's expert Dr. Bell agreed that the treatments undertaken by Drs. Ellenson and Robinson were appropriate. In fact, no evidence was presented to the contrary, whether it be regarding the potential efficacy of the treatments prescribed by Ms. C's doctors, or her good faith efforts to get better so she can return to work. No suggestion was made by any witness, nor any argument presented by the Division, to the effect that Ms. C has been anything less than a model patient who is committed to getting back to work if at all possible.

On the other hand, the Division's evidence regarding the potential efficacy of the other available treatment modalities urged by Dr. Bell was completely speculative, when viewed through the lens of <u>whether the treatments will allow Ms. C to go back to work</u>. The entirety of Dr. Bell's testimony was that there are many treatments available for migraine attacks that have

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102 *In re MM*, OAH No. 07-0524-PER (2009) at 48.

103 It was clear that in her written report, Dr. Bell construed this issue to be whether Ms. C's condition is "permanent" in the traditional meaning of the word, i.e., that she will never improve, rather than whether in the foreseeable future she will improve to a great enough extent that she can go back to work.

not yet been tried with Ms. C, and that until more of those options are tried, her condition should not be considered "permanent" in the traditional sense of the word. Dr. Bell could only speculate as to whether these treatments would be effective, the degree to which they might be effective, whether they might succeed in allowing Ms. C to go back to work, and if so, when that might take place, if ever. Dr. Bell herself admitted to the speculative nature of this evidence, testifying "I don't have a crystal ball" and "I can't say at this point when she hasn't even had the additional treatment trials, if she will be able to return to her job." Under the *In re DJ* sliding scale approach, the balances clearly tip in favor of the efforts of Ms. C and her physicians to treat her migraines so that she can someday return to work.

Ms. C has met her burden, under the standards enunciated in *In re MM* and *In re DJ*, and pursuant to a common-sense application of the entire scheme of statutes and regulations governing PERS disability benefits, of establishing that her migraine-based disability is "presumably permanent" for purposes of determining her eligibility for nonoccupational disability benefits.

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IV. The Division's Proposal for Action

Under the administrative appeal process that applies to retirement appeals, after receiving the initial proposed decision from the Administrative Law Judge, a party may file a "proposal for action" (PFA).[104] The process allows the party to address issues with the proposed decision before the decision is adopted by the final decisionmaker. On July 22, 2019, Ms. C filed a PFA, stating simply that she had no objections to the proposed decision. On the same date, the Division filed a PFA, taking issue with several primary aspects of the proposed decision.[105]

In its PFA, the Division argues that the proposed decision "fails to follow Alaska Supreme Court holdings with respect to the proper application of the term 'presumably disabled,'" and therefore the ALJ should revise the decision and uphold the Division's denial of Ms. C's claim. The PFA focuses on the analysis of "presumably disabled" in the Alaska Supreme Court decision in *Stalnaker v. Williams*, 690 P.2d 590 (Alaska 1998) and argues that the proposed decision is inconsistent with the Court's holding therein.

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104 AS 44.64.060(e).

105 The Division's PFA also points out an error on page 14 of the proposed decision, where a Division regulation was incorrectly described as a "Department of Health and Social Services regulation." The error has been corrected in this final decision.

An initial, critical flaw in the Division's argument is that prior to filing its PFA, the Division never discussed, cited or mentioned *Stalnaker v. Williams* for the purpose of defining the proper interpretation of the term "presumably disabled."[106] The Division had many opportunities to do so – in its pre-hearing brief, during discussions on the record during the hearing, and in its post-hearing brief – but did not. To allow the Division to assert this argument now would raise due process concerns, because Ms. C is provided no opportunity to respond – OAH procedures do not allow for the filing of a response to an adversary's proposal for action.[107]

The Division should not have waited until filing its PFA to make this argument based on *Stalnaker v. Williams*, and by not making the argument at an earlier juncture it waived the opportunity to do so. Even if no waiver occurred, however, a brief discussion demonstrates the substantive flaws in the Division's argument.

Stalnaker v. Williams involved a former state employee's claim for occupational disability benefits; the case was decided by the Alaska Supreme Court at a time when the Public Employees' Retirement Board (Board) decided PERS appeals. The former employee appealed the Board's denial of her occupational disability claim, and the superior court found that the Board had applied the incorrect definition of "presumably permanent," because the Board had relied on the testimony of a treating physician who opined that the claimant's condition "was not permanent," which the physician understood to mean a condition that would "last a lifetime."[108] The Supreme Court affirmed, agreeing with the superior court that the Board "was looking for evidence of a permanent, rather than presumably permanent, disability"[109]

A key point not mentioned in the Division's PFA, however, is that neither party in *Stalnaker v. Williams* argued that the superior court had adopted "an erroneous definition of 'presumably permanent.'"[110] Thus, the Division's assertion in its PFA that the Supreme Court

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106 Prior to filing its PFA, the Division cited *Stalnaker v. Williams* for two other propositions: that a member applying for disability benefits has the burden of proving all required elements of the statutory nonoccupational disability standards, and that the statute does not set up a presumption in favor of coverage that the Division must rebut. *See* Division's pre-hearing brief at 9, Division's post-hearing brief at 15, 23.

107 *See* AS 44.64.060(e). Late in the day on July 22, 2019 Ms. C filed a short "response to Division's proposal for action," stating a general objection to the effect that the parties had already briefed and argued the definition of "presumably disabled" prior to issuance of the proposed decision.

108 *Stalnaker v. Williams*, 690 P.2d at 594. The physician's focus on the permanence of the claimant's condition appears very similar to Dr. Bell's inappropriate emphasis in this case on permanence in the traditional sense of the word, as discussed above. *See, e.g.,* fn. 103.

109 *Id.* at 595.

110 *Id.* at 594.

"upheld the superior court's definition of *presumably permanent*" is inaccurate. The specific, narrow issue of whether the superior court properly defined the term "presumably permanent" was not even before the Court. If the Division's assertion were correct, it would be extremely difficult, if not impossible, to square *Stalnaker v. Williams* with the Alaska Supreme Court's much more recent decision in *McKitrick* and its affirmance of *In re MM*.[111]

The Division's PFA raises two additional issues. It argues that the discussion in the proposed decision of the sliding scale analysis in *In re DJ*[112] contradicts the statement in *Stalnaker v. Williams* to the effect that the statutory "presumably permanent" language "is not a presumption" and "does not shift the burden of proof … from the employee to the employer."[113] Yet the Division's PFA makes no suggestion as to the proper way to analyze the competing evidence of a disability and treatment modalities presented by a member and the Division in a nonoccupational disability hearing such as Ms. C's. In addition, the Division's analysis of the concept of a rebuttable presumption misses the point. The cited language in *Stalnaker v. Williams* simply means that the statute *per se* does not set up a rebuttable presumption; it does not mean that the evidence presented by the parties cannot lend itself to being weighed in that manner. The key question to be decided is, did the member present adequate evidence of her disability and its presumed permanence, and if so, did the Division present sufficient evidence to counter the member's showing and to demonstrate that the condition is not presumably permanent? Whether labeled as a rebuttable presumption or not, that is the question that Ms. C more than adequately answered in this case.

The Division also argues in its PFA that the proposed decision improperly "is based on an analysis that focuses on the member's treatment efforts rather than whether the member's condition is permanent." First, this argument fails to acknowledge the Division's own heavy emphasis at the hearing on evidence of alternative treatment modalities available to Ms. C that the Division argued she could and should undergo in the future. Second, the Division fails to explain how one is to examine the presumed permanence of Ms. C's disabling condition without analyzing the treatments she has undertaken in the past and up to the time of the hearing. On a close reading, it is clear that the Division presents this argument as just another way of saying that Ms. C had to prove that her condition is "permanent" in the traditional sense of the word.

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111 284 P.3d 832 (AK 2012).
112 OAH No. 16-1087-PER (2016).
113 690 P.2d at 594.

That issue has been fully addressed above, and the Division's contentions to the contrary in its PFA are without merit.[114]

The Division's arguments in its PFA fail to alter the conclusion that Ms. C met her burden of establishing that her disabling condition is presumably permanent.

V. Conclusion

The Administrator's decision denying Ms. C's claim for nonoccupational disability benefits is reversed.

Dated this 6th day of August, 2019.

Signed
Andrew M. Lebo
Administrative Law Judge

[114] The Division's PFA also fails to address the manner in which its interpretation of "presumably permanent" would render some of its own regulations essentially meaningless, as discussed in the proposed decision.

Adoption

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 Rule of Appellate Procedure 602(a)(2) within 30 days of the date of this decision.

DATED this 6th day of August, 2019.

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

[This document has been modified to conform to the technical standards for publication. Names may have been changed to protect privacy.]