ALASKA WORKERS' COMPENSATION BOARD

P.O. Box 115512 **Juneau, Alaska 99811-5512**

BEVERLY SUMPTER, Employee, Claimant,	)	FINAL DECISION AND ORDER
v.	)	AWCB Case No. 201400344
FNSB SCHOOL DISTRICT, Self-Insured Employer, Defendant.	)	AWCB Decision No. 18-0083 Filed with AWCB Fairbanks, Alaska on August 15, 2018

Beverly Sumpter's October 24, 2014 claim, amended at hearing, was heard on June 21, 2018, in Fairbanks, Alaska, a date selected on March 12, 2018. Attorney James Hackett appeared and represented Employee. Attorney Wendy Doxey appeared and represented Fairbanks North Star Borough (FNSB) School District (Employer). Witnesses for Employee included: Employee; Employee's husband, Patrick Sumpter; Employee's sister, Linda Bullington; and PA-C Jan DeNapoli. Ms. Bullington testified telephonically. Witnesses for Employer included: Matthew Raymond, M.D. and Charles Brooks, M.D. The record closed when the parties submitted post-hearing briefs on July 16, 2018.

ISSUE

Employee contends her December 18, 2013 work injury is the substantial cause of her disability and her need for medical treatment. Consequently, she claims Permanent Total Disability (PTD) benefits, past and future medical benefits, a 15 percent permanent partial impairment (PPI) rating and attorney fees and costs.

Employer contends Employee did not suffer a work injury. Employer contends in the alternative, that if Employee did suffer a work injury, it was a muscle sprain or strain, and Employee was paid the appropriate benefits during that time period. Employer contends the substantial cause of Employee's need for additional benefits is her pre-existing degenerative disc disease and her previous cervical fusion. Employer contends Employee is not entitled to PTD benefits because she was released to work without restrictions by her own treating physician. Employer contends the 15 percent PPI rating Employee is seeking was given by the employer medical examiner (EME), Dr. Brooks, and was based on her pre-existing condition. Employer also contends Employee is not entitled to attorney's fees and costs until it is determined she has prevailed on any of the issues.

Is the work injury the substantial cause of Employee's disability and need for medical treatment, and, if so, to what benefits is Employee entitled?

FINDINGS OF FACT

The following facts and factual conclusions are either undisputed or found by a preponderance of the evidence:

1) On, or about June 18, 1998, Employee was involved in a motor vehicle accident. She was the front seat passenger of a midsized sedan and was wearing a seat belt. The driver stopped quickly and Employee turned around to see if a car was coming and had turned back around about half-way and was facing the driver when they were rear-ended. She did "a flip flop sideways." She had no immediate symptoms, but about an hour later when driving home, she turned her head to talk to her friend and it got stuck. Employee subsequently treated with Peter Marshall, M.D., in North Pole, AK. Employee remembered Dr. Marshall could not tell anything from the cervical x-ray that indicated a problem related to the motor vehicle accident, but noted that she had a lot of degeneration. (EME Report, December 10, 2014; Employee Hearing Testimony, June 21, 2018).

2) Records pertaining to the motor vehicle accident were not submitted, but the information came from Employee's statements to the EME physician and her testimony at hearing. (Record; EME Report, December 2014; Employee).

3) Employee began suffering from neck pain in 2007 when she woke up in pain. (Employee).

4) On November 13, 2007, Employee treated with W.J. Harrison, M.D., for neck pain and tingling down the right arm for two months' duration, with associated migraine headaches. She woke up in pain in September 2007. X-rays demonstrated cervical kyphosis and degenerative disc disease at C5-6 and C6-7. Dr. Harrison prescribed chiropractic treatments. (Dr. Harrison Chart Note, November 13, 2007).

5) On December 14, 2007, Employee again treated with Dr. Harrison. He indicated Employee's symptomology had improved with the chiropractic treatments, but her symptoms had not completely resolved. (Dr. Harrison Chart Note, December 14, 2007).

6) On March 27, 2008, Employee saw Dr. Harrison, complaining of neck pain; stiffness, tightness, and muscle tension across the upper back; and pain, numbness and tingling in her right upper extremity from shoulder to elbow. Employee began waking up in pain on March 20, 2008. Employee reported a history of arthritis in the spine. He continued to prescribe chiropractic treatment. (Dr. Harrison Chart Note, March 27, 2008).

7) Employee denies she reported a history of arthritis in the spine to Dr. Harrison and this should have been in her family history, not her personal history. (Employee).

8) On December 22, 2009, Employee treated with Michael Pomeroy, PA-C, for persistent neck pain, as well as numbness in the arms. Employee denied any specific history of trauma. X-rays demonstrated advanced degenerative changes in the mid-cervical spine. It was noted that Employee was a long term smoker, smoking 1/2 to 1 pack of cigarettes per day over the previous 30 years. An MRI was performed and the findings were reviewed on December 29, 2009. He referred Employee for a surgical evaluation. (PA-C Pomeroy Chart Notes, December 22, 2009; December 29, 2009).

9) On January 19, 2010, Employee treated with James Tate, M.D., for a neurological consultation. Dr. Tate opined degenerative changes and disc bulging were present, but no urgent lesion. He prescribed a series of cervical epidural blocks which Employee underwent in early 2010. (Dr. Tate Chart Note, January 19, 2010).

10) On February 12, 2010, Employee treated with Scott Conover, PA-C, who noted the epidural injections were benefitting Employee. (PA-C Conover Chart Note, February 12, 2010).

11) On June 10, 2010, Employee treated with neurosurgeon, Paul Jensen, M.D., who noted that epidurals had improved the pain, but that she still had severe weakness in both arms, and her gait had been unsteady. Dr. Jensen reviewed a December 2009 MRI and felt Employee to have

advanced C5-6 and C6-7 spondylosis, with severe stenosis. He also thought Employee was demonstrating a myeloradiculopathy. Dr. Jensen initially recommended a two-level anterior cervical decompression and fusion at C5-6 and C6-7. He ordered an updated MRI on August 26, 2011 and then opined Employee would be best treated with a three level anterior cervical decompression and fusion, including C4-5, C5-6, and C6-7. Dr. Jensen indicated there had been progressive spinal cord deformity at C4-5 over the past 2 years, and that Employee had severe mechanical symptoms, as well as myelopathic-type symptoms. (Dr. Jensen Chart Notes, June 10, 210 and September 18, 2011; MRI, August 26, 2011).

12) On September 26, 2011, Employee underwent the anterior cervical decompression and fusion at C4-5, C5-6, and C6-7. (Dr. Jensen Chart Note, September 26, 2011).

13) On October 7, 2011, Employee treated with PA-C DeNapoli. The chart note states:

> [Employee] states that her pre-op symptoms are improving, she has some soreness in her muscles and some right arm residual decreased strength but overall is doing quite well. She is already aware that she is improving significantly. She no longer has the aching, sore, dead feeling in her arms. She is taking meds as needed, but does not need a refill yet. . . . She has no other complaints today and feels she is doing quite well already. . . . She is a half pack per day cigarette smoker. (PA-C DeNapoli Chart Note, October 7, 2011).

14) On December 8, 2011, Employee underwent a debridement and rotator cuff repair with orthopedic surgeon, Mark Wade, M.D. (Record).

15) On December 22, 2011, Employee treated again with PA-C DeNapoli three months post her fusion operation. The chart note states:

> [Employee's] pre-op symptoms are resolved. She has some soreness in her muscles but overall is doing quite well. She had right shoulder surgery about 3 weeks ago and is doing well post op from that as well. She no longer has the aching, sore, dead feeling in her arms. She is taking meds as needed, but does not need a refill. She has no other complaints today and feels she's doing quite well. She would like to try something to help with the spasms such as massage therapy. . . . She is a half pack per day cigarette smoker. (DeNapoli Chart Note, December 22, 2011).

16) Employee did not use the massage therapy prescription. (Employee).

17) Employee, Employee's husband, Patrick Sumpter, and Employee's sister, Linda Bullington all testified Employee was back to her normal self after the fusion and they deemed the fusion to be a success. Employee and her husband testified about extensive work Employee

performed on a deck for their home the summer of 2013 and provided receipts and pictures of the deck. (Employee; Sumpter; Bullington; Employee's Hearing Brief, June 14, 2018).

18) On April 13, 2013, Employee saw PA-C Scott Conover. The chart note states:

> [Employee] is now requesting . . . care for multiple joint pains including her neck [s/p surgery for cervical fusion, right shoulder pain s/p surgery] bilat. shoulder pain knee pain/back pain, with significant life stresses. . . . Labs were ordered in response to her joint complaints. (PA-C Conover Chart Note, April 13, 2013).

19) Employer points to the April 13, 2013 medical record as evidence Employee was having pain in her neck after her 2011 surgery. (Employer Hearing Argument).

20) Employee testified she was having pain in all of her joints equally and this pain subsided after about a week. (Employee).

21) Prior to Employee's 2011 fusion, Employee's work history included cleaning buildings at Eielson, Air Force Base for nine months, cooking for Dinner Date, and caring for an elderly woman. Employee also primarily cared for her three children, one with epilepsy, because her husband worked out of town. (Employee; Sumpter).

22) On November 4, 2013, Employee began to work for Employer as an Intensive Resource Teacher Aide. One of the qualifications for the applicant was the ability to lift a minimum of 50 pounds safely and regularly. (Employee's Hearing Brief, June 14, 2018, Exhibit 5).

23) On November 18, 2013, Employee underwent a physical examination with U.S. Health Works for Employer. She listed the following surgical procedures: "10/13 varicose vein removal; 7/13 cyst removal lt. flank; 9/11 c-spine 3 level fusion; 12/11 shoulder surgery, and 10/09 hysterectomy." (U.S. Health Works Exam & Questionnaire, November 18, 2013).

24) Dr. Raymond testified this physical examination is not really intended to establish fitness for duty. It is an annual or bi-annual requirement that employees perform a physical assessment to establish whether or not they are safe to work around children and generally safe to do the job required of them. In these exams, the examiner feels pressured because they do not want to impact the person's employability with this exam. This is not the greatest exam for determining fitness for duty because it would not determine if one were capable of lifting 50 lbs. (Dr. Raymond).

25) On December 18, 2013, Employee was working for Employer when she reported a "strain on neck developed after lifting student in wheelchair to adjust his seating position." (Report of Occupational Injury or Illness, December 31, 2013).

26) Employee testified the injury occurred when she was in front of the student and scooted him forward by his belt loops. On this occasion, she felt a momentary, sharp pain in her neck. This happened at 1:55 p.m. She did not think took much of it because it went away quickly. It felt more like a Charlie horse. In her deposition, Employee said she felt an immediate jolt of 10 of 10 pain for two seconds and then it was gone. A few hours later she was sore. She had soreness, headaches, and tenderness and it developed continually and got worse on Christmas Eve. (Employee; Deposition of Beverly Sumpter, February 3, 2016).

27) On December 18, 2013, Employee contacted her husband, Patrick Sumpter, who was working out of town and told him she had been lifting the student at school and hurt herself. She said it was like an "electrical shock." When he got home, she was holding her head differently and was not turning her neck, she was stiff and was not carrying herself the same. (Sumpter).

28) Employee returned to work the next day and worked on December 19 and 20, 2013. (Employee).

29) Employee originally listed December 19, 2013 as the date of injury, but later corrected it to December 18, 2013. (Employee Email to Adjuster, January 8, 2014).

30) Some medical records cite the December 18, 2013 date while some cite December 19, 2013. (Observations.)

31) On December 23, 2013, Employee treated with Donna Strigle, PA-C, regarding smoking cessation, anxiety and high blood pressure. PA-C Strigle prescribed Ambien, Trazodone, Wellbutrin, and Ziac. Employee did not mention a neck injury to PA-C Strigle. (PA-C Strigle Chart Note, December 23, 2013).

32) The record of Employee's December 23, 2013 visit to PA-C Strigle was not received by Employer until late 2017 when Employee filed it with the board. This was, therefore, received after the employer medical examination (EME) and the second independent medical examination (SIME), and depositions. Doctors were deprived of the opportunity of opining on the relevance or importance of this record. (Employer's Hearing Brief, June 14, 2018; Observation; Judgment; Inferences drawn from Experience).

33) Employee testified she set up the December 23, 2013 appointment with PA-C Strigle two weeks in advance because her doctor was retiring and she needed to establish a relationship with a new doctor so she could receive a refill on her prescriptions. She was there to get her medications refilled and did not mention her injury. (Employee).

34) On December 23, 2013, the same day as the PA-C Strigle appointment, Employee saw the mother of the student she was lifting, Deborah Kitelinger, at Sears' Department Store. Employee told her that she had hurt herself lifting her son. Employee attached a copy of her Sears' receipt that day. (Employee; Employee's Hearing Brief, June 14, 2018, Exhibit 8).

35) At hearing, the designee twice attempted to call Employee's witness, Deborah Kitelinger, but was unsuccessful. (Record).

36) At some point in mid-late December, Employee contacted her sister, Linda Bullington, and told her she was making a maneuver with the student and felt a "pop or jolt" and she was worried about it. It was close to Christmas break and she hoped it would settle down during Christmas break. She described a sharp, shooting pain. (Bullington).

37) Employee notes her sister is mistaken when she used the words "pop or jolt." (Employee).

38) Employee and her husband both testified she could not get out of bed on December 24, 2013 (Christmas Eve). She rolled over and slid off the bed and had to hold her head up with her hands. Employee's husband had to take over all the cooking on Christmas because she could not do it. (Employee; Sumpter).

39) On December 27, 2013, Employee saw Grayson Westfall, MD, at Tanana Valley Clinic's (TVC) 1st Care. Under history of present illness:

> 1. Back pain. Onset: 1 week ago. Severity is 7 Duration: 1 week. The problem is stable. It occurs persistently. Location of pain is neck. The patient describes the pain as sharp. Context was at work, and thereafter, felt neck pain and occipital pain. Symptoms are aggravated by extension, flexion, rolling over in bed and twisting. The patient denies relieving factors. Associated symptoms include spasms and tenderness. . . .
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> Under nursing comments, note, it states:
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> Pt here with a WC neck injury on the 19th of December. She has had a fusion 3 years ago and she lifts a para and cares for him and thinks she injured it caring for him.
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> Under history, it was noted she was a current, every day smoker. Under Assessment/Plan:
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> The patient suffered neck pain on December 19, 2013. It happened right after work, so it is difficult for me to say whether this is a work related injury or not. Her x-ray shows solid anterior fusion C4-C7 with disc spacers and anterior fusion, hardware in good position. No acute cervical spine injury. Moderate

> neuroforaminal narrowing C2-C3 through C6-C7 levels is more apparent on the left side. I have recommended referral to an Occupational Medicine physician to help us follow the injury as well as to determine whether this was work-related or not, but I cannot make that determination for her today. Ice the neck. Start phys therapy. Start Naprosyn x 2 week. Norco for severe pain, and Flexeril for spasm. . . . (Dr. Westfall Chart Note, December 27, 2013).

40) On December 31, 2013, Employee followed up with Matthew Raymond, DO, at TVC's 1st Care. Under history of present illness:

> 1. Musculoskeletal Pain. 51 y/o female here for neck pain. She works as a caregiver at North Pole Elementary assisting with handicapped kids. She cares for a 70# quadriplegic student doing patient transfers for diaper changes and position shifting in his wheelchair. On 19 December 2013 she picked him up by his belt loops while she was leaning forward, facing the student. She did this twice. After school she notices a headache at the base of the occiput. Later her neck became stiff and sore, more on the right side and midline with shooting pains to the scalp. This got to the point that she could not get out of bed without rolling onto her knees. No focal neuro deficits or radicular symptoms. She was seen in 1st Care on 12/27/13 and was given Norco and Naprosyn. C-spine film was negative for acute injury. She also has Tramadol at home for neck pain. She had a c-spine fusion in 2011 secondary to DDD at C4-7. She has been doing well. The DDD and c-spine fusion was not work related. She was doing well until this event. . . .
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> Under nursing comments, note, it states:
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> [Employee] is here following 1st Care visit with complaint of neck pain. States that is feeling better than she was before.
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> Under Assessment/Plan:
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> WC report for sedentary duty. Patient's chronic neck condition and hx of c-spine fusion is a concern for this particular job where she has to lift a 70# paraplegic student for diaper changes and repositioning. She has been in this position less than two months and already is having problems. Certainly there will be future exacerbations of the neck pain. We discussed whether this is an appropriate job for her given her neck problems. The school district may not be able to accommodate a 12# wt lift/carry restriction indefinitely. Also there is a question of work relatedness. The pain came on at home after work. In my opinion this job exceeds her baseline functional capacity with her neck fusion. This is not a work-related injury, but an exacerbation of a pre-existing condition. She can expect to have these with any strenuous activity at home or work. Continue ibuprofen, Flexeril, heat or ice for comfort. Massage prescribed. F/u in two weeks. (Dr. Raymond Chart Note, Work Ability Report, December 31, 2013).

41) Employee never followed up with Dr. Raymond. (Agency file).

42) Employee contends Dr. Raymond's chart note that she has Tramadol at home for neck pain is inaccurate. She was prescribed Tramadol in March 2011 and did not use it up. She had some minor surgeries in 2013 before the injury, involving a cyst removal and removal of varicose veins and was prescribed pain medication for those surgeries. This is the pain medication Dr. Raymond is referring to. (Employee).

43) Dr. Raymond testified as follows: He got the history regarding Tramadol from Employee. She did not tell him she felt immediate pain from moving the student. If she had said that he would have included that because it relates to causality. Causality in a case like this is one of the toughest things to determine. He felt this was more of an exacerbation of her baseline medical condition which can happen anytime. Other activities that involve some kind of significant musculoskeletal effort could bring on a similar scenario. The mechanism for injury could be felt in the cervical spine, particularly if you have some preexisting condition that makes you prone to injury. He found this injury was not work-related because there was no temporal relationship between the on-set of the symptoms and the reported activity at school. There were hours of feeling okay and a gap of time between when she started to experience neck pain. Considering the prior surgery and her significant degenerative disc disease, this is an exacerbation and could have happened whether or not she was at work. The pre-existing condition is the substantial cause for the need for treatment on December 31, 2013. You could not exclude the possibility of work-relatedness. It is possible to have a musculoskeletal injury from a lift like this, however, the facts that he took into consideration included a lapse in time between the symptoms from the lift. If there was an acute injury, he would expect her to feel it at the time of the lift. He was told the onset of pain happened later. Employee is going to experience intermittent neck pain from lots of activities for the rest of her life and this is why she has Tramadol at home. The surgery and the degenerative disc disease are the pre-existing conditions. A large population has asymptomatic degenerative disc disease, and a trauma could possibly cause symptoms. He is not sure if she had pain right away; we do know she had pain afterward, and the rest is speculation. He was focused on the pre-existing condition and the mechanism of injury, which is usually felt more in the back. The primary contributor is the presence of disc disease and her surgery. She was supposed to follow-up in two weeks and she did not come back, so he just thought it was a "speed bump" and the type of neck pain she will experience. She has a terrible neck and she has going to have a lifetime of neck pain.

He gave her a twelve pound lifting and pulling restriction and if she continued to have problems, he may recommend a permanent restriction. His chart notes state she was given Tramadol for neck pain, and his opinion would change if he found out this Tramadol was for other procedures, but she told him she had Tramadol at home for neck pain. (Dr. Raymond).

44) Employer contends the fact that Employee had a prescription for Tramadol demonstrates she had neck pain after the fusion. (Employer hearing arguments).

45) Employee testified that at her December 1, 2013 appointment, Dr. Raymond asked her who her Employer was and she responded that it was the school district. He said he knew the claims adjuster there, Bev Shuttleworth, and said she was a very nice lady and he did not think it was fair that the school district has to pay for something that he believed was going to inevitably happen to her sooner or later. Dr. Raymond also indicated he did not believe she should have been in that line of work after her fusion surgery. (Employee).

46) Dr. Raymond testified he knows Bev Shuttleworth and had worked with her for several years and has great respect for her. It is possible he made a comment that [Employer] should not have to pay for the injury, but he did not record it and does not recall. He does not take much stock in whether a worker believes their injury is work-related. (Dr. Raymond).

47) Employee contends Dr. Raymond's comments shows he is biased against finding a work injury. (Employee's Post-Hearing Brief, June 6, 2018).

48) Employee did not make an appointment with her surgeon, Dr. Jensen, because she believed he was working in Anchorage and was only coming to Fairbanks once in a while. She originally attempted to make an appointment with PA-C DeNapoli on December 27, 2013, instead of being treated at 1st Care, but DeNapoli was out of town during the 2013 holidays and January 2, 2014 was the soonest appointment she could get. DeNapoli confirmed she was out of town during the 2013 holidays. (Employee's E-mail to Adjuster, January 8, 2014; DeNapoli).

49) On January 2, 2014, Employee treated with PA-C DeNapoli for her neck pain. The chart note states:

> [Employee is seen today as a self-referral for a complaint of neck pain. She was working 12/19/2013 lifting a paraplegic male who weighs 70 pounds, from his wheelchair. Pain began instantly at the base of her skull, spread down neck on both sides. She states that pain is very similar to the pain she had before surgery except she has no upper extremity symptoms. She has not tried any conservative treatment yet and would like to do that if possible. She had a 3 level fusion in September

> 2011 with Dr. Jensen and right shoulder surgery about 3 months after that. She has to lift this 70# boy daily for the past 2 months at her job and is having difficulty with it. Since surgery she states, she's done fairly well, aching often but no other symptoms. She states that her pain is constant. . . . She states the pain primarily shot up the occiput area but that area is a bit better. Now the right side of her neck is cramping quite often and sometimes she has difficulty getting out of bed but has some improvement with time. . . . Employee would like to wait before having an MRI or follow-up visit. She would like to be referred to Home Town Physical Therapy. (PA-C DeNapoli Chart Notes, January 2, 2014).

50) PA-C DeNapoli testified she did not review the chart notes of Drs. Westfall or Raymond and relied only on what Employee told her. (PA-C DeNapoli).

51) Employer, EME Dr. Brooks, and SIME physician Jon Scarpino, M.D., all note that PA-C DeNapoli's January 2, 2014 chart note is the first time Employee stated her pain occurred instantaneously. Employer contends this is important because it is immediately after Dr. Raymond did not find her symptoms work-related. (Employer hearing argument).

52) On January 8, 2014, Employee informed Employer that John Carlile, D.C., would be her attending physician. (Employee Email to Adjuster, January 8, 2014).

53) On January 9, 2014, Employee resigned from her position with Employer. (Employee's Hearing Brief, June 14, 2018).

54) On January 14, 2014, Employee treated with Dr. Carlile. His case history stated, "Employee was involved in a work related incident on Wednesday, December 18, 2013 at 3:42:00 PM. Patient was lifting a paraplegic. As she lifted the child [Employee] felt pain in her neck. Patient stated that a headache pursued. Her body was bent over in the front. As she picked the child up and over the chair bar, the pain came on suddenly." Dr. Carlile noted Employee said her current neck condition was a direct result of a work-related incident. (Dr. Carlile Chart Note, January 14, 2014).

55) Employer contends December 18, 2013 was a half-day for students, so it would not have been possible for the work incident to occur at 3:42 p.m. Additionally, Dr. Carlile noted, "according to the patient, she has not had any surgical procedures, yet she stated she was hospitalized for neck operation. . . ." (Employer's Hearing Brief, June 14, 2018, North Pole School Calendar, Exhibit B; Dr. Carlile's Chart Note, January 14, 2014).

56) On January 30, 2014, Employee had been continuing chiropractic care and treatment with Dr. Carlile, who noted, "Pt conditions are now resolved: lower back, upper back and neck." He

completed a "Fitness for Duty" form that said Employee could return to work with no restrictions. (Dr. Carlile Chart Note; Fitness for Duty Form, January 30, 2014).

57) Employee denies telling Dr. Carlile she felt good on this day. (Employee).

58) Employer contends Employee is not entitled to PTD benefits because her own designated treating physician released her to work with no restrictions. (Employer's Post-Hearing Brief, July 16, 2018).

59) In March 2014, Employee went to Maui with her husband, and her sister and her husband. This vacation was planned before the injury. Employee's sister, Linda Bullington, stated Employee was very stiff from the flight. She noticed how much pain she was in on the road trip to Hana and Employee had to hold her head to get through it and it was painful to watch her. When Bullington saw her, she observed very restrictive movement in her neck and she could not do anything for very long without having excruciating pain. (Bullington).

60) On March 28, 2014, Employer denied certain benefits, but that Controversion Notice was not filed with the board. (Agency file; Employer's Hearing Brief, June 14, 2018).

61) On July 22, 2014, Employer denied all time loss benefits and all treatment not provided or directed by the designated treating physician. (Controversion Notice, July 22, 2014).

62) On September 19, 2014, Employee treated with Milton Wright, D.O., who performed osteopathic manipulative therapy. Employee described chronic and fairly controlled symptoms that she related to a lifting injury one year prior. (Dr. Wright Chart Note, September 19, 2014).

63) On October 24, 2014, Employee, *pro se*, claimed TTD, PTD and noted (when rated), medical costs, transportation costs, review of reemployment benefit decision as to eligibility, compensation rate, penalty, interest, and unfair or frivolous controversion. For description of the injury, Employee stated, "I was re-adjusting a student in his wheelchair by standing in front of him, lifting him by his belt loops." For part of body injured, Employee wrote, "neck/c-spine, shoulders" and checked the right and left box. For nature of injury, Employee wrote, "I have preexisting injuries to my neck and had a 3 level fusion operation in 2011. Also pre-existing injury to my right shoulder, surgery in 2011. When lifting the student I reinjured/aggravated my neck and shoulders." (Workers' Compensation Claim, October 24, 2014).

64) On November 11, 2014, Employee again sought chiropractic treatment with Dr. Carlile who prescribed chiropractic treatments once a week. (Dr. Carlile chart note, November 11, 2014).

65) On November 18, 2014, Employee treated with Dr. Wright who noted minimal improvement with osteopathic manipulative therapy, and he prescribed a trial of Medrol Dosepak. (Dr. Wright chart note, November 18, 2014).

66) On December 5, 2014, Employee treated again with Dr. Wright, who noted improved neck pain. (Dr. Wright chart note, December 5, 2014).

67) On December 10, 2014, Employee attended an EME with Dr. Brooks. In a written "History Questionnaire" for the EME, Employee described the following:

> I was adjusting my 70 lb student in his wheelchair by standing in front of him with my rt knee between his legs and lifted him by his belt loops to raise him and shift his body over. Sharp pain at the base of skull that quickly subsided. Approx 10-15 mins later, began having headache at back of head, was also very tender to the touch. . . .

Dr. Brooks opined Employee's degenerative and stenotic changes in her cervical spine, and not the reported work injury, are the substantial cause of her need for medical treatment. He opined, assuming Employee had an exacerbation of her chronic intermittent headache and neck pain due to occupational activities on December 19, 2013, it would have caused a temporary worsening, probably resolved, in one to several days and prior to the next or more significant exacerbation that occurred on December 24, 2013. Dr. Brooks also opined that no further treatment was reasonable and necessary for any effect of Employee's job. He did not feel Employee had sustained any permanent impairment due to her occupational activities on December 19, 2013. Dr. Brooks found she had a pre-existing impairment secondary to a multilevel spine fusion, which he estimated to be a 15 percent whole person rating. (Dr. Brooks report, December 10, 2014).

68) It is this 15 percent PPI rating Employee seeks from Employer, despite the fact the EME physician attributes this rating to her pre-existing condition. (Employer's hearing argument).

69) Dr. Brooks testified as follows: In reviewing Employee's records, the thing that stuck out the most were historical inconsistencies as to what happened on the date of injury, December 19, 2013, that was changed to December 18, 2013. He agrees with Employee that she is a bad historian; she is unreliable. He looks for consistency. Not necessarily identical, but it should be consistent from one chart note to another, from one provider to another and that is not the case here. He notes there is no indication in the December 23, 2013 visit to PA-C Strigle about the injury. If someone is injured on December 18, 2013, and was progressively getting worse, you

expect them to report it at a doctor appointment five days later. He labels this as "History Zero." "History 1" is for Dr. Westfall and Dr. Raymond. He labels them as "History A" and "History B" because there are some variations in those. Both of them discuss later symptoms, but not immediate symptoms. Dr. Westfall recorded "thereafter" she felt neck pain. Dr. Raymond, stated "after school" she felt a headache and soreness. The story then changes when she sees PA-C DeNapoli on January 2, 2014, and the symptoms then came on immediately after the lift. He refers to this as "History 3." Dr. Jensen recorded she lifted under the arms, and felt immediate symptoms including a snap and pop in her neck. Dr. Richard Cobden, M.D., recorded immediate symptom onset, lifting the patient by his arms and shoulders and pain in the upper back radiating down her left arm. Drs. Jensen and Cobden are "History 4." People that tell the truth, tell the same story over and over again. Medical providers don't always record exactly what was told to them. They get it right probably 90-95%, but errors do creep into records. But it is difficult to conclude, that a reliable historian would end up with such discrepancies in the record. A change in the history could be based on memory. He is not here to say Employee is credible or not. The histories are unreliable. Memory fades with time. The initial histories are most likely accurate. After that, a person's memories often change to their expectations and their desires. And it's not necessarily lying, it's just human nature that people recall what they want to believe. He gives greater credence to the initial histories -- December 23, 2013 no symptoms reported, December 27, 2013 no immediate symptoms, December 31, 2017 symptoms come on after. Then a claim is filed and the history changes on January 2, 2014. He called DeNapoli a naïve historian because she did not read the records of PA-C Strigle or of Drs. Westfall and Raymond and does know about the inconsistency in the story provided to her and the three prior providers. He calls it the parrot phenomena. Rather than taking the time to acquire and review a set of records, the provider simply reiterates whatever his or her patient said and that it is accepted as fact. If he was going to make casual conclusions, he would want to have a reasonable comprehensive set of evidence. If you are going to make medical/legal conclusions, you want to be well informed. He diagnosed: chronic intermittent headaches which began on November 2, 2007, which he believes are cervogenic and referred from the neck, cervical sprain strain due to the June 1998 motor vehicle collision, degenerative disc disease and degenerative arthritis in the cervical spine due to genetics and aging, and accelerated by chronic smoking, and multi-level disc herniations in the cervical spine at every level from C3-4 to C7-T-1, including disc bulges at each level and disc protrusion at C3-4 and C6-

7, and multi-level cervical, spinal stenosis, and narrowing of the central canal, at every level from C3-4 to C7-T1 due to degenerative changes. The motor vehicle collision contributed indirectly. She was in a bad position to get hit in the motor vehicle collision, she was leaning forward, and this probably resulted in accelerated degeneration of the cervical spine. Smoking causes narrowing of blood vessels, diminished blood supply to tissues including the spinal discs, which already have marginal blood supply, leads to accelerated disc degeneration. He opines there was no work injury. He says this with a reasonable degree of medical probability. He believes Dr. Scarpino said it best and agrees with his report. If she were to sustain an injury as she described the event, he would expect it to be lumbar. The mechanism of repositioning a child in a wheelchair is not likely to cause a neck injury. Not every symptom indicates an injury. If there was a strain, it would have been minimal and would have resolved in a few days, a week. If you have a significant injury, you usually have immediate symptoms. Whatever she did sleeping the night of December 23-24 is far more significant than any injury on the 18th. This is not the first time she has had these problems; this was the same symptoms as pre-surgery in 2007. Bad things can happen when you are sleeping. It would be silly to call it an injury. People often get their neck in an awkward position, flexed, extended, rotated, when sleeping and if you already have a narrow spinal canal, that awkward positioning results in compression of the spinal cord and/or nerve roots and its painful when you wake up. He recommends she sleep in a soft cervical collar. Normally it is not a good idea to wear it during the day because it results in stiffness and weakness in the muscles, but when sleeping it is a good idea to have something that keeps it in a relatively neutral position to prevent flare-ups. If you fuse a motion segment in the spine, the adjacent, mobile segments, have to pick up slack, motion is no longer shared equally, and those other segments degenerate faster. What she is experiencing is normal for a post 3 level fusion patient. These operations are not very good at relieving pain. Accelerated degeneration occurs above and below the fusion. Degenerative and arthritic processes do not get better over time. He gave her a 15 percent PPI rating due to the pre-existing pathology and surgery. She is partially disabled; she could do sedentary work. She might need to be at a job where she could do intermittent positional changes. He is skeptical about whether she could do medium work; definitely would not recommend heavy work. In April 2013, she was complaining of pain in her neck and all her joints. His understanding is that an occupational injury must be as great as or greater than any other cause in order to be the substantial cause. Possible causes include the degenerative and stenotic disease in her cervical

spine, lifting, sleeping wrong on December 23-24, residuals of the 1998 motor vehicle collision. The substantial cause of her condition is pre-existing degenerative and stenotic changes in her cervical spine. He believes sleeping funny is the substantial cause of the need for treatment. The fact she did not seek treatment immediately matters. A degenerative disc is more likely to bulge, protrude, and herniate. Employee should not have been hired for the job because it exceeds her capabilities and he would not have approved her for this job. He considers the three level fusion a success because it eliminated her upper extremity symptoms. The fact that she woke up in pain is evidence she was sleeping in awkward position and has pain from that. (Dr. Brooks).

70) On December 20, 2014, Employee reevaluated at Laser Precision Spine Clinic with Dr. Wright. He indicated Employee's symptoms were worse at that point than they had been a year earlier when she was evaluated. He recommended further plain x-rays with flexion-extension views to check the integrity of the fusion, and to evaluate for instability, as well as an MRI of the cervical spine. (Dr. Wright chart notes, December 20, 2014).

71) On February 3, 2015, Employer denied all benefits based on Dr. Brooks' December 10, 2014 EME Report. (Controversion Notice, February 3, 2015).

72) On January 15, 2015 and January 29, 2015, Employee treated with Dr. Jensen who had previously performed her fusion surgery. Employee indicated she was helping with a student transfer. She had one leg forward and lifted the student from under the arms, at which time she felt a snap and heard a pop in her neck, followed by continuous basal neck pain and ascending spasms, as well as burning pain in the right trapezius. A CT scan was performed. Dr. Jensen opined the symptoms were coming from a junctional spondylosis at C7-T1. Dr. Jensen recommended a nerve root injection and possible fusion surgery. (Dr. Jensen records, January 15 and January 29, 2015).

73) Employer, EME Dr. Brooks, and SIME Dr. Scarpino note Employee gave Dr. Jensen a different history and the words "snap" and "pop" are now used. (Employer's hearing argument).

74) Employee subsequently asked Dr. Jensen to correct his January 15, 2015 chart note because she denies ever using the word "snap" or "pop." (Employee).

75) On February 17, 2015 and February 20, 2015, Employee treated with pain management specialist, Robert Valentz, M.D. Employee complained of cramping, spasms and radiation of pain into her right arm stopping at the elbow. He carried out a right C8 selective nerve root block under fluoroscopic guidance. (Dr. Valentz chart notes, February 17 and February 20, 2015).

76) On March 12, 2015, Dr. Jensen indicated the selective nerve root block had been of benefit, but the symptoms had returned, indicating that she got, at most, about 23 days of improvement in pain. (Dr. Jensen chart note, March 12, 2015).

77) On May 15, 2015, Employee treated with Dr. Kim Wright, M.D., for a second surgical opinion. He indicated Employee would be better treated if she underwent further surgery with a decompression and fusion at C3-4, as well as at C7-T1. He noted she was developing significant adjacent-level degeneration with kyphosis and cord compression at C3-4, and that this level actually looked more pathologic on the MRI studies than the C7-T1 level. She would undoubtedly not be pain free, due to the fact she had significant arthropathy in the more proximal cervical spine. (Dr. Wright chart note, May 15, 2015).

78) On May 21, 2015, Dr. Wright filled out a physician's statement for the State of Alaska Division of Retirement and Benefits for Employee. He describes the nature of injury as "cervical degenerative disc disease, post cervical fusion, upper extremity neuropathy." He lists the probable cause of the injury as "listing student 4x day stress c-spine." He did not expect improvement and did not anticipate Employee would return to her pre-injury state. (Dr. Wright Physician Statement, May 21, 2015).

79) On June 1, 2015, Dr. Jensen also filled out a physician statement for Retirement and Benefits for Employee. He describes the nature of injury as "injured lifting handicap patient." He lists the probable cause of the injury as "cervical strain." He recommended extending the fusion and noted Employee would not improve without surgery. He also stated the Employee could not go back to heavy lifting. (Dr. Jensen Physician Statement, June 1, 2015).

80) Employee subsequently received public employee retirement system (PERS) occupational disability benefits based on Drs. Wright and Jensen's physician statements on her behalf to the State of Alaska Division of Retirement and Benefits. Employee contends this fact should be considered. Employer moved to exclude this evidence, or in the alternative, to cross-examine the author's of certain documents regarding the projection of Employee's benefits, the application for benefits, and "benefit information." Employee conceded at hearing that occupational benefits are awarded based on a different standard than applied in this case. The parties agreed to move forward with the hearing and Employer did not call witnesses in relation to the documents. The fact Employee is receiving occupational benefits is relevant, but not very probative because a

different legal standard is applied, so not much weight is given to this evidence. (Record, Inferences drawn from Experience, Hearing Arguments, June 21, 2018).

81) On June 10, 2015, Dr. Jensen wrote the following letter:

> This letter is intended to reiterate the fact that I believe the work-related injury that [Employee] sustained December 19, 2013 is the substantial cause to [Employee's] present need for medical treatment of the C7-T1 cervical level. I believe the December 19, 2013 injury is also the substantial cause for the advanced spondylosis at C7-T1 manifest by moderate to moderately severe bilateral foramina disc-osteophyte complexes.
>
> Although [Employee] had previous surgery at the level above the present symptomatic C7-T1 level, I believe the patient's injury from December of 2013 is the substantial factor for her present symptomatology and reluctant need for treatment.
>
> Again I reiterate [Employee] will benefit from extending the previous fusion to include C7-T1, I would expect [Employee] to have full recovery over the course of 4-6 months following the procedure and to allow her to return to gainful employment. (Dr. Jensen Letter, June 10, 2015).

82) On February 3, 2016, Employee was deposed. She stated she took care of an elderly woman in 2013 prior to working for Employer. A couple of months ago while preparing for the case, she looked up this woman's name and realized she did this work in 2011 prior to her fusion surgery and not in 2013, as she stated in her February 3, 2016 deposition. She realizes this is bad memory and that she is a bad historian. She found the elderly person's obituary, and realized she had misspelled her name in the deposition. (Employee's Deposition, February 3, 2016; Employee; Dulcie Thurmond Obituary, June 29, 2011).

83) On October 24, 2016, Employee treated with Dr. Jensen who said Employee was having some episodic sensory disturbances in the right upper extremity involving the little finger and loss of hand strength. Dr. Jensen opined that if further surgery were needed, this would include removal of the hardware from the previous surgery and extension of the fusion to C7-T1. Employee wanted to monitor her condition and return to him on as-needed. (Dr. Jensen chart note, October 24, 2016).

84) On July 5, 2017, Employee attended an SIME with Dr. Scarpino. He reviewed 750 pages of medical records. He noted a change in the reported mechanism of injury when Employee began to treat with DeNapoli from January 2, 2014, in the immediacy of her symptoms. He also noted a

different mechanism of injury reported to Dr. Jensen on January 15, 2015. Dr. Scarpino reviewed all of the imaging studies and opined:

> The current cause of [Employee's] disability is adjacent-level cervical degenerative disc disease following her previous surgery for multilevel spinal stenosis with clinical diagnosis of radiculomyelopathy. Initially, by history, she may have had a mild upper back muscular strain that might have required supportive treatment in the form of medication, time, and possibly brief physical therapy. However, with treatment, this would not have been expected to exceed 6 weeks. . . . Mechanically, the act of lifting a 70-pound child in partial deadlift type would not be expected to impact the cervical musculature or the cervical spine structures themselves, and at most, could cause a slight strain of the upper back muscles and spinal erectors, as well as possibly the gluteals, hamstrings, and adductors. This would have been an extremely mild injury that would have required treatment for at most 6 weeks' time. [Employee] has a significant underlying problem with adjacent-level disc degeneration above and below the fusion, with elements, of spinal stenosis above and possibly radicular irritation at the C7-T1 level below. This condition was not aggravated or accelerated by the subject, which by mechanism was, at most, a simple cervical strain. Treatment for the upper back strain should not have exceeded 6 weeks, at most, and could have consisted of medical management of the pain with an appropriate short course of physical therapy as indicated. The current symptomatology is related to her pre-existing condition and not related to the subject incident of December 19, 2013. . . . The 12/19/13 injury did not produce a temporary or permanent change in the pre-existing condition. The mechanism of injury is not consistent with injury to the cervical spine. (SIME Dr. Scarpino report, July 26, 2017).

85) At hearing, Employer re-iterated an objection to two of the questions posed to the SIME physician by Employee and the parties agreed this issue should be addressed in the decision and order (D&O). The first issue was that the first the question referred to repeated lifting injuries and only one occurred in this case. The second objection was that the Employee asked a question about chronic pain and pain management, which is not disputed. These objections are overruled. It was proper for Employee to ask a question about repeated lifting, as repeated lifting did occur in this case. Second, the board previously ruled that while a pain management specialist would not be added to the SIME panel, the parties could ask the SIME physician questions about chronic pain and pain management in its October 28, 2016 D&O, which ordered an SIME (*Sumpter I*). (Hearing arguments, June 21, 2018; *Sumpter I*).

86) Employee's argument regarding Dr. Scarpino goes to the weight of the evidence and is not grounds to "strike." (Inferences drawn from Experience).

87) On September 18, 2017, Employee treated with Dr. Cobden for a PPI rating. The chart notes state, "Employee was lifting the student from his chair by pulling on his arms," with "sudden immediate pain in the upper back radiating mostly down the left arm. . . ." Dr. Cobden gave Employee a one percent whole person impairment rating for her upper extremity. He noted all of her cervical findings are pre-existing to the injury of December 19, 2013, and she was not precluded from going back to work. (Dr. Cobden chart note, September 18, 2017).

88) Employee denies telling Dr. Cobden she lifted the student by his arms and shoulders. He was retiring at the time and had her meet him in the emergency room because he no longer had an office. She thought he was very distracted. She called twice to try to have this record corrected and did not get a response. (Employee).

89) On October 25, 2017, Employee treated with PA-C DeNapoli for neck pain. The chart notes states:

> [Employee] appears to have significant exacerbation of her chronic neck pain since her injury 12/18/2013. This injury appears to have caused advanced spondylosis at the C7-T1 level below her previous fusion. Her imaging shows moderate to moderately severe bilateral foraminal disc-osteophyte complexes at this level. While she is hesitant to have further surgery at this time, she is aware that at some point it might become necessary for her to extend her fusion. She would need a new neurosurgical consult at that time, should her symptoms worsen. Until she is able to do something to gain control of her pain and symptoms, she appears unable to return to gainful employment. I do not feel she should return to the job she was doing at the time of injury but if she can gain control of her pain, she may be retrained to perform another, less physically demanding job. (PA-C DeNapoli chart note, October 25, 2017).

90) PA-C DeNapoli opined Employee definitely sustained a new injury. Employee was more like she was before her fusion surgery and was in a significant amount of pain, had difficulty moving her neck, and had spasms in her neck and some issues in her right arm. She believes she is in a good position to say the injury is new because she knew Employee before and after her fusion surgery and knew she had healed. In DeNapoli's opinion, the new injury is the substantial reason why Employee is seeking medical care. She is aware Employee was involved in a 1998 motor vehicle accident and suffered some whiplash injury. This accident does not change any of her opinions because mild to moderate whiplash injuries typically resolve on their own. The work injury is the cause of her current need for treatment. It is not 100 percent the cause, but it is a majority of it. The previous problems with her neck are a contributing factor, but she did not have

the amount of problems she has now, before the work injury. She would have been going along fine with occasional pain. This new injury has made it impossible for her to work and it has caused some pain in her arms, she has had to have injections, and has had a lot more treatment because of it and she is still not okay. Employee's previous condition actually made it a little more likely that this injury became more significant because she has a lot more issues with the levels above and below that fusion. But without that, she still could have had the same lifting injury, so it is pretty difficult to determine. Would she have been as debilitated after the work injury if she did not have the previous fusion? She does not know. She recommends a facet block to determine if a rhizotomy would help her. Worst case scenario, Employee needs a fusion at that C-7, T-1 level. Smoking does increase degeneration. She is aware she has been called a "historically naive medical care provider" by EME Dr. Brooks and disagrees with that statement. She probably knows Employee medically better than anyone in the room and better than any of the medical providers that have performed an independent medical exam on her. She spends a lot of time with her patients and opened her own practice so that she can do so. (PAC DeNapoli).

91) On March 22, 2018, Dr. Scarpino was deposed. At the deposition, Dr. Scarpino referred to a set of photographs. One of the photographs was of a partial deadlift. Employee participated in the deposition telephonically. After the deposition, Employee contacted the court reporter, Elsie Terada, to contact Dr. Scarpino and ask clarifying questions regarding which photograph he was referring to. Ms. Terada responded via e-mail. Employer moved to strike this e-mail or in the alternative to call Ms. Terada as a witness. Employee ultimately withdrew this e-mail at hearing. (Scarpino Deposition, March 22, 2018; Hearing Arguments, June 21, 2018).

92) In Employee's closing brief, Employee moved to strike, Dr. Scarpino's opinion of a minor work injury pursuant to the board's gate-keeper function under Evidence Rule 703 because at his deposition, Dr. Scarpino brought photographs of a weightlifter and used them as reference when discussing body mechanics. Employee contends a photograph of a well-conditioned weightlifter, whose body and spine are supported while resting on a wooden board, performing weight-lifting exercises, should not be used to support an opinion Employee did not receive a significant work-injury, when lifting/repositioning a 70 pound quadriplegic student with no back or spine support of any kind. Employee contends no reasonable or similar medical expert or SIME physician would rely on these types of photographs and Dr. Scarpino interjected his own, past, immaterial weight-

lifting experiences into the case. (Scarpino Deposition, March 22, 2018; Employee's Closing Argument, July 16, 2018).

93) Also at Dr. Scarpino's March 22, 2018 deposition, he testified Employee's pain was not cervical in origin and referred to a pain drawing she did during the SIME which indicated most of the pain was at the base of the neck and in the shoulders. (Scarpino Deposition, March 22, 2018).

94) Employee denies telling Dr. Scarpino she was not having neck pain. Her pain fluctuates. When she drew on the pain chart, she was indicating aching in the back of her neck and in her shoulders. (Employee).

95) Employer contends Employee suffered a recurrence of pre-existing neck pain with associated symptoms, which recurred in the same way she experienced onset of symptoms prior to the claimed December 18, 2013 event: onset of pain with no apparent injury event. The initial treatment records indicate Employee originally reported her pain developed sometime after the claimed work injury and that approximately a week later she woke up unable to move her neck. This is consistent with her pre-existing history. After her initial treatment and a determination that no work injury occurred, Employee presented to a different provider and then claimed she had pain immediately at the time of the claimed work injury. Employer contends that even if Employee did feel pain immediately, she would have merely experienced a strain or sprain type injury that would have resolved in six weeks. Employer paid benefits to Employee during this time period. However, all other treatment and requested benefits are for Employee's pre-existing condition. Employer points to the inconsistencies and timing of Employee's reports to providers after her alleged injury. (Employer's Hearing Brief, June 14, 2018).

96) Employer contends Employee admitted, "I'm a bad historian." This affects the histories she has given to her doctors and their opinions must be viewed critically. The EME and SIME physician agree human memory is more reliable in time to the event being recounted. Employer notes it is the fourth doctor's visit after the work injury where the symptoms become immediate and it is deemed a work injury. (Employer's Post-Hearing Brief, July 16, 2018).

97) Employee contends Employer cannot overcome the attached presumption with the opinions of Drs. Brooks and Scarpino. Dr. Brooks' testimony that Employee slept wrong did not rebut the presumption because he did not ask her if she "slept wrong" and he has no evidence that she "slept wrong." Dr. Scarpino's testimony is equally speculative because he said "he can't tell" why Employee experienced increased pain symptoms on December 24, 2013. As noted above in

Finding of Fact #47, Employee contends Dr. Raymond is biased against finding work-relatedness. Employee contends Dr. Raymond's biased opinions have "fatally infected" Dr. Scarpino's opinions because Dr. Scarpino testified at deposition he considers reports from the initial doctors to be most important. Employee contends her position exceeded her physical capacities. Employee was pain-free after her fusion surgery and before her work injury. Employee does not dispute Employer paid her TTD benefits for about three months in the total amount of $3,359.16. (Employee's Closing Argument, July 16, 2018).

98) Employee admitted she is not a good historian; this impacts her credibility. Employee was incorrect in the date of her injury. Employee disagreed with a substantial amount of her medical records, even when the providers noted they received the disputed history directly from Employee. The immediacy of pain, the type of pain, and the way the injury had occurred has also changed over time. (Record; Observations, experience and inferences drawn from the above).

99) All other witnesses were credible. However, their facts and opinions are based on what they learned from Employee, who admittedly is not a good historian. (*Id*.).

PRINCIPLES OF LAW

> **AS 23.30.001. Intent of the legislature and construction of chapter.** It is the intent of the legislature that
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> (1) this chapter be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter;
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> . . . .
>
> (4) hearings in workers' compensation cases shall be impartial and fair to all parties and that all parties shall be afforded due process and an opportunity to be heard and for their arguments and evidence to be fairly considered.

The board may base its decisions not only on direct testimony and other tangible evidence, but also on the board's "experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler,* 747 P.2d 528, 533-34 (Alaska 1987). An adjudicative body must base its decision on the law, whether cited by a party or not. *Barlow v. Thompson,* 221 P.3d 998 (Alaska 2009).

> **AS 23.30.010. Coverage.** (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.
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> **AS 23.30.095. Medical treatments, services, and examinations.** (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. However, if the condition requiring treatment, apparatus, or medicine is a latent one, the two-year period runs from the time the employee has knowledge of the nature of the employee's disability and its relationship to the employment and after disablement. It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require. . . .
>
> **AS 23.30.120. Presumptions.** (a) In a proceeding for the enforcement of a claim for compensation under this chapter it is presumed, in the absence of substantial evidence to the contrary, that
>
> (1) the claim comes within the provisions of this chapter . . ..

Under AS 23.30.120, benefits sought by an injured worker are presumed to be compensable, and the burden of producing evidence is placed on the employer. *Sokolowski v. Best Western Golden Lion Hotel*, 813 P.2d 286, 292 (Alaska 1991). The Alaska Supreme Court held the presumption of compensability applies to any claim for compensation under the Act. *Meek v. Unocal Corp*., 914 P.2d 1276 (Alaska 1996). An employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski* at 292.

A three-step analysis is used to determine the compensability of a worker's claim. At the first step, the claimant need only adduce "some" "minimal" relevant evidence establishing a "preliminary link" between the injury claimed and employment. *McGahuey v. Whitestone Logging, Inc.*, 262 P.3d 613, 620 (Alaska 2011). The evidence necessary to attach the presumption of compensability varies depending on the claim. In claims based on highly technical medical considerations, medical evidence is often necessary to make that connection. *Burgess Construction Co. v. Smallwood*, 623 P.2d 312 (Alaska 1981). In less complex cases, lay evidence may be sufficiently probative to establish causation. *VECO, Inc. v. Wolfer*, 693 P.2d 865 (Alaska 1985). Witness credibility is not weighed at this step in the analysis. *Resler v. Universal Services Inc.*, 778 P.2d 1146, 1148-49 (Alaska 1989).

At the second step, to rebut the presumption, an employer must present substantial evidence that either (1) something other than work was the substantial cause of the disability or need for medical treatment or (2) that work could not have caused the disability or need for medical treatment. *Huit v. Ashwater Burns, Inc.*, 372 P.3d 904 (Alaska 2016). "Substantial evidence" is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 611-12 (Alaska 1999). At the second step of the analysis, the employer's evidence is viewed in isolation, without regard to the claimant's evidence. Issues of credibility and evidentiary weight are deferred until after a determination whether the employer has produced a sufficient quantum of evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051 (Alaska 1994).

If the presumption is raised but not rebutted, the claimant prevails and need not produce further evidence. *Williams v. State*, 938 P.2d 1065 (Alaska 1997). If the employer successfully rebuts the presumption, it drops out, and the employee must prove all elements of his case by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381. At this last step of the analysis, evidence is weighed and credibility considered. To prevail, the claimant must "induce a belief" in the minds of the fact finders the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71 (Alaska 1964). The presumption does not apply if there is no factual dispute. *Rockney v. Boslough Construction Co.*, 115 P.3d 1240 (Alaska 2005).

In *Huit*, the Supreme Court analyzed the effect of the 2005 change in AS 23.30.010 from "a substantial factor" to "the substantial cause" on the presumption analysis. The Court examined the legislative history and determined there was no indication the legislature intended to change how an employee raises the presumption or how an employer rebuts it. Consequently, any weighing of competing causes must occur at the third stage of the analysis.

A fundamental principle in workers' compensation law is the "eggshell skull doctrine," which states an employer must take an employee "as he finds him." *Fox v. Alascom, Inc.*, 718 P.2d 977, 982 (Alaska 1986). A pre-existing condition does not disqualify a claim if the employment aggravated, accelerated or combined with the pre-existing condition to produce the disability or need for medical treatment for which compensation is sought. Under the Act, there is no distinction between the aggravation of symptoms and the aggravation of the underlying condition. *DeYonge v. NANA/Marriott*, 1 P.3d 90 (Alaska 2000).

In *City and Borough of Juneau v. Olsen*, AWCAC Decision No. 11-0185 (August 21, 2013), the commission explained the application of "the substantial cause" in cases where a work injury "aggravates or accelerates" or "combines" with a preexisting condition. When an employee asserts a work injury caused the aggravation or acceleration of a preexisting condition, the board must evaluate the relative contribution of both the preexisting condition and the work injury. To establish causation, the employee must show the work injury played a greater role in the disability or need for medical treatment than did the preexisting injury. *Olsen, 17-18*. When an employee asserts his disability or need for medical treatment arose as a result of a combination of his work injury and a preexisting condition, the employee must establish two additional facts to prevail, first, that the disability or need for treatment would not have happened "but for" the work injury, and second that reasonable persons would regard the work injury as the substantial cause of the disability or need for medical treatment. *Olsen, 18-19*.

Where an Employee has a pre-existing condition, "[b]oth the work injury and the pre-existing condition must be evaluated, and the relative relationship of both must be weighed, before determining if the need for ongoing medical treatment is the result of the aggravation by the work

injury of the underlying condition." *ARCTEC Alaska v. Traugott*, AWCAC Decision No. 249 (June 6, 2018). The claimed work event must be examined in relation to previous work events and the underlying condition. Even if an event hastened the need for treatment, it does not necessarily make the event the substantial cause of the need for treatment. *Alaska Interstate Construction, LLC v. Morrison et al.*, AWCAC Decision No. 243 (January 25, 2018). Further, even if "but for" the work event an employee may not have needed additional treatment, "all causes must be weighed against each other before work can be found to be the substantial cause of the ongoing disability." *ARTEC*, at 16. Although an employer takes an employee as the employer finds the employee, where such an employee has a pre-existing condition which may make the employee more susceptible to a work injury, the work injury must still be the substantial cause for any need for medical treatment under AS 23.20.010(a). *ARTEC*, at 14. There can only be one substantial cause. *Morrison*, at 8. Employment cannot be 'the substantial cause' if something else is more of a cause. *Morrison*, at 10.

The timing of the onset of pain relative to an injury may be evidence of causation, but as the Alaska Supreme Court reiterated in *Rivera v. Wal-Mart Stores, Inc.*, 247 P.3d 957 (Alaska 2011), continuing pain following a work injury does not invariably lead to the conclusion that the work injury caused the pain.

> **AS 23.30.122. Credibility of Witnesses.** The board has the sole power to determine the credibility of a witness. A finding by the board concerning the weight to be accorded a witness's testimony, including medical testimony and reports, is conclusive even if the evidence is conflicting or susceptible to contrary conclusions. The findings of the board are subject to the same standard of review as a jury's finding in a civil action.

ANALYSIS

Is the work injury the substantial cause of Employee's disability or need for medical treatment, and, if so, what benefits is Employee entitled?

The cause of Employee's disability or need for medical treatment is a factual issue subject to the presumption analysis. Relevant to the presumption analysis here is the "eggshell skull doctrine," under which an employer takes an employee as they finds them. It is undisputed Employee had

pre-existing degeneration and a cervical fusion. Nevertheless, her injury may be compensable if her work activities aggravated, accelerated, or combined with the pre-existing condition to cause Employee's disability and need for medical treatment. *Fox*; *DeYonge*; *Olsen.* On the other hand, if the pre-existing degeneration and cervical fusion themselves are ultimately found to be the substantial cause of the disability or need for medical treatment, then Employer prevails. AS 23.30.010(a).

At the first step of the analysis, Employee showed a preliminary link between her neck problems and the employment. At this stage, neither credibility nor the weight of the evidence is considered. Employee raised the presumption through her testimony that lifting the student led to her neck problems, and with PA-C DeNapoli's testimony that lifting the student was the cause of the injury. Dr. Jensen's statements regarding causation are also sufficient to attach the presumption. Employer does not dispute the presumption has been raised.

Because Employee raised the presumption, Employer was required to rebut it. Again, neither credibility nor the weight of the evidence is considered at this step. Employer rebutted the presumption through the testimony of urgent care physician Dr. Raymond, EME physician Dr. Brooks and SIME physician Dr. Scarpino that any work injury was a sprain or strain and would have resolved quickly and that Employee's current need for treatment is based on Employee's pre-existing degenerative disease and cervical fusion. Additionally, Drs. Brooks and Scarpino opined the claimed work event- adjusting a student in a wheelchair- could not have the caused the claimed injury because the maneuver described would not have put forces on Employee's neck.

Because Employer rebutted the presumption, the analysis proceeds to the third step, in which Employee must prove by a preponderance of the evidence that the employment was the substantial cause of her disability or need for medical treatment. *Saxton*. In making that determination, credibility is considered, the evidence weighed, and the relative contribution of other causes is considered.

Drs. Raymond, Brooks, and Scarpino all opined the substantial cause is Employee's pre-existing degenerative disease and cervical fusion. More weight is given to Drs. Brooks and Scarpino's

reports, as they did a thorough records review. Most weight is given to Dr. Scarino's report, as he is independent of both parties. AS 23.30.122. It is also important to note that Drs. Brooks and Scarpino agree with each other. When determining whether the disability or need for medical treatment arose out of and in the course of employment, the relative contribution of different causes of the disability and the need for medical treatment is compared. *Traugott*. Additionally, Drs. Brooks and Scarpino applied the appropriate legal analysis and weighed all the potential causes, ultimately finding the pre-existing degeneration and fusion to be the substantial cause.

On the other hand, PA-C DeNapoli has opined the work injury is the substantial cause of Employee's disability and need for treatment. Less weight is given to DeNapoli's opinion because she did not do a records review, and specifically did not review the records immediately after the work injury and before she gave her opinion on causation. AS 23.30.122. Her opinion is based solely on what Employee has told her. This is troubling, as Employee's own recognition of the event and her medical history is unreliable and has changed over time. DeNapoli is the first medical provider to opine the injury was work-related, but she is also the first medical provider to learn from Employee that the pain was immediate. DeNapoli's opinion is also based on the fact that Employee's symptoms are similar to her pre-fusion status. However, those original symptoms occurred without a trauma. Employee simply woke up in pain. The pain Employee is now experiencing is the type of pain Drs. Brooks and Scarpino would expect her to have from the pre-existing degeneration and fusion.

Dr. Jensen's opinion work is the substantial cause is also given less weight because he did not weigh all of the causes in determining the substantial cause. AS 23.30.122. His opinion is also based on a different history reported to him by Employee that she lifted the student under the arms and felt a "snap" and heard a "pop."

Employee additionally points to the physician's statement filled out by Dr. Wright in support of Employee in her application of occupational disability benefits. This opinion is also given less weight because he does not find the work injury to be the substantial cause and did not weigh all of the potential causes. AS 23.30.122. Employee also concedes the occupational disability benefits are determined by a different legal standard and this opinion is therefore given less weight.

In comparison to all other causes, Employee's pre-existing degeneration and cervical fusion is the substantial cause of Employee's disability and need for medical treatment. Employee is therefore not entitled to any additional benefits.

Even if there was a finding that the work injury was the substantial cause of Employee's disability and need for medical treatment, it is unclear what benefits Employee would be entitled to, as her designated treating physician, Dr. Carlile, has released her to work with no restrictions and the PPI ratings she has received were based on the pre-existing condition. Employee has not prevailed on any issues and therefore would not be entitled to attorney's fees and costs.

CONCLUSION OF LAW

Employee's work injury is not the substantial cause of her disability or need for medical treatment.

ORDER

Employee's claim is denied.

Dated in Fairbanks, Alaska on August 15, 2018.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Kelly McNabb, Designated Chair

/s/
Togi Letuligasenoa, Board Member

/s/
Lake Williams, Board Member

APPEAL PROCEDURES

This compensation order is a final decision. It becomes effective when filed in the office of the board unless proceedings to appeal it are instituted. Effective November 7, 2005 proceedings to appeal must be instituted in the Alaska Workers' Compensation Appeals Commission within 30 days of the filing of this decision and be brought by a party in interest against the boards and all other parties to the proceedings before the board. If a request for reconsideration of this final decision is timely filed with the board, any proceedings to appeal must be instituted within 30 days after the reconsideration decision is mailed to the parties or within 30 days after the date the reconsideration request is considered denied due to the absence of any action on the reconsideration request, whichever is earlier. AS 23.30.127.

An appeal may be initiated by filing with the office of the Appeals Commission: 1) a signed notice of appeal specifying the board order appealed from and 2) a statement of the grounds upon which the appeal is taken. A cross-appeal may be initiated by filing with the office of the Appeals Commission a signed notice of cross-appeal within 30 days after the board decision is filed or within 15 days after service of a notice of appeal, whichever is later. The notice of cross-appeal shall specify the board order appealed from and the ground upon which the cross-appeal is taken. AS 23.30.128.

RECONSIDERATION

A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accord with 8 AAC 45.050. The petition requesting reconsideration must be filed with the board within 15 days after delivery or mailing of this decision.

MODIFICATION

Within one year after the rejection of a claim, or within one year after the last payment of benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, a party may ask the board to modify this decision under AS 23.30.130 by filing a petition in accord with 8 AAC 45.150 and 8 AAC 45.050.

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of BEVERLY SUMPTER, employee / claimant; v. FNSB SCHOOL DISTRICT, self-employer; defendant; Case No. 201400344; dated and filed in the Alaska Workers' Compensation Board's office in Fairbanks, Alaska, and served on the parties on August 15, 2018.

/s/
Ronald C. Heselton, Office Assistant II