ALASKA WORKERS' COMPENSATION BOARD

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

SHANNON RAE CORONA,	)	
	)	
Employee, Claimant,	)	FINAL DECISION AND ORDER
	)	
	)	AWCB Case No. 201709310
v.	)	
	)	AWCB Decision No. 20-0032
STATE OF ALASKA,	)	
	)	Filed with AWCB Anchorage, Alaska
Self-insured Employer,	)	on May 21, 2020
Defendant.	)	
	)	

Shannon Corona's (Employee) January 16, 2018 claim was heard on April 21, 2020, in Anchorage, Alaska, a date selected on January 29, 2020. A December 20, 2019 hearing request gave rise to this hearing. Attorney Tasha Porcello appeared and represented Employee who appeared and testified. Attorney Adam Franklin appeared and represented the State of Alaska (Employer). Scot Youngblood, M.D., testified by phone for Employer. As a preliminary matter, Employee sought an order excluding articles Employer had filed from learned treatises. Employer sought an order excluding an October 20, 2017 report from Loren Jensen, M.D., on grounds it had exerted its right to cross-examine Dr. Jensen but he had not been produced for cross-examination. Oral orders denied these requests. This decision examines the oral orders and decides Employee's claim on its merits. The record remained open to receive Employee's supplemental fee affidavit and any response and closed on April 27, 2020.

ISSUES

Employee contended articles that second independent medical evaluation (SIME) physician David Slutsky, M.D., provided in response to Employer's request should not be considered because the SIME physician is not being called as a witness.

Employer contended the articles should be considered because SIME Dr. Slutsky provided them. It also contends he relied on them to support his opinions.

1) Was the oral order admitting articles from learned treatises correct?

Employer contended Dr. Jensen's October 20, 2017 report is not admissible because Employer filed a Smallwood objection to the report and Employer has not had an opportunity to cross-examine him. Employer contended it does not have to file a second Smallwood objection on the same record after Employee filed her Affidavit of Readiness for Hearing, as that would be an unnecessary redundancy.

Employee contended the regulation addressing cross-examination of a doctor's report is clear. The regulation required Employer to file a Smallwood objection on the subject report within 10 days after service of her Affidavit of Readiness for Hearing. She contends this requirement gives her notice that she will have to present the physician by deposition or at hearing. Because Employer failed to comply with this regulation, she contends Employer waived its right to object to the report.

2) Was the oral order refusing to strike a medical record correct?

Employee contends her bilateral carpal tunnel syndrome (CTS) arose out of and in the course of her employment with Employer. She seeks an order so holding.

Employer contends objective medical evidence does not support causation. It contends science shows there is no connection between the work Employee does for Employer and her CTS diagnosis. It seeks an order denying the claim based on lack of causation.

3) Did Employee's CTS arise out of and in the course of her employment with Employer?

Employee contends she is entitled to temporary total disability (TTD) benefits for her left CTS. She seeks a TTD benefit award in accordance with Exhibit A attached to her hearing brief.

Employer contends Employee's left CTS is not work-related. Therefore, it seeks an order denying her left-hand TTD claim.

4) Is Employee entitled to a TTD benefit award for her left CTS?

Employee contends she is entitled to permanent partial impairment (PPI) benefits for her left CTS. She seeks a PPI benefit award in accordance with Exhibit A attached to her hearing brief.

Employer contends Employee's left-hand CTS is not work-related. Therefore, it seeks an order denying her left-hand PPI benefit claim.

5) Is Employee entitled to a PPI benefit award for her left CTS?

Employee contends she is entitled to medical care and related transportation expenses for her bilateral CTS. She seeks an order awarding reimbursement for out-of-pocket medical expenses, additional payments to her physician and prescription and mileage reimbursements, all in accordance with Exhibit A attached to her hearing brief.

Employer contends Employee's bilateral CTS is not work-related. Therefore, it seeks an order denying her claim for associated medical benefits.

6) Is Employee entitled to medical care and transportation expenses for bilateral CTS?

Employee contends she is entitled to interest, attorney fees and costs related to her CTS claim.

Employer contends she is not entitled to interest, attorney fees or costs related to her claim because her CTS is not work-related.

7) Is Employee entitled to interest, attorney fees and costs?

FINDINGS OF FACT

A preponderance of the evidence establishes the following facts and factual conclusions:

1) On September 8, 2014, Employee saw Crystal Thornton, ANP, because she thought she might have diabetes. She specifically denied "burning, numbness, or tingling in her feet or hands." There was no diabetes diagnosis at this visit. (Thornton report, September 8, 2014).

2) On November 9, 2015, Employee's glucose was normal. (Beacon Occupational Health & Safety, November 11, 2015).

3) On August 10, 2016, Employee completed an intake sheet at her doctor's office and stated she has never had diabetes or carpal tunnel disease. (Beacon report, August 10, 2016).

4) On November 22, 2016, Employee reported a November 19, 2016 rear-end motor vehicle accident. She had a pulling feeling in her right shoulder and had neck and back pain; Employee had headaches two or three times a day. An emergency room visit on the accident date diagnosed a concussion from a head bump and right knee and left ankle pain. There were no hand-related diagnoses. (Jamie Ash, PA-C, report, November 22, 2016).

5) On November 22, 2016, Employee's glucose was slightly elevated. (LabCorp. report, November 22, 2016).

6) On December 7, 2016, Employee completed a health history while being treated at Chugach Physical Therapy (PT) for her motor vehicle accident. The form provided three columns for check marks next to various alphabetically listed medical conditions for which she had a "History of," that "Currently applies" or she was "Currently taking Meds for." Employee checked the "Currently applies" and "Currently taking meds for" boxes in the "Depression" row but did not check the "History of" box. The next listed condition is "Diabetes" after which Employee wrote "(winter time)" and checked the "History of" box. There is no mention of hand or wrist complaints in this or any other PT report. (PT reports, December 7, 2016 through February 24, 2017).

7) On May 22, 2017, Employee sought care for indigestion and said she took Lexapro for major depressive disorder but only in winter; she reported no joint pain. (Beacon report, May 22, 2017).

8) On May 22, 2017, Employee's glucose was normal. (LabCorp. report, May 22, 2017).

9) On June 30, 2017, Employee reported CTS symptoms in both wrists. She gave "2017" as the injury date and noticed symptoms while working for the Alaska State Troopers, and had 10 plus years employment with the state in positions using a keyboard. Employee referenced her keyboard and "base station dispatch microphone" as objects contributing to her symptoms. She stated:

> I have been having numbing, pain, stiffness, loss of motion, tingling, throbbing, etc. starting approximately four months ago in both wrists. It has now gotten to the point I sometimes cannot move my left wrist. The symptoms are happening on a much more frequent basis, and the pain has gotten progressively worse. As of late I am sometimes unable to sleep at night due to the wrist pain. (Employee Report of Occupational Injury or Illness to Employer, June 30, 2017).

10) On July 5, 2017, Employee's supervisor completed an injury report and assigned noon on June 30, 2017, as the injury's administrative time and date. (Employer Report of Occupational Injury or Illness to Division of Workers' Compensation, July 5, 2017).

11) On July 5, 2017, Employee told Michael Reeves, M.D., she was a dispatcher with the Alaska State Troopers and had significant pain in both wrists and hands, with the left being much worse. Her pain did not arise from an auto accident but was work-related with an injury date listed as "2017." Employee was concerned about bilateral CTS, which she had been noticing for about four months; her symptoms had increased over the last two weeks. She had pain down her fingers to her wrist and elbow, with tingling, numbness, falling asleep and throbbing; "Feels like a zap." There was, "No injury per se but is a dispatcher and pretty much types all day long." Employee's Tinel's test was negative bilaterally but her Phalen's test on the left was too painful to continue past 20 seconds. He suspected CTS and ordered nerve conduction studies (NCS) for further evaluation. (Reeves report, July 5, 2017).

12) On July 7, 2017, Dr. Reeves reviewed the cervical x-ray and NCS, which were negative. He referred Employee to a neurologist. (Reeves report, July 7, 2017).

13) On July 18, 2017, Stanford Downs, M.D., neurologist, examined Employee and recorded:

> This is a very pleasant 41-year-old female referred by Dr. Michael Reeves for numbness of the bilateral wrist and fingers. Her problem she thinks started about four months ago. Her wrist and her fingers started hurting. The frequency has increased and severity is markedly increased. Her work has for the last year consisted of a lot of use of her hands. She is a dispatcher for I believe the state troopers. She is constantly using a radio and she keys the mic with the fingers of her left hand. She opens and closes prison cells, she is dispatcher and for a number of officers, she monitors a lot of monitors, she has three mice, and a keyboard. She works 7.5 hours per day five days per week, and they look up hundreds of names per day. For example, Tuesdays and Thursdays which are her biggest days because they are indictment days, they typically look up 200 names per courtroom. She has been doing this work for a little over a year, and prior to that she has worked for the state for 10 years in administration. Her problems only occur at work, never on the weekends, and go away after she goes home in the evening. It typically starts

> in her second hour at work and starts with pain in the wrist, much more marked on the left, and the right side is involved so modestly that by comparison it is not a problem at all. . . . She has no numbness and tingling of the hands in the morning, she has no problems with the feet, and no problems with neck pain.

Dr. Downs diagnosed "pain" with a history suggesting CTS. However, given the specificity of Employee's pain, he suspected it might also be tendinitis or tenosynovitis causing inflammation with a "bystander effect" on the median nerve. He recommended a left wrist magnetic resonance imaging (MRI). (Downs report, July 18, 2017).

14) On July 18, 2017, Employee's left wrist MRI with gadolinium enhancement showed a normal wrist but the median nerve showed "some flattening" and findings within the carpal tunnel suggested edema "that might correlate with the patient's symptoms." (MRI report, July 18, 2017).

15) On July 20, 2017, Dr. Downs found the left wrist MRI results "extremely interesting." The median nerve was flattened within the carpal tunnel, suggesting edema. He could not explain the discrepancy between normal nerve conduction findings and abnormal MRI results "but the latter clearly supports a diagnosis of CTS with perhaps some transient increased irritation of both the median nerve and of the ulnar nerve." Dr. Downs diagnosed bilateral CTS and recommended a surgical release on the left and conservative treatment on the right. (Downs report, July 20, 2017).

16) On July 24, 2017, Employee went to the emergency room for left wrist pain. Laura Levoy, M.D., diagnosed left-wrist CTS. Information the hospital gave Employee to review included:

> The carpal tunnel is a narrow area located on the palm side of your wrist. The tunnel is formed by the wrist bones and ligaments. Nerves, blood vessels, and tendons pass through the carpal tunnel. Repeated wrist motion or certain diseases may cause swelling within the tunnel. This swelling pinches the main nerve in the wrist (*median nerve*) and causes the painful hand and arm condition called carpal tunnel syndrome.

Other listed causes included wrist injuries, obesity, pregnancy and diseases including diabetes, alcoholism, hyperthyroidism and kidney failure. (Levoy report, July 24, 2017; italics in original).

17) On July 24, 2017, Employee returned to Dr. Reeves for a note excusing her from work; he diagnosed bilateral CTS and took her off work until July 31, 2017. (Reeves report, July 24, 2017).

18) On July 28, 2017, Loren Jensen, M.D., saw Employee who reported pain, numbness and tingling in both hands for six months with no specific injury; she attributed her symptoms to repetitive hand motions on her job as an emergency services dispatcher for the State Troopers.

Her previous diagnostic testing was within normal limits though her MRI on the left hand showed increased edema within the nerve; her symptoms were much worse on the left. She initially said she did not have paresthesias at night or with prolonged grasping; pain was her major complaint. Upon further questioning, Employee reportedly said she had obtained a brace, which controlled nocturnal paresthesias and her initial complaint five months earlier had been nighttime paresthesias. Her symptoms were worse with activity during the day. Dr. Jensen's impression was left hand pain, numbness and tingling with an unclear diagnosis. He said it could be median nerve compression at the wrist, but not bad enough to proceed surgically. Dr. Jensen opined the NeuroMetrix NCS testing she had was unreliable. He administered a corticosteroid injection in the left carpal canal and asked Employee to return in 10 days. (Jensen report, July 28, 2017).

19) On August 4, 2017, Employee reported the left carpal canal injection had been and was continuing to be helpful. On examination, she had a positive carpal compression test on the left; Dr. Jensen did not test the right. He opined Employee's recently good result from the injection showed a surgical release would be helpful. (Jensen report, August 4, 2017).

20) On September 1, 2017, Employee reported no further benefit from the left carpal canal injection. Her previous numbness, tingling and pain had resolved with the injection but now all had returned. X-rays showed no significant abnormality. Dr. Jensen diagnosed left hand pain, numbness and tingling. He deferred on any specific treatment until after her scheduled employer's medical evaluation (EME). (Jensen report, September 1, 2017).

21) On September 15, 2017, Scot Youngblood, M.D., performed an EME on Employee, whose chief complaints were left-much-greater-than-right wrist pain, numbness and tingling mostly in the left second through fourth fingers, and pain at the base of the left thumb. She reported beginning her current job in April or May 2016. She began noticing pain mostly in her left hand about 11 months later; she ascribed this to "wear and tear" on the job and denied any "injury." Her symptoms progressed and she sometimes would awaken at night two or three times a week with pain in her left wrist. Employee did significant typing and word-processing and her pain increased toward week's end. By Saturday afternoon, her pain was gone if she did not use her hand. After the carpal canal injection, her symptoms went away completely for about a month until they gradually returned. Employee denied any previous injuries, treatments, evaluations, x-rays, MRIs, injections or surgeries on her bilateral wrists or hands "prior to the industrial activities on or about June 30, 2017." (Youngblood report, September 15, 2017).

22) Dr. Youngblood noted Employee's history of depression more specifically described as seasonal affective disorder (SAD) during winter months. Her family history was positive for maternal diabetes. Employee denied chronic or recent neck, shoulder or elbow pain. Dr. Youngblood diagnosed: (1) left-much-greater-than-right CTS, "related to the examinee's age, genetics, gender and obesity" and not substantially caused by "the industrial activities on or about June 30, 2017"; (2) Exogenous Class III or Extreme obesity, with a body mass index of 42.5, not substantially caused by the industrial activities on or about June 30, 2017, but "giving rise in part to the diagnosed carpal tunnel syndrome."

> The described work activities have not been shown in the medical literature to be associated with the development of carpal tunnel syndrome. Clearly, however, the condition of carpal tunnel syndrome is associated with advancing age, female gender and an elevated body mass index. *While the condition may be more symptomatic during the described work activities*, it does not aggravate the condition in a material way. It should be noted that some of the most prominent symptoms are nocturnal, during which there is no occupational activity ongoing. Thus, I am unable to relate the described work activities on or about June 30, 2017, as being the substantial cause of the examinee's carpal tunnel syndrome (emphasis added).

Dr. Youngblood said no "conditions are deemed due to the work activities." He opined Employee's CTS is not a preexisting condition "per se" and was not substantially caused by the described work activities. Dr. Youngblood said "the work activities on or about June 30, 2017, would not be deemed the substantial cause" of the need for current or subsequent treatment. He acknowledged the left wrist MRI was somewhat abnormal with median nerve compression at the carpal tunnel and some edema in the nerve. Dr. Jensen's injection alleviated her symptoms and would "be considered a positive test" for CTS. He did not think the symptoms appeared reasonable given the "mechanism(s) of injury." Dr. Youngblood recommended CTS surgery but opined it would "not be deemed substantially caused by the industrial activity." In his opinion, no "true industrial injury is identified" but Employee has CTS, not substantially caused by the described work activities. Consequently, in his view she has "no industrially related impairment." He did not otherwise provide a PPI rating. An accompanying "Pain Diagram" shows Employee has similar symptoms in both hands but with symptoms going up the forearm in the left hand but not in the right. (Youngblood report, September 15, 2017).

23) Later on September 15, 2017, Employee returned to Dr. Jensen who re-injected her left carpal tunnel. (Jensen report, September 15, 2017).

24) On October 19, 2017, Employer denied all benefits, citing Dr. Youngblood's report. Although there is no controversion notice found in the agency file, a copy is attached to Employee's hearing brief as Exhibit G. (Controversion Notice, October 19, 2017; Employee's Hearing Brief, April 14, 2020, Exhibit G).

25) On October 20, 2017, Dr. Jensen saw Employee and wrote:

> **INTERVAL HISTORY**: The patient had an independent medical evaluation performed on September 15, 2017, by Dr. Scot Youngblood. Dr. Youngblood concluded that the patient did, indeed, have a carpal tunnel syndrome despite the negative electrodiagnostics, and he gave as his diagnosis a left much greater than right carpal tunnel syndrome. He felt, however, that the diagnosis was not due to her workplace activity as a dispatcher but rather to genetics, gender and obesity.
>
> He felt that her condition was not substantially caused by the workplace activities about June 30, 2017.
>
> Patient has continued to work without significant time loss, as a Dispatcher, and she has continued to experience significantly [sic] numbness and tingling involving the median nerve distribution, right much more so than left, in her hands and with nocturnal paresthesias and with workplace worsening.
>
> **EXAMINATION**: Examination shows positive Phalen's on the left, though equivocal on the right. Compression test is positive for median nerve paresthesias, left more so than right.
>
> **IMPRESSION**: Left greater than right carpal tunnel syndrome.
>
> **PLAN**: Despite electrodiagnostics, we are willing to agree with Dr. Youngblood that this represents a carpal tunnel syndrome. We dispute, however, that this is due to obesity and aging process. Certainly, these are factors that do cause some degree of worsening of her condition; however, I believe that on a more probable than not basis the etiology of the carpal tunnel syndrome should be considered the workplace activity. This is based upon Alaska State Law, examination, and the fact that she did not have symptoms prior to the specific Dispatcher activity.
>
> I believe that there is no compelling reason to disregard the workplace contribution and this greater than 50 percent contribution from the workplace simply because of the obesity that she has. Certainly, obesity is a cause of carpal tunnel syndrome; however, I believe that it is disingenuous to attribute the 51% cause of her carpal tunnel syndrome to the obesity while ignoring the workplace contribution.

> I will attempt to have the office manager schedule the surgery, which will cause a "push to shove" regarding the work-relatedness of her condition. The claim, presumably, has been controverted at this point.
>
> However, I believe that it is appropriate to do the carpal tunnel release, and I believe that it is appropriate to consider this a workplace-related condition. I understand that this is a controversial determination, however, I believe that it is, again, disingenuous to attribute her condition entirely to an obesity and her body mass index and, therefore, to call it preexisting. (Jensen report, October 20, 2017).

26) On November 16, 2017, Employee had her initial consultation with Porcello. (Affidavit of Counsel in Support of Attorney's Fees and Costs, April 16, 2020).

27) On January 11, 2018, Employee's blood sugar was within normal limits. (LabCorp. report, January 11, 2018).

28) On January 16, 2018, Employee claimed TTD and temporary partial disability (TPD) benefits, PPI benefits, medical and transportation costs, attorney fees and costs. She cited "[r]epetitive use of bilateral hands" as the injury cause. (Claim for Workers' Compensation Benefits, January 16, 2018).

29) On January 31, 2018, Thomas Umbach, M.D., recorded Employee's "long history of morbid obesity." (Umbach report, January 31, 2018).

30) A "long history" usually extends beyond two years. (Experience; judgment).

31) On February 22, 2018, Employee filed and served Dr. Jensen's medical records dated July 28, August 4, September 1, September 15, and October 20, 2017. Because these documents record Dr. Jensen's examination findings and opinions, they are all typical chart notes from an attending physician similar to those seen in innumerable workers' compensation cases. (Medical Summary, February 22, 2018; judgment; experience).

32) On February 28, 2018, Employer "Smallwooded" Dr. Jensen's reports dated July 28, August 4, September 1, September 15, 2017, and October 20, 2018 [sic]. The request did not identify a medical summary on which to find these records but stated Employer wanted to question Dr. Jensen's evaluation, diagnoses, opinions and conclusions vis-à-vis Dr. Youngblood's. (Request for Cross-Examination, February 28, 2018).

33) On March 16, 2018, Dr. Youngblood wrote an addendum to his earlier EME report.

> It is noted that in the July 28, 2017 evaluation with Dr. Jensen that the original complaint was actually nocturnal paresthesias, not paresthesias that occurred during

> work activities. How awakening in the middle of the night with numbness and tingling would be associated with one's work during the day it is unclear.
>
> One of the best sources in the medical literature regarding causation of various diagnoses is the *AMA Guides to the Evaluation of Disease Injury Causation*, 2nd edition. It discusses the occupational and nonoccupational risk factors for carpal tunnel syndrome in summary of the available evidence in the medical literature, on pages 278 to 301. The evidence for highly repetitive work of low force is **conflicting evidence**. There is **very strong evidence** for highly repetitive work with significant force and exertion, such as "meatpacking, poultry processing, automobile assembly work, and other occupations requiring intensive manual exertion of distal upper limbs." Unfortunately, Ms. Corona's work as a Dispatcher would not constitute "intensive manual exertion," but would be characterized as highly repetitive work requiring low force. Keyboard activities are also discussed in the *Guides* as having insufficient evidence for causation. Thus, for Ms. Corona's work, we have either **conflicting evidence** or **insufficient evidence** to conclude that her occupation caused her carpal tunnel syndrome.
>
> For her nonoccupational risk factors, there is much stronger evidence of a causation link. First, increasing age is **very strong evidence**. Many of the studies cited by the *Guides* referred to subjects older than 40 years. A high BMI is also **very strong evidence**. Most of the studies cited by the *Guides* referred to a BMI greater than 30, some referred to a BMI from 25 to 29.9. Ms. Corona's BMI is 42.5. Her female gender also has **very strong evidence**. Biopsychosocial factors, such as a diagnosis of depression, also demonstrate **very strong evidence** of causation.
>
> Thus, based on all of the above, Ms. Corona has at least four independent <u>nonoccupational</u> risk factors that constitute **very strong evidence** for causation. For her occupational risk factors, we have at most **conflicting evidence** or **insufficient evidence**. Perhaps if there was significant exertion or force or vibration in her work activities, one could make an argument for work relation. However, this is not the case. An independent medical examiner is forced to look at the available medical literature in order to determine causation in a given case. I cannot see how in the face of four independent nonoccupational risk factors for carpal tunnel syndrome with **very strong evidence** (and none for occupational risk factors), one could make the argument that the substantial cause of her carpal tunnel syndrome was in fact her occupation. Therefore, the original conclusion and recommendations of my independent medical evaluation of September 15, 2017, stand without revision. (Youngblood report, March 16, 2018; emphasis in original).

34) The agency file has no February or March 2017 medical record stating her initial complaint was only nocturnal paresthesias and not paresthesias during work activities. (Agency file).

35) By May 18, 2018, following her gastric sleeve surgery Employee's weight reduced to 205 pounds. (Beacon Health report, May 18, 2018).

36) On May 22, 2018, Employee's glucose was normal. (LabCorp. report, May 22, 2018).

37) On June 6, 2019, Employee returned to Dr. Downs to discuss the previously recommended CTS surgery and gave him Drs. Jensen's and Youngblood's reports and said her symptoms had become so severe she could not wait any longer for relief. Her left wrist was much worse and hurt almost nonstop shortly after she got to work until long after she got home. When Employee went on vacation, two days into it she had no CTS symptoms. On one occasion while vacationing, she had some symptoms because she was driving extensively. Dr. Downs said:

> She is still doing dispatch for the state troopers. Her radio has a desk-mounted mike on her left with a push-to-talk bar on the base and she was also pressing that with the third digit, left hand, and given the fact that is the most symptomatic side and the most symptomatic digit, it appears to be what has the patient thinking that this represents a worker's comp issue. . . .

Dr. Downs was "pretty sure there is a component of carpal tunnel syndrome," but his examination made him concerned there may be an ulnar component as well. He referred Employee to another physician for surgery because splints were no longer working. Dr. Downs reiterated his previous recommendations and concerns from his last report and recommended a new electromyography (EMG) and a nerve conduction velocity (NCV) study. (Downs report, June 6, 2019).

38) On June 7, 2019, Dr. Downs performed EMG and NCV tests; he found right CTS that was essentially asymptomatic and very mild left CTS that was "very symptomatic," both of which failed conservative therapy; he referred Employee for surgery. (Downs report, June 7, 2019).

39) On August 1, 2019, Traci Barthel, M.D., examined Employee on referral and recommended a left CTS release, which she performed that day. (Barthel report, August 1, 2019).

40) On October 24, 2019, Dr. Slutsky examined Employee for an SIME. He is an orthopedic surgeon who operates The Hand & Wrist Institute and is a Diplomate, American Board of Orthopedic Surgeons with Added Qualifications in Hand Surgery. Dr. Slutsky personally took a history from and examined Employee, spending one hour face-to-face with her. He spent three hours reviewing her medical records, one hour reviewing medical testing and one hour preparing his written report. Dr. Slutsky diagnosed right and left CTS. As for causation he said, "The patient's signs and symptoms are due to the work-related injury of 6/13/2017 [sic]." There was no preexisting condition. The right and left CTS contribute 100 percent to Employee's disability and need for medical treatment. Specifically, Dr. Slutsky stated:

> The right and left carpal tunnel syndrome are the substantial cause of the claimant's disability and need for medical treatment. The claimant did not have any of the symptoms of carpal tunnel syndrome at the time she was hired as a dispatcher for the State of Alaska, Dept. of Transportation. She developed carpal tunnel after working approximately six months. This has been documented in the submitted medical records.

The work injury "was the substantial cause of the claimant's disability. The work-related disability continues." Employee was not medically stable from her August 2, 2019 left CTS release; in many cases this would take up to one year. Dr. Slutsky opined Employee continued with right CTS symptoms and is a candidate for right CTS release. He calculated an estimated number of times Employee would depress an intercom button with her left hand based on her history and, depending upon how many hours per day she worked, she would depress the button between 375 to 1,200 times a day, 7500 to 24,000 times per month and 45,000 to 144,000 times over a six-month period; she also types and writes. Based on this information, her records and examination, Dr. Slutsky concluded "in all medical probability" her CTS symptoms are "causally related to her normal work-related activities." (Slutsky report, October 24, 2019).

41) On November 27, 2019, Employer wrote to Dr. Slutsky seeking additional answers and clarifications on his SIME report. Employer's questions are set forth in factual finding 42, below. Employer attached to its letter the title page from AMA *Guides to the Evaluation of Disease and Injury Causation*, *Second Edition* and pages 278-301. (Franklin letter, November 27, 2019).

42) On December 3, 2019, Employee wrote to Dr. Slutsky with concerns about Employer's November 27, 2019 letter to him. Employee's letter also asked Dr. Slutsky to consider statements in her letter before he responded to Employer's. (Porcello letter, December 3, 2019).

43) On December 10, 2019, Dr. Slutsky provided a supplemental report in response to Employer's request. He spent three hours reviewing medical literature and one hour to prepare his second report. Dr. Slutsky provided the following responses:

> (1) Do you believe that any factor(s) aside from Ms. Corona's work for the State of Alaska played a causal role in her development of bilateral carpal tunnel syndrome, e.g., her age, gender, BMI, activities outside of work, or any other factor?
>
> Answer: No I do not.

(2) If you believe any other factors played a causal role in Ms. Corona developing bilateral carpal tunnel syndrome, please evaluate the relative contribution of different causes (including her employment activities) of Ms. Corona's bilateral carpal tunnel syndrome.

Answer: Not applicable.

(3) Considering all of the causal factors you [sic] listed above, can you identify one cause of Ms. Corona's bilateral carpal tunnel syndrome as "the substantial cause" or "the most important or material cause related to [Ms. Corona's bilateral carpal tunnel syndrome]?" *See Morrison v. Alaska Interstate Construction, Inc. & SKW Eskimos, Inc.*, 440 P.2d 224, 238 (Alaska 2019). If so, which one?

Answer: The claimant estimates that she depresses an intercom button with her left hand from 500 to 100 times per hour. Assuming she works 20 days per month and 7 ½ to 12 hours per day, this would equal 375 to 1200 times a day, which is 7500 to 24,000 times per month and between 45,000 to 144,000 times over a six-month period. In addition to this the claimant also types and rights. In view of this the claimant's signs and symptoms of carpal tunnel syndrome (CTS) or [sic] in all medical probability causally related to her normal work related activities which is the substantial cause of the claimant's bilateral carpal tunnel syndrome.

(4) In your response to the Board's Question #2, you stated that "there is no pre-existing condition." Do you have any bases for that conclusion beyond Ms. Corona's claim she did not have a pre-existing condition and Ms. Corona's lack of medical treatment for carpal syndrome prior to beginning employment for the State of Alaska? If so, please state the additional bases for your conclusion.

Answer: The claimant states that she had no pre-existing conditions prior to being employment [sic] for the state of Alaska. There were no submitted medical records documenting that the claimant had any pre-existing conditions. If these records become available I would be happy to review them and revise my opinion accordingly.

(5) In response to Employer's Question #2, you stated that you disagree with the assertion in the AMA Guides to the Evaluation of Disease and Injury Causation, Second Edition, that there is "insufficient evidence" to identify keyboard activities as an occupational risk factor for median nerve entrapment at the wrist. A copy of those materials included with these questions. Could you please provide the basis for your disagreement, including citations to any literary and/or epidemiological sources of information on which you relied?
Answer: If you read my report dated 10/24/2019 you will see that I did not opine that the claimant's keyboard activities were the predominant occupational risk factor for the development of carpal tunnel syndrome. I did however postulate that the repetitive depression of an intercom button was a risk factor in the development of carpal tunnel syndrome as described in answer 3. The incidence and prevalence

of CTS working populations supports the claim that CTS's work-related. I have provided a number of peer-reviewed publications that discuss the available literature on the subject.

A study conducted by Roquelaure et al examined the relationship between employment status and CTS incident rate. The purpose of this study was to estimate the incidence of carpal tunnel syndrome (CTS) in a general population according to employment status and to assess the proportion of cases attributable to work. CTS occurring in patients aged 20-59 years living in the French Maine and Loire region were included prospectively from 2002 to 2004. Medical and occupation history was gathered by mailed questionnaire. Incidence rates of CTS and relative risks (RRs) of CTS were computed in relation to employment status. The attributable fractions of risk of CTS to work among the exposed persons (AFEs) were calculated. A total of 1168 patients (819 women, 349 men) were included during the 3-year period. The mean incidence rate of CTS per 1000 person-years was higher in employed than unemployed persons (1.7 vs. 0.8 in women and 0.6 vs. 0.3 in men). **The excess risk of CTS was statistically significant for male (RR 4.2) and female (RR 3.0) blue-collar workers and female lower-grade white collar workers (RR 2.5). The AFE to work in general was 47% (95% confidence interval: 39-54) in women. AFEs reached higher values in female blue-collar workers [67% (65-68)] and lower-grade services, sales, and clerical white-collar workers [61% (57-64)]. The AFE in male blue-collar workers was 76% (72-80). These data show a higher incidence of CTS in the working than the non-working population and suggest that a substantial proportion of CTS cases diagnosed in lower-grade white-collar and blue-collar workers are attributable to work.**

Maghsoudipour et al study evaluated both occupational and non-occupational factors associated with CTS in industrial workers. A cross sectional study was designed with 400 industrial workers (77% male, 23% female) randomly selected. Workers' upper extremities were examined and related signs and symptoms were assessed. The nonoccupational factors consisted of age, gender, race, BMI, smoking, education and marital status. The occupational factors were bend/twist of the wrist, force, work speed, job rotation and vibration. Questionnaires about personal and occupational risk factors were completed and suspicious cases were referred for NCV (nerve conduction velocity) testing and documentation of diagnosis. About 395 workers from automobile industry factories were assessed by interview and electrodiagnostic studies. Among 395 workers, 47 met the definition of CTS to yield a prevalence of 11.9%. These 47 workers averaged 29.85 years of age (SD = 6.28), and the mean age of the healthy group was 27.95 (SD = 4.86). 395 workers included 91 women (23%) and 304 men (77%). Using multivariate logistic regression model the largest adjusted odds ratios of personal and occupational factors for CTS were: exertion of force over one kilogram 6.38 (1.91-2.02); bending/twisting of the hands/wrists > 30 degrees, 5.62 (0.56-55.6); history of cigarette smoking 4.68 (1.80-11.80); rapid movement of hands 4.44 (1.41-14.02); and use of vibrating tools 3.23 (1.46-7.15). The results were analyzed

using a multivariate logistic regression model whereby an odds ratio was calculated for each factor. An odds ratio determines the strength of an association between data, such that higher values indicate a stronger association. Of the risk factors studied, the top 5 risk factors identified to contribute to CTS were: exertion of force over 1 kg, bending/twisting of the hands/wrist >30 degrees, history of cigarette smoking, rapid movement of the hands, and use of vibrating tools. **Their conclusions were that some occupational factors including force exertion, bending/twisting of the hands, rapid movement of the hands and vibration are associated with CTS.**

Ricco and Signorelli performed a cross-sectional study on 434 workers (236 males, 198 females, 37.0±10.6 years old, working age: 12.6±10.8 years) from meat processing industries. Occupational risk factors were assessed through a questionnaire and direct assessment by investigators. Adjusted odds ratios (OR_{adj}) for factors of interest were estimated through binary logistic regression. The diagnosis of the CTS was reported for 61 out of 434 subjects (14.1%) for an incidence of 11.3/1000 person- years. In general, signs and symptoms for the CTS were associated with the following demographic factors: smoking history (OR = 1.909, 95% confidence interval (CI): 1.107- 3.293), previous traumas of the upper limb (OR = 3.533, 95% CI: 1.743-7.165), hypothyroidism status (OR = 7.897, 95% CI: 2.917-21.38) and, in the case of female participants only, previous pregnancies (OR = 2.807, 95% CI: 1.200-6.566) as well as a personal history of oral contraceptive therapy and/or steroidal replacement therapy (OR = 11.57, 95% CI: 4.689-28.56). The carpal tunnel syndrome cases were associated with the following occupational factors (> 4 h/day): forceful hand exertion (OR_{adj} = 3.548, 95% CI: 1.379-9.131), repeated trauma of the hand (OR_{adj} = 3.602, 95% CI: 1.248- 10.395), repeated movements of the wrist (OR_{adj} = 2.561, 95% CI: 1.100-5.960). **They concluded that increasing levels of hand activity and force were associated with the increased CTS prevalence among participants.**

Lund and coworkers performed a large cohort study to investigate the association between work-related wrist movements carpal tunnel syndrome (CTS). Electrogoniometric measurements of wrist movements were performed for 30 jobs (e.g., office work, child care, laundry work and slaughterhouse work). We measured wrist angular velocity, mean power frequency (MPF) and range of motion (ROM). We established a cohort of Danish citizens born 1940-1979 who held one of these jobs from age 18-80 years, using Danish national registers with annual employment information from 1992 to 2014. We updated the cohort by calendar year with job-specific and sex-specific means of measured exposures. Dates of a first diagnosis or operation because of CTS were retrieved from the Danish National Patient Register. The risk of CTS by quintiles of preceding exposure levels was assessed by adjusted incidence rate ratios (IRRadj) using Poisson regression models. We found a clear exposure-response association between wrist angular velocity and CTS with an IRRadj of 2.31 (95% CI 2.09 to 2.56) when exposed to the highest level compared with the lowest. MPF also

> showed an exposure response pattern, although less clear, with an IRRadj of 1.83 (1.68 to 1.98) for the highest compared with the lowest exposure level. ROM showed no clear pattern. Exposure response patterns were different for men and women. **The authors concluded that high levels of wrist movement were associated with an increased risk of CTS**.
>
> A systematic literature review was completed for 38 articles to examine the evidence linking CTS with work. The researchers found evidence that regular and prolonged use of hand-held vibratory tools increases the risk of CTS >2 fold. They also concluded that even higher risks are associated with prolonged and highly repetitive flexion and extension of the wrist, especially when coupled with a strong grip. Similarly, Fung and associates identified that frequent flexion/extension, and sustained force of the wrist increases the risk of developing CTS. From the findings of these two researchers we can conclude that jobs requiring repetitive and/or forceful hand/wrist tasks increase the risk of developing CTS.
>
> (6) In your "Discussion" on page 13 of your report, you note that Ms. Corona depresses an intercom button with her "left hand." Could you provide further explanation (and whatever sources you relied upon) regarding how pressing an intercom button with a finger on her left hand contributes to median nerve entrapment in either/both of her wrists?
>
> Answer: I believe that in all medical probability performing any repetitive task from 375 to 1200 times a day, which is 7500 to 24,000 times per month and between 45,002 144,000 over a six-month period could contribute to the development of carpal tunnel syndrome.
>
> The literature that I have reviewed above notes that there is a higher incidence of CTS with **force exertion, bending/twisting of the hands, rapid movement of the hands and high levels of wrist movement, all of which could occur with repetitive pressing of an intercom button.** (Slutsky report, December 10, 2019; emphasis in original).

44) On January 29, 2020, Employee's issues were TTD, TPD, PPI benefits, medical benefits and mileage, interest, attorney fees and costs. (Prehearing Conference Summary, January 29, 2020).

45) On March 3, 2020, on referral from Dr. Barthel, Ed Barrington, DC, took a history, reviewed medical records including reports from Drs. Youngblood, Jensen and Slutsky, tested and examined Employee and performed a PPI rating on her left hand. He provided a three percent whole-person PPI rating for her left CTS under the AMA *Guides to the Evaluation of Permanent Impairment, Sixth Edition*. (Barrington report, March 3, 2020).

46) On April 14, 2020, the parties filed and served their hearing briefs and attachments. Both parties clearly set forth their arguments and supporting evidence, which are similar to their hearing

presentations. Employer's main contention was, "Does science matter?" Attached to Employee's brief is Exhibit A, summarizing the benefits she seeks, with supporting calculations and record citations. These include TTD benefits from July 24, 2017 through July 26, 2017, July 27, 2017 through July 30, 2017, July 29, 2019 through September 2, 2019, and October 23, 2019 through October 25, 2019, totaling $3,959.44; PPI totaling $5,310 based on Dr. Barrington's three percent PPI rating; Employee's payments to Alaska Hand Rehabilitation totaling $748.43; Employee's payments to Dr. Downs totaling $445 with $200 still owed; prescriptions Employee purchased totaling $35.02; and medical mileage totaling $237. (Employer's Hearing Brief, April 14, 2020; Employee's Hearing Brief, April 14, 2020).

47) On April 17, 2020, Employee filed her attorney's affidavit and itemization of attorney fees and costs through August 16, 2020. Porcello bills her attorney time at $400 per hour and her paralegal services at $200 per hour. She does not charge for clerical work she performs. She requested $29,640 in attorney fees and $243.60 in costs. (Affidavit of Counsel in Support of Attorney's Fees and Costs, April 16, 2020).

48) At hearing on April 21, 2017, Employee testified consistent with her deposition and added additional details. She worked for Employer in different capacities for about 12 years; she had been the dispatcher since April or May 2016. She operates her base station with her left middle finger because her other fingers are not strong enough to hold down the button; Employee believes the button is spring-loaded. Using a postal scale, with assistance from other officers, Employee calculated the base station microphone button required 12 to 13 ounces pressure to push it down and 1.13 to 1.86 ounces to hold it down while she was talking into the microphone. Employee used her right hand to push an intercom button, which her testing showed took from one pound to one pound three ounces to depress. Her job requires multi-tasking and she deals with approximately 140 inmates per day: Employee uses a phone, base station and computer keyboard, covers security, handles prisoners' needs using an intercom, operates her base station and considers her work hand-intensive. She has several monitors and three computer mice. For several months, Employee worked considerably more hours per day during staff shortages, used the restroom approximately twice a day and took no other breaks or lunch. She was taking no breaks around the time her CTS symptoms began. Employee's job requires constant, repetitive motion and she typically must look up 550 inmates' names to determine if they are in custody. She talks on the radio constantly, all day. She "bends and twists" her hands all day long at work. When not at

work, Employee likes to swim, walk and hike on trails; she does not have social media or use a computer at home; she is not a “gamer.” She did not recall Dr. Youngblood asking her if she was depressed, dissatisfied with her work, would recommend it to another person, would do it again, disliked her supervisors or coworkers or went home exhausted each night. Nevertheless, Employee is not depressed, but has SAD in the winter only, loves her job, would recommend it to others, would accept employment there again, loves her supervisor and coworkers and does not feel exhausted after work. She has never provided a DNA sample for genetic testing. Employee has no relatives that have ever had CTS or surgery for it. She denied stating her initial complaint was nocturnal paresthesias and said her left wrist began hurting at work and got worse. Eventually, her left hand fell sleep at night so she sought medical care. Employee’s CTS symptoms began approximately 9 to 12 months after she started working at her current job. She does not have CTS symptoms on weekends and does not have them upon arising in the morning. However, within two hours at work, her CTS symptoms return each day. Employee does not have diabetes nor is she pre-diabetic. Employee’s mother has diabetes so she is careful to monitor for it regularly. All her blood tests have been normal. On one health questionnaire where she checked a box for diabetes, Employee mistakenly thought it referred to her family history too. Employee identified Exhibit A to her hearing brief as the funds she expended for CTS treatment on her left hand. Private insurance paid for some treatment and they want to be reimbursed. By August 2019, Employee’s right hand was getting worse and reminded her of how her left hand symptoms started. Employee considered her SIME exam “thorough.” Dr. Slutsky asked detailed questions about her work. For his PPI rating, Dr. Barrington took measurements, strength testing and reviewed her records. Employee still has weakness in the left hand and is not fully recovered. Notwithstanding her body mass index (BMI), Employee admits she is overweight but disagrees she is “obese.” She describes herself as “super curvy” with a “flat stomach” and “wide butt.” Employee denied having chronic depression and did not injure her hands in any accident or injury outside work. She pushes the button on her base station with her left hand at least 375 times per day minimum and uses the intercom 50 to 100 times per day with her right hand; this is in addition to using her keyboard and three mice constantly. Employee is busy even on Fridays when the court is closed half the day because her section is open and preparing for the Monday court calendar. (Employee).

49) At hearing, Dr. Youngblood testified consistent with his written reports and added details and opinions. He is an orthopedic surgeon, with a fellowship in foot and ankle surgery. He has

experience with CTS and tendinitis and has performed CTS releases. He performs 200 to 250 EMEs per year almost always for employers. In his view, medical literature is "very important" in determining causation, but "has limitations." For example, studies must generalize the subjects' work. Dr. Youngblood describes CTS as a natural occurring condition; some activities are associated with a higher CTS risk. The AMA *Guides to the Evaluation of Disease and Injury Causation* has drawn together extensive literature about risk-factors for CTS, and in his opinion is the best source for causation literature. Dr. Youngblood interprets the *Guides* to suggest that "keyboarding" is not a known risk factor to cause CTS. Some factors such as obesity, have a 2.5 or 3.0 risk factor meaning that some people are two and one-half to three times more likely to develop CTS than people who do not have these risk factors. Female gender and age also increase the risk of developing CTS. If a person has more than one risk factor, these are added together according to Dr. Youngblood. Obesity is a medical diagnosis based on BMI without passing judgment. A BMI over 40 is considered "extreme" obesity; at times Employee has had a 45 BMI. While "forceful" repetitive work with the hands is a risk factor for CTS, 10 keyboarding studies revealed either no association, not a risk factor, no risk, or insignificant results. In other words, according to the literature the general population has the same CTS occurrence as those who work in keyboarding. Dr. Youngblood categorized using an intercom or base station button into the same category as "keyboarding." Even if it took up to one pound of force to push the intercom button, it would not change his opinion. In his view, a physician cannot make an accurate causation decision without reference to scientific literature. Employee's CTS makes no sense from a biomechanical standpoint in Dr. Youngblood's opinion, because of the way she used her hands at work. He disagrees with Dr. Slutsky's interpretation of the learned treatise articles Dr. Slutsky provided in response to Employer's request. He distinguishes these articles because, in his view, they all refer to "forceful" repetitive wrist use and he does not believe Employee demonstrated this was a factor with her job. He noted the left and right wrists have no connection and Employee's right hand actually had more electrodiagnostic CTS evidence than her left wrist. Dr. Youngblood conceded Employee's symptoms are atypical but the injection in the left carpal tunnel demonstrated she has CTS. He agreed Employee performs repetitive hand movements at her job. He conceded a "risk-factor" is a factor associated with the increased likelihood of developing a medical condition; if a person has the risk-factor it does not mean that a person will get the condition. Dr. Youngblood removed genetics from his first opinion and added biopsychosocial

issues in his second report. When asked about genetics as a risk factor in this case, Dr. Youngblood said it meant the "inherent nature of the patient" rather than a DNA test. He agreed he did not have a genetic profile for Employee. Dr. Youngblood agreed the *Guides* contains statistics not necessarily tied to Employee's situation. Evidence of biopsychosocial factors include the fact Employee takes medication for depression, which he understands is SAD. Dr. Youngblood admitted he knows nothing about Employee's job satisfaction or similar factors. Nevertheless, the fact Employee takes Lexapro for SAD was adequate for him to conclude biopsychosocial factors contribute to her CTS. Dr. Youngblood agrees there are problems with medical research especially if one only looks at one study. He could not find a contemporaneous initial medical report stating Employee's complaint started as nocturnal paresthesias. Dr. Youngblood characterizes Employee's job, which he admits he has never seen her do, as "data entry." He agreed he cannot attach or connect the studies upon which he relies to Employee specifically. When asked for an example of repetitive hand movements that he would agree could cause CTS, Dr. Youngblood used the example of a fish processor in Alaska cutting, tearing and processing fish. If Employee did that work, in Dr. Youngblood's view "we would not be here today." When asked if Employee's multiple risk-factors that he noted "predisposed" her to develop CTS, Dr. Youngblood responded, "Yes." (Youngblood).

50) The work-place photographs Employee offered into evidence at hearing over Employer's objection were not helpful and played no role in this decision. (Experience; judgment). Franklin took pictures of these photographs with his cell phone and sent them to Dr. Youngblood for his review prior to his testimony. (Record).

51) At hearing, in addition to ruling that Employer had waived its right to object to Dr. Jensen's October 20, 2017 report, an oral order also concluded this report was a "business record" under Alaska Civil Rule 803(6), and because there were no foundational objections the document was therefore admissible over Employer's objection. (Record).

52) Employer at hearing did not dispute Exhibit A to Employee's April 14, 2020 hearing brief and did not argue or present evidence contrary to the benefits Employee seeks. (Employer's Hearing Brief, April 14, 2020; record).

53) On April 23, 2020, Employee filed and served a supplemental attorney fee and cost affidavit and itemization, covering April 17, 2020 through April 23, 2020. She requested fees for an additional 24 hours preparing for and attending the hearing, totaling $9,600. She requested $1,470

for Dr. Barrington's PPI rating; it is unclear whether she seeks payment of this amount or reimbursement. Her revised total request is $39,240 in attorney fees and $269.26 in costs. Considering the nature, length and complexity of services performed and the significant benefits to Employee if she prevails, Employee's attorney fees are reasonable. (Supplemental Affidavit of Counsel in Support of Attorney's Fees and Costs, April 23, 2020).

54) It is often difficult to arrange for a physician's deposition or hearing testimony quickly because their medical appointments are frequently booked months in advance. It is usually easier to schedule a non-medical professional's testimony. (Experience).

PRINCIPLES OF LAW

> **AS 01.10.040. Words and phrases; meaning of "including."** (a) Words and phrases shall be construed according to the rules of grammar and according to their common and approved usage. Technical words and phrases and those that have acquired a particular and appropriate meaning, whether by legislative definition or otherwise, shall be construed according to the peculiar and appropriate meaning.
>
> (b) When the words "includes" or "including" are used in a law, they shall be construed as though followed by the phrase "but not limited to."

The board may base its decision on not only direct testimony, medical findings, 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." That "some reasonable persons may disagree with a subjective conclusion does not necessarily make that conclusion unreasonable." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987).

> **AS 23.30.010. Coverage.** (a) . . . compensation or benefits are payable under this chapter for disability . . . or the need for medical treatment of an employee if the disability . . . or the employee's need for medical treatment arose out of and in the course of the employment. . . . When determining whether or not the . . . 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 the need for medical treatment. Compensation or benefits under this chapter are payable for the disability . . . or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability . . . or need for medical treatment.

Construing §010(a), *Morrison v. Alaska Interstate Construction, Inc.*, 440 P.3d 224 (Alaska 2019), said the board must consider different causes of the "benefits sought" and the extent to which each

cause contributed to the need for the specific benefit at issue. The board must then identify one cause as "the substantial cause." *Morrison* said:

> The statutory language does not require the Board to look at the type of injury in identifying the substantial cause of the need for medical treatment. Alaska Statute 23.30.010(a) requires the Board to "evaluate the relative contribution of different causes of . . . the need for medical treatment." That subsection then provides, "Compensation or benefits under this chapter are payable for . . . medical treatment if, in relation to other causes, the employment is the substantial cause of the . . . need for medical treatment" (citation omitted). When read together, these sentences do not reflect an instruction to consider the type of *injury* when evaluating compensability; instead, they require the Board to look at the *cause* of the injury or symptoms to determine whether "the employment" was a cause important enough to bear legal responsibility for the medical treatment needed for the injury. (*Id*. at 233-34; emphasis in original).

Morrison held the statute does not require the substantial cause to be a "51% or greater cause, or even the primary cause, of the disability or need for medical treatment." The board need only find, which of all causes, "in its judgment is the most important or material cause related to that benefit." (*Id*.). *Morrison* further held that preexisting conditions, which a work injury aggravates, accelerates or combines with to cause disability or the need for medical treatment, can still constitute a compensable injury. (*Id*. at 234, 238-39). The board's decision need only be supported by "substantial evidence," which is such "relevant evidence as a reasonable mind might accept as adequate to support a conclusion." (*Id*. at 239.)

> **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. . . . 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. . . .

The presumption applies to any claim for compensation. *Meek v. Unocal Corp*., 914 P.2d 1276 (Alaska 1996). In the first step, the claimant need only adduce "minimal" relevant evidence

establishing a "preliminary link" between the injury and employment. *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.,* 742 P.2d 239, 244 (Alaska 1987). Credibility is not weighed here. *Resler v. Universal Services Inc.*, 778 P.2d 1146 (Alaska 1989). If the employee's evidence raises the presumption, it attaches to the claim and the production burden shifts to the employer.

In the second step, the employer has the burden to overcome the presumption with substantial evidence to the contrary. *Tolbert v. Alascom, Inc.*, 973 P.2d 603 (Alaska 1999). Credibility is not examined at the second step either. *Resler*. Further addressing substantial evidence to rebut the presumption, *Huit v. Ashwater Burns, Inc.*, 372 P.3d 904 (Alaska 2016), said an employer can rebut the presumption by showing the worker's injury did not arise out of his employment. To do so, it needs to show the work injury could not have caused the condition requiring treatment or causing disability (the negative-evidence test) or that another, non-work-related event or condition caused it (the affirmative-evidence test).

In the third step, if the employer's evidence rebuts the presumption, it drops out and the employee must prove his claim by a preponderance of the evidence. *Huit* held in determining whether the disability or need for treatment arose out of and in the course of employment, the factfinders in the third step must evaluate the relative contribution of different causes of the disability or need for treatment. The employee must "induce a belief" in the fact-finders' minds that the asserted facts are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). However, *Huit* found if "no other cause was identified" as contributing to the employee's injury, the board need not evaluate the relative contribution of different causes in the third step. The evidence is weighed, inferences drawn and credibility determined. *Steffey v. Municipality of Anchorage*, 1 P.3d 685 (Alaska 2000).

> **AS 23.30.122. Credibility of witnesses.** The board has the sole power to determine the credibility of a witness. . . .

The board's credibility finding "is binding for any review of the Board's factual findings." *Smith v. CSK Auto, Inc.,* 204 P.3d 1001, 1008 (Alaska 2009). When doctors disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.*, AWCAC Decision. No. 087 (August 25, 2008).

> **AS 23.30.145. Attorney fees.** (a) Fees for legal services rendered in respect to a claim are not valid unless approved by the board, and the fees may not be less than 25 percent on the first $1,000 of compensation or part of the first $1,000 of compensation, and 10 percent of all sums in excess of $1,000 of compensation. When the board advises that a claim has been controverted . . . the board may direct that the fees for legal services be paid by the employer or carrier in addition to compensation awarded; the fees may be allowed only on the amount of compensation controverted and awarded. . . . In determining the amount of fees the board shall take into consideration the nature, length, and complexity of the services performed, transportation charges, and the benefits resulting from the services to the compensation beneficiaries. . . .

Attorney fees in these cases should be fully compensatory and reasonable so injured workers can retain competent counsel. *Cortay v. Silver Bay Logging,* 787 P.2d 103 (Alaska 1990).

> **AS 23.30.155. Payment of compensation**. . . .
> . . . .
>
> (p) An employer shall pay interest on compensation that is not paid when due. . . .

> **AS 23.30.185. Compensation for temporary total disability.** In case of disability total in character but temporary in quality, 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the disability. Temporary total disability benefits may not be paid for any period of disability occurring after the date of medical stability.

> **AS 23.30.190. Compensation for permanent partial impairment; rating guides**. (a) In case of impairment partial in character but permanent in quality, and not resulting in permanent total disability, the compensation is $177,000 multiplied by the employee's percentage of permanent impairment of the whole person. . . .

> **8 AAC 45.052. Medical summary.** (a) A medical summary on form 07-6103, listing each medical report in the claimant's or petitioner's possession which is or may be relevant to the claim or petition, must be filed with a claim or petition. The claimant or petitioner shall serve a copy of the summary form, along with copies of the medical reports, upon all parties to the case and shall file the original summary form with the board.
> . . . .
>
> (c) Except as provided in (f) of this section, a party filing an affidavit of readiness for hearing must attach an updated medical summary, on form 07-6103, if any new medical reports have been obtained since the last medical summary was filed.
>
> (1) If the party filing an affidavit of readiness for hearing wants the opportunity to cross-examine the author of a medical report listed on the medical summaries

that have been filed, the party must file with the board, and serve upon all parties, a request for cross-examination, together with the affidavit of readiness for hearing and an updated medical summary and copies of the medical reports listed on the medical summary, if required under this section.

(2) If a party served with an affidavit of readiness for hearing wants the opportunity to cross-examine the author of a medical report listed on the medical summaries filed as of the date of service of the affidavit of readiness for hearing, a request for cross-examination must be filed with the board, and served upon all parties, within 10 days after service of the affidavit of readiness for hearing.

(3) After an affidavit of readiness for hearing has been filed, and until the claim is heard or otherwise resolved,

> (A) all updated medical summaries must be accompanied by a request for cross-examination if the party filing the updated medical summary wants the opportunity to cross-examine the author of a medical report listed on the updated medical summary; and
>
> (B) if a party served with an updated medical summary and copies of the medical reports listed on the medical summary wants the opportunity to cross-examine the author of a medical report listed on the updated medical summary, a request for cross-examination must be filed with the board and served upon all parties within 10 days after service of the updated medical summary.

(4) If an updated medical summary is filed and served less than 20 days before a hearing, the board will rely upon a medical report listed in the updated medical summary only if the parties expressly waive the right to cross-examination, or if the board determines that the medical report listed on the updated summary is admissible under a hearsay exception of the Alaska Rules of Evidence.

(5) A request for cross-examination must specifically identify the document by date and author, generally describe the type of document, state the name of the person to be cross-examined, state a specific reason why cross-examination is requested, be timely filed under (2) of this subsection, and be served upon all parties.

> (A) If a request for cross-examination is not in accordance with this section, the party waives the right to request cross-examination regarding a medical report listed on the updated medical summary.
>
> (B) If a party waived the right to request cross-examination of an author of a medical report listed on a medical summary that was filed in accordance with this section, at the hearing the party may present as the party's witness

> the testimony of the author of a medical report listed on a medical summary filed under this section.

(d) After a claim or petition is filed, all parties must file with the board an updated medical summary form within five days after getting an additional medical report. A copy of the medical summary form, together with copies of the medical reports listed on the form, must be served upon all parties at the time the medical summary is filed with the board.

8 AAC 45.120. Evidence. . . .

. . . .

(f) Any document, including a compensation report, controversion notice, claim, application for adjustment of claim, request for a conference, affidavit of readiness for hearing, petition, answer, or a prehearing summary, that is served upon the parties, accompanied by proof of service, and that is in the board's possession 20 or more days before hearing, will, in the board's discretion, be relied upon by the board in reaching a decision unless a written request for an opportunity to cross-examine the document's author is filed with the board and served upon all parties at least 10 days before the hearing. The right to request cross-examination specified in this subsection does not apply to medical reports filed in accordance with 8 AAC 45.052; a cross-examination request for the author of a medical report must be made in accordance with 8 AAC 45.052.

. . . .

(h) If a request is filed in accordance with (f) of this section, an opportunity for cross-examination will be provided unless the request is withdrawn or the board determines that

(1) under a hearsay exception of the Alaska Rules of Evidence, the document is admissible;
(2) the document is not hearsay under the Alaska Rules of Evidence; or
(3) the document is a report of an examination performed by a physician chosen by the board under AS 23.30.095(k) or AS 23.30.110(g). . . .

8 AAC 45.900. Definitions. (a) In this chapter

. . . .

(11) "Smallwood objection" means an objection to the introduction into evidence of written medical reports in place of direct testimony by a physician; see Commercial Union Insurance Companies v. Smallwood, 550 P.2d 1261 (Alaska 1976). . .

> **Evidence Rule 803. Hearsay Exceptions-Availability of Declarant Immaterial**. The following are not excluded by the hearsay rule, even though the declarant is available as a witness:
> . . . .
>
> (6) **Business Records**. A memorandum, report, record, or data compilation, in any form, of acts, events, conditions, opinions, or diagnoses, made at or near the time by, or from information transmitted by, a person with knowledge acquired of a regularly conducted business activity, and if it was the regular practice of that business activity to make and keep the memorandum, report, record, or data compilation, all as shown by the testimony of the custodian or other qualified witness, unless the source of information or the method or circumstances of preparation indicate lack of trustworthiness. The term ‘business' as used in this paragraph includes business, institution, association, profession, occupation, and calling of every kind, whether or not conducted for profit.

In *Dobos v. Ingersoll*, 9 P.3d 1020 (Alaska 2000), a personal injury case, the Alaska Supreme Court held “medical records, including doctors’ chart notes, opinions, and diagnoses, fall squarely within the business records exception to the hearsay rule,” unless there is some reason to doubt the records’ authenticity. *Id.* at 1027. Ingersoll asked Dobos to admit that Ingersoll's medical records were genuine under the Alaska Civil Rules. Dobos refused, arguing the evidence was hearsay. He wanted Ingersoll to put the witnesses on the stand at her expense so he could question them. During trial, Ingersoll called her doctors to testify and lay a foundation for the records. On appeal, the Alaska Supreme Court noted medical records are exceptions to the hearsay rule under Evidence Rule 803(6) and remanded back to the trial court for sanctions against Dobos for failing to admit the genuineness of Ingersoll’s medical records. The court reasoned, “Requiring testimony that medical records were made and kept in the regular course of business is a waste of time unless there is some reason to believe that the records are not genuine or trustworthy.” *Id.* at 1028. Further, the Court said Dobos could have called Ingersoll’s doctors to the stand himself after he denied Ingersoll’s request to admit their records. *Id.* at 1028.

In *Meili v. Sterling Assisted Living, Inc*., AWCB Decision No. 20-0010 (February 28, 2020), the board declined to allow testimony from an EME and declined to consider articles from learned treatises because they were obtained after the hearing was over. The employer in *Meili* did not demonstrate that the “newly discovered” information could not have been provided through due

diligence before the merits hearing. The "newly-obtained" testimony and material was not considered because it was simply a backdoor route to retrying the case.

In *Lindhag v. State, Department of Natural Resources*, 123 P.3d 948 (Alaska 2005), the Alaska Supreme Court explained the *post hoc ergo proptor hoc* logical fallacy. Just because a claimant's asthma diagnosis came after a workplace exposure does not mean the exposure caused the asthma.

ANALYSIS

1) Was the order admitting articles from learned treatises correct?

At hearing, Employee objected to various CTS articles Employer filed, which came from learned treatises; it obtained these documents from SIME Dr. Slutsky. Employer filed and served these articles on February 21, 2020, clearly more than 20 days before the April 21, 2020 hearing. The applicable regulation §120(f) uses the word "including" meaning the documents affected by this subsection are not limited to those listed. Thus, the regulation is broad enough to apply to documents from learned treatises. AS 01.10.040(a), (b). Employee did not file a request to cross-examine these documents' authors. Further, *Meili* is distinguished from this case; in *Meili* the employer tried to submit post-decision evidence without showing it could not have obtained it with due diligence before the merits hearing. For these reasons, the oral order admitting articles from learned treatises was correct.

2) Was the oral order refusing to strike a medical record correct?

On February 22, 2018, Employee filed Dr. Jensen's medical records on a medical summary as required under §052(a), (d). On February 28, 2018, Employer filed a request for cross-examination on Dr. Jensen's reports. 8 AAC 45.900(11). On December 23, 2019, Employee filed her only Affidavit of Readiness for Hearing. At hearing on April 21, 2020, Employer waived objection to all records on the February 22, 2018 medical summary except Dr. Jensen's October 20, 2017 report. Employer contended it Smallwooded that report on February 28, 2018, Employee did not present Dr. Jensen for questioning and consequently his report was inadmissible as evidence. Employee contended Employer did not follow the applicable regulation and did not file its

Smallwood objection within 10 days after she filed her December 23, 2019 Affidavit of Readiness for Hearing, under §052(c)(2). An oral order at hearing ruled in Employee's favor on this issue.

Employer contended it should not have to file more than one Smallwood objection to the same medical report. It relies on §120(f), which states any document, including but not limited to those listed, filed and served upon the parties and in the agency file 20 or more days before hearing will be relied upon unless a written request for an opportunity to cross-examine the document's author is filed at least 10 days before the hearing. Because it filed its February 28, 2018 request for cross-examination on Dr. Jensen's October 20, 2017 report over two years before the hearing, Employer contends it satisfied its duty. Although the word "including" in §120(f) makes it broad enough under AS 01.10.040 to include documents other than those listed, §120(f) makes two specific exceptions regarding medical records. First, the right to request cross-examination specified in §120(f) expressly "does not apply to medical reports filed in accordance with 8 AAC 45.052." A Smallwood objection under §052 must be made in accordance with procedures under §052. Second, the Smallwood request made under §120(f) expressly does not apply to SIME physicians' reports. 8 AAC 45.120(f), (h).

Attending physician Dr. Jensen's October 20, 2017 report was required to be, and was, filed on a medical summary under §052(a), (d). Therefore, the specific procedure for Smallwooding that report fell under §052(c)(2), which states if a party served with an affidavit of readiness for hearing wants to cross-examine the author "of a medical report listed on the medical summaries filed as of the date of service of the affidavit of readiness for hearing," its Smallwood request must be filed and served "within 10 days *after* service of the affidavit of readiness for hearing" (emphasis added). Since Employer did not Smallwood Dr. Jensen's October 20, 2017 report within10 days after December 23, 2019, the date Employee filed her affidavit of readiness for hearing, it waived its objection to that report and it can be considered as evidence. 8 AAC 45.052(c)(5)(A), (B).

Employer contended this interpretation violates norms in statutory construction and renders §120(f) superfluous. It also contended it unnecessarily requires two Smallwood objections to the same report, which raises form over substance. But Employer's contention renders §052(c)(2) superfluous and ignores the differences between medical reports and other documentary evidence

a party could file. Regulations §052 and §120(f) serve different purposes; §052 addresses only medical records (excepting SIME reports, which have their own rules) while §120(f) addresses everything else. When promulgating these regulations, the division determined different requirements for Smallwooding different documents were important. For example, experience shows it is difficult at times to arrange for and obtain testimony from an EME or attending physician; these individuals are often scheduled to provide medical services weeks or months in advance. The authors of non-medical documents are typically easier to arrange for cross-examination. *Rogers & Babler*. This is especially true because the time between a party filing an Affidavit of Readiness for Hearing and the time a hearing is held is typically much shorter than the time between a party filing a claim and the time they become fully prepared for a hearing.

It would have made no sense for Employee, shortly after Employer's February 28, 2018 Smallwood objection, to depose Dr. Jensen; the parties' discovery was not yet complete, there had been no SIME and neither party was ready for hearing. She could not have known her hearing would occur on April 21, 2020, and it would have been fruitless to ask the doctor about his availability to testify at hearing that far in the future even if she could have predicted when her hearing would occur. Had Employer followed §052(c)(2), and Smallwooded the October 20, 2017 report within 10 days of December 23, 2019, it would have given Employee notice that she had to either obtain hope Dr. Jensen's report was admissible over the Smallwood objection, or arrange for his cross-examination. Absent a timely Smallwood objection following her Affidavit of Readiness for Hearing, Employee had a right to expect the October 20, 2017 report was admissible. Furthermore, this interpretation does not require Employer to file two Smallwood objections. Under §052(c)(2), it only needed to file one -- "within 10 days after service of the affidavit of readiness for hearing." Thus, the oral order admitting the October 20, 2017 report was correct.

Alternately, in passing the designated chair also found the October 20, 2017 Jensen report was a "business record." Under §052(c)(4), factfinders will not rely on a Smallwooded medical record unless a party expressly waives its right to cross-examine the record's author, or the medical record is admissible under a hearsay exception in Alaska's evidence rules. Alaska Evidence Rule 803(6) refers to "business records" as admissible exceptions to the hearsay rule. Rule 803(6) specifically identifies such records to include a "report, record . . . in any form, of acts, events, conditions,

opinions, or diagnoses, made at or near the time by, or from information transmitted by, a person with knowledge acquired of a regularly conducted business activity." This fits Dr. Jensen's report perfectly. If it was the "regular practice of that business activity to make and keep the memorandum, report, [or] record" the document is an admissible business record absent a valid foundational objection. Employer made no foundational objections to this report; the Alaska Supreme Court in *Dobos* admonished an attorney for insisting a party call a medical witness to lay a foundation for what were clearly medical records. Dr. Jensen's subject record is a routine, contemporaneous chart note similar to thousands like it presented as evidence in workers' compensation cases. *Rogers & Babler*. The fact Dr. Jensen gave Rule 803(6) "opinions" on another physician's report does not change his report from being a "business record" into something else. It was not a letter written to an attorney in response to questions; Dr. Jensen wrote it before Employee's November 16, 2017 initial consultation with Porcello and was written in the context of a regular examination. For this additional reason, the oral order admitting it over Employer's objection was correct because the medical record in question would have been admitted as a business record under Rule 803(6) even had the Smallwood objection been timely.

3) Did Employee's CTS arise out of and in the course of her employment with Employer?

Employer's primary contention in this case is, "Does science matter?" It contends medical evidence does not support Employee's claim because the physicians supporting her position on causation do not base their opinions on "scientific evidence." It contends only Dr. Youngblood's opinion is based on scientific evidence and it does not support Employee's claim. Employee contends the overwhelming lay, and medical evidence from several physicians, including two hand specialist, is substantial evidence supporting her CTS claim. These factual disputes raise questions to which the statutory presumption analysis applies. AS 23.30.120(a)(1); *Meek*.

Without regard to credibility, Employee raises the presumption that her CTS claim is compensable through her lay testimony and through expert medical opinions from Drs. Jensen and Slutsky. Employee testified she had no CTS symptoms before working for Employer at her current job, which requires intensive and repetitive bilateral hand and wrist movements, and developed CTS symptoms in both hands shortly thereafter. Her symptoms waned overnight and disappeared on weekends only to return within two hours of going to work each morning. Dr. Jensen opined on a

more probable than not basis the etiology of her CTS should be considered the workplace activity. SIME Dr. Slutsky stated “in all medical probability” her CTS symptoms are “causally related to her normal work-related activities.” *Resler*; *Cheeks*.

Without regard to credibility, Employer rebuts the raised presumption with Dr. Youngblood’s opinion. He said Employee’s work activities “would not be deemed the substantial cause” of the need for current or subsequent treatment. He suggested Employee’s age, gender and obesity were the substantial cause. *Resler*; *Tolbert*. The burden shifts to Employee to prove her claim by a preponderance of the evidence. *Huit*; *Saxton*.

There are no CTS symptoms, diagnoses or surgery in Employee’s medical history or her family history. Her symptoms began a few months after starting her current job, which is repetitive-hand-movement-intensive. Her symptoms subsided gradually after she went home each night and promptly resumed within two hours after she returned to work each day. Employee had no other injury to her bilateral hands and does not use a computer at home and is not a gamer. Her lay testimony is credible, persuasive and supported by her medical records. AS 23.30.122; *Smith*.

In addition to Employee’s convincing lay testimony, Dr. Reeves suspected CTS. Dr. Downs similarly suspected CTS given her job duties. Her left-wrist MRI showed “some flattening” of the median nerve and carpal tunnel edema, correlating with her symptoms. Dr. Downs eventually diagnosed bilateral CTS although he did not specifically offer a causation opinion.

A few days after seeing Dr. Downs, Employee went to the emergency room on July 24, 2017, for left-wrist pain. Dr. LaVoy diagnosed CTS and provided her with material explaining this condition. The emergency-room-provided documents state “repeated wrist motion” can cause swelling within the carpal tunnel causing CTS. Since a major medical center provided this information, is credible and given some weight. AS 23.30.122; *Smith*.

Dr. Jensen, a hand specialist, was initially uncertain if Employee had CTS given her equivocal diagnostic studies and signs. Nevertheless, he administered a corticosteroid injection in the left carpal tunnel providing good relief; he eventually recommended left CTS surgery. After

considering Dr. Youngblood's opinions, Dr. Jensen examined Employee and diagnosed left greater than right CTS. He agreed obesity and aging are factors that cause worsening of her CTS. However, he also opined that on a more probable than not basis the workplace activity she described caused her CTS by more than a 50 percent probability. Because Dr. Jensen is a hand specialist, his opinions are credible and given significant weight. AS 23.30.122; *Smith*.

Lastly, Dr. Slutsky, an orthopedic surgeon with added qualifications in hand surgery, diagnosed bilateral CTS. Though he listed the wrong administrative injury date in one answer in his report, Dr. Slutsky said Employee's signs and symptoms are due to her work-related injury and she had no preexisting condition. Her bilateral CTS contribute 100 percent to her disability and need for medical treatment. Her work was "the substantial cause of the claimant's disability." Dr. Slutsky noted Employee's repetitive work with her upper extremities and estimated how many times she would depress a button with her left hand over a six-month period. He concluded her CTS symptoms are "causally related to her normal work-related activities." Later, in response to Employer's request for additional information, he provided articles from learned treatises, which he read to suggest that repetitive hand movement at the wrist is a risk factor for causing CTS. As a surgeon with added qualifications for hands, Dr. Slutsky's opinions are credible and are given considerable weight. AS 23.30.122; *Smith*; *Huit*; *Steffey*.

By contrast, only Dr. Youngblood supports Employer's position. Though an orthopedic surgeon who has performed CTS surgery, Dr. Youngblood's focus is on lower extremities. He primarily focuses on Employee's obesity, as opposed to her work for Employer, as the substantial cause of her CTS. He bases this opinion on his reliance on studies from learned treatises. There are several problems with Dr. Youngblood's opinion.

First, though Employee meets the medical definition of "obese," Dr. Umbach on January 31, 2018 charted Employee's "long history of morbid obesity." Presumably, this "long history" extends before she began her job with Employer two years earlier in 2016. *Rogers & Babler*. One would think if obesity was the substantial cause of Employee's CTS, it would have caused CTS symptoms, need for treatment and disability long before 2016. There is no evidence of that.

Second, after her most recent abdominal surgery, by May 2018, Employee's weight reduced to 205 pounds, a dramatic decrease. Though this weight may still fit the medical definition of "obese," her CTS symptoms do not appear to have abated as one might expect they would if obesity was the substantial cause of her CTS symptoms.

Third, Employer contends "science" does not support Employee's causation position because selected statistical studies and Dr. Youngblood's opinion do not show a relationship between "keyboarding" or "data entry" and CTS. However, Employer cites to no statute, regulation or relevant case law suggesting that an attending doctor's opinion, or this decision, must be supported by a double-blind, placebo-controlled study. This decision need only be supported by "substantial evidence," which is such "relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Morrison*. It is extremely unlikely that a reasonable person seeking a CTS diagnosis and causation opinion would ask their attending physician if their opinion is backed up by any scientific studies. A reasonable mind would accept a hand expert's medical opinion that her work probably caused her to develop CTS symptoms ultimately diagnosed as CTS. *Rogers & Babler*. Dr. Youngblood conceded that the studies upon which he relied were statistical studies demonstrating risk factors; if a person has one or more risk factors, it does not necessarily mean that person will develop CTS; he could not correlate any study to Employee's specific case.

Fourth, Drs. Slutsky and Youngblood disagree on how to interpret some studies. Furthermore, though Dr. Youngblood likens Employee's work to simple keyboarding Drs. Jensen and Slutsky do not. All three physicians are scientists. Employer criticizes Dr. Slutsky for charging it for providing medical articles, which he believes support his opinions, and implies he had none before he wrote his report. As mentioned, there is no requirement that a physician support his or her opinions with articles from learned treatises. Moreover, Employer asked Dr. Slutsky to provide studies upon which he relied in forming his opinions. It is unreasonable for Employer to imply that Dr. Slutsky would have such articles committed to his memory or at his fingertips. It is far more likely Dr. Slutsky was aware there are such studies that he interprets as supporting his views, which he researched and provided at Employer's express request. Drs. Jensen and Slutsky are both hand specialists, while Dr. Youngblood is not. Drs. Jensen and Slutsky are more credible and their opinions will be given more weight. AS 23.30.122; *Smith*; *Steffey*; *Moore*.

Fifth, no study cited by Dr. Youngblood expressly stated the work Employee was performing for Employer when she developed CTS symptoms could not cause those symptoms. Dr. Youngblood did not so state either; to the contrary, he admitted "the condition may be more symptomatic during the described work activities." At best, all he could state was that in his view a majority of scientific studies showed keyboarding was not a risk-factor for CTS. Moreover, this decision disagrees with his assessment that Employee's work was essentially keyboarding or "data entry"; it was more physically demanding on her hands than that. *Saxton*.

Employer contends that neither Dr. Jensen nor Dr. Slutsky ever expressly weighed the relative contribution of different causes of Employee's disability or need for medical treatment and then decided work was the substantial cause, under §010(a). However, causation is an administrative decision. The Act does not require a physician to perform this weighing; the fact-finders are expressly directed to make this determination. AS 23.30.010(a); *Morrison*.

Employer contends medical opinions on which Employee relies relate only to her left CTS and do not apply to her right. But Drs. Jensen and Slutsky both agree Employee's work is the substantial cause of her CTS in both hands. Both physicians had detailed explanations of Employee's work using both hands and the resultant symptoms, left greater than right. That Dr. Slutsky emphasized the left hand in his reports does not alter his explicit opinions on bilateral causation.

The evidence suggests there are several risk- and causative-factors for Employee's bilateral CTS: diabetes; female gender; obesity; repetitive hand movements; genetics; biopsychosocial factors and age. There is no evidence Employee has diabetes; with one exception when her blood sugar was slightly elevated, all her sugar levels were within normal limits. Further, no physician diagnosed her with diabetes. There is no disputing Employee is female; presumably she has always been female; but she never developed CTS until she began working for Employer at this hand-intensive position. She meets the definition of "obese," but as discussed above, she has met that definition for years yet did not develop CTS until she began this job. When her weight went down dramatically, her CTS symptoms did not abate. There is no question Employee's job involves repetitive hand movements; two hand experts disagree with a lower extremity expert on the medical consequences of these movements. Genetics can be ruled out; even Dr. Youngblood

admitted his initial "genetics" opinion did not mean a finding based on DNA testing; it meant family history and her general body habitus. But there is no evidence Employee or any member of her family ever had CTS symptoms, diagnoses or surgeries. It is unclear how biopsychosocial factors can cause swelling in Employee's bilateral carpal tunnel to cause CTS. Lastly, Employee has reached an age that is considered a risk factor for developing CTS. But clearly, not every person Employee's age develops CTS. *Rogers & Babler*. Dr. Youngblood's combined risk-factors do not conform to the statute and case law, which require this decision to identify "the" substantial cause, and not a group of risk-factors added together as the substantial cause.

On balance, and given the above analyses and medical opinions, Employee's work with Employer as she described it, compared to all other possible risk- and causative-factors, is the substantial cause of her bilateral CTS in accordance with §010(a) and *Morrison*. No physician suggests Employee had preexisting CTS; all who opined say she did not. Dr. Youngblood's comment that she did not have preexisting CTS "per se," is unclear and confusing as is his comment that "the condition may be more symptomatic during the described work activities." A condition becoming more symptomatic implies the condition already exists. Either she had a preexisting CTS or she did not. The normal causation test under §010(a) is whether the employment is the substantial cause of disability or need for medical treatment; the law does not require the work to be the substantial cause of the actual condition, CTS. In this instance, except for Dr. Youngblood's confusing opinion, all physicians opining on causation stated the work with Employer actually caused the CTS condition itself. Substantial evidence supports a finding that Employee's CTS arose out of and in the course of her employment with Employer. This proof far exceeds the level required for Employee to prove her case under §010(a) and *Morrison*. *Saxton*.

The above evidence and analyses are not a *post hoc ergo proptor hoc* conclusion. *Lindhag*. In the *post hoc* logical fallacy, a person concludes that an event following an act necessarily was caused by the act. For example, using this fallacy, a person driving down the road who sees a black cat cross the street in front of his car may conclude that the black cat caused his car to crash several miles down the road. In other words, the driver concludes that one event necessarily and inescapably led to the other. The obvious problem with this logic is that there is no possibility that a black cat simply running across the road can cause an automobile to crash several miles later.

The medical evidence in this case not only suggests it is possible Employee's bilateral CTS developed from her employment with Employer, but more likely than not, it did. Nothing in the evidence Employer presented states this conclusion is impossible. Most notably, Dr. Youngblood agreed Employee's risk factors, including female gender, age, and obesity, "predisposed" her to develop CTS. Accordingly, it is not surprising that her intense, repetitive hand movements at work for Employer, given her scientifically proven, preexisting risk-factors, resulted in bilateral CTS especially in light of the combined risk-factors she had, noted by Dr. Youngblood.

4) Is Employee entitled to a TTD benefit award for her left CTS?

Employee seeks TTD benefits for her left CTS. AS 23.30.185. Employer's main contention was that Employee's CTS did not arise out of her employment. It did not dispute Employee's request for benefits listed in her hearing brief, Exhibit A. It did not offer contrary evidence or argument to Employee's TTD benefit calculations. Since this decision finds the left CTS covered under §010(a), Employee is entitled to TTD benefits. Employer will be ordered to pay TTD benefits in accordance with calculations set forth in Employee's Exhibit A.

5) Is Employee entitled to a PPI benefit award for her left CTS?

She also seeks PPI benefits. AS 23.30.190. The same analysis applies to her left CTS PPI benefit claim. Dr. Barrington provided a sixth edition AMA *Guides* PPI rating totaling three percent whole-person impairment. There is no contrary rating. Employer will be ordered to pay Employee $5,310 in PPI benefits.

6) Is Employee entitled to medical care and related transportation expenses for her CTS?

Employee seeks medical benefits. AS 23.30.095(a). Similarly, as there is no objection to the treatment for Employee's left CTS, Employee is entitled to reasonable and necessary medical care and related transportation expenses for her left CTS. Employer will be ordered to reimburse Employee, and pay her outstanding medical bills related to her left CTS, in accordance with her hearing brief Exhibit A. Since this decision found her bilateral CTS compensable under §010(a), she is also entitled to reasonable and necessary medical care for her right CTS. Further, Employer will be ordered to pay directly to Employee's medical providers all medical bills Employee has

provided to date for her bilateral CTS, in accordance with the Act and the medical fee schedule. To the extent Employee's private health insurance has paid some of these bills, the providers will reimburse the healthcare providers. It is unclear from the record if Dr. Barrington's bill for providing a PPI rating has been paid. If it has not been paid for this service, Employer will be directed to pay it in accordance with the medical fee schedule. If Employee has paid his bill, Employer will be directed to reimburse her in accordance with the fee schedule.

7) Is Employee entitled to interest, attorney fees and costs?

Employee requests interest. Interest is mandatory and will be awarded under AS 23.30.155(p). She also requests attorney fees and costs. AS 23.30.145(a). Employer offered no objection to Employee's request for attorney fees and costs, other than a complete denial based on its primary defense. Employee prevailed on her claim; her claimed attorney fees and costs reasonable and meet all requirements under §145(a). While the agency's electronic file contains no formal controversion notice, there is one attached to Employee's brief. In any event, Employer clearly resisted paying benefits and Employee is entitled to attorney fees and costs. Therefore, Employee will be awarded $39,240 in attorney fees and $269.26 in costs under AS 23.30.145(a). *Cortay*.

CONCLUSIONS OF LAW

1) The order admitting articles from learned treatises was correct.
2) The oral order refusing to strike a medical record was correct.
3) Employee's CTS did arise out of and in the course of her employment with Employer.
4) Employee is entitled to a TTD benefit award for her left CTS.
5) Employee is entitled to a PPI benefit award for her left CTS.
6) Employee is entitled to medical care and related transportation expenses for her CTS.
7) Employee is entitled to interest, attorney fees and costs.

ORDER

1) Employer will pay Employee TTD benefits from July 24, 2017 through July 26, 2017, July 27, 2017 through July 30, 2017, July 29, 2019 through September 2, 2019, and October 23, 2019 through October 25, 2019, totaling $3,959.44.

2) Employer will pay Employee PPI benefits totaling $5,310.

3) Employer will reimburse Employee for her payments to Alaska Hand Rehabilitation totaling $748.43 and to Dr. Downs totaling $445 and will pay Dr. Downs $200 still owed, all in accordance with the fee schedule.

4) Employer will reimburse Employee for work-injury-related prescriptions she purchased totaling $35.02 and medical mileage totaling $237.

5) Employer will pay to Employee, or to her providers, interest in accordance with the Act.

6) Employer will process all CTS bills and pay Employee’s medical providers for services rendered in respect to her bilateral CTS in accordance with the Act and the medical fee schedule.

7) Employer will pay to Employee’s attorney $39,240 in attorney fees and $269.26 in costs.

8) Employer will pay Dr. Barrington’s fee for his PPI rating, or will reimburse the appropriate person if his bill has already been paid, all in accordance with the fee schedule.

9) Employee’s bilateral CTS conditions are compensable.

Dated in Anchorage, Alaska on May 21, 2020.

ALASKA WORKERS’ COMPENSATION BOARD

/s/
William Soule, Designated Chair

/s/
Nancy Shaw, Member

/s
Robert C. Weel, Member

If compensation is payable under terms of this decision, it is due on the date of issue. A penalty of 25 percent will accrue if not paid within 14 days of the due date, unless an interlocutory order staying payment is obtained in the Alaska Workers’ Compensation Appeals Commission.

If compensation awarded is not paid within 30 days of this decision, the person to whom the awarded compensation is payable may, within one year after the default of payment, request from the board a supplementary order declaring the amount of the default.

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 Shannon Rae Corona, employee / claimant v. State oF Alaska, employer; defendant; Case No. 201709310; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on May 21, 2020.

/s/
Nenita Farmer, Office Assistant