No. 74413-5

IN THE COURT OF APPEALS
OF THE STATE OF WASHINGTON
DIVISION I

938164

LORI ANN HULL,

Appellant,

v.

PEACEHEALTH,

Respondent.

RESPONDENT'S PETITION FOR REVIEW TO THE SUPREME COURT

The Law Office of Gress & Clark

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TABLE OF AUTHORITIES

I. IDENTITY OF THE PETITIONER

This petition is brought by PeaceHealth, a self-insured employer, who was the respondent in the litigation in Court of Appeals Division One Docket No. 74413-5-I. PeaceHealth is the self-insured employer responsible for Industrial Insurance Claim No. SB43989. The claim was filed by Ms. LoriAnn Hull on or about **October 23, 2006.** (Clerks Papers, herein "CP" at 94 & 250-251).

II. INTRODUCTION

On September 26, 2016, under Docket No. 74413-5-I, the Court of Appeals issued an unpublished opinion in which they reversed the trial court and found in favor of LoriAnn Hull. They held that Ms. Hull's thoracic outlet syndrome and sequelae arose naturally and proximately out of the distinctive conditions of her employment with PeaceHealth. Due to the fact that the Court of Appeals considered work exposure that occurred subsequent to the date that Ms. Hull filed her industrial claim, PeaceHealth filed a motion for reconsideration on October 4, 2016. The Court of Appeals issued an Order denying PeaceHealth's motion for reconsideration on October 10, 2016.

Pursuant to RAP 13.4, PeaceHealth requests that the Supreme Court grant review of both the Court of Appeals Decision dated September 26, 2016 and of the Court of Appeals Order Denying PeaceHealth's Motion for Reconsideration dated October 10, 2016.

III. ISSUES PRESENTED FOR REVIEW

1. Did Ms. Hull's condition diagnosed as thoracic outlet syndrome and sequelae arise naturally and proximately from the distinctive conditions of her employment prior to October 23, 2006, which was the date her claim was filed?

The Supreme Court should grant review of this case because the Court of Appeals based its decision in consideration of Ms. Hull's work exposure that occurred after October 23, 2006. PeaceHealth believes the Court of Appeals erred as a matter of law. This case gives the Supreme Court an opportunity to substantiate the law as it is currently applied before the Board of Industrial Insurance Appeals. It additionally gives the Court an opportunity to clarify to lower courts that a fact-finder may only consider work exposure that occurred prior to the date that the claim was filed when evaluating which condition(s) are compensable as an occupational disease.

2. Did the Court of Appeals abuse its discretion when it denied PeaceHealth's Motion for Reconsideration?

In its decision, the Court of Appeals relied upon an application of the law that was not raised by Ms. Hull, nor was this application consistent with the law as it exists within the Industrial Insurance Act or with the law applied by the Board of Industrial Insurance Appeals and by the Department of Labor & Industries. In all likelihood, this was presumably due to inconsistencies in the record and in the pleadings, compounded by

the lack of oral argument. If the Court had reconsidered its opinion, it would have likely held that Ms. Hull's thoracic outlet syndrome should not have been allowed under this claim because the medical evidence overwhelmingly attributed its cause to work exposure that occurred after Ms. Hull's claim was filed on or about October 23, 2006.

IV. STATEMENT OF THE CASE

1. Procedural History:

Ms. Hull worked for PeaceHealth as an admitting representative and registration specialist in the emergency room. CP at 231. She filed an occupational disease claim for bilateral medial epicondylitis on October 23, 2006. CP at 94.

On September 13, 2013, the Department of Labor & Industries ("Department") directed PeaceHealth to accept thoracic outlet syndrome under the claim. PeaceHealth protested this order and on October 17, 2013, the Department amended the September 13, 2013 order and directed PeaceHealth to also accept pulmonary conditions, balance problems, dysphagia, and cricopharyngeal spasms as a consequence of Ms. Hull's subsequent treatment for thoracic outlet syndrome. The Department had also issued an order on May 1, 2013, directing PeaceHealth to allow an adjustment disorder with depressed mood condition as part of the occupational disease. For the purpose of this petition, these secondary conditions are herein referred to as the "sequelae" of Ms. Hull's thoracic

outlet syndrome. PeaceHealth does not dispute that the sequelae are related to the thoracic outlet syndrome.

On October 2, 2013, the Department directed PeaceHealth to authorize and pay for the prescription medication known as Cymbalta for treatment of the claimant's alleged thoracic outlet syndrome. PeaceHealth appealed the May 1, 2013, October 2, 2013, and October 17, 2013, Department orders to the Board of Industrial Insurance Appeals ("Board").

A hearing was held on May 23, 2014, before an Industrial Appeals Judge. The Industrial Appeals Judge published a Proposed Decision and Order on October 6, 2014 in which she affirmed all of the Department's orders under appeal. PeaceHealth filed a Petition for Review with the Board on November 18, 2014 and the Board issued an Order Denying the Petition for Review and adopting the Proposed Decision and Order as its own on December 8, 2014. In response, PeaceHealth filed an appeal to Superior Court in Whatcom County on the basis that the Board incorrectly affirmed the Department's orders.

The Superior Court held a bench trial and issued an order on December 2, 2015, which found in favor of PeaceHealth on all issues. CP at 823. Specifically, Judge Uhrig held that the claimant's thoracic outlet syndrome and sequelae did not arise naturally and proximately from Ms. Hull's distinctive conditions of employment. CP at 828. The Court of Appeals subsequently reversed Judge Uhrig's decision when it held that the thoracic outlet syndrome was allowable under this occupational

disease claim "because she began feeling pain in her shoulder about five months after filing the claim for her bilateral elbow condition and in those five months she continued to work." (Court of Appeals Dec. No 74413-5-I, at 8).

2. Summary of the Evidence:

While working for PeaceHealth, Ms. Hull's job duties included gathering and inputting patient information onto paper and then into the PeaceHealth's computer system. CP at 209-217. Ms. Hull sought medical treatment in late 2006 for pain in both her elbows. She was diagnosed with bilateral medial epicondylitis (golfer's elbow) when she initially filed her industrial insurance claim. CP at 239 & 251. Her bilateral elbow condition was allowed as a condition proximately caused by her distinctive conditions of employment. CP at 94.

Ms. Hull was released from work for a short time and then returned to work, at which point she indicated that she performed less reaching in the course of her job duties. CP at 260. However, roughly five months after she filed her claim for the bilateral elbow condition, she subsequently developed symptoms in her left shoulder and underwent a shoulder surgery. *Id.* Following the surgery, she complained of numbness, tingling, and temperature changes in her left upper arm. CP at 262. After her symptoms did not resolve, she underwent a thoracic outlet surgery which was followed by alleged muscle spasms and loss of balance. CP at

245. Additionally, she began to suffer from mental health problems following her second surgery. CP at 246.

Dr. Kremer, a general vascular and thoracic surgeon, conducted an Independent Medical Examination ("IME") on September 2, 2012. CP at 460 and 466. He indicated that Ms. Hull's occupational disease claim was initially the bilateral elbow condition and that her thoracic outlet syndrome did not develop until an entire year after she had filed her claim. CP at 477. He specifically stated that the diagnostic imaging studies from February of 2007 showed no indication of thoracic outlet syndrome. CP at 479. He also testified that there was no evidence that her thoracic condition and sequelae were proximately caused by her distinctive conditions of employment through November of 2006 because there would have been evidence of the condition in February of 2007. CP at 478-479. He also indicated that usually if a person has thoracic outlet syndrome, the symptoms will actively manifest when the person is doing the activity that is causing the condition. CP at 480.

Dr. Hughes, a general practitioner, evaluated Ms. Hull multiple times as her primary care physician prior to and subsequent to her filing the claim for bilateral epicondylitis in October of 2006. At the time the claim was filed, he indicated that the medical evidence showed that her only diagnosable condition and symptom complex was bilateral medial epicondylitis. CP at 437 and 441. He treated her in November of 2006 after she filed the claim and diagnosed her with bilateral medial

epicondylitis. CP at 439. When he saw Ms. Hull in January of 2007, he indicated that her condition had not changed in comparison with her presentation in November of 2006. *Id.* He referred her for electrodiagnostic studies which were performed on February 9, 2007 and did not show any evidence of thoracic outlet syndrome. CP at 440. He indicated that Ms. Hull reported that she was experiencing pain in her shoulder in July of 2007. CP at 441. He testified that she had no evidence of thoracic outlet syndrome up through July of 2007. CP at 445.

Dr. Hughes further indicated that if repetitive activity was going to cause or worsen thoracic outlet syndrome, he would expect the symptoms to be close in time to such an activity. CP at 450. He stated the symptoms, if due to repetitive work activity, would not come on over a year later. CP at 450-451. Finally, he concluded there was no connection between her thoracic outlet syndrome and the elbow condition. CP at 451.

According to Dr. Johansen, the doctor who performed Ms. Hull's shoulder surgeries, she did not have symptoms consistent with thoracic outlet syndrome when she initially filed her claim for her bilateral elbow condition. CP at 752-753. In fact, Dr. Johansen indicated that she had actually developed the thoracic outlet syndrome sometime after November 2006. *Id.*

Dr. Johansen also admitted that his ultimate opinion in regards to what caused her thoracic outlet syndrome was based on employment conditions that occurred after the date of claim allowance. CP at 754-755.

During cross-examination, Dr. Johansen admitted that "like all of the consultants, I continue to be uncertain about exactly what is going on with [Ms. Hull]." CP at 765.

V. ARGUMENT

1. Ms. Hull's thoracic outlet syndrome did not arise naturally and proximately from the distinctive conditions of her employment as of the date she filed the claim, October 23, 2006.

Pursuant to RCW 51.08.140, an "occupational disease" means such disease or infection that arises naturally and proximately out of employment. A valid claim for occupational disease is a claim for exposure to distinctive conditions of employment causing a disease to develop. *Dennis v. Department of Labor & Indus.*, 745 P.2d 1295; 109 Wn.2d 467 (1987). Furthermore, according to the *Dennis* decision, "the causal connection between a claimant's physical condition and his or her employment must be established by competent medical testimony which shows that the disease is probably, as opposed to possibly, caused by the employment." 109 Wn.2d 467, at 477 (citing *Ehman v. Dep't of Labor & Indus.*, 33 Wn.2d 584; 206 P.2d 787 (1949)).

a. *The Court should confirm the Board's Significant Decision and hold that occupational diseases must be based on distinctive conditions of employment prior to the date of claim filing.*

According to a significant decision of the Board, in an adjudication regarding benefits stemming from an occupational disease, the adjudicator should only consider the employment through the date of claim filing. *In re: Mike J. Rasmussen*, BIIA Dec. 09 14857, at 10-11 (2009). In that case,

the Board was asked to determine whether an injured worker sustained an occupational disease prior to filing the claim or whether the occupational disease occurred after the claim was filed, thus making another employer responsible due to the last injurious exposure rule. As the Board noted, the last injurious exposure rule is intended to mitigate the burden on the worker in proving which employers were responsible for causing the occupational condition. *Id.* at 7. They further concluded that "the filing of a claim for an occupational disease requires consideration of the existence of a medical condition arising naturally and proximately out of the conditions of a worker's employment in addition to a determination of the insurer on the risk as of the last injurious exposure giving rise to the claim." *Id.* at 9.

In the *Rasmussen* significant decision, the Board reasoned that the adjudicator should only consider the employment through the date of claim filing because workers and potential subsequent employers would be subject to the uncertainty of who is responsible to pay benefits. *Id.* at 10.

If this rule is not followed, a worker could hypothetically sustain an occupational disease under one employer and then switch employers and potentially have a condition caused by the second employment exposure covered under the claim for the first employer. This would be contrary to the last injurious exposure rule. It would also be fundamentally unfair to the first employer who could potentially be subject to the risk

associated with employment exposure that is not of its own control. In the case at hand, Ms. Hull was working for the same employer – although with different working conditions – but the rule should still apply nonetheless because a worker could change job duties while with the same employer.

Additionally, as the Board pointed out in *Rasmussen*, but for the rule barring an inquiry into work exposure subsequent to the date of claim filing, "an incomplete or disputed claim could have a chilling effect on the employability of workers with occupational disease claims in progress." *Id.* at 10. This would be detrimental to injured workers who have suffered an occupational disease and are looking for new employment.

b. *WAC 296-14-350 and the Industrial Insurance Act supports PeaceHealth's position that an occupational disease must arise naturally and proximately from the distinctive conditions of employment prior to the date of claim filing.*

Pursuant to WAC 296-14-350 which states that "the liable insurer in occupational disease cases is the insurer on risk at the time of the last injurious exposure to the injurious substance or hazard of disease during employment [covered by the Industrial Insurance Act] which gave rise to the claim for compensation." This administrative rule implies that the only employment exposure that should be considered when determining compensability is the employment of the last injurious exposure prior to filing the claim. In Ms. Hull's case, the last injurious exposure rule is not an issue in dispute because she continued to work for PeaceHealth in

various limited capacities, but the rule should still apply for a number of reasons.

For example, pursuant to RCW 51.32.080(7), the monetary value of an injured worker's permanent partial disability ("PPD") award is governed by the schedule in effect at the date of injury or claim filing for an occupational disease. These schedules increase annually by amounts determined by the Department. Specifically, RCW 51.32.080(1)(b)(ii) states that awards for PPD shall be annually readjusted to reflect the percentage change in the consumer price index. The Department adjusts the value of the total body impairment and then all partial impairments are apportioned based upon a percentage of the total body impairment. If adjudicators were to look beyond the date of claim filing for injured workers, then it is likely the workers would be unjustly harmed by having what should be new claims, ham-fisted into previously filed claims in order to lower potential exposure for PPD awards. In fact, by looking at Ms. Hull's case, we can see how this framework would be detrimental to injured workers.

In the matter currently under dispute, the Court of Appeals indicated Ms. Hull's thoracic outlet syndrome and sequelae should be covered under this claim which was filed in 2006. However, her thoracic outlet syndrome did not manifest until the second half of 2007 and, according to the medical experts, it was not proximately caused by the work exposure prior to her filing the claim. If she would have filed a new

occupational disease claim for her thoracic outlet syndrome and received PPD, it would be based on the schedule for the year 2007. Assuming her impairment ratings for the thoracic outlet syndrome and the sequelae would have been the same regardless of which claim it was under, she would receive a larger PPD award under the properly filed 2007 claim. The monetary difference between 2006 and 2007 total body impairment value is roughly $5,000.00.[1] Even a one-year difference can be substantial, but the economic harm to the injured worker could be potentially much worse for each additional year. This could potentially incentivize employers to group subsequent new injuries or occupational diseases into previously filed occupational claims to avoid paying larger PPD awards.

Additionally, an injured worker faces more monetary risk pursuant to RCW 51.08.178(1), which states that "the monthly wages an injured worker was receiving from all employment at the time of injury shall be the basis upon which compensation is computed unless otherwise provided specifically in the statute concerned." Hypothetically, one can envision a scenario where an injured worker suffered an occupational disease, subsequently gets a substantial pay raise, and then sustains a new and unrelated disease two years later. If the worker's new disease is grouped under the previous claim, then any time-loss compensation would be received at a much lower wage than if a new claim was filed.

[1] Comparing the *Permanent Partial Disability Category Awards* published by the Department of Labor & Industries on an annual basis. Appendix – 1.

As one can see based on the PPD and time-loss statutes, workers receive benefit when occupational diseases only consider work exposure prior to the date of claim filing. As such, it is essential for both injured workers and employers to administer occupational disease claims based on employment exposure that has already occurred and not subsequent employment exposure.

Essentially, the law can be succinctly summarized accordingly: If an injured worker who filed an occupational disease claim later works for the same or a subsequent employer and sustains a new condition or disease; then the trier-of-fact must determine whether it was a late arising disease or whether it relates back to the original condition for which the claim was filed. If the condition was not a late arising disease and was not secondary to the original condition, then a new claim must be filed. That is exactly what occurred in Ms. Hull's case and she should have filed a new occupational disease claim.

c. *Applying the law to the facts in this case, Ms. Hull's thoracic outlet syndrome and sequelae did not arise naturally and proximately from the distinctive conditions of employment as of October 23, 2006.*

As discussed in the factual summary, a substantial amount of medical evidence exists showing that Ms. Hull's thoracic outlet syndrome and sequelae did not arise naturally and proximately from the distinctive conditions of employment prior to October 23, 2006. The testimony of Dr. Kremer and Dr. Hughes both testified that Ms. Hull did not have thoracic outlet syndrome as of February 2017, according to objective

diagnostic testing. This was roughly four months after the claim was filed. In fact, there was no evidence of any shoulder pain or symptoms of thoracic outlet syndrome until July of 2007.

Even more persuasively, there is absolutely no evidence showing that Ms. Hull's thoracic outlet syndrome was proximately caused by work exposure prior to October 23, 2006. Dr. Johansen admitted that she did not have symptoms consistent with thoracic outlet syndrome when she initially filed her claim for her bilateral elbow condition. All three medical doctors who testified regarding the causation of thoracic outlet syndrome indicated that they would expect the condition to manifest concurrently with the activity that is causing it. This is to say that employment conditions that occurred in 2006 would not have caused thoracic outlet syndrome to manifest in July of 2007. In fact, Dr. Johansen admitted during cross-examination that Ms. Hull had actually developed her thoracic outlet syndrome sometime after 2006. This admission means that there is absolutely no evidence linking Ms. Hull's thoracic outlet syndrome to her distinctive conditions of employment prior to when the claim was filed on October 23, 2006.

2. The Court of Appeals abused its discretion by not granting PeaceHealth's Motion for Reconsideration.

Pursuant to RAP 12.4(c), a party may raise with particularity the points of law or fact which the moving party contends the Court has overlooked or misapprehended when requesting reconsideration. Here, PeaceHealth did just that and the Court denied its motion for

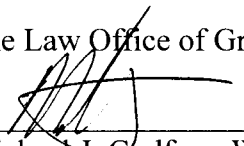
reconsideration which, considering the points of law raised, was an abuse of the Court's discretion. In its earlier briefing and in the record, both parties did not address the issue regarding what period of employment should be considered in contemplation of whether the thoracic outlet syndrome should be accepted under the claim. Perhaps it was taken for granted by the trial court and the parties that the occupational disease analysis was retrospective in terms of which employment exposure was under consideration. Regardless, the Court of Appeals should have reexamined its opinion when PeaceHealth pointed out that only that employment exposure that should be considered is that which occurred prior to the claim filing.

VI. CONCLUSION

The Supreme Court should grant review because the decision by the Court of Appeals is inconsistent with existing law. Ms. Hull filed her occupational disease claim on October 23, 2006. As a matter of law, if her thoracic outlet syndrome is going to be covered under the claim, then it must have arisen naturally and proximately out of the distinctive conditions of her employment prior to October 23, 2006. The Court of Appeals incorrectly relied upon conditions of employment subsequent to the claim being filed. By granting review, the Supreme Court has an opportunity to clarify any ambiguity currently held by lower courts. If the Court is unwilling to grant review, then it should remand this back to the Court of Appeals using the correct temporal framework for its analysis

regarding whether the thoracic outlet syndrome and sequelae should be allowed under this claim.

The Law Office of Gress & Clark



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Permanent Partial Disability Awards Schedule
for Dates of Injury from July 1, 2006 through June 30, 2007

LEG	
Leg above the knee joint with short thigh stump (3" or less below the tuberosity of ischium)	$98,486.85
Leg at or above the knee joint with functional stump	88,638.09
Leg below knee joint	78,789.51
Leg at ankle (syme)	68,940.78
FOOT	
Foot at mid-metatarsals	34,470.45
TOE	
Great toe with resection of metatarsal bone	20,682.27
Great toe at metatarsophalangeal joint	12,409.29
Great toe at interphalangeal joint	6,565.80
2nd lesser toe with resection of metatarsal bone	7,550.61
3rd lesser toe with resection of metatarsal bone	7,550.61
4th lesser toe with resection of metatarsal bone	7,550.61
5th lesser toe with resection of metatarsal bone	7,550.61
2nd lesser toe at metatarsophalangeal joint	3,676.77
3rd lesser toe at metatarsophalangeal joint	3,676.77
4th lesser toe at metatarsophalangeal joint	3,676.77
5th lesser toe at metatarsophalangeal joint	3,676.77
2nd lesser toe at proximal interphalangeal joint	2,724.84
3rd lesser toe at proximal interphalangeal joint	2,724.84
4th lesser toe at proximal interphalangeal joint	2,724.84
5th lesser toe at proximal interphalangeal joint	2,724.84
2nd lesser toe at distal interphalangeal joint	689.40
3rd lesser toe at distal interphalangeal joint	689.40
4th lesser toe at distal interphalangeal joint	689.40
5th lesser toe at distal interphalangeal joint	689.40
ARM	
Arm at or above the deltoid insertion or by disarticulation of the shoulder	98,486.85
Arm at any point below the deltoid insertion to below the elbow joint at the insertion of the biceps tendon	93,562.41
Arm at any point from below the elbow joint distal to the insertion of the biceps tendon to and including mid-metacarpal amputation of the hand	88,638.09
FINGER	
All fingers except the thumb at the metacarpophalangeal joints	53,182.77
Thumb at metacarpophalangeal joint or with resection of carpometacarpal bone	35,445.26
Thumb at interphalangeal joint	17,727.63
Index finger at metacarpophalangeal joint or with resection of metacarpal bone	22,159.56
Index finger at proximal interphalangeal joint	17,727.63
Index finger at distal interphalangeal joint	9,750.15
Middle finger at metacarpophalangeal joint or with resection of metacarpal bone	17,727.63
Middle finger at proximal interphalangeal joint	14,182.11
Middle finger at distal interphalangeal joint	7,977.48
Ring finger at metacarpophalangeal joint or with resection of metacarpal bone	8,863.83
Ring finger at proximal interphalangeal joint	7,091.07
Ring finger at distal interphalangeal joint	4,431.84
Little finger at metacarpophalangeal joint or with resection of metacarpal bone	4,431.84
Little finger at proximal interphalangeal joint	3,545.55
Little finger at distal interphalangeal joint	1,772.73
MISC.	
Loss of one eye by enucleation	39,394.65
Loss of central visual acuity in one eye	32,828.91
Complete loss of hearing in both ears	78,789.51
Complete loss of hearing in one ear	13,131.51
Compensation for unspecified disabilities of 100% as compared to total bodily impairment	164.144.61

Permanent Partial Disability Awards Schedule
for Dates of Injury from July 1, 2007 through June 30, 2008

LEG	
Leg above the knee joint with short thigh stump (3" or less below the tuberosity of ischium)	$101,628.57
Leg at or above the knee joint with functional stump	91,465.65
Leg below knee joint	81,302.91
Leg at ankle (syme)	71,139.99
FOOT	
Foot at mid-metatarsals	35,570.07
TOE	
Great toe with resection of metatarsal bone	21,342.03
Great toe at metatarsophalangeal joint	12,805.14
Great toe at interphalangeal joint	6,775.26
2nd lesser toe with resection of metatarsal bone	7,791.48
3rd lesser toe with resection of metatarsal bone	7,791.48
4th lesser toe with resection of metatarsal bone	7,791.48
5th lesser toe with resection of metatarsal bone	7,791.48
2nd lesser toe at metatarsophalangeal joint	3,794.07
3rd lesser toe at metatarsophalangeal joint	3,794.07
4th lesser toe at metatarsophalangeal joint	3,794.07
5th lesser toe at metatarsophalangeal joint	3,794.07
2nd lesser toe at proximal interphalangeal joint	2,811.75
3rd lesser toe at proximal interphalangeal joint	2,811.75
4th lesser toe at proximal interphalangeal joint	2,811.75
5th lesser toe at proximal interphalangeal joint	2,811.75
2nd lesser toe at distal interphalangeal joint	711.39
3rd lesser toe at distal interphalangeal joint	711.39
4th lesser toe at distal interphalangeal joint	711.39
5th lesser toe at distal interphalangeal joint	711.39
ARM	
Arm at or above the deltoid insertion or by disarticulation of the shoulder	101,628.57
Arm at any point below the deltoid insertion to below the elbow joint at the insertion of the biceps tendon	96,547.05
Arm at any point from below the elbow joint distal to the insertion of the biceps tendon to and including mid-metacarpal amputation of the hand	91,465.65
FINGER	
All fingers except the thumb at the metacarpophalangeal joints	54,879.30
Thumb at metacarpophalangeal joint or with resection of carpometacarpal bone	36,586.29
Thumb at interphalangeal joint	18,293.13
Index finger at metacarpophalangeal joint or with resection of metacarpal bone	22,866.45
Index finger at proximal interphalangeal joint	18,293.13
Index finger at distal interphalangeal joint	10,061.19
Middle finger at metacarpophalangeal joint or with resection of metacarpal bone	18,293.13
Middle finger at proximal interphalangeal joint	14,634.51
Middle finger at distal interphalangeal joint	8,231.97
Ring finger at metacarpophalangeal joint or with resection of metacarpal bone	9,146.58
Ring finger at proximal interphalangeal joint	7,317.27
Ring finger at distal interphalangeal joint	4,573.23
Little finger at metacarpophalangeal joint or with resection of metacarpal bone	4,573.23
Little finger at proximal interphalangeal joint	3,658.65
Little finger at distal interphalangeal joint	1,829.28
MISC.	
Loss of one eye by enucleation	40,651.35
Loss of central visual acuity in one eye	33,876.15
Complete loss of hearing in both ears	81,302.91
Complete loss of hearing in one ear	13,550.40
Compensation for unspecified disabilities of 100% as compared to total bodily impairment	169,380.81

CERTIFICATE OF MAILING

I hereby certify that I caused to be served the foregoing **Respondent's Petition for Review** on the following individuals on November 4, 2016, by mailing to said individuals true copies thereof, certified by me as such, contained in sealed envelopes, with postage prepaid, addressed to said individuals at their last known addresses to wit:

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Court Clerk
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And deposited in the post office at Portland, Oregon, on said date.

I further certify that I filed the original of the foregoing with:

Court of Appeals
Division I
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Seattle, WA 98101-1176

by FedExing it on: November 4, 2016.

LAW OFFICE OF GRESS AND CLARK, LLC

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IN THE COURT OF APPEALS FOR THE STATE OF WASHINGTON

LORIANN HULL, Appellant, v. PEACEHEALTH MEDICAL GROUP, Respondent.	)	No. 74413-5-I DIVISION ONE UNPUBLISHED OPINION FILED: September 26, 2016

SPEARMAN, J. — While employed at St. Joseph Hospital PeaceHealth Medical Group (PeaceHealth) or shortly thereafter, LoriAnn Hull began to feel pain in her shoulders. This led to surgeries for thoracic outlet syndrome which resulted in significant complications that continue to plague her. Four years after the surgeries, PeaceHealth challenged the Department of Labor and Industries' (Department) determination that Hull's employment caused thoracic outlet syndrome. The trial court found that Hull's condition was not caused by her employment. On appeal, Hull contends the trial court's finding is not supported by substantial evidence. We agree and reverse.[1]

[1] Subsequent to withdrawal of her counsel, appellant submitted a number of documents including a letter, email exchanges between her and PeaceHealth, medical records, and other documents. To the extent these documents were not already a part of the record on appeal, we do not consider them because they are untimely.

FACTS

Appellant LoriAnn Hull worked for St. Joseph Hospital PeaceHealth for 20 years as an admitting representative in the emergency room. Her duties included gathering patient information, inputting information, pulling forms and patient charts, affixing labels to documents, assembling and breaking down charts, sorting and stacking documents in piles, and cleaning name badges. These duties involved reaching over an arm-length away at waist level, reaching for items at or above her forehead, writing on paper, and typing on a computer.

Hull filed a worker's compensation claim on October 23, 2006 after experiencing elbow discomfort, aggravated by repetitive motion at work. She had difficulty bending and extending her arms. The Department issued an order allowing her claim on December 3, 2007. It did not specify the conditions allowed.[2]

On November 7, 2006, Hull saw her primary care provider, Dr. Hughes, who diagnosed her with left and right medial epicondylitis, a condition of the tendons in the elbow. Dr. Hughes saw Hull again on January 12, 2007. The elbow diagnosis remained the same and she was referred for electrodiagnostic studies. These were performed on February 9, 2007 and were normal.[3]

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[2] The record does not include Hull's claim or the Department's order. However, a jurisdictional history to which the parties stipulated at hearing "for jurisdictional purposes only" includes information about the Department's December 3, 2007 order. Clerk's Papers (CP) at 94.

[3] A normal electrodiagnostic test does not rule out thoracic outlet syndrome. Thoracic outlet syndrome potentially shows up on an electrodiagnostic test only if it is serious. Intermittent thoracic outlet syndrome can result in a normal study. While an electrodiagnostic test is frequently used in the diagnostic process for thoracic outlet syndrome, it is not, by itself, helpful in ruling in or out the diagnosis.

Hull continued to work. To avoid pain, she adjusted her motions. To reach for something, she twisted her shoulder towards it so to avoid extending her arm fully. Hull began to feel pain in her left shoulder in March 2007. She continued to work at PeaceHealth at least through that date.

Hull saw Dr. Hughes again on July 9 and 26, 2007, reporting that she had pain in her left shoulder. Hull was referred to an orthopedic surgeon for the shoulder problem. She tried non-invasive treatment such as physical therapy, but ultimately had acromioplasty surgery on her left shoulder in October, 2007.[4] It did not resolve the problem. Hull attempted to return to work after that surgery.[5] With her left side immobilized from the surgery, she began feeling pain in her right shoulder.

Because acromioplasty surgery did not resolve her pain, Hull was referred to a thoracic outlet syndrome specialist. Thoracic outlet syndrome refers to three separate types of conditions in which either the artery, the veins, or the nerve are compressed at one of several sites in the body. Neurogenic thoracic outlet syndrome, Hull's condition, arises where the nerves that pass through from the spinal cord and the neck out to the arms are compressed. Neurogenic thoracic outlet syndrome is characterized by steadily worsening pain, numbness, tingling, and weakness in the shoulder, neck, arm, and hand.

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[4] The record does not explain the nature of this procedure.

[5] Hull's full work history is not in the record.

Hull saw a thoracic outlet specialist, Dr. Johansen, on March 24, 2009. She reported steadily worsening pain, numbness, tingling, and weakness in her left arm and described her working conditions and onset of symptoms. Dr. Johansen reviewed prior testing and did a physical examination. One of the prior tests that he considered was a scalene block – an anesthetic procedure that temporarily relieved Hull's symptoms - which is an accurate and specific test for thoracic outlet syndrome. The effectiveness of the scalene block demonstrated that Hull had thoracic outlet syndrome. Dr. Johansen diagnosed Hull with neurogenic thoracic outlet syndrome based on workplace repetitive motion injury, appropriate story, symptoms, physical examination findings, and a strongly positive scalene block.

On April 22, 2009, Dr. Johansen performed surgery on Hull to correct the thoracic outlet syndrome. It did not resolve the symptoms. He performed a second surgery on December 21, 2009. This surgery resulted in significant complications, including balance problems, breathing problems, difficulty swallowing, dry heaving, and emotional problems including adjustment disorder with depressed mood.

In 2013, the Department issued three orders that directed PeaceHealth to pay for complications from Hull's thoracic outlet syndrome surgery. Those orders, which are the subject of this litigation directed PeaceHealth to pay for post-surgery complications including pulmonary conditions, balance problems, dysphasia, cricopharyngeal spasms, and adjustment disorder with depressed mood. They also directed PeaceHealth to pay for the psychiatric medication

Cymbalta. PeaceHealth appealed these orders to the Board of Industrial Insurance Appeals (Board).

The appeal proceeded to an evidentiary hearing before an Industrial Appeals Judge (IAJ) on May 23, 2014. Hull's attending physician, Dr. Johansen, testified in support of Hull's claim. PeaceHealth presented testimony by several physicians, including Dr. Kremer, a retired vascular surgeon. He reviewed Hull's medical records and performed a one-time partial evaluation of Hull in September 2012, nearly three years after her second thoracic outlet syndrome surgery. Dr. Kremer testified that Hull never had thoracic outlet syndrome and even if she did, it was not caused by her working conditions.

The IAJ issued a proposed decision and order on October 6, 2014 upholding the Department's orders directing PeaceHealth to pay for complications from Hull's thoracic outlet syndrome. PeaceHealth filed a petition for review. The Board denied the petition for review and adopted the IAJ's proposed decision. The decision and order upheld the Department's determination that Hull's thoracic outlet syndrome arose naturally and proximately out of the distinctive conditions of her employment with PeaceHealth, thereby allowing the downstream consequences of her surgeries.

PeaceHealth appealed this decision to Whatcom County Superior Court, which held a bench trial on August 25, 2015 and issued a memorandum decision

overturning the Board and finding in favor of PeaceHealth.[6] The court issued an order on December 2, 2015 which included the following "Conclusion of Law":

1. The Board of Industrial Insurance Appeals erred in admitting evidence regarding payment of services associated with defendant's thoracic outlet syndrome under Evidence Rule 409 and as such evidence regarding payment of such services is stricken from the record.

. . .

3. Defendant was subsequently diagnosed with a condition of thoracic outlet syndrome for which surgery was recommended and performed April 22, 2009 and December 21, 2009. Defendant's thoracic outlet syndrome did not arise naturally and proximately from the distinctive conditions of her employment with PeaceHealth Medical Group.

. . .

8. The Board of Industrial Insurance Appeals' decision dated December 8, 2014, is reversed.

CP at 823-30. Hull appeals.

DISCUSSION

The Industrial Insurance Act includes judicial review provisions that are specific to workers' compensation determinations. The superior court's review of a Board determination is de novo. RCW 51.52.115. The Board's decision is prima facie correct, and a party attacking the decision must support its challenge by a preponderance of the evidence. Rogers v. Dep't of Labor & Indus., 151 Wn. App. 174, 180, 210 P.3d 355 (2009) (citing Ruse v. Dep't of Labor & Indus., 138 Wn.2d 1, 5, 977 P.2d 570 (1999)). By contrast, this court reviews the superior court's decision under the ordinary standard of review for civil cases. "We review whether substantial evidence supports the trial court's factual findings and then review, de novo, whether the trial court's conclusions of law flow from the

[6] The memorandum decision is not in the record.

findings." Watson v. Dep't of Labor & Indus., 133 Wn. App. 903, 909, 138 P.3d 177 (2006) (citing Ruse, 138 Wn.2d at 5; RCW 51.52.115).

The Industrial Insurance Act (IIA) provides that a worker suffering disability from an occupational disease shall receive benefits under the Act. RCW 51.32.180. An occupational disease is defined as "such disease or infection as arises naturally and proximately out of employment." RCW 51.08.140. "[A] worker must establish that his or her occupational disease came about as a matter of course as a natural consequence or incident of distinctive conditions of his or her particular employment." Dennis v. Dep't of Labor & Indus., 109 Wn.2d 467, 481, 745 P.2d 1295 (1987). "The causal connection between a claimant's physical condition and his or her employment must be established by competent medical testimony which shows that the disease is probably, as opposed to possibly, caused by the employment." Id. at 477 (citing Ehman v. Dep't of Labor & Indus., 33 Wn.2d 584, 206 P.2d 787 (1949)). The disease is not "proximate" if there is an intervening, independent and sufficient cause for disease, so that it would not have been contracted but for working conditions. Simpson Logging Co. v. Dep't of Labor & Indus., 32 Wn.2d 472, 202 P.2d 448 (1949). "A physician's opinion as to the cause of the claimant's disease is sufficient when it is based on reasonable medical certainty even though the doctor cannot rule out all other possible causes. . . ." Intalco Aluminum v. Dep't of Labor & Indus., 66 Wn. App. 644, 654-55, 833 P.2d 390 (1992) (citing Halder v. Dep't of Labor & Indus., 44 Wn.2d 537, 543-45, 268 P.2d 1020 (1954)). "The evidence is sufficient to prove causation if, from the facts and circumstances and the medical testimony given, a reasonable

person can infer that a causal connection exists." Id. at 655 (citing Douglas v. Freeman, 117 Wn.2d 242, 252, 814 P.2d 1160 (1991)). In a worker's compensation dispute, special consideration should be given to the opinion of a worker's attending physician. Hamilton v. Dep't of Labor & Indus., 111 Wn.2d 569, 761 P.2d 618 (1988). The trier of fact needn't give more weight or credibility to the attending physician's testimony, but must give it careful thought. Id. at 571.

In this case, the record shows that Hull began feeling symptoms of what was eventually diagnosed as thoracic outlet syndrome either during, or immediately following, her employment with PeaceHealth. She testified that she began feeling pain in her shoulder about five months after filing the claim for her elbow condition and that in those five months she continued to work.[7] During this time at work, she used her shoulders more in order to reduce the pain in her elbows caused by extending her arms. Expert medical testimony confirms that Hull should feel thoracic outlet syndrome symptoms concurrently with the work activity that caused the condition. There is no evidence of an intervening cause of her shoulder pain.

Hull's attending physician, Dr. Johansen, explained how Hull's particular job duties caused thoracic outlet syndrome.[8] He testified that repetitive out in front use of her arms and overhead work such as that performed by Hull is a

[7] Hull's work history is incomplete in the record. She testified that she worked for St Joseph's starting in 1990 or 1991, and worked there for 19 years and 11 months. Therefore, she was an employee of St. Joseph's until 2010 or 2011. Once she started feeling symptoms in her shoulder, there is no information in the record about whether she worked continuously.

[8] Dr. Johansen performs the majority of thoracic outlet syndrome surgeries in Washington State and authored chapters in a medical textbook on neurogenic thoracic outlet syndrome.

cause of thoracic outlet syndrome. Hull's body habitus and height made her more susceptible to injury in these work conditions. Her elbow problems indicated that her work activities were causing repetitive motion injuries. Under Hamilton, "special consideration" should be given to Dr. Johansen's testimony as Hull's attending physician. There is no indication that the trial court gave such special consideration. It did not make a finding that PeaceHealth's experts were persuasive or that Dr. Johansen was not credible.

PeaceHealth offered testimony by forensic physicians that does not provide substantial evidence that Hull's thoracic outlet syndrome was not caused by her work activity. One expert, Dr. Madhani, deferred on the cause of Hull's thoracic outlet syndrome. Another expert, Dr. Kremer, testified that the working conditions of hairdressers and carpenters would cause thoracic outlet syndrome, but he denied that Hull's out in front and overhead use of her arms caused it. Dr. Kremer points to electrodiagnostic testing from February 2007 that was negative for thoracic outlet syndrome. However, this test was before Hull reported shoulder pain, and is not reliable to rule out intermittent thoracic outlet syndrome.[9]

If thoracic outlet syndrome is an allowed occupational disease, then the downstream complications of Hull's surgeries, the sequelae, are also allowed. Claimants must be reimbursed "[u]pon the occurrence of any injury to a worker

[9] PeaceHealth also argues that Hull's injury must have occurred prior to when the claim was allowed by the Department, but they erroneously cite December 3, 2006 as the date the claim was allowed. In fact, it was allowed on December 3, 2007 and Hull did complain of shoulder problems prior to that date.

entitled to compensation. . . ." RCW 51.36.010(2)(a). Compensation is required for all "proper and necessary medical and surgical services. . . ." Id. Proper and necessary treatment encompasses conditions secondary to the occupational disease, such as complications from surgery. See Anderson v. Allison, 12 Wn.2d 487, 122 P.2d 484 (1942).

PeaceHealth concedes that Hull's balance problems, pulmonary condition, dysphagia, and cricopharyngeal spasms are proximately related to treatment for her thoracic outlet syndrome, and as conditions secondary to thoracic outlet syndrome, they are allowed. PeaceHealth does argue that Hull's adjustment disorder with depressed mood is not proximately related to her surgeries. They support this argument with Dr. Friedman's testimony. However, Dr. Friedman testified that Hull's mental health conditions were not caused by her elbow condition. That is not at issue. The issue is whether her mental health condition was secondary to thoracic outlet syndrome, which is well supported by expert medical testimony. All of Hull's downstream conditions listed in the orders appealed to the Department are allowed.

Lastly, Hull argued that the trial court erred by excluding evidence that PeaceHealth paid for Hull's surgeries. The trial court correctly excluded evidence of payment under ER 409 and our analysis does not incorporate this fact.

We conclude that there is not substantial evidence to support the trial court's finding that Hull's thoracic outlet syndrome and its sequelae did not arise naturally and proximately from her employment with PeaceHealth. As discussed above, the opinions of PeaceHealth's experts are insufficient to support the trial

court's conclusion. In addition, the timeline of Hull's symptoms, her work history and the testimony of her attending physicians strongly support the conclusion that her work activities caused thoracic outlet syndrome. And because the thoracic outlet syndrome was proximately caused by Hull's working conditions, the downstream consequences of her surgery are also covered.

The trial court's order is reversed, the Board's Decision and Order is affirmed and the case is remanded.

Spearman, J.

WE CONCUR:

Trickey, ACJ

Schindler, J.

IN THE COURT OF APPEALS FOR THE STATE OF WASHINGTON

LORIANN HULL, Appellant, v. PEACEHEALTH MEDICAL GROUP, Respondent.	)	No. 74413-5-I DIVISION ONE ORDER DENYING MOTION FOR RECONSIDERATION

Respondent PeaceHealth Medical Group filed a motion for reconsideration of the unpublished opinion filed on September 26, 2016. A majority of the panel has determined the motion for reconsideration should be denied.

NOW THEREFORE, it is hereby ordered that respondent's motion for reconsideration is denied.

DATED this 10th day of October, 2016.

Presiding Judge