ALASKA WORKERS' COMPENSATION BOARD

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

DONNA L HENDRICKS, Employee, Claimant,	)	FINAL DECISION AND ORDER
v.	)	AWCB Case No. 200916608
BANNER HEALTH SYSTEMS, Employer,	)	AWCB Decision No. 14-0016
and	)	Filed with AWCB Fairbanks, Alaska on February 05, 2014
SENTRY INSURANCE MUTUAL CO, Insurer, Defendants.	)	

Donna Hendricks (Employee) and Banner Health Systems's joint petition for a determination regarding whether a spinal cord stimulator is reasonable and necessary treatment for Employee's work injury was heard on January 16, 2013 in Fairbanks, Alaska. This hearing date was selected on October 11, 2013. Attorney Jason Weiner appeared and represented Employee. Attorney Dennis Cook appeared and represented Banner Health Systems and Sentry Insurance Mutual Co. (Employer). There were no witnesses. The record closed on January 16, 2014.

ISSUE

The parties request a determination regarding whether a spinal cord stimulator is reasonable and necessary treatment for Employee's October 29, 2009 work injury.

Is a spinal cord stimulator reasonable and necessary treatment for Employee's October 29, 2009 work injury?

FINDINGS OF FACT

The following facts and factual conclusions are established by a preponderance of the evidence:

1) On October 29, 2009, Employee injured her right hand, thumb and hip while working for Employer as a hospital environmental technician. She was holding several patient trays and slipped on a puddle of water. She fell onto her right side and hit her right hip and right thumb. (SIME Report, Leah Ridge, M.D., July 6, 2012; Chart Note, Kenneth Glaeser, M.D., October 29, 2009).

2) On October 29, 2009, Kenneth Glaeser, M.D., with the Fairbanks Memorial Hospital Emergency Department, treated Employee for multiple complaints after a fall and diagnosed a right hip contusion and right wrist and elbow sprains. (Chart Note, Kenneth Glaeser, M.D., October 29, 2009).

3) On November 4, 2009, Employee was again treated at the Fairbanks Memorial Hospital Emergency Department for right hand and thumb pain with no numbness in her hand. Her hip pain had resolved. Employee reported she could not move her thumb and, therefore, believed she could no longer work. (Chart Note, Mark Simon, M.D., November 4, 2009).

4) On December 9, 2009, an MRI of Employee's right thumb with gadolinium showed the ulnar collateral ligament and other ligaments and tendons of Employee's right thumb were intact and "normal." Small amounts of fluid were present in the MCP joint, suggesting a mild inflammatory process." (University Imaging Center, MRI Report, December 9, 2009).

5) Employee continued to have thumb pain and on January 11, 2010, Michael McNamara, M.D., performed right MP fusion with CMC arthroplasty with tendon interposition. The postoperative diagnosis was right thumb pantrapezial osteoarthritis, MP arthritis, and chronic ligament tear. (Alaska Surgery Center Surgical Report, Michael McNamara, M.D., January 11, 2010).

6) Based upon Employee's continued post-surgical pain complaints, she was referred to pain management specialist Nancy Cross, M.D. (Chart Note, Advanced Pain Centers, Tom Grissom, M.D., March 23, 3010).

7) Dr. Cross planned to perform a series of six stellate ganglion blocks for complex regional pain syndrome in Employee's upper extremity. Ultimately, Dr. Cross performed eight stellate ganglion blocks; however, her medical reports were never accurate regarding how far along Employee was in the course of six stellate ganglion blocks. (Chart Notes, Advanced Pain

Centers, Nancy Cross, M.D., March 26, 2010, March 31, 2010, April 7, 4010, April 21, 2010, May 5, 2010, June 9, 2010, July 26, 2010, August 16, 2010).

8) On April 2, 2010, Employee was discharged from the Fairbanks Memorial Hospital Physical Therapy (FMH PT) program. Employee reported she was directed by Dr. Cross to "hold off" therapy at FMH PT until advised to return. Therapist Franciol attempted to contact Dr. Cross but her calls were not returned. (Chart note, Fairbanks Memorial Hospital Physical Therapy Therapist Franciol, April 2, 2010).

9) On June 25, 2010, Dr. Cross reported Employee had no physical disability and her activities of daily living were normal. However, Employee's pain on that same day was reported by Dr. Cross as both 7/10 and 9/10. (Chart Note, Dr. Cross, June 25, 2010).

10) On July 26, 2010, Employee's activities of daily living continued to be normal and she had no physical disabilities. (Chart Note, Dr. Cross, July 26, 2010).

11) On August 16, 2010, Employee's activities of daily living continued to be normal and she had no physical disabilities. (Chart Note, Dr. Cross, July 26, 2010).

12) On September 10, 2010, Dr. Cross reported Employee's pain level was two out of 10 and has increased her function and uses her right hand more; Employee had no physical disability and normal activities of daily living; Employee had no muscle aches, no joint pain, and no joint stiffness. Dr. Cross recommended additional stellate ganglion blocks and a spinal cord stimulator. (Chart Note, Dr. Cross, September 12, 2010).

13) On October 12, 2010, Employee's skin was "normal," as was muscle bulk and tone. Dr. Cross's report contained many inconsistencies:

a) Pain is with a "sharp quality…dull, aching quality."
b) "Generalized pain frequently (75% of the time)…generalized pain constantly (100% of the time)."
c) "Feeling poorly…not feeling poorly."
d) "A tendency for easy bruising…no tendency for easy bruising."
e) "Muscle aches…no muscle aches."
f) "Anxiety…no anxiety."
g) "Pain localized to one or more joints…No localized joint pain."
h) "Stiffness localized to one or more joints…No localized joint stiffness."

(Chart Note, Dr. Cross, October 12. 2010).

14) Dr. Cross lacks credibility. Dr. Cross did not accurately record the treatment she provided Employee. Her reports contain many inconsistencies. The inconsistencies exist not only from report to report, but also within the same report.

15) On November 9, 2010, Employee's thumb was doing very well and she had no pain in the thumb base. She did have burning sensation in the right thumb, complaints of numbness and tingling in several fingers, relieved by wearing a splint. Dr. McNamara found Employee's thumb motion satisfactory. He recommended neurologic testing for possible carpel tunnel syndrome. (Chart Note, Dr. McNamara, November 9, 2010).

16) On December 1, 2010, orthopedic surgeon John Joosse, M.D., evaluated Employee for an employer's medical evaluation (EME). His diagnoses included a long history of degenerative arthritis of both hands, specifically right thumb MCP and CMC joints; cervical spondylosis, worst at the C5-6 level where there is mild to moderate central stenosis prominently on the right side; and a history of lumbar disc herniation treated with surgery and lumbar spondylosis. Dr. Joosse opined the MCP fusion CMC arthroplasty were treatments for Employee's preexisting arthritis aggravated by the October 29, 2009 injury. Dr. Joosse assessed Employee for CRPS using the *Guides to the Evaluation of Permanent Impairment*, Sixth Edition (*Guides*), and opined Employee did not meet the criteria for Complex Regional Pain Syndrome (CRPS). He noted Employee has no pain when at rest and her pain complaints are varying; however, a CRPS diagnosis requires continuous disproportionate pain. A CRPS diagnosis also requires the individual have one symptom in three of four categories. Dr. Joosse evaluated these as follows:

> **Sensory: Hyperesthesia and / or allodynia.** Employee complained of allodynia, but was inconsistent in her responses. She did not describe hyperesthesia.
>
> **Vasomotor: Reports of temperature asymmetry and / or skin color changes and / or skin color asymmetry.** Employee complained of both.
>
> **Sudomotor / Edema: Reports of edema and / or sweating changes and / or sweating asymmetry.** Employee complained of swelling, which may be the same as the required edema. She did not complain of any sweating or sweating asymmetry.
>
> **Motor / Tropic: Reports of decreased range of motion and / or motor dysfunction (weakness, tremor, dystonia) and / or trophic changes (hair, nail, skin).** Employee complained of decreased range of motion and weakness, but not tremor or dystonia.

Dr. Joosse found Employee complained of four of the four symptoms required for diagnosis of CRPS. However, for a CRPS diagnosis, an individual must also display at least one objective

sign in two or more of the above categories when evaluated. Employee's evaluation revealed the following:

> **Sensory: Hyperesthesia and / or allodynia.** No hyperesthesia, but Employee complained of inconsistent allodynia.
>
> **Vasomotor: Reports of temperature asymmetry and / or skin color changes and / or skin color asymmetry.** A temperature asymmetry was displayed during exam using an infrared thermometer. There were no skin color changes. Dr. Joosse found the asymmetry minor and insignificant.
>
> **Sudomotor / Edema: Reports of edema and / or sweating changes and / or sweating asymmetry.** There were no findings which indicated sudomotor changes.
>
> **Motor / Tropic: Reports of decreased range of motion and / or motor dysfunction (weakness, tremor, dystonia) and / or trophic changes (hair, nail, skin).** Dr. Joosse found decreased range of motion, likely due to disuse, but that could qualify for a CRPS diagnosis. He noted Dr. McNamara's November 2010 evaluation, which reported Employee's thumb motion was satisfactory.

The final criterion to diagnose CRPS is there is no other diagnosis that better explains the signs and symptoms, which requires a differential diagnosis. In Employee's case, Dr. Joosse found other diagnoses could include an unrecognized medical disorder, somatoform disorder, factious disorder, or malingering. Dr. Joosse found Employee did not meet the criteria for CRPS. (EME Report, Dr. Joosse, December 1, 2010).

17) Dr. Joosse found a spinal cord stimulator is not reasonable and necessary medical treatment for Employee's work injury. Dr. Joosse explained Employee has good control of her symptoms using only occasional narcotics every other day in addition to some antidepressant medication. He noted per her medical records, Employee had markedly improved. Per the *Guides*, Dr. Joosse propounded there is little evidence to support spinal cord stimulator use as an effective treatment for CRPS; however, a progressive, active exercise program, which include a monitored home exercise program that requires desensitization and weight bearing of the extremity would be helpful. Additionally, return to work would be therapeutic. (*Id.*).

18) The only future treatment Dr. Joosse recommended for Employee's October 29, 2009 work injury was to continue an active home exercise program and occasional pain medication on an as needed basis, and return to work. (*Id.*).

19) On April 8, 2011, orthopedic surgeon Michael McNamara, M.D., evaluated Employee determined she was medically stable as of March 3, 2011, and assessed eight percent combined

value whole person impairment under the Sixth Edition of the American Medical Association *Guides to the Evaluation of Permanent Impairment* (AMA *Guides*). (Chart Note, Dr. McNamara, April 8, 2011).

20) On September 26, 2011, Dr. Joosse evaluated Employee for a follow-up EME. Dr. Joosse agreed with Dr. McNamara's opinion Employee was medically stable with regard to her work injury as of July 2010 and medically stable with regard to her carpel tunnel syndrome on April 8, 2011. Dr. Joosse found no relationship between the work injury and Employee's carpel tunnel syndrome; work was not the substantial cause of Employee's need for medical treatment for or disability due to carpel tunnel syndrome. Employee had a long history of hand and wrist pain prior to her work injury. Dr. Joosse again opined Employee does not have CRPS, and no further treatment is necessary. (EME Report, Dr. Joosse, September 26, 2011).

21) On November 15, 2011, Employer controverted all medical benefits after September 26, 2011 based on Dr. Joosse's report. (Controversion Notice, November 15, 2011).

22) On October 5, 2012, Employee filed a claim for benefits, including medical costs. (Claim, October 5, 2012).

23) On October 12, 2012, Employer answered Employee's claim, denying any medical treatment after the date of medical stability or treatment that was not work-related. (Answer, October 12, 2012).

24) On January 12, 2012, Dr. Cross agreed with Drs. McNamara and Joosse that Employee was medically stable as of April 8, 2011. (Dr. Cross Response dated January 12, 2012 to Employer Letter dated January 11, 2012).

25) On July 6, 2012, neurologist Leah Ridge, M.D., evaluated Employee for a second independent medical evaluation (SIME). Dr. Ridge diagnosed work-related traumatic central cord syndrome and recommended additional testing. Dr. Ridge identified Employee's pre-existing conditions as right thumb osteoarthritis and cervical spondylosis. Dr. Ridge's future treatment recommendations were a "more thorough EMG/NCS comparing R and L upper extremities and a CT myelogram of the cervical spine to help tease out the subtleties of her cervical pathology." Dr. Ridge did not recommend a spinal cord stimulator. (SIME Report, Dr. Ridge, July 6, 2012).

26) On May 31, 2013, neurologist J. Greg Zoltani, M.D., evaluated Employee for an EME. Dr. Zoltani's diagnoses included: 1) right hip contusion, work-related, 2) right wrist strain,

work-related, 3) pre-existing cervical degenerative disc disease, unaffected and unrelated to work, 4) pre-existing degenerative arthrosis of the wrists, and 5) right carpel tunnel syndrome, not work-related. Although Employee had pre-existing degenerative arthrosis of the wrists, the work injury aggravated the pre-existing condition. The cause for her right hand complaints is degenerative arthrosis of the wrists. No neurologic findings support a diagnosis of central cord syndrome. Employee has none of the manifestations required for a reflex sympathetic dystrophy diagnosis. No additional treatment is reasonable or necessary for Employee's continued complaints, and neither injections nor a spinal cord stimulator are indicated. (EME Report, Dr. Zoltani, May 31, 2013).

PRINCIPLES OF LAW

> **AS 23.30.001. Intent of the legislature and construction of chapter.** It is the intent of the legislature that
>
> (1) this chapter be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter;
>
> (2) workers' compensation cases shall be decided on their merits except where otherwise provided by statute. . . .

The board may base its decision not only on 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." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987).

> **AS 23.30.010. Coverage.** (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the

> employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.

A finding reasonable persons would find employment was or was not a cause of the Employee's disability and impose or deny liability is, "as are all subjective determinations, the most difficult to support." *Rogers & Babler*, 747 P.2d at 534.

> **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. . . . It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require.
> . . .

"Process of recovery" language allows the board to authorize continuing care beyond two years after date of injury and does not preclude an award for purely palliative care where evidence establishes such care promotes an employee's recovery from individual attacks caused by chronic condition. *Municipality of Anchorage, v. Carter*, 818 P.2d 661, 665-66 (Alaska 1991). However, such language also means the board may disallow a claimant's claim for continuing care if it does not promote recovery from the original injury or aid in an employee's chronic condition. In *Carter*, the Court held the Act does not require the board to provide "continuing or palliative care in every instance. Rather, the statute grants the board discretion to award such 'indicated' care 'as the process of recovery may require.'" *Id.* at 664.

> **AS 23.30.120 Presumptions**. (a) In a proceeding for the enforcement of a claim for compensation under this chapter it is presumed, in the absence of substantial evidence to the contrary, that
>
> (1) the claim comes within the provisions of this chapter. . . .

Under AS 23.30.120(a)(1), benefits sought by an injured worker are presumed to be compensable. *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996). The presumption of

compensability is applicable to any claim for compensation under the workers' compensation statute, including disability and medical benefits. *Carter,* 818 P.2d at 665; *Meek*, 914 P.2d at 1279; *Moretz v. O'Neill Investigations,* 783 P.2d 764, 766 (Alaska 1989); *Olson v. AIC/Martin J.V.*, 818 P.2d 669, 675 (Alaska 1991).

The application of the presumption involves a three-step analysis. To attach the presumption of compensability, an employee must first establish a "preliminary link" between his or her injury and the employment. *See, e.g., Tolbert v. Alascom, Inc.*, 973 P.2d 603, 610 (Alaska 1999). If the employee establishes the link, the presumption may be overcome when the employer presents substantial evidence the injury was not work-related. *Id.* at 611. An employer may rebut the presumption of compensability with an expert opinion the claimant's work was probably not a substantial cause of the disability or need for medical treatment. *Gillispie v. B&B Foodland,* 881 P.2d 1106, 1110 (Alaska 1994). For determinations of the compensability of continuing care under AS 23.30.095(a), an employer may rebut the presumption by adducing "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion" that continued care is either not indicated, or not indicated as the employee contends. *Municipality of Anchorage, v. Carter,* 818 P.2d 661, 665 (Alaska 1991). Because the board considers the employer's evidence by itself and does not weigh the employee's evidence against the employer's rebuttal evidence, credibility of the parties and witnesses is not examined at this point. *Veco, Inc. v. Wolfer,* 693 P.2d 865, 869-870 (Alaska 1985). If the board finds the employer's evidence is sufficient, the presumption of compensability drops out and the employee must prove his or her case by a preponderance of the evidence. *Miller v. ITT Arctic Services*, 577 P.2d 1044, 1046 (Alaska 1978). This means the employee must "induce a belief" in the minds of the board members the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). At this point, the board weighs the evidence, determines what inferences to draw from the evidence, and considers the question of credibility.

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

The board's finding of credibility "is binding for any review of the Board's factual findings." *Smith v. CSK Auto, Inc.*, 204 P.3d 1001, 1008 (Alaska 2009). The board has the sole power to determine witness credibility, and its findings about weight are conclusive even if the evidence is conflicting. *See, e.g., Harnish Group, Inc. v. Moore*, 160 P.3d 146, 153 (Alaska 2007); *Thoeni v. Consumer Electronic Services*, 151 P.3d 1249, 1253 (Alaska 2007); *Municipality of Anchorage v. Devon*, 124 P.3d 424, 431 (Alaska 2005). The board has the sole discretion to determine the weight of the medical testimony and reports. When doctors' opinions disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.*, Alaska Workers' Comp. App. Comm'n Dec. No. 087 at 11 (Aug. 25, 2008). The board can choose not to believe its own expert. *Rosario v. Chenega Lodging*, 297 P.3d 139, 147 (Alaska 2013).

ANALYSIS

Is a spinal cord stimulator reasonable and necessary treatment for Employee's October 29, 2009 work injury?

The presumption of compensability applies to this issue. Employee's treating physician Dr. Cross recommended employee be treated with a spinal cord stimulator. This evidence is sufficient to raise the presumption of compensability the spinal cord stimulator is reasonable and necessary medical treatment for Employee's October 29, 2009 wrist injury.

Once the presumption is raised, Employer must rebut the presumption the treatment at issue is medically indicated with substantial evidence, which is viewed in isolation and without a determination of credibility. Employer relies on the opinions of EME physicians Drs. Joosse and Zoltani, who opined a spinal cord stimulator is not reasonable and necessary medical treatment for Employee's injury. Drs. Joosse and Zoltani's reports are substantial evidence rebutting the presumption because they unequivocally state use of a spinal cord stimulator is not medically indicated for treatment of Employee's October 29, 2009 work injury.

Once Employer rebuts the presumption of compensability, Employee must prove her claim by a preponderance of the evidence. Employee is unable to meet this burden.

Neither Dr. Grissom, nor Dr. Cross applied the criteria for assessment or CRPS when making Employee's diagnosis. Neither considered differential diagnoses. Neither Dr. Grissom, nor Dr. Cross's diagnosis of CRPS is given weight. Dr. Cross, upon Dr. Grissom's CRPS diagnosis, proceeded to treat Employee with stellate ganglion blocks, which improved Employee's pain symptoms. However, after reporting Employee had increased her level of functioning, Employee's pain was two out of ten, Employee had no muscle aches, no joint pain, and no joint stiffness, and Employee had no physical disability and had normal activities of daily living Dr. Cross recommended a spinal cord stimulator. Neither Dr. Cross's reports nor her treatment recommendations are given great weight. Dr. Cross did not accurately account for Employee's treatment, did not accurately report Employee's symptoms, and did not properly assess Employee when diagnosing CRPS. Without an accurate diagnosis, Dr. Cross's treatment recommendations are not entitled to deference.

Drs. Joosse and Zoltani's reports offer the most thorough and detailed analysis regarding whether use of a spinal cord stimulator is reasonable and necessary medical treatment for Employee's injury. Their reports are given the most weight. AS 23.30.122.

Dr. Joosse determined a spinal cord stimulator is not reasonable and necessary medical treatment for Employee's work injury because Employee had good control of her symptoms using only occasional narcotics in addition to some antidepressant medication. Dr. Joosse noted Employee had markedly improved, which is counter to Dr. Cross's recommendation for treatment with a spinal cord stimulator. Dr. Joosse supported a progressive, active home exercise program with desensitization and weight bearing of the extremity, and found return to work would be therapeutic. Besides a home exercise program, occasional pain medication on an as needed basis is the only medical treatment Dr. Joosse found reasonable and necessary.

Prior to addressing whether a spinal cord stimulator was reasonable and necessary medical treatment for Employee's injury, Dr. Joosse assessed whether the criteria for a CRPS diagnosis were met. Dr. Joosse found Employee failed to meet the first criterion, continuous disproportionate pain, because Employee reported no pain when she was at rest and that her pain levels vary. Despite this finding, he continued the assessment. A CRPS diagnosis requires one symptom in

three of four categories, those being sensory, vasomotor, sudomotor / edema, and motor / tropic. Dr. Joosse found Employee complained of symptoms in all four categories; therefore, he proceeded to assess whether Employee displayed at least one objective sign in two or more of the categories when evaluated. Upon evaluation, Dr. Joosse found no definitive objective signs which qualified Employee for a CRPS diagnosis. The final criterion to diagnose CRPS is upon a differential diagnosis, there is no other diagnosis that better explains the signs and symptoms. Dr. Joosse found based upon his review of the entirety of Employee's record, other diagnoses could include an unrecognized medical disorder, somatoform disorder, factious disorder, or malingering. Upon determining Employee did not meet the criteria for a CRPS diagnosis, he made recommendations regarding reasonable and necessary treatment.

Dr. Joosse's opinion, supported by Zoltani's report, is given the greatest weight. Dr. Joosse's report offers the most thorough and detailed analysis of Employee's need for future medical treatment, and what treatment is reasonable and necessary. Dr. Joosse and Dr. Zoltani, without question, state use of a spinal cord stimulator in not reasonable or necessary medical treatment for Employee's October 29, 2009 work injury.

The preponderance of the evidence demonstrates use of a spinal cord stimulator is not reasonable and necessary medical treatment for Employee's October 29, 2009 work injury. This medical treatment is therefore not compensable and will be denied.

CONCLUSIONS OF LAW

A spinal cord stimulator is not reasonable and necessary treatment for Employee's October 29, 2009 work injury.

ORDER

1) The parties' request for a determination regarding whether a spinal cord stimulator is reasonable and necessary treatment for Employee's October 29, 2009 work injury is granted.
2) A spinal cord stimulator is not reasonable and necessary treatment for Employee's October 29, 2009 work injury and is not compensable; a claim, if any, for a spinal cord stimulator is denied.

Dated in Fairbanks, Alaska on February 05, 2014.

ALASKA WORKERS' COMPENSATION BOARD

_____
Janel Wright, Designated Chair

_____
Linda Hutchings, Member

_____
Patricia Vollendorf, Member

APPEAL PROCEDURES

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

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

RECONSIDERATION

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

MODIFICATION

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

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of DONNA L. HENDRICKS, employee / claimant; v. BANNER HEALTH SYSTEMS, employer; SENTRY INSURANCE MUTUAL CO., insurer / defendants; Case No. 200916608; dated and filed in the Alaska Workers' Compensation Board's office in Fairbanks, Alaska, and served on the parties on February 05, 2014.

_____

Anna Subeldia, Office Assistant I