ALASKA WORKERS' COMPENSATION BOARD

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

VANCE RICHARDSON, Employee, Claimant,	)	FINAL DECISION AND ORDER
v.	)	AWCB Case No. 201010244
INTERIOR ALASKA ROOFING, INC., Employer,	)	AWCB Decision No. 15-0045
and	)	Filed with AWCB Fairbanks, Alaska on April 21, 2015
ALASKA NATIONAL INSURANCE, Insurer, Defendants.	)	

Employer's March 10, 2015 petition regarding the effective date of the parties' February 24, 2015 compromise and release agreement (C&R) and the parties' April 1, 2015 stipulation as to the compensability of certain medical conditions as well as the reasonableness and necessity of specific medical treatments were considered on the written record on April 2, 2015, in Fairbanks, Alaska. This hearing date was selected on March 26, 2015. Attorney Michael Jensen represented Vance Richardson (Employee). Attorney Theresa Hennemann represented Interior Alaska Roofing, Inc. and Alaska National Insurance (Employer). There were no witnesses. The record closed at the hearing's conclusion on April 2, 2015.

ISSUES

On February 24, 2015, the parties filed a C&R in which Employee agreed to waive all future benefits with the exception of future compensable medical costs. The agreement states it will not become effective for five days after a board determination on the compensability those costs, and

the parties can withdraw prior to that time. A board designee informed the parties the C&R was effective on the date of filing.

1) *Was the C&R effective when filed?*

In the C&R, the parties agreed to request a board determination as to the compensability of treatment for Employee's neck, wrists, heart, hips, and bilateral polyneuropathy conditions, as well as the medical reasonableness and necessity of further spinal injections, rhizotomies, and neurostimulator treatments.

2) *Are Employee's neck, bilateral wrist, heart, hypertension, bilateral hip, or bilateral polyneuropathy conditions compensable?*

3) *Are further epidural steroid injections, rhizotomies, or implanted neurostimulator treatments medically reasonable and necessary?*

FINDINGS OF FACT

All findings of fact in *Richardson v. Interior Alaska Roofing*, AWCB Decision No. 12-0212 (December 18, 2012) (*Richardson I*) are incorporated herein. The following facts and factual conclusions are reiterated from *Richardson I* or established by a preponderance of the evidence:

1) On July 29, 2010, while working for Employer, Employee injured his back "lifting a roll of rubber roofing." (*Richardson I*).

2) On August 2, 2010 Employee sought treatment at Fairbanks Urgent Care Center, where he was diagnosed with a lumbar strain and taken off work for one week. (*Id*).

3) On August 11, 2010, Employee underwent an MRI, which showed diffuse disc desiccation and mild annular bulging at L5-S1, prominent on the left; diffuse disc desiccation with left lateral and left foraminal disc herniation at L4-L5; and diffuse disc desiccation, moderate loss of disc height and left lateral disc-osteophyte complex at L1-L2. Radiologist Jeffrey Zuckerman, M.D. diagnosed moderate spondylosis at L4-L5, L5-S1 and L1-L2, with left foraminal disc herniation at L4-L5. (*Id*).

4) On November 2, 2010, Employee saw neurosurgeon Daniel Kim, M.D. complaining of lower back pain with left-sided lumbar radiculopathy. Dr. Kim reviewed the August 11, 2010

MRI and informed Employee "he may benefit from surgery" based on the MRI findings. Dr. Kim diagnosed low back pain, herniated nucleus pulposus and lumbar radiculopathy. (*Id*).

5) On November 9, 2010, Dr. Kim performed a left L4-L5 epidural steroid injection. (*Id*).

6) On December 2, 2010, Employee reported to Dr. Kim the November 9, 2010 epidural steroid injection had provided relief for several days only and his pain had "returned to baseline." Dr. Kim recommended radiofrequency ablation at left L4-L5 for pain relief. (*Id*).

7) On January 11, 2011, Dr. Kim performed a second epidural steroid injection. (*Id*).

8) On February 24, 2011, Employee reported to PA Jim Nguyen the second epidural steroid injection had provided him pain relief for only half a day and he had returned to baseline. He complained of pain radiating up to his neck and down his left buttock to his left foot. (*Id*).

9) On May 31, 2011, Employee received another epidural steroid injection from Dr. Kim. (Brigham EME Report, November 26, 2013).

10) On June 28, 2011, Dr. Kim noted Employee had received only "minimal relief" from the epidural steroid injections. (Brigham EME Report, October 7, 2014).

11) On March 30, 2012, Peter Diamond, M.D. issued an SIME report, having examined Employee in person on February 7, 2012. Dr. Diamond diagnosed lumbar sprain/strain with left-sided sciatica and clinical suggestion of lumbar radiculopathy; L4-5 disc herniation, superimposed on degenerative disc disease; and L5-S1 multiloculated cyst secondary to degenerative joint disease. Dr. Diamond opined Employee was not a candidate for radiofrequency ablation as he had not yet had a trial of medial branch blocks. Because Employee had not benefited from previous epidural steroid blocks, Dr. Diamond did not recommend further blocks, and he did not recommend a radiofrequency ablation (rhizotomy). He recommended further diagnostic testing, specifically electromyography (EMG) and nerve conduction studies to identify the primary pain generator before considering surgery. Finally, he opined a trial of a TENS unit and continued home exercise program would be appropriate. Dr. Diamond opined Employee had reached maximum medical improvement as of October 15, 2011, assuming Employee did not wish to pursue surgical treatment. He opined all medical treatment Employee had received to that date for his lumbar spine symptoms had been reasonable and necessary. Finally, Dr. Diamond assessed a 12% whole person impairment rating. (*Richardson I*; Diamond SIME Report, March 30, 2012).

12) On May 21, 2012, Employee underwent an EMG, which demonstrated "no evidence of radiculopathy or generalized neuropathy." (*Richardson I*).

13) On May 24, 2012, Employee saw Rubin Bashir, M.D. Based on Employee's complaints of low back and left leg pain, Dr. Bashir recommended a selective nerve root block and selective nerve root tests. He opined Employee was not currently a surgical candidate. (*Id*).

14) On June 25, 2012, Dr. Diamond issued an addendum to his March 30, 2012 SIME report. Dr. Diamond indicated he had reviewed additional records of Drs. Kim and Bashir, as well as the EMG and nerve conduction studies, and opined the additional information confirmed his prior opinion Employee is not likely a candidate for discectomy surgery, as there is no indication of radiculopathy on the tests. Dr. Diamond indicated he agreed with Dr. Bashir's assessment that a pain generator had not yet been identified, and recommended Employee undergo a selective nerve root block and medial branch block trial. He indicated if the medial branch-block trial results in significant improvement, he may recommend a rhizotomy. (*Id*).

15) On July 17, 2012, Dr. Kim performed a radiofrequency medial branch rhizotomy at left L4-L5. (*Id*).

16) On July 24, 2012, Employee underwent a second radiofrequency medial branch rhizotomy at L4-5. (Brigham EME Report, November 26, 2013).

17) On July 30, 012, Dr. Kim noted Employee had not received much relief from the radiofrequency rhizotomies. (Kim Chart Note, July 30, 2012).

18) On August 3, 2012, Employee underwent an MRI, which showed mild chronic compression deformities of T12 and L1 and disk bulges at L4-5 and L5-S1 with moderate foraminal stenosis on the left at L4-5 and on the right at L5-S1. (*Richardson I*).

19) Also on August 3, 2012, Employee underwent a lumbar myelogram, which showed small anterior extradural defects at L4-L5 and L5-S1 consistent with disk bulges, but no nerve root sleeve deformity or spinal canal stenosis. (*Id*).

20) On August 28, 2012, Kim Wright, M.D. opined: "Based on the patient's description of symptoms and previous MRI report, I can't help but think that his disabling back pain is due to problems described above at the L4-5, 5-1 (sic) levels…. Clearly he has failed extensive conservative treatment and I believe he is most likely going to require surgical intervention." (*Id*).

21) *Richardson I* was issued December 18, 2012. *Richardson I* held Employee was entitled to further medical treatment including surgery if recommended by his treating physician, and was entitled to other benefits including temporary total disability (TTD) benefits. (*Id*).

22) On February 9, 2013, Veena Basava, M.D. examined Employee and noted he was using a TENS (transcutaneous electrical nerve stimulator) unit, which was providing some relief. (Brigham EME Report, November 26, 2013).

23) On February 13, March 13, and September 23, 2013, Dr. Basava administered more epidural steroid injections. (*Id*).

24) On May 15, 2013, Employee underwent a microdiscectomy at L4-5. (*Id.*).

25) On August 7, 2013, Steven Imbody, M.D., a neurologist, performed electrodiagnostic testing which suggested Employee had peripheral neuropathy. (Brigham EME Report, October 7, 2014).

26) On August 23, 2013, Employee reported to PA-C Sowmya Oommen that even after the microdiscectomy he still had persistent low back pain radiating to his legs and numbness in his feet. (Brigham EME Report, November 26, 2013).

27) On November 26, 2013, Lance Brigham, M.D., an orthopedic surgeon, saw Employee for an employer's medical evaluation (EME). Employee reported to Dr. Brigham that he had received eight epidural steroid injections, only one of which provided relief for a short time. Dr. Brigham diagnosed failed a laminectomy and discectomy, and opined Employee would need further medical treatment, but he did not recommend further epidural injection or a spinal fusion. Dr. Brigham diagnosed a lumbar strain as well as the laminectomy and discectomy, which were due to the work injury. He also diagnosed peripheral neuropathy, but stated it was not related to the work injury. (*Id*).

28) On December 3, 2013, Employee was seen by Dr. Wright. His blood pressure was normal. (Wright, Chart Note, December 3, 2013).

29) On January 22, 2014, Heath Mcanally, M.D. noted Employee had received eight epidural steroid injections that had not helped him any. (Mcanally, Chart Note, January 22, 2014).

30) On February 3, 2014, Employee underwent surgery for an L4-5 laminectomy and fusion. (Providence Alaska Medical Center, Operative Report, February 3, 2014; Brigham EME Report, October 7, 2014).

31) On March 21, 2014, Dr. Mcanally diagnosed Employee with hypertension as his blood pressure was well above normal. He did not believe the hypertension was solely due to Employee's pain, and he did not prescribe any medication. (Mcanally, Chart Note, March 21, 2014).

32) On April 12, 2014, Employee reported to Dr. Wright that he continued to experience back and leg pain. Dr. Wright recommended an MRI of Employee's hips. Employee also noted some shoulder and neck pain, and Dr. Wright stated his physical exam suggested this was due to carpal tunnel syndrome… (Dr. Wright, Chart Note, April 12, 2014).

33) On April 24, 2014, Employee had an MRI of both hips that showed degenerative joint disease, and a right subchondal cyst. (Brigham EME Report, October 7, 2014).

34) On May 8, 2014, Mark Wade, M.D. reviewed the MRI and diagnosed right hip osteoarthritis and femoral acetabular impingement. He concluded, however, that Employee's pain complaints were more likely radicular, and not due to the degenerative condition in his hip. (Wade Chart Note, May 8, 2014).

35) On August 8, 2014, Employee reported shoulder and neck pain to Dr. Wright who recommended a neurological consult. Employee's blood pressure was only slightly above normal. (Brigham EME Report, October 7, 2014).

36) On August 28, 2014, Employee was seen by Robert Valentz, M.D. His blood pressure was again only slightly above normal. (Valentz Chart Note, August 28, 2014).

37) On October 7, 2014, Employee was again seen by Dr. Brigham for another EME. Employee reported he had recently gone to the emergency room, where he had been diagnosed with high blood pressure. Dr. Brigham stated no further injections or rhizotomies were medically necessary. He also opined that a spinal cord stimulator was not medically necessary, and cited a study by the State of Washington Department of Labor and Industries showing they were not effective. (Brigham EME Report, October 7, 2014). The medical records in the board's file do not include an emergency room report indicating Employee had high blood pressure. (Observation).

38) On November 7, 2014, Employee returned to Dr. Mcanally who stated Employee might benefit from a thorocolumbar spinal cord stimulator. (Mcanally, Chart Note, November 7, 2014).

39) On December 20, 2014, Employee saw Dr. Luis Arias Pulgarin who opined Employee's high blood pressure was due to the pain from his failed back surgeries. (Pulgarin Chart Note, December 20, 2014). Dr. Pulgarin's chart notes do not include a blood pressure measurement. (Observation).

40) There is no indication in the medical records that Employee is taking or has been prescribed medication for high blood pressure. (Observation).

41) On February 24, 2015, the parties filed a C&R in which Employee settled and waived all benefits under the Act, with the exception of compensable medical costs related to his L4-5 condition. The agreement, however, is conditional on a board hearing and decision as to whether Employee's neck, wrists, heart, hips, and bilateral polyneuropathy conditions are compensable, as well as a determination as to the medical reasonableness and necessity of further spinal injections, rhizotomies, and neurostimulator treatments. (C&R, February 24 2015).

42) On March 3, 2015, a board designee sent the parties a letter stating the C&Rdid not require board review and was effective February 24, 2015, when it was filed. (Letter to the Parties, March 3, 2015).

43) On March 13, 2015, Employer filed a petition seeking board review of the designee's decision that the compromise and release was effective when filed. (Petition, March 10, 2015).

44) At the March 26, 2015 prehearing conference, the parties agreed to a written record hearing to address the effectiveness of the compromise and release agreement as well as the compensability of the medical conditions and treatments. (Prehearing Conference Summary, March 26, 2015).

45) On April 2, 2015, the parties filed a stipulation regarding the compensability of medical conditions and forms of treatment. The parties stipulated Employee's neck, bilateral wrist, heart, bilateral hip, and bilateral polyneuropathy conditions were not caused by the July 2010 work injury and, as a result, are not compensable. While they stipulated Employee's L4-5 condition is compensable, they agreed further spinal injections, rhizotomies, and neurostimulator treatments related to that condition were neither reasonable nor necessary. The stipulation cites many of the medical records to support the parties' position. (Stipulation, April 2, 2015).

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;

. . .

(4) hearings in workers' compensation cases shall be impartial and fair to all parties and that all parties shall be afforded due process and an opportunity to be heard and for their arguments and evidence to be fairly considered.

The board may base its 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.

AS 23.30.012. Agreements in regard to claims.
(a) At any time after death, or after 30 days subsequent to the date of the injury, the employer and the employee or the beneficiary or beneficiaries, as the case

> may be, have the right to reach an agreement in regard to a claim for injury or death under this chapter, ….
>
> (b) The agreement shall be reviewed by a panel of the board if the claimant or beneficiary is not represented by an attorney licensed to practice in this state, the beneficiary is a minor or incompetent, or the claimant is waiving future medical benefits….

A workers compensation C&R is a contract "subject to interpretation as any other contract." *Seybert v. Cominco Alaska Exploration*, 182 P.3d 1079, 1093 (Alaska 2008).

> **AS 23.30.095. Medical 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, ….

The Supreme Court interpreted the phrase "which the nature of the injury or the process of recovery requires," in AS 23.30.095 to mean reasonable and necessary medical care. *Bockness v. Brown Jug, Inc.*, 980 P.2d 462 (Alaska, 1999).

> **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 medical benefits. *Municipality of Anchorage v. 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).

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). Medical evidence may be needed to attach the presumption of compensability in a complex

medical case. *Burgess Constr. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). However, an employee "need not present substantial evidence that his or her employment was a substantial cause of his disability." *Fox v. Alascom, Inc.*, 718 P.2d 977, 984 (Alaska 1986) "In making the preliminary link determination, the Board may not concern itself with the witnesses' credibility." *Excursion Inlet Packing Co. v. Ugale*, 92 P.3d 413, 417 (Alaska 2004).

If the employee establishes the preliminary link, then the employer can rebut the presumption by presenting substantial evidence that demonstrates that a cause other than employment played a greater role in causing the disability or need for medical treatment or by substantial evidence that employment was not the substantial cause. *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 (Mar. 25, 2011) at 7); *Ashwater Burns Inc. v. Huit*, AWCAS Decision No. 191 (March 18, 2014). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Fireman's Fund Am. Ins. Companies v. Gomes*, 544 P.2d 1013, 1015 (Alaska 1976). The determination of whether evidence rises to the level of substantial is a legal question. *Id*. Because the employer's evidence is considered by itself and not weighed at this step, credibility is not examined at this point. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 869-870 (Alaska 1985).

If the presumption is raised and not rebutted, the claimant need produce no further evidence and prevails solely on the raised but un-rebutted presumption. *Williams v. State*, 938 P.2d 1065 (Alaska 1997). "If the employer rebuts the presumption, it drops out, and the employee must prove, by a preponderance of the evidence, that in relation to other causes, employment was the substantial cause of the disability, need for medical treatment, etc. Should the employee meet this burden, compensation or benefits are payable." *Runstrom* at 8.

> **8 AAC 45.050. Pleadings 8 AAC 45.050. Pleadings**
> . . . .
>
> (f) Stipulations.
> . . . .
>
> (2) Stipulations between the parties may be made at any time in writing before the close of the record, or may be made orally in the course of a hearing or a prehearing.

> (3) Stipulations of fact or to procedures are binding upon the parties to the stipulation and have the effect of an order unless the board, for good cause, relieves a party from the terms of the stipulation. A stipulation waiving an employee's right to benefits under the Act is not binding unless the stipulation is submitted in the form of an agreed settlement, conforms to AS 23.30.012 and 8 AAC 45.160, and is approved by the board.
>
> (4) The board will, in its discretion, base its findings upon the facts as they appear from the evidence, or cause further evidence or testimony to be taken, or order an investigation into the matter as prescribed by the Act, any stipulation to the contrary notwithstanding.

ANALYSIS

1) Was the C&R effective when filed?

A C&R is a contract between the parties. *Seybert*. Although the board may be required to approve or reject some agreements, the agreements remain the parties' agreements; the board cannot dictate terms. Consequently, if a C&R states that it is not effective until a contingency is met, it is not effective when filed even though it otherwise meets the requirements of AS 23.30.012(b). Contrary to the board designee's March 3, 2015 letter, the parties' February 24, 2015 C&R was not effective when filed. Because the agreement does not otherwise require board approval, it will become effective when, and if, the contingencies are met.

2) Are Employee's neck, bilateral wrist, heart, hypertension, bilateral hip, or bilateral polyneuropathy conditions compensable?

These are factual questions to which the presumption of compensability applies. When an employee is being treated for a work-related injury, it is not uncommon for doctors to discover other conditions or disorders. Whether those conditions or disorders were caused by the work injury is typically a complex medical issue, and medical evidence is needed to attach the presumption of compensability. Employee needs only "some," or "minimal," relevant medical evidence to raise the presumption. In determining whether the presumption is met, credibility is not considered nor is the evidence weighed against competing evidence.

As to Employee's neck, wrists, heart, hips, and bilateral polyneuropathy, there is no medical evidence indicating employment was even a factor in causing the conditions. Employee has not

raised the presumption. Because Employee failed to raise the presumption as to these conditions, he must prove, by a preponderance of the evidence, that work was the substantial cause of any disability resulting from the conditions or the need for medical treatment. He cannot do so.

The only evidence as to causation of Employee's neck and wrist conditions is Dr. Wright's April 12, 2014 opinion that these were due to carpal tunnel syndrome. The only evidence as to the cause of Employee's hip condition is Dr. Wade's May 18, 2014 opinion that it was caused by osteoarthritis and acetabular impingement. Dr. Imbody diagnosed peripheral neuropathy after his electrodiagnostic testing on August 7, 2013, but he did not opine as to the cause. In his November 26, 2013 EME report, Dr. Brigham also diagnosed peripheral neuropathy, but stated it was not related to the work injury. There is no evidence in the record that Employee suffers from any heart condition. The preponderance of the evidence establishes that employment was not the substantial cause of Employee's neck, bilateral wrist, heart, bilateral hip, and bilateral polyneuropathy conditions. Consequently, employment is not the substantial cause of any disability due to those conditions or the need for medical treatment necessitated by the conditions.

The presumption of compensability also applies to the question of whether Employee's hypertension was caused by the work injury. Employee successfully raised the presumption as to hypertension. Dr. Mcanally diagnosed Employee with hypertension on March 21, 2014, and his report suggests the high blood pressure may be due in part to Employee's pain. On December 20, 2014, Dr. Pulgarin stated Employee's high blood pressure was due the pain from Employee's failed back surgeries. Without considering credibility or competing evidence, Dr. Mcanally's and Dr. Pulgarin's reports are sufficient to raise the presumption.

Employer successfully rebutted the presumption through Dr. Wright's August 8, 2014 and Dr. Valentz' August 28, 2014 chart notes showing only slightly elevated blood pressure as well as evidence that no provider had prescribed medication to treat hypertension. Again, Employer's evidence is considered by itself and not weighed against competing evidence at this step, and credibility is not considered.

Because Employer successfully rebutted the presumption, Employee was required to prove by a preponderance of the evidence that work is the substantial cause of his hypertension. He did not do so. There is nothing in the medical records to indicate Employee was ever prescribed medication or other treatment for hypertension. Dr. Pulgarin's statement that Employee's hypertension was caused by the pain of his work injury is suspect and is given little weight because there is no evidence Dr. Pulgarin took Employee's blood pressure at the time. Dr. Wright's August 8, 2014 diagnosis of hypertension appears to have been based on an isolated instance of high blood pressure, as does Employee's report of high blood pressure at the emergency room. The bulk of Employee's medical records do not show chronic high blood pressure; they reflect a normal or only slightly elevated blood pressure. On the whole, the medical records do not establish that Employee suffers from hypertension, let alone that it was caused by the work injury.

The medical records establish that the July 2010 work injury is not the substantial cause of Employee's neck, bilateral wrist, heart, hypertension, bilateral hip, or bilateral polyneuropathy conditions. The parties' stipulation to that the conditions are not compensable is well supported by the evidence and will be approved.

3) Are further epidural steroid injections, rhizotomies, or implanted neurostimulator treatments medically reasonable and necessary?

In the February 24, 2015C&R, the parties agreed that Employee's L4-5 condition is compensable and future medical benefits related to that condition are not waived. The treatments at issue here were either performed or have been recommended as treatment for Employee's L4-5 condition. The question is whether the treatments are reasonable and necessary now or in the future.

The reasonableness and necessity of medical treatment is also an issue to which the presumption of compensability applies. The reasonableness and necessity of specific medical treatments are complex medical issues, and medical evidence is needed to attach the presumption of compensability. Employee needs only "some," or "minimal," relevant medical evidence to raise the presumption, and the credibility of the evidence is not considered nor is the evidence weighed against competing evidence. Employee successfully raised the presumption the

epidural steroid injections are reasonable and necessary through the evidence that Dr. Kim and Dr. Basava have each prescribed and administered the injections. As to rhizotomies, Employee successfully raised the presumption through the evidence Dr. Kim had prescribed and performed the procedure. Dr. Mcanally's statement that Employee might benefit from a spinal cord stimulator is sufficient to raise the presumption for the spinal cord stimulator.

Employer successfully rebutted the presumption for each of the conditions. In his March 30, 2012 report, Dr. Diamond recommended against further epidural steroid injections. In both his November 26, 2013 and October 7, 2014 reports, Dr. Brigham did not recommend further injections. Those reports are sufficient to rebut the presumption as to the epidural steroid injections. Dr. Diamond recommended against rhizotomies in his March 30, 2012 report, and in his October 7, 2014 report, Dr. Brigham stated no further rhizotomies were medically necessary. Those opinions are sufficient to rebut the presumption as to the rhizotomies. As to an implanted neurostimulator, Employer rebutted the presumption with Dr. Brigham's October 7, 2014 opinion that a spinal cord stimulator was not medically necessary.

Because Employer rebutted the presumption as to the medical treatments, Employee must prove by a preponderance of the evidence the treatments are medically reasonable and necessary. On June 8, 2011, Employee reported to Dr. Kim that he had only received minimal relief from the epidural steroid injections. He told Dr. Brigham he had received eight epidural steroid injections only one of which had provided any relief. He also told Dr. Mcanally he had received eight injections, but had not experienced "any relief." Dr. Diamond and Dr. Brigham both recommend against further epidural injections. There is no evidence that any doctor continues to recommend epidural steroid injections, now or in the future. Whether Employee received six or eight injections, it is clear he received little, if any, benefit. The preponderance of the evidence is that, in Employee's case, epidural steroid injections are an ineffective treatment, which no doctor currently favors and at least two doctors oppose. Further epidural steroid injections are neither medically reasonable nor necessary.

Dr. Brigham has opined no further rhizotomies are medically necessary, and, after Employee's spinal fusion, no doctor has indicated otherwise. The preponderance of the evidence is that further rhizotomies are neither medically reasonable nor necessary.

Only Dr. Mcanally suggests Employee may benefit from an implanted neurostimulator. However, because Dr. Mcanally only states Employee "might" benefit from the stimulator, his opinion is given less weight. Dr. Brigham's opinion is much more certain; in his October 7, 2014 report he stated a stimulator "was not" medically necessary, and he to a medical study to support his position. The preponderance of the evidence is that an implanted neurostimulator is not reasonable or necessary medical treatment. This does not include Employee's use of a TENS unit, which, although it provides nerve stimulation, is not implanted.

CONCLUSIONS OF LAW

1) The C&R was not effective when filed; it will become effective when, and if, the contingencies are met.

2) Employee's neck, bilateral wrist, heart, hypertension, bilateral hip, or bilateral polyneuropathy conditions are not compensable.

3) Further epidural steroid injections, rhizotomies, or implanted neurostimulator treatments are not medically reasonable and necessary.

ORDER

1) Employer's March 10, 2015 petition for review of the board designee's determination as to the effective date of the February 24, 2015 C&R is granted.

2) The February 24, 2015 C&R will become effective when, and if, the contingencies are met.

3) The parties' April 1, 2015 stipulation is approved.

4) Employee's neck, bilateral wrist, heart, hypertension, bilateral hip, or bilateral polyneuropathy conditions are not compensable.

5) Further epidural steroid injections, rhizotomies, or implanted neurostimulator treatments are not medically reasonable and necessary.

Dated in Fairbanks, Alaska on April 21, 2015.

ALASKA WORKERS' COMPENSATION BOARD

/s/_____
Amanda Eklund, Designated Chair

/s/_____
Jacob Howdeshell, 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 VANCE RICHARDSON, employee / claimant; v. INTERIOR ALASKA ROOFING, INC., employer; ALASKA NATIONAL INSURANCE, insurer / defendants; Case No 201010244; dated and filed in the Alaska Workers' Compensation Board's office in Fairbanks, Alaska, and served on the parties on April 21, 2015.

/s/_____
Darren Lawson, Office Assistant II