ALASKA WORKERS' COMPENSATION BOARD

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

DEVIN A. McNULTY, Employee, Claimant, v. LAST FRONTIER BAR, Employer, and COMMERCE AND INDUSTRY INSURANCE COMPANY, Insurer, Defendants.	)	FINAL DECISION AND ORDER ON PETITION FOR MODIFICATION AWCB Case No. 200907861 AWCB Decision No. 20-0029 Filed with AWCB Anchorage, Alaska on May 11, 2020

The Last Frontier Bar's November 14, 2019 petition for modification of *McNulty v. Last Frontier Bar*, AWCB Decision No. 18-0127 (December 13, 2018) (*McNulty I*), was heard on March 5, 2020 in Anchorage, Alaska, a date selected on January 9, 2020. A December 6, 2019 affidavit or readiness for hearing gave rise to this hearing. Attorney Eric Croft appeared and represented Devin A. McNulty (Employee). Attorney Aaron Sandone appeared and represented Last Frontier Bar and Commerce and Industry Insurance Company (Employer). There were no witnesses. The record closed at the hearing's conclusion on March 15, 2020.

In *McNulty I*, Employee sought an order requiring Employer to resume paying for the medications he had been prescribed at the time Employer controverted, diazepam and oxycodone. At the time of the controversion, Employee had been prescribed a daily morphine equivalent dose of 270 mg of oxycodone as well as diazepam. By the *McNulty I*

hearing, Employee was taking a daily morphine equivalent dose of 90 mg, which is the maximum recommended by the Center for Disease Control (CDC) in its new guidelines. *McNulty I* ordered Employer to resume paying for a 90 mg morphine equivalent dose.

ISSUE

Employer contends *McNulty I* should be modified based both on a mistake in fact and a change in condition. Employer first contends *McNulty I* erred in finding, "There is no evidence the continuation of opioids at the 90mg. morphine equivalent level until surgery is either unreasonable or unnecessary." Employer's second contention is that there has been a change in circumstances because Employee has not undergone the surgery anticipated in *McNulty I*. Employee contends *McNulty I* correctly found the ongoing opioids allowed Employee to function at home and at work, there has not been a change in circumstances, and *McNulty I* should not be modified.

Should McNulty I be modified?

FINDINGS OF FACT

All findings of fact in *McNulty I* are incorporated herein by reference. The following additional facts and factual conclusions are undisputed or established by a preponderance of the evidence:

1) Employee worked for Employer as a bouncer. On March 22, 2009, he was escorting a customer off the premises when a fellow bouncer who weighed about 400 pounds stepped on Employee's left foot. (*McNulty I*).

2) After the injury on March 22, 2009, Employee went to the emergency room complaining of ankle pain. X-rays revealed a normal ankle, but showed a fractured fourth metatarsal in his left foot. The emergency department note states it was Employee's fifth metatarsal that was fractured. Employee's foot was wrapped, he was given opioids, and he was instructed to follow up with an orthopedist. (*McNulty I*).

3) On March 23, 2009, Employee was seen by PA-C Tracie Rieker at Orthopedic Research Clinic of Alaska. X rays showed Employee had fractured his sesamoid bone and the base of his third metatarsal. He was prescribed a metatarsal boot and restricted from work for three weeks. (*McNulty I*).

4) On April 13, 2009, Employee was seen by Doug Vermillion, M.D. Employee's foot was markedly tender, and he complained of pain. X-rays showed a widening of the first and second metatarsal interspaces, a fracture of the fourth metatarsal, and a possible fracture of the third metatarsal. Dr. Vermillion diagnosed a left foot Lisfranc injury and recommended open reduction internal fixation surgery. (*McNulty I*).

5) On April 16, 2009, Dr. Vermillion performed the surgery, and on June 25, 2009, he again operated to remove the hardware from Employee's foot. (*McNulty I*). .

6) On December 4, 2009, Dr. Vermillion released Employee to work full time without any restrictions. (*McNulty I*).

7) On April 2, 2010, Employee reported increased pain to Dr. Vermillion, who recommended a fusion. (*McNulty I*).

8) On September 17, 2010, Employee was seen by John Ballard, M.D., for an employer's medical evaluation (EME). Dr. Ballard examined Employee, reviewed his medical records, and identified the March 22, 2009 work injury as the only cause of Employee's Lisfranc disruption. Dr. Ballard agreed Employee was medically stable at the time of Dr. Johnston's PPI rating on November 12, 2009 and agreed with Dr. Johnston's three percent impairment rating. Dr. Ballard did not recommend further treatment at the time, but noted a fusion might be warranted in the future. (*McNulty I*).

9) On January 19, 2011, Employee reported to Dr. Vermillion the pain in his foot was getting worse, and on March 24, 2011, Dr. Vermillion performed the fusion surgery. (*McNulty I*).

10) On September 8, 2011, Employee was seen by Dr. Ballard for another EME. Employee reported to Dr. Ballard the pain was much worse since the surgery and he had decreased range of motion. Dr. Ballard again opined the cause of Employee's medical condition was the March 29, 2009 work injury. He found Employee was not medically stable and recommended a CT scan. Dr. Ballard noted Employee seemed to have subjective pain complaints that were not substantiated by objective findings. (*McNulty I*).

11) On October 7, 2011, Employee was seen by Eugene Chang, M.D., who reviewed a CT scan of Employee's foot. Dr. Chang noted good fusion as the first metatarsal cuneiform joint, but found questionable healing at the second metatarsal cuneiform joint. Because Employee

clearly had pain over the head of one of the implanted screws, Dr. Chang recommended removal of the screw. (*McNulty I*).

12) On October 11, 2011, Dr. Chang removed the screw from Employee's foot. (*McNulty I*).

13) Employee was seen by PA-C John Love on December 28, 2011 with continued foot pain. PA Love noted Employee could be suffering from nerve pain and there might not be a surgical solution. Employee asked for referral to a chronic pain clinic as there were no further surgical options. (*McNulty I*).

14) On January 6, 2012, Dr. Chang agreed Employee's pain was likely neuropathic and he offered no surgical options at the time. (*McNulty I*).

15) On January 16, 2012, Employee was seen by Shawn Johnston, M.D. Employee explained he had been prescribed a variety of pain medication since the injury. Employee signed a medication management agreement, and Dr. Johnston prescribed Roxicodone and Mobic. (*McNulty I*).

16) On March 16, 2012, Dr. Johnston referred Employee to Leon Chandler, M.D., a pain specialist at AA Spine & Pain Clinic. (*McNulty I*).

17) Employee was seen by Dr. Chandler on May 14, 2012. Employee reported opioids did not provide pain relief, but Demerol had worked in the past. Dr. Chandler prescribed Demerol and Valium. (*McNulty I*).

18) On May 15, 2012, Employee was seen by Sidney Baucom, M.D., in Seattle. Dr. Baucom noted Employee's pain appeared neuropathic, and he recommended physical therapy and treatment at a pain clinic. Dr. Baucom noted it might be worth removing the remaining screw if Employee's pain continued. (*McNulty I*).

19) On May 23, 2012, Dr. Vermillion stated Employee had not been medically stable during 2010. However, on October 31, 2012, Dr. Vermillion stated Employee had been able to work between August 26, 2009 and the March 24, 2011 fusion surgery. (*McNulty I*).

20) On March 1, 2013, Employee began treating with David Randall, D.P.M., at which time Dr. Randall prescribed new orthotics. On April 12, 2013 Dr. Randall discussed revision surgery with Employee. (*McNulty I*).

21) On June 28, 2013, Employee was again seen by Dr. Ballard for an EME. He reviewed additional medical records, examined Employee, and Ballard stated the work injury was still the substantial cause of Employee's disability and need for medical treatment, but Employee was

medically stable under the legal definition. Dr. Ballard did not find any indication Employee's pain was neuropathic, and stated Employee's narcotic medications were appropriate. Dr. Ballard noted additional surgery to fuse the second tarsometatarsal joint was possible. (*McNulty I*).

22) On March 6, 2014, Dr. Randall performed surgery to fuse Employee second and third metatarsocuneiform joint and his Lisfranc complex. (*McNulty I*).

23) On April 15, 2014, Employee reported to Dr. Randall that his pain was about the same as it had been before the surgery. (*McNulty I*).

24) On October 15, 2014, Dr. Randall performed surgery to remove hardware from Employee's foot. (*McNulty I*).

25) On January 9, 2015, Employee was again seen by Dr. Ballard. Dr. Ballard again found the work injury to be the substantial cause of Employee's need for treatment. He noted Lisfranc injuries can result in chronic midfoot pain, but Employee was medically stable. Dr. Ballard stated narcotics were reasonable if monitored and controlled, but it would be best if Employee was weaned off narcotics. (*McNulty I*).

26) On August 26, 2015, Employee asked Dr. Randall if a below the knee amputation would allow him to be pain-free. Dr. Randall explained he could continue to experience pain even with an amputation. (*McNulty I*).

27) On August 23, 2016, Employee was seen by Carol Frey, M.D., for a Board-ordered second independent medical evaluation (SIME). Dr. Frey examined Employee and reviewed the medical records relating to the work injury. Dr. Frey diagnosed a history of a Lisfranc fracture dislocation at the first, second, and third metatarsocuneiform joint, degenerative arthritis/overuse of the fourth and fifth metatarsocuboidal joint, over use of the fourth and fifth metatarsals, impingement of the deep peroneal nerve, possible exuberant bone formation from the fusions, a very tight left Achilles tendon, and long-term opioid use. She stated the substantial cause of the Lisfranc injury was the work injury, and all of the other diagnoses were the direct result of the Lisfranc injury. Dr. Frey stated it was common for pain to continue after a Lisfranc injury. Dr. Frey noted Employee might benefit from surgery to shorten his fourth and fifth metatarsals, but the surgery was only successful about 75 percent of the time. She found Employee reached medical stability six months after the October 4, 2014 surgery, but if he elected to have the shortening surgery it would take six months to recover. Dr. Frey stated Employee would require pain management over a five-year period. (*McNulty I*).

28) Dr. Frey is an orthopedic surgeon specializing in feet and ankles. (Dr. Frey, SIME Report, August 23, 2016).

29) Employee returned to Dr. Randall on August 10, 2017. He explained he had stepped wrong and felt "cracking and popping" and increased pain in his foot. Employee told Dr. Randall about the surgery Dr. Frey had recommended. Dr. Randall referred Employee for an MRI, and asked for Dr. Frey's report. (*McNulty I*).

30) On November 16, 2017, Employee was seen by Gary Olbrich, M.D., a pain management and addictive disease specialist for an EME. Dr. Olbrich reviewed Employee's medical records, noting Employee's prescriptions. Employee told Dr. Olbrich he had abused alcohol when young, but had never blacked out or been in legal trouble as a result. He had voluntarily reduced his consumption to one to three drinks per week. Employee explained to Dr. Olbrich that narcotics, regardless of the type or dosage had never done more than take the edge off his pain. Dr. Olbrich diagnosed severe substance abuse disorder including opioid and diazepam use, as well as chronic pain disorder as the result of long-term narcotics use. Dr. Olbrich explained severe substance abuse disorder was also known as addictive disorder, which is a brain disease with a physiological basis. Only about ten percent of the U.S. population are susceptible to the disease which causes physiological changes in the brain pathways. Dr. Olbrich explained chronic pain disorder is caused by the use of opioids for longer than 90 days. One effect of long-term usage is that stimuli that were not previously perceived as painful become painful. Dr. Olbrich stated the Centers for Disease Control (CDC) recently published new guidelines for long-term opioid use. Opioids for postoperative pain should be limited to 10 days, and the morphine equivalent dose of any opioid should never exceed 90 mg. per day. Additionally opioids and benzodiazepines should not be prescribed concurrently. Dr. Olbrich recommended Employee be weaned off opioids and suggested two inpatient facilities. (*McNulty I*).

31) On May 17, 2018, in reliance on Dr. Olbrich's EME Report, Employer controverted opioids and valium after August 12, 2018, if Employee did not begin the weaning process recommended by Dr. Olbrich by June 17, 2018. (*McNulty I*).

32) On June 4, 2018, Employee filed a petition asking that his current medications be continued until he had the surgery recommended by Dr. Frey. (*McNulty I*).

33) On July 5, 2018, Employee's June 4, 2018 petition was set for hearing. The issues were Employees June 4, 2018 petition for continued prescription medication, TTD, PPI, compensation

rate adjustment, interest, and attorney fees and costs. (Prehearing Conference Summary, July 5, 2018).

34) On August 8, 2018, Employee returned to Derek Hagen, D.O., for his monthly pain management visit. His monthly prescriptions for oxycodone and diazepam were renewed. (*McNulty I*).

35) Employee began tapering off the oxycodone on his own, and by September 27, 2018, he had taken his last pill. (*McNulty I*).

36) Dr. Hagen was deposed on October 5, 2018. He explained he was amenable to weaning Employee off his medications, but he did not want Employee to suffer just to prove a point. Dr. Hagen noted that while Employee's dosage had increased over the years, the increase was slower than that sought by addicts and was due to Employee's increased tolerance. (*McNulty I*).

37) On October 10, 2018, Employee told Dr. Randall his fourth and fifth metatarsals moved out of place and needed to be "popped" back in several times per day. He also explained he had been cut off from opioids and had some withdrawal symptoms for a couple weeks. (*McNulty I*). Dr. Randall opined Employee would "require prolonged and likely lifetime pain management" due to the injury. (Dr. Randall, Chart Note, October 10, 2018).

38) On October 13, 2018, Employee reported he had been off medications for over a month. He was prescribed 30 mg. morphine, three times per day. The valium and oxycodone prescriptions were discontinued. (*McNulty I*).

39) At the *McNulty I* hearing, Employee testified he had not abused his medications, and had never asked his doctors to increase the dosage, although he had told them he was not getting much relief. He had been prescribed opioids after two prior injuries, but had used them for only a short period. After his oxycodone had been controverted and he was without, he discovered the opioids had been providing more relief than he previously believed. He explained he wanted to proceed with the surgery Dr. Frey had recommended, but his compensation rate was so low he could not afford to be off work for the time it would take to recover. He had continued to work after the work injury except for short periods after each of his surgeries, and he believed the opioids helped him to do that. (*McNulty I*).

40) Brandy Larson has lived with Employee since December 2015. She also uses opioids as a result of a degenerative soft-tissue injury, and they both kept their prescriptions in separate locked boxes and never shared or loaned each other pills. Employee's pain medication had

allowed him to work and do things with his family, although he would often "work through the pain" rather than take another pill. While on the pain medications he had never missed work because of the pain, but he had missed some days since his medications were cut off. (*McNulty I*).

41) At the *McNulty I* hearing, Dr. Olbrich explained opioids are more effective for musculoskeletal pain, and much less so for neurogenic pain. They are powerful psychological stimulators; they cause people to feel calm with a sense of well-being, and act as an energizer. When used to treat pain, opiates work well for a short period of time, but have not been shown effective for long periods. The strength of different opioids varies, and to compare dosages, drugs are given a morphine equivalent; oxycodone has a morphine equivalent of 1.5, so each milligram of oxycodone is equivalent to 1.5 milligrams of morphine. Recently, the CDC issued guidelines for the long-term use of opioids, and dosages should be limited to 90 mg. morphine equivalent per day. The CDC also cautions against prescribing opioids in combination with hypnotics, such as Valium (diazepam), and Dr. Olbrich noted Employee was being prescribed a high dose of diazepam together with the opioids. One significant side effect of opioids is they depress respiration. While people can develop a tolerance to opioids and the dosage necessary to obtain pain relief increases, there is no increase in tolerance for respiratory depression. Individuals prescribed opioids for longer than 90 days begin to experience what had previously been non-painful stimuli as painful. Dr. Olbrich explained the gold standard for long term opioid use is the patient must show a significant increase in function, and an increase in function is more important than a decrease in pain. He reviewed entries in several of Employee's medical records where Employee reported the opioids were not really helping his pain and he showed no increase in function. Employee had been started on a very high dose in 2012, and the dose had been increased over time to the point Employee was prescribed a morphine equivalent dose of 270 mg. Dr. Olbrich explained the best option for weaning was an inpatient program. While weaning could be done through a pain clinic, pain clinics typically lack the resources to provide the attention each patient requires. However, even without a program, he would still recommend reducing opioids gradually, to the 90 mg. morphine equivalent level if possible. He would not recommend going "cold turkey," and, if Employee was to proceed with the recommended surgery, he would not recommend weaning before that time as some pain medication would be necessary after the surgery. (*McNulty I*).

42) Dr. Olbrich is a specialist in addiction and pain medicine. (Dr. Olbrich).

43) Dr. Olbrich stated he did not believe it was wise to restart Employee on opioids after he had weaned himself, but if Employee was going to have surgery in the near future, he would not take Employee off opioids entirely. Dr. Olbrich was then asked if opioid doses within the CDC limits could ever be appropriate if alternative treatments had not been effective. He responded that after a trial of perhaps six months without opioids, it would be within the standard of care to give opioids another try. (Dr. Olbrich).

44) Despite the CDC Guidelines, Dr. Olbrich testified that in his opinion, opioids should never be used for longer than 90 days in any situation. (Dr. Olbrich).

45) At the *McNulty I* hearing Dr. Frey testified she had reviewed additional medical records, as well as the depositions of Dr. Hagen, Dr. Randall, and Dr. Olbrich. She no longer believed the surgery she recommended would improve Employee's function, but it could still provide a reduction in his pain. Dr. Frey explained the "popping out of place" described in Dr. Randall's October 10, 2018 chart note was more significant. At this time, Employee's election to have the surgery depends on how compromised he is by the pain, and he is more likely to benefit if the pain is localized. However, if Employee does not get the surgery within five years of the March 6, 2014 fusion, she would no longer recommend it. She clarified the statement in her August 23, 2016 report that Employee would need pain management for five years. The statement should have been that Employee would have pain for five years after his last surgery, and, therefore, would need pain management during that time. She found Dr. Olbrich's EME report to be excellent and supported weaning Employee off opioids. (*McNulty I*).

46) As to the need for the surgery, Dr. Frey explained that after viewing the surveillance videos, Employee was so functional she would no longer recommend the surgery, and "I think the surgery would make him worse." She explained that "even in the best hands," the surgery was only 75 percent successful and there was a chance Employee could get worse. In any event, he would be off work for about three months after the surgery. The decision to proceed should be based on whether Employee functionally worsened from what is shown on the 2017 surveillance videos, but the choice for surgery should be left completely up to Employee. (Dr. Frey).

47) At the *McNulty I* hearing, Employer confirmed the surgery recommended by Dr. Frey had not been controverted, and Employee was free to pursue the surgery if he desired. (*McNulty I*).

48) *McNulty I*, which was issued on December 13, 2018, determined the issue of whether Employee was entitled to ongoing opioid medication was, at its core, a question as to whether the treatment was reasonable and necessary. In holding ongoing opioids were reasonable and necessary, *McNulty I* relied heavily on portions of Dr. Olbrich's testimony as well as testimony from Dr. Frey. In particular, *McNulty I* relied on Dr. Frey's testimony that even though the recommended surgery was no longer likely to improve Employee's function, it might reduce his pain if done within five years, which had not yet elapsed. And while Dr. Olbrich was clear he believed Employee should be completely weaned from opioids, he stated Employee should at least be weaned to a dose of 90 mg. morphine equivalent per day until surgery, which implicitly acknowledges such a dose would be reasonable and necessary. As a result, *McNulty I* ordered Employer to resume paying for up to 90 mg. morphine equivalent opioids per day. (*McNulty I*).

49) Dr. Hagen monitored Employee's use of pain medication on a monthly basis, including periodic drug testing. All of Dr. Hagen's chart notes indicate Employee has a potentially fatal allergy to two common topical pain relievers. (Dr. Hagen, Chart Notes). On October 29 2019, Employee confirmed to Dr. Hagen that while his pain had not changed significantly, his mobility and function improved while taking his pain medication and he continued to be employed. (Dr. Hagen, Chart Note, October 29, 2019).

50) On November 14, 2019, Employer filed a petition for modification of *McNulty I*. Employer contended *McNulty I* erred in construing. Dr. Olbrich's testimony and also that there had been a change in conditions in that Employee had not had the surgery within the five years in which Dr. Frey said it would be reasonable. (Employer Petition and Memorandum, November 14, 2019).

51) On November 24, 2019, Dr. Olbrich issued an addendum to his November 16, 2017 EME report after reviewing Dr. Hagen's medical reports from June 2018 through October 29, 2019. Dr. Olbrich responded to several questions from Employer. He stated it was still his opinion that Employee's ongoing use of opioid medication was neither reasonable nor necessary. He explained the ongoing use of opioids had not been effective as there had not been an improvement in the severity of his pain or evidence of a significant improvement in the quality

of his life. Dr. Olbrich opined there had been "more than adequate time" for Employee to get the surgery recommended by Dr. Frey, but given the lapse the need for surgery should be reevaluated. It is not clear from Dr. Olbrich's report whether he had reviewed *McNulty I*. (Dr. Olbrich, EME Addendum).

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;
>
> (3) this chapter may not be construed by the courts in favor of a party;
>
> (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 23.30.095. Medical treatments, services, and examinations.**
> (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. However, if the condition requiring the treatment, apparatus, or medicine is a latent one, the two-year period runs from the time the employee has knowledge of the nature of the employee's disability and its relationship to the employment and after disablement. It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require.

In *Bockness v. Brown Jug, Inc.*, 980 P.2d 462, 466 (Alaska 1999) the Supreme Court clarified that medical treatment under AS 23.30.095 is limited to reasonable and necessary treatment:

> While the Workers' Compensation Act may require employers to authorize some medical care during periods of medical instability as Bockness claims, the Act does not require employers to pay for any and all treatments chosen by the injured

> employee. Although no single provision states that all medical treatments must be reasonable and necessary, at several points in the Alaska Workers' Compensation Act the statutes make reference to that concept.

And in *Phillip Weidner & Assocs., Inc. v. Hibdon*, 989 P.2d 727, 732 (Alaska 1999), the Court addressed the issue of reasonableness of medical treatment:

> The question of reasonableness is "a complex fact judgment involving a multitude of variables." However, where the claimant presents credible, competent evidence from his or her treating physician that the treatment undergone or sought is reasonably effective and necessary for the process of recovery, and the evidence is corroborated by other medical experts, and the treatment falls within the realm of medically accepted options, it is generally considered reasonable. (citations omitted).

> **AS 23.30.130. Modification of awards.**
> (a) Upon its own initiative, or upon the application of any party in interest on the ground of a change in conditions, including, for the purposes of AS 23.30.175, a change in residence, or because of a mistake in its determination of a fact, the board may, before one year after the date of the last payment of compensation benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, whether or not a compensation order has been issued, or before one year after the rejection of a claim, review a compensation case under the procedure prescribed in respect of claims in AS 23.30.110. Under AS 23.30.110 the board may issue a new compensation order which terminates, continues, reinstates, increases, or decreases the compensation, or award compensation.

The Supreme Court also provided guidance when a party contends a decision should be modified based on a change in condition or a mistake in fact:

> In order to modify a previous order on the theory of mistake, a new order should make it clear that it is doing so, should review the evidence of the first hearing and should indicate in what respect the first order was mistaken-whether in the inaccuracy of the evidence, in the impropriety of the inferences drawn from it, or, as may be true in the present case, because of the impossibility of detecting the existence of the particular condition at the time of the earlier order. *Fischback & Moore of Alaska, Inc. v. Lynn*, 430 P.2d 909, 911-12 (Alaska 1967).

ANALYSIS

Should McNulty I be modified?

Employer first contends *McNulty I* should be modified because it mistakenly misconstrued Dr. Olbrich's report and testimony. It did not; *McNulty I* chose to rely on those portions of Dr. Olbrich's report and testimony the hearing panel believed most relevant. At the time of Dr. Olbrich's November 2017 EME report, Employee was taking a daily 270 mg. morphine equivalent dose of opioids. Dr. Olbrich opined that was too high, and opioids for postoperative pain should be limited to 10 days and never exceed 90 mg. per day. While he testified it would be preferable if Employee was weaned entirely from opioids, he acknowledged a dose of 90 mg. morphine equivalent until surgery was acceptable. By the time of the *McNulty 1* hearing, Employee was receiving a 90 mg. morphine equivalent daily dose, which *McNulty I* found to be consistent with Dr. Olbrich's testimony.

Dr. Olbrich's November 24, 2019, EME addendum is not persuasive that *McNulty I* misunderstood his testimony. Dr. Olbrich's opinion that Employee's ongoing use of opioid medication was neither reasonable nor necessary is clear. However, that conclusion is given little weight as it relies on a misunderstanding of the facts of the case. At the *McNulty I* hearing, Dr. Olbrich testified that the "gold standard" for long term opioid use is the patient must show a significant increase in function, and an increase in function is more important than a decrease in pain. In his addendum, he focuses on Employee's ongoing pain levels, and states there was no evidence of a significant improvement in the quality of his life. That disregards the credible testimony of Employee and Ms. Larson at the *McNulty I* hearing that except for time to recover after his surgeries, Employee had missed only minimal time for work except during the period when opioid medications were controverted. It also appears to ignore Employee's October 29 2019, statement to Dr. Hagen that while his pain had not changed significantly, his mobility and function improved while taking his pain medication and he continued to be employed.

Employer's second contention is that *McNulty I* should be modified due to a change in condition, specifically because Employee did not have the surgery as recommended by Dr. Frey. In her August 23, 2016 SIME report, Dr. Frey noted Employee might benefit from the surgery, but it

was only successful about 75 percent of the time. At the *McNulty I* hearing, she clarified that while there was a 75 percent chance the surgery would be successful, there was also a chance his condition could get worse. After viewing the surveillance videos, Dr. Frey noted Employee's functioning was better than expected because he was able to compensate for the injury. She no longer believed the surgery would improve his function, although it might reduce his pain, but in any case the decision should be left to Employee.

Employer contends the fact Employee did not have the surgery is a change in condition. The analysis in *McNulty I* focused on the need for opioid before the proposed surgery because that was what Employee's petition requested. At the time Employee's petition was filed, Dr. Frey was recommending the surgery. It was not until the *McNulty I* hearing that she no longer recommended the surgery unless Employee's function decreased, and she also stated the decision should be left to Employee.

Given Dr. Frey's testimony at the *McNulty I* hearing, the panel had evidence the surgery might not occur, particularly within the five years Dr. Frey initially recommended. As a result, *McNulty I*'s order, was not limited to the time before surgery; it simply ordered Employer to pay for ongoing opioid medication up to 90 mg. morphine equivalent per day. The fact the surgery has not yet occurred is not a change in circumstances. Dr. Olbrich's November 2019 EME addendum does not change that fact. His opinion that there had been "more than adequate time" for Employee to get the surgery recommended by Dr. Frey, entirely disregards Dr. Frey's opinion that the surgery was unnecessary unless Employee's function decreased and it was Employee's decision whether to proceed with the surgery. As an addiction and pain medicine specialist, Dr. Olbrich's opinion as to the timing of the surgery is given far less weight than the opinion of Dr. Frey, an orthopedic specialist who specializes in feet and ankles. Employee's failure to have the surgery within the five years originally recommended by Dr. Frey is not a change in circumstances warranting modification of *McNulty I*.

CONCLUSION OF LAW

McNulty I will not be modified.

ORDER

1) Employer's November 14, 2019 petition for modification of *McNulty I* is denied.

Dated in Anchorage, Alaska on May 11, 2020

ALASKA WORKERS' COMPENSATION BOARD

/s/
Ronald P. Ringel, Designated Chair

/s/
Nancy Shaw, Member

/s/
Robert C. Weel, 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 on Petition for Modification in the matter of DEVIN A McNULTY, employee / claimant v. LAST FRONTIER BAR, employer; COMMERCE AND INDUSTRY INSURANCE COMPANY, insurer / defendants; Case No. 200907861; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on May 11, 2020.

/s/
Kimberly Weaver, Office Assistant II