ALASKA WORKERS' COMPENSATION BOARD

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

AARON D. UNSEL, Employee, Claimant, v. KLEBS MECHANICAL, INC., Employer, and LIBERTY NORTHWEST INSURANCE CORP., Insurer, Defendants.	)	FINAL DECISION AND ORDER AWCB Case No. 201117973 AWCB Decision No. 24-0007 Filed with AWCB Anchorage, Alaska on February 14, 2024

Klebs Mechanical, Inc.'s (Employer) September 29, 2023 petition was heard on February 13, 2024, in Anchorage, Alaska, a date selected on November 9, 2023. A November 1, 2023 hearing request gave rise to this hearing. Attorney Martha Tansik appeared and represented Employer and its insurer. Attorney Jason Weiner appeared by Zoom and represented Aaron D. Unsel (Employee) who appeared by Zoom and testified. James Holt testified by Zoom on Employee's behalf. The record closed on February 13, 2024.

ISSUES

As a preliminary matter, Employer had petitioned for an order striking "Dr. Forest Tennant" from testifying at hearing. It contended Dr. Tennant is a hired expert outside the legal parameters for

Employee to obtain a medical witness, and is "trial by ambush." Employer further contended Employee's witness list did not conform with the regulation and was untimely.

Employee contended he has been frustrated in trying to find appropriate treatment for his arachnoiditis, to which he attributes all his symptoms. He contended Dr. Tennant is an appropriate person to offer an expert opinion on how to address this difficult disease. An oral order declined to allow Dr. Tennant's testimony at hearing.

1) Was the oral order disallowing Dr. Tennant's testimony correct?

Employer contends a spinal cord stimulator (SCS) is neither reasonable nor necessary medical treatment for Employee given his circumstances. Nevertheless, it requests an order finding the SCS is or is not compensable as future medical treatment.

Employee contends he has no objection to an order finding the SCS is not a reasonable treatment for him. He currently does not want to undergo any further SCS treatment.

2) Is an SCS reasonable medical treatment?

Employer contends Employee should be ordered to attend an inpatient multidisciplinary pain program. It contends his current treatment, which consists mainly of pain medication, is not helping him and it needs to end. Employer seeks an order terminating his narcotic entitlement should he fail to attend.

Employee contends he wants to get off narcotic medication and wants to attend a clinic so long as it is with physicians familiar with arachnoiditis, and is not just a "detox" clinic.

3) Should Employee be required to attend, and Employer be required to pay for, an inpatient multidisciplinary pain program?

4) Should benefit suspension be decided at this time?

FINDINGS OF FACT

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

1) Prior to 1988, parties to workers' compensation cases routinely sought numerous medical opinions to support a claim or defense. This was called "doctor shopping." In 1988, the legislature amended the Alaska Workers' Compensation Act (Act) to prevent this practice. (Experience).

2) On November 18, 2011, Employee reported he slipped on ice, fell and injured his tailbone while working for Employer. (Report of Occupational Injury or Illness, November 25, 2011).

3) On November 21, 2011, Sharon Lemmons, MD, saw Employee who reported having fallen on ice at work four days earlier. He landed on his back and shoulder and complained about low-back pain and radiating pain down his right leg, which had worsened over the weekend. Dr. Lemmons prescribed, among other things Hydrocodone/APAP [Percocet] and physical therapy (PT). (Lemmons report, November 21, 2011).

4) On December 22, 2011, Employee had low-back magnetic resonance imaging (MRI), which showed mild findings at the upper-lumbar-spine areas, but at L5-S1 there was a disc protrusion with annular tear and bilateral neural foraminal narrowing. (MRI report, December 22, 2011).

5) On December 27, 2011, Colin Hickenlooper, PA-C, at Orthopedic Physicians Anchorage (OPA) examined Employee who reported his injury and low-back pain with occasional "loss of bladder function." Employee denied alcohol and illicit drug use. PA-C Hickenlooper's review was "significant for incontinence when he is kneeling with back pain." He advised rest, and heat and ice on his back, and prescribed Employee non-narcotic medications and PT. (Hickenlooper report, December 27, 2011).

6) On February 16, 2012, James Glenn, PA-C at OPA saw Employee, ordered an epidural steroid injection (ESI) and renewed Norco [an opioid]. (Glenn report, February 16, 2012).

7) On September 6, 2012, Employee was in a work-related motor vehicle accident (MVA) while working for Employer. (Record).

8) On September 12, 2012, when Employee's symptoms had not subsided, PA-C Glenn referred him for another ESI, discussed a surgical referral and prescribed Ultram [an opioid] for his ongoing pain. (Glenn report, September 12, 2012).

9) On October 23, 2012, on referral from PA-C Glenn for medication management, Brandy Moates, DNP, under supervision from Larry Levine, MD, saw Employee who gave his post-injury treatment history and stated he had been rear-ended in an MVA on September 6, 2012. "He notes the impact on the seatbelt was significant." Since that accident, Employee's back pain had flared. Employee was taking Ambien [a sedative], Ultram and Valium [a benzodiazepine]. Moates gave

Employee a lumbar brace, referred him back to PT, started him on Zanaflex [a nonsteroidal anti-inflammatory] and refilled his Ultram and Norco. (Moates/Levine report, October 23, 2012).

10) On October 30, 2012, Employee told PA-C Glenn he still had persistent symptoms, despite all the above interventions. (Glenn report, October 30, 2012).

11) On October 30, 2012, Employee had another MRI. (MRI report, October 30, 2012).

12) On November 2, 2012, PA-C Glenn reviewed the October 30, 2012 MRI and compared it to the December 22, 2011 MRI. It showed "he is getting a lot more neural foraminal narrowing at the L4-5 level," but it was worse on the left than the right. The left L5-S1 had significant neural foraminal narrowing but there were no large disc protrusions or herniations. PA-C Glenn also said the L4-5 neuroforamina were "a little bit tighter" than they were in 2011. Employee was having no left-sided pain. Since the ESIs did not provide significant relief, PA-C Glenn tried a diagnostic and therapeutic ESI at the right L4-5 area. (Glenn report, November 2, 2012).

13) On November 21, 2012, DNP Moates discontinued short-acting Ultram and replaced it with long-acting. "He wanted the option of using more than three hydrocodone daily." She prescribed another 90. "Hopefully, he is not going to end up using six a day." DNP Moates continued Employee's PT. (Moates/Levine report, November 21, 2012).

14) On December 4 and 12, 2012, Michael Fraser, MD, orthopedic surgeon, and Dennis Chong, MD, physiatrist, saw Employee for an employer's medical evaluation (EME). Employee stated his 2012 motor vehicle accident "did exacerbate some of his back symptoms and (he feels) brought them back to the point of his initial injury." He was taking Meloxicam, Ultram, Zolpidem [Ambien], Valium, Zanaflex and Vicodin [an opioid]. Drs. Fraser and Chong diagnosed (1) a work-related lumbar sprain/strain which they said was likely resolved. Employee had a recent symptom exacerbation with his MVA, but they did not feel "this significantly altered the course of his current symptoms"; (2) lumbar spondyloses, preexisting, but exacerbated by the work injury; (3) transient, right-sided radicular symptoms, work-related; (4) left-sided lumbar MRI findings not related to his work injury; and (5) a midline sacral subcutaneous mass. Drs. Fraser and Chong recommended that Employee continue with his OPA visits and ask his surgeon to compare the 2011 and 2012 MRI images to check for progression. Employee needed imaging for his subcutaneous mass, and electromyography (EMG) to rule out radiculopathy. He had no preexisting condition aggravated by the work injury. Employee was not capable of returning to his normal job. The work injury was the substantial cause of Employee's need for treatment.

Employee should be medically stable within six months. It was too early to determine a permanent impairment rating. (Fraser/Chong report, December 4 and 12, 2012).

15) By December 13, 2012, Employee still had low-back pain and was using "about six hydrocodone daily" in combination with Ultram. He thought the short-acting Ultram was better. Employee was beginning to feel depressed. Moates discontinued Hydrocodone and prescribed Percocet 10/325 up to six per day and discontinued Ultram altogether. (Moates/Levine report, December 13, 2012).

16) On January 4, 2013, James Eule, MD, orthopedic surgeon at OPA, saw Employee and suggested diagnostic nerve root blocks to determine whether Employee's symptoms were disc- or facet-generated. Thereafter, Dr. Eule could offer surgery. (Eule report, January 4, 2013).

17) On January 31, 2013, DNP Moates saw Employee whose right-leg pain "calmed down" with diagnostic injections. Employee had some abdominal pain in Michigan and, "He is not sure whether he had been overdoing it with the hydrocodone or Percocet due to the increased abdominal pain, but he has had difficulty with vomiting for the past several days." He found Percocet more helpful for pain. Employee's medications included six Percocet 10/325 a day, Hydrocodone 10/500 from the emergency room in Michigan, Valium, Ambien and Zanaflex. Employee asked Moates if she would refill his Ambien and Valium prescribed by "Dr. Ellenson"; she declined and referred him to Dr. Ellenson. DNP Moates talked to Employee about using one opioid at a time and told him to stop using Hydrocodone and only use Percocet 10/325 maximum six per day. He would have to get off this before surgery. (Moates/Levine report, January 31, 2013).

18) On February 11, 2013, Dr. Eule performed surgery on Employee to decompress the L4-5 and L5-S1 foramina. (Operative Report, February 11, 2013).

19) On February 26, 2013, Employee reported to Gregory Gootee, PA-C at OPA that his radiating leg pain was completely resolved post-surgery, but he still had back pain. "His goal is to discontinue narcotics totally." PA-C Gootee charted:

> The patient is in pain management. They are weaning him down to the hydrocodone. However, he does not have enough to transition from his Percocet to his hydrocodone. He would like another supply of the Percocet. I recommend instead of taking two of the 10 mg at a time, he takes one and halves his time between medications and then starts to increase the time between Percocet and then transition down to the hydrocodone and Ultram. The patient is in agreement with this. I did say we will refill the Percocet this one time and at his next follow up I

> would expect him to be strictly on the hydrocodone, if he is even needing that. We will probably begin [PT] at that point. . . . (Gootee report, February 26, 2013).

20) On March 25, 2013, Employee saw Paul Gibson, PA-C at Dr. Levine's office.

> He states that he is here for medication refills and follow-up on his lower back pain. He has had good results with his pain management with the current medication regime and that [he] wishes to continue with the current medications. The patient states that all in all he is much improved since two to three months ago.

Employee was taking Percocet, Valium, Ambien and Zanaflex. He was receiving his Valium and Ambien "from his neurologist." PA-C Gibson recorded:

> I have refilled the patient's current medications of hydrocodone. He states that he wishes to discontinue the Ultram as that did not seem to be helpful. I have increased the number of tablets on his hydrocodone to 120 to make up the difference between the Ultram. The patient to take this medication as directed. . . .
>
> Employee was to do a urine drug screen on this visit and we will follow-up with him when the results are returned. (Gibson/Levine report, March 25, 2013).

21) On March 26, 2013, Employee told Dr. Eule his leg pain was "dramatically better" than it was pre-surgery and although his back was "still pretty sore," he felt deconditioned but was "definitely much better than he was before." (Eule report, March 26, 2013).

22) On April 29, 2013, Employee told PA-C Gibson that since his last visit "he has had no improvement on his lower back pain, but is not getting any worse either." His current pain medications are helping to maintain his pain levels and he "wishes to continue with this medication." He did not request a refill. Employee was taking Percocet, Valium, Ambien, and Zanaflex. (Gibson/Levine report, April 29, 2013).

23) On May 16, 2013, Employee told Dr. Eule he was feeling better but a week prior while at PT, he felt a "pop" in his back and "he was miserable." Dr. Eule stopped PT temporarily. (Eule report, May 16, 2013).

24) On May 29, 2013, Employee returned to PA-C Gibson for medication refills. His pain levels were about the same as they were at his last visit. Employee was taking Hydrocodone, Valium, Ambien and Zanaflex. (Gibson/Levine report, May 29, 2013).

25) On June 27, 2013, PA-C Gibson refilled Employee's medications, which remained the same. (Gibson/Levine report, June 27, 2013).

26) On July 2, 2013, Employee told Dr. Eule his lower back still hurt, so Dr. Eule ordered another lumbar MRI. (Eule report, July 2, 2013).

27) On July 5, 2013, Marc Beck, MD, radiologist, performed an MRI on Employee's lumbar spine and compared it to the 2012 MRI. Dr. Beck found the right neural foraminal disc bulge at L5-S1 had progressed and the disk space narrowing at L4-5 "may have slightly progressed as well." (Beck report, July 5, 2013).

28) On July 9, 2013, Dr. Eule was "perplexed" that Employee's recent MRI showed "some pretty significant foraminal narrowing," notwithstanding his recent surgery. X-rays taken that day showed what Dr. Eule believed was early instability at L4-5. He recommended a nerve block and ESI to "get things settled down" and more PT. (Eule report, July 9, 2013).

29) On July 25, 2013, Employee told PA-C Gibson that Hydrocodone was very effective in reducing his pain and helped to "improve his activities of daily living." His medications were the same. PA-C Gibson refilled Employee's Hydrocodone. (Gibson/Levine report, July 25, 2013).

30) On August 3, 2013, Dr. Eule released Employee to light-duty, modified work effective August 13, 2013, and stated he would probably be released to regular work in about three months. (Eule letter response, August 3, 2013).

31) On August 20, 2013, Dr. Eule recommended Employee have a lumbar fusion at L4-5. (Eule report, August 20, 2013).

32) On October 17, 2013, Employee told Dr. Levine he was scheduled for surgery with Dr. Eule, but it was canceled. He reported increasing back pain over the prior four weeks and increased pain radiation into his legs as well as difficulty with urinary and bowel function. Dr. Levine thought this might represent a surgical emergency and told Employee to tell his "State-ordered independent medical exam" [an EME] scheduled for later that day about it, as well as Dr. Eule. "He denies other issues, although what he is telling me is substantially different than what we had before." Dr. Levine refilled his Hydrocodone. (Levine report, October 17, 2013).

33) On October 17, 2013, Charles Craven, MD, orthopedic surgeon, saw Employee for an EME. Employee reported his pain level was higher than it was since his work injury. Dr. Craven diagnosed (1) work-related lumbar sprain/strain that had resolved. There was an exacerbation with a September 2012 MVA which Dr. Craven said "did not significantly alter the course of the examinee's symptomatology"; (2) lumbar spondylosis and annular tear at L5-S1. In Dr. Craven's opinion, the spondylosis was preexisting, but the annular tear and stenosis were substantially

caused by the work injury; (3) prior decompressive foraminotomies, substantially caused by the work injury; and (4) ongoing pain with radicular symptomatology caused by the work injury and surgery. Dr. Craven agreed with Dr. Eule that Employee would benefit from a spinal fusion, and this arose from the work injury and surgery. In his view, the work injury permanently aggravated Employee's preexisting spondylosis, requiring the need for medical treatment. Dr. Craven anticipated Employee could return to work approximately three to six months following a successful spinal fusion. The work injury was the substantial cause for the recommended L4-5 fusion, and Employee was not medically stable. (Craven report, October 17, 2013).

34) On November 14, 2013, Employee saw PA-C Gibson for prescription refills and new medication for "breakout pain" not controlled by his Hydrocodone. PA-C Gibson refilled the medication and gave him a small prescription for Ultram for breakout pain. (Gibson/Levine report, November 14, 2013).

35) On November 20, 2013, Dr. Eule performed a fusion at the L4-5 level. (Operative Report, November 20, 2013).

36) On December 3, 2013, Employee was taking Ambien, Dilaudid, Norco and Ultram. (Glenn report, December 3, 2013).

37) By December 31, 2013, Employee still had symptoms post-surgery and was trying to wean pain medications. "He has been on narcotics for quite a while because this has been going on for some time." Dr. Eule switched him to Ultram and Lyrica. (Eule report, December 31, 2013).

38) By February 13, 2014, Employee was "not doing that well." He still had back pain and bilateral leg numbness and pain. He could not sit or stand very long or walk very far. His wife and he were becoming concerned about his mood. Dr. Eule added depression as a diagnosis. He recommended lower-extremity EMG because Employee "should be doing better than what he is right now." Employee was taking two forms of Ambien and Lyrica, Norco, Cymbalta and Valium. (Eule report, February 13, 2014).

39) On February 24, 2014, Dr. Levine found an abnormal EMG showing right lumbar radiculopathy in the L5 distribution. "It appears that there is something going on affecting the nerves still." (Levine report, February 24, 2014).

40) By March 6, 2014, Employee had trouble sleeping and Dr. Eule was afraid he would become habituated to sleep aids. His medications were the same. (Eule report, March 6, 2014).

41) On April 1, 2014, an MRI showed definite evidence of arachnoiditis with "clumping of nerve roots" at the L4-5 level. (MRI report, April 1, 2014).

42) On April 24, 2014, Dr. Levine noted Employee was taking as many as eight Hydrocodone a day and "still having the breakthrough pain." He suggested Employee try a Butrans patch, one per week, and a trial "TENS" unit. (Levine report, April 24, 2014).

43) On May 23, 2014, Dr. Levine referred Employee to the University of Washington Medical Center Pain Clinic (UW). (Levine letter, May 23, 2014).

44) On June 3, 2014, Dr. Eule rescinded his previous light-duty work release pending Employee's visit with UW physicians. (Eule report, June 3, 2014).

45) On July 22, 2014, Irakli Soulakvelidze, MD, at UW diagnosed among other things "failed back syndrome." (Soulakvelidze report, July 22, 2014).

46) On September 24, 2014, on Dr. Eule's referral, Employee went to Rehabilitation Institute of Washington (RIW), a pain clinic. He was taking Lyrica, Cymbalta, Ambien and Hydrocodone 10/325 mg six times a day and Nambumetone [a nonsteroidal anti-inflammatory]. RIW suggested he first go to Swedish Hospital for conversion to Suboxone. His RIW treatment was expected to last from four to six weeks. (RIW report, September 24, 2014).

47) On October 10, 2014, RIW charted Employee had been taking 60 to 80 mg of Hydrocodone daily since approximately February 2013. He had tried Butrans which worked well but caused sweating; Hydromorphone [an opioid] which worked; and Morphine [an opioid], which was not helpful. Gabapentin [an anticonvulsant] caused severe nausea, vomiting and diarrhea and Mobic [a nonsteroidal anti-inflammatory] was associated with a gastrointestinal bleed. Trazodone, Amitriptyline and Nortriptyline [all antidepressants] did not help for sleep, and he took Seroquel [an antipsychotic] for sleep, which caused depression. His pain level averaged 7.5/10 and 8/10 at worst. Employee said he started using Hydrocodone about 10 years earlier when he had diverticulitis. Depression had been more constant since he was diagnosed with arachnoiditis. Employee's diagnoses included major depression, single episode, opioid dependence and insomnia. (RIW report, October 10, 2014).

48) On October 11, 2014, physicians at Swedish Hospital evaluated Employee and found a history of "Opioid dependence." After his first day on Suboxone, Employee had "not been well controlled." He had low blood pressure and oxygenation possibly related to sleep apnea. (Swedish Hospital reports, October 11, 2014).

49) On October 15, 2014, after four days at Swedish Hospital, Employee returned to RIW. He "had a rough course" at "detox." When transitioned to Suboxone, he had hyperventilation and low blood pressure with associated chest pain. He was tapered down to 3 mg Suboxone daily, but his pain was "only partially controlled on this dose." Employee was worried about having respiratory episodes at night while on Suboxone and wanted to resume his prior Hydrocodone dose and taper that. RIW physician Heather Kroll, MD, found Employee's Suboxone caused significant side effects. She considered his return to Hydrocodone beneficial, and he could taper that in the pain program. She recommended PT. (Kroll report, October 15, 2014).

50) On October 16, 2014, after an echocardiogram and stress test, Employee had chest pain suggesting ischemia caused by coronary artery disease. Dr. Kroll recommended he avoid vigorous physical activity. (Kroll report, October 16, 2014).

51) On October 20, 2014, Employee left RIW so he could return to Anchorage for an angiogram. He was taking 10 mg Hydrocodone six times per day and was advised to continue that dose until he returned to RIW after his cardiac treatment. (Kroll report, October 20, 2014).

52) On October 30, 2014, Employee underwent another stress test in Anchorage, after not taking Suboxone. Alan Skolnick, MD, at Alaska Heart & Vascular Institute opined Employee's stress test showed no ischemia. (Skolnik report, October 30, 2014).

53) However, on November 18, 2014, Mark Selland, MD, found Employee's recent stress test was mildly abnormal and suggested ischemia; Dr. Selland recommended coronary angiography. (Selland report, October 30, 2014).

54) On December 16, 2014, Dr. Selland stated Employee did not have significant coronary artery disease. (Selland report, December 16, 2014).

55) On January 20, 2015, Employee called Dr. Kroll at RIW to discuss returning. He was taking Hydrocodone and Tramadol [Ultram] for pain without relief. (Kroll report, January 20, 2015).

56) On February 3, 2015, on referral from Jeffrey Kim, MD, Employee saw Steven Johnson, MD, at AA Spine & Pain Clinic (AA Spine) in Anchorage for assistance with his chronic back and leg pain. Dr. Johnson ordered PT and put him on Oxycodone 10 mg six per day, Celebrex 200 mg per day, Ambien 12.5 mg per day, and discussed a spinal cord stimulator (SCS) trial. (Johnson report, February 3, 2015).

57) On April 14, 2015, Dr. Eule stated Employee's ongoing lumbar spine issues were expected to continue for at least three years. (Eule letter, April 14, 2015).

58) On May 18, 2015, Joseph Bablonka, PhD, at AA Spine saw Employee for pain disorders related to psychological factors. Employee wanted to control his pain and medications. Dr. Bablonka made a treatment plan for cognitive behavioral therapy (CBT) for Employee individually and potentially in a group. (Bablonka report, May 18, 2015).

59) At some point in summer 2015, Employee relocated to Tennessee. (Agency file).

60) On August 6, 2015, Graf Hilgenhurst, MD, pain specialist in Tennessee, saw Employee who had tried various medications with varying results: Fentanyl (good), Butrans (good), Lortab (fair), and Percocet (fair). Dr. Hilgenhurst diagnosed, among other things, continuous opioid dependence, and prescribed Percocet 10/325 as needed and OxyContin 10 mg, controlled release one every 12 hours. (Hilgenhurst record, August 6, 2015).

61) On August 12, 2015, adjuster Deborah Freels referred Employee to Clinton Devin, MD, for a second opinion with possible option to treat. (Judy Caldwell message, August 12, 2015).

62) On September 3, 2015, Employee told Dr. Hilgenhurst that his pain level was "8/10" before medication and "7.5/10" after taking narcotics. Dr. Hilgenhurst increased his OxyContin to 20 mg and refilled his Percocet and other medications. (Hilgenhurst report, September 3, 2015).

63) By October 5, 2015, Employee's medication reduced his normal "7/10" pain down to "6/10." Nevertheless, without explanation Dr. Hilgenhurst increased Employee's OxyContin from 20 mg to 30 mg. (Hilgenhurst report, October 5, 2015).

64) On October 13, 2015, Employee told Dr. Hilgenhurst's assistant that he had a new kind of back pain, and his pain level was "8/10" that reduced to "7.5/10" after narcotics. He referred Employee to PT. (Peter Molnar, NP, report October 13, 2015).

65) On October 29, 2015, Dr. Hilgenhurst recommended an SCS trial for Employee. (Letter, October 29, 2015).

66) On November 6, 2015, Tonya Ellis, NP, at Dr. Hilgenhurst's office increased Employee's OxyContin to 40 mg and refilled his other prescriptions. Employee said he decided against the SCS, feeling it could aggravate his arachnoiditis. He requested a referral to a neurosurgeon for his "worsening symptoms." (Ellis report, November 6, 2015).

67) On December 1, 2015, on referral from Dr. Hilgenhurst, William Schooley, MD, neurosurgeon, saw Employee. Employee told Dr. Schooley he was having "electric shock" pains similar to what he had before his 2013 fusion. (Schooley report, December 1, 2015).

68) On December 7, 2015, Employee told NP Ellis that his pain was "8/10" before medication and "7/10" after. Employee had stomach issues and wanted to change his medication from Lortab to Percocet, which she did, and wanted to increase his OxyContin, which she declined. He had changed his mind and wanted to try the SCS. (Ellis report, December 7, 2015).

69) A December 8, 2015 MRI showed Employee had moderate canal narrowing at L3-L4, mild to moderate neural foraminal narrowing at the L3-S1 levels, and degenerative changes. (MRI report, December 8, 2015).

70) On December 29, 2015, Dr. Schooley reviewed the recent MRI report with Employee and discussed possibly extending his lumbar fusion. (Schooley report, December 29, 2015).

71) On January 26, 2016, Dr. Schooley proposed an SCS. (Schooley report, January 26, 2016).

72) On February 5, 2016, Employee reported his pain before narcotics was "8/10," and after taking narcotics it was "7/10." His OxyContin remained at 40 mg and his Percocet at 10/325 mg. (Hilgenhurst, February 5, 2016).

73) On February 22, 2016, James Wiesman, Jr., MD, examined Employee for an EME. Employee said he was doing "fine" after his work injury until he had an MVA in September 2012. Dr. Wiesman diagnosed lumbosacral radiculopathy on the right with an annular tear and neural foraminal stenosis; failed lumbar decompression L4-5 and L5-S1; failed L4-5 fusion; spondylolisthesis; arachnoiditis; and L5-S1 radiculopathy secondary to a disk bulge. He opined the substantial cause for Employee's disability and need for medical treatment was "initially" the November 18, 2011 work injury, but the September 16, 2012 MVA permanently aggravated his underlying condition. The work injury and the MVA each contributed 50 percent to his disability and need for treatment. As for his current disability or need for treatment, he stated the work injury accounted for 30 percent of Employee's disability as did the MVA; 20 percent of his disability was caused by the first surgery and an equal percentage to the lumbar fusion, which together resulted in arachnoiditis. Dr. Wiesman opined the pain Employee had was coming from arachnoiditis "which is directly related to the injury that occurred in November 2011. . . ." In his view, Employee's medical treatment had been reasonable and necessary. Dr. Wiesman recommended PT, medication, weaning Employee off narcotics, bracing and retraining. Since Employee was receiving neither an increase in function nor a decrease in pain, Dr. Wiesman said OxyContin and similar pain medications were not reasonable or necessary. He recommended an SCS. Palliative care would be reasonable and necessary and should be something that enabled

him to participate in a vocational reemployment plan. In Dr. Wiesman's opinion, Employee was medically stable having achieved that on August 10, 2015. He had a 15 percent whole-person permanent partial impairment (PPI) rating under the AMA *Guides*, Sixth Edition. Employee's work restrictions were "less than sedentary." (Wiesman report, February 22, 2016).

74) On February 23, 2016, Brian Thomas, Psy.D, psychologist, saw Employee for a psychological EME. Employee was interesting in pursuing an SCS if, as advertised, it would reduce his pain by 40 percent and lower his need for medication. Dr. Thomas diagnosed Employee with pain disorder with related psychological factors, and depression, not otherwise specified. He opined Employee was appropriate for an SCS. Dr. Thomas suggested he have psychiatric consultation to evaluate his appropriateness for psychotropic medication and to address his depression. (Thomas report, February 23, 2016).

75) On February 26, 2016, Robert Weiss, MD, neurosurgeon, saw Employee for an EME. He opined contrast material from an MRI produced arachnoiditis. In his experience, 50 percent of patients using an SCS for arachnoiditis obtained relief. Dr. Weese noted Employee had a "difficult situation." He opined that "almost none of the underlying degenerative factors was in any major way responsible for all his need for all of these therapies, invasive, and noninvasive, and particularly, the surgeries." Dr. Weiss said 100 percent of his medical care was related to his work injury, and opined an SCS trial would be reasonable. "If the pain clinic wants to increase his OxyContin dose, so be it." However, Dr. Weiss noted, "It is obviously not working," but deferred to a pain specialist. He further stated, "narcotic medications seem to be necessary in this case since he is now habituated. . . ." Dr. Weiss did not believe Employee had reached "medical stability" as defined in Alaska, and it was too early to assign impairment. He opined Employee would "not ever" return to his job on his injury date. If an SCS was successful, Employee may be able to return to sedentary work. (Weiss report, February 26, 2016).

76) On March 4, 2016, Dr. Hilgenhurst charted that Employee's urine test came back positive for Hydrocodone and Employee did not know how or why that was possible. He refilled Employee's narcotics at the same dosages. (Hilgenhurst report, March 4, 2016).

77) On April 29, 2016, Kenith Robins, PhD and Lisa Webb, PhD, psychologists, stated Employee was mentally fit for SCS implantation. (Robbins/Webb report, April 29, 2016).

78) On July 12, 2016, Dr. Hilgenhurst implanted leads for a trial SCS into Employee's lower back. (Hilgenhurst report, July 12, 2016).

79) On July 19, 2016, after Employee's "successful" SCS trial, Dr. Hilgenhurst removed the leads. (Hilgenhurst report, July 19, 2016).

80) On January 13, 2017, on referral from Dr. Hilgenhurst, Daniel Lonergan, MD, saw Employee to evaluate his chronic pain and a possible SCS permanent implant. Employee said he was "pleased" with the trial SCS results. He was reporting urinary and bowel incontinence. (Lonergan report, January 13, 2017).

81) On May 18, 2017, Employee said his pain was increasing, and he was waiting for a permanent SCS. Dr. Hilgenhurst said, "I am willing to increase his [breakthrough] medication to Oxycodone 15 mg. . . ." He changed Employee's Percocet 10/325 mg to Oxycodone 15 mg, and refilled his 40 mg OxyContin and the other non-narcotic medications as previously prescribed. On Employee's next visit, Dr. Hilgenhurst changed back to Percocet because Employee did not notice much difference between the two. (Hilgenhurst report, May 18, 2017; July 6, 2017).

82) On July 13, 2017, Employee had a lumbar myelogram and computerized tomography (CT) scan that showed "adjacent disc disease" at L3-4. (Radiology reports, July 13, 2017).

83) On July 19, 2017, Dr. Schooley reviewed Employee's recent radiology reports and opined he was "an excellent candidate for a further decompression and extension of his fusion." (Schooley report, July 19, 2017).

84) On September 12, 2017, Dr. Wiesman performed another EME on Employee. He again opined Employee's condition was directly related to his original work injury with Employer. Dr. Wiesman said results from the proposed L3-4 surgery "would certainly be at risk." He recommended repeat EMG to determine if Employee's pain was coming from an appropriate nerve root for the proposed procedure. (Wiesman report, September 12, 2017).

85) On October 9, 2017, Jeffrey Hazelwood, MD, performed EMG on Employee and found chronic radiculopathy bilaterally at L5-S1 but no evidence of acute lumbosacral radiculopathy involving either lower extremity. (Hazelwood report, October 9, 2017).

86) On November 9, 2017, Dr. Wiesman performed a records review EME and concluded the recent EMG showed no acute radiculopathy in either lower extremity. Therefore, he reiterated his previous advice that another fusion at L3-4 "would be most likely to not succeed." (Wiesman report, October 9, 2017).

87) On November 29, 2017, Dr. Hilgenhurst saw Employee and determined, "His most recent MRI shows an L3 compression fracture." He recommended a "fusion revision" at L4-5. (Hilgenhurst report, November 29, 2017).

88) On January 29, 2018, Dr. Hilgenhurst formally requested approval for Dr. Lonergan to implant a Boston Scientific SCS. (Hilgenhurst letter, January 29, 2018).

89) On March 14, 2018, Employee told Dr. Hilgenhurst's office that he did not want to go forward with the SCS because workers' compensation had not approved it even though he had sent the recommendation twice to his caseworker. "He wants to be done with Liberty Mutual." Dr. Hilgenhurst was going to refer him to "Dr. Babat." (Hilgenhurst record, March 14, 2018).

90) On August 21, 2018, Dr. Hilgenhurst performed another trial SCS on Employee. (Hilgenhurst report, August 21, 2018).

91) On August 21, 2018 the SCS battery failed and did not give Employee an "accurate test." He requested another trial SCS. (Hilgenhurst report, October 1, 2018).

92) On November 19, 2018, Dr. Wiesman saw Employee again for an EME. He told Dr. Wiesman that his arachnoiditis was going up his spine and causing hand numbness. Employee said the first SCS "increased his pain," but the second one from a different manufacturer relieved it for about 12 hours. He now had a "snap in his back once to twice every day," which could make his pain better or worse. Dr. Wiesman's diagnoses remained the same. He opined Employee was under "satisfactory pain management" and though "unfortunate," narcotic continuation "is appropriate at this time." However, it would be "optimal" to wean him off narcotics. There was no evidence that narcotics increased his function or decreased Employee's pain since September 12, 2017. Dr. Wiesman said he was not a pain specialist and would leave it up to Dr. Hilgenhurst to wean Employee. In his opinion, a permanent SCS was "certainly a viable option and should be pursued at this time." Dr. Wiesman did not think Employee was psychologically ready for work-hardening. He recommended Employee work with his pain clinic, get weaned off narcotics, and return to a more normal lifestyle with physical activity and psychological support. He could then try a work-hardening program. (Wiesman report, November 19, 2018).

93) On November 28, 2018, Dr. Hilgenhurst at Employee's request decreased Employee's OxyContin from 40 mg to 30 mg. (Hilgenhurst report, November 28, 2018).

94) On January 25, 2019, Employee asked Dr. Hilgenhurst to refer him to a psychiatrist to address chronic pain. He tolerated lowering OxyContin from 40 mg to 30 mg, "but doesn't want to go lower for now." Employee wanted PT. (Hilgenhurst report, January 25, 2019).

95) On July 18, 2019, Employee went to Accurate Clinic for a medical records review. Eric Ehlenberger, MD, reviewed his records, examined him and made treatment recommendations. (Ehlenberger reports, July 18, 2019).

96) On January 23, 2020, Employee's Morphine milligram equivalent (MME) was 180. (Hilgenhurst report, January 23, 2020).

97) On January 31, 2020, Employee claimed disability and impairment benefits, medical and transportation costs, an unfair or frivolous controversion, attorney fees and costs. (Workers' Compensation Claim, January 30, 2020).

98) On May 23, 2020, Gary Olbrich, MD, pain and addiction specialist, conducted a records-review EME, and adamantly opined Employee should be weaned off all opioids as rapidly, safely and humanely as possible. His lengthy report cites changes in medical thinking regarding long-term opioid use for non-malignant conditions. Dr. Olbrich noted the current realization was that long-term opioid use is a "double-edged sword." One edge included a list of "significant seriousness" side effects from long-term opioid use; he did not discuss the other edge, which is presumably pain relief. "Iatrogenic Opioid Use Disorder" was now recognized as a distinct chronic pain condition entirely caused by medical providers' medications of choice used to treat pain complaints. Dr. Olbrich volunteered the following in bold-faced words:

> **This diagnosis will be significantly important for future medication treatment decisions. Furthermore, <u>it cannot be proposed as a "new condition"</u> <u>to be accepted for a current claim</u>, since it is simply the natural outcome of using narcotic analgesics for long-term daily treatment (emphasis in original).**

Dr. Olbrich determined Employee had 150 MME per day, which he said, "far exceeds the currently widely accepted CDC guidelines, which encourage usage of no greater than an MME of 50. The maximum that is recommended, under special circumstances is 90." He found no irregularities in Employee's drug tests during treatment. In Dr. Olbrich's opinion, until Employee's body had been opioid free for three to six months, his central nervous system would not be restored, and he would continue to interpret any pain in an exaggerated manner. Until that time, no pathological pain producers could be found, and no medical decisions made to address them. Dr. Olbrich believed

Employee could be weaned 10 mg per day every seven days. He will need psychological support with regular sessions with a physician or psychologist familiar with chronic-pain patients. Employee was not an SCS candidate and opined that unless his narcotics were weaned there could be no meaningful SCS results. However, SCSs are not his "area of expertise." Dr. Olbrich referenced studies and reproduced an abstract that concluded opioid treatment was not superior to non-opioid medications for improving pain-related functions. He did not believe opioids were medically reasonable or necessary. Therefore, he opined Employee was at risk to himself and others in anything other than sedentary work. (Olbrich report, May 23, 2020).

99) On June 22, 2020, EME Dr. Wiesman stated Employee met all medical criteria for referral to an addiction and pain specialist. (Wiesman letter, June 22, 2020).

100) On July 6, 2020, Employee told Dr. Hilgenhurst his original SCS trial provided "50% relief," and he was still interested in pursuing a permanent SCS. (Hilgenhurst report, July 6, 2020).

101) On August 5, 2020, Employee said he was waiting for the adjuster to approve a permanent SCS. (Hilgenhurst report, August 5, 2020).

102) On October 5, 2020, Dr. Hilgenhurst said Employee never got a "true trial" on his SCS, because the leads slipped but even then, he still got "50%" relief. There was still "an excellent chance he would get great relief with an SCS." (Hilgenhurst report, October 5, 2020).

103) On November 19, 2020, Dr. Hilgenhurst said Employee was only capable of limited sedentary- and light-duty work, indefinitely. (Hilgenhurst response, November 19, 2020).

104) Employee's symptoms and treatment continued through 2021. On September 23, 2021, Employee told Christina Burks, NP, at Dr. Hilgenhurst's office that he had been "feeling much better recently" and had been taking Prednisone QOD for asthma and stated, "I'm feeling great on it." (Agency file; Burks report, September 23, 2021).

105) On November 4, 2021, the parties settled Employee's claims, waving everything except past and future medical and related benefits necessitated by the work injury. (Compromise & Release Agreement (C&R), November 4, 2021).

106) Employee filed no claim with the Division for additional benefits since the parties filed the November 4, 2021 C&R, and he has no pending claim. (Agency file).

107) On June 3, 2022, Employee told Dr. Hilgenhurst he was willing to "try anything" including an SCS or pain pump to relieve his pain. (Hilgenhurst report, June 3, 2022).

108) On July 11, 2022, Dr. Wiesman performed another EME. Employee said he settled his case and kept his medical benefits open, but was frustrated because he was trying to get an SCS. He "emphatically" stated he wanted to get off opioids and was trying to find a rehabilitation center to monitor his withdrawal. Employee had been having spasms in his lower-back and legs. Dr. Wiesman diagnosed bilateral lumbosacral radiculopathy, failed L4-5 and L5-S1 decompression and fusion, "anteriorlisthesis/retrolisthesis," arachnoiditis, degenerative disc disease at several levels and Iatrogenic Opioid Use Disorder. (Wiesman report, July 11, 2022).

109) Dr. Wiesman still opined the 2011 work injury was the initial injury that started Employee's progressive spine problems. He said none of the treatment Employee had received was below the standard of care and all of it had been reasonable and necessary. He opined an attempt should be made to mobilize and wean Employee from narcotics. Dr. Wiesman recommended gradual withdrawal and "consideration of a[n] [SCS]." Palliative care defined under Alaska law was reasonable and necessary. Dr. Wiesman said he is not a pain specialist, expert in pain management or an opioid addiction expert. (Wiesman report, July 11, 2022).

110) As an orthopedic surgeon, Dr. Wiesman determined Employee had 150 MME a day. He cited Centers for Disease Control (CDC) recommendations to "reassess benefits and harms" when increasing opioid dosages to more than 50 MME a day. He agreed under CDC guidelines Employee's current MME was "quite high," and was not returning him psychologically or physically to a stable lifestyle where he could work or retrain, and put him at risk for overdosage and side-effects. As an orthopedic surgeon, Dr. Wiesman said, "I'm not recommending detoxification or weaning off narcotics from the point of view of a pain medicine doctor who is supervising his narcotic use." Nevertheless, he opined Employee should return to a healthier drug-free lifestyle "from an orthopedic standpoint." In responding to several questions, Dr. Wiesman referred Employer to Dr. Hilgenhurst. (Wiesman report, July 11, 2022).

111) In Dr. Wiseman's opinion, it is "certainly appropriate" for Employee to use Lidocaine patches and take an anti-inflammatory once a day; however, he implied that Cymbalta, Zanaflex, Lyrica, Percocet, and Ambien were not relieving his pain and not helping his depression or sleeping and therefore, were not reasonable or necessary. He referred Employer to Dr. Hilgenhurst as a pain management specialist for answers because Dr. Wiesman did not treat many chronic pain patients. Dr. Wiesman had no opinion on the standard of care for Dr. Hilgenhurst's prescriptions. He recommended psychiatric treatment for Employee's depression. "The only surgical procedure

that should be considered at this time" would be a trial and permanent SCS, and referred Employer to Dr. Hilgenhurst. Dr. Wiesman opined if Employee decreased narcotics, an inpatient functional therapy and work-oriented rehabilitation program would be reasonable and necessary. He referred Employer to Dr. Hilgenhurst for specifics. Dr. Wiesman "from an orthopedic surgeon standpoint" opined it would be unreasonable for Employee to refuse to attend such a program, especially since he said he wanted to go to one previously. (Wiesman report, July 11, 2022).

112) On August 30, 2022, Kalima Charway, PhD, psychologist, saw Employee regarding an SCS implant that he was seeking "to reduce his pain and improve his quality of life." Testing put him in the "76th percentile" in the "crippled" range of disability. His "predicted prognostic category for the [SCS] procedure is good." (Charway report, August 30, 2022).

113) On December 8, 2022, Employee told Marybeth Floyd, NP, at Dr. Hilgenhurst's office that his pain level was "9/10" before taking his narcotics and "6/10" after. He was still trying to get an SCS. When he obtained a new SCS, the plan was to "begin weaning down narcotic medication." (Floyd report, December 8, 2022).

114) On April 20, 2023, Employee told Darrell Madden, PA, at Dr. Hilgenhurst's office that he no longer wanted to have an SCS "due to a myriad of issues with a family member who had repeated SCS and revisions." Employee said Employer wanted him to go into a rehab facility to get him off narcotics because it claimed he had a urinalysis absent for prescribed medication. "I checked his UDS for the past 3 years and found no discrepancies." Employee was "resistant" to going into a rehab facility and wanted trigger-point injections for his lumbar spine "due to the increased pain." He currently had "sharp, burning, dull" pain in his lumbar spine and lower extremities as well as in his arms and head. (Madden report, April 20, 2023).

115) On July 13, 2023, Dr. Hazelwood, who had performed EMG on Employee in 2017, saw him for an EME. Employee said his first SCS trial did "not help at all" because the leads came loose, and he got an infection and the device "never did work right." He also said his second SCS "did not help at all." When Dr. Hazelwood stated his medical records said there was some relief from the second SCS trial, Employee said it was just the anesthetic and had nothing to do with the SCS. (Hazelwood report, July 13, 2023).

116) Employee told Dr. Hazelwood he went to Accurate Clinic twice on his own seeking relief for arachnoiditis. He asked Dr. Hilgenhurst to reduce his medication, which he did, but since it was reduced, his pain worsened. Employee was afraid to get the SCS, and did not want it, because

his wife's relative had complications with hers. He reported Dr. Hilgenhurst said he had nothing more to offer except for medication. (Hazelwood report, July 13, 2023).

117) Employee was agreeable to attending a multidisciplinary pain program, but wanted a doctor's recommendation not the insurance company, and wanted a clinic that knows something about arachnoiditis. He was adamant that his medications helped and said if he missed a dose he felt a difference. Employee did not appear sedated. (Hazelwood report, July 13, 2023).

118) Dr. Hazelwood reviewed seven inches of Employee's medical records. Employee's primary diagnosis is opioid hyperalgesia. He also has a centralized pain syndrome, Iatrogenic Opioid Use Disorder and arachnoiditis. Dr. Hazelwood said Dr. Weiss, a "very conservative surgeon," conclusively stated Employee had arachnoiditis. (Hazelwood report, July 13, 2023).

119) Dr. Hazelwood found Employee was not malingering and did not show symptom magnification. He opined Employee's condition and chronic opioid usage from prescription medication that led to his opioid hyperalgesia would not have occurred but for the initial slip on the ice and subsequent motor vehicle accident at work for Employer. He could not say that any of the treatment rendered to Employee had been below the standard of care. Dr. Hazelwood stated Employee's "current treatment being rendered certainly is not atypical as seen in pain clinics." Nevertheless, he disagreed with the current treatment because it was not improving Employee's life, function or pain. He based this on Employee stating he is "miserable every day." However, Dr. Hazelwood also conceded "many pain specialists" disagree with his opinion and do not agree with evidence-based medication guidelines. (Hazelwood report, July 13, 2023).

120) Dr. Hazelwood disagreed with a third SCS trial, because the first two did not work. The only additional medical treatment he recommended was "an inpatient multidisciplinary program and a weaning of opioids to have any chance for success." Dr. Hazelwood did not recommend "palliative treatment" as defined in Alaska law because Employee was not working, could not participate in a vocational reemployment plan and still had chronic debilitating pain. He considered Employee a "disaster" case that could only be treated at an inpatient multidisciplinary pain center. (Hazelwood report, July 13, 2023).

121) Dr. Hazelwood agreed Employee was currently taking 150 MME daily. This dosage increased his risk for unintended overdose death by 10- to 15-fold. He further noted under the CDC Revision Guidelines it was not appropriate to wean someone completely off opioids in a "legacy" case," unless it is in a highly controlled setting. Dr. Hazelwood agreed as Dr. Weiss said

that sometimes, "The horse is already out of the barn" and nothing can be done. He saw no "red flags" suggesting Employee was overusing or abusing opioids. Dr. Hazelwood agreed many pain clinics and specialists use his level of opioids, but he disagrees with it. Although he is not an addiction specialist or psychiatrist, Dr. Hazelwood sensed Employee was not addicted to narcotics. He took his medication exactly as his pain specialist directed. Dr. Hazelwood disagreed with Dr. Olbrich that weaning can be done quickly. According to 2022 CDC Guidelines Revisions, weaning "must be done very slowly, and sometimes is very difficult to do. . . ." Dr. Hazelwood said there are no risks from detoxification if done slowly. If in fact Employee has "addiction disease," Suboxone would be the medicine of choice, but Employee had a bad reaction to this previously. A specialist would have to be careful to use Suboxone and give Employee a reduced dosage. (Hazelwood report, July 13, 2023).

122) Dr. Hazelwood agreed there are many potential negative side-effects with narcotic use. He agreed Lyrica is reasonable, but would favor CBT and Melatonin over Ambien for Employee's sleep disorder. Cymbalta is appropriate for chronic pain and mood disorder. He implied Lidocaine and Celebrex are not effective since Employee is already on 150 MME per day. Nevertheless, Dr. Hazelwood agreed Employee's "polypharmacy" is typically used "by many pain clinics." He recommended strong psychological intervention with a multidisciplinary inpatient pain program. It would be up to a psychologist to determine if Employee needed psychiatric assistance. In Dr. Hazelwood's opinion, Employee is not a surgical candidate, because surgery would probably make his situation worse. He was "absolutely" certain an SCS "would have a dismal outcome in this case." Dr. Hazelwood admitted with an inpatient multidisciplinary approach "there is no guarantee." Employee must "buy into this concept" and be ready to embark on it. Dr. Hazelwood is familiar with Brooks and Rosomoff clinics in Florida, Baylor College of Medicine, Northwestern University in Chicago, and one in Arizona. In his opinion, it would be unreasonable for Employee to refuse to attend the recommended pain program because he is already miserable and has essentially no function. Dr. Hazelwood thought it would take "a doctor that he trusts," like Dr. Hilgenhurst, to explain to Employee in detail the benefits of such a program. Nevertheless, Employee said he would be willing to go, and he had checked out some programs in Florida. (Hazelwood report, July 13, 2023).

123) On September 29, 2023, Employer petitioned for "the termination of ongoing narcotics and an order compelling" Employee to "attend functional rehabilitation as recommended" by its EME

physicians. It contended Employee had ignored two years of Employer's offers to pay for and facilitate this treatment. (Petition, September 29, 2023).

124) On November 9, 2023, the parties appeared before a Board designee to state the issue for a February 13, 2024 hearing. The only issue was Employer's September 29, 2023 "petition to terminate narcotics and compel attendance at functional rehabilitation." The parties stipulated to serve and file witness lists and evidence in accordance with the applicable regulations. (Prehearing Conference Summary, November 9, 2023).

125) By regulation, the parties' witness lists had to be filed and served by no later than February 6, 2024. (Experience, judgment).

126) On February 6, 2024, Employer contended that due to "Employee's Medicare status," the parties sought an order "clarifying compensability" for (1) "detoxification/functional restoration" and (2) an SCS. It contended the parties "are in agreement" that a detoxification and functional restoration program is compensable, and the Board should order the SCS is not compensable. Employer suggested that "to have legally binding weight with Medicare," the Board must issue a decision addressing these two issues. It contended the issues therefore are (1) should Employee be compelled to attend an inpatient multidisciplinary pain clinic, and (2) is an SCS reasonable and medically necessary treatment? (Employer's Hearing Brief, February 6, 2024).

127) As legal support, Employer relied on AS 23.30.001(1) and contended the Board has the right to suspend compensation under AS 23.30.095(d). It further contended medical treatment must be "reasonable and necessary," and relied on *Bockness*. Employer conceded treatment for substance abuse and narcotic addiction resulting from prescription medication for a work injury has been found reasonable and necessary in *Parris-Eastlake*. Moreover, it contended Employee has an obligation to minimize his damages and relies on *Phillips Petroleum Co*., *Mendoza*, *Bignell* and *Metcalf* for support. Employer also relied on CDC guidelines and articles from learned treatises. (Employer's Hearing Brief, February 6, 2024).

128) Employer contended risks associated with Employee's continued narcotic use far outweigh benefits he would get from weaning at a multidisciplinary pain center. It contended Employee does not get functional increase or significant pain reduction from his opioid treatments. Employer noted Employee wants to go to a pain clinic. It seeks a "proactive determination that refusal to participate in the reasonable and appropriate recommendation for inpatient substance

abuse/functional restoration program should result in a termination of compensability for narcotic medication benefits." (Employer's Hearing Brief, February 6, 2024).

129) As for the SCS, Employer suggested "all physicians" continued to opine an SCS is a viable option. It further noted Employee does not want it and Employer cannot force him to get one. Employer said because physicians said it is an option, "the parties cannot settle the claim" because needs predictability "about a very large cost item." It seeks an order stating an SCS is not reasonable and medically necessary treatment and thus "not compensable" as future treatment for Employee's recovery. (Employer's Hearing Brief, February 6, 2024).

130) On February 6, 2024, Employee timely filed and served a witness list for the February 13, 2024 hearing. It listed Employee, "Dr. Forrest Tennant" with his phone number and email address but no other information, and James Holt from Dr. Hilgenhurst's office with his address and phone number but no additional information. Employee untimely filed an exhibit list to which he attached an October 9, 2020 Internet article from Dr. Tennant, a December 11, 2022 article from the "NCBI Bookshelf," and a January 12, 2023 review from "Cureus" discussing spinal adhesive arachnoiditis. (Employee's Witness List; Employee's Exhibit List, February 6, 2024).

131) On February 8, 2024, Employee said he would "love to attend" the recommended inpatient multidisciplinary pain clinic. He did not want to continue with pain medicine and currently did not want to have an SCS. Employee contended the Board should listen to Dr. Tennant who is an expert in arachnoiditis. He had "no objection to the Board finding that a spinal cord stimulator is not a reasonable treatment" for him "under the circumstances." He objected to a pain clinic with physicians who do not know how to treat arachnoiditis. Employee requested attorney fees for responding to Employer's petition. (Employee Hearing Brief, February 8, 2024).

132) On February 8, 2024, Employee filed and served an amended witness list "to comply with 8 AAC 45.112." He did not provide all required information for Dr. Tennant but said he would testify telephonically "to explain his pain management program." Employee added that James Holt would testify telephonically as to "handling of lab tests and procedures for [Dr. Hilgenhurst's office]. (Amended Employee's Witness List, February 4, 2024).

133) On February 9, 2024, Employer filed a "motion" to strike Dr. Tennant as a witness at hearing. It contended Employee was attempting "trial an ambush" with an expert who had never examined him or prepared a report. Employer further contended the witness list did not conform to regulations because it did not include an address, telephone number or a brief description of the

subject matter and substance of Dr. Tennant's expected testimony. It also cited *Phillips* for support, which held an injured worker has no right to hire a medical expert outside the Act's limitations. (Motion to Strike Witness Forest Tennant, February 9, 2024).

134) At hearing on February 13, 2024, Holt testified that he is the laboratory technician at Dr. Hilgenhurst's office and handles drug tests. He explained the clinic's procedures for evaluating drug testing and found the clinic providers had always determined that Employee had no inconsistent drug testing at their clinic. The clinic performs its own testing and sends out its results to a third-party laboratory that uses more sophisticated means to confirm the results. When shown results from a date in 2023, Holt admitted that "medically" those results were inconsistent, but relied on the providers' opinions that they were within an acceptable range. (Record).

135) At hearing, Employee testified he has adhesive arachnoiditis, which causes debilitating pain, and said he is in "sheer pain, pretty much constantly." He confirmed that his 2012 MVA was work-related, and it made his symptoms different and worse. Employee tried a "detox" clinic in Washington and failed because a provider gave him a mixture including Suboxone and another medication that caused him to lose blood pressure and have cardiac issues. He stated, "I'm not going to go forward with something that is going to shut my heart down." Given that experience, Employee fears "rehab programs." (Record).

136) Employee did his own research and found that the Mayo and Cleveland Clinics will work to reduce his medications and treat arachnoiditis. He did not think that they were "rehab programs." Employee explained two treatments he learned about to treat arachnoiditis, the condition to which she attributes all his pain symptoms. He has no problem going to a pain clinic with a physician trained in treating arachnoiditis. Employee had difficulty finding one but eventually found the Mayo and Cleveland Clinics. Before he can present his insurance adjuster with details that they requested, Employee would have to go to a clinic and be evaluated. (Record).

137) Dr. Hilgenhurst's clinic has not referred Employee to the Mayo or Cleveland Clinics. He has been asking for a referral for four months. Dr. Hazelwood expressly asked him about eating bagels and poppy seeds, and Employee said he eats these on a regular basis. Employee said Dr. Hazelwood told him this could account for minor deviations in his drug urinalyses. (Record).

138) Employee's ultimate goal is pain reduction. If he attends an inpatient multidisciplinary pain program and it is unsuccessful in reducing his pain, Employee will continue with his current treatment regimen. When asked if he wanted to get off painkillers, Employee said he wanted to

change medications because there is a stigma and judgment attached to his current painkillers. Employee is not concerned about an accidental overdose death because he takes his medication as directed and takes no other non-prescribed narcotics. (Record).

139) Employee does not want an SCS. He reviewed his records and complications he had, including an infection, and this convinced him that an SCS is not an option. (Record).

140) In its closing argument, Employer modified its position somewhat. On the SCS issue, Employer stated the Board should rule either that the SCS is compensable, or it is not. Employer just wanted predictability in planning for a possible settlement or expected future expenditures. As for the inpatient multidisciplinary pain program, Employer said it wanted Employee to attend one to assist him with his medication dependency brought about by his work injury and related treatment. Nevertheless, it contended that if Employee did not go to a Board-ordered inpatient multidisciplinary pain program, within a specific time, the Board should order that Employer need not pay for his prescription painkillers. It added, Medicare will not cover certain benefits without a Board order finding them not compensable. Employer believes the parties are talking about the same thing regarding the clinical setting Employee needs to improve his situation. It has received no referral from Employee's physician to an inpatient multidisciplinary pain program. Employer cannot manage Employee's medical care. (Record).

141) At hearing and in his closing argument, Employee contended an SCS is not a solution for him but acknowledged the technology may improve over time. He does not foreclose the possibility that he may change his mind and want an SCS later. Employee contended Employer simply wants to "detox him" and he has already had a bad reaction to Suboxone. He wants to get better and not be "judged" anymore. Employee likens Employer's petition to "extortion." He contended the Board cannot order him to attend an inpatient multidisciplinary pain clinic. Employee said he did not hire Dr. Tennant; Dr. Tennant agreed to testify without payment. However, Employee admitted that he wanted to call Dr. Tennant because he was an expert in treating arachnoiditis. (Record).

PRINCIPLES OF LAW

AS 23.30.001. Legislative intent. It is the intent of the legislature that

> (1) this chapter be interpreted . . . to ensure . . . quick, efficient, fair, and predictable delivery of . . . medical benefits to injured workers at a reasonable cost to . . . employers. . . ;
>
> **AS 23.30.005. Alaska Workers' Compensation Board**. . . .
>
> (h) The department shall adopt rules . . . and shall adopt regulations to carry out the provisions of this chapter. . . . Process and procedure under this chapter shall be as summary and simple as possible. . . .

The Board may base its decision not only on direct testimony 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) . . . When medical care is required, the injured employee may designate a licensed physician to provide all medical and related benefits. The employee may not make more than one change in the employee's choice of attending physician without the written consent of the employer. Referral to a specialist by the employee's attending physician is not considered a change in physicians. Upon procuring the services of a physician, the injured employee shall give proper notification of the selection to the employer within a reasonable time after first being treated. Notice of a change in the attending physician shall be given before the change. . . .
> . . . .
>
> (d) If at any time during the period the employee unreasonably refuses to submit to medical or surgical treatment, the board may by order suspend the payment of further compensation while the refusal continues, and no compensation may be paid at any time during the period of suspension, unless the circumstances justified the refusal.
>
> (e) The employee shall, after an injury, at reasonable times during the continuance of the disability, if requested by the employer or when ordered by the board, submit to an examination by a physician or surgeon of the employer's choice authorized to practice medicine under the laws of the jurisdiction in which the physician resides, furnished and paid for by the employer. The employer may not make more than one change in the employer's choice of a physician or surgeon without the written consent of the employee. Referral to a specialist by the employer's physician is not considered a change in physicians. . . .

The law in Alaska Workers' Compensation cases is clear on how parties obtain admissible medical evidence. "The Alaska Workers' Compensation Act gives each injured worker the right to choose

an attending physician (footnote omitted). But in order to curb potential abuse -- especially doctor shopping -- the Act allows an injured worker to change attending physicians only once without the consent of the employer." *Bloom v. Tekton, Inc*., 5 P.3d 235 (Alaska 2000).

The Alaska Workers' Compensation Appeals Commission (Commission) in *Wood v. Grant Aviation*, AWCAC Dec. No. 289 (June 28, 2021) found the injured worker was "seeking a particular kind of treatment. . . ." He saw a physician on his own accord for that purpose without a referral, and had no legal basis for doing so. Consequently, the Commission affirmed the Board's order excluding the medical opinions from that physician. *Wood* also stated the employee was "doctor-shopping, the very issue the statute and regulation were attempting to address."

Phillips v. Bilikin Investment Group, Inc., AWCB Dec. No. 14-0020 (February 19, 2014) addressed the identical issue raised in the instant case regarding an independent medical expert, and excluded the employee's physician's expert opinion and testimony stating:

> The Act and regulations contain no suggestion a party has a right, apart from those provided under AS 23.30.095(a) and (e), to obtain additional opinions or evaluations from medical experts. Such practice would contravene the statutes and revert back to "doctor shopping," which the legislature eliminated years ago. In some cases, parties have procured medical experts without objection from opposing parties and these experts' opinions have been considered. This is not one of those cases. . . . Regulation 8 AAC 45.082(c) codifies decisional law disallowing reliance by a party on unlawfully obtained medical opinions. If a party makes an unlawful change of physician in violation of AS 23.30.095(a) or (e), or 8 AAC 45.082, the panel "will not consider the reports, opinions, or testimony of the physician in any form, in any proceeding, or for any purpose." The panel has no discretion. . . .

Addressing an injured worker's duties in respect to medical care, *Phillips Petroleum Co. v. Alaska Industrial Board*, 17 Alaska 658 (Alaska 1958) stated:

> It is recognized that an injured workman will be denied a right to compensation from his employer for any disability which may be removed or modified by surgical treatment not involving serious suffering nor attended by great danger, where the employee refuses to undergo such an operation (citations omitted). The law contemplates that the injured workman will do everything humanly possible to restore himself to his normal strength so as to minimize his damages, and where he fails to do so, the consequent disability results from the voluntary conduct of the employee, and not the injury (citations omitted). It is only where an injured

> employee's refusal to undergo surgical treatment is termed reasonable that his refusal will not act as a bar to further compensation. The test of "reasonableness" is to be determined in the light of consideration of the degree of pain accompanying the operation, consequent inconvenience to the employee, and possible risk of life attending the nature of the operation. Each of these factors is to be considered in relation to the possible benefit that may be derived from the operation, so that a determination may be properly made as to whether a refusal is justified.

Phillips Petroleum Co. determined the seriousness of a disc operation, the attendant suffering and the fact that the operation could give at most only a 20 percent reduction in permanent partial disability would not warrant a finding that "refusal to submit the operation was unreasonable."

Fluor Alaska, Inc. v. Mendoza, 616 P.2d 25 (Alaska 1980) addressed an employee's refusal to submit to spinal surgery under AS 23.30.095(d). *Mendoza* found the Board's conclusion that the employee's refusal to have surgery was reasonable and supported by substantial evidence. The employee was afraid he might die on the surgical table. One relative had serious surgical complications during simple operations. *Mendoza* held that a refusal to undergo medical treatment was reasonable "if a conscious weighing of the results of having" the treatment could have led to the refusal, "regardless of whether such weighing actually occurred."

Bignell v. Wise Mechanical Contractors, 651 P.2d 1163 (Alaska 1982) stated, "It has been recognized by both case law (citation omitted) and statute (citation omitted) that an injured employee must submit to reasonable medical treatment."

Metcalf v. Felec Services, 784 P.2d 1386 (Alaska 1990) stated the factors used in determining reasonableness of "treatment refusal" under AS 23.30.095(d) include: the risk and seriousness of side-effects, the chance of cure or improvement, and any first-hand negative experience or observations from the patient regarding either the subject procedure or other medical care in general. *Metcalf* found the record supported the Board's finding that the employee's refusal for treatment was unreasonable, because it proposed no life-threatening surgery, unanimous medical opinions said negative side-effects from the medication in question were unlikely and the employee's problem could be partially alleviated by the medicine. The employee had no firsthand experience with any of the suggested treatments.

Bockness v. Brown Jug, Inc., 980 P.2d 462 (Alaska 1999) addressed the Act's chiropractic frequency of treatment standards, and the reasonableness of trigger-point injections. *Bockness* held the employee failed to show that the frequency standards were unreasonable for his injury. It also affirmed the Board's reliance on medical evidence that disagreed with the attending chiropractor's opinion. Those witnesses said passive treatments including trigger-point injections did not help the employee "functionally progress" and should have been discontinued when they did not "produce significant gains."

Parris-Eastlake v. State of Alaska, Department of Law, 26 P.3d 1099 (Alaska 2001) addressed a situation similar to the instant matter. The employee developed work-related headaches and back and neck pain with associated drug addiction. While being treated for her physical issues, the employee admitted to "drug-seeking" activities including lying to her doctors, exaggerating her pain and hoarding pills for later use in higher-than-prescribed doses. Nonetheless, *Parris-Eastlake* held that a statute barring benefits where the worker's injury was caused by the influence of drugs did not apply because the employee claimed her addiction was the "direct consequence" of her work injury and was itself an injury.

> **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; . . .

Benefits sought by an injured worker are presumptively compensable and the presumption applies to any claim for compensation under the Act. *Meek v. Unocal Corp*., 914 P.2d 1276 (Alaska 1996). The presumption's application involves a three-step analysis. To attach the presumption, and without regard to credibility, an injured employee must first establish a "preliminary link" between his injury and the employment. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 610 (Alaska 1999). Once the presumption attaches, and without regard to credibility, the employer must rebut the raised presumption with "substantial evidence." *Huit v. Ashwater Burns, Inc*., 372 P.3d 904 (Alaska 2016). If the employer's evidence rebuts the presumption, it drops out and the employee must prove his claim by a preponderance of the evidence. *Id*. This means the employee must "induce a belief" in the fact-finders' minds that the facts being asserted are probably true. *Saxton v. Harris*,

395 P.2d 71, 72 (Alaska 1964). In the third step, evidence is weighed, inferences are drawn, and credibility is considered. *Huit*.

> **8 AAC 45.082. Medical treatment**. . . .
>
> (b) A physician may be changed as follows:
> . . . .
>
> (2) except as otherwise provided in this subsection, an employee injured on or after July 1, 1988, designates an attending physician by getting treatment, advice, an opinion, or any type of service from a physician for the injury; . . .
> . . . .
>
> (c) If, after a hearing, the board finds a party made an unlawful change of physician in violation of AS 23.30.095(a) or (e) or this section, the board will not consider the reports, opinions, or testimony of the physician in any form, in any proceeding, or for any purpose. If, after a hearing, the board finds an employee made an unlawful change of physician, the board may refuse to order payment by the employer. . . .

ANALYSIS

1) Was the oral order disallowing Dr. Tennant's testimony correct?

In 1988, the Alaska legislature amended the Act to prevent "doctor shopping." *Wood*. Before 1988, it was commonplace for parties to obtain multiple medical opinions until they obtained an opinion to their liking. *Rogers & Babler*. The legislature implemented AS 23.30.095(a) and (e) in 1988 to end this practice. *Bloom*; *Wood*. Employee's right to obtain medical opinions falls under AS 23.30.095(a). It states Employee may not make "more than one change" in Employee's "choice of attending physician" without Employer's written consent. However, "referral to a specialist" by Employee's attending physician or obtaining a "substitution" physician "is not considered a change" in physicians. Employee must give notice "of a change in his attending physician before the change." This statute is plain on its face and states Employee can select a physician, and can "change" his physician only one time. Nothing in the law authorized Employee to obtain a medical expert. AS 23.30.095(a); 8 AAC 45.082(b)(2).

Employer has a similar limitation found in AS 23.30.095(e). This section requires Employee to attend medical evaluations when Employer requires it, with some restrictions. Employer may not

make more than one change "in its choice" of physician without Employee's written consent. Referral to a specialist by Employer's physician is not a change in physician. Employer also has the right to have Employee seen by a multi-physician "panel," again with some restrictions. Both Employee and Employer have ample opportunity to have Employee seen by multiple physicians. But "changing" physicians by either party is strictly regulated to prevent doctor shopping.

There is no evidence any attending physician referred Employee to Dr. Tennant. At hearing, Employee admitted he intended to call Dr. Tennant because he is an expert in treating arachnoiditis. Whether a party pays for an expert's opinion, or the physician volunteers testimony, opinions from medical experts not obtained in accordance with AS 23.30.095 are not admissible in any form, in any proceeding, or for any purpose. 8 AAC 45.082(c). Therefore, the oral order disallowing Dr. Tennant's testimony at hearing was correct. *Phillips*.

2) Is an SCS reasonable medical treatment?

Employer initially sought an order finding an SCS is not reasonable and necessary medical treatment for Employee's injury. At hearing, it changed his position and simply wanted a decision stating the SCS is or is not compensable. Employee states he does not object to such an order. The parties appear to be trying to settle Employee's remaining medical treatment and related transportation benefits and feel this decision is important to facilitate settlement. The parties' positions place this issue in an unusual posture. Ordinarily, an injured worker wants a procedure and the employer refuses to pay for various reasons. In such circumstances, it is appropriate for fact-finders to apply the statutory presumption of compensability analysis. AS 23.30.120(a)(1). Nevertheless, even though Employee currently does not want an SCS, there is a factual dispute on the SCS issue, and this decision will apply the presumption analysis.

Here, the question is whether an SCS is reasonable medical treatment. Based on Employee's previous position on this issue, he raises the presumption with Dr. Hilgenhurst's October 29, 2015 and continuing opinion that Employee should have another SCS trial followed by an implanted SCS. *Meek*. Dr. Hilgenhurst has repeatedly stated an SCS will likely reduce Employee's pain. *Tolbert*. Employer rebuts the presumption with Drs. Olbrich's and Hazelwood's opinions that he should not have an SCS. *Huit*. They both point to poor results from the prior trials and Employee's

position that he does not want one. This shifts the burden back to Employee who, if he wanted an SCS, would have to prove it is reasonable treatment by a preponderance of the evidence. *Saxton*. In this step, evidence is weighed, inferences drawn, and credibility considered. *Huit*.

Five physicians suggested an SCS as reasonable treatment for Employee's injury: Dr. Johnson on February 3, 2015; Dr. Hilgenhurst on October 29, 2015, and continuing; Dr. Schooley on January 26, 2016; Dr. Wiesman on February 22, 2016, and again on July 11, 2022; and Dr. Weiss on February 26, 2016. Of these five, two physicians, Drs. Wiesman and Weiss, are EME doctors. Four physicians found Employee was psychologically appropriate for an SCS: Drs. Thomas on February 26, 2013, Robins and Webb on April 29, 2016, and Charway on August 30, 2022. Only two physicians opined against Employee having an SCS: Dr. Olbrich on May 23, 2020, who admitted that SCSs were not his expertise, and Dr. Hazelwood on July 13, 2023.

Employee has vacillated between wanting and not wanting an SCS. Most recently he stated he did not want an SCS, based on a family member's negative experiences with them and his review of his own medical records reminding him of his own complications from previous attempts. At hearing, he testified that based on his past experience with trial SCSs, including malfunctions, poor results and an infection, they were no longer an option for him. On the other hand, Employee stated he would attend a specified inpatient multidisciplinary pain program to wean himself from medications and hopefully gain functional restoration. At least one physician stated it is not possible to determine a pain source unless Employee is cleansed from narcotics and other unnecessary medications so physicians can pinpoint a pain generator and apply possible medical treatment or procedures to reduce or eliminate that pain. Employee is confident that arachnoiditis is the sole cause of his painful symptoms; he could be mistaken.

Given the above, and assuming Employee attends an inpatient multidisciplinary pain program and is weaned from narcotics and other inapplicable or inappropriate medications, he may reduce his overall pain level. That is the goal. At that point, his physicians may be able to pinpoint the source of any remaining pain, including but not limited to arachnoiditis. If, hypothetically, physicians at that point all agree an SCS would probably be helpful in reducing his remaining pain and increasing his function, Employee may vacillate yet again and decide an SCS is appropriate

treatment for him after all. In closing argument at hearing, Employee stated an SCS is not completely foreclosed, because new and better devices may be developed in the future. If this decision finds an SCS is not reasonable treatment, it is likely Employee would have to pay for that himself or place the burden on taxpayers to pay for it under Medicare. Neither party explained why either outcome is better than Employer paying for an SCS if it continues to be reasonable treatment and Employee changes his mind and chooses to try one again.

Based on an abundance of substantial evidence, including credible opinions from Drs. Johnson, Hilgenhurst, Schooley, Wiesman, and Weiss, and opinions from Drs. Thomas, Robins, Webb and Charway who stated Employee was psychologically fit for an SCS, an SCS is reasonable treatment for attempting to reduce Employee's symptoms. AS 23.30.122; *Smith*. Drs. Olbrich's and Hazelwood's opinions are given less weight on the SCS issue because Dr. Olbrich acknowledged that SCSs were not his expertise; furthermore, he sounded more like an advocate for Employer by volunteering with bold-faced emphasis that addiction does not count as an injury, which is a principal contrary to Alaska law. *Parris-Eastlake*. Drs. Olbrich's and Hazelwood's opinions stand against the weight of five other physicians, some of whom with SCS expertise. AS 23.30.122; *Smith*. This finding does not mean Employee has to have a third SCS trial or an SCS implant. It simply answers the question presented, and the parties are free to use this finding and decision for whatever purpose they deem appropriate. But absent a change in circumstances, if Employee decides to have an SCS in the future, Employer will have to pay for it.

3)Should Employee be required to attend, and Employer be required to pay for, an inpatient multidisciplinary pain program?

On July 11, 2022, Employee told Dr. Wiesman he was trying to find a "rehabilitation center" to monitor his withdrawal from pain medication. Dr. Wiesman endorsed that option from an orthopedic surgeon's viewpoint, but deferred to Dr. Hilgenhurst the pain specialist for particulars. He added that if Employee could decrease narcotic dependence an "inpatient functional therapy and work-oriented rehabilitation program" would be reasonable. On April 20, 2023, Employee told PA Madden he was "resistant" to going into a "rehab facility," because Employer suggested he needed "detox" from narcotics because he had inconsistent urinalyses. At hearing, Employee testified he never took non-prescribed narcotics, always took medication as directed, and

frequently ate bagels with poppy seeds. He understood that eating poppy seeds could account for minor discrepancies in his urinalyses. Employee is credible. AS 23.30.122; *Smith*.

On July 13, 2023, Employee told Dr. Hazelwood he was agreeable to attending a "multidisciplinary pain program," but wanted his doctor to recommended it, not the insurance company, and wanted the clinic to know something about arachnoiditis. Dr. Hazelwood recommended "an inpatient multidisciplinary program" and weaning of opioids to have any chance for success. At hearing, Employee made it clear he would attend an inpatient multidisciplinary pain program at the Mayo Clinic or Cleveland Clinic, because he had done research, and Employee understands that these clinics treat arachnoiditis.

Unlike the SCS issue, there are no medical providers suggesting Employee should not attend a "rehabilitation center," a "rehab facility," or an "inpatient multidisciplinary pain program." Thus, there is no factual dispute on this issue and the presumption analysis need not be applied.

Employer noted that the parties are likely talking about the same thing even though various terms are used for the clinical experience numerous physicians recommended, and Employee says he wants. To simplify the terminology, this decision uses "inpatient multidisciplinary pain program," to encompass all features physicians say Employee needs, and he says he wants, to reduce medication consumption, decrease pain and increase function. There is no readily identifiable downside to Employee attending an inpatient multidisciplinary pain program as Drs. Wiesman and Hazelwood both recommended. Employee may decline Suboxone since he now knows he had a bad reaction to that substance. Thus, an inpatient multidisciplinary pain program, absent any evidence to the contrary and giving weight and credibility to Drs. Wiesman's and Hazelwood's opinions, and considering Employee's valid concerns, is reasonable treatment for the intended purposes. AS 23.30.122; *Smith*; *Phillips Petroleum*; *Mendoza*; *Bignell*; *Metcalf*; *Bockness*.

Employee may seek a referral to an inpatient multidisciplinary pain program from his Dr. Hilgenhurst, but a referral is unnecessary. To interpret and apply the Act to make this process quick, efficient, fair, predictable and to deliver medical benefits to Employee at a reasonable cost to Employer, and to make the process simple and summary, this decision will order Employee to

attend, and Employer to pay for, an inpatient multidisciplinary pain program at either the Cleveland or Mayo Clinics at Employee's option. AS 23.30.001(1); AS 23.30.005(h).

Neither party should have any objection to this process since Employee stated he wanted to go, and Employer stated he needs to go and will pay for it. To get this process moving, Employee will be directed to select one of these clinics and make an appointment for whatever preliminary evaluation is necessary within 30 days; the appointment need not occur within 30 days, but the appointment must be made. It is possible that these clinics may not accept workers' compensation claimants. If that occurs, Employee will be directed to find an inpatient multidisciplinary pain program that accepts Alaska workers' compensation cases, and this panel reserves jurisdiction to resolve any disputes on this issue. If a clinic sees Employee for an evaluation, Employer will pay for the visit and Employee will submit a transportation log through his and Employer's attorneys to the adjuster for reimbursement in accordance with the Act and applicable regulations. If Employee is admitted to an inpatient multidisciplinary pain program, Employer will pay the costs in accordance with the Act and regulations. Both parties' rights and defenses are reserved.

4) Should benefit suspension be decided at this time?

Employer primarily relies on AS 23.30.095(d) to seek an order "terminating" Employee's right to narcotic medication if he refuses to attend an inpatient multidisciplinary pain program. However, that statute requires a finding that Employee "unreasonably" refused to "submit to medical" treatment. That finding requires an evidentiary hearing after Employee refuses to go to the inpatient multidisciplinary pain program as directed in this decision. His medical benefits may be "suspended," not terminated, "while the refusal continues" and no compensation may be paid during the suspension "unless the circumstances justified the refusal." Therefore, this decision will not address any suspension remedy unless Employee refuses or constructively refuses to attend the pain program as directed, and after an evidentiary hearing.

CONCLUSIONS OF LAW

1) The oral order disallowing Dr. Tennant's testimony was correct.
2) An SCS is reasonable medical treatment.

3) Employee will be required to attend, and Employer will be required to pay for, an inpatient multidisciplinary pain program.
4) Benefit suspension will not be decided at this time.

ORDER

1) Employer's September 29, 2023 petition is denied in part and granted in part.
2) Employer's petition to terminate narcotics is denied.
3) Employer's petition to compel Employee's attendance at an inpatient multidisciplinary pain program is granted. Employee is directed to make an appointment for a preliminary evaluation at an inpatient multidisciplinary pain program of his choice within the continental United States within 30 days from the date this this decision is issued. The parties through counsel are directed to work together to arrange Employer's payment for an evaluation to see if the clinic will accept Employee as a patient. Employee is directed to submit an itemized travel log through attorneys to the adjuster for reimbursement for travel to and from any preliminary evaluation.
4) If an inpatient multidisciplinary pain program accepts Employee as a patient, the parties are directed to work together through counsel to make payment arrangements.
5) The panel reserves jurisdiction over this issue if inpatient multidisciplinary pain programs decline to accept Employee as a patient for any reason.
6) An SCS is reasonable medical treatment compensable under the Act for Employee's work injury with Employer.

Dated in Anchorage, Alaska on February 14, 2024.

ALASKA WORKERS' COMPENSATION BOARD

/s/
William Soule, Designated Chair

/s/
Mark Sayampanathan, Member

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

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

APPEAL PROCEDURES

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

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

RECONSIDERATION

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

MODIFICATION

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

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of Aaron D. Unsel, employee / claimant v. Klebs Mechanical, Inc., employer; Liberty Northwest Insurance Corp., insurer / defendants; Case No. 201117973; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by certified US Mail on February 14, 2024.

/s/
Pamela Hardy, Workers Compensation Technician