Alaska Workers' Compensation Appeals Commission

Last Frontier Bar and Commerce and Industry Insurance Company, Appellants, vs. Devin A. McNulty, Appellee.	Final Decision Decision No. 285 April 12, 2021 AWCAC Appeal No. 20-009 AWCB Decision No. 20-0029 AWCB Case No. 200907861

Final decision on appeal from Alaska Workers' Compensation Board Final Decision and Order on Petition for Modification No. 20-0029, issued at Anchorage, Alaska, on May 11, 2020, by southcentral panel members Ronald P. Ringel, Chair, Nancy Shaw, Member for Labor, and Robert C. Weel, Member for Industry.

Appearances: Aaron M. Sandone, Griffin & Smith, for appellants, Last Frontier Bar and Commerce and Industry Insurance Company; Eric Croft, The Croft Law Office, for appellee, Devin A. McNulty.

Commission proceedings: Appeal filed June 9, 2020; briefing completed November 25, 2020; oral argument held January 7, 2021.

Commissioners: James N. Rhodes, Amy M. Steele, and Deirdre D. Ford, Chair.

By: Deirdre D. Ford, Chair.

1. Introduction.

Devin A. McNulty (Mr. McNulty) sustained an injury while working for Last Frontier Bar (insured by Commerce and Industry Insurance Company) (Last Frontier) in 2009. The Alaska Workers Compensation Board (Board) heard his claim for benefits on October 31, 2018, and November 8, 2018, and awarded him benefits.[1] In 2019, Last Frontier petitioned the Board for modification of *McNulty I*, and the issue was heard on

[1] *McNulty v. Last Frontier Bar*, Alaska Workers' Comp. Bd. Dec. No. 18-0127 (Dec. 13, 2018)(*McNulty I*).

March 5, 2020. The Board issued its decision denying modification on May 11, 2020.[2] Last Frontier timely appealed *McNulty III* to the Alaska Workers' Compensation Appeals Commission (Commission). The Commission heard oral argument on January 7, 2021, and now affirms *McNulty III* as supported by substantial evidence in the record as a whole.

2. Factual background and proceedings.

Mr. McNulty worked for Last Frontier as a bouncer when, on March 22, 2009, a fellow bouncer, who weighed about 400 pounds, stepped on Mr. McNulty's left foot.[3] Following the injury, Mr. McNulty went to the emergency room complaining of ankle pain, and X-rays revealed a normal ankle, but a fractured fourth metatarsal in his left foot.[4] The next day, Mr. McNulty was seen by PA-C Tracie Rieker at Orthopedic Research Clinic of Alaska. X rays showed Mr. McNulty had fractured his sesamoid bone and the base of his third metatarsal.[5]

On April 13, 2009, Mr. McNulty saw Doug Vermillion, M.D., who diagnosed a left foot Lisfranc injury and recommended open reduction internal fixation surgery.[6] He performed surgery on April 16, `2009, and on June 25, 2009, he again operated to remove the hardware from Mr. McNulty's foot.[7]

Shawn Johnston, M.D., on November 12, 2009, examined Mr. McNulty for a permanent partial impairment (PPI) rating and found Mr. McNulty had a three percent whole person PPI from the Lisfranc injury.[8] On December 4, 2009, Dr. Vermillion released

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2 *McNulty v. Last Frontier Bar*, Alaska Workers' Comp. Bd. Dec. No. 20-0029 (May 11, 2020)(*McNulty III*). *McNulty v. Last Frontier Bar*, Alaska Workers' Comp. Bd. Dec. No. 18-0133 (Dec. 31, 2018)(*McNulty II*) involved a petition for reconsideration and is not at issue in this appeal.

3 *McNulty I* at 3, No. 1; Exc. 001.

4 *Id.*, No. 2.

5 *Id.*, No. 3.

6 *Id.*, No. 4.

7 *Id.*, No. 5.

8 *Id.*, No. 6.

Mr. McNulty to work full-time without any restrictions.[9] On April 2, 2010, Mr. McNulty reported increased pain to Dr. Vermillion, who recommended a fusion.[10]

On September 17, 2010, Mr. McNulty saw John Ballard, M.D., for an employer's medical evaluation (EME). Dr. Ballard examined Mr. McNulty, reviewed his medical records, and identified the March 22, 2009, work injury as the only cause of Mr. McNulty's Lisfranc disruption. Dr. Ballard agreed Mr. McNulty was medically stable at the time of Dr. Johnston's PPI rating on November 12, 2009, and agreed with Dr. Johnston's three percent PPI rating. Dr. Ballard did not recommend further treatment at the time, but noted a fusion might be warranted in the future.[11]

On January 19, 2011, Mr. McNulty reported to Dr. Vermillion the pain in his foot was getting worse, and on March 24, 2011, Dr. Vermillion performed fusion surgery.[12]

Mr. McNulty, on September 8, 2011, saw Dr. Ballard for another EME. Dr. Ballard again opined the cause of Mr. McNulty's medical condition was the March 29, 2009, work injury, and he found Mr. McNulty not medically stable. He recommended a computerized tomography (CT) scan. Dr. Ballard noted Mr. McNulty seemed to have subjective pain complaints that were not substantiated by objective findings.[13]

On October 7, 2011, Mr. McNulty saw Eugene Chang, M.D., who reviewed the CT scan of Mr. McNulty's foot, and noted good fusion at the first metatarsal cuneiform joint. He found questionable healing at the second metatarsal cuneiform joint. Because Mr. McNulty clearly had pain over the head of one of the implanted screws, Dr. Chang recommended removal of the screw.[14] On October 11, 2011, Dr. Chang removed the screw from Mr. McNulty's foot.[15]

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9 *McNulty I* at 3, No. 7.

10 *Id.*, No. 8.

11 *Id.* at 4, No. 9.

12 *Id.*, No. 10.

13 *Id.*, No. 11.

14 *Id.*, No. 12.

15 *Id.*, No. 13.

Mr. McNulty saw Dr. Johnston on November 28, 2011, for another PPI rating. Dr. Johnston stated Mr. McNulty's PPI remained at three percent.[16]

On January 6, 2012, Dr. Chang agreed Mr. McNulty's pain was likely neuropathic, and he offered no surgical options. Dr. Chang referred Mr. McNulty back to Dr. Johnston.[17] On January 16, 2012, Mr. McNulty saw Dr. Johnston and explained he had been prescribed a variety of pain medications since the injury. Mr. McNulty signed a medication management agreement, and Dr. Johnston prescribed Roxicodone and Mobic.[18]

Dr. Johnston, on March 16, 2012, referred Mr. McNulty to Leon Chandler, M.D., a pain specialist at AA Spine & Pain Clinic.[19] He saw Dr. Chandler on May 14, 2012, and reported opioids had not provided pain relief. Dr. Chandler prescribed Demerol and Valium.[20]

On May 15, 2012, Mr. McNulty saw Sidney Baucom, M.D., in Seattle, who noted Mr. McNulty's pain appeared to be neuropathic. He recommended physical therapy and treatment at a pain clinic, and noted it might be worth removing the remaining screw if Mr. McNulty's pain continued.[21]

Dr. Vermillion, on May 23, 2012, stated Mr. McNulty had not been medically stable during 2010.[22] However, on October 31, 2012, Dr. Vermillion stated Mr. McNulty had been able to work between August 26, 2009, and the March 24, 2011, fusion surgery.[23]

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16 *McNulty I* at 4, No. 14.

17 *Id.* at 5, No. 17.

18 *Id.*, No. 18.

19 *Id.*, No. 19.

20 *Id.*, No. 20.

21 *Id.*, No. 21.

22 *Id.*, No. 22.

23 *Id.*, No. 22.

On March 1, 2013, Mr. McNulty began treating with David Randall, D.P.M., at which time Dr. Randall prescribed new orthotics. On April 12, 2013, Dr. Randall discussed revision surgery with Mr. McNulty.[24]

Mr. McNulty again saw Dr. Ballard, on June 28, 2013, for an EME. Dr. Ballard reviewed additional medical records and examined Mr. McNulty, and again stated the work injury was still the substantial cause of Mr. McNulty's disability and need for medical treatment. However, Mr. McNulty was now medically stable. Dr. Ballard did not find any indication Mr. McNulty's pain was neuropathic, and he stated Mr. McNulty's narcotic medications were appropriate. Dr. Ballard noted additional surgery to fuse the second tarsometatarsal joint was possible.[25]

On March 6, 2014, Dr. Randall performed surgery to fuse Mr. McNulty's second and third metatarsocuneiform joint and his Lisfranc complex.[26] Dr. Randall, on October 15, 2014, performed surgery to remove hardware from Mr. McNulty's foot.[27]

On January 9, 2015, Mr. McNulty again saw Dr. Ballard, who found the work injury still to be the substantial cause of Mr. McNulty's need for treatment. He noted Lisfranc injuries can result in chronic midfoot pain, but Mr. McNulty was medically stable. Dr. Ballard reevaluated Mr. McNulty's PPI rating and determined it had increased from three percent to four percent. Dr. Ballard's PPI rating was based on a mild motion deficit diagnosis. Dr. Ballard stated narcotics were reasonable if monitored and controlled, but it would be best if Mr. McNulty was weaned off narcotics.[28]

David Mulholland, D.C., on September 8, 2015, examined Mr. McNulty for a PPI rating and found Mr. McNulty to be medically stable. Based on a diagnosis of metatarsal-tarsal fracture, Dr. Mulholland rated Mr. McNulty with an eleven percent PPI.[29]

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24 *McNulty I* at 5, No. 23.

25 *Id.* at 5-6, No. 24.

26 *Id.* at 6, No. 25.

27 *Id.*, No. 27.

28 *Id.*, No. 28.

29 *Id.*, No. 30.

On November 20, 2015, Mr. McNulty saw Dr. Ballard for another EME. Dr. Ballard opined the work injury was not the substantial cause of the need for treatment for Mr. McNulty's knee, mid or lower back, shoulder, or arm complaints. Dr. Ballard disagreed with Dr. Mulholland's PPI rating, and restated his rationale for the four percent rating. Dr. Ballard noted Mr. McNulty continued to have subjective pain complaints out of proportion to his objective findings.[30]

Mr. McNulty, on August 23, 2016, saw Carol Frey, M.D., for a Board-ordered second independent medical evaluation (SIME). She diagnosed a history of a Lisfranc fracture dislocation at the first, second, and third metatarsocuneiform joint, degenerative arthritis/overuse of the fourth and fifth metatarsocuboidal joint, overuse of the fourth and fifth metatarsals, impingement of the deep peroneal nerve, possible exuberant bone formation from the fusions, a very tight left Achilles tendon, and long-term opioid use. She stated the substantial cause of the Lisfranc injury was the work injury, and all of the other diagnoses were the direct result of the Lisfranc injury. She added it was common for pain to continue after a Lisfranc injury. Dr. Frey noted Mr. McNulty might benefit from surgery to shorten his fourth and fifth metatarsals, but the surgery was only successful about seventy-five percent of the time. She found Mr. McNulty reached medical stability six months after the October 4, 2014, surgery, but if he elected to have the shortening surgery it would take six months to recover. Dr. Frey stated Mr. McNulty would require pain management over a five-year period. One of the questions asked of Dr. Frey was whether she agreed with Dr. Ballard's "9% lower extremity (4% whole person)" impairment rating. In response, Dr. Frey calculated a lower extremity rating of twenty-seven percent based on Mr. McNulty's fusions and arthritis.[31] The Board converted her rating to a whole person rating using Table 16-10 of the *Guides to the Evaluation of Permanent Impairment*. Under Table 16-10, a twenty-seven percent lower extremity rating is equivalent to an eleven percent whole person rating.[32]

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30 *McNulty I* at 6, No. 31.

31 *Id.* at 7, No. 32; Exc. 10-67.

32 *Id.*, No. 33.

On November 16, 2017, Mr. McNulty saw Gary Olbrich, M.D., a pain management and addictive disease specialist, for an EME. He reviewed Mr. McNulty's medical records, noting Mr. McNulty's prescriptions. Mr. McNulty explained to Dr. Olbrich that narcotics, regardless of the type or dosage, had never done more than take the edge off his pain. Dr. Olbrich diagnosed severe substance abuse disorder including opioid and diazepam use, as well as chronic pain disorder as the result of long-term narcotics use. Dr. Olbrich explained severe substance abuse disorder was also known as addictive disorder, and is a brain disease with a physiological basis. Dr. Olbrich explained chronic pain disorder is caused by the use of opioids for longer than ninety days. One effect of long-term usage is that stimuli that were not previously perceived as painful become painful. Dr. Olbrich stated the Centers for Disease Control (CDC) recently published new guidelines for long-term opioid use. Opioids for postoperative pain should be limited to ten days, and the morphine equivalent dose of any opioid should never exceed 90 mg per day. Additionally opioids and benzodiazepines should not be prescribed concurrently. Dr. Olbrich recommended Mr. McNulty be weaned off opioids and suggested two inpatient facilities.[33]

On August 8, 2018, Mr. McNulty returned to Derek Hagen, D.O., for his monthly pain management visit. His monthly prescriptions for oxycodone and diazepam were renewed.[34]

Mr. McNulty began tapering off the oxycodone on his own, and by September 27, 2018, he had taken his last pill.[35]

Dr. Hagen testified by deposition that he was amenable to weaning Mr. McNulty off his medications, but he did not want Mr. McNulty to suffer just to prove a point. Dr. Hagen noted that while Mr. McNulty's dosage had increased over the years, the increase was slower than that sought by addicts and was due to Mr. McNulty's increased tolerance.[36]

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[33] *McNulty I* at 8, No. 36.

[34] *Id.*, No. 39.

[35] *Id.*, No. 40.

[36] *Id.* at 9, No. 42.

On October 13, 2018, Mr. McNulty reported he had been off medications for over a month. He was prescribed 30 mg morphine, three times per day. The valium and oxycodone prescriptions were discontinued.[37] At hearing, Mr. McNulty testified he had not abused his medications, and had never asked his doctors to increase the dosage, although he had told them he was not getting much relief. After his oxycodone had been controverted and he was without it, he discovered the opioids had been providing more relief than he previously believed. He explained he wanted to proceed with the surgery Dr. Frey had recommended, but his compensation rate was so low he could not afford to be off work for the time it would take to recover. He had continued to work after the work injury except for short periods after each of his surgeries, and he believed the opioids helped him to do that.[38]

Dr. Olbrich testified at hearing that opioids are more effective for musculoskeletal pain, and much less so for neurogenic pain. They are powerful psychological stimulators; they cause people to feel calm with a sense of well-being, and act as an energizer. When used to treat pain, opiates work well for a short period of time, but have not been shown effective for long periods. The strength of different opioids varies, and to compare dosages, drugs are given a morphine equivalent; oxycodone has a morphine equivalent of 1.5, so each milligram of oxycodone is equivalent to 1.5 milligrams of morphine. Recently, the CDC issued guidelines for the long-term use of opioids, and dosages should be limited to 90 mg morphine equivalent per day. The CDC also cautions against prescribing opioids in combination with hypnotics, such as Valium (diazepam), and Dr. Olbrich noted Mr. McNulty was being prescribed a high dose of diazepam together with the opioids. Individuals prescribed opioids for longer than ninety days begin to experience what had previously been non painful stimuli as painful. Dr. Olbrich explained the gold standard for long-term opioid use is the patient must show a significant increase in function, and an increase in function is more important than a decrease in pain. He reviewed entries in several of Mr. McNulty's medical records where Mr. McNulty reported

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37 *McNulty I* at 9, No. 44.

38 *Id.* at 9-10, No. 46.

the opioids were not really helping his pain and he showed no increase in function. Mr. McNulty had been started on a very high dose in 2012, and the dose had been increased over time to the point Mr. McNulty was prescribed a morphine equivalent dose of 270 mg. Dr. Olbrich explained the best option for weaning was an inpatient program. While weaning could be done through a pain clinic, pain clinics typically lack the resources to provide the attention each patient requires. However, even without a program, he would still recommend reducing opioids gradually, to the 90 mg morphine equivalent level if possible. He would not recommend going "cold turkey", and, if Mr. McNulty was to proceed with the recommended surgery, he would not recommend weaning before that time as some pain medication would be necessary after the surgery.[39]

Dr. Frey also testified at hearing. She no longer believed the surgery she recommended would improve Mr. McNulty's function, but it could still provide a reduction in his pain. Dr. Frey explained the "popping out of place" described in Dr. Randall's October 10, 2018, chart note was more significant. At the time of the hearing, Mr. McNulty's election to have the surgery depended on how compromised he was by the pain, and he was more likely to benefit if the pain was localized. However, if Mr. McNulty did not get the surgery within five years of the March 6, 2014, fusion, she would no longer recommend it. She clarified the statement in her August 23, 2016, report that Mr. McNulty would need pain management for five years. The statement should have been that Mr. McNulty would have pain for five years after his last surgery, and, therefore, would need pain management during that time. She found Dr. Olbrich's EME report to be excellent and supported weaning Mr. McNulty off opioids.[40]

In *McNulty I,* Mr. McNulty sought an order requiring Last Frontier to resume paying for the medications he had been prescribed at the time Last Frontier controverted diazepam and oxycodone. The Board awarded ongoing prescriptions for the opioids.[41] By the *McNulty I* hearing, Mr. McNulty was taking a daily morphine equivalent dose of

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39 *McNulty I* at 10-11, No. 49.

40 *Id.* at 11, No. 50.

41 *Id.* at 26.

90 mg, which is the maximum recommended by the CDC in its new guidelines. *McNulty I* ordered Last Frontier to resume paying for the 90 mg morphine equivalent dose.[42]

Dr. Hagen has monitored Mr. McNulty's use of pain medication on a monthly basis, including periodic drug testing. Dr. Hagen's chart notes indicate Mr. McNulty has a potentially fatal allergy to two common topical pain relievers.[43] On October 29 2019, Mr. McNulty confirmed to Dr. Hagen that, while his pain had not changed significantly, his mobility and function improved while taking his pain medication and he continued to be employed.[44]

On November 14, 2019, Last Frontier filed a petition for modification of *McNulty I*. Last Frontier contended *McNulty I* erred in construing Dr. Olbrich's testimony and that there had been a change in conditions because Mr. McNulty had not had the surgery within the five years in which Dr. Frey said it would be reasonable.[45]

On November 24, 2019, Dr. Olbrich issued an addendum to his November 16, 2017, EME report after reviewing Dr. Hagen's medical reports from June 2018 through October 29, 2019. Dr. Olbrich responded to several questions from Last Frontier. He stated it was still his opinion that Mr. McNulty's ongoing use of opioid medication was neither reasonable nor necessary. He explained the ongoing use of opioids had not been effective as there had not been an improvement in the severity of his pain or evidence of a significant improvement in the quality of his life. Dr. Olbrich opined there had been "more than adequate time" for Mr. McNulty to get the surgery recommended by Dr. Frey, but now the need for surgery should be reevaluated. The Board found it was not clear from Dr. Olbrich's report whether he had reviewed *McNulty I*.[46] The Board denied the petition for modification.

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42 *McNulty I* at 23, 26.

43 *McNulty III* at 10, No. 49.

44 *Id.*

45 *Id.*, No. 50.

46 *Id.* at 10-11, No. 51.

3. Standard of review.

The Board's findings of fact shall be upheld by the Commission on review if the Board's findings are supported by substantial evidence in light of the record as a whole.[47] Substantial evidence is relevant evidence that a reasonable mind might accept as adequate to support a conclusion.[48] "The question of whether the quantum of evidence is substantial enough to support a conclusion in the contemplation of a reasonable mind is a question of law."[49] On questions of law and procedure, the Commission does not defer to the Board's conclusions, but rather exercises its independent judgment.[50]

However, the Board's conclusions with regard to credibility are binding on the Commission, since the Board has the sole power to determine the credibility of witnesses.[51] The weight given to the witnesses' testimony, including medical testimony and reports, is the Board's decision to make and is, thus, conclusive. This is true even if the evidence is conflicting or susceptible to contrary conclusions.[52]

4. Discussion.

Last Frontier asserts that the Board erred in denying its petition for modification since Mr. McNulty has not discontinued use of the opioids, and he has not undergone surgery. Last Frontier contends the Board made a mistake regarding the testimony of Dr. Olbrich by ignoring his recommendation that Mr. McNulty be weaned from his use of opioids. The Board held the continuation of opiates at 90 mg morphine equivalent level was reasonable and necessary, because Dr. Olbrich approved continued use of opioids

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47 AS 23.30.128(b).

48 *See, e.g., Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051, 1054 (Alaska 1994).

49 *McGahuey v. Whitestone Logging, Inc.*, Alaska Workers' Comp. App. Comm'n Dec. No. 054 at 6 (Aug. 28, 2007) (citing *Land & Marine Rental Co. v. Rawls*, 686 P.2d 1187, 1188-1189 (Alaska 1984).

50 AS 23.30.128(b).

51 AS 23.30.122; AS 23.30.128(b); *Sosa de Rosario v. Chenega Lodging*, 297 P.3d 139 (Alaska 2013)(*Sosa de Rosario*).

52 AS 23.30.122.

until Mr. McNulty had surgery. Last Frontier asserts that this is a misconstruction of Dr. Olbrich's testimony. Last Frontier adds that Dr. Olbrich was adamant that Mr. McNulty's continued use of opiates over a long period of time was detrimental to his health and had caused him to develop chronic pain, a condition that looks much like addiction. The only possible treatment is complete removal from use of the opioids.

According to Dr. Olbrich, opioids totally rewire a person's brain and it is an irreversible condition. The addictive disease is uncurable, but can be put into remission, according to Dr. Olbrich, by the total discontinuation of the opiate. Last Frontier states, therefore, Dr. Olbrich testified that Mr. McNulty should not continue using opioids and should go into withdrawal under a treatment plan. However, he did add that if Mr. McNulty was undergoing surgery in the immediate future then he should not be taken off opioids pending this surgery since Mr. McNulty would need pain medication following surgery. Mr. McNulty did not have surgery, and Last Frontier contends this is a change in conditions from *McNulty I*. As such, it necessitates modification of *McNulty I*. Last Frontier asserts that the Board erred in not modifying *McNulty I* and abused its discretion in failing to grant its petition. Moreover, Last Frontier asserts that the Board's decision in *McNulty III* is not supported by substantial evidence in the record as a whole.

Mr. McNulty, on the other hand, contends that the ongoing opioid regimen he is currently on has enabled him to continue to work to support his family and to function at home. He further contends that surgery is no longer recommended. His current opioid regimen follows the CDC guidelines and is, therefore, appropriate for him. Thus, he asserts there has not been a change in circumstances, and the Board was correct in not granting the petition to modify. Mr. McNulty asserts that the Board's decision is supported by substantial evidence in the record as a whole and, thus, *McNulty III* should be affirmed.

The Board, in *McNulty I*, found both Dr. Olbrich and Dr. Frey credible and relied on their testimony in reaching its decision. The Board also found Mr. McNulty and Ms. Larson credible in their testimony that his medications significantly increased his functionality. In fact, Mr. McNulty testified to the Board that he realized when he discontinued the opioids just how much they were helping. He further testified that the opioids enabled him to work and to participate in family events. The only time he missed

work has been when he stopped taking the opioids. These credibility findings are binding on the Commission. The Board based its decision on this testimony and awarded ongoing prescriptions pursuant to the CDC guidelines.

"The board's findings regarding the credibility of testimony of a witness before the board are binding on the commission. The board's findings of fact shall be upheld by the commission if supported by substantial evidence in light of the whole record."[53] The Board found the testimony of Mr. McNulty and Ms. Larson regarding his ability to work while using the opioids and his inability to work when he terminated the opioids to be credible. The Board further found that the testimony and reports of Dr. Olbrich and Dr. Frey also to be credible and relied on their testimony and reports in reaching its decision. The Alaska Supreme Court (Court) has affirmed the right of the Board to choose which parts of which medical reports to support its decisions.[54]

AS 23.30.130 provides for modification of a prior Board decision in certain circumstances. This statute states that a modification may be proper if there has been a change in conditions, or there was a mistake in the determination of a fact. The Board has one year after the last payment of compensation benefits to consider modification of its prior decision. In considering Last Frontier's petition for modification the Board reviewed its findings of facts in *McNulty I*.[55]

The Board looked at Last Frontier's claim that the Board, in *McNulty I*, had mistakenly construed Dr. Olbrich's report and testimony. The Board relied on Dr. Olbrich's testimony that the CDC guidelines for long-term usage of opioids should be limited to 90 mg morphine equivalent per day. Dr. Olbrich further testified that the "gold standard" for long-term opioid use is whether a patient shows a significant increase in function and that the increase in function is more important than a decrease in pain. The Board also relied on Dr. Olbrich's testimony that, if Mr. McNulty were going to have surgery, he

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[53] AS 23.30.128(b); *Sosa de Rosario*, 297 P.3d 139 (Alaska 2013).

[54] *See, Traugott v. ARCTEC Alaska*, 465 P.3d 499 (Alaska 2020).

[55] *See, Fischbach & Moore of Alaska, Inc. v. Lynn*, 430 P.2d 909, 911-12 (Alaska 1967).

should not be taken off opioids entirely because he would have to restart some pain medication following surgery. The Board also noted that while Dr. Olbrich cited to functionality as a basis for continuing an individual on opioids, Dr. Olbrich did not discuss that the opioids enabled Mr. McNulty to continue to work.

The Board found Mr. McNulty credible when he testified that the pain medication enabled him to continue working. The only time he had missed work was during the period of time in which he weaned himself off of the opioids. The Board found this testimony persuasive in showing that the opioids were necessary to his improved function, whether there had been a decrease in his perceived pain. Moreover, the Board relied on Dr. Olbrich's testimony that the CDC had a guideline for long-term opioid use and relied on the fact that Mr. McNulty's treating doctors were prescribing the recommended dosage of 90 mg morphine equivalent per day for Mr. McNulty.

Last Frontier contends the Board ignored Dr. Olbrich's testimony that long-term usage was not generally recommended, but the Board did in fact look at this testimony when the Board stated "[Dr. Olbrich] acknowledged a dose of 90 mg morphine equivalent until surgery was acceptable."[56] The Board further relied on the testimony from Dr. Frey that Mr. McNulty was so functional she would no longer recommend the surgery, and added she felt surgery might make him worse.[57] Dr. Olbrich also stated long-term use would be appropriate when functionality was improved.[58] The Board accepted Mr. McNulty's and Ms. Larson's testimony regarding his improved functionality.

Last Frontier also contends that Mr. McNulty's decision not to have surgery constitutes a change in conditions. However, this contention ignores the fact that Dr. Frey stated that she no longer felt surgery would be a benefit to Mr. McNulty and might even make his condition worse. Furthermore, the Court has held that an injured worker's decision to refuse or delay surgery is reasonable if the worker has weighed the risks and rewards and comes to a personal decision. The Court, in *Fluor Alaska, Inc. v.*

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56 *McNulty III* at 14.

57 *Id.* at 15.

58 Exc. 202.

Mendoza, stated, "If there is a real risk involved (in surgery) and particularly if there is a considerable chance that the operation will result in no improvement or even perhaps in a worsening of the condition, the claimant cannot be forced to run the risk of losing his statutory compensation rights."[59]

Dr. Frey no longer recommends surgery and Mr. McNulty has stated he is not sure he is willing to run the risk. These facts were before the Board in *McNulty I* and nothing has changed. There is no change in circumstances from the fact that Mr. McNulty has not undergone surgery. The Board further stated that it had not ordered payment of the opiate medication solely for the time before surgery, but had ordered that Last Frontier continue to provide opioid medication up to 90 mg morphine equivalent per day.

Last Frontier did not provide any medical testimony that surgery should be reconsidered by Mr. McNulty, nor did it provide new evidence that the opioid medication was no longer providing him with the ability to continue to work and to support his family. Under AS 23.30.095, ongoing palliative care is reasonable and necessary if it enables "the employee to continue in the employee's employment at the time of treatment."[60] Mr. McNulty's testimony at hearing was that the opioids enabled him to keep working and the Board found him credible. The Board found the ongoing prescriptions to be reasonable and necessary. That conclusion is supported by substantial evidence in the record as a whole.

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[59] *Fluor Alaska, Inc. v. Mendoza*, 616 P.2d 25, 27-28 (Alaska 1980).

[60] AS 23.30.095(o).

5. Conclusion.

The Board's decision not to modify *McNulty I* is supported by substantial evidence in the record as a whole and the Board did not abuse its discretion. *McNulty III* is AFFIRMED.

Date: *12 April 2021* Alaska Workers' Compensation Appeals Commission

Signed
James N. Rhodes, Appeals Commissioner

Signed
Amy M. Steele, Appeals Commissioner

Signed
Deirdre D. Ford, Chair

APPEAL PROCEDURES

This is a final decision. AS 23.30.128(e). It may be appealed to the Alaska Supreme Court. AS 23.30.129(a). If a party seeks review of this decision by the Alaska Supreme Court, a notice of appeal to the Alaska Supreme Court must be filed no later than 30 days after the date shown in the Commission's notice of distribution (the box below).

If you wish to appeal to the Alaska Supreme Court, you should contact the Alaska Appellate Courts *immediately*:

Clerk of the Appellate Courts
303 K Street
Anchorage, AK 99501-2084
Telephone: 907-264-0612

RECONSIDERATION

A party may ask the Commission to reconsider this decision by filing a motion for reconsideration in accordance with AS 23.30.128(f) and 8 AAC 57.230. The motion for reconsideration must be filed with the Commission no later than 30 days after the date shown in the Commission's notice of distribution (the box below). If a request for reconsideration of this final decision is filed on time with the Commission, any proceedings to appeal must be instituted no later than 30 days after the reconsideration decision is distributed to the parties, or, no later than 60 days after the date this final decision was

distributed in the absence of any action on the reconsideration request, whichever date is earlier. AS 23.30.128(f).

I certify that, with the exception of changes made in formatting for publication, this is a full and correct copy of Final Decision No. 285, issued in the matter of *Last Frontier Bar and Commerce and Industry Insurance Company v. Devin A. McNulty*, AWCAC Appeal No. 20-009, and distributed by the office of the Alaska Workers' Compensation Appeals Commission in Anchorage, Alaska, on April 12, 2021.

Date: *April 14, 2021*

Signed

K. Morrison, Appeals Commission Clerk