ALASKA WORKERS' COMPENSATION BOARD

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

JOSEPH TRAUGOTT, Employee, Claimant,	)	FINAL DECISION AND ORDER
v.	)	AWCB Case No. 201309316
ARCTEC ALASKA, Self-Insured Employer, Defendant.	)	AWCB Decision No. 17-0103
	)	Filed with AWCB Fairbanks, Alaska on August 29, 2017

Joseph Traugott's July 16, 2015 and November 10, 2015 claims were heard on July 6, 2017 in Fairbanks, Alaska. This hearing date was selected on March 8, 2017. Attorney Eric Croft appeared and represented Joseph Traugott (Employee). Attorney Robert Bredesen appeared and represented ARCTEC Alaska (Employer). Witnesses included Employee and Marilyn Yodlowski, M.D., who appeared in person, and Jerry Grimes, M.D., and Carol Frey, M.D., who testified telephonically. The record closed after deliberations concluded on July 27, 2017.

After a February 18, 2016 hearing on Employee's claims, the panel concluded it lacked sufficient understanding of the medical records to properly weigh the medical testimony. As a result, *Traugott v. ARCTEC Alaska*, AWCB Decision No. 16-0018 (March 10, 2016) (*Traugott I*) ordered a second independent medical evaluation (SIME).

ISSUES

Employee contends his work for Employer was the substantial cause of his osteomyelitis, and consequently his resulting disability and need for medical treatment are compensable under the Act. Employer contends Employee's disability and need for medical treatment are due to

Charcot arthropathy, a consequence of his preexisting diabetes, and, as a result, he is not entitled to benefits under the Act.

1. Was Employee's employment with Employer the substantial cause of his disability or need for medical treatment?

If Employee's work for Employer is the substantial cause of his disability and need for medical treatment, Employer contends the use of an intramedullary rod to fuse Employee's ankle was not reasonable medical treatment. Employee contends the choice of an intramedullary rod was reasonable and necessary treatment.

2. Was the implantation of an intramedullary rod reasonable and necessary medical treatment?

FINDINGS OF FACT

All findings in *Traugott I* are incorporated herein. The following facts are reiterated from *Traugott I* or are established by a preponderance of the evidence:

1. Employee was diagnosed with diabetes in 2002. (Employee Deposition).
2. On August 9, 2004, Employee reported a sore on his toe that was healing. A photograph of what appears to be an open sore on Employee's right big toe has a notation stating "old blister from shoes." (AK Kidney & Diabetes, Chart Note, August 8, 2004).
3. On February 7, 2005, it was noted that Employee's toe had "completely healed over from 8/04." (AK Kidney & Diabetes, Chart Note, February 7, 2005).
4. On April 25, 2005, Employee reported an infection on his left big toe. (AK Kidney & Diabetes, Chart Note, April 25, 2005).
5. On September 22, 2005, Employee complained of a right big toe infection, which began five days earlier, and was placed on oral antibiotics. (AK Kidney & Diabetes, Chart Note, September 22, 2005).
6. On October 3, 2005, Employee was seen by Patrick Crawford, D.P.M. Dr. Crawford reported that while working in Alaska, Employee had a callus that broke down developing a neurotrophic ulcer on his right big toe. There was no evidence of bony involvement. (Dr. Crawford, Chart Notes, October 3 and 17, 2005).
7. An October 26, 2005 chart note indicates Employee's right big toe was better, but needed debridement. (AK Kidney & Diabetes, Chart Note, October 26, 2005).

8. On January 5, 2006, Employee's right big toe ulcer was found to be infected with streptococcus. (Dr. Crawford, Chart Note, January 5, 2006).
9. On January 9, 2006, Employee was seen for follow up of his right big toe after someone had stepped on it. The toe appeared infected, and Employee was placed on oral antibiotics. (AK Kidney & Diabetes, Chart Note, January 9, 2006).
10. By March 8, 2006, Employee's right big toe had healed. (Dr. Crawford, Chart Note, March 8, 2006).
11. On September 6, 2006, Dr. Crawford diagnosed possible Charcot foot (Charcot neuroarthopathy) in Employee's right foot. (Dr. Crawford, Chart Note, September 6, 2006).
12. On August 11, 2007, Employee was diagnosed with neuropathy. (Texas Tech University, Patient Information Sheet, August 11, 2007).
13. Neuropathy, or peripheral neuropathy, is a disruption in the function of peripheral nerves, commonly due to diabetes. It most often involves nerves related to sensation or proprioception. (Dr. Yodlowski, EME Report, January 5, 2016).
14. When a person develops neuropathy, their skin stops producing the oils that lubricate the skin and they do not sweat. Because they do not feel damage to the skin, they are at risk of skin ulcers. (Dr. Grimes, Deposition Testimony, February 6, 2016).
15. On October 15, 2008, Employee reported continued pain in both feet, some of which was determined to be nerve-related. (AK Kidney & Diabetes, Chart Note, October 15, 2008).
16. On February 4, 2010, an x-ray revealed evidence of joint destruction in Employee's right foot. Dr. Crawford diagnosed Charcot neuroarthopathy in Employee's right midfoot. It was noted that the second toe on Employee's right foot was a hammer toe. (Dr. Crawford, Chart Note, February 10, 2010).
17. Charcot neuropathy or Charcot foot is a condition that occurs in a small percentage of individuals with neuropathy. It appears as inflammation in a joint or bone, and the foot gets red, swollen, and looks infected, but there is no organism present. During the inflammation stage, the bones begin to crumble and fall apart. It is unknown why Charcot foot occurs. A flare of Charcot may lead to a deformity causing an abnormal weight-bearing surface. These abnormal weight-bearing surfaces are at additional risk of ulceration because the skin breaks down very easily. (Dr. Grimes, Deposition Testimony, February 6, 2016).

18. Hammer toe can develop as a result of neuropathy. The damage to the nerve causes an imbalance in the muscles of the toe, causing the toe to curl. (Yodlowski).
19. On May 2, 2011, it was noted that Employee had decreased sensation to touch in both legs. (Amarillo Family Physicians Clinic, Chart Note, May 2, 2011).
20. On May 2, 2011, Dr. Crawford noted Employee's hammer toe had become infected and recommended surgery to correct the condition. (Dr. Crawford, Chart Note, May 2, 2011).
21. On May 5, 2011, the infection in Employee's toe was determined to be a staphylococcus infection. (Dr. Crawford, Chart Note, May 5, 2011).
22. On May 16, 2011, Dr. Crawford stated he would schedule surgery to correct Employee's hammer toes. (Dr. Crawford, Chart Note, May 2, 2011).
23. Because of unrelated medical complications, the surgery on Employee's toes was not performed until May 29, 2012, when Dr. Crawford fused the joints in the second and third toes on Employee's right foot using internal fixation. (Dr. Crawford, Chart Notes, August 17, 2011 to May 29, 2011).
24. On May 21, 2012, Employee reported the lesions on his toe had increased in size. He was diagnosed with a diabetic ulcer and bone infection (osteomyelitis). (Amarillo Family Physicians Clinic, Chart Note, May 21, 2012).
25. On June 21, 2012, the infection in Employee's second toe was found to be staphylococcus. (Dr. Crawford, Chart Note, June 21, 2012).
26. On July 23, 2012, Employee was released to work after the hammer toe surgery. (Dr. Crawford, Work Release, July 31, 2012).
27. On August 3, 2012, Employee was found to have a staphylococcus infection in his right third toe. (PPL Laboratory, Microbiology Report, August 4, 2012).
28. Employee was hired by Employer in March 2013. At the time of hiring, he was given a physical examination. He was approved for work without restriction, but was notified he should consult his doctor because a pulmonary function test had been abnormal. Employee worked about three weeks at the Indian Mountain site, and was transferred to Tin City. While at Tin City, Employee primarily worked replacing heating and cooling systems. The work was six days per week, at least 10 hours per day. Most of the work was overhead, requiring Employee to spend significant time standing on ladders. Standing on the ladders caused pressure on the

middle of his feet. (Employee Deposition, October 16, 2015; Beacon Occupational Health, Hiring Physical, March 11, 2013; Employee).

29. In the middle of May 2013, Employee developed a blister, smaller than the size of a dime, located in the middle of the arch of his right foot toward the outside. Employee believed the blister was caused by the pressure on his foot while standing on ladders. Employee did not seek medical attention, and did not report the injury. He treated the blister himself by keeping it clean; he did not use any antibiotics. The blister healed and went away within a couple of weeks. (Employee Deposition, October 16, 2015).
30. On July 5, 2013, the skin on the sole of Employee's right foot cracked open within an inch of where the blister was in May. There was a fetid discharge. Because there are no medical facilities at Tin City, Employee was flown to Nome the next day. (Employee Deposition, October 16, 2015).
31. Employee was hospitalized in Nome with an initial diagnosis of cellulitis of the foot, secondary to diabetes. He reported that while he had no recent injury to the foot, he had been experiencing foot problems for about a week. (Norton Sound Regional Hospital, Inpatient Admission Form and Admission History, July 6, 2013).
32. On July 9, 2013, Employer filed a report of occupational injury or illness. (Report of Injury, July 8, 2013). It is Employer's practice to report all injuries, whether it believes they are compensable or not. (Palazzatto).
33. Employee was discharged from Norton Sound Regional Hospital on July 11, 2013 with a diagnosis of moderately severe cellulitis. X-ray and CT scans had shown a soft tissue ulcer with no evidence of osteomyelitis, although the possibility of osteomyelitis remained a concern. Wound and blood cultures were negative, suggesting an anaerobic infection. The wound was debrided, and Employee was to receive follow-up care when he returned home to Texas. (Norton Sound Regional Hospital, Discharge Summary, July 11, 2013).
34. On July 15, 2013, Employee was seen by Dr. Crawford. Dr. Crawford reported Employee had developed a blister on his right foot in May 2013, which had cracked open and become infected. Dr. Crawford diagnosed a diabetic ulcer, cellulitis, and Charcot foot. Another wound culture was done, and Employee was to continue on antibiotics. An MRI was scheduled for July 23, 2013. (Dr. Crawford, Chart Note, July 15, 2013).

35. Employee's foot improved initially, but by August 1, 2013, he was hospitalized when osteomyelitis was suspected, and the wound was drained and debrided. Cultures revealed a Staphylococcus epidermis infection, and Employee was started on a broad-spectrum antibiotic. (BSA Health System, Discharge Summary, August 5, 2013).
36. On August 12, 2013, Employer controverted all benefits noting that Employee had been diagnosed with diabetic foot cellulitis, and there was no evidence the condition was work-related. (Notice of Controversion, August 8, 2013).
37. On December 8, 2013, Employee was found to have a Staphylococcus aureus infection in his foot. (PPL Laboratory, Microbiology Report, December 8, 2013). He received a prolonged course of intravenous antibiotic therapy. (BSA Health System, Infectious Disease Consultation, December 26, 2013).
38. Employee received wound care three times per week, and slowly improved. By June 20, 2014, the wound was nearly closed. (Dr. Crawford, Chart Note, June 20, 2014).
39. In September 2014, Employee's wound was found to be infected with methicillin resistant Staphylococcus aureus (MRSA). (PPL Laboratory, Microbiology Report, September 27, 2014).
40. By December 2, 2014, cultures showed no infection in Employee's foot. (BSA Health System, Laboratory Report, December 2, 2014).
41. By December 17, 2014, the wound had healed, although there was still some swelling and warmth. (Dr. Crawford, Chart Note, December 17, 2014).
42. On January 5, 2015, Employee returned to Dr. Crawford with a swollen right foot and ankle. An x-ray revealed partial dislocation of the right ankle, and Dr. Crawford diagnosed Charcot right foot and ankle, possibly aggravated by gout. (Dr. Crawford, Chart Note, January 5, 2015).
43. On January 20, 2015, Employee was seen by Mark Drew, M.D., at BSA Health System. Dr. Drew diagnosed severe right foot and ankle Charcot arthropathy. Dr. Drew noted that the ulcer on the sole of Employee's foot had not recurred, but he had a thick callus at the site. (BSA Health System, Chart Note, January 20, 2015).
44. On February 9, 2015, Dr. Drew noted the deformity in Employee's right ankle was worsening due to Charcot arthropathy. The sole of his foot remained intact with no ulceration. (BSA Health System, Chart Note, February 9, 2015).
45. On March 18, 2015, Dr. Drew referred Employee to an orthopedic surgeon, Dr. Risko, at Amarillo Bone and Joint Clinic. (BSA Health System, Chart Note, March 18, 2015).

46. By March 30, 2015, Employee had developed a small ulceration between the third and fourth toe of his right foot. (BSA Health System, Chart Note, March 30, 2015).
47. On March 23, 2015, Employee met with Dr. Risko. Dr. Risko concluded Employee was not a candidate for corrective Charcot surgery and recommended a below-the-knee amputation. (BSA Health System, Chart Note, April 8, 2015).
48. On July 16, 2015, Dr. Crawford filed a Physician's Report stating Employee's right foot condition was work related. He explained "stress to right foot caused blister/open area leading to infection and ulcer." (Dr. Crawford, Physician's report, July 16, 2015).
49. On November 4, 2015, Employee met with orthopedic surgeon Jerry Grimes, M.D. Dr. Grimes noted that midfoot radiographs of Employee's ankle were consistent with Charcot neuroarthropathy, but the talus was essentially gone and did not show significant fragmentation. Dr. Grimes concluded the lack of fragmentation could be secondary to infection, Charcot, or an avascular necrotic process. Based on blood tests, Dr. Grimes concluded Employee did not have active osteomyelitis. Dr. Grimes noted a below the knee amputation was reasonable, but given Employee's aversion to amputation, an ankle fusion was a reasonable alternative. (Dr. Grimes, Chart Note, November 4, 2015).
50. On November 12, 2015, Dr. Grimes performed the fusion surgery on Employee's right ankle using internal hardware. (University Medical Center, Surgical Documentation, November 12, 2015). Because of the unusual appearance of the talus during surgery, Dr. Grimes sent biopsy samples for pathology and microbiology evaluation. (Dr. Grimes, Deposition, February 5, 2016).
51. The pathology tests took several days to complete. On November 24, 2015, the pathologist reported to Dr. Grimes that the bone destruction could be consistent with Charcot, but it was more likely that osteomyelitis was an initiating or complicating factor. (Pathology Report, November 24, 2015). The microbiology reports subsequently confirmed osteomyelitis in Employee's talus. (Dr. Grimes, Deposition, February 5, 2016).
52. Determining whether the damage to a bone was caused by osteomyelitis or Charcot neuroarthropathy is very difficult using imaging such as x-rays, MRIs, and CT scans. The best way to distinguish is through a bone biopsy. (Dr. Grimes, Deposition, February 5, 2016).

53. While osteomyelitis can develop from a blood-borne infection, the infection is most commonly acquired through a break in the skin, such as a blister, cut, or ulcer. It is one of the most frequent infections of a diabetic foot. (Dr. Grimes, Deposition, February 5, 2016).
54. After receiving the pathology and microbiology reports, Dr. Grimes revised his diagnosis, concluding the collapse of Employee's talus was due to osteomyelitis rather than Charcot foot. He was convinced the osteomyelitis infection originated with the May 2013 blister on Employee's foot. Dr. Grimes stated that while Employee was at a higher risk than someone with a healthy foot, Employee would probably not have developed the ulceration and osteomyelitis with normal activities. Dr. Grimes relied, in part, on Dr. Crawford's July 16 2015 report which stated stress to Employee's right foot caused a blister or open area leading to the infection and ulcer. (Dr. Grimes, Deposition, February 5, 2016).
55. On January 25, 2016, Dr. Yodlowski performed an employer's medical evaluation (EME). Because Employee was unable to travel, Dr. Yodlowski's evaluation was limited to a review of the medical records. While Dr. Yodlowski had Employee's medical records dating to 2002, she did not have records from the November 2015 surgery. Dr. Yodlowski noted Employee had been diagnosed with both Charcot foot and osteomyelitis well before the work injury. She opined the loss of bone in Employee's ankle was most likely due to Charcot foot, but could be due to a combination of Charcot and osteomyelitis. She explained the underlying cause of Charcot foot was the peripheral neuropathy due to Employee's diabetes, and the Charcot foot develops with normal activities of living, and was not due to trauma. She further explained that MRSA was often found on a person's skin, and Employee was not at a higher risk of infection because of his work activities. In response to a question asking her to identify the substantial cause of "the diagnosed condition," Dr. Yodlowski responded the cause of the Charcot and the infections was Employee's diabetes, not his employment. (Dr. Yodlowski. EME Report, January 5, 2016).
56. At the February 18, 2016 hearing, Dr. Yodlowski testified about causation: "countless people climb ladders every day . . . and it doesn't cause a diabetic ulcer;"; "what causes a diabetic ulcer is having these underlying abnormalities . . . in your foot structure and then doing activities that people do every day without sustaining injury." She noted that "if you climb ladders and get a blister, you don't get hospitalized unless you have other pathology." She did note, however, that if an individual "didn't follow medical advice on prevention, substantial pressure on middle

of foot could likely cause him to develop an ulcer." She did not know how much of the day Employee spent on a ladder, but she had not seen nor read about ulcers as a result of standing on ladders. (Dr. Yodlowski).

57. At the February 18, 2016 hearing, Employee testified that prior to the 2013 infection, no doctor had recommended he wear orthotic or diabetic shoes, although he had been prescribed orthotic wedges he could use in work shoes. (Employee; Employee, Deposition, October 15 2015).

58. After the February 18, 2016 hearing, the panel concluded it lacked sufficient understanding of the medical records to properly weigh the medical testimony. As a result, *Traugott I*, issued on March 10, 2016 ordered a second independent medical evaluation (SIME). The SIME was to be conducted by Carol Frey, M.D., an orthopedic surgeon specializing in foot and ankle problems. In addition to the standard SIME questions, *Traugott I* ordered that Dr. Frey be asked the following:

> How likely is it that a blister that healed within a couple of weeks without treatment, including antibiotics, would be the portal of entry for the infection in the diabetic ulcer on Employee's foot that occurred about five weeks later?
>
> If the blister was not the portal of entry for the infection in Employee's subsequent midfoot ulcer, could such an ulcer develop because Employee's preexisting diabetic neuropathy and Charcot foot were aggravated by significant time spent standing on ladders?
>
> What is the likelihood Employee would have developed the midfoot ulcer had he not been engaged in work activities – in other words, how likely is it was the ulcer would have developed if Employee had only engaged in his normal activities of daily living?
>
> Was the collapse of Employee's talus was more likely due to Charcot neuroarthropathy or to osteomyelitis?
>
> If the collapse of Employee's talus was due to Charcot neuroarthropathy, did the osteomyelitis aggravate the collapse?
>
> Is it probable that the source of the osteomyelitis in Employee's talus was his midfoot osteomyelitis, or was there another, more likely, source? (*Traugott I*).

59. The Board's referral letter to Dr. Frey included the following instructions on Alaska workers' compensation law:

- First, under Alaska law, "disability" does not mean a physical impairment; it is an economic concept, and means the inability to earn the wages the employee was earning at the time of the injury.

- Second, under Alaska law at the time of Mr. Traugott's injury, the legal test for causation is that the employment be "the substantial cause" of his disability or need for medical treatment. "The substantial cause" means that, in relation to all of the causes which a reasonable person could assign responsibility, employment is more than any other the cause of the employee's disability or need for medical treatment. In determining "the substantial cause," the board is required to evaluate the relative contribution of different causes of an employee's death, disability, or need for medical treatment.

- Third, the causation analysis becomes somewhat more complicated if the employee had a pre-existing condition. Under Alaska law, an employer takes an employee with whatever pre-existing conditions he or she may have. When a pre-existing condition makes an employee more susceptible to injury, the question becomes whether the employment was "the substantial cause" in aggravating, accelerating, or combining with the pre-existing condition to result in disability or the need for medical care. In other words, if an employee has a pre-existing condition, employment may be the substantial cause of his disability or need for medical care, even though a person without that pre-existing condition may not have suffered a similar injury or consequences. (SIME Referral Letter, June 6 2016).

60. The referral letter to Dr. Frey also included the questions ordered in *Traugott I*, the Board's standard questions, and questions from both Employee and Employer. (SIME Referral Letter, June 6 2016).
61. Dr. Frey spent eighteen hours reviewing over 3,000 pages of Employee's medical record dating back to September 2005. (Dr. Frey, SIME Report, January 5, 2017; SIME Medical Records).
62. On January 5, 2017, she examined Employee and diagnosed a number of conditions. Relevant to Employee's right foot or ankle, she diagnosed:

    - Diabetes mellitus of more than a decade with evidence of poorly controlled blood sugars.

    - Peripheral neuropath likely secondary to diabetes. History of multiple wound infections and deformities in the right foot including hammertoes likely secondary to diabetes and peripheral neuropathy.

    - Right foot Charcot arthropathy documented in the medical records predating May 2013.

- Ongoing and multiple ulcerations and diabetic foot wounds.
- History of osteomyelitis and possible ongoing chronic osteomyelitis throughout the right foot and possibly now the ankle.

Dr. Frey diagnosed several other conditions that, while not directly relevant to Employee's foot and ankle, could influence the appropriate course of treatment. (Dr. Frey, SIME Report, January 5, 2017).

63. In her report, Dr. Frey's answers to several of the Board's questions were:

2. If, in your opinion, one cause of Joseph Traugott's disability, or need for medical treatment is a preexisting condition, did the 2013 employment injury aggravate, accelerate, or combine with the preexisting condition to cause disability or need for treatment?

   The employment injury combined with pre-existing condition of diabetes and neuropathy to produce a break down in the patient's foot and introduction of infection. He has a history of Charcot arthropathy on the right foot but not the left foot. He has a history of infection in the right foot, that responded to antibiotic treatment, but does not have the same history on the left. He is clearly, as a result of diabetes and neuropathy at risk for developing CHARCOT arthropathy, but does not have a history of this on the left. There were xrays taken within a year of the injury of the left ankle, and no CHARCOT was reported, even when looking for it. He did not have a history of infection on the left. He had been cleared for work from a previous left fibula fracture. The wound did not break down in the area of the fibula fracture. The patient reports that he continued to work on ladders and climbing and walking, despite pain the mid arch. This contributed to the break down in the skin and the introduction of the infection. Otherwise, there are no records to indicate that he had another site of infection at that time. There are no records to indicate that he had Charcot arthropathy on the left side, prior to the incident of pain and working through pain at work. However, he has a clear history of neuropathy and diabetes that contributed to his eventual need for long term treatment for Charcot arthropathy.

3. Please evaluate the relative contribution of different causes of Joseph Traugott's disability, or need for medical treatment identified in question one.

   Osteomyelitis, Charcot arthropathy, breakdown of the ankle are the conditions that are contributed to by his work. This condition is mainly a result of the diabetes and neuropathy, his preexisting condition, but clearly accelerated by his work injury.

4. Which of the different causes identified in question one is "the substantial cause" of Joseph Traugott's disability, or need for medical treatment? Please provide the basis of your opinion.

   Overall cause:
   75% diabetes & neuropathy
   25% work conditions

   Acceleration
   100% work related. Therefore, for this particular disability at this particular point in time, the work injury is the SUBSTANTIAL CAUSE.

9. How likely is it that a blister that healed within a couple of weeks without treatment, including antibiotics, would be the portal of entry for the infection in the diabetic ulcer on Employee's foot that occurred about five weeks later?

   Not possible to say.

10. If the blister was not the portal of entry for the infection in Employee's subsequent midfoot ulcer, could such an ulcer develop because Employee's preexisting diabetic neuropathy and Charcot foot were aggravated by significant time spent standing on ladders?

    The blister more probably than not was the portal of entry.

11. What is the likelihood Employee would have developed the midfoot ulcer had he not been engaged in work activities - in other words, how likely would the ulcer have developed if Employee had only engaged in his normal activities of daily living?

    More probable than not that he would have developed a skin ulcer on the outside, but not at all likely that it would have appeared this quickly. Clearly accelerated by the work and continuing to work through pain.

12 Was the collapse of Employee's talus more likely due to Charcot neuroarthropathy or to osteomyelitis?

    50/50. Impossible to determine by any reasonable evaluation. Therefore given equal weight.

13. If the collapse of Employee's talus was due to Charcot neuroarthropathy, did the osteomyelitis aggravate the collapse?

    Yes

14 Is it probable that the source of the osteomyelitis in Employee's talus was his midfoot osteomyelitis or was there another more likely source?

Yes, most likely from a break in the skin, as no other source is identified. (Dr. Frey, SIME Report, January 5, 2017).

64. Dr. Frey responded to Employee's SIME questions as follows:

2. Working for Arctec at Tin City, Mr. Traugott was wearing new boots, was working 60 hours a week, which involved a substantial amount of walking and carrying, and was working on ladders more than on any other job he had ever had. [] "Being on ladders all the time . . . creates a lot of pressure on the middle of our foot." [] In May 2013, he developed a blister in his arch that did not ulcerate and healed cleanly. In July 2013, he developed a blister near the first that ulcerated [].

   In your professional opinion, is this the type of work activity that would lead to the blisters Mr. Traugott experienced in May and July 2013?

   Yes, especially with boots and ladder use. Mid arch is a very common location.

2.[sic] In the medical records, there are two potential causes of Mr. Traugott's osteomyelitis, a 2012 hammertoe procedure with no complications and the 2013 blisters, with substantial osteomyelitis complications.

   2013 blister, as the 2012 infection had cleared, according to medical records.

6. On January 5, 2016, Dr. Yodlowski stated that Mr. Traugott's "foot would not be reasonably treated by any kind of reconstructive surgery other than a below-knee amputation." Do you agree that amputation is an appropriate medical recommendation for Mr. Traugott?

   No, there are the options that I mentioned above. Although BKA is the quickest it is not the only recommendation. (Dr. Frey, SIME Report, January 5, 2017).

65. Dr. Frey's responses to Employer's SIME questions are as follows:

2. In the context of diabetic midfoot ulcers, does the medical community regard activities of daily living such as walking, standing or climbing (either up/down stairs or ladders), as a pathological cause of the ulcers, and do physicians attach responsibility to those activities?

   No. Not for ADLs.

4. Which factors do you regard as a cause and attach responsibility to, for the development of Mr. Traugott's diabetic midfoot ulcer?

   Working through pain and continuance of loading his midfoot, not only by wearing a boot (tends to fit the arch more tightly than a shoe), but also use of ladders & long term standing. The patient also reports working through pain.

7. Which of the identified factors is "the substantial cause" of Mr. Traugott's talus osteomyelitis?

   The midfoot ulcer. This is taking into consideration acceleration. Had it not been for his diabetes and neuropathy he would not have had Charcot. Had it not been for his skin ulcer he would not have had osteomyelitis. Had it not been for his work injury, he would not have had the skin ulcer at the time he had it. He very well may have had skin break down at some point in time, but it is not possible to know when. This skin break down, caused this infection at this point in time

9. Was the surgery performed by Dr. Grimes reasonable and necessary?

   Yes. (Dr. Frey, SIME Report, January 5, 2017).

66. Employee's foot was sore to walk on for about a week before it broke open on July 5, 2013. Employee is averse to amputation because he knew someone who had a lower leg amputation which led to a total amputation, after which the person died. Employee believes the November 2015 surgery was highly successful. At the time of the July 6, 2017 hearing, he was no longer taking pain medication and was on a reduced dosage of antibiotics. He is able to walk using a cane, and stairs are difficult, but he no longer requires a cast-boot. He is receiving Social Security disability, although he would have continued to work had the injury not occurred. (Employee, July 6, 2017 Hearing).

67. Dr. Grimes explained that at the time of the November 2015 surgery, there were three potential options to treat Employee's ankle. The first, joint replacement, is contraindicated in patients with neuropathy, so it was not an option. The second, amputation, is the most reliable, and would return Employee to activity the fastest. The biggest disadvantage is the lack of mobility without the prosthesis. The third option, fusion, can be done by two methods internal stabilization or external stabilization. Internal fixation, using an intramedullary rod which is cemented into the bone, is what was used on Employee. External fixation consists of rings around the leg with wires going to the bones to hold them in place. Internal fixation is more

stable, more convenient for the patient, and has a lower complication rate. Doing a bone biopsy requires surgery, a cut is made and a needle introduced to the area, which entails the risk of introducing infection and is only accurate about 70 percent of the time. Dr. Grimes determined a biopsy was not needed because Employee was essentially free of infection symptoms; he had no open wound, his foot was not red or swollen, his white blood cell count was normal, a C-reactive protein test was barely above normal, and his Procedure Site Sedimentation Rate was normal. It is likely Employee's implant is infected; because of the lack of blood supply to the implant itself, it isn't possible to clear an infection, and antibiotics are needed to suppress it. With all he knows today, Dr. Grimes would not have used the same procedure, but would have chosen external fixation instead. (*Dr. Grimes, July 6, 2017 Hearing).*

68. Dr. Grimes agreed with Dr. Frey's SIME report regarding how boots fit and the possibility of blisters when wearing boots and working on ladders. (*Id.*).
69. Dr. Grimes opined the infection in Employee's talus was the ultimate cause of the need for surgery. He concluded the source of Employee's hindfoot infection was the infection in his midfoot, but he could not offer an opinion as to whether work caused the midfoot infection. (*Id.*).
70. Dr. Grimes explained that when a healthy person gets a blister, the skin provides a biologic barrier and should be left in place until it ruptures. Because a diabetic is more prone to infections, a blister is often opened or "unroofed," allowing more aggressive wound care. It is possible for an infection to get in even if a blister has not ruptured. (*Id.*).
71. Dr. Yodlowski testified the disintegration of bones from Charcot foot can cause a deformity in the arch, such that it becomes a pressure point, and just walking, or standing can wear away the skin causing a diabetic ulcer. She opined diabetes was a direct cause of Employee's midfoot ulcer; the ulcer would not have occurred but for the diabetes. Employee's midfoot ulcer was not dependent on his work for Employer; there was nothing specific about his work conditions that was any different than his recreational activities. Dr. Yodlowski acknowledged that even an unruptured blister can become infected, but she discounted the blister as the source of Employee's infection because there is no documentation Employee's May 2013 blister became infected. She believed it was more likely that because of the deformity in Employee's foot, a bone got very close to the skin, wore a hole in it, and that was the source of the infection. She could not find anything in the medical literature saying ladders caused an increase risk. She

stated "hundreds, thousands of people work at ARCTEC and do similar types of jobs and they don't get those conditions, so, no, there's no basis for the work [at] ARCTEC being the cause of those conditions." Employee's diabetes is so important of a cause that it should be considered the substantial cause of his disability and need for medical treatment. (Dr. Yodlowski, July 6, 2017 Hearing).

72. Given that Employee had osteomyelitis that had lasted for months, Dr. Yodlowski stated more testing, including a biopsy, would have been appropriate before surgery. It was unreasonable to use an implanted rod without knowing if an infection was present. Dr. Yodlowski noted that the literature published by the manufacturer of the intramedullary rod used on Employee cautioned against its use when infection was present. (*Id.*).
73. Dr. Yodlowski would have expected symptoms if the blister on Employee's foot had been infected. When a foot has collapsed as the result of Charcot, blisters or diabetic ulcers can form as the result of pressure in areas that were not built for that, such as the arch. She believed the ulcer that formed in July 2013 was a diabetic ulcer, unrelated to the May 2013 blister that healed without any sign of infection. (*Id.*).
74. Dr. Frey agreed with Dr. Grimes's choice not to perform ankle replacement, especially given the loss of bone in Employee's ankle. She also agreed there are advantages and disadvantages to both amputation and fusion, and a patient's desire is an important consideration in making a surgical decision. The lack of physical signs, the blood tests, and an MRI indicated the absence of infection, and a bone biopsy is uncommon before surgery. You cannot just stick a needle into a bone and hope to find something; there needs to be a pool of fluid visible on an x-ray to sample. Additionally, there is the risk of introducing an infection while doing the biopsy. (Dr. Frey, July 6, 2017 Hearing).
75. Dr. Frey concluded the osteomyelitis accelerated Employee's underlying preexisting Charcot causing it to become symptomatic at the time it did. The most likely cause of the infection in Employee's talus is the blister that progressed to an ulcer and an infection. Blisters are more common when wearing a stiff-soled shoe or boot, and boots tend fit more snugly in the arch, and being on a ladder places most of the weight on the mid-arch. Blisters are caused by friction and overuse. While diabetics with neuropathy are at a higher risk, but for standing on the ladder all day wearing stiff-soled boots, Employee would not have developed the blister that introduced

the infection. Although the infection could come from other breaks in the skin, there is no evidence in the record of any break in the skin except the blister. (*Id.*).

76. Dr. Frey stated Employee's work for ARCTEC is the substantial cause of his disability and need for medical treatment. She explained Employee's preexisting diabetes and neuropathy were 75 percent of the cause of his disability or need for medical treatment, and work contributed 25 percent. However, the acceleration was solely due to work; but for the work, he would not have had the infection, which caused the acceleration of the Charcot food deformity. It is more probable than not that Employee's preexisting conditions would have been just fine for the rest of his life had it not been for the work. (*Id.*).
77. Extended time working on ladders causes increased pressure on the middle of the foot. (Experience, Observation).

PRINCIPLES OF LAW

> **AS 23.30.001. Intent of the legislature and construction of chapter**. It is the intent of the legislature that
> (1) this chapter be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter;
>
> . . . .
>
> (4) hearings in workers' compensation cases shall be impartial and fair to all parties and that all parties shall be afforded due process and an opportunity to be heard and for their arguments and evidence to be fairly considered.

The board may base its decision not only on direct testimony, medical findings, and other tangible evidence, but also on the board's "experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987). An adjudicative body must base its decision on the law, whether cited by a party or not. *Barlow v. Thompson*, 221 P.3d 998 (Alaska 2009).

> **AS 23.30.010. Coverage.**
> (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for

> medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.
>
> **AS 23.30.120. Presumptions.**
> (a) In a proceeding for the enforcement of a claim for compensation under this chapter it is presumed, in the absence of substantial evidence to the contrary, that
>
> (1) the claim comes within the provisions of this chapter . . . .

Under AS 23.30.120, benefits sought by an injured worker are presumed to be compensable, and the burden of producing evidence is placed on the employer. *Sokolowski v. Best Western Golden Lion Hotel*, 813 P.2d 286, 292 (Alaska 1991). The Alaska Supreme Court held the presumption of compensability applies to any claim for compensation under the Act. *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996). An employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski* at 292.

A three-step analysis is used to determine the compensability of a worker's claim. At the first step, the claimant need only adduce "some" "minimal" relevant evidence establishing a "preliminary link" between the injury claimed and employment. *McGahuey v. Whitestone Logging, Inc.,* 262 P.3d 613, 620 (Alaska 2011); *Smith v. Univ. of Alaska, Fairbanks,* 172 P.3d 782, 788 (Alaska 2007); *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.,* 742 P.2d 239, 244 (Alaska 1987). The evidence necessary to attach the presumption of compensability varies depending on the claim. In claims based on highly technical medical considerations, medical evidence is often necessary to make that connection. *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). In less complex cases, lay evidence may be sufficiently

probative to establish causation. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Witness credibility is not weighed at this step in the analysis. *Resler v. Universal Services Inc.*, 778 P.2d 1146, 1148-49 (Alaska 1989).

At the second step, once the preliminary link is established, the employer has the burden to overcome the presumption with substantial evidence. *Kramer* at 473-74, quoting *Smallwood* at 316. To rebut the presumption, an employer must present substantial evidence that either (1) a something other than work was the substantial cause of the disability or need for medical treatment or (2) that work could not have caused the disability or need for medical treatment. *Huit v. Ashwater Burns, Inc.*, 372 P.3d 904 (Alaska 2016). "Substantial evidence" is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 611-612 (Alaska 1999). At the second step of the analysis, the employer's evidence is viewed in isolation, without regard to the claimant's evidence. Issues of credibility and evidentiary weight are deferred until after a determination whether the employer has produced a sufficient quantum of evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051, 1054 (Alaska 1994); *Wolfer* at 869-870.

If the presumption is raised but not rebutted, the claimant prevails and need not produce further evidence. *Williams v. State*, 938 P.2d 1065, 1075 (Alaska 1997). If the employer successfully rebuts the presumption, it drops out, and the employee must prove all elements of his case by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381. At this last step of the analysis, evidence is weighed and credibility considered. To prevail, the claimant must "induce a belief" in the minds of the fact finders the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

In *Huit*, the Supreme Court analyzed the effect of the 2005 change in AS 23.30.010 from "a substantial factor" to "the substantial cause" on the presumption analysis. The Court examined the legislative history and determined there was no indication the legislature intended to change how an employee raises the presumption or how an employer rebuts it. Consequently, any weighing of competing causes must occur at the third stage of the analysis.

A fundamental principle in workers' compensation law is the "eggshell skull doctrine," which states an employer must take an employee "as he finds him." *Fox v. Alascom, Inc.*, 718 P.2d 977, 982 (Alaska 1986), citing *S.LW, v. Alaska Workmen's Compensation Board*, 490 P.2d 42, 44 (Alaska 1971); *Wilson v. Erickson, All* P.2d 998, 1000 (Alaska 1970). A pre-existing condition does not disqualify a claim if the employment aggravated, accelerated or combined with the pre-existing condition to produce the disability or need for medical treatment for which compensation is sought. Under the Act, there is no distinction between the aggravation of symptoms and the aggravation of the underlying condition. *DeYonge v. NANA/Marriott*, 1 P.3d 90, 96 (Alaska 2000); *Peek v. SKW/Clinton*, 855 P.2d 415, 416 (Alaska 1993).

In *City and Borough of Juneau v. Olsen*, AWCAC Decision No. 11-0185 (August 21, 2013), the commission explained the application of "the substantial cause" in cases where a work injury "aggravates or accelerates" or "combines" with a preexisting condition. When an employee asserts a work injury caused the aggravation or acceleration of a preexisting condition, the board must evaluate the relative contribution of both the preexisting condition and the work injury. To establish causation, the employee must show the work injury played a greater role in the disability or need for medical treatment than did the preexisting injury. *Olsen, 17-18*. When an employee asserts his disability or need for medical treatment arose as a result of a combination of his work injury and a preexisting condition, the employee must establish two additional facts to prevail, first, that the disability or need for treatment would not have happened "but for" the work injury, and second that reasonable persons would regard the work injury as the substantial cause of the disability or need for medical treatment. *Olsen, 18-19*.

In *Tinker v. Veco, Inc.*, 913 P.2d 488 (1996), a worker with a long-standing diabetic foot condition suffered frostbite and a blister on his right foot while at work. His right foot became infected, as did his left foot. He returned to work, and injured his left ankle when he slipped on ice. He was diagnosed with Charcot arthropathy, and underwent surgery on both feet. He returned to work again, but was evacuated after becoming ill with food poisoning. His left leg was later amputated below the knee, and he filed workers' compensation claims. The Board held the Employee had failed to timely notify the Employer of the frostbite injury, and rejected that claim. The Board also found he had failed to prove his claims related to the fall and the food

poisoning. The Supreme Court affirmed the Board as to the fall and the food poisoning, but determined the Employee's failure to give timely notice of the frostbite injury was excusable. The Court remanded to the Board for further consideration, noting: "Tinker's diabetes would not have barred his compensation claim, so long as the injury he received on the job aggravated, accelerated, or combined with his medical condition in a manner that resulted in the loss of the leg." *Id.*, footnote 2.

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

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

> While the Workers' Compensation Act may require employers to authorize some medical care during periods of medical instability as Bockness claims, the Act does not require employers to pay for any and all treatments chosen by the injured employee. Although no single provision states that all medical treatments must be reasonable and necessary, at several points in the Alaska Workers' Compensation Act the statutes make reference to that concept.

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

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

The Supreme Court has held that the consequences of medical malpractice in treating a compensable injury are also compensable:

> A physician may be wrong in a diagnosis without being negligent. [But], even if there was negligence, the general rule is that the consequences of medical negligence committed while treating a compensable injury are themselves compensable. *Ribar v. H & S Earthmovers*, 618 P.2d 582, 584 (Alaska 1980)

> **AS 23.30.395. Definitions.**
> . . . .
>
> (16) "disability" means incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment;

ANALYSIS

1. Was Employee's employment with Employer the substantial cause of his disability or need for medical treatment?

The cause of Employee's disability or need for medical treatment is a factual issue subject to the presumption analysis. Relevant to the presumption analysis here is the "eggshell skull doctrine," under which an employer takes an employee as he finds him. It is undisputed that Employee had pre-existing pathologies, such as peripheral neuropathy and Charcot foot as a result of his diabetes, which predisposed him to diabetic ulcers. Nevertheless, his injury may compensable if his work activities aggravated, accelerated, or combined with the pre-existing condition to cause the diabetic ulcer that resulted in osteomyelitis leading to Employee's disability and need for medical treatment. *Fox*; *DeYonge*; *Olsen.* On the other hand, if the pre-existing pathologies themselves are ultimately found to be the substantial cause of the disability or need for medical treatment, then Employer would prevail. AS 23.30.010(a).

At the first step of the analysis, Employee was required to show a preliminary link between his osteomyelitis and the employment. At this stage, neither credibility nor the weight of the evidence is considered. Employee successfully raised the presumption through his testimony that the significant amount of work on ladders resulted in a blister combined with Dr. Crawford's July 16, 2015 statement that stress to Employee's right foot caused a blister leading to the infection and ulcer and Dr. Grimes' testimony that the midfoot infection was the source of the

infection in Employee's talus. Additionally, Dr. Frey's testimony that working in boots on ladders could lead to blisters, and that the blister was more likely than not the portal of entry for the bacteria causing the osteomyelitis is also sufficient to attach the presumption.

Because Employee raised the presumption, Employer was required to rebut it. Again, neither credibility nor the weight of the evidence is considered at this step. Employer rebutted the presumption through the testimony of EME physician Dr. Yodlowski. Dr. Yodlowski testified that Employee's diabetes was the cause of his Charcot foot, which was, in turn, the cause of the diabetic ulcer on his foot. She stated that climbing ladders does not cause diabetic ulcers, and Employee was not at a higher risk of infection because of his work activities.

Because Employer rebutted the presumption, the analysis proceeded to the third step, in which Employee must prove by a preponderance of the evidence that the employment was the substantial cause of his disability or need for medical treatment. In making that determination, credibility is considered, the evidence weighed, and the relative contribution of other causes is considered.

Dr. Yodlowski opined the substantial cause of Employee's Charcot and infection was his diabetes; the diabetes was the direct cause of Employee's midfoot ulcer. Her opinion is given the least weight for four reasons. First, and most importantly, she appears to misunderstand that when a preexisting condition is aggravated, accelerated, or combines with a work injury the focus is on whether the aggravation results in disability or the need for medical treatment, rather than the underlying condition. The question is not whether "hundreds, thousands of people work at ARCTEC and do similar types of jobs and they don't get those conditions, so, no, there's no basis for the work [at] ARCTEC being the cause of those conditions." Rather, the question is whether the work would cause someone with the conditions of diabetic neuropathy and Charcot foot, like Employee, to become disabled or need medical treatment. Second, Dr. Yodlowski discounts the May 2013 blister as the source of Employee's infection because there is nothing in the record documenting the infection. Instead, she believes it is more likely that because of the deformity in Employee's foot, a bone wore through the skin creating the portal of entry for the infection. However, there is nothing in the record documenting a bone wearing through the skin of

Employee's foot. Third, Dr. Yodlowski's opinions are based solely on a review of the medical records; she did not physically examine or speak to Employee. And fourth, Dr. Yodlowski's focus on the lack of medical literature regarding an increased risk of blisters or diabetic ulcers from working on ladders ignores common experience.

Dr. Grimes' and Dr. Crawford's opinions on causation are given more weight, although neither opinion alone establishes the cause of the infection in Employee's talus. Dr. Crawford, who treated Employee's midfoot infection after he returned to Texas from Alaska, opined that stress to Employee's right foot caused a blister leading to the infection and ulcer. Given that Drs. Grimes, and Frey agree that extended work on ladders can cause a blister, this is substantial evidence that Employee's midfoot infection was caused by work for Employer. Although Dr. Grimes was unable to opine on the source of Employee's midfoot infection, he stated the midfoot infection was the most likely source of the infection in Employee's talus. Between Drs. Crawford and Grimes, a complete chain of causation is established from the May 2013 blister to the infection in Employee's talus.

Dr. Frey's opinion is given the most weight. She examined Employee and reviewed extensive medical records. She explained that wearing boots and working on ladders could lead to blisters, and Employee's May 2013 blister was the most likely cause of the infection that progressed to the ulcer and subsequent osteomyelitis. Dr. Frey estimated Employee's diabetes and neuropathy were 75 percent of the "overall cause" of Employee's disability or need for medical treatment, but the work injury was "the substantial cause," because it accelerated the Charcot foot deformity. She explained that it was more probable than not that Employee's preexisting conditions would have been just fine for the rest of his life. In other words, although Employee's diabetes and neuropathy place him at significant risk for injury, he would not have become disabled or needed medical treatment at the time he did but for the work injury. Employer suggests Dr. Frey framed her answers only in terms of "but for," and ignored the "reasonable persons would regard the injury as the substantial cause" portion of the inquiry. However, the referral letter sent to her clearly explains: "'The substantial cause' means that, in relation to all of the causes which a reasonable person could assign responsibility, employment is more than any other the cause of the employee's disability or need for medical treatment." Nothing suggests she ignored that instruction.

When determining whether the disability or need for medical treatment arose out of and in the course of the employment, the Board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Employee's preexisting diabetes and neuropathy are, without question, significant factors in his disability and need for medical treatment. Absent those preexisting conditions, it is highly unlikely Employee would have suffered the work injury. On the other hand, as Dr. Frey stated, it was more probable than not that Employee's preexisting conditions would have been just fine for the rest of his life absent the work injury. In comparison to all other causes, the May 2013 blister, together with the subsequent infection, is the substantial cause of Employee's disability and need for medical treatment.

2. Was the implantation of an intramedullary rod reasonable and necessary treatment?

Because this issue is, at its heart, a question of medical benefits, the AS 23.30.120 presumption applies. This case, however, presents an unusual situation. Up to and during the placement of the intramedullary rod, Dr. Grimes believed the cause of Employee's collapsed talus was Charcot arthropathy, a consequence of Employee's diabetes that is unrelated to the work injury. It was only after he received the pathology report several days later that he learned of the osteomyelitis and, consequently, the connection to Employee's work injury. It is undisputed the intramedullary rod would have been appropriate had there been no infection. The question becomes whether it was unreasonable for Dr. Grimes to do the surgery without further testing, which would have revealed the osteomyelitis.

Employee successfully raised the presumption through the testimony of Dr. Grimes and Dr. Frey. While both doctors agreed there were additional tests that could have been done, they also agreed that given Employee's blood tests, the lack of signs of an infection, and the possible complications and uncertainty of a biopsy, it was reasonable to proceed with the surgery without the additional tests.

Employer rebutted the presumption through Dr. Yodlowski's testimony that it was unreasonable to use an implanted rod without knowing if an infection was present, and more testing, including a biopsy should have been done first.

In weighing the conflicting evidence, the most weight is given to Dr. Frey's testimony. As the Supreme Court noted in *Hibdon*, the question of the reasonableness of medical treatment is "a complex fact judgment involving a multitude of variables." As an independent expert, Dr. Frey is less likely to be biased one way or the other. Her opinion that the surgery performed by Dr. Grimes was reasonable and necessary provides the corroboration by a medical expert discussed in *Hibdon*. Dr. Grimes' decision to proceed with the implantation of the intramedullary rod was reasonable. Additionally, even if Dr. Grimes was negligent in proceeding without further testing, because he was treating a compensable injury, the consequences of his treatment are still compensable. *Ribar*.

CONCLUSIONS OF LAW

1. Employee's employment with Employer is the substantial cause of his disability or need for medical treatment.

2. The implantation of the intramedullary rod was reasonable and necessary medical treatment.

ORDER

1. Employee's May 2013 work injury with Employer was the substantial cause of his subsequent disability and need for medical treatment.
2. The implantation of the intramedullary rod was reasonable and necessary medical treatment.
3. Jurisdiction is retained as to Employee's entitlement to specific benefits.

Dated in Fairbanks, Alaska on August 29, 2017.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Ronald P. Ringel, Designated Chair

/s/
Jacob Howdeshell, Member

APPEAL PROCEDURES

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

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

RECONSIDERATION

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

MODIFICATION

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

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of JOSEPH TRAUGOTT, employee / claimant; v. ARCTEC ALASKA, self-insured employer / defendant; Case No. 201309316; dated and filed in the Alaska Workers' Compensation Board's office in Fairbanks, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on August 29, 2017

/s/

Ronald C Heselton, Office Assistant II