ALASKA WORKERS' COMPENSATION BOARD

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

JESSE LEINARD, Employee, Claimant,	)	FINAL DECISION AND ORDER
v.	)	AWCB Case No. 201320694
ARCTEC ALASKA, Employer, and ARCTIC SLOPE REGIONAL CORP., Insurer, Defendants.	)	AWCB Decision No. 15-0048
	)	Filed with AWCB Fairbanks, Alaska On April 23, 2015

Jesse Leinard's (Employee) claim was heard in Fairbanks, Alaska on March 12, 2015, a date selected on February 24, 2015. Attorney Joseph Kalamarides appeared and represented Employee, who also appeared and testified on his own behalf. Attorney Robert Griffin appeared and represented Arctec Alaska (Employer). Marilyn Yodlowsky, M.D., appeared telephonically and testified on Employer's behalf. The record was held open at the hearing's conclusion to afford individual panel members an opportunity to evaluate the Employee's complete medical record, including the deposition of Carol Frey, M.D. The record closed at the conclusion of deliberations on March 31, 2015.

ISSUES

Employer contends the law is clear and acknowledges that neither it, nor the board, can force Employee to undergo invasive testing, such as an electromyogram (EMG). However, it contends both its medical evaluator and the board's medical evaluator agree an EMG would be

"determinative" on the issue of whether or not Employee has peripheral neuropathy, which it contends is a critical issue in this case. Employer contends, because Employee has a "duty" to prove his claim by a preponderance of the evidence at the third step of the presumption analysis, Employee's decision not to undergo EMG testing should be considered when deciding the compensability of his claim. Employer offers an Alaska Civil Pattern Jury Instruction in support of its contentions.

Employee contends Employer's proposed jury instruction is inapplicable because it only applies to cases where evidence is already available but a party does not wish to present it, and that is not the case here because there are no EMG records to present. He further contends an EMG is not "carbon dating"; even if he were to undergo electrodiagnostic testing that showed he has neuropathy, it would not be evidence he had neuropathy at the time of injury. Employee contends Employer cannot force invasive testing and it would be improper for the panel to consider his decision not to undergo testing at the third step of its presumption analysis.

1) **Should Employee's decision not to undergo invasive diagnostic testing be considered when analyzing the compensability of his claim?**

Employee contends he suffered a compensable work injury while employed by Employer when he stepped off a loader into a hole causing a Lisfranc fracture dislocation to his right foot. He relies on the opinions of his treating physician, Nathan Jeppesen, D.P.M., and the second independent medical evaluator (SIME), Carol Frey, M.D.

Employer contends work was not the substantial cause of Employee's disability and need for medical treatment. Instead, it contends Employee had a Charcot foot resulting from his preexisting diabetes condition and possible peripheral neuropathy, which caused the bones in his foot to crumble and fragment. Employer relies on the opinions of Chakri Inampudi, M.D., a radiologist; Mark Caylor, M.D., an orthopedic surgeon who evaluated Employee; and Marilyn Yodlowsky, M.D., its medical evaluator (EME).

2) Is Employee's July 31, 2013 compensable?

Employee seeks reasonable attorney's fees and costs based on an award of compensation and medical benefits.

Employer denies Employee is entitled to compensation and medical benefits, so neither would he be entitled to attorney's fees based an award of benefits.

3) Is Employee entitled to an award of attorney's fees and costs?

FINDINGS OF FACT

The following facts and factual conclusions are established by a preponderance of the evidence:

1) Employee's pre-injury medical record is significant and documents numerous industrial injuries dating back 30 years before the instant injury, including a chain saw laceration to an unspecified leg, a puncture wound to his left hand, and a high pressure injury involving fuel being injected into his left hand. (Record; observations, experience, Physician's Report, September 1, 1983; Arizona Industrial Commission Worker's Report, April 18, 1990).

2) Employee's pre-injury medical record contains significant documentation of medical management by Ed Manning, PA-C, of numerous chronic conditions, including obesity, hypertension, lipid disorder, hyperglycemia and diabetes dating back to over ten years prior to the instant injury. (Record; observations, experience; Manning chart notes, May 2, 2002 to October 26, 2012).

3) Employee's pre-injury medical records contains numerous laboratory reports, including lipid panels, thyroid panels, basic metabolic panels, comprehensive metabolic panels, hepatitis panels, urinalysis, and complete blood counts (CBC), dating back to ten years prior to the instant injury. (Lab Reports, June 24, 2003 to February 8, 2012).

4) On November 4, 2011, PA Manning diagnosed non-insulin dependent diabetes mellitus (NIDDM) ("type 2" diabetes), which he noted was asymptomatic at that time, and prescribed a glucose meter, Glucotrol and Metformin. (Manning chart notes, November 4, 2011).

5) On February 7, 2012, Employee saw PA Manning, who reported:

> Employee also wants to get his hemoglobin A1C done . . . . He states his blood sugars have been running about 100 to 120 routinely when he checks them. He is

> pretty comfortable with his medications. . . . He states he feels good and his diabetes has not been a problem for him. He just takes the pills, has had no side effects and is feeling better.

Employee's blood pressure medications included Lotrel and Bystolic. PA Manning also added hydrochlorothiazide (HTZD) (Linsinopril) to Employee's treatment plan for hypertension. (Manning chart notes, February 7, 2012).

6) Employee's February 8, 2012 lab report shows his A1C as "in range." (Lab report, February 8, 2012).

7) On October 26, 2012, Employee saw PA Manning for his annual laboratory work and a review of his medications. PA Manning assessed Employee's diabetes as "well controlled." (Manning chart notes, October 26, 2012).

8) On July 31, 2013, Employee was working for Employer as a mechanic at Cape Lisburne, Alaska and reported he twisted his right ankle exiting a loader. (Report of Occupational Injury of Illness, August 20, 2013).

9) On August 2, 2013, Employee sought treatment for his right foot pain at the Mat-Su Regional Medical Center. He reported twisting his ankle stepping off his loader. X-rays were consistent with multiple mid-foot fractures and a computed tomography (CT) scan was ordered to rule out a Lisfranc dislocation. However, Mat-Su Regional Medical Center's CT scanner was not large enough to support Employee's weight, so Employee was referred to the Providence Medical Center for the CT scan. (Emergency Department Note, August 2, 2013).

10) The August 2, 2013 emergency department note lists Employee's blood pressure medications, Lotrel and Hydrochlorothiazide, but not his diabetes medications, Glucotrol and Metformin. (*Id.*; observations).

11) On August 2, 2013, Employee was evaluated by Kane Curtis, M.D., at the Providence Medical Center Emergency Department. Employee reported stepping into a hole and suffering an inversion injury. Dr. Curtis ordered a right, lower extremity CT scan, which was interpreted by Chakri Inampudi, M.D., to show intraarticular comminuted fractures of the first, second and third metatarsal bases and fractures of the medial, middle and lateral cuneiform bones. The margins were indistinct with "early callus formation" indicating the fractures were subacute. There was significant edema surrounding the midfoot. Although there were no obvious drainable fluid collections on the non-contrast study, a large hematoma along the plantar aspect

was suspected. "Heterotopic new bone formation" was also noted. Dr. Inampudi's impression was: "Extensive midfoot injury is clearly subacute with persistent large amount of edema and/or hematoma with involvement and comminution of the bases of the first, second and third metatarsals with fractures of the medial, middle and lateral cuneiform bones with no significant displacement. Heterotopic new bone formation is noted along the plantar aspect…." (Inampudi report, August 2, 2013).

12) Dr. Curtis' final impressions were: 1) cuneiform fracture, foot; 2) Lisfrancs sprain; and 3) traumatic fracture of the metatarsal joint with minimal displacement. He discharged Employee with pain medications and instructed him to follow-up with Mark Caylor, M.D. (Curtis report, August 2, 2013).

13) Dr. Curtis' August 2, 3013, report lists Employee's blood pressure medications, Lotrel and HCTZ, but not his diabetes medications, Glucotrol and Metformin. (*Id*.; observations).

14) On August 5, 2013, Dr. Caylor evaluated Employee's right foot. Employee reported the sudden onset of symptoms after twisting his ankle while exiting his 966 loader. Dr. Caylor reviewed Employee's x-rays and CT scan, which he interpreted to show a "variant of a Lisfranc fracture dislocation" of the midfoot, marked impaction comminution at the base of the first metatarsal, additional fractures at the base of the second and third metatarsals, as well as all three cuneiforms. Employee informed Dr. Caylor he was planning on going to Arizona, where he has family, to undergo surgical intervention. (Caylor report, August 5, 2013).

15) Dr. Caylor's August 5, 2013 report lists Employee's blood pressure medications, Lotrel and HCTZ, but not his diabetes medications, Glucotrol and Metformin. It also states Employee's current medical conditions include hypertension, but does not mention diabetes. (*Id*.; observations).

16) On August 8, 2013, Employer controverted all benefits based on based on Dr. Inampudi's opinion Employee's injury was "clearly subacute." (Controversion, August 8, 2013).

17) On August 12, 2013, Employee saw Nathan Jeppesen, D.P.M., for a new patient visit at the CORE Institute. Employee reported twisting his right foot when he stepped into a hole. Dr. Jeppesen interpreted Employee's x-rays to show "a comminuted fracture to the base of the first metatarsal with inter-articular involvement." Some lateral shift of the second and third metatarsals was also apparent. He interpreted Employee's CT scan to show "a comminuted inter-articular right first metatarsal fracture with a mild comminution and lateral dislocation of

the left second and third metatarsal joints Lisfranc avulasion fracture present…" Dr. Jeppesen proposed surgery consisting of reduction of the Lisfranc fracture with fusion of the first, second and third metatarsal joints with bone marrow aspiration application. However, Employee's skin was too swollen for surgery, so his foot was placed in a non-weight bearing splint. Dr. Jeppesen planned to evaluate Employee's skin in a week. (Jeppesen report, August 12, 2013).

18) Dr. Jeppesen's August 12, 2013 report lists Employee's blood pressure medications, Lotrel and Hydrochlorothiazide, but not his diabetes medications, Glucotrol and Metformin. It also states Employee's past medical history includes hypertension, but does not mention diabetes. (*Id*.; observations).

19) On August 12, 2013, Dr. Jeppesen completed a physician's report form indicating Employee's right foot condition was work-related and he was unable to return to work. (Physician's Report, August 12, 2013).

20) Employee's medical record contains an "OrthoInfo" fact sheet, titled *Lisfranc (Midfoot) Injury*, published by the American Academy of Orthopaedic Surgeons. It explains:

> Lisfranc (midfoot) injuries result if bones in the midfoot are broken or ligaments that support the midfoot are torn. The severity of the injury can vary from simple to complex, involving many joints and bones in the midfoot….A Lisfranc injury is often mistaken as a simple sprain, especially if the injury is a result of a straightforward twist and fall. However, injury to the Lisfranc joint is not a simple sprain that should simply be 'walked off.' It is a severe injury that may take many months to heal and may require surgery to treat….Cause: These injuries can happen with a simple twist and fall. It is a low-energy injury. It is commonly seen in football and soccer players. It is often seen when someone stumbles over the top of a foot flexed downwards. More severe injuries occur from direct trauma, such as a fall from a height. These high-energy injuries can result in multiple fractures and dislocations of the joints.

(American Academy of Orthpaedic Surgeons, Orthoinfo: *LisFranc (Midfoot) Injury*, December 2011).

21) The Orthoinfo fact sheet was printed on August 13, 2013. (*Id*.; observations).

22) On August 14, 2013, Dr. Jeppesen completed an "Activity/Work Status Report," which states:

> The patients [sic] problem is not due to a pre existing condition. He suffered a lis franc [sic] fracture with mild dislocation on 7/31/13 but was unabvle [sic] to seek initial treatment until 8/2/13 due to the remote location of his work. He was then

> unable to travel to AZ for treatment until he saw me for initial appointment on 8/12/13. We have CT scans and Xrays showing the comminuted and dislocated fractures involving several small joints in his foot. The severe joint comminution and multiple number of joints involved is why fusion surgery is the treatment choice for this pt as opposed to traditional ORIF of his fractures. If ORIF was chosen he would likely develop degenerative joint disease in these joints necessitating midfoot fusion in 1-2 years. The proposed surgery will prevent this from developing and prevent future surgery as a result of this injury.

(Jeppesen report, August 14, 2013).

23) On August 14, 2013, Employee designated Dr. Jeppesen as his attending physician. (Employer's form, August 14, 2013)

24) On August 16, 2013, Dr. Caylor documented a "Nurse Care Management Consult." His report states:

> Met with though [sic] workers comp case manager. There is a question about the timing of this patient's injury. By his report occurred about 2 days prior to his evaluation with a CT scan. On review of the CT scan in retrospect does show the same fracture that I previously stated however I am in agreement with the radiologic report which states that there is some callus formation present as well as some soft tissue present in the soft tissues consistent with a subacute injury. My opinion this would take the injury at least 10 to 14 days prior to the scan. Signed the paperwork which a copy will be placed into the chart. States that my opinion callus would not be present 2 days and because of this the findings present are unrelated to his injury he sustained at work at least on the day specified.

(Caylor report, August 16, 2013).

25) On August 16, 2013, Dr. Caylor signed a letter prepared by Employer's nurse case manager indicating callus formation at the fracture site was not [sic] visible in the CT scan two days following the injury, and Employee's July 31, 2013 injury was not the substantial cause of Employee's foot fractures and need for surgical intervention. (Employer's letter, August 15, 2013).

26) It is presumed Dr. Caylor intended to indicate callus formation was visible in Employee's August 2, 2013 CT scan. (Experience, facts of the case and inferences drawn therefrom).

27) On August 19, 2013, Employee saw Dr. Jeppesen for an edema check. Employee's swelling was slightly decreased from the previous visit, but Dr. Jeppesen did not think he was ready for skin incisions yet. (Jeppesen report, August 22, 2013).

28) Dr. Jeppesen's August 19, 2013 report lists Employee's blood pressure medications, Lotrel and Hydrochlorothiazide, but not his diabetes medications, Glucotrol and Metformin. It also states Employee's past medical history includes high blood pressure, but does not mention diabetes. (*Id*.; observations).

29) On August 27, 2013, Employee filed a claim seeking temporary total disability (TTD) from August 3, 2013 continuing, permanent partial impairment (PPI), medical and transportation costs, interest, a reemployment eligibility evaluation and attorney's fees and costs. (Claim, August 26, 2013).

30) Employee's August 29, 2013, laboratory test results show an A1C result of 5.3, and provide a normal range for this result of 4.8 - 5.6. (Laboratory test results, August 29, 2013).

31) On September 3, 2013, Employee underwent surgery for his right foot condition. Dr. Jeppesen performed an open reduction of the Lisfranc fracture dislocation; first, second and third metatarsal joints fusion; and bone marrow aspiration application. (Operative report, September 3, 2013).

32) On September 4, 2013, Marilyn Yodlowsky, M.D., performed a file review for Employer. The August 2, 2013 reports and x-rays from the Mat-Su Medical Center were not provided to Dr. Yodlowsky, but a compact disc (CD) was provided of Employee's August 2, 2013 CT study**.** She summarized Employee's August 2, 2013 CT scan as follows: "Overall impression is midfoot fragmentation and fracture with adjacent soft tissue calcification. The sclerosis and adjacent soft tissue calcification indicate that this is not an acute traumatic fracture. It may represent a Charcot foot with recent worsening based on the associated soft tissue swelling." Employee's medical records prior to the date of injury were also not available to Dr. Yodlowsky. Based on the August 2, 2013 CT scan, she opined the injury was not acute, but rather at least several weeks old. Dr. Yodlowsky diagnosed a right Lisfranc/midfoot fracture involving the first, second, and third metatarsals and cuneiforms. She also thought the information available to her suggested Employee may have a Charcot foot. She based this diagnosis on Employee being ambulatory between the date of injury and his evaluation on August 2, 2013, and on "chronic" changes seen in his CT scan. Dr. Yodlowsky explained "a Chorcot foot occurs when there is deterioration, fragmentation, and a fracture chronically secondary to an underlying neuropathic condition that worsens with progressive weightbearing." She also diagnosed morbid obesity, with a body mass index of greater than 50, and suspected neuropathy, which could be secondary

to a chronic condition such as diabetes. In response to an Employer question inquiring about callus formation in the August 2, 2013 CT scan, Dr. Yodlowsky explained:

> New bone formation and callus formation at a fracture site occurs only after a period of time, generally a minimum of two to three weeks. This is because the healing process at a fracture first involves the formation of hematoma or blood clot. This is then converted to fibrous tissue and then the process of calcification and new bone formation occurs. This occurs over a period of weeks and would not happen in just two days following an injury. In addition, there is calcification/ossification noted in the surrounding soft tissue adjacent to the fracture, further supporting this as a chronic, nonacute injury.

In response to Employer's question about the contributions of other medical conditions, she stated:

> The records available for my review do not provide enough information for me to answer this question. However, based on my clinical experience and knowledge, his presentation could represent Charcot foot. This is a condition which involves neuropathy, meaning that the sensory input from the foot is abnormal. Individuals with this condition often will develop a chronic fragmentation and fracture pattern, which progressively worsens. It is only at the point when the fragmentation fracture and disrupted joints create a reaction in the soft tissue, such as severe swelling and redness, that the individual notices the abnormality in the foot. The underlying process of fracture and fragmentation has been going on long-term, but has not been detected by the individual due to the neuropathy. There are no medical records to substantiate that [Employee] has this condition. However, there are also no medical records to indicate whether he was closely examined and tested for this condition, or whether he had an underlying associated condition, for example diabetes.

Based on the medical records available to her, Dr. Yodlowsky wrote the cause of Employee's right foot Lisfranc fracture dislocation and fragmentation was "unknown." She thought further medical investigation was necessary, including ruling out diabetes and electrodiagnostic studies to determine whether Employee has significant peripheral neuropathy. Dr. Yodlowsky also stated the July 31, 2013 injury was "not" the substantial cause of the underlying pathology. She thought, if Employee had already fractured and fragmented across his midfoot joints, "when he misstepped on his right foot on 07/31/13, at that point, his underlying condition might have become symptomatic enough for him to notice it. That is not the equivalent to it being the substantial cause." Dr. Yodlowsky provided an alternative explanation that excluded

Employee's work injury as the cause of his condition, which was a diagnosis of neuropathic arthoropathy, instead of acute fractures. She opined it was "essential" for Employee to be evaluated for underlying neuropathy before surgery because of potential difficulty with healing and an attempted fusion. (Yodlowsky report, September 4, 2013) (emphasis in original).

33) On September 16, 2013, Employee saw Dr. Jeppesen, who prescribed Augmentin for a mild superficial infection of Employee's midfoot incision. (Jeppesen report, September 16, 2013).

34) Dr. Jeppesen's September 16, 2013 report Employee's blood pressure medications, Lotrel and Hydrochlorothiazide, but not his diabetes medications, Glucotrol and Metformin. It also states Employee's past medical history includes high blood pressure, but does not mention diabetes. (*Id*.; observations).

35) On September 20, 2013, Employee answered and controverted Employee's August 26, 2013 claim, denying all benefits based on Drs. Caylor's and Inampudi's opinions Employee's injury was subacute. (Employer's Answer, September 20, 2013; Controversion, September 20, 2013).

36) On September 23, 2013, Dr. Jeppesen removed Employee's sutures and directed him to continue his antibiotics. (Jeppesen report, September 23, 2013).

37) Dr. Jeppesen's September 23, 2013 report lists Employee's blood pressure medications, Lotrel and Hydrochlorothiazide, but not his diabetes medications, Glucotrol and Metformin. It also states Employee's past medical history includes high blood pressure, but does not mention diabetes. (*Id*.; observations).

38) On October 7, 2013, x-rays were taken of Employee's right foot, which showed one of the screws backing out of the medial column with no change in alignment to the fusion site. Dr. Jeppesen ordered a bone stimulator for Employee. (Jeppesen report, October 7, 2013).

39) Dr. Jeppesen's October 7, 2013 report lists Employee's blood pressure medications, Lotrel and Hydrochlorothiazide, but not his diabetes medications, Glucotrol and Metformin. It also states Employee's past medical history includes high blood pressure, but does not mention diabetes. (*Id*.; observations).

40) On October 30, 2013, Dr. Jeppesen interpreted x-rays taken that same day to show osseous union across Employee's second and third metatarsal joints. He thought the x-rays showed either some early osseous bridging across Employee's first metatarsal joint or represented some

fragmentation present within the arthrodesis site. Dr. Jeppesen planned for a CT scan to be performed in three weeks to assess the level of osseous union. (Jeppesen report, October 30, 2013).

41) Dr. Jeppesen's October 30, 2013 report lists Employee's blood pressure medications, Lotrel and Hydrochlorothiazide, but not his diabetes medications, Glucotrol and Metformin. It also states Employee's past medical history includes high blood pressure, but does not mention diabetes. (*Id*.; observations).

42) On November 27, 2013, Dr. Jeppesen wrote a "To Whom It May Concern" letter, which stated, in his opinion, Employee's Lisfranc fracture was "completely inconsistent" with a subacute injury. He further stated: "In all cases where patients [sic] are non-neuropathic (as this patient is) this injury is not compatible with normal walking, working, or weightbearing due to the severity of the nature of this injury." Dr. Jeppesen opined Employee's injury could not have occurred prior to the reported day of trauma. He also wrote a CT scan performed on November 25, 2013, showed Employee had a delayed union of his first metatarsal joint with little or no bony bridging, and only partial union of the second and third metatarsal joints with minimal bony bridging across the joint space. (Jeppesen letter, November 27, 2013).

43) On December 6, 2013, Employee filed a petition seeking a second independent medical evaluation (SIME). (Employee's Petition, December 5, 2013).

44) On January 2, 2014, Employer filed an answer to Employee's December 5, 2013 petition seeking a SIME. (Employer's Answer, December 30, 2013).

45) On February 5, 2014, Dr. Jeppesen wrote a "To Whom It May Concern" letter, in which he reiterated his opinion Employee's foot was sensate, and his fracture was inconsistent with any standing, walking or normal function due to the pain and inherent instability of such fractures. Dr. Jeppesen did not think Employee fractured his foot prior to reporting to the work site because he would not have been able work at all without severe pain and dysfunction. He further opined, "[i]f this patient would have walked on this fracture pattern for 6+ weeks prior to reporting, as is contended, the deformity at time of presentation would have been far worse . . . ." Dr. Jeppesen also wrote:

> There is a plausible explanation for the diffuse comminuted fractures at the tarsometatarsal joint which led the radiologist to interpret this injury as 'subacute.' [Employee] had to, out of necessity walk on his foot following the

> injury for several days prior to being able to get to the hospital. Given the necessary weight bearing on an unstable fracture pattern that occurred with patients [sic] larger body type could have caused these findings to be present.

(Jeppesen letter, February 5, 2014).

46) On February 19, 2014, Dr. Jeppesen released Employee to work with no restrictions. (Jeppesen report, February 19, 2014).

47) On February 20, 2014, Employee gave his deposition and testified as follows: He has been employed by Employer since June 2009, and worked as a heavy equipment mechanic. Employee worked at a radar station at Cape Lisburne, Alaska, which had two mechanics, one radar technician and one service technician. Cape Lisburne is on the coast, 68 miles north of Point Hope. "It's pretty much in the middle of nowhere on the coastline." The Cape Lisburne facility is a functioning radar station and is "related" to the Federal Aviation Administration (FAA) and the Air Force. Employee travels to the site via small aircraft. He lives, eats and sleeps in the same building he works in. The two mechanics handle fuel delivery by barge, plowing, power generation and sewage. They also do drywall repair to tacking down carpet strip. Mechanics have to be very versatile and understand electrical and equipment. They also have to "get along with everybody" because they are in such a tight, confined space. There is a cold storage building at the work site, along with the building they live in. The radar station is a "self-contained unit all by its lonesome" at the end of a gravel road. Employee usually works a minimum of 48 hours per week, and as much as 60 hours per week. He works 90 day "hitches" at Cape Lisburne and takes three or four vacations a year. A typical workday consists of going through the power plant and checking the switchgear, driving down the road to check the airfield, checking sewage runoff, pumping water and checking chlorine levels. Every month Employee also gets between 180 to 210 written maintenance requests from the Air Force that could be anything from squirting three squirts of grease into a bearing on a fan motor somewhere, to changing the oil in a pickup, or even waxing a pickup. The Air Force does quarterly inspections, but has no personnel on site. On the date of injury, Employee was hauling gravel to the beach where the barge comes in. He had hauled two loads in the 966 loader, and on the third load, he got off the machine. There was a "divot or a crease from a rock that had been moved, but there was actually a hole." He came down the ladder and stepped, and twisted his ankle, which folded his foot upward, and "it really threw a bind on my ankle and the top of my

foot. And I shook it off and went about life. It hurt. It hurt." It was early morning. Employee "went through" lunchtime, told "Baker" he had twisted his ankle and "looked up the paperwork on-line" later in the afternoon. By evening, his right foot had swollen up quite dramatically. Employee finished his work day, but the weather got bad and he spent the next two days trying to "get out of there." He was 47 or 48 days into his 90 day hitch. Employee also could not leave until his relief could come in. His foot was swollen and looked like a "small football." He had to cut the side of his boot to get it on. Employee flew out on August 2nd and went to Kotzebue, then to Anchorage. A shuttle service took Employee to his house in Palmer then he drove his own vehicle to Mat-Su Regional Medical Center. They told him he had a broken metatarsal and sent him to Anchorage to get a CT scan, because their machine "wasn't big enough to do me." Employee is six feet six and weighs 424 pounds. The day before the injury, Employee was taking hypertension medication and Metformin to control his blood sugar. He had not had any problems with his right foot before the work injury. (Employee deposition, February 20, 2014).

48) At a March 19, 2014 prehearing conference, the parties agreed to a SIME by Carol Frey, M.D., an orthopedic surgeon specializing in ankle and foot conditions. (Prehearing Conference Summary, March 19, 2014).

49) On June 9, 2014, Dr. Yodlowsky performed an employer's medical evaluation (EME). Employee provided Dr. Yodlowsky with the following history of his present injury:

> On 07/31/12 [sic], [Employee] was running a loader for placement of rocks to make a ramp. He got off the loader, and as he came down the ladder, he put his foot down into a hole in the ground. He said the hole pushed his foot up and twisted it…. When this occurred, he said it caused him to go down on his knees…. [Employee] said he had pain in his right ankle, but he "shook it off" and continued working. He told me he was 'absolutely able' to walk and weight bear, and he continued to work …. The next morning when he woke up, his right foot was so swollen that he was unable to get his boot on. He said most of the pain was in his ankle …. That morning, he called his boss. He said the weather was so bad that a relief person could not arrive until Monday…. [Employee] said he had to cut his boot in order to get his foot in the boot. Although the weather was too severe for relief to come in, he was able to get off the site the next day, which he recalls was a Friday.

Employee's medical records prior to the date of injury were available to Dr. Yodlowsky, as were the August 2, 2013 reports and x-rays from the Mat-Su Medical Center. Dr. Yodlowsky interpreted Employee's August 2, 2013 x-rays to show a comminuted fracture at the base of the

first metatarsal with some well-rounded calcifications in the soft tissue both medial and lateral to the first metatarsal cuneiform articulation. She interpreted Employee's August 2, 2013 CT scan to show fragmentation and a comminuted fracture of the midfoot, most severe at the first metatarsal cuneiform, but also involving the second and third metatarsal cuneiform joints. Dr. Yodlowsky further opined the fragments appeared to have sclerosis, and there was calcification/ossification in the surrounding soft tissue. Her overall impression was midfoot fragmentation and fracture with adjacent soft tissue calcification. She remarked the sclerosis and adjacent soft tissue calcification indicate a nonacute traumatic fracture and may represent a Charcot foot with recent worsening based on the associated soft tissue swelling. Employee reported to Dr. Yodlowsky he has lost some feeling and sensation in the distal portion of his foot, and upon examination, pinprick sensation was decreased in his right foot distally in all toes. In the discussion section of her report, Dr. Yodlowsky wrote:

> The fact [Employee] apparently was able to walk on his right foot for at least one day while performing all of his usual duties following the injury event, coupled with the imaging studies indicating the fragmentation and fractures predated 07/31/13 suggest that he has diabetic neuropathy and this is a Charcot foot. Along the same lines, his current lack of painful sensation could merely reflect that he has diabetic neuropathy, not that the fusions are healed.

In response to Employer's questions, Dr. Yodlowsky stated the availability of additional medical records did not change the opinions expressed in her September 4, 2013 report. She added the additional records confirm Employee does have diabetes, and his recent clinical presentation of having no pain in in his right foot despite x-rays showing a nonunion, as well as Employee's decreased perception of pinpick that day, were consistent with neuropathy. Dr. Yodlowsky added Employee had not had any electrodiagnostic studies to confirm neuropathy, nor had he been evaluated by a neurologist. She diagnosed right Charcot foot arthopathy across the midfoot with Lisfranc fracture, dislocation, and fragmentation in a setting of diabetes and likely neuropathy. Dr. Yodlowsky considered substantial factors for Employee's condition to be diabetes and likely diabetic neuropathy, coupled with morbid obesity. She wrote: "Although [Employee] may have twisted his foot when he stepped in the hole on 07/31/13, this was superimposed upon the preexisting conditions. The imaging studies confirm that the chronic loss of normal anatomy across the Lisfranc joint with soft tissue calcification and early callus formation were present prior to 07/31/13." Dr. Yodlowsky identified "the substantial cause" of

Employee's condition as preexisting Charcot foot due to morbid obesity and likely diabetic neuropathy. She could not state whether Employee was medically stable, or whether he could return to work, or whether he had any work restrictions without additional x-rays and electrodiagnostic testing. Dr. Yodlowsky also remarked she thought Dr. Jeppesen's notes indicated he had no awareness of Employee's diabetes. (Yodlowsky report, June 9, 2014).

50) On June 10, 2014, Carol Frey, M.D., performed a SIME. Upon physical examination, Employee had gross sensation to touch on all aspects of both feet, but decreased sensation to filament on the plantar aspect. X-rays were performed that showed no obvious fusion at the first metatarsal cuneiform articulation. The fusion at the second and third metatarsal cuneiform articulations appeared to have been successful. Dr. Frey diagnosed status post Lisfranc dislocation; adult-onset diabetes and high blood pressure; obesity, lipid disorder and high cholesterol; and possible early neuropathy. In her opinion, Employee's work injury caused a fracture dislocation of his midfoot, and aggravated, accelerated or combined with a preexisting condition to cause his disability and need for treatment. Dr. Frey attributed 20 percent of Employee's disability or need for medical treatment to an unspecified "diabetes related disorder," preexisting condition, and 80 percent to the work injury. Dr. Frey's report does not identify a specific preexisting condition, but it states, "[n]o evidence documented in the past of foot complaints, peripheral neuropathy or prior fracture." Dr. Frey identified the work injury of July 31, 2013 as "the substantial cause" of Employee's disability or need for medical treatment and also remarked, "[t]here is no documentation of prior foot complaints, [C]harcot foot or peripheral neuropathy by internal medicine and family physicians who have treated the patient for obesity, lipid disorder and diabetes." Dr. Frey did not think Employee was medically stable and opined Employee could return to work, but should have restrictions, such as no walking for more than four hours total in a day, or for one hour at a time, and no climbing ladders, because his bones had not completely fused. In regards to future treatment, Dr. Frey thought Employee might need orthotic devices, stability shoes, a bone stimulator, compression stockings, an electromyography/nerve conduction study (EMG/NCS), follow ups with an orthopedic surgeon approximately four times per year until he was healed, and possible additional surgery to remove metal and bone graft. (Frey report, June 10, 2014).

51) On September 20, 2014, Dr. Frey clarified her opinion on the contribution of a preexisting condition. She wrote:

> I noted that the injury was 20% pre-existing. No pre-existing problem was mentioned in the records review for the Lis Franc Joint. No pre-existing fracture, dislocations or Charcot foot. Acute swelling was present at the time of injury. Heterotopic bone may not be callus. Injury pattern was consistent with a Lis Franc fracture dislocation.

(Frey letter, September 20, 2014).

52) On January 15, 2015, Dr. Frey gave her deposition and testified as follows: She thought Employee needed an EMG/NCS because it is an objective test for neuropathy, and described Employee's injury as a fracture in his midfoot or Lisfranc fracture. Dr. Frey also described how broken bones heal. First, there is an inflammatory period that involves the recruitment of inflammatory cells that a "civilian" would see as swelling. This phase can last days to weeks. The second phase involves the recruitment of healing cells that not only build, but also destroy bone. This phase can take weeks to months. Employee has comorbidities of high blood pressure, which most likely does not affect bone healing; and obesity, which makes it hard to rest the bone, and which might cause the bone to take longer to heal. Eighty percent of time, if someone is over 400 pounds, it will take them longer to heal. Employee also has diabetes, which will slow healing and increase the risk of having a nonunion or a delayed union. Dr. Frey cannot look at a CT scan and estimate when a break occurred. Regarding Dr. Inampudi's August 2, 2013 CT report, she explained "subacute" means it didn't just happen in the last few days, but it is not an exact timeframe; and "heterotopic" means bone or ossification of tissue outside the bone, like calcification of muscle, tendon, surrounding soft tissues. To an orthopedist, heterotopic bone means something "pretty distinct." Heterotopic bone means that there is calcium forming in the soft tissues, which can take one to two weeks to show on an x-ray, and about a week to show on a CT scan. "Callus" is bone that forms in reaction to a fracture, heterotopic bone is not. Dr. Frey reviewed Employee's August 2, 2013 CT scan during the deposition, which she agreed showed heterotopic new bone, but not necessarily callus. She disagreed with Dr. Caylor's opinion Employee's injury shown on the CT scan had occurred 10 to 14 days prior to that date of injury. Dr. Frey agreed with Dr. Yodlowsky's opinion Employee's CT scan showed ossification in soft tissue. The ossification is the heterotopic bone "that an orthopedic surgeon makes a distinction about. That's not callus bone." Employee's heterotopic bone can just be from "wear and tear and the trauma of standing." It also could be some calcification of his vascularity, which you get with diabetes. But usually it is just "chronic

trauma, wear and tear to the bottom of the foot in a 400 pound man." Employee told Dr. Frey he monitors his blood sugar levels and they sit around 90. Dr. Frey looked at the three-dimensional (3-D) reformations of the CT scan and thought they were "very interesting," because the heterotopic calcification was calcification of tissues and not in the bones. The heterotopic calcification appeared to be in Employee's vascularity and was not where the fracture was. She opined it was calcification of Employee's blood vessels. Looking at the 3-D reconstruction, Dr. Frey thought: "… it's pretty textbook. It looks like a Lisfranc fracture dislocation. This is not how a Charcot foot looks, which I know." Although Dr. Yodlowsky brought up the issue of a Charcot foot, that's not Dr. Frey's opinion. When Dr. Frey looks at the 3-D reconstruction, "it's very straightforward." Charcot foot is the destruction of the foot related to diabetes and other forms of neuropathy, and is the sequela of somebody walking on a foot after a minor injury, the foot becomes destroyed and collapses, "and you end up with a very destroyed joint. And that's Charcot, and that's not here at all." On August 31, 2011, Employee's glucose was 300, which was high; and his A1C was 11.4, which was also high. Dr. Frey explained A1C is not "spontaneous . . . [i]t takes a while to get to that level." She was "interested in" providers seeing hematoma and severe swelling on August 2, 2013, because it indicates an acute injury. Dr. Frey saw heterotopic bone formation on the 3-D reconstruction, mainly on the bottom of the foot, which was not new, but an indicator of either chronic trauma to the bottom of the foot, or perhaps calcification or heterotopic bone formation around the vascularity or other soft tissues. She remarked: "There's some inconsistencies [in Employee's reports], but the most consistent thing is that he reports an injury on 7-31-13. That is exactly how a Lisfrancs fracture dislocation occurs - stepping in a hole and the foot folding up…. Perfect description of how it occurs." Dr. Frey disagreed with Dr. Yodlowsky's opinion Employee could not stand or walk with a significant Lisfranc fracture unless he had significant neuropathy. She explained: "It was not like he was walking normal. He reports quite a bit of disability and increasing disability throughout that period of time." Employee was not symptom-free. He had immediate pain and a lot of swelling. It is not unusual to be able to walk on a Lisfranc fracture dislocation, and it is often misdiagnosed as a sprain of the foot, especially early on. "[T]he only reason he took so long and had to walk on it is that he was in a remote location, and there was apparently very bad weather conditions." Dr. Frey opined Employee's weight was not a substantial factor in his injury, but his diabetes was a substantial factor of his disability. The substantial cause of

Employee's injury was his stepping in a hole. Dr. Frey agreed Dr. Inampudi used a few words to describe bone, including "callus formation," in his report interpreting Employee's August 2, 2013 CT scan, but then stated:

> Having said that, the radiologist generally doesn't examine the patient or talk to the patient . . . or know the history of the patient. My feeling is that if he did, he would go with heterotropic new bone formation and not have suggested all the other words. . . . That happens. Not uncommonly.

When asked to comment on Dr. Caylor's opinion Employee's injury was between ten and fourteen days old, Dr. Frey answered:

> Given your theory they're right [Drs. Caylor, Inampudi and Yodlowsky], it's almost incomprehensible because you need to have trauma to have this kind of fracture pattern. And its usually pretty significant trauma. So you have to assume that he had some other trauma that he's just not telling you about. Or he didn't notice. Highly unusual. Unless he had very severe peripheral neuropathy, which has never been documented and never caused him a problem before. So, again, there's a lot of theories that are unproven to really explain that scenario. So I don't buy it. The most common thing and the most obvious thing is usually the right thing. He stepped in a hole, folded in half, fracture dislocation, Lisfrancs.

When asked to "square" her opinion with Dr. Caylor's opinion on the date of Employee's fracture, Dr. Frey replied:

> I don't square it, but I don't know where he gets that date, considering there's no injury 10 to 14 days prior. . . . I don't know where he got that timeframe. I think he's . . . looking at the report of the CT scan, and more and more and more weight is being put on the callus description . . . . I don't know where he got his date. . . . There's no carbon dating on a CT scan. Absolutely not. Hundred percent of orthopedists will say that.

Although "clearly not treatment," Dr. Frey thought an EMG would be helpful for Employee's future treatment plans. She also thought, if an EMG showed Employee did not have peripheral neuropathy, it "kind of clears up [Employer's] theory." Dr. Frey also explained peripheral neuropathy "doesn't appear overnight," but an EMG would not "carbon date it…. It won't really tell us where [Employee] was … at the time of injury." On cross examination, Dr. Frey testified Employee's mechanism of injury was "classic."

53) On February 18, 2015, Employee filed affidavits of attorney's fees, paralegal fees and costs, which show Employee's attorney worked for 8.47 hours at a rate $350 per hour for a total of $2,964.50, and 11.10 hours at a rate of $400 per hour for a total of $4,440. Employee's paralegal worked 31.18 hours at a rate of $150 per hour for a total of $4,677, and 11.56 hours at a rate of $175 per hour for a total of $2,023. Employee's total costs are as $302.66. The combined total of Employee's fees and costs are $14,407.16. (Employee affidavits, February 16, 2015).

54) As a preliminary matter at hearing, Employer stated it did not object to Employee's February 16, 2015 affidavits of attorney's and paralegal fees. (Record).

55) The parties agree the main issue in this case is whether Employee suffered a Lisfranc fracture dislocation as a result of stepping off the loader, as opined by the SIME physician, Dr. Frey; or whether Employee's midfoot injury was the result of a diabetic related condition called Charcot foot, as opined by EME physician, Dr. Yodlowsky. (Employee's Hearing Brief, February 16, 2015; Employer's Hearing Brief, February 17, 2015).

56) At hearing, Employee testified substantially similar to his deposition. He also testified to additional facts as follows: On July 31, 2013, Employee was hauling material from a stockpile to the beach in a 966 loader in order to build a ramp to receive the fuel barge. Cape Lisburne only receives a fuel delivery once per year, when the barge brings 200,000 gallons or more of fuel. The 966 loader weighs approximately 46,000 pounds, has a five and a quarter cubic yard bucket and the operator sits eight and one half to nine feet off the ground and uses a ladder on the side to get into the machine. Immediately prior to the injury, Employee backed away from a pile, put the brake on and opened the door. He has been taught to have three points of contact when exiting equipment. He thought he had stepped onto solid ground, but there was a hole and his foot folded up and to the right. Employee initially thought he had sprained his ankle. His ankle hurt a lot. He went to his room and elevated his foot and used ice. The next morning his foot was extremely swollen. In the past, Employee has had "no problems with his foot – period." He was diagnosed with type 2 diabetes in 2010 and has hypertension. The CORE Institute, where he treated for his foot, was "fully aware" of his diabetes. Employee's blood sugar was taken at CORE before surgery and by another doctor before CORE would do surgery. Employee had a long recovery, and later was determined to be fit for duty by Employer's occupational health service. However, he was called to jury duty in March 2014 and actually returned to work in

April 2014. Employee's foot "feels fine" and he has "no problems" with it. Sometimes he gets pain from standing long days on concrete. Employee has never had an EMG before. He stated: "Needles and electricity – I don't need that now." No treating physician has ever recommended he have an EMG. If a treating physician told Employee he needed an EMG, he would get one. On cross-examination, Employee testified he had received copies of both Dr. Yodlowsky's EME reports. He had also received a copy of Dr. Frey's SIME report. Employee has read "most of" Dr. Frey's deposition. Employee did not discuss Dr. Yodlowsky's first EME report with Dr. Jeppesen. He does not remember reading Dr. Yodlowsky's recommendations for electrodiagnostic testing. Employee does recall reading Dr. Frey's recommendations regarding future treatment. He does not see a pattern in the reports. Until a provider tells Employee he needs an EMG, "it isn't going to happen." On re-direct examination, Employee testified his recovery took a full seven months, which was longer than he had expected. PA Manning diagnosed Employee's diabetes and prescribed medications to treat his diabetes. PA Manning has never suggested an EMG. On re-cross, Employee testified Dr. Jeppesen did not suggest an EMG. (Lienard).

57) Employee is generally credible, but not credible when he testified the CORE Institute was "fully aware" of his diabetes. (Experience, observations facts of the case, and inferences drawn therefrom).

58) At hearing, Dr. Yodlowsky testified as follows: She reviewed the actual images from Employee's August 2, 2013 CT scan and noted changes in his foot that were a "classic presentation" of long-term Charcot foot. Charcot foot is a fragmentation of the bones in the anatomy and Employee's CT scan shows the bones have smooth borders, sclerosis or scarring and early callus formation, which is new bone. Such changes would take one month to six weeks to occur. When the foot fragments, it changes shape, the bones spread out and get less sharp and other bones try to "latch on." Dr. Yodlowsky sees some of Employee's bones are sharp, and some are rounded, on his August 2, 2013 x-rays. She also sees soft tissue calcification, which can be bones or calcium in an artery. When bones in the foot crumble, they fragment with every step a person takes. During this process, "plateaus" occur, and "little, acute events" happen on top of a chronic condition. Prior to her 2013 EME report, no medical records indicated to Dr. Yodlowsky Employee had diabetes, but she concluded Employee probably was diabetic. She thought it "essential" Employee be screened for underlying peripheral neuropathy

because it is a common complication of diabetes and would be important in making treatment decisions. Diagnostics for neuropathy include a history of patient reports of burning pain or numbness, physical examination involving feeling and touching, and the "gold standard" is electrodiagnostic studies. If electrodiagnostic studies show "there is no neuropathy, then there is no Charcot foot." Studies would rule out Charcot foot. In Dr. Yodlowsky's opinion, Employee's fracture occurred before July 31, 2013. She explained Employee's reported symptoms on July 31, 2013 as follows: It is not unusual for crumbling and fragmentation to occur in small amounts over time. The process is like a road or a bridge. When the structure collapses, the foot becomes hot, red and very swollen, and is often thought to be the result of an infection. When asked for her opinion on "the substantial cause" of Employee's need for treatment, Dr. Yodlowsky thought Employee's fracture was most consistent with a Charcot foot and a chronic fracture, and not by stepping down on the date of injury. Dr. Yodlowsky had additional records available to her for her June 14, 2014 EME that clarified Employee's diabetic condition. Medical records do not show Employee has had previous electrodiagnostic studies performed. Diabetes can dramatically increase the risk of surgery because it increases the risk of infection and increases the time it takes to heal. Diabetes also effects incision and hardware placement choices and increases the risk of surgery failing by having screws back out and hardware failing. Dr. Yodlowsky was "very surprised, to say the least," that Dr. Jeppesen's records did not mention Employee's diabetes. Dr. Frey reached a different conclusion in her report than Dr. Yodlowsky "to some extent." Dr. Frey describes Employee's injury the same way as Dr. Yodlowsky, then to Dr. Yodlowsky's "surprise," Dr. Frey concludes Employee does not have a Charcot foot. Dr. Yodlowsky identified several "substantial factors" for Employee's need for treatment including diabetes and possible neuropathy. She noted both she and Dr. Frey found decreased sensation in Employee's foot upon physical examination. Employee's weight was also a substantial factor, which increased the amount of force on Employee's foot. Stepping in the hole on the date of injury was also another substantial factor, and she added, even just walking could have been a substantial factor. Of these substantial factors, Employee's diabetes and possible neuropathy is "the substantial cause" of his need for treatment. On cross-examination, Dr. Yodlowsky acknowledged she presumes Employee to have a Charcot foot. If Employee did not have Charcot foot, walking would not be a substantial factor in his need for medical treatment. If Employee did not have a Charcot foot, his weight would not likely be a

substantial factor, but a stress fracture would still be possible. Dr. Yodlowsky did not review any pre-injury x-rays. The medical records prior to the injury do not mention neuropathy, fractures or a swollen right foot. Regarding Employee's weight, Dr. Yodlowsky does not think employers have to only hire thin people, but "if they take that risk, it's up to them." Employer already knew Employee was at risk of a stress fracture because of his weight. Stepping off a ladder could cause a Lisfranc fracture and is a "fairly common way" one occurs. Dr. Jeppesen did comment on Employee being "non-neuropathic" in his letters, but he also stated Employee would not be able to walk on his fractures. Dr. Yodlowsky finds Dr. Jeppesen's statements confusing. Dr. Yodlowsky disagrees with Dr. Frey's opinion Employee fractured his foot on July 31, 2013, but rather thinks Employee had a preexisting Charcot foot. Nobody really knows how severe a person's neuropathy must be for them to have a Charcot foot. On re-direct, Dr. Yodlowsky testified the July 31, 2013 injury did not cause the fractures seen on Employee's August 2, 2013 imaging studies. Employee clearly has dislocation and bony abnormalities before the injury. In response to panel questions, Dr. Yodlowsky opined Employee might not have had swelling prior to the injury because Charcot foot is a gradual process. In response to a question whether Employee's injury could have irritated his condition or caused it to have flared up, she explained Employee's foot was already disintegrating and it was "just a matter of time," whether Employee stepped in a hole or stepped on a curb, which is also a common cause for midfoot fracture. Dr. Yodlowsky does not doubt Employee's fracture could have happened at the time of injury, but emphasized he kept working. She explained 3-D CT scan images are computer reformatted and thinks calcification shows up far better in "individual cuts." Dr. Yodlowsky disagrees with Dr. Frey opinion Employee's CT scan shows he has calcification in a blood vessel. Dr. Yodlowsky sees calcification in Employee's bone. A person with a Charcot foot can injure it stepping out of a car or off a curb, which could "put it over the threshold." Dr. Yodlowsky thinks Employee's records show it is harder to reconstruct a Charcot foot, and it can take longer to heal, because they indicate a screw backing out and drainage, redness and his wound pulling apart. They also show Dr. Jeppesen was worried about a non-union and prescribed Employee a bone stimulator at that point. On re-direct, Dr. Yodlowsky thought Dr. Frey's SIME report, which noted one of Employee's bones had not fused, indicated a slowing down of the healing process. Because Employee's bone did not heal indicates Employee has neuropathy and he just can't feel his bone is not healed. On re-cross, Dr. Yodlowsky testified it

is unusual for bones to take one year to 18 months to heal; usually they heal in six months. (Yodlowsky).

59) Dr. Yodlowsky is credible. (Experience, observations facts of the case, and inferences drawn therefrom).

60) Employee seeks a finding his July 31, 2013 injury is compensable and an order for Employer to pay compensation, medical costs and attorney's fees. (Employee's Hearing Brief, February 16, 2015).

61) Employer submitted Alaska Civil Pattern Jury Instruction 02.23, *Closing Instructions – Failure to Present Evidence,* as an exhibit to its hearing brief. The instruction reads:

> The evidence should be evaluated not only by its own intrinsic weight but also according to the evidence which is in the power of one party to produce and the other party to contradict. If weaker and less satisfactory evidence is offered when it appears that stronger and more satisfactory evidence was within the power of one party to produce, the evidence offered should be viewed with caution.

The instruction also contains a "Use Note," which states:

> Alaska R. Civ. P. 51(b)(4) requires such an instruction 'on <u>all</u> proper occasions.' This instruction could be given if it appears that a party held back non-privileged evidence which was available and which might have been better evidence than the evidence than the evidence that was presented.

(Employer Hearing Brief, Ex. 13, February 17, 2015) (emphasis in original instruction).

62) During closing arguments at hearing, Employer argued in support of its request for the panel to weigh Employee's decision not to undergo invasive testing against him during the presumption analysis. It contended this is a "knotty case," and further contended there is "only one person who has a key to that knot." Employer also contended: "There is one person who could have saved us all this time today." Employer was clearly frustrated with Employee's decision not to undergo EMG testing and the lack of electrodiagnostic test results in the record. (Record, experience, observations, facts of the case and inferences drawn therefrom).

63) On March 19, 2015, Employee filed supplemental affidavits of attorney fees, paralegal fees and costs, which show Employee's attorney worked for 8.47 hours at a rate $350 per hour for a total of $2,964.50, and 29.14 hours at a rate of $400 per hour for a total of $11,656. Employee's

paralegal worked 31.18 hours at a rate of $150 per hour for a total of $4,677, and 13.18 hours at a rate of $175 per hour for a total of $2,306.50. Employee's total costs are as $1,197.41. The combined total of Employee's fees and costs are $22,801.41. (Employee affidavits, March 16, 2015).

64) Employee's counsel is an experienced litigator and has represented injured employees in workers' compensation cases for many years. (Experience).

65) Employer has not filed any objections to Employee's March 16, 2015 affidavits of attorney's and paralegal fees. (Record).

PRINCIPLES OF LAW

The board may base its decision not only on direct testimony, medical findings, and other tangible evidence, but also on the board's "experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987).

> **AS 23.30.001. Intent of the legislature and construction of chapter.** It is the intent of the legislature that
>
> (1) This chapter be interpreted . . . to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to . . . employers . . . .
>
> **AS 23.30.010. Coverage**. Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability . . . or the need for medical treatment of an Employee if the disability . . . 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 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 the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the . . . 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 . . . 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 the need for medical treatment. Compensation or benefits under this chapter are payable for the disability . . . or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability . . . or need for medical treatment. . . .

Compensation or benefits are owed under AS 23.30.010 if employment was "the substantial cause" in bringing about the disability or need for medical treatment. A preexisting disease or infirmity does not disqualify a claim if employment aggravated, accelerated, or combined with disease or infirmity to produce death or disability. *Thornton v. Alaska Workers' Compensation Board*, 411 P.2d 209; 210 (Alaska 1966) (applied under the current AS 23.30.010 in *City and Borough of Juneau v. Olsen*, AWCAC Decision No. 185 (August 21, 2013) at 15-16).

An aggravation of a preexisting condition occurs when a job worsens an employee's symptoms such that she can no longer perform her job functions, even when the job does not worsen the underlying condition. *Hester v. State, Public Employee's Retirement Board*, 817 P.2d 472; 476 (Alaska 1991). For an employee to establish an aggravation claim, the employment need only have been the substantial factor in bringing about the disability. *Olsen* at 17-18 (*citing DeYonge v. NANA/Marriott*, 1 P. 3d 90 (Alaska 2000)). Whether employment is the substantial cause of the need for medical treatment requires an evaluation of the relative contributions of the employment and the preexisting condition. *Id.* Aggravation of a preexisting condition may be found absent any specific traumatic event. *Providence Washington Insurance v. Banner*, 680 P.2d 96; 99 (Alaska 1984). To prove a work injury combined with a preexisting condition to produce a disability, the employee must show: 1) the disability would not have happened "but for" an injury sustained during the course and scope of employment; and 2) reasonable persons would regard the injury as the cause of the disability and attach responsibility to it. *Thurston v. Guys With Tools*, 217 P.3d 824; 828 (Alaska 2009) (applied under the current AS 23.30.010 in *Olsen* at 18).

> **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 . . . .

"The text of AS 23.30.120(a)(1) indicates that the presumption of compensability is applicable to *any* claim for compensation under the workers' compensation statute." *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996) (emphasis in original). Therefore, an injured worker is afforded a presumption all the benefits she seeks are compensable. *Id.* Medical benefits including continuing

care are covered by the AS 23.30.120(a) presumption of compensability. *Municipality of Anchorage v. Carter*, 818 P.2d 661, 664-65 (Alaska 1991). The Alaska Supreme Court in *Sokolowski v. Best Western Golden Lion*, 813 P.2d 286, 292 (Alaska 1991) held a claimant "is entitled to the presumption of compensability as to each evidentiary question." A finding reasonable persons would find employment was a cause of the employee's disability and impose liability is, "as are all subjective determinations, the most difficult to support." *Rogers & Babler*, 533-34. However, there is also no reason to suppose Board members who so find are either irrational or arbitrary. *Id.* at 534. That "some reasonable persons may disagree with a subjective conclusion does not necessarily make that conclusion unreasonable." *Id*.

The presumption's application involves a three-step analysis. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381 (Alaska 1991). First, Employee must establish a "preliminary link" between the "claim" and her employment. In less complex cases, lay evidence may be sufficiently probative to make the link. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Whether or not medical evidence is required depends on the probative value of available lay evidence and the complexity of the medical facts involved. *Id.* Employee need only adduce "some," minimal relevant evidence (*Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987)) establishing a "preliminary link" between the "claim" and the employment. *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). The witnesses' credibility is of no concern in this first step. *Excursion Inlet Packing Co. v. Ugale*, 92 P.3d 413, 417 (Alaska 2004).

Second, in claims arising after November 7, 2005, employment must be the substantial cause of the disability or need for medical treatment. AS 23.30.010(a). In *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 (March 25, 2011), the Alaska Workers' Compensation Appeals Commission (commission) set out how to apply the presumption analysis for claims arising after November 5, 2005. An employer can rebut the presumption with substantial evidence a cause other than employment played a greater role is causing the disability and is not required to rule out employment as a factor in causing the disability. *Id.* at 7. "If the employer rebuts the presumption, it drops out, and the employee must prove, by a preponderance of the evidence, that in relation to

other causes, employment was the substantial cause of the disability, need for medical treatment, etc. Should the employee meet this burden, compensation or benefits are payable." *Id.* at 8.

"Substantial evidence" is the amount of relevant evidence a reasonable mind might accept as adequate to support a conclusion. *Miller v. ITT Arctic Services*, 577 P.2d 1044, 1046 (Alaska 1978). Employer's evidence is viewed in isolation, without regard to Employee's evidence. *Id.* at 1055. Therefore, credibility questions and weight accorded Employer's evidence are deferred until after it is decided if Employer produced a sufficient quantum of evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Compensation Board*, 880 P.2d 1051, 1054 (Alaska 1994); *citing Big K Grocery v. Gibson*, 836 P.2d 941 (Alaska 1992).

If an employer produces substantial evidence work is not the substantial cause, the presumption drops out and the employee must prove all elements of the "claim" by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1381 (*citing Miller v. ITT Services,* 577 P 2d. 1044, 1046). The party with the burden of proving asserted facts by a preponderance of the evidence must "induce a belief" in the fact-finders' minds the asserted facts are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

> **AS 23.30.122. Credibility of witnesses**. The board has the sole power to determine the credibility of a witness. A finding by the board concerning the weight to be accorded a witness's testimony, including medical testimony and reports, is conclusive even if the evidence is conflicting or susceptible to contrary conclusions. The findings of the board are subject to the same standard of review as a jury's finding in a civil action.

The legislative history of AS 23.30.122 states the intent was "to restore to the Board the decision making power granted by the Legislature when it enacted the Alaska Workers' Compensation Act." *De Rosario v. Chenega Lodging*, 297 P.3d 139, 146 (Alaska 2013). The Alaska Workers' Compensation Appeals Commission is required to accept the board's credibility determinations. *Id.* The Alaska Supreme Court defers to board's credibility determinations. *Id.* If the board is faced with two or more conflicting medical opinions, each of which constitutes substantial evidence, it may rely on one opinion and not the other. *Id.* at 147. The board may choose not to rely on its own expert. *Id.*

In *Rockstad v. Chugach Eareckson Support Services*, AWCAC Decision No. 140 (November 5, 2010), the Appeals Commission upheld the board's denial of the employee's claim, finding the board had properly discounted the weight of the employee's treating physicians' reports, as they were based on the employee's inaccurately reported history and symptoms. The board panel had noted, "While [the employee's treating physicians] are all fine doctors in their fields and well meaning, in this case, their opinions are no more reliable than the false or exaggerated information provided them by an untruthful reporter." *Id*.

> **AS 23.30.135. Procedure before the board.** (a) In making an investigation or inquiry or conducting a hearing the board is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by this chapter. The board may make its investigation or inquiry or conduct its hearing in the manner by which it may best ascertain the rights of the parties. . . .
>
> **AS 23.30.145. Attorney fees**. (a) Fees for legal services rendered in respect to a claim are not valid unless approved by the board, and the fees may not be less than 25 percent on the first $1,000 of compensation or part of the first $1,000 of compensation, and 10 percent of all sums in excess of $1,000 of compensation. When the board advises that a claim has been controverted, in whole or in part, the board may direct that the fees for legal services be paid by the employer or carrier in addition to compensation awarded; the fees may be allowed only on the amount of compensation controverted and awarded. . . .
>
> (b) If an employer fails to file timely notice of controversy or fails to pay compensation or medical and related benefits within 15 days after it becomes due or otherwise resists the payment of compensation or medical and related benefits and if the claimant has employed an attorney in the successful prosecution of the claim, the board shall make an award to reimburse the claimant for the costs in the proceedings, including a reasonable attorney fee. The award is in addition to the compensation or medical and related benefits ordered.

In *Harnish Group, Inc. v. Moore*, 160 P.3d 146 (Alaska 2007), the Alaska Supreme Court discussed how and under which statute attorney's fees may be awarded in workers' compensation cases. A controversion, actual or in-fact, is required for the board to award fees under AS 23.30.145(a). "In order for an employer to be liable for attorney's fees under AS 23.30.145(a), it must take some action in opposition to the employee's claim after the claim is filed." *Id*. at 152. Fees may be awarded under AS 23.30.145(b) when an employer "resists"

payment of compensation and an attorney is successful in the prosecution of the employee's claims. *Id*. In this latter scenario, reasonable fees may be awarded. *Id.* at 152-153.

In *Wise Mechanical Contractors v. Bignell*, 718 P.2d 971, 974-975 (Alaska 1986), the Court held attorney's fees awarded by the board should be reasonable and fully compensatory. Recognizing attorneys only receive fee awards when they prevail on the merits of a claim, the contingent nature of workers' compensation cases should be considered to ensure competent counsel is available to represent injured workers. *Id*. The nature, length, and complexity of services performed, the resistance of the employer, and the benefits resulting from the services obtained, are also considerations when determining reasonable attorney's fees for the successful prosecution of a claim. *Id*. at 973, 975.

When an employee files a claim to recover controverted benefits, subsequent payments, though voluntary, are the equivalent of a board award, and attorney's fees may be awarded where the efforts of counsel were instrumental in inducing the payments. *Childs v. Copper Valley Elect. Ass'n.*, 860 P.2d 1184; 1190 (Alaska 1993).

The statute at AS 23.30.145(a) establishes a minimum fee, but not a maximum fee. *Lewis-Walunga v. Municipality of Anchorage*, AWCAC Decision No. 123 (December 28, 2009) at 5. A fee award under AS 23.30.145(a), if in excess of the statutory minimum fee, requires the board to consider the "nature, length, and complexity of the services performed, transportation charges, and the benefits resulting from the services to the compensation beneficiaries." *Id.*

ANALYSIS

1) Should Employee's decision not to undergo invasive diagnostic testing be considered when analyzing the compensability of his claim?

Even though Employer acknowledges Employee cannot be compelled to undergo invasive diagnostic testing, it contends Employee has a "duty" to prove his claim by a preponderance of the evidence at the third step of the presumptions analysis, and since he has decided not to undergo testing, Employee's decision to forego this testing should be weighed against him when deciding the compensability of his claim. Employer's proposition is rejected for the following

reasons: First, Employer does not cite to any decisional authority in support of its request, and none is immediately known. Second, neither does it cite to any applicable statutory or regulatory authority in support of its request. Instead, Employer submits an Alaska Civil Pattern Jury Instruction in support of its contention, but that instruction need not apply to this proceeding. AS 23.30.135(a). Third, as Employee contends, the instruction is inapplicable on its face because Employee has not "held back" "available evidence."

Nevertheless, this decision does make some ancillary observations regarding the available evidence in this case. Employer was clearly frustrated with Employee's decision not to undergo EMG testing and the lack of electrodiagnostic test results in the record. Its frustration is not entirely without basis. As will be addressed further below, Dr. Yodlowsky testified she was "very surprised, to say the least," when she saw Dr. Jeppesen's reports did not mention Employee's diabetes. Not only does an independent review of the record confirm Dr. Yodlowsky's testimony in this regard, but it also shows records from the Mat-Su Regional Medical Center, Dr. Curtis, and Dr. Caylor did not document Employee's diabetes or list his diabetes medications. From these facts, one might well infer Employee withheld information about his diabetes from these providers following his injury. This inference, when combined with Employee's continuing reluctance to undergo EMG testing, could create a further inference that Employee either knew, or suspected, he has diabetes-related peripheral neuropathy or a Charcot foot.

2) Is Employee's July 31, 2013 compensable?

This is a factual question involving a benefit under the Act to which the presumption of compensability applies. AS 23.30.120; *Meek*. Employee raises the presumption of compensability with numerous documents, including Dr. Jeppesen's August 12, 2013 Physician's Report, his August 14, 2013 work status report, and his November 27, 2013 letter; as well as Dr. Frey's June 10, 2014 SIME report, and her January 15, 2015 deposition; all of which indicate Employee's need for treatment arose from the July 31, 2013 industrial injury. *Wolfer*. Employer similarly rebuts the presumption with numerous documents, including Dr. Caylor's August 16, 2013 report and responses, as well as Dr. Yodlowsky's September 4, 2013 and June 9, 2014 EME reports, which indicate Employee's need for treatment was due to a preexisting condition. *Miller*. Employee is

required to prove by a preponderance of the evidence the July 31, 2013 work injury is "the substantial cause" of his disability and need for medical treatment. *Koons.*

The parties agree the specific issue to be decided is whether Employee suffered a Lisfranc fracture dislocation as a result of stepping off the loader, as opined by the SIME physician, Dr. Frey; or whether Employee's midfoot injury resulted from a diabetes-related condition called Charcot foot, as opined by EME physician, Dr. Yodlowsky. In addition to Dr. Frey, Employee also relies on the opinion of his treating physician, Dr. Jeppesen, who opines Employee's fractures were work-related and occurred on the date of injury, not before. In addition to Dr. Yodlowsky, Employer also relies on two other medical opinions to support of its theory of the case. On August 2, 2014, Dr. Inampudi, a radiologist, interpreted Employee's CT scan to show indistinct margins, early callus formation, and heterotopic new bone formation. From these observations, Dr. Inampudi concluded Employee's extensive midfoot injury was "clearly subacute." Another physician, Dr. Caylor, who initially evaluated Employee following the injury, interpreted the Employee's August 2, 2013 imaging study to show "some callus formation" and "soft tissue present." He concluded these observations were consistent with a "subacute injury" that had occurred at least 10 to 14 days prior to the study. The evidentiary analysis will begin with Drs. Inampudi's and Caylor's opinions.

At her deposition, Dr. Frey testified "callus" and "heterotopic" calcification are "pretty distinct" terms of art. Callus is bone that forms in reaction to a fracture, while heterotopic refers to ossification of tissue outside the bone, like muscle, tendon and surrounding soft tissues. When questioned about Dr. Inampudi's use of both terms in his August 2, 2013 report, Dr. Frey pointed out radiologists generally do not examine patients, talk to patients, or know a patient's history. This also appears to have been the case with Employee. From the record, it appears Dr. Inampudi merely provided an interpretation of Employee's August 2, 2013 CT scan, and nothing more. For these reasons, Dr. Inampudi's report is afforded little weight in the evidentiary analysis.

Dr. Caylor's August 5, 2013 evaluation did involve an examination and conversation with Employee. After recording Employee's history of his present illness, which included a description of the mechanism of injury, Dr. Caylor reviewed Employee's August 2, 2013 imaging studies and concluded they showed a "variant of a Lisfranc fracture dislocation." Notably absent from Dr.

Caylor's August 5, 2013 report is any mention of callus formation in Employee's imaging studies. Next, three days later, Employer controverted based on Dr. Inampudi's opinion Employee's CT scan showed callus formation. Then, little more than a week after that, Employer's nurse case manager, who had "a question about the timing of [Employee's] injury," met with Dr. Caylor. At this point, when presented with Dr. Inampudi's report, and after looking at Employee's CT scan a second time, Dr. Caylor concluded "in retrospect" he did observe callus formation in the study, which then caused him to also conclude Employee's injury was "subacute" and had occurred some 10 to 14 days prior to the study. Dr. Caylor then signed a letter, which had been prepared in advance by Employer's nurse case manager, indicating the July 31, 2013 work injury was not the substantial cause of Employee's foot fractures.

Again, Dr. Frey's deposition testimony is insightful. When she was asked to "square" her opinion with Dr. Caylor's, she answered: "I don't square it …. I think he's … looking at the report of the CT scan, and more and more and more weight is being put on the callus description …." The surrounding facts support Dr. Frey's assessment of Dr. Caylor's emerging opinion on what Employee's CT scan shows. At the urging of Employer's nurse case manager, Dr. Caylor did place increased weight Dr. Inampudi's description of callus, which resulted in a significant modification of his August 5, 2013 opinions. For these reasons, Dr. Caylor's August 16, 2013 opinions are afforded little weight.

Of the remaining medical opinions in this case, Dr. Yodlowsky's, Dr. Frey's, and Dr. Jeppesen's, all appear to be firmly held. At hearing, Dr. Yodlowsky testified Employee's August 2, 2013 CT scan shows bone with smooth borders, sclerosis and early callus formation, which she opined was a "classic presentation" of a long-term Charcot foot. During her deposition, Dr. Frey disagreed and testified what appears as callus formation to Dr. Yodlowsky, is actually either calcification of Employee's vascularity resulting from his diabetes, or heterotopic new bone resulting from "wear and tear to the bottom of the foot in a 400 pound man." According to Dr. Frey, the CT scan is "very straightforward" and shows a "textbook" Lisfranc fracture dislocation. Meanwhile, Dr. Jeppesen decidedly wrote Employee's fracture was "completely inconsistent" with a subacute injury.

Given Dr. Jeppesen was Employee's treating physician, his opinion would initially be afforded considerable weight in this analysis. However, as Dr. Yodlowsky points out, there is an area of concern. Dr. Yodlowsky credibly testified at hearing about diabetes increasing the risk of surgery. It can increase the risk of infection, increase healing time and increase the chances of hardware failure, such as screws backing out. Yet, just as Dr. Yodlowsky contended, Dr. Jeppesen's reports do not evidence he was aware of Employee's diabetes. Although Employee testified Dr. Jeppesen was "fully aware" of his diabetes, he is not credible in this regard. Given the importance of this information on decisions affecting surgery such as incision and hardware placement, one would expect to see Employee's diabetes documented in Dr. Jeppesen's reports. Since it appears Dr. Jeppesen was unaware of Employee's diabetes, and since it also appears he did not review all the available medical records as Drs. Yodlowsky and Frey did, his opinion is less reliable than Dr. Yoldlowsky's and Dr. Frey's, and is therefore afforded little weight. *Rockstad.*

As to the remaining opinions between Dr. Yodlowsky and Dr. Frey, in her September 4, 2013 report, Dr. Yodlowsky hypothesized Employee "may" have a Charcot foot, which "could" have been secondary to a chronic condition such as diabetes, but the time of her report, the cause of Employee's Lisfranc fracture dislocation and fragmentation was still "unknown." Given that certain critical evidence, such as Employee's pre-injury medical record, was not available to Dr. Yodlowsky at the time of her September 4, 2013 records review, it might initially seem she was being appropriately cautious with her opinions. However, in her later report on June 9, 2014, when Employee's entire medical record was available to her, Dr. Yodlowsky's stated opinions continued to be Employee's CT scan "may" represent a Charcot foot, which coupled with Employee's ability to walk on his foot following the injury, "suggest" he has diabetic neuropathy. In the final analysis, one cannot ignore the speculative nature of Dr. Yodlowsky's opinions. Even at hearing, Dr. Yodlowsky candidly acknowledged she continues to *presume* Employee has a Charcot foot.

Although there is some evidence to lend inferential support to Dr. Yodlowsky's theory Employee has a Charcot foot, such as Employee's elevated A1C levels at the time of his diabetes diagnosis, Dr. Jeppesen's October 7, 2013 x-ray that shows one of the screws backing out, and Dr. Frey's June 10, 2014 x-rays that show no obvious fusion at Employee's first metatarsal cuneiform articulation, when viewed in light of the entire record, Dr. Yodlowsky's opinion remains a theory

in search of greater evidence. This conclusion is also supported by Employer's obvious frustration over the lack of electrodiagnostic testing in the medical record and its contention this lack of evidence should now somehow be factored against Employee at this stage of the analysis. Dr. Frey also commented on the speculative nature of Dr. Yodlowsky's and Employer's theory during her deposition:

> Given [Employer's] theory they're right [Drs. Caylor, Inampudi and Yodlowsky], it's almost incomprehensible because you need to have trauma to have this kind of fracture pattern. And its usually pretty significant trauma. So you have to assume that he had some other trauma that he's just not telling you about. Or he didn't notice. Highly unusual. Unless he had very severe peripheral neuropathy, which has never been documented and never caused him a problem before. So, again, there's a lot of theories that are unproven to really explain that scenario. So I don't buy it. The most common thing and the most obvious thing is usually the right thing. He stepped in a hole, folded in half, fracture dislocation, Lisfrancs.

As Dr. Frey repeatedly points out in her reports and deposition testimony, there simply is no documented evidence in Employee's considerable pre-injury medical record of preexisting fracture, dislocation, foot complaints, peripheral neuropathy or Charcot foot while he underwent treatment for obesity, lipid disorder and diabetes.

Between the competing opinions of Drs. Yodlowsky and Frey, Dr. Frey's is better supported by evidence in the existing record. Chief among this evidence is the mechanism of injury itself, which Dr. Frey mentioned above. Employee reported stepping off the loader's ladder into a hole, and twisting his right ankle. Dr. Frey wrote, "[t]hat is exactly how a Lisfranc fracture dislocation occurs – stepping into a hole and the foot folding up. . . . Perfect description of how it occurs." Her opinion also comports with the OrthoInfo fact sheet published by the American Academy of Orthopaedic Surgeons, which describes the mechanism of injury as a "straightforward twist and fall," or resulting from a fall from a height, and even comports to a lesser extent with Dr. Yodlowsky, who identified Employee stepping in a hole as "a substantial factor" of Employee's need for treatment at hearing, and who further acknowledged stepping off a ladder is a "fairly common way" a Lisfranc fracture dislocation occurs. Furthermore, Dr. Yodlowsky does not doubt Employee's fracture could have happened at the time of injury.

Dr. Yodlowsky also places great emphasis on Employee's ability to walk on his fractures following the injury, which according to her, demonstrates Employee has peripheral neuropathy. However, Dr. Frey testified it is not unusual to be able to walk on a Lisfranc fracture dislocation and explained these injuries are often misdiagnosed as foot sprains. Here again, her opinion comparts with the OrthoInfo Fact Sheet, which states: "A Lisfranc injury is often mistaken as a simple sprain. . . . However, injury to the Lisfranc joint is not simple sprain that should simply be "walked off." Even after discounting Dr. Jeppesen's opinions, a preponderance of the evidence shows it is not unusual for a person to be able to walk with a Lisfranc injury.

Moreover, Employee's job duties clearly required appreciable physical activity. Even though both Dr. Yodlowsky and Dr. Frey reported Employee had decreased sensation in his foot upon physical examination, neither reported Employee's foot to be entirely numb. It is difficult to imagine Employee continuing to work for one or two weeks with numerous preexisting fractures in his foot. Furthermore, Employee's post-injury swelling is well documented throughout the record and he reported to Dr. Yodlowsky his foot was so swollen the day after the injury he had to cut his boot to get it on. This fact is not insignificant. Neither was it insignificant to Dr. Frey, who found documentation of severe swelling by a number of Employee's providers "interesting" because it indicates an acute injury.

Ultimately, Dr. Yodlowsky's opinion Employee has a Charcot foot stands alone in the record. When Employee was first evaluated at the Mat-Su Regional Medical Center, x-rays were consistent with multiple midfoot fractures and a CT scan was ordered because a Lisfranc dislocation was suspected. Next, at Providence Medical Center, Dr. Curtis, who had the benefit of Dr. Inampudi's CT scan interpretation, nevertheless diagnosed Lisfrancs sprain and *traumatic* fracture with *heterotopic new bone*, not callus formation, along the plantar aspect. Even Dr. Caylor initially diagnosed "a variant of Lisfranc fracture dislocation" before he revised his opinion. Dr. Jeppesen diagnosed a work-related Lisfranc fracture dislocation, as did the board's independent medical evaluator, Dr. Frey.

Not only is Dr. Frey's opinion best supported by the evidence in this case, it is also recognized as the most likely explanation of Employee's need for treatment. *Saxton.* As she aptly said: "The

most common thing and the most obvious thing is usually the right thing. He stepped in a hole, folded in half, fracture dislocation, Lisfrancs." This decision again agrees; and as a result, Employee's July 31, 2013 work injury is compensable. *Runstrum*.

As a concluding note, since it has not been established Employee has peripheral neuropathy or a Charcot foot, it is not necessary to consider whether Employee's July 31, 2013 work injury aggravated, accelerated or combined with a preexisting condition to produce his disability or need for medical treatment.

3) Is Employee entitled to an award of attorney's fees and costs?

Employee seeks an award of attorney's fees and costs. Here, Employer resisted paying compensation by controverting and litigating benefits. Employee retained counsel, who has successfully litigated the compensability of Employee's claim and made valuable benefits, such as indemnity and medical benefits, available to him. Thus, Employee is entitled to reasonable attorney's fee and costs under AS 23.30.145(b).

In making attorney's fee awards, the law requires consideration of the nature, length and complexity of the professional services performed on the employee's behalf, and the benefits resulting from those services. An award of attorney fees and costs must reflect the contingent nature of workers' compensation proceedings, and fully but reasonably compensate attorneys, commensurate with their experience, for services performed on issues for which the employee prevails. *Bignell*.

Employee's counsel is an experienced litigator and has represented injured employees in workers' compensation cases for many years. Employer controverted benefits and continued to deny them throughout litigation, which necessitated a hearing on the merits of Employee's case. Litigation in this case has involved complex issues, which necessitated the taking of depositions and a SIME. Additionally, given the conflicting medical opinions in this case, the final outcome of litigation was not certain.

Employee's counsel provided affidavits of attorney's fees and costs, which show he worked for 8.47 hours at a rate $350 per hour for a total of $2,964.50, and 29.14 hours at a rate of $400 per hour for a total of $11,656. Employee's paralegal worked 31.18 hours at a rate of $150 per hour for a total of $4,677, and 13.18 hours at a rate of $175 per hour for a total of $2,306.50. Employee's total costs are as $1,197.41. Employer has not objected to these fees. Employee is therefore entitled fees and costs in an amount of $22,801.41.

CONCLUSIONS OF LAW

1) Employee's decision not to undergo invasive diagnostic testing should not be considered when analyzing the compensability of his claim.

2) Employee's July 31, 2013 injury is compensable.

3) Employee is entitled to $22,801.41 in attorney's fees and costs.

ORDER

1) Employer shall provide Employee with compensation and medical benefits in accordance with in the Alaska Workers' Compensation Act.

2) Employer shall pay attorney's fees and costs in the amount set forth above.

Dated in Fairbanks, Alaska on April 23, 2015.

ALASKA WORKERS' COMPENSATION BOARD

/s/_____
Robert Vollmer, Designated Chair

/s/_____
Lake Williams, Member from Labor

SARA LEFEBVRE, MEMBER FROM INDUSTRY, CONCURRING

The concurrence agrees with the majority's conclusions on each of the three issues: Employee's decision not to undergo invasive diagnostic testing should not be considered when analyzing the compensability of his claim; Employee's July 31, 2013 injury is compensable; and Employee is entitled to his claimed amount of attorney's fees and costs. However, it sets forth a separate opinion to distinguish its analysis of one of the medical opinions in the case; to further emphasize evidentiary observations made by the majority; and to clarify Dr. Yodlowsky's hearing testimony.

First, the majority affords Dr. Caylor's August 16, 2013 opinions, where he concludes Employees' August 2, 2013 CT scan shows a subacute injury that had occurred 10 to 14 days prior to the study, less weight in its evidentiary analysis because these opinions were not included in his initial August 5, 2013 report. Without knowing specifically what additional information Employer's nurse case manager called to Dr. Caylor's attention on August 16, 2013 that was not available to him on August 5, 2013, the concurrence would not afford his opinion less weight on that same basis. Although the concurrence agrees Dr. Caylor's August 16, 2013 opinions should be afforded less weight than Drs. Yodlowsky's and Frey's, the more proper basis for that conclusion is because Dr. Caylor did not review all the available medical records as Drs. Yodlowsky and Frey did.

Second, the majority notes Employee's preexisting diabetes and his diabetes medication does not appear in the post-injury medical records of numerous providers. It then goes on to point out these observations, along with Employee's ongoing reluctance to undergo EMG testing, could create an inference Employee either knew, or suspected, he has diabetes-related peripheral neuropathy or a Charcot foot. The concurrence wishes to reinforce the majorities observations in this regard, and to further emphasize the inferences created might well be true. However, as the majority correctly

points out, there is simply no documented evidence of preexisting fracture dislocation, foot complaints, peripheral neuropathy or a Charcot foot in the medical record. Therefore, the concurrence must also, reluctantly, conclude Employee's work injury was the substantial cause of his need for medical treatment.

Finally, the concurrence wishes to offer a point of clarification on Dr. Yodlowsky's hearing testimony. She made clear a Charcot foot and a Lisfranc fracture dislocation are not necessarily mutually exclusive conditions. "Lisfranc" is simply a descriptive term referring to the midfoot joint. Thus, a person whose bones are crumbling as a result of a Charcot foot can also suffer a fracture dislocation at the Lisfranc joint. Although there is insufficient evidence to prove Employer's alternative theory of causation in this case, the concurrence still recognizes the possibility Employee could have had a Charcot foot, which might have been the substantial cause of his Lisfranc fracture.

/s/_____
Sarah Lefebvre, Member

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

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

APPEAL PROCEDURES

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

An appeal may be initiated by filing with the office of the Appeals Commission: 1) a signed notice of appeal specifying the board order appealed from and 2) a statement of the grounds upon which the appeal is taken. A cross-appeal may be initiated by filing with the office of the

Appeals Commission a signed notice of cross-appeal within 30 days after the board decision is filed or within 15 days after service of a notice of appeal, whichever is later. The notice of cross-appeal shall specify the board order appealed from and the ground upon which the cross-appeal is taken. AS 23.30.128.

RECONSIDERATION

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

MODIFICATION

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

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of JESSE LEINARD, employee / claimant; v. ARCTEC ALASKA, employer; ARCTIC SLOPE REGIONAL CORP., insurer / defendants; Case No. 201320694; dated and filed in the Alaska Workers' Compensation Board's office in Fairbanks, Alaska, and served on the parties on April 23, 2015.

/s/_____
Darren Lawson, Office Assistant II